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VOLUME 1 OF 2

STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

Appeal from Charleston County
Stephanie P. McDonald, Circuit Court Judge

Appellate Case No. 2014-002129

Indictment No. 2012-GS-10-6844-06845, 06846

RECEIVED
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SC Court of Appeals

STATE OF SOUTH CAROLINA, **Appellant,**

v.

MARVIN REGINALD BROWN

Respondent.

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INDEX

INDEX i

MARCH 26, 2013 TRANSCRIPT 1

Testimony

i. Jerome Fleming 8
ii. David Allen Brunson, Jr. 45
iii. Dendria Brunson 57
iv. Desmonte Goodwin 59

DECEMBER 10, 2013 TRANSCRIPT 102

MOTION TO SUPPRESS HEARSAY TESTIMONY OF VICTIM (MARCH 13, 2013) 117

MEMO IN SUPPORT OF MOTION TO SUPPRESS HEARSAY TESTIMONY (MARCH 25, 2013) 118

SOURCE CITATIONS IN RESPONSE TO DEFENSE MOTION TO SUPPRESS STATEMENT 131

ORDER GRANTING DEFENDANT'S MOTION TO EXCLUDE HEARSAY TESTIMONY OF DEFENDANT'S IDENTIFICATION (AUGUST 18, 2014) 135

AUTOPSY REPORT 140

COURT'S EXHIBIT 1 – MEDICAL UNIVERSITY OF SOUTH CAROLINA RECORDS ... 153

COURT'S EXHIBIT 2 (B) – LINEUP AND ADMONITION FORM FOR LINEUP 672

COURT'S EXHIBIT 4 – AUTOPSY REPORT 675

COURT'S EXHIBIT 5 – COLOR LINEUP 688

INDICTMENTS 690

THE FOLLOWING EXHIBITS ARE ON FILE WITH THIS COURT:
COURT'S EXHIBIT #2 (B) – LINEUP AND ADMONITION FORM FOR LINEUP
COURT'S EXHIBIT #3 (C) [AUDIO RECORDING]
COURT'S EXHIBIT #4 – AUTOPSY REPORT
COURT'S EXHIBIT #5 – COLOR LINEUP

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STATE OF SOUTH CAROLINA)		IN GENERAL SESSIONS COURT
)		
COUNTY OF CHARLESTON)		NINTH JUDICIAL CIRCUIT
STATE OF SOUTH CAROLINA,)		
)		
State,)		
)	Case No.:	2012-GS-10-6844
vs.)	Case No.:	2012-GS-10-6845
)	Case No.:	2012-GS-10-6846
MARVIN BROWN,)		
)		
Defendant.)		

ORIGINAL

TRANSCRIPT OF PROCEEDINGS
SUPPRESSION HEARING
HEARD BEFORE JUDGE STEPHANIE McDONALD
ON MARCH 26, 2013

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INDEX

DESCRIPTION	PAGE
PROCEEDINGS	4
WITNESS: JEROME FLEMING	
Direct Examination By Mr. Simpson	8
Cross-Examination By Ms. Ehrlich	19
Redirect Examination By Mr. Simpson	41
WITNESS: DAVID ALLEN BRUNSON, JR.	
Direct Examination By Mr. Simpson	45
Further Direct Examination By Mr. Simpson	67
Cross-Examination By Mr. Groeber	69
WITNESS: DAVID ALLEN BRUNSON, III	
Direct Examination By Mr. Simpson	49
Cross-Examination By Mr. Groeber	55
WITNESS: DENDRIA BRUNSON	
Direct Examination By Mr. Simpson	57
WITNESS: DESMONTE GOODWIN	
Direct Examination By Mr. Simpson	59
Cross-Examination By Mr. Groeber	61
REPORTER'S CERTIFICATE	102

EXHIBITS

DESCRIPTION	PAGE
*Court's Exhibit Numbers 1, 2, 3, and 4	5
*Court's Exhibit Number 5	30

*(Judge McDonald retained exhibits.)

The above-styled cause came on for hearing on the 26th day of March, 2013, at 10:07 a.m., before Judge Stephanie McDonald, Judge at Large, presiding over the General Sessions for the County of Charleston, when the following proceedings were had and entered of record, to wit:

PROCEEDINGS

SUPPRESSION HEARING

(The Defendant is present in the courtroom and assisted by his counsel.)

MR. GROEBER: I've got more materials, files, if you want --

THE COURT: Sure.

MR. GROEBER: It's stuff that I E-mailed you about. Really, the only thing that is any different is the medical records --

THE COURT: Okay.

THE DEPONENT: -- which I tried to E-mail, but were too big.

THE COURT: Yeah, we have trouble getting, too, the downloads --

MR. SIMPSON: I think we're stipulating to all of this.

THE COURT: Okay.

MR. SIMPSON: If we can just I.D. them as

Court's Exhibits?

THE COURT: Sure. We can mark them.

(Court's Exhibit Numbers 1, 2, 3, and 4 are marked for identification.)

THE COURT: All right. Whenever everybody is ready.

MR. SIMPSON: Thank you, your Honor. I believe that State's going to begin with just taking some testimony.

THE COURT: Sure.

MR. SIMPSON: The State calls former Detective Jerome Fleming.

THE COURT: All right. Mr. Fleming, if you'll come up and be sworn.

MR. GROEBER: Your Honor, sorry. Just for the record.

THE COURT: Sure.

MR. GROEBER: The State, just kind of walk through what we're doing?

THE COURT: You're certainly welcome to. Just so y'all know for the record, I've reviewed what you've sent in addition to poking around some law just for my -- attempting to learn what the different splits of opinions are on Crawford in dying declarations. But if y'all want to just put a little bit -- tell me what your

issue is and what your motion is -- it's a Motion to Suppress; correct?

MR. GROEBER: Correct, your Honor. A motion to exclude identification and statements by the victim to Detective Fleming specifically pursuant to Crawford, and we'd argue also that it's hearsay. We also believe that Neil versus Biggers would be an appropriate thing that we should examine. I believe there are other statements that the State would intend to introduce by the victim to people other than Detective Fleming that we would object. I think our basis for that would have to be hearsay. I don't believe the confrontation clause -- well, we'll -- we would argue that they would both apply to that as well.

THE COURT: Okay. I mean, I looked at -- I think more specifically 804(b)(2) and Crawford and just the general case law. I think we had Justice Burnett's opinion about the person who passed away 22 days after he gave a declaration. So all of that is going to come into play. But I will see what y'all tell me, first. How about that?

MR. SIMPSON: Just for the Court's illumination about the other statements, in speaking with the victims' family this morning, just so -- there were some further statements that the victim gave to his brother,

I figured -- again, and I apologize to Mr. Groeber, they just came to my attention this morning.

THE COURT: Okay.

MR. SIMPSON: I thought it would be easier, for efficiency-wise, to get all that out this morning, and I think the arguments are going to be similar for the -- whether it's for the exclusion or admissibility of --

THE COURT: Whatever y'all want to cover today, we can. We can go as long as you need. We'll have to break about 1:15 because I have an appointment at 1:30. But we can pick back up and keep going from there.

MR. SIMPSON: And for planning purposes, I think the testimony is going to be fairly -- I don't think it will need to go past 1:15.

State calls Detective Jerome Fleming.

(The oath is administered by the Clerk of Court, and the witness answers as follows:)

THE WITNESS: I do.

THE CLERK: Please have a seat and state your name for the record, spelling your last name.

THE WITNESS: Jerome Fleming, F-l-e-m-i-n-g.

JEROME FLEMING,

having been first duly sworn by the Deputy Clerk of Court to tell the truth, the whole truth, and nothing but the truth, was examined and testified upon his oath

as follows:

DIRECT EXAMINATION

BY MR. SIMPSON:

Q Mr. Fleming, good morning.

A Good morning.

Q Where do work currently?

A Currently I'm employed by the medical university, MUSC, safety and security department.

Q And who is your former employer?

A The City of Charleston Police Department.

Q And were you working for the City of Charleston Police Department in May of 2011?

A Yes, I was.

Q And what was your position?

A I was detective, assigned to the homicide unit.

Q And on -- were you also working in that capacity in April of 2011?

A Yes.

Q On April 29th, 2011, do you recall taking a statement that brings us here today?

A Yes, I do.

Q And have you reviewed your reports --

A Yes.

Q -- on that statement?

A Yes.

Q Can you describe for the Court the circumstances that -- that started your involvement in this case?

A Started my involvement in the case. I think it was the day after the shooting occurred that I was assigned the case and given a briefing on the details of the case, and I know that at that time, the victim, himself, was at the medical university hospital in the intensive care unit.

Q You didn't workup, so to speak, the actual incident, but came in to follow up on some of the points; is that a fair statement?

A That is correct. I did not respond to the scene of the incident, no.

Q Okay. And in that capacity, did you go to the medical university on April 29th, 2011?

A Yes, I did.

Q And about what time?

A Approximately noontime, on that day.

Q Okay. And I see you're referring to something in front of you. Is that your report?

A This is the incident report -- that supplemental report that I wrote.

Q Regarding the statement you took?

A Yes.

Q Can you describe for the Court what you observed when you went to the medical university?

A Well, when I went into the Intensive Care Unit, I think even before, I went into the unit, I made contact with the victim's parents, the mother and father, and -- which I believe the father informed me that he had spoken with his son that night, and his son was lucid and was able to communicate at the time, regarding the shooting.

Q And did you then go into Mr. Goodwin's hospital room?

A Yes, I did.

Q And you had some -- you audio recorded a good portion of this statement; correct?

A Yes, I did.

Q Did you have some preliminary discussions with the victim before the audio recording began?

A I did, yes.

Q And what was the nature of those conversations?

A The nature of the conversation was to convince the victim to cooperate with me as far as the investigation is concerned.

Q And did he express some hesitancy initially in that regard?

A Yes, he did. It is common knowledge, as far as

a lot of victims, out here, a lot of victims and witnesses that are out here that -- subject to -- a witness to crimes, living in a community, they don't want to be identified as being an individual that assisted police.

Q It's not looked upon favorably in some areas to cooperate with the police; is that a fair?

A That is correct.

Q So describe the actual conversations prior to the recording that you had with the victim.

A Well, it was pretty much he stated to me that he didn't want to get involved. My comments to him was that he's the victim here of this shooting, and very fortunate at that time to say that -- to be alive. And no matter, you know, the opinion of the people, that there was no one out there really to come forward to say that they witnessed this shooting, and he was the only guy that could say -- we could say establish who the perpetrator of the crime was and bring him to justice.

Q And following that conversation, did the victim agree to provide you with a statement?

A Yes, he did.

Q Let's talk for a second -- and I realize you're not a medical doctor, but what from your observation was the condition and demeanor of the victim when you went

to see him?

A Well, he was very weak, he was lying in this bed in the Intensive Care Unit, and there were -- the tubes and -- that were attached to his body. But unable to really raise his hands or arms, *per se*, and speak loudly.

Q And at one point you -- we'll get to this in a second. But he needed to circle something on a piece of paper; correct?

A Right, uh-huh.

Q And did you express anything about his ability to use his hands in your report?

A Yes, I did. Which I did ask him to circle the photograph that he pointed to, and he stated to me that he was too weak to accomplish that task.

Q He stated he was too weak to even lift his hand to circle?

A Right.

Q And, again, this is in the Intensive Care Unit in the hospital?

A This is in the Intensive Care Unit.

Q So after this preliminary conversation regarding his cooperation, you recorded this statement; correct?

A Yes, I did.

Q And there's a moment in the recording where you cease recording his statement?

A Yes.

Q And can you explain to the Court the purpose -- the reasoning behind stopping the recording at some point?

A The reason that I stopped the recording is because I was standing next to his bed with the -- I had a -- a hand-held digital recorder in my hand that I placed up close to his mouth to be able to hear the statement that was given. And in order for me to -- after receiving his statement, in order for me to show him the photo lineup, I -- I couldn't place anything on his bed, and I didn't -- it's a small room that we're in. And to say -- to have anything -- a desk or anything there that I could utilize to put a recorder and continue doing what I was doing, I saw fit to say I'll just shut the recorder off. Utilize both my hands to present -- I had to read an admonition statement from the lineup to show to him and also get him to sign and circle the picture on the lineup. So I needed both hands.

Q Okay. So it was a matter -- you're in a cramped hospital room, tubes and medical equipment --

A Yes.

Q You didn't stop the recording to -- so you could suggest to him who to pick or anything like that, did you?

A No. And his parents were present during that whole time. So that was -- I had no reason to do anything like that.

Q And he did -- eventually did sign -- did at least mark a piece of paper with his hand?

A He did. He attempted to write his initials -- or sign by the picture that he pointed to.

Q And is that weakness that we discussed earlier indicative in that attempt to sign?

A Yes. Yes.

MR. SIMPSON: Your Honor, at this time, the State would seek to publish what I believe has been marked as Court's Exhibit 3, which is the audio.

MS. EHRLICH: No objection.

(Court's Exhibit Number 3 is being played for the Court. Not transcribed for the record.)

(Time is 10:24 a.m. until 10:30 a.m.)

Q (By Mr. Simpson) So that's where you paused to show him the lineup?

A Yes.

Q When we talk about the lineup, I know it's a pretty basic question, but what are we talking about?

A You're talking about what we consider a six-pack. It will be six photos on the same sheet of paper, consisting of six individuals with similar qualities.

Q Okay. Was the Defendant, Marvin Brown, one of the individuals in that six-pack?

A Yes, he was.

Q And do you recall why he was included as an individual in that six-pack?

A He was included as one of the -- as the suspect based on information we received from an anonymous caller stating that Marvin Brown was the individual that committed the crime.

Q And could you describe for the Court what occurred while the recording was not running in this case?

A Basically what I did was -- the photo lineup itself is covered by an admonition sheet -- an admonition form that was read to the victim or witness where it's typically stapled onto -- on top of the lineup covering it; and to see the lineup, the investigator or detective would have to fold the sheet back and present it to the victim.

MR. SIMPSON: May I approach the witness?

THE COURT: You may.

Q (By Mr. Simpson) Detective, I'm showing you a copy of what's already been entered as Court's Exhibit 2, I believe. Is that the lineup and the admonition that we're referring to?

A Yes, it is.

Q Okay. And, again, we see some scrawls on the front, the initialing, and whatnot. Is that the -- is that the victim?

A It is from the victim, yes.

Q And does that indicate he understands your admonition?

A Yes.

Q We also see something interesting that he's written the word "pig" by Number 6?

A Yes.

Q Okay. Is that -- you asked him in the recording, does this individual have a street name or anything, and he said no. Do you recall where the --

A That came from where the victim, himself, attempted to initial or sign the photo that he selected by the Number 6. That would be -- instead of P-I-G, it looks like maybe D-I --

Q So maybe I'm reading it wrong.

A Yeah.

Q Okay. Okay. Did -- did the victim -- when

shown the six-pack, select an individual?
A Yes. He pointed to Photo Number 6.
Q And he told you that -- while he didn't know the person's name, he had known this person's face from the neighborhood for quite some time?
A Yes, he did.
Q Did he express any hesitation or reluctance in his I.D.?
A No.
Q Did he ever indicate to you, despite the earlier hesitancy to cooperate, any doubt in that I.D.?
A No.
Q The six-pack?
Okay. And you didn't investigate, so to speak, the incident or the underlying crime; correct?
A As far as the preliminary --
Q Yes.
A -- at the scene --
Q And things of that nature?
A I did not respond to the scene on the morning of the incident, no.
Q But I believe in your follow-up, that we're going to listen to in just a minute, you do indicate that he got a pretty good look at the person that shot him?

A Yes.

MR. SIMPSON: Your Honor, at this time, we will play the second half.

THE COURT: Okay.

(Playing Court's Exhibit Number 3 -- not transcribed for the record, 10:34 a.m. to 10:37 a.m.)

Q (By Mr. Simpson) Detective, you testified earlier that the victim was obviously very weak at the time?

A Yes.

Q Had some difficulties using his hands?

A Yes.

Q All right. Is that -- I realize you're not a doctor. Is his weak and his -- is his weakness and his medical state apparent in his voice on that recording?

A Clearly.

Q As to the lineup, at any point, either previous to the recording, during the recording, when the recording is off, or later, did you do anything to suggest to the victim the right answer, so to speak, on identifying this individual from the lineup?

A No, I did not.

Q Any -- any pointing, any -- this is the guy we think did it, or anything to that nature?

A No, I did not.

MR. SIMPSON: Detective Fleming, please answer any questions that the Defense has for you?

THE WITNESS: Sure.

THE COURT: Thank you. Cross-Examination.

CROSS-EXAMINATION

BY MS. EHRLICH:

Q Hi, Detective Fleming.

A Hi.

Q Are you still Detective Fleming?

A No, I'm not. I'm retired.

Q Okay. Mr. Simpson, asked you a little bit about the condition of Mr. Goodwin, but you interviewed -- you said you did interview him at the hospital?

A Yes, I did.

Q To your recollection, was he -- he was not under -- he didn't have a breathing tube at the time, did he? He was able to speak?

A He was able to speak, yes.

Q And you indicated that he was able to communicate with you about the case?

A Yes.

Q I believe you said that he was lucid and alert?

A Yes.

Q And I think we can hear from listening to the

audio, there are points where he was able to correct you if you misheard something he said?

A Yes.

Q Okay. And the incident, itself, where he was shot, that happened on the 26th?

A The exact date, I'm not 100 percent sure. I know it was in the a.m., because I did not respond to the scene where the incident occurred. I came in the following day. Let's just say, it would be that same day, at my normal time, and was given the case to follow up on.

Q Your interview, though, was on the 29th?

A Interview was on the 29th.

Q And, to your knowledge, he had never -- he had been in the hospital the entire time?

A Yes.

Q And I think you described, he was in a room -- hospital room?

A He was in one of the Intensive Care Units.

Q Okay. And there was no restrictions for him as far as phone use, to your knowledge? I'm just asking you, to your knowledge.

A To my knowledge, no, but I would say as far as his condition is concerned, prior to me meeting with him, he wasn't able to utilize a phone.

Q Well, you weren't -- you didn't see him at any time until the 29th, though; right?
A I came there after he was at the hospital during a time he was incubated.
Q Okay. You didn't write a report about that, though; right?
A I didn't. I don't know. I don't recall.
Q But, to your knowledge -- your knowledge, there was no restriction on -- he had visitors; right?
A Knowing how the system is at the medical university, as far as the parents --
Q His parents were in there with him --
A -- would control the visitation, as far as the patient is concerned.
Q To your -- I mean, when you got there, though, he had visitors?
A His parents were there.
Q Okay. And I believe you said that they stayed in the room while you interviewed him?
A Yes.
Q And you didn't ask them -- there was no point where they left the room? They were in there with you?
A They were in there with me, yes.
Q Okay. And they were also present when you went through the identification procedure with him?

A Yes, they were.
Q And your role, up until this point in the case, was -- this was your first real assignment as far as getting a statement from Mr. Goodwin?
A When you say "first real assignment"?
Q You hadn't interviewed any other witnesses at that point?
A I was involved with the case, and there were people that we had attempted to interview, which -- I can't tell you who they all were. Right now I can't really tell you who all the detectives were that had their hand in this case.
Q Let me ask this a different way for you. During your interview with him on that day, you didn't have any conversations with him about whether or not he talked to other people about this incident?
A That was my first time speaking with them.
Q Okay.
A Yes.
Q And you didn't ask him if he had been talking to other people about the incident?
A No.
Q Okay. And you -- you didn't tell him about the anonymous tip that came in?
A No.

Q Okay. At the time that you worked this case, you were an investigator with the city police?
A That is correct.
Q And as part of a police officer, you get training on how to do your job?
A Yes.
Q They teach you how to investigate the case?
A Yes.
Q Interview witnesses?
A Yes.
Q Gather the facts?
A Yes.
Q Write reports?
A Yes.
Q Document your investigation?
A Yes.
Q And your job is to be complete, as far as what you report?
A Yes.
Q You want to be accurate?
A Yes.
Q Because your documentation of your investigation is going to be used by the prosecutor to prosecute the case?
A That is correct.

Q The Defense will have an opportunity to review all of that?
A Yes.
Q When the case comes to court, you may review your police reports?
A Yes.
Q And that helps you testify accurately?
A Yes.
Q And in addition to the training that you get on reporting, or writing reports, you get training on how to interview witnesses?
A Yes.
Q And, also, identification procedures?
A Yes.
Q So, like, for identification, that's important because part of your duty is your interview a witness, or victim?
A Yes.
Q You might interview suspects? As part of your job when you were a police officer for the City of Charleston?
A Yes.
Q And the reason you do that is to get information about the case to possibly make an arrest?
A Yes.

Q And, ultimately, the goal is to be able to prosecute the case?
A Ultimately, yes.
Q And statements -- I think you don't work for CP now, but CP goes as far as having, at the police station, a room -- two rooms, I think, where you can audio and video record interviews with witnesses?
A That is correct.
Q And when there's not an opportunity to do that, you have the ability to do the audio recording? I believe you described having a digital recorder?
A Uh-huh.
Q When you have that, it leaves no question as to what somebody says during an interview when it's recorded?
A That is correct.
Q Okay. And identifications are used the same way statements are; you want an identification to be able to make an arrest; right?
A Positive identification, yes.
Q And the arrest leads to an indictment, the indictment leads to prosecution, and your goal is a conviction?
A Ultimately, yes.
Q Okay. And so a positive identification will --

helps that case get to court?

A It does.

Q And at this point in your investigation, you needed an identification because the only information -- only thing that you had pointing to the Defendant's involvement was an anonymous tip?

A That is correct.

Q And you even testified earlier about having to convince him to talk to you -- that you needed that, you needed him to be able to talk to you to be able to prosecute the case?

A Yes.

Q Okay. While you were working with the City of Charleston Police Department, you guys had like a policy book to follow when you were working a case? Right?

A We have policies and procedures, yes.

Q Okay. And there's a section in there about identifications? Do you remember?

A I will say, yes.

Q And the policy of -- of the police department is to establish guidelines for the use of eyewitness identifications whether or not it's a showup or a photographic lineup?

A Uh-huh.

Q And I believe the policy says it is critical

that the identification be done in a nonsuggestive manner and be supported by written documentation?

A Uh-huh.

Q And that it is incumbent upon the investigator to ensure the lineup is shown in a nonsuggestive way?

A Yes.

Q And one of the policies is that the suspect doesn't stand out from the other photographs used?

A Yes.

Q And so the filler photographs are people who are not suspects, that are put into the lineup for purposes of creating a lineup for somebody to view, and you have guidelines on what fillers are supposed to be?

A Yes.

Q And so I believe that the policy would be that they reasonably resemble the suspect?

A That is correct.

Q And at the time that the lineup was put together in this case, you knew who the suspect was, and that's how the lineup was put together?

A Yes.

Q At any point, did you review the lineup to make sure that the Defendant did not stand out among the fillers?

A Yes, I did receive the lineup and looked at it,

yes.

Q Okay.

A To ensure that the -- the Defendant was present in the lineup.

Q You reviewed that to make sure he was present in the lineup?

A In the lineup.

Q But you didn't review it to make sure he didn't stand out among the fillers?

A You always look at your lineup -- let me say this, I didn't make the lineup. I asked my intelligence unit at the time to -- gave them the name, and they supplied me with the lineup.

Q Okay.

A Okay.

Q Prior to showing it to Mr. Goodwin, did you review it to make sure that he did not stand out among the fillers?

A Yes, I did.

Q Okay. And do you have a copy of the lineup here?

A Right here before me.

MS. EHRLICH: Is that -- has that already been put in?

MR. SIMPSON: Yes, I think so. Court's 2.

THE COURT: I have it.

THE WITNESS: I have the original, yes.

MS. EHRLICH: Your Honor, at this time, because we have an identification issue, I'd like to admit the color version as well.

MR. SIMPSON: No objection. That's just the original, so I'd like to be able to hang on to it for trial.

THE COURT: Sure.

MR. SIMPSON: But no objection.

THE COURT: Why don't we do this, can we mark it, and then let Mr. Simpson have it back, and we'll substitute this one with the understanding that that is the exhibit, the color one is going to come in -- we can get another copy of the color one if we need to.

MR. SIMPSON: Yes, your Honor, that's -- that's fine.

THE COURT: However, y'all want to handle it.

MR. GROEBER: I just want to make sure that it survives -- the color copy survives.

THE COURT: Sure.

MR. GROEBER: We can later get a color copy, and we can get a --

THE COURT: Sure.

MR. SIMPSON: I'll save the original.

THE COURT: Okay.

MR. GROEBER: But I prefer that we have a color copy that is an exhibit.

THE COURT: I think that makes more sense.

MR. GROEBER: Not that I don't trust Mr. --

THE COURT: I know that's not what it is. It's more of an issue of something happening to it. Which is why our very kind court reporter normally doesn't let me have originals or things like that. But we'll make sure we have a color copy, if we need to have that. Or the color original, whichever.

(Discussion is held off the record between the Judge and the Court Reporter.)

THE COURT: Do y'all want to leave this as 2, and just make that Court's 5?

MS. EHRLICH: That's fine.

(Original Six-Pack Lineup is marked as Court's Exhibit 5 and admitted.)

Q (By Ms. Ehrlich) Detective Fleming, just to clarify the record, what's been marked as Court's 5, this is the original copy of the identification?

A Yes, it is.

Q And that contains the colored photographs?

A Yes, it does.

Q And this is the actual lineup that was shown to

Mr. Goodwin at the hospital?

A Yes.

Q Those photographs you just reviewed to make sure that your suspect at the time was in there --

A Uh-huh.

Q -- you didn't do any review to see if they were similar complexion or age or anything like that?

A Yes, I did.

Q Okay. You did?

A Did I -- you asked me did I look at the photo lineup to make sure it was similar?

Q I'm sorry?

A You asked did I look at the photo lineup to ensure that the photographs were similar?

Q Right.

A Yes, I did.

Q And about two minutes ago, before we marked that as Court's Exhibit 5, do you remember stating here in court, that you only reviewed it to make sure the suspect was in there --

MR. SIMPSON: Your Honor, I apologize for the interruption. But he testified that he -- that is not how he testified.

THE COURT: I didn't hear the testimony exactly that way. So let's rephrase your question.

MS. EHRLICH: Okay.

Q (By Ms. Ehrlich) Did you review the photographs to see if they resembled the suspect?

A Yes.

Q How did you review them?

A Looked at the photographs to ensure that it did include my suspect.

Q Okay.

A Okay. And to ensure that the photos were similar.

Q Okay. Did you show the -- the lineup to any sort of officer uninvolved with the case and have them review the lineup?

A No.

Q And I think you testified earlier -- or we heard in the interview, that you -- before you showed it to him, you asked him if he had any problem picking the person out of a photo lineup?

A Yes, I did ask him that question.

Q Okay. And on the recording, you go through most of the admonition form, but I think that you don't go all the way through the form; correct?

You don't ask him, upon reviewing these photos, do not discuss the results or this procedure with other victims or witnesses? That's not on the --

A I did not say that on the recording, no.
Q On the recording, though, you did say in front of him, I believe several times, you called the suspect by the name Marvin?
A Yes.
Q And I believe also in front of him you said that he had made a positive identification?
A In my closing statement in the recording, yes.
Q Okay. And Mr. Simpson already asked you whether or not -- kind of went over that you didn't record the entire conversation with Mr. Goodwin, and that included the identification portion of the interview?
A That is correct. When I showed the -- I turned the recorder off when I showed the photo lineup.
Q Okay. And in your police report, you don't -- or on the admonition form, part of what you do on the admonition form is there's a section for notes; right?
A Yes.
Q And that's where you would maybe indicate details of the identification? For example, how certain somebody was or how certain somebody was about a identification?
A I asked that question on the recording --
Q Okay.

A -- whether or not he was positive.
Q Okay. You asked that when he wasn't being recorded; right?
I think that's what's in your police report?
A Possibly when it wasn't being recorded, was he sure about the identification, yes.
Q Okay. And the interview, like we said, took place on the 29th; do you remember what day you actually wrote the report?
A On the 29th, I believe.
Q Would reviewing your report refresh your memory as to the date you wrote the report?
A I'm looking at it now. Shows the 4th, 5-4.
Q So May the 4th?
A Uh-huh.
Q All right. By the time you interviewed Mr. Goodwin, you did have some knowledge about the case? For example, you knew there had been a tip about the Defendant?
A Yes.
Q I think you also knew that there were certain things in evidence, so during the interview process, you correct him and said the cell phone -- the police have your cell phone; they weren't taken during the robbery?
A I believe so, yes.

Q Okay. And as far as your -- your knowledge of the Defendant, you have -- you had -- had knowledge of him from prior investigations, I believe?

A Yes.

Q And so you -- you knew more about him than you would maybe the average suspect in a case you or case we don't know anything about? You had investigated him before?

A Repeat the question.

Q He had been investigated by you before?

A By other investigators that had cases.

Q Okay. So you knew his name?

A I knew his name, yes.

Q Despite knowing his name and knowing something about the case, you still were the person who took the statement from Mr. Goodwin and did the lineup?

A Yes.

Q No other officers were brought in or involved with the lineup, as far as showing it to Mr. Goodwin?

A No other officers showed Mr. Goodwin this lineup, no.

Q And no other officer witnessed the lineup procedures?

A No. His mother and father were there when I did that.

Q I want to shift gears a little bit about the statement. When you first interviewed him, he said that he did not know who shot him?

A Yes, he did.

Q I think he said he did not know him at all? Or he responded to your questioning, you don't know him at all?

A He said he did not know his name.

Q First, though, he said he didn't know him at all; right?

A Yes.

Q Okay. And then during the course of the interview, that's when he said that he knew him by sight but not by name?

A Yes.

Q Was there a conversation when the recording wasn't going on, where there was a discussion about his name?

A No. I would say that, for the most part, that name came out of my mouth.

Q Okay.

A Okay.

Q So Marvin Brown came from you?

A Came from me. Because --

Q Before, y'all don't call him that. After that

identification, I think you referred to him as Marvin several times?

A Right. Right.

Q Your report was written on May the 4th, and I believe in your report you said that you saw and interviewed Mr. Goodwin around 12:10?

A Yes.

Q But from listening to the recording -- of the recording, you said that you interviewed him at 10:12 a.m.?

A You said 10:12?

Q I believe that's what --

A I know I heard that on the recording, saying time, and I may have gotten the time --

Q Wrong?

A -- wrong on the paper saying it's 12:10. It should have been 10:12.

Q I think also in your report, in your narrative, you don't include anything about him initially denying who the shooter was?

A No, I did not put that in there. No.

Q We know from listening to the recording that he did deny knowing who the shooter was at the beginning of the interview?

A He denied knowing his name.

Q Okay. Also in your report you indicated that the subject approached him and asked him did he have his -- did he have a problem, stating he always does this when he's been drinking. Do you remember writing that?

A Yes.

Q In the recorded statement, though, you say something along the lines, you ask him, what does it mean when he said do you have a problem? And Mr. Goodwin says, that he doesn't know that boy be drunk up. He didn't say he's always drunk; right?

A I believe his statement to me was: He's always doing that when he's drunk.

Q Okay.

A I'm trying to recall.

Q In your police report, you also indicated that he stated that the person took money from him?

A Yes.

Q But when you listen to the recorded interview today, did it refresh your memory when he said that he wasn't sure because he didn't know where his pants were?

A He informed me that he had $120 in his pants. And he wouldn't know where his pants were because they were taken in, as far as evidence was concerned.

Q Okay. But from listening to the audio today, you heard him say that he wasn't sure if the money was

taken?

A He did say that, yes.

Q The first -- you talked to him first without recording, and that was to convince him to talk to you?

A Yes, to cooperate with me.

Q Say again.

A To cooperate with me.

Q Okay. And then you record -- start recording the interview with him?

A Yes.

Q But you don't record the part where he makes the identification?

A And I gave reason why.

Q Yeah.

A You see how weak his voice was? I was holding the recorder with one hand to his mouth. It was going to be difficult for me to now show him a present -- a photo lineup to him and show him the photo lineup.

Q His parents were in the room; correct?

A They were, yes.

Q Okay. And it was -- you were at MUSC. So I'm sure that there were nurses and doctors throughout the building?

A Yes.

Q Okay. In your report, you don't document how

long you turned the audio recorder off, do you?
A Long enough to show him the photo lineup.
Q Okay --
A And to try to get him to sign it.
Q You don't, when you turn the recording back on, state that it's now this time, and I'm starting back with the interview?
A No, I did not.
Q And once you start recording again, you do not ask him any questions about how positive he was about the identification? You move on to additional details about the incident?
A Yes.
Q And you did not record the portion where I think you probably revealed to him the suspect's name, Marvin?
A That came out during the conversation with him, because he had been identified in the photo lineup, and that was my slip by using his name.
Q Okay. All these things that we're talking about now, that wasn't recorded by you?
A The --
Q The name; the discussion about how positive he was about the lineup; none of that was recorded?
A I don't believe so.

Q Okay. And was it you who -- and it's you at the end of the tape who says this is a positive identification of the suspect?

A Yes.

MS. EHRLICH: Court's indulgence?

THE COURT: Sure.

(Ms. Ehrlich speaks with Mr. Groeber off the record.)

MS. EHRLICH: I don't have any other questions, your Honor.

THE COURT: Okay.

Yes, sir?

REDIRECT EXAMINATION

BY MR. SIMPSON:

Q Detective Fleming, in that recording you use the name Marvin?

A Uh-huh.

Q And that was after the positive I.D. from the six-pack; correct?

A Yes.

Q At no time -- at any time prior to the showing of the six-pack, did you suggest the name Marvin to the victim?

A No, I did not.

Q You took the recording that you took, and you

put it into evidence; correct?

A Yes, I did.

Q And that's partially so it can also be available to the Defendant?

A Yes.

Q So when you end the recording, the victim says something like the phrase, drunk up? They're going to hear that on the recording; right?

A Yes.

Q And you put in your report that the Defendant was drunk all the time, and you phrased it slightly differently; is that correct?

A Right.

Q But the recording, it's in evidence, and that's going to be available?

A Yes.

Q Initially, Ms. Ehrlich asked you some questions about investigating cases generally. And how your goal, of course, is to apprehend the right person?

A That's correct.

Q And hopefully have your investigation lead to a successful prosecution?

A Yes.

Q It is also a motive of yours in investigating a crime, to take a dangerous person off the street?

A Yes.

Q And in a case like this, where I think Ms. Ehrlich very adequately covered, you needed that information to take -- from the victim was -- your main basis of taking someone off the street; correct? Who you believe is dangerous?

A And the person that committed the crime against him, yes.

Q Right. Because it's not a good thing for Charleston to have a person with a -- possibly a gun rooming around who's shown the capability of doing that?

A That is correct.

Q So in the investigation like this, is there also a motivation of public safety behind investigating a crime and apprehending a person?

A Yes.

Q Again, you put the recording into evidence?

A Yes.

Q But he does initially say to you, do you know him, and the victim responds no. But then through follow-up questions, he realizes, I don't know his name, but he, in fact, does know his face from the neighborhood --

A That is correct.

Q -- is that accurate?

Similarly, he expresses his phone may have been missing from his pants pocket?

A Yes.

Q Follow-up questioning you -- he explains to you he had camos with several pockets on it, and he notices his pockets were gone through by the Defendant, is a little unsure as to what items specifically were taken and what were left?

A That is correct.

MR. SIMPSON: Nothing further, your Honor.

THE COURT: Sir, you may step down.

THE WITNESS: Thank you.

MR. SIMPSON: Your Honor, may Detective Fleming be excused?

THE COURT: Any objection?

MS. EHRLICH: No objection.

THE COURT: You may leave.

THE WITNESS: Thank you.

THE COURT: Yes, sir.

(The witness is excused.)

MR. SIMPSON: Your Honor, at this time the State calls David Brunson, Sr. [sic].

THE COURT: Mr. Brunson, if you will come forward and be sworn.

(The oath is administered by the clerk of

Court, and the witness answers as follows:)

THE WITNESS: I affirm to tell the truth as God is my witness.

THE CLERK: Please have a seat. State your full name, spelling your last name for the record?

THE WITNESS: David A. Brunson, Jr.

DAVID ALLEN BRUNSON, JR.,

having been first duly sworn by the Clerk of Court to tell the truth, the whole truth, and nothing but the truth, was examined and testified upon his oath as follows:

DIRECT EXAMINATION

BY MR. SIMPSON:

Q Mr. Brunson, good morning.

A Good morning.

Q I'm sorry for the reasons we're here today. What was your relationship to Davon Goodwin?

A I'm the grandfather.

Q And did you have a close relationship with him?

A Yes.

Q Did you spend a lot of time with him in his life?

A Yes.

Q And what were the kind of things you like to do together?

A Well, they would -- I like to get all my grandkids at the house, you know, let them play and whatnot, and I would load up all my boys -- grandkids, grandsons, and ride them around, and eventually get all of them in the car, the girls too, and ride them too, but mainly be the boys.

Q So you would ride around killing time in the car; that's something you would do?

A Yeah.

Q And did you do that with Davon?

A Oh, yeah.

Q Did Davon -- did you speak with Davon while he was in the hospital?

A Yes, I did.

Q You went to visit him?

A Yes.

Q Spend a good amount of time with him?

A Yes.

Q At any time did you have a conversation with Davon specifically about these rides that you guys used to take?

A Yeah.

Q And, if you could, just describe for the Court that conversation that you had with Davon?

A Well, there was -- we had more than one, but

one particular that hit me the hardest was -- he was laying up there. . .

And I can't do this.

Q I'm sorry. Take as much time as you need, Mr. Brunson. I know this is incredibly hard.

(Pause in proceedings.)

THE COURT: Do we need to take a break for a few minutes?

MR. SIMPSON: I just have one question for him. I think it will be easier if we just. . .

THE COURT: Okay.

Q (By Mr. Simpson) Mr. Brunson, if you are ready, if you can just describe that conversation that you had with Davon, and that will be the last question I have for you today.

A I was sitting there holding his hand, and we were talking about the times we had, and the subject came up about us riding around, and -- he would always sit on the front, near the door on the passenger side. And he said he wouldn't be able to ride with me, and that my other grandson Kaleem (phonetic) would have his seat. Because him and Kaleem, they would always fight over the front seat.

Q And did you take that to mean that he was fearful he may not ever have the opportunity to take

these rides with you again?

A Yes.

Q Did he also apologize to you for some of the decisions that he had made in his life?

A Yes, he did.

MR. SIMPSON: Your Honor, I have no further questions.

Please answer any questions that the Defense might have for you, Mr. Brunson.

MR. GROEBER: I have no questions for Mr. Brunson. Thank you.

THE COURT: All right. Sir, you may step down.

(The witness is excused.)

MR. SIMPSON: State calls David Brunson, Jr. [sic].

THE CLERK: Please raise put your left hand here raise your right hand.

(The oath is administered by the Clerk of Court, and the witness answers as follows:)

THE WITNESS: Yes.

THE CLERK: Please have a seat, state your full name, spelling your last name for the record.

THE WITNESS: David Allen Brunson, III.

DAVID ALLEN BRUNSON, III.,

having been first duly sworn by the Clerk of Court to

tell the truth, the whole truth, and nothing but the truth, was examined and testified upon his oath as follows:

DIRECT EXAMINATION

BY MR. SIMPSON:

Q Good morning, Mr. Brunson.

A Good morning.

Q What was your relationship to Davon Goodwin?

A That's my son.

Q Okay. And did you spend time with him during his hospital stay, 2011?

A Yes.

Q Could you describe for the Court -- we realize you're not a medical doctor. Could you describe for the Court generally his condition during the hospital stay.

A When I got there that morning he was still in surgery, and I waited. You know, I spoke to the doctor -- the doc spoke to me right after he came out of surgery, and then -- then they brought him out, and his head was swollen real -- real big, his feets, and hands were real big, his stomach was cut from here, all the way down, wide open, and his legs were swollen real big from the gunshot going in the inner thigh, tore up all his inner organs -- his small kidneys -- I mean, his small intestines, his liver, all that was damaged. And

the doc pretty much told me, you know -- you know, we -- we did what we can do, but, you know, I'm -- I'm just telling you, it don't look like he may make it, but, you know -- and it's because the small intestines got damaged real bad. And what they went in and did, they tried to fix it. And for right now he's stable, but any moment, it can be bad for him, so, you know.

Q So obviously as a father you're having conversations with the doctors?

A Uh-huh.

Q And the surgery?

A Uh-huh.

Q Correct me if I'm wrong, but they conveyed to you that it went as well as could be expected?

A Best they can do. They said they couldn't do surgery again because that was it, because of the damage and stuff, and he wouldn't be strong enough for them after this if anything happened, that was just it, they couldn't do anything else for him.

Q But they also made a point to apprise the family that with these kind of injuries --

A Uh-huh.

Q -- hope for the best, prepare for the worst; is that a fair enough statement?

A Yeah.

Q What was Davon's demeanor following surgery?
A Almost like a -- a child just happy to see his parents, because he know -- he know I'm dad, I'm going take care of him, you know. You know, more like, for example, like if your child got in a fight at school or beat up with a gang and be happy to see their parents when they see them, because they scared or whatever, you know. So he was pretty much scared, you know, in the dark -- he was in a deep stare, and always want you to hold his hand, and you know.
Q As a father, is it fair to say that you understood him to be afraid?
A Yeah. Yeah. He was -- he was -- he was scared.
Q And then, you know, he was a young man; correct?
A Uh-huh.
Q And in life before this incident, would he often hold your hand or hold other peoples' hands?
A No. He -- no, he don't hold your hand. He was mostly like -- you know strong, and, you know, real playful. You know he liked to play, like -- like, you know, my little nephew and them, you know, he just liked to play with his little sisters and nephews and everybody, you know. Like you heard my dad say, they

fight over the front seat. He still was a kid even though he was big. He's like my size, a little bigger. He ain't holding your hands.

Q But throughout this hospital stay, he'd often like to be holding somebody's hand?

A Yes.

Q And as your father, you took that to mean he was afraid?

A Yeah.

Q You mentioned briefly about the stares. Can you tell the Court a little bit more about that, the staring?

A We would be around and, you know, trying to -- me and his mother or whoever we let come in the room, because, you know, no one can come in and see him, not unless we said they could come in and see him. The visitation wasn't allowed. And -- and, you know, when they do come in, he would just -- you know, be looking in the corner, like -- like in a deep stare, and, you know, while holding his hand or whatever. Try to talk to him. Keep -- he was just scared, man. You know, I would be too. But. . . yeah.

Q All right. Is there anything else you can share with us about his condition?

A When -- when I got there, you know, like

-- after I spoke to the doctors and everything, you know, he -- like -- like they told me, he was real tired and everything, and the detective came, and they talked and everything to -- to me. Asked me could they go in and see him. You know, nobody could go in and see him. And he asked, could he talk to him; and I was, like, you know, he's asleep right now. But the doctors they gave him some type of medicine to where if they took it off, he could wake up. Because he was in so much pain, you know. Stomach was bust wide open and his intestines swollen, so it was hanging out. So -- so they were able to like -- like if -- if you needed to talk to him, they can pinch it where the medicine would stop going in, and he can wake up. But they wouldn't let him stay up. It wasn't like -- he could just stay up for an hour or so like that, because he was in too much pain, they would let it go back so he would go back to sleep and stuff like that.

Q And that was just following his surgeries?

A Right. Right.

Q And it was during that time, just following surgery, that the detectives came?

A The detective came in, you know, because we didn't know how -- we -- what his state was going to be in, and, you know -- like the doctor said, he can just

go backwards any second, you know. And so -- I had them let him wake up to talk to the detective, you know.

Q And just briefly, you're in the room when the detective came and took that statement?

A Yeah.

Q Did the detective at any time during that interview feed your son the answer to the question?

A No. He -- as a matter of fact, he never even mentioned that he had an anonymous call come in. He never even told us that. You know, our understanding was they didn't have any suspects -- I mean, they -- they had people that said things, but they were scared of this guy right here because he do so much in the community, and always get in a lot of trouble, so they was kind of scared, because they'd say he'd come back and he'd do this and he'd do that. So that was more the case of -- of -- a lot of the fear that Davon had, but, you know -- like -- like he told him, you know, you don't have to worry about nobody coming back to do nothing to you when you do the right thing. You know, you have to -- you have to speak when people do things to you, you know.

Q But at any time, did they suggest to Davon who out of the six-pack was the right person or who he should be looking for?

A No.
Q And, in fact, you didn't even know that a suspect --
A No, I don't even know that guy. I've never seen him. I don't know him.
MR. SIMPSON: That's all I have for you. Please answer any questions that Defense has.
THE WITNESS: All right.
MR. GROEBER: Could I have one moment, your Honor?
THE COURT: Sure.
(Pause in proceedings.)
MR. GROEBER: Just a few questions, Mr. Brunson.

CROSS-EXAMINATION

BY MR. GROEBER:

Q I think that when you were describing your son's condition that his head was swollen, his legs were swollen, that was right after he had surgery; right?
A Yeah. But that lasted a while. It didn't go down in one day.
Q Okay. That was on the 26th, though, that you talked to the doctor at that time?
A I don't recall the dates.
Q Was it right after his surgery?

A Yeah. I got there that morning when he was in surgery, as I stated, and -- and I spoke to the doctors when he came out of surgery. He was in the room -- he was still down, but they told me that, you know -- they could, you know, wake him up whenever they can with the. . .

Q And do you remember the detectives coming one time to see if they could get a statement from Davon, and they were unable to because he was still recovering from the surgery?

A No.

Q Okay.

A It was only one detective. The detective that just left.

Q Okay. So it's your testimony he only came the one time that he gave the statement?

A That's the only time I saw him.

Q So it's possible -- it's possible he could have come another time and you didn't see him or speak with him?

A Couldn't get around us, because they had to ask to come in the room.

MR. GROEBER: Okay. Could I have a moment, your Honor?

THE COURT: Uh-huh.

(Mr. Groeber speaks with Ms. Ehrlich off the record.)

MR. GROEBER: I have no further questions. Thank you.

THE COURT: Okay. Anything further.

MR. SIMPSON: No, your Honor.

THE COURT: Sir, you may step down.

(The witness is excused.)

MR. SIMPSON: State calls Dendria Brunson.

THE CLERK: Please put your left hand here and raise your right hand.

(The oath is administered by the Clerk of Court, and the witness answers as follows:)

THE WITNESS: Yes.

THE CLERK: Please have a seat, state your full name, and spell your last name for the record.

THE WITNESS: Dendria Brunson, B-r-u-n-s-o-n.

DENDRIA BRUNSON,

having been first duly sworn by the Clerk of the Court to tell the truth, the whole truth, and nothing but the truth, was examined and testified upon her oath as follows:

DIRECT EXAMINATION

BY MR. SIMPSON:

Q What was your relationship to Davon?

A My brother.
Q And I'll keep this very brief. Did you spend time up at the hospital with Davon --
A Yes.
Q -- while he was up there?
A Yes.
Q Did you know Davon in life, prior to incident, to be a really emotional crying-type person?
A No.
Q Did you see him cry a lot?
A No.
Q Did you ever see Davon cry?
A No.
Q Okay. I know this is hard to talk about. But when you spent time with Davon in the hospital following his surgeries, did you see him cry?
A Yes.
Q All right. Was it frequently?
A Not a lot. He -- when I used to wipe his face and stuff, I would see tears fall. I don't think he wanted us to see him crying. But he used to always -- seemed tired, and he was ready to go home.
Q Okay. And so at times, you did witness -- he tried to hide from you, but he did -- you did see tears from Davon in the hospital?

A Yes.
Q Was that an unusual thing for you to see?
A Yes.
MR. SIMPSON: I have nothing further.
MR. GROEBER: I have no questions, your Honor.
THE COURT: Okay. Ma'am, you may step down.
(The witness is excused.)
MR. SIMPSON: Your Honor, the final witness would be Desmonte Goodwin.
THE COURT: Okay. Sir, if you will step up.
(The oath is administered by the Clerk of Court, and the witness answers as follows:)
THE WITNESS: Yes, ma'am.
THE CLERK: Please have a seat and state your name for the record, spelling your last name.
THE WITNESS: Desmonte Goodwin, G-o-o-d-w-i-n.

DESMONTE GOODWIN,

having been first dluly sworn by the Clerk of the Court to tell the truth, the whole truth, and nothing but the truth, was examined and testified upon his oath as follows:

DIRECT EXAMINATION

BY MR. SIMPSON:

Q Mr. Desmonte, what was relationship to Davon?
A My big brother.

Q Did you look up to him?
A Yes, something like that. We come up at the same times, coming up.
Q Did you go visit him while in the hospital following the incident?
A Yeah, I went with him all the time.
Q You spent a lot of time with him?
A (The witness moves head up and down.)
Q Can you explain to the Court Davon's demeanor during this time, the stay at the hospital?
A He -- he just keep telling me everything will be all right and -- and he went outside that night, stay out there, because my birthday was the next day, and he was trying to buy me something. But he just keep saying he -- the boy shot him and stuff like that, and he didn't know why because he getting off work.
Q Did he ever tell you that -- who the boy that shot him was?
A Yes. Same one right there.
Q Did he ever use a name?
A He didn't really use no name. He just said shot him, and I know who he is.
Q Okay. That's all the questions I have for you today.
Thank you. I'm sorry. One more.

Detectives did try to come talk to you about this case?

A Yes.

Q And you gave a statement?

A Yes.

Q Did you ever indicate that he I.D.'d Mr. Brown, the Defendant?

A That my brother I.D.'d him?

Q Yeah.

A I wasn't in the room, so I --

Q I mean, did you ever tell the detectives that your brother told you it was Marvin?

A Oh, yes, I did tell them that.

Q Would it surprise you to learn that a report says that you didn't -- you didn't tell them that?

A I did tell him that.

Q Okay. Please answer any questions Mr. Groeber has.

CROSS-EXAMINATION

BY MR. GROEBER:

Q Just a quick follow-up on those final questions. It's your testimony that you did not tell Directive Osborne that you heard Davon say anything about Marvin?

A Excuse me, sir?

Q Let me try to phrase that better. Your testimony is that you told Detective Osborne that Davon said that Marvin had done it?

A Yes.

(Mr. Groeber speaks to Mr. Simpson off the record.)

MR. GROEBER: No further questions. Thank you.

THE COURT: Okay.

Anything further?

MR. SIMPSON: Nothing from the State, your Honor.

THE COURT: Sir, you may step down.

(The witness is excused.)

MR. SIMPSON: Your Honor, would you mind if we took a quick break before argument?

THE COURT: Sure.

THE COURT: Y'all want to talk about ten minutes and come in and argue?

MR. GROEBER: That will be great.

THE COURT: Okay. We'll be at ease for ten minutes.

(A break is taken from 11:33 a.m. until 11:44 a.m.; at which time, the proceedings proceed as follows:)

(The Defendant is present in the courtroom and

assisted by his counsel.)

THE COURT: All right. I'm ready whenever y'all are.

MR. GROEBER: Thank you, your Honor. I guess maybe you want to tell us how to proceed from here. We've got, really, four questions to answer: whether or not it's a dying declaration, whether or not it is testimony -- testimonial pursuant to Crawford and the other cases; whether it survives the Neil v. Biggers hearing; and then whether or not -- if it is a dying declaration and testimonial, whether there's -- dying declarations are an exception. I guess I'll defer to you how to proceed.

THE COURT: Let me give y'all my initial thoughts and then maybe you can tailor the arguments. As far as the testimonial/nontestimonial distinction, to me this is a little bit different than the situation where they come upon the person in the alley, or, you know, the sexual assault victim who's just been assaulted, and there's a perpetrator running around, and they're looking for that person. I mean, they're obviously looking for the perpetrator here, but this is a few days after or the next day. It's not that 911-call situation that I think the ongoing emergency distinction applies to. So I mean this is more -- and

the officer even said it: Well, to get the perpetrator; to find the person that did it. What I'm really most interested in is -- and I need to look at the medical records in more detail in light of what y'all have told me, is -- I've got to determine what the victim's state of mind was from the totality of the circumstances, and whether he truly felt that he was -- death was imminent or it was a statement made under impending death. I think that if it does fall into that exception under 804(b)(2), I think is what it is, reading Crawford and then a couple of the footnotes, I think Michigan versus Bryant. Maybe the Michigan case. And then there's a very persuasive case from the Eastern District of North Carolina, Calhoun versus Keller; it's 2011 Westlaw 6257060. Which breaks down what the majority rule is and the states and then analyzes some of the other cases on the other side of it. The majority rule appears to be at this point, although it is still developing, is that Crawford would not bar a so-called dying declaration because that exception has existed for so long -- it says: To exclude such evidence is volatile of the right of -- to confrontation would not only be contrary to all the precedents in England and here, but abhorrent to the sense of justice in regard for individual security and public safety. And then it goes

from there. That seems to comport with what our appellate courts would say. So we're back to the issue -- and I understand y'all disagree and would probably go with -- I think the case is maybe Jordan -- something from California. It's cited in that Calhoun case. That certainly is an approach some courts have taken. But it's the "whether the decedent felt that he was facing imminent death" that's the biggest concern to me. But I understand y'all -- I mean, y'all argue whatever. I'm happy to listen to it. I don't -- there's not a clear answer, as I see it, to this exact situation. But I've pulled up the Satter-White case that y'all mentioned, and I've read the Briefs. So just whatever you think you need to do. And I don't even get to the Neil-Biggers issue, I don't think, until we get through all of that.

MR. GROEBER: Okay. Do you want to start, or shall I? I actually think it's the State, so I think they argue first.

THE COURT: Well, I think the burden is on the State, and actually did pull up -- this is one thing that -- for the statement to be admissible as a dying declaration, the burden is on the State, it says, because the Government produced no evidence establishing that the decedent in that particular case made his

statement believing that his death was imminent.

So that does suggest that it's the State's burden and it is --

I just need you to --

MR. SIMPSON: Absolutely.

THE COURT: -- show me.

What would be helpful is when he made the statement to the grandfather about you're going to have to find somebody else to ride with you. That's pretty persuasive. And then the chronology of the surgeries is helpful, I think, to me.

MR. SIMPSON: Okay. May I have a moment to speak with the grandfather?

THE COURT: Sure. Sure.

MR. SIMPSON: Yeah, understandably, exactly a certain --

THE COURT: I understand.

MR. SIMPSON: -- something happened -- it's a little -- let me have one moment and see if I can't --

THE COURT: Okay.

MR. GROEBER: Would we be recalling him, your Honor?

THE COURT: If y'all need to.

MR. SIMPSON: I'm happy to recall on that issue.

THE COURT: I just wasn't sure if I had just missed it.

MR. GROEBER: Your Honor, the North Carolina case, we don't have Westlaw.

THE COURT: Oh, here.

MR. GROEBER: Do you have a different cite in particular?

THE COURT: Here, just take it.

(Document is handed to Mr. Groeber from the Judge.)

MR. GROEBER: Thanks.

THE COURT: Sure.

MR. SIMPSON: Your Honor, I think we would like to put Mr. Brunson, Sr. [sic]. I'm sorry. As hard as it is talking about it for him, just very briefly on the stand to address that issue.

THE COURT: Okay. Let's do that. And y'all will be able to cross-examine if you need to.

Sir, if you will come back on up. You're still under oath.

(The witness resumes the stand.)

FURTHER DIRECT EXAMINATION

BY MR. SIMPSON:

Q Mr. Brunson, I'm sorry to call you again. Just a couple of quick questions. Is it difficult to

remember exact dates and times when conversations happened this long after the fact?

A I can't recall exactly.

Q But did you just mention to me that these types of conversations happened on more than one occasion while he was in the hospital?

A Yes.

Q And what did you just tell me specifically about helping him out with something he had to do medically?

A After they sewed him back up, he -- I guess, he was leaking inside because he started to swell. And he was rubbing his belly and kept saying, granddaddy, my belly -- I'm burning inside. And -- I recall asking the nurse for something and she went to the doctor and they told me to go to the drugstore and get some itch cream and put on his belly. And me and grandson walked over there, came back, and I sat there, and I was rubbing it, and -- he just point-blank asked me, he wasn't going to make it.

Q And that post -- after being sewn up, post-operative, with that, and the conversation about driving in the car, any -- I know this is tough. -- but any indication of during his hospital stay when that occurred?

A The car incident was before the --
Q The belly?
A -- the rubbing of the belly.
Q Okay. And was the -- was the -- the belly incident, and when you're helping him out with that, is that soon after being sewn back up?
A Yeah, it was a little bit after he was sewn back up because his eyes were yellow like a banana.
Q Okay. Did me know that, that his eyes were turning yellow?
A I can't recall if we discussed that or not.
Q Okay. So you say -- you had the conversation while you were putting the cream on his belly, and the car conversation preceded that?
A Yeah.
MR. SIMPSON: Okay. I don't have any further questions for you at this point. Thank you.

CROSS-EXAMINATION

BY MR. GROEBER:

Q I apologize. I actually did not hear what you said his statement was to you. After he was sewn up, I did not hear what you said. Could you repeat it?
A The incident where I was rubbing the cream on him --
Q Yes, sir.

A -- you talking about?

Yeah, he just pretty much pointblank said he wasn't going to make it -- he didn't think he was going to make it.

Q And you testified, too, though, that the discussions about the car happened several times?

A No. The incident talking about the car -- well, it was -- we talked about it a couple of times, but the specific one I mentioned was first.

Q Okay. But -- and you don't know -- you can't say which day that was that he --

A No, I can't remember exactly when.

MR. GROEBER: One moment, your Honor?

THE COURT: Okay.

(Mr. Groeber speaks with Ms. Ehrlich off the record.)

MR. GROEBER: No further questions. Thank you.

THE COURT: All right. Thank you, sir.

(The witness is excused.)

MR. SIMPSON: Thank you, your Honor. I will try my best to be as brief and direct as I can.

THE COURT: Whatever y'all need to do.

MR. SIMPSON: I'll kind of take these in the order that you did. On Michigan versus Bryant and the issue of testimonial or nontestimonial, I agree with the

Court that that is probably the most tangential here because it's -- if we find again, like the Court seems to be inclined to do, that this about -- that Crawford v. Washington does not impact on dying declarations, and that this was a dying declaration. We don't have to get into the Michigan v. Bryant.

On that point, I would just say that you have sort of a -- with respect a wishy-washy standard to put forward as the testimonial or nontestimonial by the majority in Michigan versus Bryant, seeming to leave open the possibility that a gunman on the loose isn't an emergency. And I think the detective also acknowledged on the stand, that, yes, while, of course, they do their work to later prosecute and get a conviction, that also -- a motivation of theirs also is, of course, public safety and then in getting a dangerous person off the street. That being said, you look at the elements put forward in Michigan versus Bryant, and I admittedly have an uphill battle.

One of the factors that you didn't mention, your Honor, was the formality of the statement, and I don't think I can dispute in this case that this, you know -- with a digital recorder at a hospital room, this is a fairly formal statement. You know, all that being said, I would just like to preserve our position that,

you know, there is an argument to be made that this is nontestimonial under Michigan versus Bryant even though some of those factors do work against us clearly.

THE COURT: Okay.

MR. SIMPSON: The brunt of our argument, however, is the classic dying declaration. I agree with what your -- the Court sort of indicated, that while this is an undecided question by our U.S. Supreme Court, it's not without some very suggestive dicta in the cases and in the footnotes that you've mentioned where the Court, itself, in both Michigan versus Bryant and Crawford versus Washington seems to be confused on why the State keeps abandoning the issue of why this isn't a dying declaration. I think you can certainly read into that and it's tipping of the cards, that because it's -- has such a long history, the dying declaration is preserved as an exception to the Sixth Amendment and to hearsay law, notwithstanding the holding in Crawford versus Washington, which brings us to the heart of this issue. And I agree with your Honor on this, which is, was this statement a dying declaration? And I don't know what the Court's intentions are; I just want to let you know, for your information, that I've explained to the family, who are present here today, we very likely might not get a decision on this hearing today. This

might be something that's very weighty that the Court wants to spend some time on. And I just want you to know -- I don't know what your intentions are, but they understand.

THE COURT: I'll tell you now. I want -- I need to go through the medical records with more of a fine-toothed comb. Because some of it, I couldn't -- we couldn't open because of the size, but I've got the hard copy now. And it's also just because sometimes my eyes are old, and they get tired. So I'm going to look at this. That's going to make a big difference because we have a couple of days' lapse in what's going on here.

MR. SIMPSON: Sure. And I can address that right now. Me and Mr. Groeber, we've had a lot of conversations about the medical records and what they mean. And I appreciate his point of view. I'm sure he appreciates from mine. But there's not a lot of disagreement. That's why we just entered them to let your Honor review.

A few nitpicky things, we were just talking about, trying to sort out. Obviously, the Defendant had majorly, invasive surgery, emergency surgery, in critical condition when he arrives on the 26th of April.

And, Cody, you can correct me if I get any of

the dates wrong.

I know I've reviewed the record --

And it's a lot, so if I'm mistaken on this point, forgive me.

-- that explains that he had further exploratory surgery on the 27th. Following this hearing, since we're going to take some time to process all this, I will provide for Cody and your Honor the specific page where I read that.

THE COURT: Great.

MR. SIMPSON: But I believe that there was some surgery done -- major surgery done on the 26th, and then some pretty exploratory, major, medical procedures, at the very least, followed up on on the 27th.

This statement was taken on the morning of, I think, the earlier -- properly corrected at 10:12 on the morning of the 29th. So you have major procedures on the 26th, the 27th, and that -- and that -- because of that day, between the 28th, is not just nonsensical. He had a breathing tube. He was intubated. The breathing tube was removed, I think, on the morning of the 29th -- or late the 28th. But, again, we can -- we can hammer that out after this hearing.

So the statement is taken a short duration once the tube is removed from his mouth, allowing him to

speak.

The records are what they are. In my -- how I would characterize what these medical records, when you have time to process all of them, your Honor, are going to show that the doctors believed that surgery was successful, that they were hopeful of a favorable prognosis. That's not something that the Defense and I disagree with. That the doctors conveyed to the family, hey, you know, surgery went as well as can be expected, and we're hopeful.

I would argue to your Honor, however, that that prognosis takes place in a context, and it takes place in a context of a gunshot wound to the abdomen and majorly invasive surgery. And I would also point you to the text -- the testimony of Mr. Brunson, Jr., when he conveyed to you sort of the -- a generalization of the news that they were receiving from the hospital, which was, hey, we're hopeful but concerned and to please prepare yourself and your family for the, you know, always a possibility with an injury like this and always a possibility on a major surgery like this, prepare yourself for the possibility that this might go south at any moment, and that was a very realistic possibility.

And so, obviously, his actual medical condition is a relevant consideration when making this decision,

but I would submit to the Court it is far from your only consideration. I will point to all of the line of cases, which says, look, the fact that the victim passed 33 days later, two weeks later, that's immaterial. I would say that suggests -- the person's actual medical condition, while relevant, is not the end of the discussion here. The relevant discussion was a person -- and it's difficult, because the person has passed. But was that person subjectively in fear of death, and I think when you look at the medical records, was that fear of death, of imminent death, a reasonable fear to have at that time. I would submit to you, your Honor, that as McConney says, when you take a look at all of the facts and circumstances surrounding the statement and all the testimony we've heard today, consider it as a whole and granted, there is things that cut both ways. But considered as a whole, I think that this victim was actually in fear of imminent death and that fear was reasonable.

Also, as I suggested in my Brief, I think the modern approach to these dying declarations, like you see in McConney, is not -- and I'm not trying to suggest that the element of imminent fear of imminent death is no longer an element. Certainly it is. But I think McConney and the cases cited therein suggest you can

take a broader, more reasonable approach. Obviously, it's not required that the person die the next day.

So let's review, and then, your Honor, I'll sit down. The evidence that we have suggesting this fear of imminent death. First, the medical records themselves, you have a statement taken assuming that in fact on the 27th there was further major surgery done, you have a statement taken about 48 hours after major invasive surgery. And I don't think I can overstate, that that is surgery to repair a bullet that had ripped through the body of Davon. Also included is the medical examiner's report that further bolsters just the severity of the surgery that's done and gives you a little insight into the later cause of his death. We've consented to and admitted 500 pages of medical records. And I think, while you see things in there that are hopeful and things that are suggestive of a possibility of him getting better, you also see plenty that echoes the severity of the situation that he was under and how he was in fact still in the woods, so to speak, and, in fact, possibly going to die.

You then have testimony of Jerome Fleming who explained to you that he couldn't use his hands. You can look at the actual statement itself and see how weak and scrawled his initials are on that. In the ICU,

again, we're in intensive care, in critical condition. And, your Honor, heard his invoice on the actual recording. And I submit to the Court, you can hear the weakness and the pain in that voice. He is, you know, answering questions intelligently and seems lucid. But you also heard from his father, Brunson, Jr., about that, you know. To become lucid, they would have to cut off the medication he had to keep him asleep.

Following up, you've heard probably the most -- the State's estimation of substantial evidence as to his subjective fear of imminent death, and that's the conversation that he had with his grandfather. I think you heard; he was close to his grandfather. They had this kind of relationship, and it was kind of a relationship where he would probably say things a little more frankly than maybe he wouldn't say to his friends and some of his younger family members. And you've heard the statement from the grandfather that, you know, very sad. I hope you don't think I was trying to be overly dramatic when I put him on, but it's directly relevant to the issue that we're here about today, which is that he was very upset that that could very well be his last ride with his granddad that he was going to have. And I think -- and also that's a direct statement of, you know, suggesting he was fearful of death. But

he went on to apologize to his grandfather for some of the decisions and some of the mistakes he had made in his life, and I think again that sort of apology, fearing -- is suggestive of a fear of imminent death.

We go on to the testimony of his father, David Brunson, Jr., he gives you a good summation of the news that the family is receiving from the hospital, and he acknowledged, you know, some of that was favorable; but the overall tone is that these things can turn at any moment; you need to prepare, both your son and your family for that possibility.

You heard from his father, David Brunson, Jr., that he would often stare off into space and sort of lose track. Obviously, you know, he's on medication, but then obviously that's some circumstantial evidence toward a fear and the fact that, you know, this wasn't -- Davon wasn't the kind of touchy-feely guy that would walk around holding people's hand. But while in the hospital, he almost constantly wanted someone's hand to hold. I think, again, that's circumstantial evidence of the degree of the fear that he was under.

You heard from his sister, Dendria Brunson, about the crying and some attempts to hide it from the family, but that on more than one occasion, he began to cry. I think from a person -- you know, Davon, you

heard from her, wasn't again an overly emotional person that would just cry in a bad situation. I think that again is indicative, looking at all the circumstances of a very realistic fear of imminent death.

It's a tough issue, your Honor, and there are -- again, things you've heard from the stand and things from the medical record, but we're not going to argue with Defense on this -- some signs of hope. I would submit to your Honor that -- and maybe the law just does a bad job in this category. But being hopeful of recovery and fearful of imminent death are not mutually exclusive propositions for someone in this kind of situation. I think it is very natural for someone in this kind of situation would have ebbs and flows and fear death -- you know, have a persistent fear of death while remaining somewhat hopeful of a recovery.

When you're faced with sort of a lot of mixed evidence like this, I would say you go to the heart of what goes most directly to the relevant issue, which is what is on Davon Goodwin's mind, and I submit that the best evidence you're going to hear on that is his conversation with his grandfather. And when weighing different evidence, that goes right to the heart of it, the State suggests that that tips the scale, this -- while it doesn't fit neatly in a lot of the

precedents, this is a -- it is a dying declaration when you apply a modern approach to that perception, and obviously it's already been discussed. Furthermore, Crawford v. Washington does not fit in that.

That's all I have.

THE COURT: Okay. All right.

Yes, sir.

MR. GROEBER: Thank you, your Honor. I'll start with the dying declaration, and then finish up with whether or not it's an exception.

I think that it's helpful to step back and remember why it is that this long exception to the hearsay rule exists. And the whole reason that it exists is because a person who believes that they're about to meet their maker wouldn't lie, that there's a reflection, there's a pause, there's a -- a thought of, I've got to be clean. I've got to be clear. I've got to clear my conscience.

And the reason that that is so protected, and that it's so important, and that the exception is so narrow is because it is so important that a defendant be able to confront his witnesses.

The second thing -- I want to talk a little bit about the first condition. I think that the modern approach to the -- Mr. Simpson is referencing -- I'm not

quite sure that there is a, quote, modern approach. I suppose -- I mean, I did cite several old cases in my Brief. Of course, there's really not a whole lot of cases. There's the Cunning in 2001, Bethia in 1963, and then you get back in to the '20s. And all of the cases up to Bethia say that there are three kind of requirements for it. And the first is that the person actually be in imminent danger of death. I sub- -- my guess is that the rule was adopted after Bethia and is in effect during McConney sort of gets away with that first requirement.

I don't know if that requirement still exists or not. I think we would argue that it does, and that it should. And the reason is, is because -- I suppose you could think of an example where someone wasn't actually in fear of imminent death or -- or was not actually in imminent death, but had some kind of unreasonable fear. I don't think that's the case here, but I do think that the first condition is out there and needs to be dealt with, and we would argue it still applies.

I think that McConney probably doesn't address that first condition, in addition to -- it's not specifically stated in the rule -- is that it's so obvious in McConney that the person is in -- is in

imminent -- is -- in extremis, is about to die. And that's because she has a huge gash in her throat that one person describes they can put their arm in. It's so obvious, in McConney, that that first condition is met, and so it's not discussed.

What is discussed in McConney, and the other cases, is that the second condition required to admit a dying declaration. And that is whether or not the victim was aware of imminent death and had any hope at life. I think if the State concedes to you that there was a mixture of hope and fear, then I believe that the cases are clear that if hope exists, then the statement does not come in. And I think that every single case talks about this requirement, that they have any hope.

It's true that those declarants need not express in direct terms an awareness of their condition. And that you can infer from the facts and circumstances, you know, what their -- what they were thinking at the time they gave the statement. I don't think there's any argument about that.

In McConney, the person actually did express knowledge to her imminent death. That is not anything that anyone in this case has testified about. It's not in the medical records, and it was not in any of the testimony today.

In McConney, there was a clear rejection by the person who -- the statement rejecting the nurse telling her she would be okay. The nurses are saying she's okay. Ms. McConney, she says, No, I'm not going to make it. She loses consciousness, never regains it, and dies many days later.

The other considerations that your Honor should consider -- and these are in McConney -- again, is repeated questions about the survival by the declarant. Am I going to make it? Am I going to make it? There's been no testimony to that today, less than reassuring answers to that question. I don't believe there's any testimony presented by the State to that.

Obviously, you can consider the nature of the wound, the condition of the victim. I think there is a lot of facts that kind of cut both ways when we're talking about what condition he was in. And I remind your Honor that the question is, what's the condition he's in at the moment he's giving the statement? Not right after his surgery, not five days after the surgery, and two days before he dies, but at the moment that he's giving that statement.

And that's why it's important, if you remember, the point of the exception for dying declarations to hearsay, is that it's supposed to be this almost

sacrosanct moment. And I don't believe that the evidence in this case suggests that there was this sacrosanct moment when he gave his statement to Detective Fleming.

I will point to a few facts in the medical records in the -- I guess I'll just refer to my Brief and ask your Honor to refer to that. The pages are directly on there. I'm not going to rehash those, because I know you have them and will read them again.

In addition, through the testimony today, I would highlight a few facts. All the testimony about when he gave his statement was that he was lucid and alert. Detective Fleming tells him, and it says on the statement, that he is recuperating from his injury. He had the ability -- Mr. Goodwin had the ability to correct mistakes or misunderstandings in his conversation with Detective Fleming.

I would urge your Honor to look at the medical records around the time that Mr. Goodwin gave his statement, because I don't believe that they support what his dad said about pinching the line. I believe that there would be evidence there was some kind of change in medication within the medical records that shows that there was a decrease of a certain narcotic. I don't believe that that is evidenced in the medical

records.

His sister testified that he told her that he was tired, and he was ready to go home. I think that clearly speaks that he had hope that he was going to go home. His brother testified that Mr. Goodwin told him that, quote, Everything will be all right. I think that also evidences hope that he will get better and go home. At no time --

I think the State mentioned kind of what the prognosis of the doctors were and what they were telling the family. And they were telling them that, you know, this -- it's a possibility that things could go bad. Well, that doesn't suggest that he is upon -- he has the -- that he is in imminent danger of death at the time he gives a statement. It just says that there's a possibility, and a possibility we don't think rises to the level needed in this case.

I think that the testimony of the grandfather is powerful testimony. And I would just say, your Honor, that it's unclear when these statements were given to the grandfather. I would also say that an apology can show hope to change in the future. And it does not necessarily mean that one is contemplating death at the time that statement is given.

MR. GROEBER: If I could have one moment, your

Honor?

THE COURT: Sure. Can I grab that case back from y'all?

MR. GROEBER: Yes, ma'am.

THE COURT: Thank you.

(Document is handed from Ms. Ehrlich back to the Judge.)

MR. GROEBER: Just a few more cases that I'd like to highlight that I E-mailed your Honor --

THE COURT: Okay.

MR. GROEBER: -- that I think are pertinent when comparing it to this case. One is State v. Riley, 1914. The statement was, Yes, I'm going to die. I may get up for a few days, but this one will kill me. And it said, This shot will eventually kill me. That did not rise to the level of a dying declaration, according to the Court. And I believe it's because he did not say he would die anytime soon.

I think that the cases of State v. Hall -- there's two cases. State v. Hall -- what I call one -- is 1924. The Court ruled in that case that there was not evidence to support a dying declaration exception, because there was no evidence that he had abandoned hope. Quote, and that is, he said that he had to die and could not live. That's State v. Hall, 1924 134- --

excuse me. -- 127 South Carolina 256.

They tried Mr. Hall again, and the same witness testifies -- the same witness who told her that he said that he had to die and could not live, she testified in the second trial, and she, I would say, corrected her testimony and said that he -- that the declarant said, I am dying. There is no hope for me. Fred Hall has killed me. Clearly that is an exclamation of no hope, the requirement that you have no hope. And he specifically says that there's no hope.

I'll also note in that one, that they did have a doctor testify about State v. Hall two. And I apologize. That's 127 South Carolina 256.

THE COURT: Okay. Thanks.

MR. GROEBER: They have a doctor testify about how -- how the victim was in imminent peril at all times during his injuries.

And then finally, I'll tell you to look at State v. Davis. And this is a specific -- to the question about the slightest hope of recovery. The holding is, if the deceased -- excuse me -- State v. Davis is 19 -- or 98 South Carolina 386, 19 -- I apologize.

THE COURT: We have it.

MR. GROEBER: Okay. All right.

THE COURT: That's fine.

MR. GROEBER: The quote there is, I don't believe I'm going to make it. That was not enough to qualify for the dying declaration exception. Mainly because the -- the holding was that if there was the slightest hope of recovery when the declarations were made, they are inadmissible.

So we would argue, your Honor, that case law is -- is instructive, those cases specifically, when compared to this case. We would argue that the State has not met its burden in proving that it is a dying declaration in this case.

THE COURT: Okay.

MR. GROEBER: That is enough for me on that issue. I would like to address quickly whether or not -- if you did find that this was a dying declaration, the exception. I think my Brief lays out the two main arguments. I would encourage your Honor to read the article that Michael Pylel (phonetic) wrote that is cited within my Brief. I think it has a good explanation of the history that is the opposing view.

And I haven't read the case you cited, but I've read some of the opinions about the majority idea. And I will ask you to consider that as a criticism to the majority --

THE COURT: Okay.

MR. GROEBER: -- holding on that exception.

THE COURT: I will read it.

MR. GROEBER: And I think that's all from me. Thank you, your Honor.

THE COURT: Do y'all want to talk to me about the Biggers issue now? Or do you want to wait and -- this is my thought process -- we're in general sessions next week; correct?

THE CLERK: Uh-huh.

THE COURT: I want to read everything that y'all have talked about this morning that I haven't had a chance to read yet, and I want to go through the medical records. Tell me if this will work for y'all. We're in trial, I think. But we're in GS next week. If y'all are going to be around, we can get a time that I can rule on the record so y'all will have a record. And then y'all can do an order if you want to, and then y'all can argue the Biggers issue, or you can do it now. It doesn't matter to me.

MR. SIMPSON: I'd rather go ahead and do it.

THE COURT: If you want to do it now, that's fine. Whatever y'all want.

MR. SIMPSON: Our position on the -- our position on the Biggers issue is pretty straightforward.

You have factors -- the Neil v. Biggers factors, but you don't even get to those factors unless there's an initial showing of suggestivity --

THE COURT: Right.

MR. SIMPSON: -- that the police did something improper and suggested an answer, you don't even get to the Neil v. Biggers factor. So we're, in the State's estimation, dead in the water right there. Nothing that was done by Detective Fleming suggested an answer. Even if you do find there was some sort of police misconduct -- remember, that's what Neil v. Biggers is meant to combat, is some sort of suggestive misconduct by the police. If you find suggestive conduct, then you move on to the factors. And the factors, while they may not have been on the recording, expressly rattled off one, two, three, four, five -- I think they're all covered. The opportunity to view, the -- the defendant is suggested. His certainty, you've heard -- while not on the recording, you heard the circumstantial evidence that he didn't express any hesitation, it didn't take him much time, he looked right at it, he pointed at it.

But without wasting the Court's time, I think we've got the Neil v. Biggers factors satisfied as well, but we don't get to those factors unless there's some kind of showing of suggestibility, and I don't think

that showing's been made.

THE COURT: Okay.

Yes, ma'am?

MS. EHRLICH: Thank you, your Honor. As far as whether or not the procedures were suggestive, I want to just kind of lay out our position. First, the identification was done in the hospital, that he was questioned in front of the parents, where there's the added pressure to give the answers. But the two main issues that we have with the procedures and the lineup that was done is, number one, the actual lineup itself. That's why we wanted the color copy admitted to the Court. I know that Detective Fleming testified that he chose the photographs -- or he reviewed the photographs to make sure that the fillers were similar. I don't know if that -- I don't know if I agree with him on the fillers being similar to the Defendant in the case. The only similarity I really see is the race. They appear to have different face structures, ages, complexion. And that -- that concerned us, as far as who the people are in the identification, as far as the fillers.

The reason I brought up, on cross-examination, his training and what he's supposed to do in documenting is that he knows that he's supposed to fully document everything. And even the things that were recorded by

Detective Fleming and then later put in a police report, there are inconsistencies. And our concern is that if there's an inconsistency in his testimony or a police report with what's actually recorded, what did really happen in the room when the recording didn't happen?

It's the most important part of the interview. He testifies that he's doing this to try to help, you know, make an arrest. But he turns off the digital recorder at the most important time. And there's not real clear testimony about what actually happened in the room at the time. Then by the time the recording comes back on, he's referring to the suspect by the name of Marvin. He says in front of everybody that this is -- you know, this is the person, that that's a positive identification. And also, Detective Fleming testified that he had prior knowledge of the Defendant and that -- our position is that that influenced him when he was doing a lineup, that it should have been somebody independent of Detective Fleming, somebody who didn't know anything about the investigation, didn't know anything about the Defendant, and didn't go in there with kind of a preconceived notion, this is who he should identify.

THE COURT: Y'all make sure I'm clear on this. My understanding, from the detective's testimony, was

that he didn't say the name Marvin -- he being the detective -- until the Defendant had already been identified. I mean, I didn't hear anybody say Marvin before.

MS. EHRLICH: I think that's what his testimony was today.

THE COURT: Okay. And does the tape state anything different? I didn't see that -- hear that.

MR. SIMPSON: No, your Honor.

THE COURT: Okay. And then the -- the fact that it was a positive identification in the detective's mind, again, came after the picture had been identified; correct?

MS. EHRLICH: If -- if you believe all of the testimony and you believe that nothing happened when the recording was off.

THE COURT: Okay.

MS. EHRLICH: Yes.

THE COURT: I mean, I believe, based on what I heard and observed today, that the detective was uncomfortable in a tiny little ICU room at the MEDU, or wherever this was, and there isn't a lot of room in those areas to place things. His testimony, as I heard it, was that he turned the video [sic] recorder off so he could get everything situated, and wasn't allowed to

put stuff on top of the Defendant because he had tubes sticking out of him, I think. If I'm wrong about that, y'all clear me up.

MS. EHRLICH: My only response to that is that there were two other people in the room that could have held the recorder for him. I --

THE COURT: Okay.

MS. EHRLICH: -- mean, maybe it was just an honest mistake on his part that he didn't think about it. But there are -- and then there is a hospital full of people who could have come in and held the recorder. I've had other cases where the nurse is holding a light up for the person to help the person make an identification. I don't think that's a sufficient reason for not recording the most important part of the interview.

THE COURT: Y'all correct me if I'm wrong. I'm just trying to think this through. I think I've had people testify about six-pack lineups and identifications when nothing was recorded. They just gave their testimony that he picked him up out of the six-pack; correct?

MR. SIMPSON: Absolutely. And that's our position. He went above and beyond in recording this. And had a parent of the victim assisted in any way, we

would be here right now arguing about how improper that was. I just think it's a practical thing to cut off the recording for a brief period of time. It is what it is.

THE COURT: All right. Well, doing the Neil v. Biggers analysis, I do not find that the identification process was unduly suggestive. I've looked at the photos. And, of course, they don't all look exactly alike, and they don't all have the same complexions, but I don't find them to be so dissimilar as to be unduly suggestive, particularly since they're all dressed the same way. You know, we don't have different people -- sometimes six-packs have made the mistake of having some people in a jail jumpsuit and other people dressed differently. I don't have a problem with the composition of the six-pack lineup itself.

And I do find that -- that it was reliable, and that there was no substantial likelihood of misidentification. Certainly, the witness had the opportunity to view the perpetrator at the time of the crime. He would have been paying a great degree of attention to him. He was medicated and brought out of medication to identify him but didn't demonstrate any doubt about who he selected. So I'm comfortable with that. So if we get to that point, I would not exclude that -- the identification under Neil v. Biggers.

Now, I still need to make a determination as to the -- whether this was a dying declaration or not. And I do want to read that law review article that sets forth the minority rule such that we have it so far, because a lot of courts are still trying to figure out where to go based on the United States Supreme Court's dicta and this somewhat wavering on Crawford. So let me take a look at that, and I will try to figure that out by the end of the week.

Y'all aren't up next week?

MR. SIMPSON: I am.

THE COURT: You're in a different matter, though; right?

MR. SIMPSON: In front of Judge Dennis, right.

THE COURT: But not this?

MR. SIMPSON: Oh, not this case, no.

THE COURT: I just want to make sure I'm not holding y'all up if it takes me until Friday to figure this out.

MR. SIMPSON: No.

THE COURT: Okay.

MR. SIMPSON: I do have one thing to say in response to Mr. Groeber. I don't mean to waste your time.

THE COURT: Sure. No, we're fine.

MR. GROEBER: Because I think I stated something on the record a little inartfully, and I want to correct myself.

THE COURT: Let me just stop y'all real quick.

Okay. You're in front of Judge -- am I in trials or pleas next week?

THE CLERK: Yeah, pleas.

THE COURT: We're both doing trials?

MR. SIMPSON: It's a case that you're recused on because you know Bill Capps.

THE COURT: Oh, gotcha. Okay. Thank you.

MR. SIMPSON: We moved it to Dennis to start on Monday.

THE COURT: Gotcha. Okay. I just want to make sure I'm in the right place. I'm sorry to interrupt you, Mr. Simpson.

MR. SIMPSON: I'll be as brief as I can.

THE COURT: That's fine.

MR. SIMPSON: The first element that Mr. Groeber mentioned is imminent danger of death. I would just stress to you that that is danger of death, not imminent death. I meant danger of death. We think that's certainly -- precedents in the case.

And, second, as to the element of any hope of life. First, I think you'll find those, again, in -- in

more of these more rigid analyses that you'll find a hundred years ago. When you look at McConney, and especially look at the cases cited in McConney, because it's a great little nationwide review; while, of course, they don't reverse that element, I think their analysis of that element is a little less rigid than you find in the old cases.

And most important to correct something I said. There is hopeful news coming from the doctors at times. You will see that in the medical records. But the evidence that goes to the state of mind, the most relevant evidence, overwhelmingly points to the fear of death and not to hope. I received a note from the family. Take this how you will, your Honor. But their interpretation of his statement, I'm ready to go home was, I'm ready to pass. I'm ready to pass on to Heaven. And they wanted to make sure I conveyed that to you. That was their interpretation of him saying that.

And I would just submit that the other direct evidence quoted by the Defense, everything will be all right, is a person telling his little sister and brother not to worry about him. I don't think that that's really indicative of hope of a full recovery.

THE COURT: Well, and I think even in McConney, the Court acknowledged that there are lots of situations

where medical personnel are going to tell a victim or someone that they're going to be fine. You know, the Defense's response to that is, in McConney, the defendant shook her head and said, No, I'm not. So I understand that part, and I appreciate that.

Okay. I will read all of the rest of your submissions and the law review article and the medical records, and we'll go from there.

MR. GROEBER: The only thing -- I read the cases that McConney references. The facts are so different. So I -- that would be my response to -- I think there's a couple of Louisiana cases and a Texas case, and we could address those at a later hearing if we need to. But I would argue the facts are, as in McConney, so different than in this case.

MR. SIMPSON: Okay. We could probably do this all day.

THE COURT: I mean, we can argue about this and find different distinctions the whole time. I'm going to tell y'all what I find significant. I think the autopsy report is significant, because you had substantial bacterial growth, even into the muscle. There's probably no question that the decedent was in a significant amount of pain and scared to death when he's in bed. Granted, there was medication. And I think all

of that plays into somebody's state of mind as to whether they think they're in fear of imminent death or not, or in danger of imminent death. But I need to look at it, and we'll go from there. Okay? Thank you.

Anything else we need to look at while we've got you in here?

MR. GROEBER: I don't think so. Thank you, your Honor.

THE COURT: All right. Good job, y'all. This is complicated. To me, at least. Thank you.

WHICH WAS ALL THE EVIDENCE ADDUCED AT THIS CAUSE.

(The hearing of this cause concluded at 12:38 p.m., on March 26, 2013.)

STATE OF SOUTH CAROLINA	)	COURT OF GENERAL SESSIONS
	)	NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	)	
	)	
The State,	)	CASE NO. 2012-GS-10-06844
	)	2012-GS-10-06845
APPELLANT,	)	2012-GS-10-06846
	)	
VS.	)	
	)	TRANSCRIPT OF RECORD
Marvin Brown,	)	
	)	
RESPONDENT.	)	
	)	

December 10, 2013

Charleston, South Carolina

B E F O R E:

The Honorable Stephanie P. McDonald

A P P E A R A N C E S:

Chad Simpson, Assistant Solicitor
For the Appellant

Cody Grober, Esquire
For the Respondent

I N D E X

HEARING -- 3

Dying Declaration Hearing/Bond Reconsideration

CERTIFICATION OF TRANSCRIPT -- 17

Look for an original signature in blue ink on the certification sheet to verify that the court reporter has certified the transcript you are viewing.

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THE COURT: On the record in State versus Marvin Brown. All right. I certainly apologize for how long it has taken me to get the ruling to y'all on this. I think as you know I have been struggling with it because it is somewhat uncharted territory at least in the confrontation clause area, although I have some thoughts on that.

But after reviewing the medical records, the information about the extubation of the victim and his health status at the time of him looking at the six-pack that the officer brought, I do not think that this falls within 804(b)(2) which deals with the statement upon belief of impending death.

Because at that point it's my understanding that the victim was extubated. I believe there was testimony from a sister that said he just seemed tired and ready to go home. And if I'm wrong on that, y'all correct me.

But he was ambulatory I believe the next day or perhaps later that day. He actually was screened for a physical therapy session, and everyone thought he was getting better.

This to me was different than the situation in McConey which was the case that was most helpful. Let me just pull up my notes on that. There you had a victim that I believe never regained consciousness after she made her declaration. Her throat was cut. The court did not find necessarily relevant the fact that she didn't die for two more weeks,

but it was the fact that she never regained consciousness and shook her head and thought she was going to die at the time.

So I would not -- I find that the hearsay exception of 804(b)(2) does not apply. I think for that reason I don't need to reach the confrontation clause issue. But if y'all want me to for purposes of appeal, I'm happy to do that. That would be advisory on my part, I guess. But and the court may.

But what I did find so far, it was certainly testimonial. I mean the officer went there with a six-pack for him to look at. And even though he did really well saying no we were trying to get a dangerous criminal off the street it wasn't the emergent situation where you have the first person dying in a back alley.

MR. SIMPSON: And I believe we conceded that at the hearing, Your Honor.

THE COURT: Okay. And I appreciate that.

MR. SIMPSON: Certain testimonial ---

THE COURT: Y'all were great to deal with with the facts that you stipulated to and the information that you provided.

The other exception obviously -- issue under the confrontation clause is when it is a common law -- I mean this is the dicta I believe we have out of Crawford and

maybe Michigan v Bryant referred to it. But talking about how the common law allowed the declaration of the deceased long before we had our hearsay rules or specifically even our constitution in Crawford I found the case indicated from time and memorial they had been treated as competent testimony and no one would have the hardihood at this day to question their admissibility -- well, that is a split.

I mean there is a split in the courts. But the majority seemed to be going the way of allowing statements upon eminent death, which is I think is the way the federal rule refers to it or statements upon a belief of impending death which is the way our rule, and not finding those banned by the confrontation clause.

But again, I don't have to get to that if y'all don't want me to because I am finding that we don't have an 804(b)(2) situation.

I just don't believe that the intent of the exception deals with someone in the health condition that the victim was in. And it wasn't just a spontaneous declaration, you know, so and so did it. This is an officer that went to his room with a six-pack to look at. That is just another reason why likely 804(b)(2) would not apply.

Now I am happy if one of y'all wants to give me a proposed order so y'all can tee it up for appeal, or however y'all want to handle it. Chad, Cody, ya'll ---

MR. SIMPSON: Well ---

THE COURT: Whatever y'all want to do.

MR. SIMPSON: It would be, you know, obviously ---

THE COURT: Okay.

MR. SIMPSON: --- my side would be seeking this appeal.

THE COURT: Okay.

MR. SIMPSON: I don't know that we will ---

THE COURT: It doesn't hurt my feelings one bit. We need to know ---

(Pause for Court's comments on attorney entering courtroom for unrelated case.)

MR. SIMPSON: I think considering that -- I am not trying to put more work on Mr. Grober. I think since they, quote, unquote, won, so to speak, that it would be more appropriate for him to draft the order.

THE COURT: Well, if Mr. Cody -- if Mr. Grober just wants to turn his brief into an order and then send it to me in Word so that I can jump into it with the additional law that I pulled and a little bit of what I just said ---

MR. GROBER: Sure.

THE COURT: --- I will get that in a posture so that you can discuss it with whoever you need to discuss it to decide if you want to appeal or not. And I don't even have to address the confrontation clause issue unless y'all just want me to.

MR. SIMPSON: Well, I think should an appeal be -- you know, both sides I think conceded this is incredibly close. And were an appeal to be sought it would be ---

THE COURT: Okay.

MR. SIMPSON: --- for clarification of a tough issue. I think if that is -- again, I don't know that it is. But if that is the route we take ---

THE COURT: Okay.

MR. SIMPSON: --- I think the ruling on both ---

THE COURT: All right.

MR. SIMPSON: --- prongs would be most helpful.

THE COURT: Well, ---

MR. SIMPSON: --- if I understand you correctly.

THE COURT: --- let me do that. And then if Chad needs to appeal and you need to cross appeal, it doesn't hurt my feelings. But it will give them a chance to have it tee'd up.

MR. SIMPSON: For full ---

THE COURT: And by them, I mean the folks in Columbia. So that y'all don't have to re-create the wheel. Because this is going to come up again. I mean I don't know what is trickling up to the United States Supreme Court, but when there is a split like this, it is going to keep coming up.

MR. SIMPSON: Sure.

THE COURT: All right. I will do that ---

MR. GROBER: I should be able to get the brief to you tomorrow.

THE COURT: Okay. Well, I owe Rand Stoney an order before I owe this one. So I will get it to y'all as quickly as I can. What else did y'all need me to rule on, or I think there was a bond setting issue.

MR. GROBER: Yes, Your Honor.

THE COURT: Okay.

MR. GROBER: I know we did -- we did a Neil v Biggers. I believe you ruled. Obviously this supersedes that ruling to some -- I mean it doesn't change the ruling, but it kind of depends if they appeal it or not.

We do -- we would like to address bond and also motion for a speedy trial. On -- and I can ---

THE COURT: What is the current bond?

MR. GROBER: He actually has no bond.

THE COURT: Oh, no bond. Okay.

MR. GROBER: On murder. And I mean I don't know that he has bond on anything.

THE COURT: Okay.

MR. GROBER: We would ask that you -- I know he has one at least no bond on a murder.

THE COURT: Okay.

MR. GROBER: I think there is a bond set on the armed robbery.

THE COURT: Okay.
(Mr. Grober confers with client.)
MR. GROBER: Okay, and he says there is not. I apologize. I don't have it with me.
THE COURT: All right.
MR. GROBER: I do have, you know, blank form order. I can address that issue now if you would like, Your Honor.
THE COURT: What, the speedy trial issue or ...?
MR. GROBER: Well, both.
THE COURT: The bond and the speedy ---
MR. GROBER: Bond -- I mean we would move that you set a bond.
THE COURT: Well, here is the thing. I have just thrown a huge curve ball at the State's case, and so y'all may need to chat. I don't know what the other evidence is. I need to know his prior record about the bond and something that the State would like and also when you think we might be able to try this understanding that the analysis is different now that the ID is out.
MR. SIMPSON: We would -- I would ask, Your Honor -- and I'm glad you recognize this. Obviously this is going to be a full reassessment ---
THE COURT: I understand.
MR. SIMPSON: --- of the entire case. And I'm reluctant to make any ---

THE COURT: Okay.

MR. SIMPSON: --- definitive statements on the record because I need to look through ---

THE COURT: You don't -- I'm not going to make you do that.

MR. SIMPSON: --- again. I will say that our strongest most substantial evidence was -- was the statement that we are arguing about today. And it's clearly -- it's hard for me to overstate how much that changes the strength of our case.

THE COURT: I thought that might be the situation. And y'all, just to know, I like y'all both. I looked at it fully as I thought the law needed to be applied.

MR. SIMPSON: And we appreciate the time that you took. And I think certainly we have got a great record that you allowed us to make on this issue.

THE COURT: Tell me what his prior record is if you would.

MR. SIMPSON: Your Honor, he has a 2002 trespassing, possession of marijuana, and strong-armed robbery for which he served an active YOA.

THE COURT: Okay.

MR. SIMPSON: A 2005 possession of marijuana, 2007 possession of marijuana, and 2010 a second strong-armed robbery for which he received a sentence of five years.

THE COURT: Okay. And this allegedly happened shortly after he got out?

MR. SIMPSON: Yeah, this happened in May of 2011 which would have been -- I mean I don't have the actual dates of service. But ---

THE COURT: Okay. How long has he been incarcerated?

MR. GROBER: May 4th, 2011.

THE COURT: May 4th of ---

MR. GROBER: If I can give you some dates just procedurally.

THE COURT: Sure. Sure.

MR. GROBER: That was the date of his arrest. His bond essentially was denied in June of that year. A motion for a speedy trial was filed in July of that year. In July 20th of 2012 I filed a motion for a speedy trial and to revisit bond. Judge Nicholson ruled that it should be tried by January of 2013 or I be allowed to revisit bond.

THE COURT: Okay.

MR. GROBER: I held off on addressing that because I knew that we were having this hearing.

THE COURT: Okay.

MR. GROBER: Or that we were having a hearing ---

THE COURT: You were waiting on me ---

MR. GROBER: --- in March.

THE COURT: Right.

MR. GROBER: So in my -- I would say that Mr. Brown has been very patient with the process and he's really been a pleasure to work with.

So I know that initially -- it is on a couple of trial dockets, the priority dockets. One is January 27th, one is March 31st. I think I have all discovery. But we want to make -- we will meet again to talk about that to make sure.

But, you know, we were ready to move and get some resolution and certainly, you know, would like a bond to be set.

THE COURT: And, sir, please know the delay was in no part on your attorney's fault or Mr. Simpson's. And I apologize to you, sir, as well. This was an extremely close legal issue and I have struggled with it.

Did this gentleman wish to be heard? Yes, sir, if you would give me your name for the record first.

AUDIENCE: David Allen ---

THE COURT: Yes, sir, I am happy to hear from you.

AUDIENCE: I am the grandfather of Davon and I request that no bond be set at this time and even on the appeal.

THE COURT: Okay. Well, I appreciate that, sir. Thank you, sir.

MR. SIMPSON: And, Your Honor, to verify some of the dates ---

THE COURT: Sure.

MR. SIMPSON: --- Mr. Grober gave you. We are second on the priority docket for January.

THE COURT: Okay.

MR. SIMPSON: I might have the actual day wrong. But it is late January. The 27th?

MR. GROBER: I want to say ---

THE COURT: There are a lot of things, speedy trial matters popping up around then.

MR. SIMPSON: And then we're -- we think we do have a firm priority docket first up ---

THE COURT: Okay.

MR. SIMPSON: --- for March of two thousand ---

THE COURT: Well, hopefully that will give y'all time to decide your procedural posture of what you want to do ---

MR. SIMPSON: Yes, Your Honor.

THE COURT: --- and we'll go from there. The defendant has been incarcerated for quite some time. I am uncomfortable with his prior record. But under the Constitution and Title 17 he is entitled to a bond.

I'm going to set a $200,000 consolidated bond. And I will no longer be the administrative judge starting in January; but if y'all need to revisit this, you know, I'm happy to -- I know more about it. You know, Judge Young will be coming in cold. I am happy to help any way I can in moving that along. I will get ya'll the order as soon as I

can.

Cody, if you will e-mail me your brief. We may already have it in Word. Just shoot us that and we will deal with it.

MR. GROBER: Sure.

THE COURT: And we will get the order as quickly as we can. What else; anyway that I have not ruled on that I need to rule on for y'all so y'all can move this thing forward?

MR. SIMPSON: Just should there need to be a record for an appeal ---

THE COURT: Yeah.

MR. SIMPSON: --- let me -- I want to clarify and I think Mr. Grober referred to this. Just so you don't have to redo all this stuff --

THE COURT: That's fine.

MR. SIMPSON: --- if it should happen. But it was my understanding that you -- at the initial hearing it seemed to me like you ruled on the Neal v Biggers ---

THE COURT: Yeah ---

MR. SIMPSON: --- and that that wasn't a real concern to you.

THE COURT: I did not find the lineup to be unduly suggestive. I didn't think we had a Neal v. Biggers problem. My concern the whole time was the whether the hearsay exception applied and what implication the

confrontation clause would have.

Sarah and I both poured through the medical records and went over the notes and read the cases. And this just doesn't come within 804(b)(2) as I interpret it.

But, yes, I did not have a problem with under the totality and circumstances with any suggestivity problem on the part of the lineup. And I'm happy to put that in the order as well.

You know, that burden is on the defense to show that the lineup is unduly suggestive. And only if we find that it is do we even have to reach the reliability issue. But I do find that it was reliable. It just doesn't fall within that hearsay exception.

MR. GROBER: Thank you, Your Honor.

MR. SIMPSON: Thank you.

MR. GROBER: A blank order ---

THE COURT: Okay.

MR. GROBER: --- for bond purposes?

THE COURT: Oh, and I have got this one too.

MR. GROBER: Oh, okay.

THE COURT: But it doesn't matter. This is just a format they use.

MR. GROBER: Okay. That's fine.

THE COURT: You can do that if it's easier.

MR. GROBER: I am fine with that.

FILED
2013 MAR 13 PM 12:10
JULIE J. ARMSTRONG
CLERK OF COURT
BY

STATE OF SOUTH CAROLINA) **IN THE COURT OF GENERAL SESSIONS**
) **FOR THE NINTH JUDICIAL CIRCUIT**
COUNTY OF CHARLESTON) Case No(s):
) Warrant No(s): M640172; ~~C-10-11-0476;~~ M640173; M640174; M640203
) Charge(s): Poss. Wpn. During Viol. Crime; Probation Violation; Murder/Attempted; Armed Robbery; Murder

STATE OF SOUTH CAROLINA)
)
vs.) **Motion to Suppress Hearsay Testimony Of Victim**
)
MARVIN REGINALD BROWN,)
)
Defendant)

YOU WILL PLEASE TAKE NOTICE that the Defendant, by and through the undersigned attorney, will move before the Presiding Judge of the Court of General Sessions at the Charleston County Judicial Center, 100 Broad Street, Charleston, South Carolina, as soon as the matter may be heard for an Order suppressing any Hearsay statements of the Victim in the case by witnesses for the Prosecution on the grounds that introduction of such statements deny the Defendant due process, all in violation of the Laws and Constitutions of the State of South Carolina and the United States of America. This motion is filed pursuant to Crawford v. Washington, 541 U. S. 36 , S.C. Rule of Evidence 801 and 802.

Respectfully Submitted,

Cody J. Groeber
Assistant Public Defender
Attorney for Defendant

Charleston, South Carolina
Dated: 3/12/13

STATE OF SOUTH CAROLINA COUNTY OF CHARLESTON	**IN THE COURT OF GENERAL SESSIONS FOR THE NINTH JUDICIAL CIRCUIT** Indictment No(s): 2012-GS-10-6844, 6845, 6846 Charge(s): Murder, Armed Robbery, Possession of a Weapon During a Crime of Violence
STATE OF SOUTH CAROLINA vs. MARVIN BROWN Defendant	**MEMO IN SUPPORT OF MOTION TO SUPPRESS HEARSAY TESTIMONY**

I. Facts

Davon Goodwin, was shot on April 26th, 2011, around 2 a.m. on America Street in downtown Charleston, South Carolina. He was transported to the Medical University of South Carolina, where he underwent surgery on the same day. He made it through surgery and regained consciousness sometime on April 27th. The next day, the breathing tube was removed, and he was able to converse with his family and doctors. His condition was generally improving throughout his stay in the hospital. *See* attached Exhibit A, a copy of Mr. Goodwin's medical records.

On April 29th, Detective Fleming of the Charleston Police Department interviewed the victim. Detective Fleming read him a standard admonition form for photographic lineups. (Exhibit B) The victim identified the Defendant in a six-pack photo lineup. There is a partial audio recording of this identification procedure. (Exhibit C) On May 4, 2011, the victim died from complications of the gunshot wound.

II. Argument

The Defendant maintains that the victim's statements and identification of the Defendant are inadmissible. The Sixth Amendment's Confrontation Clause provides that, "[i]n all criminal prosecutions, the accused shall enjoy the right ... to be confronted with the witnesses against him" U.S. Const. amend. VI. *Crawford v. Washington*, 541 U.S. 36 (2004), held that the admission of testimonial statements by an unavailable witness whom the defense has not had a prior opportunity to cross-examine violates the defendant's Confrontation Clause rights under the Sixth Amendment.

In South Carolina, not only is this right applicable to state prosecutions under the Fourteenth Amendment, it is specifically mandated by the State Constitution. *State v. Green*, 269 S.C. 657, 661 (1977) (citing S.C. Const. art. I, § 14).

Even if a statement does not run afoul of these Constitutional Amendments, it may still be inadmissible as Hearsay. Hearsay is defined as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." Rule 801(c), S.C.R.E. Hearsay is generally inadmissible. Rule 802 S.C.R.E. An exception to this general rule is a dying declaration. Rule 804(b)(2), S.C.R.E., provides that dying declarations are admissible: "In a prosecution for homicide or in a civil action or proceeding, a statement made by a declarant while believing that the declarant's death was imminent, concerning the cause or circumstances of what the declarant believed to be impending death."

A. Confrontation Clause

The victim's statements should be excluded because they are testimonial in nature, and therefore, are subject to the confrontation clause's requirement of cross examination.

1. ***Crawford***

Crawford concerned whether the statements of the wife of the accused were admissible although she was unavailable as a trial witness. The Supreme Court held that the prior case law erroneously permitted admission of the wife's statement based on the concept of reliability. When testimonial statements are the issue, "the only indicium of reliability sufficient to satisfy constitutional demands is the one the Constitution actually prescribes: confrontation." *Crawford* at 69. The right to confrontation was found not to be a substantive guarantee that evidence be reliable, but rather a procedural guarantee that the reliability of the wife's statement be tested by cross-examination. *Id.* at 61.

The Court established a two-prong test in which statements are inadmissible: (1) if the statements are "testimonial" and (2) the witness is unavailable to testify unless the defendant has had a prior opportunity for cross-examination of the witness.

2. **"Testimonial" Statements**

a. ***Crawford***

Although *Crawford* did not fully define what constitutes "testimonial" statements, it provided guidelines for what would make a statement "testimonial." For example, the Court explained that "pretrial statements that declarants would reasonably expect to be used prosecutorially" would be categorized as "testimonial" statements. *Id.* at 51-52. "Testimony" is generally "[a] solemn declaration or affirmation *made for the purpose* of establishing or proving some fact." *Id.* at 51, citing 2 N. Webster, *An American Dictionary of the English Language* (1828) (emphasis added). The Court also noted that "accusatory statements to police officers" were "testimonial statements." *Id.* at 68.

b. ***Davis* and *Hammon***

In a pair of cases two years later, the Court clarified (to a degree) which statements to a police officer are "testimonial." See *Davis v. Washington* and *Hammon v. Indiana*, 547 U.S. 813 (2006). In *Davis*, the victim of abuse by her boyfriend called 911. While speaking with the operator, she gave her boyfriend's name and described her abuse at his hands. She did not testify at trial, and over the defendant's objection, the State was allowed to play the 911 tape. *Davis* at 818-19. In *Hammon*, the police were dispatched to the defendant's house for a report of domestic disturbance. When the police arrived, the victim first claimed that nothing happened. Then she signed an affidavit alleging that the defendant pushed and hit her. Again, at trial, the victim did not testify. Over the defendant's objection, the State was allowed to introduce the affidavit alleging the battery. *Id.* at 819-21.

The Supreme Court explained that statements are "non-testimonial" when made in the course of police interrogation under circumstances objectively indicating that the primary purpose of the interrogation is to enable police assistance to meet an ongoing emergency. *Id.* at 822. Statements are "testimonial" when circumstances objectively indicate that there is no such ongoing emergency, and that the primary purpose of the interrogation is to establish or prove past events potentially relevant to later criminal prosecution. *Id.*

The Court, applying the above reasoning, distinguished the two cases. The 911 statements were non-testimonial (and therefore not subject to the Confrontation Clause and its procedural requirement of cross examination) because the purpose of the call was to "a call for help against a bona fide physical threat." *Id.* at 827. "Ordinarily [a 911 call] is not designed to primarily "establish or prove" some past fact, but to describe current circumstances requiring

police assistance." *Id.* at 827. The victim in this case was "speaking about events *as they were actually happening*." (emphasis in original). *Id.*

When distinguishing the facts in *Davis* from the facts in *Crawford*, the Court examined the following factors: (1) how close in time was the statement made in relation to the event itself, (2) whether or not there was an ongoing emergency, (3) whether or not the questions asked elicited statements necessary to be able to resolve the present emergency, and finally, (4) the level of formality of interviews. *Id.* at 826-28.

When the Court examined the facts in *Hammon* through these factors, it determined that the victim's oral statements and affidavit were testimonial because the clear purpose was to "investigate a possible crime." *Id.* at 830. The Court found that the affidavit was a solemn declaration or affirmation made for the purpose of establishing or proving some fact that occurred in the past. *Id.* at 832. The court found these facts much closer to the facts in *Crawford.* There was no emergency in progress and no immediate threat to the victim's person. *Id.* The Court determined that the officer was not seeking to determine "what is happening" but "what happened." *Id.* at 830.

Finally, when the Court examined the level of formality, it found that it was more similar to a station house interview than a 911 call. *Id.* The victim was moved away from her husband, her account was in response to police questioning, and the interview took place some time (several minutes) after the events that she described were over. The Court believed that all of this was an obvious substitute for live testimony. Consequently, the statements should not have been admitted.

c. ***Michigan v. Bryant***

In *Michigan v. Bryant*, 131 S.Ct. 1143 (2011), the Court again waded into the waters of confrontation. In *Bryant*, the police responded to a dispatch and found the victim in a parking lot mortally wounded. In response to police questions, the victim described the circumstances of the shooting, told the police that the defendant shot him, and he had driven to the parking lot. The conversation with the officers lasted between five and ten minutes, and then EMS arrived. *Bryant* at 1150. The victim subsequently died, and his statements were admitted at trial over defense objection. The United States Supreme Court found that the statements were non-testimonial because the "primary purpose of the interrogation was to enable police assistance to meet an ongoing emergency." *Id.* This was important, because, as the Court noted, "an ongoing emergency focuses the participants not on proving past events potentially relevant to later criminal prosecution. Rather, it focuses them on ending a threatening situation." *Id.* at 1157 (citations omitted).

Bryant gives perhaps the most robust example of the "objective" evaluation a court is to undergo in determining whether or not a statement is testimonial. The court is to determine what was the "primary purpose" of the interrogation. *Id.* at 1156. When determining what the primary purpose was, a court should consider "the circumstances in which an encounter occurs." *Id.*

These circumstances include whether the statement was made "at or near the scene of the crime versus at a police station," or "during an ongoing emergency or afterwards." *Id.* The existence of an "ongoing emergency" at the time of the statement "is among the most important circumstances informing the "primary purpose" of an interrogation . . . because an emergency focuses the participants on something other than "prov[ing] past events potentially relevant to

later criminal prosecution." *Id.* at 1157. However, the existence of an emergency is not dispositive of the inquiry. "As Davis made clear, whether an ongoing emergency exists is simply one factor--albeit an important factor--that informs the ultimate inquiry regarding the "primary purpose" of an interrogation." *Id.* at 1160.

Another factor "is the importance of informality in an encounter between a victim and police." *Id.* Finally, in determining the primary purpose of the statement, a court must examine "the statements and actions of both the declarant and interrogators." *Id.*

3. **The statements to Detective Fleming are "testimonial."**

Crawford stood for the proposition that accusatory statements to the police are testimonial. When looking at the circumstances in this case objectively, it is clear that the primary purpose of the interrogation that produced the identification was to prove past events relevant to a later prosecution.

First, in examining the circumstances, it is helpful to consider the closeness in time of when the incident happened and when the statement was given. The incident happened on April 26th. In this case, the statement was given on April 29th, a full three days after the shooting. This is very factually different than *Davis*, when the statement was given *at the same time* that the incident was happening. It is also a far cry from *Bryant*, when the statements were given twenty to thirty minutes after the shooting. *Id.* at 1166.

Second, the court should examine whether or not there was an ongoing emergency. Again, the temporal distance between the incident and the identification suggests that the emergency was no longer ongoing. *Bryant* does encourage courts to consider both whether or not a suspect has been apprehended as well as what type of weapon was used. *Id.* at 1164-65. However, the "shooter on the loose" fear cannot alone determine if an emergency would still

exist. The Court in *Bryant* did not feel the need to "decide precisely when the emergency ended" because the victim's interactions with the police "occurred within the first few minutes of the police officers' arrival and well before they secured the scene of the shooting." *Id.* at 1165.

The court should also examine the scope and duration of the emergency. In *Bryant*, the police responded to an open area, and the police had no idea what happened. They needed to determine what kind of danger the victim was in, what kind of danger they, as the responding officers, were in, as well as what kind of threat the shooter posed to the public at large. *Id.* at 1166. The questioning by Detective Fleming indicates that this was not his primary purpose. His purpose was to get an identification so that he could make an arrest. He also wanted to document this: he partially recorded the procedure, he read the admonition form regarding identifications, and he asked the victim to initial and sign the identification.

Third, the court must examine the formality of the situation and interrogation. The *Bryant* court found great similarities with *Davis*, the 911 case. *Bryant* at 1166. Both were very informal, with questions designed to "simply address what they perceived to be an ongoing emergency." These "circumstances lacked any formality that would have alerted [the victim] to or focused him on the possible future prosecutorial use of his statements." *Id.*

This case is much more similar to the station house interview in *Crawford*. Detective Fleming went to the victim's hospital room. He brought a six-pack photo line-up. He also brought an admonition form. He read the admonition form to the victim. He had the victim initial the admonition form twice and sign it once.

Finally, the court must examine "the statements and actions of both the declarant and interrogators" because they can "provide objective evidence of the primary purpose of the interrogation." *Bryant* at 1160. The questions asked by Detective Fleming were aimed at a past

event and not at dealing with an ongoing emergency. His purpose was to get an identification that he could rely on for an arrest warrant, indictment, and later prosecution.

4. **Dying Declaration: An Exception?**

There is some suggestion within the confrontation cases that an exception to the cross-examination requirement may exist for dying declarations. See *Crawford* at 56 n. 6, *Giles v. California*, 554 U.S. 353, 361-362 (2008), and *Bryant* at 1151 n. 1 (majority opinion) and at 1177 (Ginsburg dissent). However, this question has never been properly preserved or presented. There are two main arguments advanced by those who argue that an exception does exist.

The first is a historical argument. At the time of the adoption of the Sixth Amendment, the Framers intent (assuming it is their "intent" that one is after") was to include any historical "exceptions" to the common law requirement of confrontation. These, under Justice Scalia's originalist interpretation of the Constitution's text, would have included dying declarations. See *Crawford* at 56 n. 6 and *Giles* at 361. This historical claim is not without criticism. *See* Michael J. Polelle, *The Death of Dying Declarations in a Post-Crawford World*, 71 Mo.L.Rev. 285 at 291 (2006). ("The suggestion that dying declarations should be differentiated historically from other hearsay exceptions rests in part on an inaccurate claim that dying declarations were the only recognized criminal hearsay exception at common law.")

This view is predicated, at least in part, upon the idea that dying declarations were the only recognized criminal hearsay exception at common law. *Crawford* at 56 n.6 (citing F. Heller, The Sixth Amendment 105 (1951)). Michael Polelle, *supra*, is not the only person to challenge this interpretation. See California v. Green, 399 U.S. 149, 178 n.12 (1970) (Harlan J.

concurring) ("This view is open to question. Wigmore, for one, takes the position that several exceptions to the hearsay rule existed as of the time the Sixth Amendment was adopted.")

This theory then, that the Framer's intent was to graft on certain exceptions to the confrontation requirement, is far from proven and accepted in the courts and the scholarly literature.

The other argument advanced by proponents of the exception is one of necessity. This is certainly seen in *Satterwhite v. Virginia*, 56 Va. App. 557 (Va. App. 2012). The victim in that case was found by his girlfriend, shot, gasping for breath, and bleeding profusely. He told both her and the police a few minutes later that the defendant was the shooter. *Satterwhite* at 559-60. The court specifically held that a dying declaration was an exception to the Sixth Amendment's requirement of confrontation. It did so both for historical reasons, *Id.* at 566, but also because of necessity. The *Satterwhite* court cited *Mattox v. United* States, 156 U.S. 237 (1895), for the proposition that dying declarations "from time immemorial have been treated as competent testimony . . . .They are admitted, not in conformity with any general rule regarding the admission of testimony, but as an exception to such rules, simply from the necessities of the case, and to prevent a manifest failure of justice." *Satterwhite* at 567.

Necessity is a convenient claim for the state when attempting to prove its case. However, "if mere need of the state to use whatever information it has to ensure a conviction suffices, then the entire array of hearsay exceptions and even confrontation guarantees risk collapse." Michael J. Polelle, *The Death of Dying Declarations in a Post-Crawford World*, 71 Mo.L.Rev. 285 at 306 (2006).

Mattox was decided over 100 years before *Crawford*, and it is uncertain that it survives it. The Majority in *Crawford* saw *Mattox* as distinguishable because its decision was based upon

"whether the defendant had had an opportunity for cross-examination" or not. *Crawford* at 59 n.9. To the extent that the *Mattox* court treated dying declarations as exceptions to the confrontation requirement, it was dicta. It certainly is inconsistent with the holding in *Crawford* that "[w]here testimonial statements are at issue, the only indicium of reliability sufficient to satisfy constitutional demands is the one the Constitution actually prescribes: confrontation." *Id.* at 68-69.

B. Are These Statements Dying Declarations?

If the court determines that the Confrontation Clause does not apply to these statements, these statements are barred under S.C. Rule of Evidence 801 and 802. They are hearsay, no exceptions exist, and they are therefore inadmissible in a court of law in South Carolina. The only arguable exception is found in S.C. Rule of Evidence 804(b)(2), a dying declaration.

This rule has long been recognized in South Carolina. See *State v. Riley*, 98 S.C. 386 (1914). It is a codification of the common law rule that "dying declarations are competent evidence, for or against the accused, upon preliminary proof of certain conditions." *State v. Bethea*, 241 S.C. 16 at 21 (1962). Those three conditions are (1) imminent death at the time the declaration is made, (2) the declarant must be fully aware of this to be without any hope of life, and (3) the circumstances of the death must be the subject of the declaration. *Id.* at 21.

"It is incumbent on the party offering to introduce in evidence a dying declaration to show that it fulfills the requirements of the law." *State v. Brown*, 108 S.C. 490 at 497-98.

1. **Was the victim in imminent danger of death?**

While there is no doubt, from the medical records, that the victim in this case was still in serious condition, he was improving. He was admitted into the hospital on April 26th, and underwent surgery the same day. See Exhibit A, page 56 of 519. He was intubated on the 26th

and extubated on the 28th. Ex. A at 186. He was moved out of the STICU on April 29th. Ex. A at 56. On the day he gave his statement, he was "adequate on the floor, transferred out of STICU, was making strides with physical therapy, and ambulating in the hall." Ex. A at 56. He received a physical therapy consult on April 29th at 14:17. Ex. A at 465. He began physical therapy on April 30th. Ex. A at 404-406. On that day he tolerated 5 – 15 minutes of uninterrupted exercise. Ex. A at 429. His death, on April 4, was listed as sudden and unexpected. Ex. A at 48.

2. **Was the victim fully aware of his imminent death, and did he have any hope?**

There is no evidence presented in the medical records or discovery that the victim was aware of his imminent demise. In fact, the evidence suggests to the contrary. His medical condition was improving. Furthermore, there is evidence to be presented at the pre-trial hearing that the victim was planning on seeking revenge. This is inconsistent with both an awareness of imminent death as well as one who has given up all hope of life.

Finally, the victim never received chaplain services, although his family did. The chaplain visited his family the day he came in and the day he died. Ex. A at 464.

3. **Were the circumstances of the death the subject of the statement?**

All parties agree that this was the case.

III. Conclusion

A defendant must be allowed to confront his accusers. This is right is enshrined in the Sixth Amendment of the United States Constitution and the Fourteenth Amendment of the South Carolina Constitution. This right ensures that testimonial statements, as in this case, are tested in the "crucible of cross-examination." *Crawford* at 61.

The victim's statements in this case are also inadmissible hearsay, and the facts do not support a finding that he was in danger of imminent death at the time he made the statements, that he was aware of imminent death, or that he had given up all hope of life.

For all of these reasons, the statements and identification of the victim should not be admitted in the trial against the Defendant.

Respectfully Submitted,

Cody J Gloeber
Assistant Public Defender
Attorney for Defendant

Charleston, South Carolina
Dated: 3/25/13

STATE OF SOUTH CAROLINA	)	IN THE COURT OF GENERAL SESSIONS
	)	
COUNT OF CHARLESTON	)	NINTH JUDICIAL CIRCUIT
	)	
STATE OF SOUTH CAROLINA	)	Indictment No(s): 2012-GS-10-06844, 45, 46
	)	Warrant No(s): M640172, 174, 203
	)	Charges: Poss. Weapon, Armed Robbery,
	)	Murder
-versus-	)	
	)	
Marvin R. Brown	)	**Source Citations in Response to Defense**
	)	**Motion to Suppress Statement**
Defendant.	)	
	)	

I. Does the holding of Crawford v. Washington, 124 S.Ct. 1354 (2004), impact analysis of a dying declaration?

1. Crawford v. Washington, 124 S.Ct. 1354, 1367 (2004):
Discussing the history of the Confrontation Clause and established hearsay exceptions, specifically holding that established hearsay exceptions do not constitute an exception to the Confrontation Clause, with one possible exception:

"But there is scant evidence that [hearsay] exceptions were [historically] invoked to admit *testimonial* statements against the accused in a *criminal* case." (emphasis in original) FN6.

FN6: "The one deviation we have found involves dying declarations. The existence of that exception as a general rule of criminal hearsay law cannot be disputed. [citations omitted] Although many dying declarations may not be testimonial, there is authority for admitting even those that clearly are. [citations omitted] We need not decide in this case whether the Sixth Amendment incorporates an exception for testimonial dying declarations. If this exception must be accepted on historical grounds, it is *sui generis*."

2. Michigan v. Bryant, 131 S.Ct. 1143, 1151 FN.1 (2011):
After first determining that the government had waived their dying declaration argument, addressing the issue of whether Crawford undoes the admissibility of dying declarations:

"FN. 1. . . . This [trial] occurred prior to our 2004 decision in Crawford v. Washington, 541 U.S. 36, 124 S.Ct. 1354 (2004), where we first suggested that dying declarations, even if testimonial, might be admissible as a historical exception to the Confront Clause. Id., at 56, n.6, 124 S.Ct. 1354; see also Giles v. California, 554 U.S. 353, 358-59, 128 S.Ct. 2678 (2008). We noted in Crawford that we 'need not decide in this case whether the Sixth Amendment incorporates an exception for testimonial dying declarations.' 541

U.S., at 56, n.6 124 S.Ct. 1354. Because of the State's failure to preserve its argument with regard to dying declarations, we similarly need not decide that question here."

From J. Ginsberg's dissent:
"I would add, however, this observation. In *Crawford v. Washington*, 541 U.S. 36, 56, n. 6, 124 S.Ct. 1354, 158 L.Ed.2d 177 (2004), this Court noted that, in the law we inherited from England, there was a well-established exception to the confrontation requirement: The cloak protecting the accused against admission of out-of-court testimonial statements was removed for dying declarations. This historic exception, we recalled in *Giles v. California*, 554 U.S. 353, 358, 128 S.Ct. 2678, 171 L.Ed.2d 488 (2008); see *id.*, at 361–362, 368, 128 S.Ct. 2678, applied to statements made by a person about to die and aware that death was imminent. Were the issue properly tendered here, I would take up the question whether the exception for dying declarations survives our recent Confrontation Clause decisions. The Michigan Supreme Court, however, held, as a matter of state law, that the prosecutor had abandoned the issue. See 483 Mich. 132, 156–157, 768 N.W.2d 65, 78 (2009). The matter, therefore, is not one the Court can address in this case."

II. The Dying Declaration Exception in South Carolina

The modern approach to dying declarations, thoroughly reviewed in State v. McHoney, 344 S.C. 85, 554 S.E.2d 30 (2001):

[Victim's parents found her with her throat slashed and abdominal stab wounds. Victim was told by medical personnel that she was going to be "fine" and would get the "best care from the best doctors." She died two weeks later. Statements she gave to police while being transported from one hospital to another were admitted in the defendant's trial]

"I. Dying Declaration

McHoney argues the trial judge erred by admitting the victim's identification of "SP" as her killer under the dying declaration exception to the hearsay rule, Rule 804(b)(2), SCRE, because there was no evidence the victim believed her death was imminent, and the victim did not die until two weeks after making the statements. We disagree.

Hearsay is not admissible unless it fits within an exception to the hearsay rule. Rule 802, SCRE. The State sought to introduce the victim's identification of "SP" as her killer under the dying declaration exception. Rule 804(b)(2), SCRE. A statement made under the belief of impending death is not excluded by the hearsay rule if the declarant is unavailable as a witness in a prosecution for homicide, the statement is made by a declarant while believing the declarant's death is imminent, and the statement concerned the causes or circumstances of what the declarant believed to be impending death. Rule 804(b)(2), SCRE; *see also* 29A AM.JUR.2D*Evidence* § 829 (Supp.2000) ("In a homicide prosecution, the dying declaration must bear on the fact of the homicide and the person

by whom it was committed. Such statements must be made voluntarily and in good faith. In addition, such statement must be made under a sense of impending death."). McHoney argues there was no evidence the victim believed her death was imminent at the time of her declaration. According to defense counsel:

"If this nurse who has been taking care of me and talking to me says I am going to be fine and I am getting the best medical treatment possible, then exactly the opposite would have been understood by the declarant. So it would not qualify as a dying declaration."

The medical personnel who attended the victim assured her she would be "fine." However, the victim shook her head no **93* in response to the assurances, indicating she was aware of her impending death. A declarant does not have to express, in direct terms, his awareness of his condition for his statement to be admissible as a dying declaration. The necessary state of mind can be inferred from the facts and circumstances surrounding the declaration. *See Louisiana v. Bell,* 721 So.2d 38 (La.Ct.App. 5th Cir.1998); *Louisiana v. Nicholson,* 703 So.2d 173 (La.Ct.App. 4th Cir.1997); *Louisiana v. Matthews,* 679 So.2d 977 (La.Ct.App. 4th Cir.1996). Repeated questioning by the declarant concerning whether he is going to live, a less than reassuring answer, the nature of the wound, and the declarant's critical condition are circumstances that indicate the declarant's awareness of approaching death. ***34 Charles v. Texas,* 955 S.W.2d 400 (Tex.Ct.App.1997).[1] In fact, a declarant can be aware of imminent death even when he is assured he will not die and will be fine. *See id.* at 404 (holding evidence was sufficient for trial court to infer victim believed her death was imminent where victim had severe burns all over her body, she asked if she was going to die, and the officer replied negatively to reassure her and to prevent shock).

Furthermore, the length of time the declarant lives after making the dying declaration is immaterial. The focus is on the declarant's state of mind when the statement is made, not on the eventual outcome of the declarant's injuries. *See State v. Hall,* 134 S.C. 361, 133 S.E. 24 (1926).[2] In *State v. *94 Hall,* we held a dying declaration was properly admitted when the declaration was made shortly after the injury, and the declarant died 33 days later. We held it was the jury's duty to pass upon the credibility of the dying declaration, and the length of time between the declaration and death is just one factor to be considered. *Id.* at 361, 133 S.E. at 26.

In the instant matter, the fact the victim died two weeks after her injury does not indicate the victim did not believe her death was imminent, where she shook her head when told she would be fine, and where she never regained consciousness after she made the declaration. Therefore, we find the trial judge properly admitted the victim's identification of "SP" as her killer under Rule 804(b)(2), SCRE."

III. Summation of State's Argument

1. While still an open question, review of the Crawford cases strongly suggests that the longstanding "dying declaration" exception does not run afoul of the Sixth Amendment. See, e.g., Satterwhite v. Virginia, 56 Va. App. 557 (2012) (Virginia State court concluding that the dying declaration exception survives Crawford)

2. The Defense cites a line of cases dating from 1914 – 1943 & 1962 to stand for the general proposition that a victim must literally be at death's door for the exception to apply (or, to use a phrase Mr. Groeber kindly taught me the other day on the phone – *in extremis*). They will argue that the favorable prognosis just following surgery negates the elements of the exception.

   Though it was admirably mentioned in an email by the defense, absent from the defense's motion is reference to State v. McHoney, 344 S.C. 85, 554 S.E.2d 30 (2001). In McHoney, the South Carolina Supreme Court, in the text of the opinion and footnotes, performs a nationwide review of modern "dying declaration" jurisprudence. While McHoney admittedly does not expressly reverse the World War I era authority cited by the defense, a reading makes clear the modern approach to the reasonable fear of "imminent death" relaxes somewhat the rigid requirements of a century ago. It is wholly within the Court's discretion to review all the facts and circumstances, including the type of injury involved, and conclude that the declarant was is in reasonable fear of imminent death. McHoney also makes clear that an extended amount of time before death happens is immaterial, as well as statements by medical personnel that the declarant has a favorable prognosis.

   The defense seeks to apply the dying declaration exception, contrary to the most recent and complete view of State law in this area, as if it must be a statement given with one's literal last breath. The State would ask the Court to look at all the facts and circumstances, including the fact that the declarant was 48 hours removed from majorly invasive surgery due to a gunshot wound to the abdomen, in deciding whether or not the exception applies according to modern jurisprudence. This is admittedly a very close and difficult case, but when all circumstances are considered as a whole, we believe the statement is admissible.

3. Should the Court find either that Crawford effectively ended the dying declaration exception or that the exception does not apply to these facts, the State preserves the issue as to whether or not the statement here was testimonial under Bryant.

Respectfully Submitted,

_____

Benjamin Chad Simpson
Assistant Solicitor, Ninth Circuit Solicitor's Office

STATE OF SOUTH CAROLINA	IN THE COURT OF GENERAL SESSIONS FOR THE NINTH JUDICIAL CIRCUIT
COUNTY OF CHARLESTON	Indictment No(s): 2012-GS-10-6844, 6845, 6846
	Charge(s): Poss. Wpn. During Viol. Crime; Armed Robbery; Murder
STATE OF SOUTH CAROLINA	
vs.	**ORDER GRANTING DEFENDANT'S MOTION TO EXCLUDE HEARSAY TESTIMONY OF VICTIM'S IDENTIFICATION**
MARVIN REGINALD BROWN,	
Defendant	

THIS MATTER CAME BEFORE THE COURT on March 25, 2013, and December 10, 2013, on the Defendant's Motion to Suppress Hearsay Testimony and Defendant's Motion to Exclude the Victim's Identification of the above-named defendant, Marvin Brown. Deputy Public Defender Cody Groeber appeared on behalf of Defendant Brown; Assistant Solicitor Chad Simpson appeared on behalf of the State.

STATEMENT OF FACTS

The victim, Davon Goodwin, was shot on April 26, 2011, around 2 a.m., on America Street in downtown Charleston, South Carolina. He was transported to the Medical University of South Carolina, where he underwent surgery that same day. He made it through surgery and regained consciousness sometime on April 27, 2011. The following day, the victim's breathing tube was removed, and he was able to converse with his family and doctors. As exhibited by Mr. Goodwin's medical records, the victim's condition was generally improving throughout his stay at MUSC. *See* Exhibit A to Defendant's Motion to Suppress Hearsay Testimony.

On April 29, 2011, Detective Fleming of the Charleston Police Department interviewed the victim. Detective Fleming read him a standard admonition form for photographic lineups. *See* Exhibit B to Defendant's Motion to Suppress Hearsay Testimony. The victim identified the Defendant in a six-pack photo lineup. There is a partial audio recording of this identification procedure. *See* Exhibit C to Defendant's Motion to Suppress Hearsay Testimony. On May 4, 2011, the victim died from complications of the gunshot wound.

LEGAL ANALYSIS

The Defendant maintains that the victim's statements are inadmissible under the Sixth Amendment's Confrontation Clause, which provides that, "[i]n all criminal prosecutions, the accused shall enjoy the right ... to be confronted with the witnesses against him." U.S. Const. Amend. VI. In *Crawford v. Washington*, 541 U.S. 36 (2004), the United States Supreme Court held that the admission of testimonial statements by an unavailable witness whom the defense has not had a prior opportunity to cross-examine violates the defendant's Confrontation Clause rights under the Sixth Amendment. In South Carolina, not only is the right applicable to state prosecutions under the Fourteenth Amendment, it is specifically mandated by the State Constitution. *State v. Green*, 269 S.C. 657, 661, 239 S.E.2d 485, 487 (1977) *citing* S.C. Const. Art. I, § 14.

In the alternative, Defendant argues that the victim's statements are hearsay and that no exception exists in this case that would allow testimony regarding the victim's identification of Defendant Brown from the six-pack photo array. Hearsay is defined as "a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the

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truth of the matter asserted." Rule 801(c), S.C.R.E. Hearsay is generally inadmissible. Rule 802 S.C.R.E.

The State argues that the victim's statements are admissible under Rule 804(b)(2), S.C.R.E., which provides an exception to the hearsay prohibition for statements made by a declarant while under the belief that his death is imminent. Specifically, Rule 804(b)(2) states that "[i]n a prosecution for homicide or in a civil action or proceeding, a statement made by a declarant while believing that the declarant's death was imminent, concerning the cause or circumstances of what the declarant believed to be impending death" is not excluded by the hearsay rule.

This "dying declaration" rule has long been recognized in South Carolina. *See State v. Riley*, 98 S.C. 386, 82 S.E. 621 (1914). It is a codification of the common law rule that "dying declarations are competent evidence, for or against the accused, upon preliminary proof of certain conditions." *State v. Bethea*, 241 S.C. 16, 21, 126 S.E.2d 846, 848 (1962). "It is incumbent on the party offering to introduce in evidence a dying declaration to show that it fulfills the requirements of the law." *State v. Brown*, 108 S.C. 490, 497-98, 95 S.E. 61, 63 (1918). The three conditions that must be proved are as follows: (1) imminent death at the time the declaration is made; (2) the declarant must be so fully aware of this as to be without any hope of life; and (3) the circumstances of the death must be the subject of the declaration. *State v. Bethea*, 241 S.C. at 21, 126 S.E.2d at 848-849.

1. Imminent Death at the Time the Declaration is Made

The Court concludes that while there is no doubt that the victim in this case was in serious condition at the time of his identification of Defendant Brown, his medical records demonstrate that he was improving and was not in imminent danger of death at the time the

statements were made. The victim was admitted into the hospital on April 26, 2011, and underwent surgery the same day. *See* Exhibit A, page 56 of 519. He was intubated on April 26th and extubated on the 28th. Ex. A at 186. Furthermore, on the day that the challenged statements were made, the Defendant, the victim was "adequate on the floor, transferred out of STICU, was making strides with physical therapy, and ambulating in the hall." Ex. A at 56. He received a physical therapy consult on April 29th, and began physical therapy on April 30th. Ex. A at 404-406 and 465. On that day, he tolerated 5-15 minutes of uninterrupted exercise. Ex. A at 429. Moreover, the victim's May 4th death was listed as sudden and unexpected. Ex. A at 48.

2. Declarant must be Fully Aware of Imminent Death to be without any Hope of Life

The Court further finds that neither the medical records nor the other evidence in the case demonstrates that the victim was aware of his imminent death when identifying the photograph of the defendant from the six-pack lineup. In fact, the evidence suggests the contrary; on April 29th, the victim's medical condition was improving. Furthermore, evidence presented at the pre-trial hearing suggested that the victim was planning on seeking revenge against his assailant. This is inconsistent with both an awareness of imminent death as well as one who has given up all hope of survival. Ex. A at 464.

3. The Circumstances of the Death Must be the Subject of the Statement

The Court concludes, and all parties agree, that the circumstances of the shooting - which resulted in the victim's subsequent death - were the subject of the hearsay statement. However, this alone does not satisfy the requirements of either Rule 804(b)(2) or the common law rule.

APM 4

CONCLUSION

Following oral arguments and a detailed review of the facts, exhibits, and case law, this Court hereby finds that the victim's statements are barred under S.C. Rules of Evidence 801 and 802. As the statements are hearsay and no hearsay exception applies, the statements are inadmissible.[1]

THEREFORE, IT IS HEREBY ORDERED that the statements of the victim shall not be admitted in the trial against the Defendant as they are inadmissible hearsay. Defendant's Motion to Suppress Hearsay Testimony is hereby GRANTED.

AND IT IS SO ORDERED.

The Honorable Stephanie P. McDonald
Chief Administrative Judge, Ninth Judicial Circuit

August 18, 2014
Charleston, South Carolina

[1] The Court also conducted a *Neil v. Biggers* hearing regarding the six-pack identification procedure at the hospital. Under the totality of the circumstances, the Court determined that the identification process was not unduly suggestive, was reliable, and that no substantial likelihood of misidentification existed. *See State v. Spears*, 393 S.C. 466, 480, 713 S.E.2d 324, 331 (S.C. App. 2011) *citing Biggers*, 409 U.S. 188, 198-99 (1972).

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Medical University of South Carolina
Department of Pathology and Lab Medicine
165 Ashley Avenue, Suite 309
PO Box 250908
Charleston, SC 29425

Patient: GOODWIN, DAVON
Med Rec: GOODVON
DOB: [redacted]
Male Race: Black
ACCESSION: FA-11-00269
Date Received: 5/5/2011
Date Collected: 5/5/2011

[redacted]

Autopsy Information

Date of Death: 05/04/11 **Time:** 8:45 a.m.
Date of Autopsy: 05/05/11 **Time:** 9 a.m.
County: Charleston
Coroner: Brittney Martin, Deputy
Attending Pathologist: S. Erin Presnell, MD
Pathologist Assistant: Eowyn Corcrain
Autopsy Technician: Kimberly Boretsky
Prosector(s): Lee Marie Tormos, MD and Jalidsa Pellicier, MD

(If Injury) How occurred: Gunshot wound
Date of Injury: 04/26/11 **Time:** ~ 2:15 a.m.
Place of Injury: Road/sidewalk

Cause of Death

Complications of single penetrating gunshot wound to abdomen

Manner of Death

Homicide

CASE HISTORY

According to the coroner and available medical records, the decedent was a 19-year-old black male who sustained a gunshot wound to the abdomen on April 26, 2011 at approximately 2:15 a.m. EMS transported him to MUSC, where he underwent an exploratory laparotomy and

MAXINE T. ROBINSON
NOTARY PUBLIC
SOUTH CAROLINA
MY COMMISSION EXPIRES APRIL 29, 2014

This is a true and accurate copy of the original.

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repair of the duodenum, inferior vena cava, and superior mesenteric vein and artery. Subsequently, he returned to the operating for an abdominal washout and drain/tube placements. The projectile was not recovered at that time. The patient improved and had begun ambulation and physical therapy. However, on May 4, 2011, he was found unresponsive in bed. Despite resuscitative efforts, he was pronounced dead at 8:45 a.m. that morning.

GROSS DESCRIPTION

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished, black male, who weighs approximately 200 pounds, is 71 inches in length, and appears compatible with the stated age of 19 years. The body is identified by the coroner; a hospital band around the left wrist and a tag around the right toe bear the decedent's name. The body is clad in a hospital gown (disposed at the autopsy). The body is cold to the touch. Rigor is fully fixed (4/4) in all extremities and jaw. Diffuse, fixed purple livor extends over the posterior surfaces of the body, except in areas exposed to pressure.

The scalp hair is dark brown/black and styled in dreadlocks up to 8.5 inches in length over the crown. The irides are brown; the pupils are bilaterally equal. The corneae are slightly clouded. The sclerae and conjunctivae are pale yellow. The nose and ears are not unusual. The lips and gums are intact. The teeth are in good condition. The deceased has scant upper lip and chin hair. The neck is without masses, and the larynx is in the midline. The thorax is symmetrical with an anteroposterior/lateral ratio of about 1:2. The abdomen is flat. The penis is unremarkable; the testes are bilaterally descended within the scrotum. The anus and back are unremarkable. The upper and lower extremities are well-developed and symmetrical, without absence of digits.

Identifying marks and scars consist of a 2.5 inch rectangular scar/pigmentation on the anterolateral right thigh; a 1.25 inch scar on the left pretibial surface; and a tattoo of the letters "ESP" on the anterior right forearm. Non-specific scars are on the knees. Evidence of emergency resuscitation and / or medical therapy includes an endotracheal tube secured with tape entering the oral cavity and extending into the trachea, an 11.5 inch stapled midline incision on the abdomen, five abdominal drains/tubes protruding through the anterior abdominal wall and

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[redacted]

showing tan opaque particulate fluid in collection containers, a bandaged intravenous catheter at the right inguinal area, and punctures in the anterior left wrist and forearm.

EVIDENCE OF INJURY

Punctate abrasions with scabs are on the medial left and lateral right forearms. Punctate and thin linear abrasions with scabs are on the epigastric area and anterior abdomen bilaterally.

A 0.38 x 0.2 inch healing defect with eschar is at the left upper quadrant of the abdomen, 23.5 inch from the top of the head and 3.5 inch to the left of midline. A 0.05 inch circumferential gray discoloration affects the tissues around the defect. The bullet pathway is through skin and subcutaneous tissues, abdominal musculature, duodenum (surgically repaired), superior mesenteric artery and vein (surgically repaired), vena cava (surgically repaired), abdominal aorta (transverse, 0.8 cm tear sutured externally with the vena cava) proximal to the iliac bifurcation, and into the right psoas muscle, where a 0.29 x 0.3 inch base diameter x 0.46 inch in length intact gray metal projectile with a copper-colored jacket is recovered. The approximate bullet trajectory through the body is 45 degrees down, 40 degrees back, and to the left.

RADIOGRAPHS: Antemortem abdominal radiographs confirm the presence of a radiopaque projectile (recovered at autopsy) in the right posterior abdomen.

EVIDENCE TRANSFER: The bullet recovered at autopsy and a postmortem blood spot on filter paper are transferred to SPO Jennifer Wooley of the Charleston Police Department on May 6, 2011.

INTERNAL EXAMINATION

BODY CAVITIES: The right and left pleural cavities contain 200 and 100 ml of serosanguineous fluid, respectively. The pericardial cavity contains 50 ml of serous fluid. The peritoneal cavity contains 500 ml of tan, turbid fluid and fibrinous debris; mesenteric saponification is noted. The liver capsule is adhesed to the diaphragm.

HEAD (CENTRAL NERVOUS SYSTEM): The brain weighs 1330 grams. The dura mater and falx cerebri are intact. The leptomeninges are thin and delicate. The cerebral hemispheres are

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symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact and free of abnormality. Sections through the cerebral hemispheres reveal no lesions within the cortex, subcortical white matter, or deep parenchyma of either hemisphere. The basal ganglia, thalami, and hippocampi are unremarkable. The cerebral ventricles are normal caliber. Sections through the brainstem and cerebellum are unremarkable.

NECK: Examination of the soft tissues of the neck, including strap muscles, thyroid gland, and large vessels, reveals no abnormalities. The hyoid bone and larynx are intact. The lingual mucosa is intact.

CARDIOVASCULAR SYSTEM: The heart weighs 400 grams. The pericardial and epicardial surfaces are smooth, glistening and unremarkable. The coronary arteries arise normally, follow the usual distribution and are patent, although the left anterior descending coronary artery demonstrates 10% atherosclerotic narrowing. The chambers and valves bear the usual size-position relationships and are unremarkable. The myocardium is dark red-brown, firm, and unremarkable; the atrial and ventricular septa are intact. The left ventricular thickness = 1.6 cm, right ventricular thickness = 0.4 cm, and the interventricular septum = 1.5 cm. Excluding findings under "Evidence of Injury," the aorta and its major branches arise normally, follow the usual course and are patent, free of significant atherosclerosis and other abnormality. The venae cavae and their major tributaries return to the heart in the usual distribution.

RESPIRATORY SYSTEM: The right and left lungs weigh 610 and 600 grams, respectively. The upper airway contains nonocclusive yellow mucoid material; the mucosal surfaces are smooth, yellow-tan and unremarkable. The pleural surfaces are smooth, glistening and unremarkable. Lobar divisions are of the usual configuration. The pulmonary parenchyma is dark red-purple, exuding moderate amounts of blood and frothy fluid. A 3 cm triangular, wedge-shaped area of parenchymal hemorrhage affects the peripheral lower lobe of the right lung; a thromboembolism occludes a medium sized artery at the apex of the hemorrhagic area. Scattered thromboemboli are identified within small and medium sized peripheral pulmonary arteries.

LIVER AND BILIARY SYSTEM: The liver weighs 1680 grams. The hepatic parenchyma is tan-brown parenchyma with geographical yellow discoloration. The gallbladder contains 27 ml of brown bile sludge; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The portal vein and its tributaries are unremarkable.

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DOB [redacted]
Male Race: Black
ACCESSION: FA-11-00269
Date Received: 5/5/2011
Date Collected: 5/5/2011

[redacted]

ALIMENTARY TRACT: The esophagus is lined by gray-white, smooth mucosa. The gastric mucosa is flattened; several small mucosal ulcerations affect the distal third. The gastric lumen contains ~ 20 mL of orange fluid. An intact suture line is identified at the distal duodenum. The jejunum shows gray discoloration and marked thinning of the wall. The appendix is not identified. The pancreas has a tan-yellow, lobulated appearance, and the ducts appear clear.

GENITOURINARY TRACT: The right and left kidneys weigh 170 and 120 grams, respectively. The renal capsules are smooth and thin, semi-transparent, and strip with ease from the underlying smooth cortical surfaces. The right kidney is pale and soft when compared to the left kidney. The cortices are delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves, and ureters are unremarkable. The relationships at the trigone are unremarkable. The urinary bladder contains 60 ml of yellow urine; the mucosa is gray-tan and smooth. The prostate and seminal vesicles are unremarkable. A section of testis shows regional yellow discoloration and minute thromboses of intratesticular vessels.

RETICULOENDOTHELIAL SYSTEM: The spleen weighs 220 grams and has a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. Focally, the vertebral bone marrow is red-purple and homogeneous, without evidence of abnormality.

ENDOCRINE SYSTEM: The pituitary, thyroid, and adrenal glands are unremarkable.

MUSCULOSKELETAL SYSTEM: Excluding the previously described findings, the bony framework, supporting musculature, and soft tissues are not unusual.

CASSETTE SUMMARY:
1. Right and left lungs
2. Lungs, thromboembolus
3. Liver, kidneys
4. Left cardiac ventricle, small bowel
5. Testis with infarct

LMT:mtr
05/05/11

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Med Rec: GOODVON
DOB: [redacted]
Male Race: Black
ACCESSION: FA-11-00269
Date Received: 5/5/2011
Date Collected: 5/5/2011

[redacted]

05/24/11

SEP:mtr
06/03/11

Lee M Tormos, M.D./ MTR

CASE SUMMARY

A complete autopsy was performed on the body of Davon Goodwin at the Medical University of South Carolina Autopsy Suite on May 5, 2011. The postmortem examination began at 9 a.m. The prosectors were Drs. Lee Marie Tormos and S. Erin Presnell. The autopsy technician was Ms. Kimberly Boretsky. The autopsy was authorized by the Charleston County Deputy Coroner, Ms. Brittney Martin.

Significant findings at autopsy included a single, penetrating gunshot wound to the abdomen with surgically repaired distal aortic/inferior vena cava, superior mesenteric artery and vein, and duodenal injuries; small bowel wall thinning and necrosis; 500 ml turbid peritoneal fluid; gastric ulcerations; hepatic geographical yellow discoloration; testicular thrombosis and infarct; peripheral pulmonary thromboemboli; right pulmonary wedge infarction; bilateral pleural serosanguineous effusions; liver-diaphragm adhesions; mild coronary atherosclerosis; cardiomegaly (400 grams); and a pale right kidney.

Microscopic examination of the lungs reveals edema, abundant intraalveolar macrophages, marked intravascular bacterial overgrowth. Multiple pulmonary thromboemboli show signs of early organization; an associated area of resolving infarction is noted. The liver shows areas of normal architecture with a transition to marked parenchymal autolysis and associated bacterial overgrowth. The kidneys also show marked autolysis and bacterial overgrowth. A focus of contraction-like bands is in the heart; myocyte hypertrophy is noted. Histologically, the thinned small bowel shows acute inflammation with associated necrosis and abundant bacterial overgrowth extending through the wall but predominantly in the muscle layers. A section of testis confirms regional parenchymal infarction.

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Med Rec: GOODVON
DOB: [redacted]
Male Race: Black
ACCESSION: FA-11-00269
Date Received: 5/5/2011
Date Collected: 5/5/2011

[redacted]

In light of the historical and clinical information and the gross and microscopic autopsy findings, it is the opinion of the prosectors that the decedent died as the result of complications of single penetrating gunshot wound to the abdomen. Furthermore, the manner of death is best deemed homicide.

FINAL DIAGNOSIS

Single, penetrating gunshot wound to abdomen
- Surgically repaired distal aortic/inferior vena cava injury
- Surgically repaired duodenal injury
- Surgically repaired superior mesenteric artery and vein injury
- Small bowel necrosis
- 500 ml turbid peritoneal fluid

Gastric ulcerations
Multiple peripheral pulmonary thromboemboli
Pulmonary edema
Pleural serosanguineous effusions
Hepatic and renal autolysis and bacterial overgrowth
Testicular thrombosis and infarct
Mild coronary atherosclerosis
Cardiomegaly (400 grams) with myocardial hypertrophy

CERTIFICATION

I certify that I personally conducted the diagnostic evaluation of the above specimen(s) and have rendered the above diagnosis(es).

S.Erin Presnell, M.D. (1-4391)
(Electronically signed by)
Verified: 06/03/2011 12:55
SP /MTR

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Medical and Forensic
Autopsy Section
Pathology and Laboratory Medicine
171 Ashley Avenue
MSC 908
Charleston SC 29425-9080
Tel 843 792 3556
Fax 843 792 3537
Forensic 843 792 3500
www.musc.edu/pathology

FORENSIC AUTOPSY PRELIMINARY REPORT

Date: May 5, 2011

To: Rae H. Wooten
Charleston County Coroner
Attn: Brittney Martin

Fax Number: 843-746-4033

RE: Davon Goodwin

Number of pages (including fax cover sheet: 3

From: Maxine T. Robinson
Forensic Operations Coordinator
MUSC, Forensic Autopsy Section
Department of Pathology & Laboratory Medicine
Rm. 281 Main Hospital

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165 Ashley Avenue, Suite 309
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Charleston, SC 29425

Patient: GOODWIN, DAVON
Med. Rec: GOODVON
DOB: [redacted]
Sex: Male Race: Black
Accession: FA-11-00269
Date Received: 5/5/2011
Date Collected: 5/5/2011

Forensic Autopsy Preliminary Report

AUTOPSY INFORMATION

Date of Death: 05/04/11 **Time:** 8:45 a.m.
Date of Autopsy: 05/05/11 **Time:** 9 a.m.
County: Charleston
Coroner: Brittney Martin
Attending Pathologist: S. Erin Presnell
Pathologist Assistant: Eowyn Corcrain
Autopsy Technician: Kim Boretsky
Prosector(s): Drs. Lee Tormos and Pellicier

(If Injury) How occurred: gunshot wound
Date of Injury: 04/26/11 **Time:** ~ 2:15 a.m.
Place of Injury: road/sidewalk

Whole organs retained for diagnostic purposes: None

Preliminary Findings: scattered peripheral pulmonary emboli, right pulmonary wedge infarction; mucus in bronchi; bilateral pleural serosanguineous effusions; gastric ulcerations; repaired distal aortic/inferior vena cava injury; repaired duodenum; hepatic geographical yellow discoloration; testicular clot/infarct; bowel necrosis with associated mesenteric saponification; pale right kidney; 500 ml turbid peritoneal fluid; liver-diaphragm adhesions; mild coronary atherosclerosis; cardiomegaly (400 grams)

PROBABLE CAUSE OF DEATH

Complications of single penetrating gunshot wound
(more specific wording pending)

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Patient: GOODWIN, DAVON
Med. Rec: GOODVON
DOB: [redacted]
Sex: Male Race: Black
Accession: FA-11-00269
Date Received: 5/5/2011
Date Collected: 5/5/2011

Forensic Autopsy Preliminary Report

MANNER OF DEATH

Homicide

S.Erin Presnell, M.D. (1-4391)
(Electronically signed by)
Verified: 05/05/2011 11:11
SP /SP

GOODWIN, DAVON
GOODVON

150

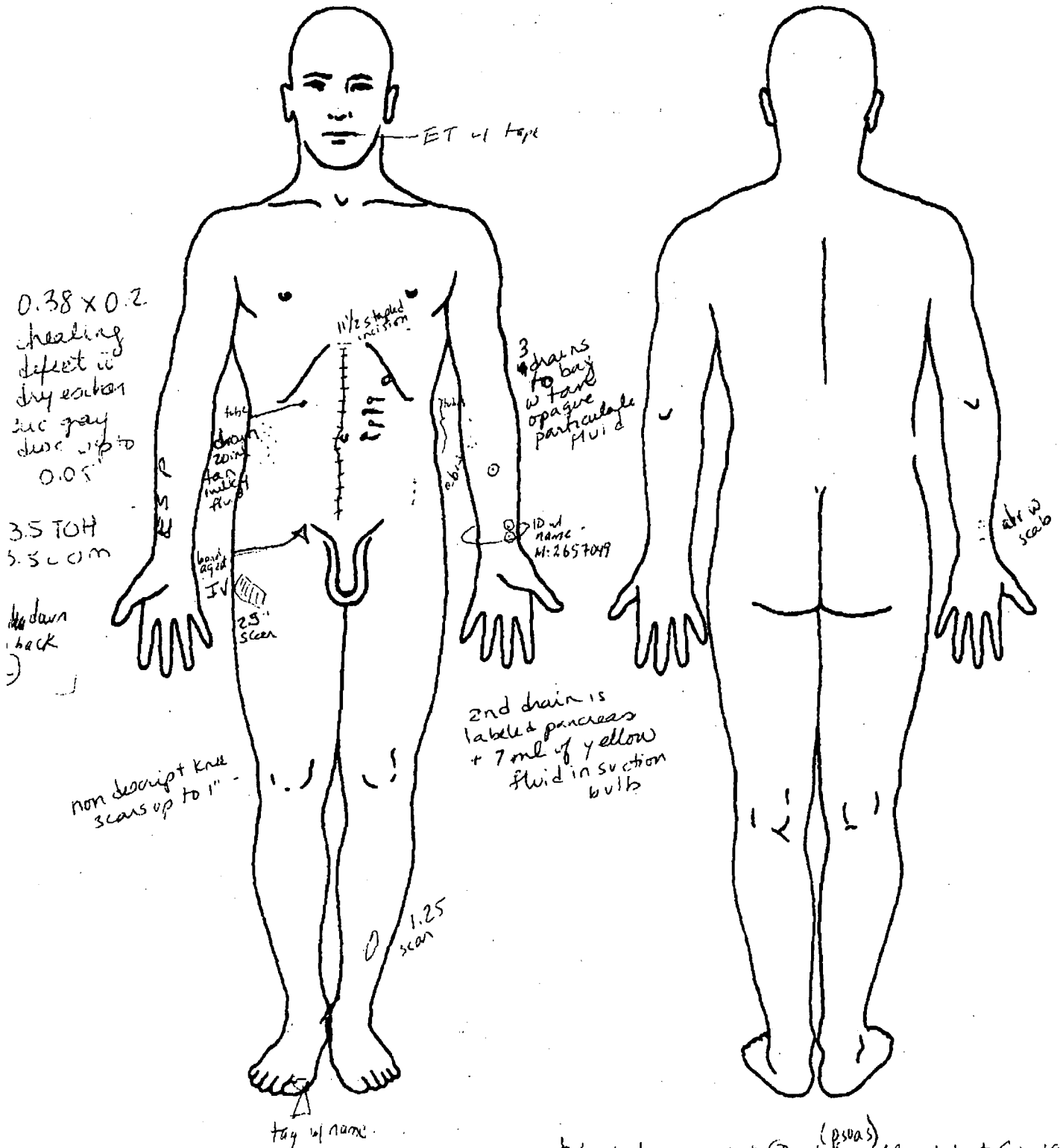
ACHA

FA-11-00269

05/05/11
DRPRESNELL/TORMOS/KB

Weight: 201
Length: 71
Temp: cold
Rigor: 4/4
Livor: post fixed
Scalp hair: brown curly dreadlocks, 8½
Facial hair: scant chin + upper lip hair stubble

Eyes: br, pupils, sclera icteric
Ears: ✓
Nose: ✓
Teeth: perm, good
Neck: no masses
Abdomen: sl. prot
Genitalia: circumcised



GOODWIN, DAVON
GOODVON
151
ACHA
FA-11-00269
05/05/11
DRPRESNELL/TORMOS/KB

MUSC DEPARTMENT OF PATHOLOGY, FORENSIC SEC
171 ASHLEY AVENUE, CHARLESTON, SC 29425
Office (843) 792-3500 FAX (843) 792-3537

EVIDENCE TRANSFER SHEET

ON May 6th 2011 (Date) AT 10:00am (Time)

NAME OF DECEASED Davon Goodwin AUTOPSY NUMBER FA11-269

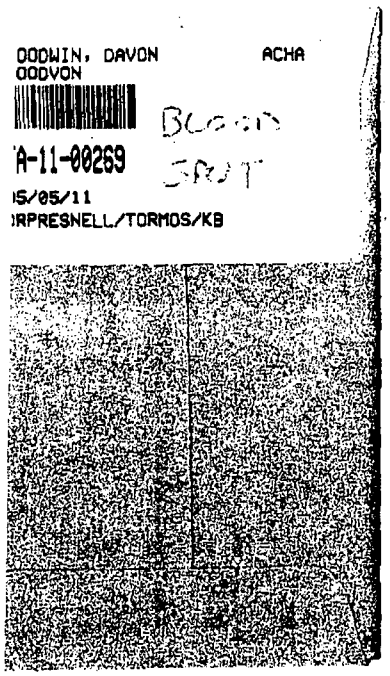
TRANSFERRED AT MUSC Forensic Department (Location)

DESCRIPTION OF EVIDENCE

Bullet
Blood Spot

From: Lee M Tormos, MD
(Print name)
(Signature)
Representing: MUSC Forensic Dept

To: SPO Jennifer Wadley
(Print name)
(Signature)
Representing: Charleston Police Department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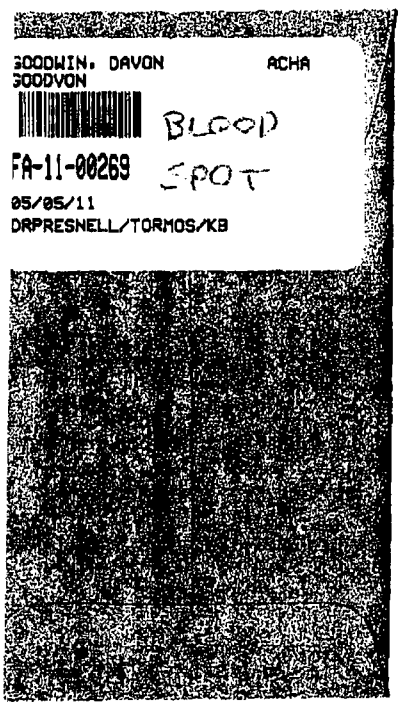
OODVON
BLOOD
A-11-00269 SPOT
5/05/11
RPRESNELL/TORMOS/KB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BLOOD
FA-11-00269 SPOT
05/05/11
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153

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
5/4/11 8:29 AM	METABOLIC PANEL, COMPREHENSIVE	Finished					*
	SODIUM (NA)		134.0 MMOL/L	135.0 -	L	GEN LAB	
	POTASSIUM (K)		8.50 MMOL/L	3.50 - 5.00	C	GEN LAB	
	CHLORIDE		96.0 MMOL/L	98.0 - 107.0	L	GEN LAB	
	CO2 CONTENT (BICARBONATE)		17 MMOL/L	22 - 32	L	GEN LAB	
	ANION GAP		21 MMOL/L	2 - 11	H	GEN LAB	
	GLUCOSE, SERUM		97.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		26.0 MG/DL	8.0 - 20.0	H	GEN LAB	
	CREATININE		3.4 MG/DL	0.6 - 1.3	H	GEN LAB	
	ESTIMATED GLOMERULAR		28 mL/min			GEN LAB	*
	CALCIUM		9.3 MG/DL	8.4 - 10.2		GEN LAB	
	BILIRUBIN, TOTAL		7.4 MG/DL	0.2 - 1.3	H	GEN LAB	
	ASPARTATE AMINOTRANSFERASE		65.0 IU/L	12.0 - 38.0	H	GEN LAB	
	ALANINE AMINOTRANSFERASE		49.0 IU/L	10.0 - 45.0	H	GEN LAB	
	ALKALINE PHOSPHATASE		87.0 IU/L	25.0 - 100.0		GEN LAB	
	TOTAL PROTEIN, SERUM		5.6 G/DL	6.0 - 8.0	L	GEN LAB	
	ALBUMIN, SERUM		2.0 G/DL	3.5 - 4.8	L	GEN LAB	
	HEMOLYSIS INDEX		3.0	0.0 - 1.9	H	GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		40.49 K/CUMM	4.80 - 10.80	H	GEN LAB	
	RED BLOOD CELL COUNT		3.56 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		10.4 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		31.6 %	42.0 - 52.0	L	GEN LAB	
	MCV		88.8 FL	80.0 - 94.0		GEN LAB	

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154

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	MCH		29.2 pg	27.0 - 31.0		GEN LAB	
	MCHC		32.9 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		15.0 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Corrected					*
	PLATELET COUNT		* K/CUMM	140 - 440		GEN LAB	
	MPV		* FL	9.15 - 12.31		GEN LAB	
	TROPONIN I ULTRA	Finished	0.11 NG/ML	<=0.06	H	GEN LAB	*
	APTT	Finished	23.2 SEC	23.3 - 35.7	L	GEN LAB	*
	MASS CKMB	Finished	2.42 NG/ML	<=4.90		GEN LAB	*
	RELATIVE INDEX		1.3	<=2.0		GEN LAB	*
	CREATINE KINASE	Finished	181 IU/L	25 - 260		GEN LAB	
	HEMOLYSIS INDEX		3.0	0.0 - 1.9	H	GEN LAB	*
5/4/11 7:29 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/4/11 3:47 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	180	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/3/11 11:36 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	99	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
5/3/11 8:15 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/3/11 3:50 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	125	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/3/11 12:09 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	138	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*

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Date Printed: 03/16/2012

155

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
5/3/11 10:10 AM	AMYLASE, FLUID	Finished					*
	AMYLASE, FLUID		378.0 U/L			GEN LAB	*
	HEMOLYSIS INDEX		2.0	0.0 - 1.9	H	GEN LAB	*
5/3/11 7:48 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	125	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/3/11 3:04 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/2/11 11:00 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	126	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/2/11 8:02 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	125	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/2/11 3:59 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/2/11 12:05 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	141	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/2/11 10:30 AM	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		136.0 MMOL/L	135.0 -		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)		26 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		7 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		112.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		6.0 MG/DL	8.0 - 20.0	L	GEN LAB	
	CREATININE		0.9 MG/DL	0.6 - 1.3		GEN LAB	

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156

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		8.0 MG/DL	8.4 - 10.2	L	GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	MAGNESIUM (MG)	Finished	2.1 MG/DL	1.6 - 2.3		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	PHOSPHORUS (PO4)	Finished	3.5 MG/DL	2.4 - 4.7		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
5/2/11 7:58 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	134	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/2/11 4:18 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 11:28 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 7:33 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	158	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 3:37 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	151	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 11:36 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 9:06 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 8:25 AM	PREALBUMIN	Finished	6.2 MG/DL	18.0 - 38.0	L	GEN LAB	
5/1/11 8:03 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*

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157

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
5/1/11 6:56 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 6:12 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 5:10 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 4:02 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 3:09 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 2:06 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	75	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 12:57 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
5/1/11 12:04 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 11:08 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 9:51 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 9:12 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	99	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 8:04 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*

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158

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Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/30/11 7:01 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 6:18 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 5:08 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 4:20 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 3:24 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 2:10 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 1:23 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	63	70 - 100	L	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 12:08 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 11:35 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	98	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 10:22 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	169	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 10:05 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	128	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 9:04 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*

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159

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/30/11 8:08 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	119	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 7:30 AM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		3.23 K/CUMM	4.80 - 10.80	L	GEN LAB	
	RED BLOOD CELL COUNT		2.67 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		7.8 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		22.2 %	42.0 - 52.0	L	GEN LAB	
	MCV		83.1 FL	80.0 - 94.0		GEN LAB	
	MCH		29.2 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.1 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.8 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		130 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.00 FL	9.15 - 12.31		GEN LAB	
4/30/11 6:53 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 6:01 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 4:56 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	124	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 4:06 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 2:52 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	126	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*

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Date Printed: 03/16/2012

160

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/30/11 2:08 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	128	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 12:54 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/30/11 12:40 AM	URINALYSIS	Finished					
	COLOR		Yellow			GEN LAB	
	PH, URINE		7.5	5.0 - 7.0	H	GEN LAB	
	BILIRUBIN		Small	Negative	A	GEN LAB	*
	BLOOD		Trace	Negative	A	GEN LAB	
	NITRITE		Negative	Negative		GEN LAB	
	PROTEIN		10.0 MG/DL	<=10.0		GEN LAB	
	SPECIFIC GRAVITY URINE		1.010	1.003 -		GEN LAB	
	GLUCOSE		Negative MG/DL	<=30.0		GEN LAB	
	KETONES		Negative MG/DL	<=10.0		GEN LAB	
	RED BLOOD CELLS		1 /HPF	0 - 1		GEN LAB	
	WBCS/HPF, URINE		<1 /HPF	0 - 2		GEN LAB	
	UROBILINOGEN		<2.0 MG/DL	<=2.0		GEN LAB	
	LEUKOCYTE ESTERASE		Negative LEU/UL	<=25.0		GEN LAB	
	MUCOUS		Few		A	GEN LAB	
4/30/11 12:07 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 11:03 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	90	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 10:03 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	208	70 - 100	H	POCT	

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Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

161

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PERFORMING LAB		See Note			POCT	*
4/29/11 8:57 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 7:54 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	94	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 7:07 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 6:23 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 5:10 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 4:40 PM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		6.86 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		2.59 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		7.6 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		21.5 %	42.0 - 52.0	L	GEN LAB	
	MCV		83.0 FL	80.0 - 94.0		GEN LAB	
	MCH		29.3 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.3 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.9 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		103 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.00 FL	9.15 - 12.31		GEN LAB	
4/29/11 4:02 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	

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Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

162

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PERFORMING LAB		See Note			POCT	*
4/29/11 3:11 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 2:04 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 1:01 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 12:11 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	115	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 11:30 AM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		6.73 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		2.57 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		7.5 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		21.4 %	42.0 - 52.0	L	GEN LAB	
	MCV		83.3 FL	80.0 - 94.0		GEN LAB	
	MCH		29.2 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.0 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.9 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		55 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.20 FL	9.15 - 12.31		GEN LAB	
4/29/11 11:15 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	131	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 9:59 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	123	70 - 100	H	POCT	

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163

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Charleston, SC

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Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PERFORMING LAB		See Note			POCT	*
4/29/11 9:01 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	129	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 8:07 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 7:00 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 5:58 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 5:03 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 4:11 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	82	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 4:00 AM	MAGNESIUM (MG)	Finished	1.8 MG/DL	1.6 - 2.3		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	PHOSPHORUS (PO4)	Finished	2.7 MG/DL	2.4 - 4.7		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		136.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		105.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		28 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		3 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		81.0 MG/DL	70.0 - 100.0		GEN LAB	

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164

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	UREA NITROGEN, BLOOD (BUN)		7.0 MG/DL	8.0 - 20.0	L	GEN LAB	
	CREATININE		1.0 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		7.2 MG/DL	8.4 - 10.2	L	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		5.38 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		1.91 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		5.7 GM/DL	14.0 - 18.0	C	GEN LAB	*
	HEMATOCRIT		16.1 %	42.0 - 52.0	C	GEN LAB	*
	MCV		84.3 FL	80.0 - 94.0		GEN LAB	
	MCH		29.8 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.4 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.7 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		90 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.40 FL	9.15 - 12.31		GEN LAB	
4/29/11 3:01 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 2:03 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/29/11 1:16 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	81	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 11:57 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	77	70 - 100		POCT	

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Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

165

Medical University of South Carolina

Charleston, SC

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Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PERFORMING LAB		See Note			POCT	*
4/28/11 11:06 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	84	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 10:03 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	74	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 8:58 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	83	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 8:01 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 6:59 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 6:02 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	74	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 5:04 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	127	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 3:58 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	128	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 3:08 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	151	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 2:00 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	142	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 1:07 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	146	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 12:02 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	154	70 - 100	H	POCT	

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166

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Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PERFORMING LAB		See Note			POCT	*
4/28/11 11:05 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	146	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 10:04 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 9:13 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	91	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 7:57 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 7:07 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 6:10 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 4:51 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 3:57 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 3:06 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	123	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 3:00 AM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.93 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		2.22 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		6.5 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		18.2 %	42.0 - 52.0	L	GEN LAB	

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167

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	MCV		82.0 FL	80.0 - 94.0		GEN LAB	
	MCH		29.3 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.7 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		14.1 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		82 K/CUMM	140 - 440	L	GEN LAB	
	MPV		11.60 FL	9.15 - 12.31		GEN LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		136.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		4.20 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		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		103.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		12.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.2 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		7.1 MG/DL	8.4 - 10.2	L	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	MAGNESIUM (MG)	Finished	1.6 MG/DL	1.6 - 2.3		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	PHOSPHORUS (PO4)	Finished	2.8 MG/DL	2.4 - 4.7		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	ARTERIAL BLOOD GAS	Finished					

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Date Printed: 03/16/2012

168

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.47	7.35 - 7.45	H	OR LAB	
	PCO2 AT 37 DEGREES C		38 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		174 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		38.0 DegC			OR LAB	
	PH AT PATIENT TEMP		7.46	7.35 - 7.45	H	OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		177 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		100.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		4.0 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		27.5 MMOL/L	22.0 - 26.0	H	OR LAB	
	CA++ MEASURED	Finished	1.11 MMOL/L	1.14 - 1.29	L	OR LAB	
4/28/11 2:06 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	121	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/28/11 1:05 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 11:57 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	79	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 11:02 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	86	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 10:15 PM	CA++ MEASURED	Finished	1.14 MMOL/L	1.14 - 1.29		OR LAB	
4/27/11 9:57 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*

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169

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/27/11 9:02 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	119	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 7:44 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 6:54 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 6:15 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	122	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 6:00 PM	CA++ MEASURED	Finished	1.12 MMOL/L	1.14 - 1.29	L	OR LAB	
4/27/11 4:59 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	138	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 3:53 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	158	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 3:00 PM	CA++ MEASURED	Finished	1.04 MMOL/L	1.14 - 1.29	L	OR LAB	
4/27/11 2:57 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	161	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 2:00 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	151	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 1:20 PM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		9.07 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		2.55 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		7.4 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		21.0 %	42.0 - 52.0	L	GEN LAB	
	MCV		82.4 FL	80.0 - 94.0		GEN LAB	

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Date Printed: 03/16/2012

170

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	MCH		29.0 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.2 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		14.0 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		64 K/CUMM	140 - 440	L	GEN LAB	
	MPV		12.00 FL	9.15 - 12.31		GEN LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					*
	SODIUM (NA)		136.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		5.00 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		106.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		26 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		139.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		13.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.3 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		6.4 MG/DL	8.4 - 10.2	C	GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	MAGNESIUM (MG)	Finished	1.7 MG/DL	1.6 - 2.3		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	PHOSPHORUS (PO4)	Finished	3.2 MG/DL	2.4 - 4.7		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
4/27/11 12:49 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*

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171

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/27/11 11:37 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	164	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 9:30 AM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		78 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT 37 DEGREES C		46 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		439 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		36.5 DegC			OR LAB	
	PH AT PATIENT TEMP		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		45 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		436 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		100.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		1.4 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		26.1 MMOL/L	22.0 - 26.0	H	OR LAB	
	TOTAL CO2 CONTENT		27.5 MMOL/L	23.0 - 27.0	H	OR LAB	
	HEMOGLOBIN		6.9 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		22 %	42 - 52	L	OR LAB	
	SODIUM (NA)		134 MMOL/L	135 - 145	L	OR LAB	
	POTASSIUM (K)		5.2 MMOL/L	3.5 - 5.0	H	OR LAB	
	CHLORIDE		107 MMOL/L	98 - 107		OR LAB	
	GLUCOSE-BLOOD GAS		149 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		1.07 MMOL/L	1.14 - 1.29	L	OR LAB	
4/27/11 8:30 AM	ARTERIAL BLOOD GAS	Finished					

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Date Printed: 03/16/2012

172

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	FRACTION OF INSPIRED OXYGEN		80 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT 37 DEGREES C		43 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		416 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		36.9 DegC			OR LAB	
	PH AT PATIENT TEMP		7.38	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		43 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		415 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.5 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		0.0 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.6 MMOL/L	22.0 - 26.0		OR LAB	
	TOTAL CO2 CONTENT		25.9 MMOL/L	23.0 - 27.0		OR LAB	
	HEMOGLOBIN		8.2 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		26 %	42 - 52	L	OR LAB	
	SODIUM (NA)		135 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		4.5 MMOL/L	3.5 - 5.0		OR LAB	
	CHLORIDE		106 MMOL/L	98 - 107		OR LAB	
	GLUCOSE-BLOOD GAS		156 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		1.07 MMOL/L	1.14 - 1.29	L	OR LAB	
4/27/11 6:16 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 4:11 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	86	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*

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173

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/27/11 3:26 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 2:35 AM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		9.70 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		2.93 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.7 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		24.3 %	42.0 - 52.0	L	GEN LAB	
	MCV		82.9 FL	80.0 - 94.0		GEN LAB	
	MCH		29.7 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.8 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.9 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		75 K/CUMM	140 - 440	L	GEN LAB	
	MPV		12.00 FL	9.15 - 12.31		GEN LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		138.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		5.30 MMOL/L	3.50 - 5.00	H	GEN LAB	
	CHLORIDE		108.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		26 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		100.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		11.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.1 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*

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Date Printed: 03/16/2012

174

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	CALCIUM		7.4 MG/DL	8.4 - 10.2	L	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	MAGNESIUM (MG)	Finished	1.5 MG/DL	1.6 - 2.3	L	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	PHOSPHORUS (PO4)	Finished	3.6 MG/DL	2.4 - 4.7		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	PROTHROMBIN TIME (PT)	Finished					
	PT		18.3 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		1.46			GEN LAB	
	APTT	Finished	35.3 SEC	23.3 - 35.7		GEN LAB	*
	LACTATE DEHYDROGENASE, SERUM	Finished	213.0 IU/L	100.0 -		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
4/27/11 2:16 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	150	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 1:17 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/27/11 12:05 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 11:15 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 10:06 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	87	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 9:02 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*

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175

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/26/11 8:35 PM	LACTATE DEHYDROGENASE, SERUM	Finished	223.0 IU/L	100.0 -		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
4/26/11 7:53 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 6:44 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 5:56 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 4:08 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	86	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 2:52 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	139	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 2:50 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.39	7.35 - 7.45		OR LAB	
	PCO2 AT 37 DEGREES C		43 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		191 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		38.2 DegC			OR LAB	
	PH.AT PATIENT TEMP		7.37	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		45 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		197 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		100.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		0.8 MMOL/L	-2.0 - 3.0		OR LAB	

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Date Printed: 03/16/2012

176

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	BICARBONATE		25.3 MMOL/L	22.0 - 26.0		OR LAB	
	LACTATE - WHOLE BLOOD	Finished	1.7 MMOL/L	0.5 - 1.6	H	OR LAB	*
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		138.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		5.30 MMOL/L	3.50 - 5.00	H	GEN LAB	
	CHLORIDE		109.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		25 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		115.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		11.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.1 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		7.6 MG/DL	8.4 - 10.2	L	GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		7.16 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		3.09 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		9.1 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		25.4 %	42.0 - 52.0	L	GEN LAB	
	MCV		82.2 FL	80.0 - 94.0		GEN LAB	
	MCH		29.4 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.8 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		14.0 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					

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177

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	PLATELET COUNT		72 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.80 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		15.9 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		1.23			GEN LAB	
	APTT	Finished	28.1 SEC	23.3 - 35.7		GEN LAB	*
4/26/11 2:15 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	115	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 1:12 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 12:20 PM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.42	7.35 - 7.45		OR LAB	
	PCO2 AT 37 DEGREES C		41 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		189 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		37.3 DegC			OR LAB	
	PH AT PATIENT TEMP		7.42	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		191 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.7 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.0 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		26.1 MMOL/L	22.0 - 26.0	H	OR LAB	
	LACTATE - WHOLE BLOOD	Finished	1.2 MMOL/L	0.5 - 1.6		OR LAB	*

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Date Printed: 03/16/2012

178

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		7.96 K/CUMM	4.80 - 10.80		GEN LAB	
	RED BLOOD CELL COUNT		2.76 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		8.1 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		22.9 %	42.0 - 52.0	L	GEN LAB	
	MCV		83.0 FL	80.0 - 94.0		GEN LAB	
	MCH		29.3 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.4 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.9 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		66 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.80 FL	9.15 - 12.31		GEN LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		141.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		4.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		110.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		27 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		101.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		11.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.0 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		7.9 MG/DL	8.4 - 10.2	L	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*

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Date Printed: 03/16/2012

179

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	APTT	Finished	33.6 SEC	23.3 - 35.7		GEN LAB	*
	PROTHROMBIN TIME (PT)	Cancelled					*
	PROTHROMBIN TIME (PT)	Finished					
	PT		17.0 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		1.33			GEN LAB	
4/26/11 11:58 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	90	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 11:01 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	88	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 10:26 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 10:01 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	55	70 - 100	L	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 9:02 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 8:26 AM	PROTHROMBIN TIME (PT)	Finished					
	PT		18.1 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		1.44			GEN LAB	
	APTT	Finished	34.3 SEC	23.3 - 35.7		GEN LAB	*
	METABOLIC PANEL, COMPREHENSIVE	Finished					
	SODIUM (NA)		141.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		4.00 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		110.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		24 MMOL/L	22 - 32		GEN LAB	

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Date Printed: 03/16/2012

180

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

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Date	Description	Status	Result	Normal	H/L	Site	Comment
	ANION GAP		7 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		115.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		10.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.2 MG/DL	0.6 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		7.8 MG/DL	8.4 - 10.2	L	GEN LAB	
	BILIRUBIN, TOTAL		1.6 MG/DL	0.2 - 1.3	H	GEN LAB	
	ASPARTATE AMINOTRANSFERASE		40.0 IU/L	12.0 - 38.0	H	GEN LAB	
	ALANINE AMINOTRANSFERASE		21.0 IU/L	10.0 - 45.0		GEN LAB	
	ALKALINE PHOSPHATASE		42.0 IU/L	25.0 - 100.0		GEN LAB	
	TOTAL PROTEIN, SERUM		4.0 G/DL	6.0 - 8.0	L	GEN LAB	
	ALBUMIN, SERUM		2.3 G/DL	3.5 - 4.8	L	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		13.85 K/CUMM	4.80 - 10.80	H	GEN LAB	
	RED BLOOD CELL COUNT		2.61 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		7.6 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		21.8 %	42.0 - 52.0	L	GEN LAB	
	MCV		83.5 FL	80.0 - 94.0		GEN LAB	
	MCH		29.1 pg	27.0 - 31.0		GEN LAB	
	MCHC		34.9 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.6 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		62 K/CUMM	140 - 440	L	GEN LAB	

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Date Printed: 03/16/2012

181

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	MPV		9.80 FL	9.15 - 12.31		GEN LAB	
4/26/11 7:24 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	185	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 6:29 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	273	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 5:30 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	212	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/26/11 5:29 AM	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		140.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		4.10 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		113.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		20 MMOL/L	22 - 32	L	GEN LAB	
	ANION GAP		7 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		191.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		11.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.1 MG/DL	0.6 - 1.3		GEN LAB	
	CALCIUM		7.2 MG/DL	8.4 - 10.2	L	GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	MAGNESIUM (MG)	Finished	2.0 MG/DL	1.6 - 2.3		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	PHOSPHORUS (PO4)	Finished	4.0 MG/DL	2.4 - 4.7		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		20.32 K/CUMM	4.80 - 10.80	H	GEN LAB	

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Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

182

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	RED BLOOD CELL COUNT		3.64 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		10.7 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		30.6 %	42.0 - 52.0	L	GEN LAB	
	MCV		84.1 FL	80.0 - 94.0		GEN LAB	
	MCH		29.4 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.0 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		13.3 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		83 K/CUMM	140 - 440	L	GEN LAB	
	MPV		10.00 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		26.0 SEC	12.0 - 15.1	H	GEN LAB	*
	INR		2.27			GEN LAB	
	APTT	Finished	63.2 SEC	23.3 - 35.7	H	GEN LAB	*
4/26/11 4:48 AM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		90 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.25	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		44 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		506 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		36.0 DegC			OR LAB	
	PH AT PATIENT TEMP		7.26	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		41 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		500 MM HG	80 - 100	H	OR LAB	*

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Date Printed: 03/16/2012

183

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	% O2 SATURATION		99.8 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-7.9 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		18.4 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		19.7 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		8.8 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		27 %	42 - 52	L	OR LAB	
	SODIUM (NA)		137 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		3.6 MMOL/L	3.5 - 5.0		OR LAB	
	CHLORIDE		111 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		184 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		1.16 MMOL/L	1.14 - 1.29		OR LAB	
4/26/11 4:21 AM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		.90 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.27	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		41 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		489 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		35.9 DegC			OR LAB	
	PH AT PATIENT TEMP		7.29	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		39 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		483 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.9 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-7.5 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		18.2 MMOL/L	22.0 - 26.0	L	OR LAB	

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Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

184

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

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Date	Description	Status	Result	Normal	H/L	Site	Comment
	TOTAL CO2 CONTENT		19.4 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		6.9 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		22 %	42 - 52	L	OR LAB	
	SODIUM (NA)		137 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		3.4 MMOL/L	3.5 - 5.0	L	OR LAB	
	CHLORIDE		111 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		175 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		1.00 MMOL/L	1.14 - 1.29	L	OR LAB	
4/26/11 3:50 AM	ARTERIAL BLOOD GAS	Finished					*
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.27	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		37 MM HG	35 - 45		OR LAB	
	PO2 AT 37 DEGREES C		470 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		35.8 DegC			OR LAB	
	PH AT PATIENT TEMP		7.29	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		35 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		463 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		100.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-9.0 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		16.5 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		17.7 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		5.2 GM/DL	14.0 - 18.0	C	OR LAB	
	HEMATOCRIT - BLOOD GAS		16 %	42 - 52	C	OR LAB	
	SODIUM (NA)		138 MMOL/L	135 - 145		OR LAB	

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Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

185

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

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Date	Description	Status	Result	Normal	H/L	Site	Comment
	POTASSIUM (K)		3.4 MMOL/L	3.5 - 5.0	L	OR LAB	
	CHLORIDE		111 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		159 MG/DL	70 - 100	H	OR LAB	
	CA++ MEASURED		0.97 MMOL/L	1.14 - 1.29	L	OR LAB	
4/26/11 3:36 AM	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		94 %			OR LAB	
	TEMPERATURE (UNCORRECTED)		37 DegC			OR LAB	
	PH AT 37 DEGREES C		7.18	7.35 - 7.45	L	OR LAB	
	PCO2 AT 37 DEGREES C		47 MM HG	35 - 45	H	OR LAB	
	PO2 AT 37 DEGREES C		496 MM HG	80 - 100	H	OR LAB	
	BODY TEMPERATURE		36.0 DegC			OR LAB	
	PH AT PATIENT TEMP		7.20	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		45 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		490 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		100.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		-10.3 MMOL/L	-2.0 - 3.0	L	OR LAB	
	BICARBONATE		16.9 MMOL/L	22.0 - 26.0	L	OR LAB	
	TOTAL CO2 CONTENT		18.4 MMOL/L	23.0 - 27.0	L	OR LAB	
	HEMOGLOBIN		7.8 GM/DL	14.0 - 18.0	L	OR LAB	
	HEMATOCRIT - BLOOD GAS		24 %	42 - 52	L	OR LAB	
	SODIUM (NA)		139 MMOL/L	135 - 145		OR LAB	
	POTASSIUM (K)		3.4 MMOL/L	3.5 - 5.0	L	OR LAB	
	CHLORIDE		111 MMOL/L	98 - 107	H	OR LAB	
	GLUCOSE-BLOOD GAS		195 MG/DL	70 - 100	H	OR LAB	

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Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

186

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	CA++ MEASURED		0.95 MMOL/L	1.14 - 1.29	L	OR LAB	
4/26/11 2:59 AM	APTT	Finished	31.2 SEC	23.3 - 35.7		GEN LAB	*
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		141.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		3.80 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		110.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		20 MMOL/L	22 - 32	L	GEN LAB	
	ANION GAP		11 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		141.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		13.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.3 MG/DL	0.6 - 1.3		GEN LAB	
	CALCIUM		8.5 MG/DL	8.4 - 10.2		GEN LAB	
	HEMOLYSIS INDEX		2.0	0.0 - 1.9	H	GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		16.36 K/CUMM	4.80 - 10.80	H	GEN LAB	
	RED BLOOD CELL COUNT		4.53 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		13.9 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		38.9 %	42.0 - 52.0	L	GEN LAB	
	MCV		85.9 FL	80.0 - 94.0		GEN LAB	
	MCH		30.7 pg	27.0 - 31.0		GEN LAB	
	MCHC		35.7 GM/DL	30.7 - 34.4	H	GEN LAB	
	RDW		12.7 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		206 K/CUMM	140 - 440		GEN LAB	

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

Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

187

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: GOODWIN, DAVON A **MRN:** 000725008

Date	Description	Status	Result	Normal	H/L	Site	Comment
	MPV		10.90 FL	9.15 - 12.31		GEN LAB	
	ALCOHOL, ETHYL	Finished	28.0 MG/DL	0.0 - 0.0	H	GEN LAB	*
	PROTHROMBIN TIME (PT)	Finished					
	PT		14.8 SEC	12.0 - 15.1		GEN LAB	*
	INR		1.12			GEN LAB	
	ABO AND RH BLOOD TYPE	Finished					
	ABO RH INTERPRETATION		B NEG			GEN LAB	
	ANTIBODY SCREEN (INDIRECT	Finished					
	ANTIBODY SCREEN INTERP		Negative ABSC			GEN LAB	

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

Printed by: GADSDEN, ADRIAN
Date Printed: 03/16/2012

MUSC Health

ECG

DAILY TELEMETRY STRIPS

Page 1 of 2

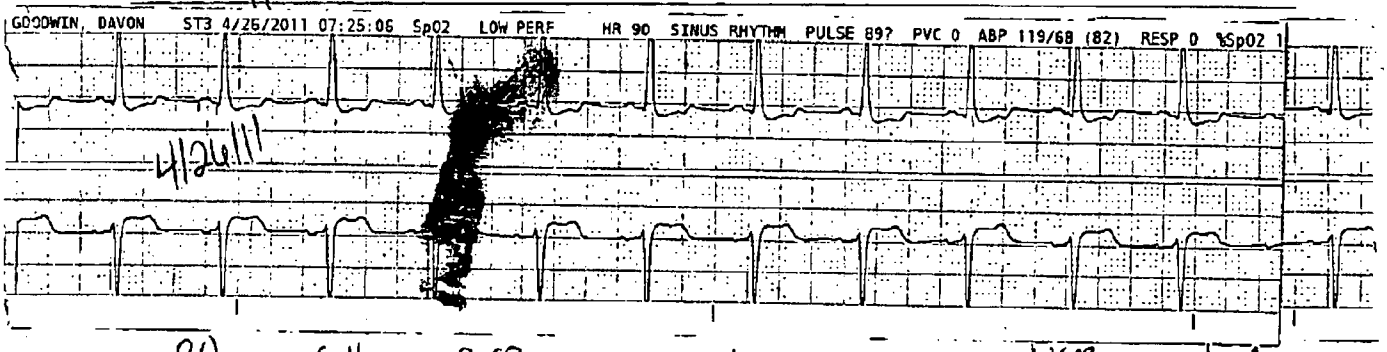
Form Origination Date: 1/00
Version: 2

Version Date: 11/05

P:495654253 DOB [redacted] U
TRAUMA
Patient Name VICTIM PP
MRN Adm:04/26/11 M:2657049

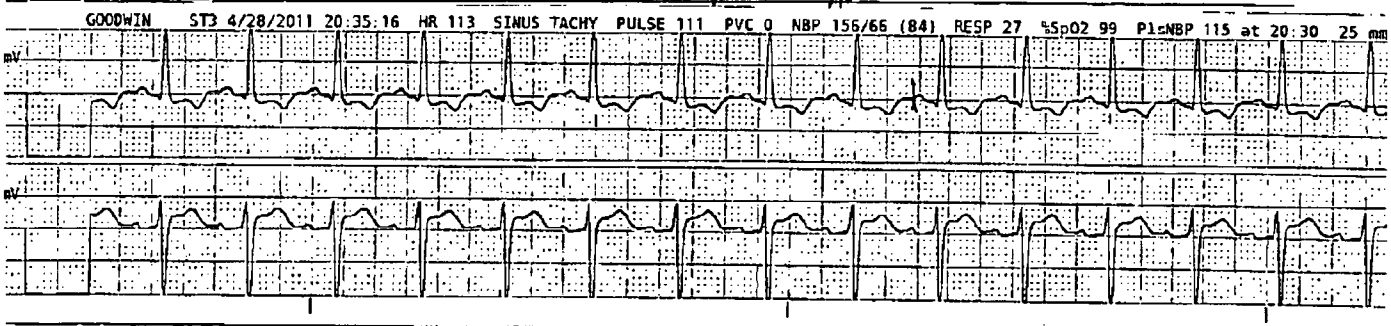
PATIENT IDENTIFICATION LABEL

DATE: 4/28/11 BOX NO: _____ ROOM NO: _____ PAGE _____ of _____



HR: 90 PRI: 0.16 QRS: 0.08 QT: _____ RHYTHM INTERPRETATION: NSR c noc dqm

TELEMETRY TECHNICIAN SIGNATURE: [signature] RN



HR: _____ PRI: .16 QRS: .06 QT: _____ RHYTHM INTERPRETATION: Sinus Tachycardia

TELEMETRY TECHNICIAN SIGNATURE: [signature] RN

TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE

TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE

TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE

HR: _____ PRI: _____ QRS: _____ QT: _____ RHYTHM INTERPRETATION: _____

TELEMETRY TECHNICIAN SIGNATURE: _____

dailytelemetry

OTC 700153 Rev. 11/05

MUSC Health

ECG

DAILY TELEMETRY STRIPS

Page 2 of 2

Form Origination Date: 1/00
Version: 2 Version Date: 11/05

P495654253
Goodwin Davon
M2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

DATE: _____ BOX NO: _____ ROOM NO: _____ PAGE _____ of _____

TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER

HR: _____ PRI: _____ QRS: _____ QT: _____ RHYTHM INTERPRETATION: _____
TELEMETRY TECHNICIAN SIGNATURE: _____

TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER

HR: _____ PRI: _____ QRS: _____ QT: _____ RHYTHM INTERPRETATION: _____
TELEMETRY TECHNICIAN SIGNATURE: _____

TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER TO EXPOSE ADHESIVE REMOVE LINER

HR: _____ PRI: _____ QRS: _____ QT: _____ RHYTHM INTERPRETATION: _____
TELEMETRY TECHNICIAN SIGNATURE: _____

dailytelemetry OTC 700153 Rev. 11/05

MUSC Health

"CONSENT"

Adult Consent for Invasive Procedures in the ICU (Universal Consent)

Page 1 of 4

Form Origination Date: 1/10
Version: 1 Version Date: 1/10

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Patient Name _ Adm:04/26/11 M:2657049 ___
MRN
PATIENT IDENTIFICATION LABEL

Date 4/26/11

I authorize the performance of:

☒ **Placement of central venous catheter** **Patient / Family Initials** DH Consent Refused ☐

Procedure: A small tube used to give fluids or medicine and measure pressure is placed in the large vein near the heart.
Indication: Need for long-term medicine treatment for pain, infection, cancer, or to supply nutrition; to give medicines that affect the heart; to measure the blood pressure inside the large vein near the heart.
Potential complications: Bleeding, caused by inserting the catheter into the vein; collapsed lung (pneumothorax); blood clots; air embolism; infection; blockage or kinking of the catheter; pain at entry site; moving of the catheter. A catheter that has moved out of place can sometimes be repositioned. If the catheter can not be moved back in to place, it must be replaced.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☒ **Placement of pulmonary artery catheter** **Patient / Family Initials** DH Consent Refused ☐

Procedure: A small tube which is passed into a large artery of the heart that carries blood to the lungs.
Indication: To detect heart failure or infection, monitor therapy, and / or evaluate the effects of drugs.
Potential complications: Irregular heartbeat, rupture or a puncture of the pulmonary artery, blood clots, infection, collapsed lung (pneumothorax), bleeding, and other problems.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☒ **Chest tube placement** **Patient / Family Initials** DH Consent Refused ☐

Procedure: A tube inserted into the lung space which allows air, blood or fluid to drain from the chest area and restores breathing.
Indication: Bleeding into the chest (hemothorax); air leaks from the lung into the chest (pneumothorax); extra fluid collected in the pleural space (pleural effusion); lung abscess or infection with pus in the chest; after surgery or trauma to the chest.
Potential complications: Problems breathing; bleeding; infection; tube may poke through body organs close to the lungs. A chest tube may move out of place and another tube may need to be put in.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☐ **Thoracentesis** **Patient / Family Initials** DH Consent Refused ☐

Procedure: A needle / syringe is inserted into the chest to remove fluid.
Indication: To help find out the cause of fluid in the lung cavity; relieve shortness of breath; relieve pain caused by excess fluid (pleural effusion)
Potential complications: Puncture the lung with a needle, a partial collapse of the lung (pneumothorax); pulmonary edema; infection; bleeding, chest pain, nausea, cough; damage to nerves, veins or organs near the lungs.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

MUSC Health

"CONSENT"

Adult Consent for Invasive Procedures in the ICU (Universal Consent)

Page 2 of 4

Form Origination Date: 1/10

Version: 1 Version Date: 1/10

P:495654253 008[redacted] B M
GOODWIN
DAVON
Adm:04/26/11 M:2657049

Patient Name ___
MRN ___

PATIENT IDENTIFICATION LABEL

Date 4/26/11

☐ **Paracentesis** **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A needle is inserted into the body, usually the chest or abdomen, to remove fluid.
Indication: Help determine the cause of fluid buildup in the abdominal cavity (ascites); diagnose infection in the fluid; help detect certain types of cancer (such as liver cancer); remove a large amount of built up fluid that is causing pain or breathing difficulty, or that is affecting the function of the kidneys or the intestines (bowel).
Potential complications: Puncture of the bladder, bowel, or a blood vessel within the abdomen; if cancer cells are present in the fluid found in abdomen, spread of the cancer cells within the abdominal cavity; shock from removal of a large amount of fluid; a decrease in kidney function.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☐ **Lumbar puncture** **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A needle is inserted into the middle area of the back to check for problems with the fluid in the brain or spine.
Indication: Frequent seizures; headache; fever; level of awakeness; diagnosis of: _____;
other: _____
Potential complications: The brain may herniate, resulting in severe injury and possibly death for patients with existing increased pressure within the brain caused by a tumor, a pocket of infection, or a major bleed minor nerve injury; infection of the cerebrospinal fluid (CSF) (meningitis); bleeding inside the spinal canal; damage to the connective tissue between the vertebrae; continued internal bleeding (for those with existing bleeding disorders currently taking blood-thinning medication (such as warfarin or heparin). For these patients, procedure will only be performed if a life-threatening illness is suspected and needs to be diagnosed immediately.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☑ **Intubation / mechanical ventilation** (MV) **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A tube is passed, usually through the mouth or nose, into the wind pipe (trachea) to maintain patient breathing and provide oxygen or anesthesia. A machine (ventilator) is then hooked to the breathing tube to provide oxygen to the lungs and breathe for the patient if required.
Indication: Being unable to breathe on your own
Potential complications: May be used short term (i.e., treating pneumonia), or it may be needed long term for permanent lung disease or trauma to the brain. Some patients on long term MV live a quality of life that is acceptable to them. For some patients, MV may only prolong the dying process. Abnormal heartbeats, damage to mouth, teeth, larynx (voice box), or wind pipe (trachea) may occur. The tube may be passed into the throat (esophagus) causing you to vomit. Infection of the lungs (pneumonia) or partial collapse of the lungs (pneumothorax) are more common in mechanically ventilated patients.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

MUSC Health

CONSENT

Adult Consent for Invasive Procedures in the ICU (Universal Consent)

Page 3 of 4

Form Origination Date: 1/10
Version: 1 Version Date: 1/10

P:495654263 DOB: [redacted] B M
GOODWIN
DAVON
Patient Name Adm:04/26/11 M:2657049
MRN

PATIENT IDENTIFICATION LABEL

Date 4/26/11

☑ **Upper gastrointestinal tract endoscopy** **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A tube is passed through the mouth that lets the doctor check the upper digestive system; throat (esophagus), stomach and part of the small intestine.
Indication: To detect a bulge of the stomach into the diaphragm (hiatal hernia); stomach ulcers, swelling, tumors, bleeding, or other findings; determine the cause of constant upper stomach pain or bloating, difficulty in swallowing, and vomiting; to diagnose an infection of the throat (esophagus) check the stomach and upper small intestine (duodenum) after surgery; obtain an emergency diagnosis of esophageal injury; collect tissue samples (biopsy); treat upper GI bleeding, including bleeding caused by engorged veins in the throat (esophageal varices); remove foreign objects that have been swallowed; perform studies for anemia.
Potential complications: Puncture to the throat (esophagus), stomach, or upper small intestine (duodenum); bleeding caused by the procedure; aspiration pneumonia.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☑ **Lower gastrointestinal tract endoscopy** **Patient / Family Initials** _____ Consent Refused ☐

Procedure A tube is passed through the rectum into the large intestine allowing doctors to test for problems.
Indication: To check for abscess or infection, swelling, polyps or tumors.
Potential complications: Bleeding caused by the procedure, abnormal heartbeat, high blood pressure, or trouble breathing. Increased pressure from the tube can cause a tear in the large intestine or rectum.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☑ **Tracheostomy** **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A small opening is made in the wind pipe (trachea) to allow a breathing tube to be inserted.
Indication: Need long term help with breathing due to illness, damage to muscles used in breathing, problems clearing mucus out of airways
Potential complications: Scar tissue can form at the opening; problems with speech; bleeding and infection at the site; increased risk of lung infections; tube can get blocked by blood clots or mucus; tube can come out on its own and need to be replaced right away; trouble swallowing; emotional problems, such as change in self-image and depression.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☐ **Bronchoscopy with lavage** **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A tube with a small camera is passed into the upper breathing airway allowing the doctor to check this area.
Indication: To see areas of swelling (inflammation) and bleeding; diagnose certain lung diseases; diagnose and find out the extent of lung cancer; remove foreign objects or thick mucus that may be blocking the airway
Potential complications: Spasms of the branches of the wind pipe, which can impair breathing; irregular heartbeats (arrhythmias); infections such as pneumonia; discomfort and coughing; reduced oxygenation.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

MUSC Health

"CONSENT"

Adult Consent for Invasive Procedures in the ICU (Universal Consent)

Page 4 of 4

Form Origination Date: 1/10
Version: 1 Version Date: 1/10

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Patient Name Adm:04/26/11 M:2657049
MRN
PATIENT IDENTIFICATION LABEL

Date 4/26/11

☐ **Bronchoscopy with biopsy-needle / forceps** **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A tube with a small camera is passed into the upper breathing airway allowing the doctor to check this area, and a small amount of fluid may be put into the tube and then removed, a piece of tissue can be taken, and sent for lab test.
Indication: To remove tissue samples for biopsy; to clear the airway of foreign bodies.
Potential complications: Spasms of the branches of the wind pipe, which can impair breathing; irregular heartbeats (arrhythmias); infections such as pneumonia; Bleeding can be caused by the needle used to collect the tissue; a tear of the lung wall can occur; discomfort and coughing; reduced oxygen.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☑ **Placement of arterial catheter** **Patient / Family Initials** _____ Consent Refused ☐

Procedure: A small tube placed into an artery, often in the wrist area, to allow for more precise monitoring of pulse and blood pressure
Indication: Need for frequent blood draws (> 4 times/day); hemodynamic instability (spread of blood and oxygen not balanced) requiring medicine for low blood pressure; high blood pressure requiring continuous IV medicines; profound obesity preventing accurate blood pressure reading; monitoring of blood flow to the brain.
Potential complications: Bleeding.
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☐ Other: _____ **Patient / Family Initials** _____ Consent Refused ☐

Procedure:
Indication:
Potential complications:
Alternatives procedures, treatments or therapies: _____
Practitioner(s) performing the procedure: _____

☐ **Anesthesia Administration** **Patient / Family Initials** _____ Consent Refused ☐

I consent to the administration of such anesthetics as may be considered necessary or advisable by the Physician, Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) performing and / or assisting with the procedure.

upon Davon Goodwin
[patient name]

I have reviewed and fully understand the indications, procedure and potential complications on pages 1-4 of this document. I (the undersigned), have had this form explained to me and fully understand the contents of this authorization.

Witness

Deatra Goodwin
Authorized Person

mother
Relationship

I have counseled this person as to the nature of, and reasons for, the proposed procedure(s).

Physician obtaining consent

4/26/11
Date

2:00 pm
Time

ah_critcare_all_consent_universalconsent

OTE 700514 1/10

MUSC Health

"CONSENT"
AUTHORIZATION FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Page 1 of 2

Form Origination Date: 1/00
Version: 7 Version Date: 07/07

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Adm:04/26/11 M:2657049

Patient Name
MRN

PATIENT IDENTIFICATION LABEL

1. I authorize the performance upon Davon Goodwin of the following
(Myself or name of patient)

operation / procedure:
re-exploration of abdomen
possible bowel resection
possible ostomy
possible closure of abdomen

(Description of operation or procedure in layman's language / Medical description of operation or procedure)
for the preoperative diagnosis of injuries secondary to gunshot wound
to be performed under the direction of Dr(s). Norcross and associates
and / or such associates, partners, assistants, or designees as may be selected by him to perform such operation / procedure. I understand that the individuals participating in my operation / procedure are physicians who are in approved medical residency training programs or are nonphysician skilled healthcare providers. All individuals participating in my operation / procedure are under the direction of Dr(s). Norcross and associates.
I understand that my primary physician for this operation / procedure will decide who should participate and in what manner at the time of my operation / procedure and that this decision will be based upon my condition and needs at the time of the operation / procedure and who is available to meet those needs. Other individuals may perform important parts of the operation / procedure such as opening and closing, harvesting grafts, dissecting or removing tissue, altering tissue, or implanting devices.

2. I recognize that during the course of the operation / procedure, unforeseen conditions may necessitate additional or different procedures or services than those set forth above, and I further authorize and request that the above-named surgeon and / or his / her associates, partners, assistants, or designees perform such procedures that are, in his / her (or their) professional judgment, necessary and desirable.

3. I consent to the disposal by hospital authorities of any tissue or members, which may be removed during the course of the operation. I further give my consent for the hospital authorities, at their discretion, to save for research and educational purposes all or part of the tissue or specimens normally thrown away. I understand that the tissue or specimens saved will not be linked to my name or any other identifier that could be traced to me. If you do not give permission for any removed tissue or specimens to be saved, strike through this paragraph and initial to the left of the paragraph.

4. For the purpose of advancing medical knowledge, I consent to the admittance of medical students and other observers, in accordance with ordinary practices of this medical facility, to the use of closed-circuit television, the taking of photographs (including motion pictures) and the preparation of drawings and similar illustrative graphic material. I also consent to the use of such photographs and other materials for scientific purposes.

5. The nature, proposed and possible consequences of the operation / procedure, possible alternative methods of treatment, the risks involved and the possibility of complications including those listed below, and the potential problems that might occur during recuperation have been fully explained to me. Although we have discussed the potential likelihood of success, no guarantees or assurances have been made or given by anyone as to the results that may be obtained.
bleeding, infection, damage to surrounding structures, need for other procedures

Patient initials DG / Physician initials AR

all_all_consent_surgicalconsent OTE 700034 Rev. 07/07

MUSC Health

CONSENT
AUTHORIZATION FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Page 2 of 2

Form Origination Date: 1/00
Version: 7 Version Date: 07/07

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Patient Name Adm:04/26/11 M:2657049
MRN

PATIENT IDENTIFICATION LABEL

Operation / Procedure (from page 1):
re-exploration of abdomen
possible bowel resection
possible ostomy
possible closure of abdomen

6. I understand and consent to blood transfusion and / or blood products if needed before, during and after my surgery until discharge. I acknowledge that my doctor's explanation included the reasonable benefit and potential risks that I have been told can occur with transfusion of blood and / or blood products such as hepatitis, AIDS, cytomegalovirus (CMV), hemolytic reactions, and fluid overload. ☒ N/A

7. I consent to the administration of such anesthetics as may be considered necessary or advisable by the Anesthesiologists, Certified Registered Nurse Anesthetists (CRNA), and others assisting with the anesthesia process. Prior to the procedure I will have the opportunity to discuss my plan of anesthesia care in detail with the Anesthesia care provider of such service with the exception of: none
(State exception or write "none")

8. The nature, proposed and possible consequences of the anesthesia / moderate sedation, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. No guarantees or assurances have been made or given by anyone as to the results that may be obtained.

I, THE UNDERSIGNED, HAVE HAD THIS FORM EXPLAINED TO ME AND FULLY UNDERSTAND THE CONTENTS OF THIS AUTHORIZATION.

[signature] Witness

Deatra Goodwin Patient or authorized person

Witness for telephone consent

mother Relationship

Physician obtaining consent [signature] Pager ID 15832 Date 4/26/11 Time 2:00 AM/PM

all_all_consent_surgicalconsent

OTE 700034 Rev. 07/07

MUSC Health

"CONSENT"

Consent for Medical Treatment

Form Origination Date: 8/99
Version: 5

Version Date: 1/11

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Adm:04/26/11 M: 2657049

PATIENT IDENTIFICATION LABEL

Your Permission is Needed

I (as patient, parent, guardian, spouse, guarantor, or other responsible party) consent to and authorize medical treatment and diagnostic procedures which may be ordered by my doctors and performed by MUSC Medical Center ("The Hospital"). I consent to have blood drawn and to be tested for infectious diseases, including but not limited to syphilis, AIDS, hepatitis and testing for drugs if my doctor orders these tests.

Initial LD

Your Agreement to Pay for Treatment

I assign and transfer to The Hospital and / or my doctors all rights, and interest in benefits I may have under any insurance policy I may have, including but not limited to hospitalization, medical, third party liability insurance coverage, workers compensation benefits, or benefits paid by Medicare or Medicaid. This assignment is intended to include any interest in benefits that I may have relating to this date of service as well as any prior dates of service. I direct that any insurance company or other party make payment of such benefits to The Hospital or my doctor. I authorize The Hospital and / or my doctor to collect benefits from any responsible third party through whatever means may be deemed necessary, and to endorse benefit checks made payable directly to me.

I understand that by signing below, I promise to pay all Hospital and doctor charges at the standard rates and terms of The Hospital or doctor including all charges not covered by my insurance or any other party. I promise to pay the patient's account at the rates stated in The Hospital's price list (known as the "Charge Master") and / or the doctor's fee schedule in effect on the date the charge is processed for the services provided. I understand that there will be a separate charge for the doctor and other professional services, but understand that The Hospital may bill for some professional fees.

I understand that The Hospital files insurance as a courtesy to me, and agree that I am responsible for payment of my bill, including any charges that are denied by my insurance or any other responsible party. I understand that care that is experimental as determined by my insurance company may not be covered and that I will be responsible for those charges. I agree that if this account is not paid, it may be turned over to a collection agency or attorney, and I must pay the amount due plus all costs of collection, including reasonable attorney's fees.

I understand that if I am unable to pay my bills, I may speak with a Financial Counselor to determine whether I qualify for assistance or for a discount. I may call (843) 792-2311 for information or questions about my hospital bill and (843) 792-6200 for information about my doctor bill.

Initial LD

Release of Information to My Referring Doctor

My referring doctor is (please print full name): [illegible] City: _____

My Primary Care Physician is (please print full name): [illegible] City: _____

Medicare Patient Certification (Medicare patients only)

I hereby certify that I have provided information about all insurance coverage available to me, including liability or worker's compensation insurance and that the information provided is correct and complete. I hereby authorize The Hospital and / or my doctors to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. I hereby authorize the payment of benefits to The Hospital or my doctors.

Initial [illegible]

OTE 700227 Rev. 1/11

all_all_consent_consentfortreat

MUSC Health

"CONSENT"

Consent for Medical Treatment

Form Origination Date: 6/99
Version: 5 Version Date: 1/11

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Adm:04/26/11 M: 2657049

PATIENT IDENTIFICATION LABEL

Retention / Disposal and Use of Blood, Body Fluids, or Tissue

I understand and agree that any blood, body fluids or tissues normally removed from my body by MUSC in the course of any diagnostic procedures, surgery, or medical treatment that would otherwise be disposed of may be retained and used for research, including research on the genetic material (DNA) or other information contained in those tissues or specimens. I acknowledge that such research by MUSC may result in new inventions that may have commercial value and I understand that there are no plans to compensate me should this occur, regardless of the value of any such invention. I understand that any research using these leftover specimens or tissues will be done in a way that will not identify me.
I also understand that if I do not want research to be done using my leftover blood, body fluids or tissue, I need to check the box shown below. If I have questions, I should call (843) 792-8300.

☑ I DO NOT agree to have my blood, body fluids or tissue used for future research studies.

Permission to Contact for Research Studies

I agree to be contacted about future research studies at MUSC for which I may be eligible. I understand that if I do not want to be contacted about future research studies, I need to check the box shown below.

☑ I DO NOT agree to be contacted about future research studies

Admission Photographs

I agree that my photograph may be taken for purposes of identifying me, or providing treatment to me. This photograph may become part of my medical record and may be disclosed if copies of my medical record are disclosed.

Initial DG

Responsibility for Personal Items

I understand that The Hospital is not responsible for valuable items which I bring with me. I understand it is my responsibility to send any valuable items (such as medications, money, jewelry, electronics, etc.) home for safe keeping. Any items left at the hospital in excess of 30 days will be disposed of.

Initial DG

I received a copy of the MUSC "Notice of Privacy Practices".

Initial DG

I certify that I have read or have had read to me this consent and agree to its terms. I also certify that I am the patient, or am duly authorized by the patient, or am duly appointed to sign this agreement. I accept and understand its terms.

4/26/11 3:02 pm
Date and Time

Signature of Witness

Signature of Patient (Parent or Legal Guardian)
Print Full Name

Signature of Guarantor / Relationship to Patient
Print Full Name Davon Goodwin

Advance Directives infomation given: ☑ **Yes** ☐ **No (If No, please explain** _____**)**

all_all_consent_consentfortreat

Original to Medical Records Copy to Patient

OTE 700227 Rev. 1/11

MUSC Health

"CONSENT"

Lewis Blackman
Hospital Patient Safety Act Acknowledgement

Page 1 of 1

Form Origination Date: 10/06
Version: 1

Version Date: 10/06

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Adm:04/26/11 M: 2657049

PATIENT IDENTIFICATION LABEL

MUSC Is a Teaching Hospital

I understand that MUSC is an academic medical center providing healthcare, teaching and research. I also understand that I may be cared for by physicians and other healthcare providers in training. My care will be supervised by an attending physician and staff. The information related to the health care I receive may be used for training or for scientific study purposes. I understand that if information contained in my health care record is used for such purposes, precautions will be taken to carefully preserve my anonymity. I also understand that pictures or other recordings may be made for purposes of my treatment or for educational purposes.

In addition, I understand that if I have questions about my medical care I can speak to my attending physician, nurse, resident, or medical student. In addition, I can contact my attending physician or the House Services Coordinator through the operator at 792-8080 (2-8080 from the bedside phone).

I acknowledge that I have received a copy of the brochure entitled "Medical University of South Carolina, An Academic Medical Center of Excellence" explaining the role of residents and students in my care.

4/26/11 3:02 PM
Date and Time

Signature of Patient (Parent or Legal Guardian)

Signature of Witness

Deatra Goodwin
Signature of Guarantor (if different from the patient)

Davon Goodwin

blackmanactacknowledge

OTE 700226 10/06

MUSC Health

DEATHPRGNT

Death Note

Form Origination Date: 10/08
Version: 3 Version Date: 8/10

Patient Name Goodwin, Davon
MRN 725008
PATIENT IDENTIFICATION LABEL

ALL STARRED (*) ELEMENTS OF THIS FORM MUST BE COMPLETED

***Called to Bedside:**
by 10 WEST CHARGE NURSE
reason: PATIENT UNRESPONSIVE

***Exam (check all that apply):**

- [x] patient unresponsive to verbal or tactile stimuli
- [ ] no carotid pulse
- [ ] absence of spontaneous respirations confirmed by inspection and auscultation
- [ ] absence of heart sounds confirmed by auscultation
- [ ] Brain death (use Brain Death Evaluation Form - Link)

***Pronouncement of Death:** (date / time at which assessment is completed - this is the official time of death)
Date: 5/4/11 Time: 0845 (am)/pm

***Suspected Cause of Death:** (Be specific, not generic. For example: myocardial infarction due to coronary atherosclerosis. Not: cardiac arrest)
PULMONARY EMBOLISM

***Notification: (Specify who did notification, person(s) notified, date, and time)**
1. Family / Next of Kin (name) BROTHER
(relation) _____ notified by: _____
on (date) _____ at (time) _____
2. Attending (name & method of notification): MONTGOMERY
3. MUSC Referring Physician (name & method of notification): _____
4. Community Referring Physician and PCP (name & method of notification): _____

***Palliative Care:**
Was patient on palliative care prior to death? [ ] Yes [x] No

Organ / Tissue Donation: _____

***Death Summary:**
[x] Death Summary dictated by _____ Pager ID: 15721 Dictation #: _____
At time of death: Attending MONTGOMERY Service: TRAUMA SURGERY

Physician Signature _____ Pager ID 15721 Date 5/4/11 Time 1834 AM/PM
all_all_docu_deathnote

MUSC Health

DEATHPRGNT

Death Note

Page 2 of 3

Form Origination Date: 10/08
Version: 3 Version Date: 8/10

P495654253
Goodwin Davon
Patient Name
MRN M2657049
PATIENT IDENTIFICATION LABEL

ALL STARRED (*) ELEMENTS OF THIS FORM MUST BE COMPLETED

Medicolegal Clearance for Disposition of Decedent

Medicolegal Clearance

Do not talk to the family about an autopsy until you have answered the questions below. If any of the circumstances below apply, you must report the death to the coroner in the county where the underlying injury or incident resulting in death occurred. Permission for autopsy can be sought only if:

- none of the circumstances below apply, or
- if the coroner has been notified and has declined to take jurisdiction, or
- if the coroner has undertaken to sign the death certificate but will allow the hospital pathologists to perform the autopsy.

Contact the morgue attendant (792-4470) for the name of the appropriate coroner and if assistance with contact/notification is needed. If the coroner cannot be reached, call the morgue attendant.

***Circumstances of death involved**: (check all that apply)

- ☑ Sudden, unexpected, unexplained death
- ☐ Admitted unconscious or death within 24 hours after admission or within 24 hours of an invasive surgical procedure
- ☐ Death related to medical procedure
- ☐ Anesthesia, postanesthesia, in recovery
- ☐ Maternal death during delivery
- ☐ Prisoner, inmate, in custody, or patient in institution
- ☐ Unusual death or suspicion of injury, foul play, violence, or neglect (possible accident, suicide, or homicide)
- ☐ Poison or drug-related death
- ☐ Injury on the job
- ☐ Delayed effect of injury (e.g., pulmonary embolism after hip fracture, post-traumatic seizure, gunshot wound complications)
- ☐ Apparent stillbirth or infant death (gestation ≥ 20 weeks) delivering outside of hospital
- ☐ Infant or fetal death due to any of the above, or possible maternal drug abuse or unlawful abortion (excluding legal termination of pregnancy).

***Did death involve any of the above circumstances?**

- ☑ No. Physician may request authorization for a medical autopsy and must complete death certificate (next page)
- ☐ Yes. **Report to Coroner** (see below)

☐ **Coroner Notified:**

Contact Numbers: Morgue Attendant: 792-4470
Berkeley County Coroner: 719-4566
Charleston County Coroner: 746-4030
Dorchester County Coroner: 832-0351

Coroner Name: _____

Notified by: _____ Date: _____ Time: _____

☐ Coroner agreed to the need for autopsy and accepts jurisdiction – coroner completes cause of death on death certificate

☐ Coroner did not agree to need for autopsy and declined jurisdiction – physician may request authorization for a medical autopsy AND must complete death certificate (next page)

Physician Signature _____ Pager ID 15721 Date 5/4/11 Time 1320 AM/PM

all_all_docu_deathnote

OTE 700479 Rev. 8/10

MUSC Health

DEATHPRGNT

Death Note

Form Origination Date: 10/08
Version: 3 Version Date: Rev. 8/10

495654253
Goodwin Davon
2/6 37049

Patient Name
MRN
PATIENT IDENTIFICATION LABEL

ALL STARRED (*) ELEMENTS OF THIS FORM MUST BE COMPLETED

Medical Autopsy → The physician should request an autopsy based on the College of American Pathologist criteria, which include:

- Inpatient deaths falling under the local / state guidelines for reporting to a medical examiner / coroner jurisdiction that have been reported but subsequently declined for autopsy by that entity.
- Cancer patients in whom there is no prior tissue diagnosis or the source of the primary is unknown.
- Patients dying of internal bleeding - not identified as to source.
- Patients with infections of undetermined type and / or source, including those potentially related to bio-terrorism.
- Transplant patients as well as organ and / or tissue donors.
- Deaths associated with blood component transfusions.
- Patients with a known or suspected therapeutic complication that may have contributed to death (e.g., pharmacotherapy, radiation therapy, chemotherapy, and / or surgical or other invasive procedures).
- Patients who have participated in clinical trials (protocols) approved by institutional review boards.
- Obstetric (maternal and fetal) and pediatric deaths, according to state law.
- Deaths in which there is a known or suspected congenital malformation, genetic disease, syndrome, or undefined metabolic disease.
- Patients with known or suspected environmental or occupational exposures, where the death is believed to be related to that exposure.
- Deaths for which there is no adequate clinical explanation.
- Deaths occurring at any age in which it is believed that an autopsy would disclose a known or suspected illness which may have a bearing on survivors.

Next of Kin: In accordance with SC Code of Laws 44-43-330, there are very specific legal requirements regarding relatives who qualify to give consent for autopsy. The statute requires that the living person with the highest priority rank be the signer(s) of the autopsy consent. This following list is the priority of individuals who may give consent for autopsy and direct disposition of the decedent's remains:

Surviving spouse unless legally divorced, legally separated, or pending a court order for the same. In SC, the partner in common law marriage is considered next of kin. If the deceased was never married, was divorced, or if surviving spouse has been declared incompetent, then,
Adult children (over 21), if none then,
Adult grandchildren (over 21), if none then,
Parents, if none then,
Adult brothers and sisters (over 21), if none then,
All grandparents, if none then,
All adult aunts and uncles, if none then,
All adult cousins, if none then,
All adult stepchildren, if none then,
Relative / Next of kin (in order above) of previously deceased spouse, if none then,
Any relative or friend who assumes custody of the body for burial, if none then,
A person given authority to make health care decisions for the patient by another statutory provision, if none then,
Hospital Administrator, 48 hours after death

Note: If two or more persons assume custody of the body, consent of one of them shall be deemed sufficient, but if this situation occurs, please contact the pathologist before proceeding with autopsy authorization.

***Autopsy:**

- ☐ Autopsy requested and accepted – authorization required
- ☐ Autopsy requested but denied
- ☐ Autopsy not requested; reason: _____

Physician Signature _____ Pager ID 15721 Date 5/4/11 Time 1535 AM/PM

all_all_docu_deathnote

OTE 700479 Rev. 8/10

DATE: 05/09/2011 MUSC Medical Center TIME: 05:53 PM
PAGE: 1 OF 1 DIAGNOSIS AND PROCEDURE SUMMARY

Patient Name: GOODWIN, DAVON MR #: 002657049 PAT #: 495654253

Sex: M Admitted: 4/26/11
Birthdate: [redacted] Discharged: 5/04/11
Age at Admit: 019 LOS: 8 FC: VZ
Attending Phys: 002639 LEON, STUART UB82 Disp: 20

Current DRG: 326 - STOM, ESOPH & DUOD PROC W MCC CODER ID: riveras
APR-DRG 220 APR-SOI 4 APR-ROM 4

Diagnoses		M1	M2	Description
1.	863.99	Y		GI INJURY NEC-OPEN
2.	902.31	Y		INJ SUPERIOR MESENT VEIN
3.	902.10	Y		INJ INFER VENA CAVA NOS
4.	567.9	Y		PERITONITIS NOS
5.	902.25	Y		INJ SUPER MESENTERIC ART
6.	518.82	Y		OTHER PULMONARY INSUFF
7.	263.9	Y		PROTEIN-CAL MALNUTR NOS
8.	285.1	Y		AC POSTHEMORRHAG ANEMIA
9.	286.9	Y		COAGULAT DEFECT NEC/NOS
10.	863.94	Y		PANCREAS INJURY NOS-OPEN
11.	863.31	Y		DUODENUM INJURY-OPEN
12.	E922.9	E		FIREARM ACCIDENT NOS
13.	E849.9	E		ACCIDENT IN PLACE NOS
14.	790.29	Y		OTHER ABNORMAL GLUCOSE
15.	787.01	Y		NAUSEA W VOMITING

	Date	Proc	Description
1.	04/26/11	46.71	DUODENAL LACERAT SUTURE
2.	04/26/11	96.71	CONT MECH VENT <96CONS HR
3.	04/26/11	39.31	SUTURE OF ARTERY
4.	04/27/11	52.09	PANCREATOTOMY NEC
5.	04/26/11	96.04	INSERT ENDOTRACHEAL TUBE
6.	04/27/11	54.25	PERITONEAL LAVAGE
7.	04/27/11	43.19	OTHER GASTROSTOMY
8.	04/27/11	96.6	EXTERN INFUS NUTRIT SUB
9.	04/27/11	46.39	ENTEROSTOMY NEC
10.	04/26/11	99.07	SERUM TRANSFUSION NEC
11.	04/26/11	99.04	PACKED CELL TRANSFUSION
12.	04/29/11	97.39	REMOVE HEAD/NECK DEV NEC

Authenticated by
STUART LEON, MD
On 05/11/2011 06:02:15 PM

PHYSICIAN SIGNATURE AND DATE

CANCER STAGING: _____T _____N _____M _____STAGING

[redacted]

********** MUSC MEDICAL RECORD FACE SHEET **********

Admit Date	4/26/11	Admission Time	03:18
Medical Record #	002657049	Source Code	811
IC FLAGS		Pat Com. #	495654253
Discharge Date	5-4-11	Patient Sex	M
Race	B	Birth Date	[redacted]
Pat. Age at Admit	019	Marital Status	S
Preadmit/Reg by	cmc21	Adm/Reg by	taylory
Patient Name ***	GOODWIN	DAVON	
Pat. Address 1	[redacted]	Advanced Directive?	N
Pat. Address 2		V DIR REP NEEDED?	N
Patient City	[redacted]		
Pat. State/Zip			
County Code		Vip Code Desc	
Pat. Phone	[redacted]	Pat. SSN	[redacted]
Fin. Class	ZZ PENDING ME	Refer. Name	
Employer Name		Pat. Emp. Phone	
Pat.Emp. Addr 1			
Pat.Emp. City			
Pat.Emp. State		Religion:	NO RELIGIO
Pat.Emp. ZIP		Room-Bed	10W0 1070 A
Patient Type	I	Attnd. Doc Name	LEON, STUART
Medical Serv	TRA	Admit. Doc Name	LEON, STUART
TAR Number		Elig. Det. Date	
EN Last Name	PRINGLE STEP DAD	EN First Name	GAVIN
EN Relationship	G8	EN Home Phone	(843)270-1709
EN Bus. Phone	(843)425-2174	Family Doctor	
Ref. Phys. Name	REFERRAL, SELF	PCP Doc Name	WORSHAM, STEPHEN
Ref. Phys. Phone		PCP Doc Phone	(843)747-4647
Ref. Phys. Addr1		PCP Address 1	CHARLESTOWNE PEDIATR
Ref. Phys. Addr2		PCP Address 2	3800 FABER PLACE
Ref. Phys. Addr3		PCP Address 3	
Ref. Phys. Addr4		PCP Address 4	NORTH CHARLESTON SC
Ref. Facility		E/R Referral	Y
Complaint	GSW RUQ, INTUBATED		
Procedure			
Primary Ins.Co.	CE01	Secondary Ins.Co	ExpAdm12/31/11

Principal Diagnosis _____ Code Number

_____

Secondary Diagnosis _____

_____

_____

_____

_____

_____

_____

Operation or Special Procedures _____

_____

_____

_____

_____

Attending _____ Date _____

Discharge Summary:

[ ] Date Dictated_____ Job # _____ Beeper # _____

OP Note:

[ ] Date Dictated_____ Job # _____ Beeper # _____

[redacted]

********** MUSC MEDICAL RECORD FACE SHEET **********

Admit Date	4/26/11	Admission Time	02:45
Medical Record #	002657049	Source Code	801
IC FLAGS		Pat Com. #	495654253
Discharge Date		Patient Sex	U
Race		Birth Date	[redacted]
Pat. Age at Admit	111	Marital Status	U
Preadmit/Reg by		Adm/Reg by	taylory
Patient Name	*** TRAUMA	VICTIM PP	
Pat. Address 1	[redacted]	Advanced Directive?	
Pat. Address 2		V DIR REP NEEDED?	
Patient City			
Pat. State/Zip			
County Code		Vip Code Desc	
Pat. Phone		Pat. SSN	[redacted]
Fin. Class	FX SELF PAY	Refer. Name	
Employer Name		Pat. Emp. Phone	
Pat.Emp. Addr 1			
Pat.Emp. City			
Pat.Emp. State		Religion:	
Pat.Emp. ZIP		Room-Bed	
Patient Type	E	Attnd. Doc Name	LEON, STUART
Medical Serv	SUR	Admit. Doc Name	LEON, STUART
TAR Number		Elig. Det. Date	
EN Last Name		EN First Name	
EN Relationship		EN Home Phone	
EN Bus. Phone		Family Doctor	
Ref. Phys. Name	REFERRAL, SELF	PCP Doc Name	PATIENT, NONE PER
Ref. Phys. Phone		PCP Doc Phone	
Ref. Phys. Addr1		PCP Address 1	
Ref. Phys. Addr2		PCP Address 2	
Ref. Phys. Addr3		PCP Address 3	
Ref. Phys. Addr4		PCP Address 4	
Ref. Facility		E/R Referral	
Complaint			
Procedure			
Primary Ins.Co.	FX01	Secondary Ins.Co	

Principal Diagnosis _____ Code Number

_____ | _____

_____ | _____

Secondary Diagnosis _____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

Operation or Special Procedures _____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

Attending _____ Date _____

Discharge Summary:

[ ] Date Dictated_____ Job # _____ Beeper # _____

OP Note:

[ ] Date Dictated_____ Job # _____ Beeper # _____

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********** MUSC MEDICAL RECORD FACE SHEET **********

Admit Date	4/26/11	Admission Time	03:18
Medical Record #	002657049	Source Code	811
IC FLAGS		Pat Com. #	495654253
Discharge Date		Patient Sex	U
Race		Birth Date	[redacted]
Pat. Age at Admit	111	Marital Status	U
Preadmit/Reg by	cmc21	Adm/Reg by	taylory
Patient Name	*** TRAUMA	VICTIM PP	
Pat. Address 1	[redacted]	Advanced Directive?	U
Pat. Address 2		V DIR REP NEEDED?	U
Patient City			
Pat. State/Zip			
County Code		Vip Code Desc	
Pat. Phone		Pat. SSN	[redacted]
Fin. Class	FX SELF PAY	Refer. Name	
Employer Name		Pat. Emp. Phone	
Pat.Emp. Addr 1			
Pat.Emp. City			
Pat.Emp. State		Religion:	UNKNOWN
Pat.Emp. ZIP		Room-Bed	4STS 478G 03
Patient Type	I	Attnd. Doc Name	LEON, STUART
Medical Serv	TRA	Admit. Doc Name	LEON, STUART
TAR Number		Elig. Det. Date	
EN Last Name		EN First Name	
EN Relationship		EN Home Phone	
EN Bus. Phone		Family Doctor	
Ref. Phys. Name	REFERRAL, SELF	PCP Doc Name	PATIENT, NONE PER
Ref. Phys. Phone		PCP Doc Phone	
Ref. Phys. Addr1		PCP Address 1	
Ref. Phys. Addr2		PCP Address 2	
Ref. Phys. Addr3		PCP Address 3	
Ref. Phys. Addr4		PCP Address 4	
Ref. Facility		E/R Referral	
Complaint	GSW RUQ, INTUBATED		
Procedure			
Primary Ins.Co.	FX01	Secondary Ins.Co	ExpAdm12/31/11

Principal Diagnosis _____ Code Number

_____ | _____

_____ | _____

Secondary Diagnosis _____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

Operation or Special Procedures _____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

Attending _____ Date _____

Discharge Summary:

[ ] Date Dictated_____ Job # _____ Beeper # _____

OP Note:

[ ] Date Dictated_____ Job # _____ Beeper # _____

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********** MUSC MEDICAL RECORD FACE SHEET **********

Admit Date	4/26/11	Admission Time	03:18
Medical Record #	002657049	Source Code	811
IC FLAGS		Pat Com. #	495654253
Discharge Date		Patient Sex	M
Race	B	Birth Date	[redacted]
Pat. Age at Admit	019	Marital Status	S
Preadmit/Reg by	cmc21	Adm/Reg by	taylory
Patient Name	*** GOODWIN	DAVON	
Pat. Address 1	[redacted]	Advanced Directive?	U
Pat. Address 2		V DIR REP NEEDED?	U
Patient City			
Pat. State/Zip			
County Code		Vip Code Desc	
Pat. Phone		Pat. SSN	[redacted]
Fin. Class	FX SELF PAY	Refer. Name	
Employer Name		Pat. Emp. Phone	
Pat.Emp. Addr 1			
Pat.Emp. City			
Pat.Emp. State		Religion:	UNKNOWN
Pat.Emp. ZIP		Room-Bed	4STS 478G 03
Patient Type	I	Attnd. Doc Name	LEON, STUART
Medical Serv	TRA	Admit. Doc Name	LEON, STUART
TAR Number		Elig. Det. Date	
EN Last Name		EN First Name	
EN Relationship	32	EN Home Phone	(843)303-5853
EN Bus. Phone	(843)853-0731	Family Doctor	
Ref. Phys. Name	REFERRAL, SELF	PCP Doc Name	PATIENT, NONE PER
Ref. Phys. Phone		PCP Doc Phone	
Ref. Phys. Addr1		PCP Address 1	
Ref. Phys. Addr2		PCP Address 2	
Ref. Phys. Addr3		PCP Address 3	
Ref. Phys. Addr4		PCP Address 4	
Ref. Facility		E/R Referral	
Complaint	GSW RUQ, INTUBATED		
Procedure			
Primary Ins.Co.	FX01	Secondary Ins.Co	ExpAdm12/31/11

Principal Diagnosis _____ Code Number

_____ | _____

_____ | _____

Secondary Diagnosis _____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

Operation or Special Procedures _____ | _____

_____ | _____

_____ | _____

_____ | _____

_____ | _____

Attending _____ Date _____

Discharge Summary:

[ ] Date Dictated_____ Job # _____ Beeper # _____

OP Note:

[ ] Date Dictated_____ Job # _____ Beeper # _____

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D 207
H&P-F-A

MORSER

MUSC Health

MEDICAL UNIVERSITY HOSPITAL
REPORT OF DEATH

Form Origination Date: 01/97
Version: 4 Version Date: 1/11

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Adm:04/26/11 M:2657049

19

A. BURIAL RESPONSIBILITY

☐ Next of kin or ☐ Person assuming responsibility for burial: Gavin Pringle

Relationship GF Stepfather. Phone [redacted]

Address

B. RELEASE OF BODY

Medical University Hospital is hereby requested and authorized to release the body to:

SMI McN (Mortician or person acting as such) Chas City 7223676 State

Witness per Note Signature of person granting permission for release

Time Date

C. MORTUARY SERVICE

Time of Death 0845 Date 04May11 Location of Death F 10 W

Time Notified 1315 Date 04May11 Arrived 1330 Time 04May11 Date

1. Received the above body [signature] Mortician Signature 1900 Time 5/5/11 Date
2. Received death certificate NONE Signature Date
3. Received personal effects Date
4. Remains disposed of by Medical University Hospital Signature of Hospital Representative Date

D. NOTIFICATIONS

1. Coroner: County Chas at ____ date ____ by Kelly to JF
2. Donor Network Agency at ____ date ____ by UNIT to GFPMT (R)
3. Pathology at ____ date ____ by ____ to ____
4. Funeral Home SMI McN at ____ date ____ by ____ to ____
5. Burial Transit Permit Number Issued ____
6. Medical Records to ____ at ____ date ____ by ____ Rec'd by ____

E. DECEDENT AFFAIRS

Met with family	☐ Yes ☐ No, why Northern	Remains ready at ____
Telephone conference	☐ Yes ☐ No	Time transported ____
Discussed options (e.g., burial, cremation)	☐ Yes ☐ No	
Provided list of local options (e.g., funeral homes)	☐ Yes ☐ No	
Did family have questions	☐ Yes, specify ____	☐ No

Notes / Comments GSW - Abd

Mortuary Attendant Signature [signature] Date / Time 04May11 1500

White – Medical Records deathreport | Canary – Pathology | Pink – Office | Goldenrod – Mortician OTC 700156 Rev. 1/11

MUSC Medical Center
DEATH SUMMARY
Patient Name: GOODWIN, DAVON
MRN: 002657049
Patcom: 495654253
Admitted: 04/26/2011
Expired: 05/04/2011
Service: Trauma Surgery
Attending: Stuart M. Leon, MD

Referring: -

Primary Care Physician: -

TIME OF DEATH: 8:45 a.m. on 05/04/2011.

HISTORY OF PRESENT ILLNESS: The patient is a 19-year-old gentleman who sustained a gunshot wound to the left upper quadrant on 04/26/2011. He was brought to MUSC for further trauma evaluation. He had episodic hypotension en route. On initial arrival, he was awake, alert, oriented, complaining of abdominal pain and coughing up bright red blood. He was urgently intubated and rapidly taken to the operating room for his penetrating abdominal (_____).

Complete past medical history, past surgical history, allergies, medications, social/family history, and review of systems could not be obtained due to his urgent need for evaluation in the operating room.

HOSPITAL COURSE: On 04/26/2011, the patient was taken to the operating room for an exploratory laparotomy. The exploration revealed an injury to his inferior vena cava as well as the third and fourth portions of his duodenum as well as the superior mesenteric vein and artery. All of these injuries were repaired. The patient was transferred to the intensive care unit postoperatively. Immediately postoperatively, the patient was continued on resuscitation and given blood products. On postoperative day 1, from an initial exploratory laparotomy he was taken back to the operating room for an abdominal washout, Stamm gastrostomy, feeding jejunostomy, and a tube duodenostomy with 2 JP drains and abdominal closure. The patient tolerated this procedure well and was transferred back to the intensive care unit postoperatively. Again, he was further resuscitated with additional blood products. He was weaned off his propofol and fentanyl drips and extubated. On 04/29/2011, the patient was adequate on the floor and transferred accordingly. Over the proceeding days, patient's tube feeds were advanced to goal. Patient made strides with physical therapy and was ambulating in the halls. The patient was on appropriate prophylaxis Lovenox 30 mg b.i.d. as well as mechanical DVT prophylaxis with SCDs. On the morning of 05/04/2011, the surgical team was urgently consulted secondary to the patient being unresponsive. On immediate evaluation, the patient coded. Appropriate ACLS protocol was followed for pulseless electrical activity. The patient failed to regain cardiopulmonary function and was pronounced dead on 05/04/2011 at 8:45 a.m.

Dictated by: Brent Michael Jewett, MD

Brent Michael Jewett, MD

Stuart M. Leon, MD
Attending

804693 / 43010 /
JOB: 6041596
DD: 05/04/11 01:46 PM
DT: 05/04/11 09:38 PM

Additional CC:
Authenticated by STUART LEON, MD On 05/05/2011 07:00:17 AM

MUSC Medical Center
HOSPITAL TRANSFER SUMMARY
Patient Name: GOODWIN, DAVON
MRN: 002657049
Patcom: 495654253
Admitted: 04/26/2011
Discharged: 04/29/2011
Service:
Attending: Stuart M. Leon, MD

Referring: -

Primary Care Physician: - (843)745-0969

HISTORY OF PRESENT ILLNESS: This is a 19-year-old male who sustained a gunshot wound to his left upper abdomen and was brought to MUSC for trauma evaluation. The patient had episodes of hypotension en route from outside hospital. When he arrived, he was awake and alert, complaining of significant abdominal pain and was either spitting up or coughing up bright-red blood. For this reason, the patient was emergently intubated in the trauma bay. He has no.

PAST MEDICAL/SURGICAL HISTORY: He has no past medical history or past surgical history.

ICU COURSE: After the patient arrived in the trauma bay he was emergently taken to the OR for a damage control laparotomy. Repair of tangential wounds to the superior mesenteric artery and superior mesenteric vein, and repair of a injury to the duodenum at the junction between the 3rd and 4th portions, repair of an inferior vena cava injury, and placement of a wound VAC for abdominal closure. Please see separate operative note for details.

Immediately postoperatively, the patient was transferred to the ST-ICU for continued resuscitation. He was given 4 units of PRBCs and 4 units of FFP. His coagulopathy corrected quickly and his hemoglobin came up appropriately. On postop day 1, he was taken back to the OR for reexploration and irrigation and washout of his abdomen. A Stamm gastrostomy, feeding jejunostomy, a tube duodenostomy, placement of 2 JP drains, and abdominal closure. Please see separate operative note for details.

Immediately postoperatively, the patient was transferred back to the PACU where he remained hemodynamically stable on 04/28. His hemoglobin dropped to 6.5, and he was transfused 1 unit of packed red blood cells. He was weaned from the propofol and fentanyl drips and was extubated. He has had no respiratory issues since then. He has had adequate oxygen saturation on 2 L of nasal cannula.

On 04/29, he was started on some oxycodone through his J-tube for pain control and he was started on tube feeds of Promote at 90, which he has been tolerating well. His hemoglobin was 5.7, and he was transfuse 2 units of packed red blood cells. His hemoglobin came up appropriately to 7.5. On additional recheck his hemoglobin was 7.6 several hours later and the decision was made that he was ready for transfer to the floor. At this time his GCS was 15. He is up and out of bed-to-chair and PT has been consulted to work with ambulation. He was started on Lovenox for DVT prophylaxis. He continued to be on Pepcid for GI prophylaxis and he is on an insulin drip for his hypoglycemia. His abdominal incision is closed and the skin is closed

with staples and is clean, dry, and intact. Both JPs are putting out serosanguineous fluid. His J-tube site is clean and without evidence of infection. He has been tolerating tube feeds through it without any difficulty. Hence, a red rubber catheter was placed in the duodenum to suction and his Stamm gastrostomy tube is to gravity.

Dictated by: Ashley Kaiser Rickey, MD

_____
Ashley Kaiser Rickey, MD

_____
Stuart M. Leon, MD
Attending

770527 / 44076 /
JOB: 6040884
DD: 04/29/11 07:44 PM
DT: 04/30/11 08:25 AM

Additional CC:_____
Authenticated and Edited by ASHLEY K. RICKEY, MD On 5/01/11 11:13:01 AM
Authenticated by STUART LEON, MD On 05/02/2011 07:02:37 AM

MUSC Health

FLOWSHEET

Trauma Resuscitation Flowsheet

Page 1 of 4

Form Origination Date: 7/01
Version: 3

Davon Goodwin Version Date: 9/09

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

Date		Sex	Race	Wt.
9-26-11	[redacted]	M	B	

Name: unknown — Allergies: ☐ NKDA ☑ Unknown

Current Medications: unknown

LMP	Last TO

Past Medical Hx: ~~Unknown~~ None; Pulmonary; Liver; Cardiac; Renal; Diabetes; Psychiatric; Immunocompromised; Other _____

Special Needs: (None noted) Hearing impaired Sight impaired Language Other _____

Injury Location: (Street) Work Farm Residence School Other _____

Mechanism of Injury: Unknown; Auto Motorcycle Bicycle; ATV 4 Wheeler; vs _____ est mph _____; Rollover Ejected; Driver Passenger; Front Back; Assault (Gunshot wound); Stabbing Crush; Amputation Snake Bite; Fall ft _____; Pedestrian vs _____; Burn: Fire Chemical, Inhalation Scald, Electrical Contact; Motor Water Related; Near Drowning; Other _____

Safety Equipment: None (Unknown); Seatbelt Helmet; Carseat Infant Child Booster; Airbag Present Deployed / Not Deployed; Other _____

Approx Time of Injury _____

Transfer	Yes	(No)	N/A
If yes, from _____			
> 5 hrs in initial hospital	Yes	No	
Self Inflicted	Yes	(No)	Unknown
LOC Yes, time _____		(No)	Unknown
Cardiac arrest PTA	Yes	No	
Original EMS report	Yes	No	

In Place Prior to Arrival: (Cervical collar) (Backboard); Limb restraints; Splints; Traction; NG tube size _____; OG tube size _____; O_2 NC _____ L/min Mask 10 L/min; Ambu _____ L/min ETT size _____; IV x 1 _____; Rapid Sequence Induction in field Yes No; Monitor _____; Foley size _____; Other _____

Time call received 0241 Arrival time 0248 ☑ Trauma A ☐ Trauma B
Trauma alert called time 0242 ☐ Adult ☐ Peds ☐ OB ☐ No trauma called
Arrival Mode ☐ Air ☑ EMS ☐ POV ☐ Walk-in Medic # M-6 / County # CC

Team Position	Name	Arrival time
ED Attending	Ramos, M.	0247
Trauma Attending	Leon	0249
Trauma Chief		
Trauma MD 1	Jewett	0249
Trauma MD 2		
ED Resident	Jennings	0247
RT	Liz	0247
Xray	George	0250
CT Tech		
RN I – Bedside	Karen	0247
RN II – Recording	Howell	0247
Primary RN		
ED Tech	~~Coffindaffer~~ Hanly	0247
Chaplain	Higgins	0250
Pharmacy		

Service Consulted	Name	Paged	Arrived

Glasgow Coma Scale

Infant < 2 Years Old		Pediatric / Adult	
Time		Time	
Eyes open to		Eyes open to	
Spontaneous	4	Spontaneous	(4)
Speech	3	Speech	3
Pain	2	Pain	2
Remained closed	1	Remained closed	1
Best Verbal		Best Verbal	
Coos babbies	5	Oriented	(5)
Irritable	4	Confused	4
Cries to pain	3	Words	3
Moans to pain	2	Sounds	2
No response	1	No response	1
Best Motor		Best Motor	
Spontaneous movements	6	Obeys commands	(6)
Withdraws to touch	5	Localizes pain	5
Withdraws to pain	4	Withdraws to pain	4
Abnormal flexion	3	Abnormal flexion	3
Abnormal extension	2	Abnormal extension	2
No response	1	No response	1
Total		Total	15

Revised Trauma Score

Pediatric		Adult	
Time		Time	
A. Size	Score	Resp. Rate	
> 20 kg	+2	10 – 29 min	(4)
10 – 20 kg	+1	> 29 min	3
< 10 kg	-1	6 – 9 min	2
B. Airway		1 – 5 min	1
Normal	+2	None	0
Maintainable	+1	Systolic BP	
Unmaintainable	-1	> 89 mmHg	(4)
C. CNS		76 – 89 mmHg	3
Awake	+2	50 – 75 mmHg	2
Obtunded	+1	1 – 49 mmHg	1
Coma	-1	No Pulse	0
D. Systolic BP		GCS	
> 90 mmHg	+2	13 – 15	(4)
50 – 90 mmHg	+1	9 – 12	3
< 50 mmHg	-1	6 – 8	2
E. Open Wound		4 – 5	1
None	+2	3	0
Minor	+1	Total	
Major	-1		
F. Skeletal			
None	+2		
Closed fracture	+1		
Open / Multiple fracture	-1		
Total (A+B+C+D+E+F)			(7)

traumaflowsheet

UP 500007 Rev. 9/09

MUSC Health

FLOWSHEET

Trauma Resuscitation Flowsheet

Page 2 of 4

Form Origination Date: 7/01
Version: 3 Version Date: 9/09

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm: 12/31/11 M2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

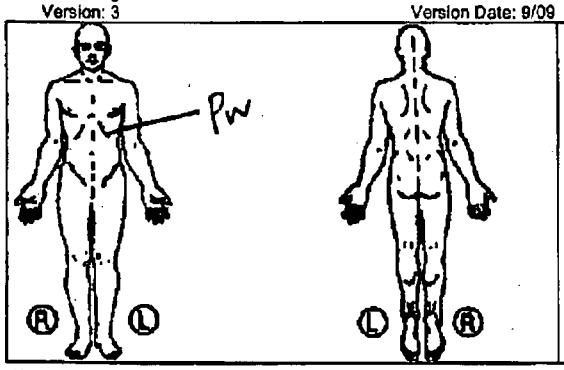


FIGURE LEGEND & ABBREVIATIONS

A = Abrasion
Amp = Amputation
AV = Avulsion
B = Burn (shade area) BSA% _____
C = Contusion
D = Deformity
E = Ecchymosis
L = Laceration
Fx = Fracture
P = Pain
PCt = Puncture wound
Pw = Penetrating wound
Sw = Swelling

Airway
☑ Patent ☐ Obstructed
Oxygen 10 L/min ☑ NRB ☐ NC
☐ Oral / Nasal airway
☐ Intubated
Time _____ by _____ size _____
_____ cm @ teeth
☐ BS equal after intubation
☐ Easy cap + placement
Vent FIO_2 _____ TV _____
PEEP _____ Rate _____

Breath sounds R L
Clear ☑ ☑
Diminished ☐ ☐
Wheezes ☐ ☐
Rales / Rhonchi ☐ ☐

Respiratory Effort
☑ Normal ☐ Labored
☐ Absent ☐ Assisted
Other _____

Chest R L
↓Chest expansion ☐ ☐
Penetrating trauma ☐ ☐
Flail segment ☐ ☐
SubQ air / Crepitus ☐ ☐
Equal expansion ☐ ☐
Chest tube
R Size _____ by _____ time _____
L Size _____ by _____ time _____
Other _____

Circulation 0 – Absent
Rhythm _____ 1 – Weak
Cap refill ☐ < 2 sec ☐ > 2 sec 2 – Normal
Pulse R L 3 – Strong
Carotid ___ ___ 4 – Bounding
Radial ___ ___ 5 – Doppler only
Femoral 2+ 2+
Dorsalis Pedis ___ ___
Skin
Warm ☐ Cool ☐ Dry ☐ Moist ☐
Pressure sores present PTA ☐ Yes ☐ No
Other _____

Head
Raccoon's eyes ☐
Battle sign ☐
Ear R L
Clear ☑ ☑
CSF ☐ ☐
Blood ☐ ☐
Teeth (Normal)
Loose site _____
Missing site _____

Neuro
LOC ☐ + ☑ -
Duration _____

	R	L
Pupil size	___	___
Brisk	___	___
Sluggish	___	___
Non-reactive	___	___

Pediatrics
Crying Yes ☐ No ☐
Consolable Yes ☐ No ☐ By _____

Behavior
Cooperative ☑
Uncooperative ☐
Unresponsive ☐
Chemically paralyzed ☐
Combative ☐
Restraints applied ☐
Type _____
Time _____
Reason _____

Extremities
(Moves all extremities)
Altered movement / sensation

	RA	LA	RL	LL
Splinted	☐	☐	☐	☐
No movement	☐	☐	☐	☐
↓Movement	☐	☐	☐	☐
No sensation	☐	☐	☐	☐
↓Sensation	☐	☐	☐	☐

Pelvis / Abd
Pelvis stable ☑ yes ☐ no
Palpation Abd
Soft ☑
Distended ☐
Firm / hard ☐
Guarding ☐
Tender ☐
Non tender ☑
Emesis ☐ yes ☑ no
NG ☐ size _____
OG ☐ time _____
by _____

GU / Rectal
Rectal tone
Present ☐
Diminished ☐
Absent ☐
Genitalia
Blood at meatus ☐
Vaginal bleeding ☐
Priapism ☐
Foley size _____
time _____
by _____
Other _____

(Time) Vascular Access
P1A Size 18 Site LAC Init EMS
0256 Size 18 Site RAC Init SL
_____ Size _____ Site _____ Init _____
_____ Size _____ Site _____ Init _____
_____ Size _____ Site _____ Init _____
_____ Central line size _____ Site _____
By _____ MD
_____ Central line size _____ Site _____
By _____ MD
_____ Arterial line size Site
By _____ MD

(Time) Lab
0300 Trauma protocol
_____ Pediatric protocol
_____ OB protocol
Type & Screen
0300 Type & Cross 6 units
_____ ABG
_____ Major bleed protocol
_____ Other _____
_____ Other _____
_____ Other _____
_____ Other _____

(Time) X-Rays / Procedures
0300 Chest
_____ Pelvis
_____ Other x-rays _____
_____ Other x-rays _____
_____ CT head / C-spine / Chest / Abd / Pelvis
_____ Other CT _____
0250 Warm blankets Bair hugger _____
0257 Warm fluids Level I _____
_____ Arteriogram
_____ Fast scan U / S abdomen + / - _____ MD
_____ EKG
_____ C-Spine collar removed by: _____ MD
_____ C-collar applied / changed
_____ Log rolled / spine board removed
_____ Laceration Repair _____ site

traumaflowsheet UP 500007 Rev. 9/09

MUSC Health

FLOWSHEET

Trauma Resuscitation Flowsheet

Page 3 of 4

Form Origination Date: 7/01
Version: 3 Version Date: 9/09

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

TIME	B/P	PULSE	RESP	TEMP	O2 SAT / O2	GCS	PUPILS R/L	PAIN / SEDATION
0255	183/134	90	18		99	15	/	LITA
0257	187/172	93	22		100	15	/	LITA
	/						/	/
	/						/	/
	/						/	/

MUSC Health

"FLOWSHEET"

Trauma Resuscitation Flowsheet

Page 4 of 4

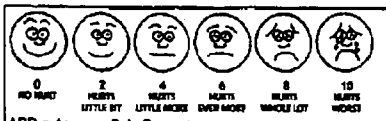
Form Origination Date: 7/01
Version: 3

Version Date: 9/09

P495654253 DOB: [redacted]
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

Patient Name _____
MRN _____

PATIENT IDENTIFICATION LABEL



APP = Assume Pain Present

From Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005.

RICHMOND AGITATION SEDATION SCALE (RASS)

+4 Combative	-1 Drowsy
+3 Very agitated	-2 Light sedation
+2 Agitated	-3 Moderate sedation
+1 Restless	-4 Deep sedation
0 Alert & Calm	-5 Unarousable

FLACC Behavioral Pain Scale (1 month to 3 years of age)

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams, or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching or being talked to distractable	Difficult to console or comfort

0 = Relaxed and comfortable 1-3 = Mild discomfort 4-6 = Moderate pain 7-10 = Severe discomfort / pain

NURSES NOTES 0246 Pt. via EMS s/p GSW unknown caliber to LUQ abd, bleeding controlled c occlusive dsg, PIVx4 @ LOC VSS Respirations non-labored, regular SOB, secretions suctioned orally. 0257 RSI meds initiated. Paralyzing MD @ HOB, pt. intubated 7.5 ETT 23@R. 0300 Pt. to OR via stretcher, intubated, RT @ BS, on full monitor. VSS. SK

FAMILY
☐ NOTIFIED TIME _____ NAME _____
RELATIONSHIP TO PT _____
PHONE # _____
☐ EN-ROUTE ☐ UNABLE TO CONTACT ☐ CHILD LIFE PRESENT

VALUABLES
☑ PERSONAL EFFECTS INVENTORY DONE
☐ TO PATIENT ☐ TO FAMILY _____ ☐ OTHER _____
☑ TO SAFE ☐ RECEIPT ON CHART, ENVELOPE # _____
☐ POLICE _____ BADGE # _____

PRIMARY RN SIGNATURE _____ INIT _____
SECONDARY RN SIGNATURE _____ INIT _____
RN SIGNATURE _____ INIT _____
RN SIGNATURE S. Knowlden INIT SK
ORDERING MD _____
ORDERING TRAUMA / EMERGENCY ATTENDING _____

@ DISPOSITION DATE 4/26/11 TIME 0300 GCS 3T VS Stable
ADMITTED RM # _____ REPORT GIVEN TO _____ RN
SERVICE / ATTENDING Trauma SX / Leon
☐ DC'D TO HOME ☐ TRANSFERRED TO _____
☐ EXPIRED DATE _____ TIME _____
PRONOUNCED BY _____ MD
TIME TRANSPORTED TO MORGUE _____
LIFEPOINT NOTIFIED _____ CORONER NOTIFIED _____

LEFT VIA
☐ AMBULATORY ☐ WHEELCHAIR ☑ STRETCHER ☐ CARRIED
☐ POV AMBULANCE / EMS TRANSPORT COMPANY _____

TRANSPORTED WITH
☑ ID BAND ☑ SR ↑ X 2 ☑ CARDIAC MONITOR ☐ PULSE OX
☑ C-COLLAR INTACT ☑ O_2 _____ L/MIN ☐ IV X 2

traumaflowsheet

Ordering MD Date 4/26/11 Time 0250 Pager # 19334
Trauma MD Date _____ Time _____ Pager # _____

UP 500007 Rev. 9/09

MUSC Health

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

FLOWSHEET
Trauma Resuscitation Flowsheet
Page 1 of 4

Form Origination Date: 7/01
Version: 3
Version Date: 9/09

Date	Bir	Sex	Race	Wt.
4.26.11	[redacted]	M	B	

Name: unknown
Allergies ☐ NKDA ☑ Unknown

Current Medications: unknown

LMP | Last TD

Past Medical Hx: ~~Unknown~~ None; Cardiac, Renal, Pulmonary, Diabetes, Liver, Psychiatric, Immunocompromised, Other

Special Needs (None noted) Hearing impaired Sight impaired
Language _____ Other _____

Injury Location
(Street) Work Farm
Residence School
Other _____

Mechanism of Injury
Unknown
Auto Motorcycle Bicycle
ATV 4 Wheeler
vs _____ est mph _____
Rollover Ejected
Driver Passenger
Front Back
Assault (Gunshot wound)
Stabbing Crush
Amputation Snake Bite
Fell ft. _____
Pedestrian vs _____
Burn
Fire Chemical
Inhalation Scald
Electrical Contact
Motor Water Related
Near Drowning
Other _____

Safety Equipment None (Unknown)
Seatbelt Helmet
Carseat Infant Child Booster
Airbag Present Deployed / Not Deployed
Other _____

Approx Time of Injury _____
Transfer Yes (No) N/A
If yes, from _____
>6 hrs in initial hospital Yes No
Self inflicted Yes No Unknown
LOC Yes, time _____ (No) Unknown
Cardiac arrest PTA Yes No
Original EMS report Yes No

In Place Prior to Arrival
(Cervical collar) (Backboard)
Limb restraints
Splints Traction
NG tube size _____ OG tube size _____
O_2 NC _____ L/min Mask 10 L/min
Ambu _____ L/min ETT size _____
IV x 1
Rapid Sequence Induction in field Yes No
Monitor _____ Foley size _____
Other _____

Time call received 0241 Arrival time 0248 ☑ Trauma A ☐ Trauma B
Trauma alert called time 0242 ☐ Adult ☐ Peds ☐ OB ☐ No trauma called
Arrival Mode ☐ Air ☒ EMS ☐ POV ☐ Walk-in Medic # M-9 / County # RC

Team Position	Name	Arrival time
ED Attending	Ramsey, M.	0247
Trauma Attending	Leon	0249
Trauma Chief		
Trauma MD 1	Jewett	0249
Trauma MD 2		
ED Resident	Jennings	0247
RT	LAZ	0247
Xray	George	0250
CT Tech		
RN I – Bedside	Kavega	0247
RN II – Recording	Howell	0247
Primary RN		
ED Tech	~~Goodwin~~ Harris	0247
Chaplain	Higgins	0250
Pharmacy		

Service Consulted	Name	Paged	Arrived

Glasgow Coma Scale

Infant < 2 Years Old		Pediatric / Adult	
Time		Time	
Eyes open to		Eyes open to	
Spontaneous	4	Spontaneous	(4)
Speech	3	Speech	3
Pain	2	Pain	2
Remained closed	1	Remained closed	1
Best Verbal		Best Verbal	
Coos babbles	5	Oriented	(5)
Irritable	4	Confused	4
Cries to pain	3	Words	3
Moans to pain	2	Sounds	2
No response	1	No response	1
Best Motor		Best Motor	
Spontaneous movements	6	Obeys commands	(6)
Withdraws to touch	5	Localizes pain	5
Withdraws to pain	4	Withdraws to pain	4
Abnormal flexion	3	Abnormal flexion	3
Abnormal extension	2	Abnormal extension	2
No response	1	No response	1
Total		Total	15

Revised Trauma Score

Pediatric		Adult	
Time		Time	
A. Size	Score	Resp. Rate	
≥ 20 kg	+2	10 – 29 min	(4)
10 – 20 kg	+1	> 29 min	3
< 10 kg	-1	6 – 9 min	2
B. Airway		1 – 5 min	1
Normal	+2	None	0
Maintainable	+1	Systolic BP	
Unmaintainable	-1	> 89 mmHg	(4)
C. CNS		76 – 89 mmHg	3
Awake	+2	50 – 75 mmHg	2
Obtunded	+1	1 – 49 mmHg	1
Coma	-1	No Pulse	0
D. Systolic BP		GCS	
> 90 mmHg	+2	13 – 15	(4)
50 – 90 mmHg	+1	9 – 12	3
< 50 mmHg	-1	6 – 8	2
E. Open Wound		4 – 5	1
None	+2	3	0
Minor	+1	Total	
Major	-1		
F. Skeletal			
None	+2		
Closed fracture	+1		
Open / Multiple fracture	-1		
Total (A+B+C+D+E+F)			12

traumaflowsheet

UP 500007 Rev. 9/09

MUSC Health

FLOWSHEET

Trauma Resuscitation Flowsheet

Page 2 of 4

Form Origination Date: 7/01
Version: 3 Version Date: 9/09

P495654263 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

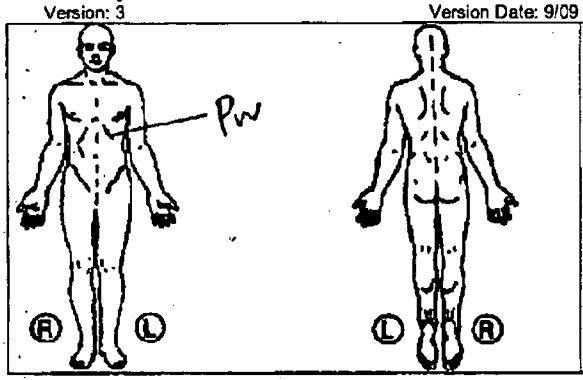


FIGURE LEGEND & ABBREVIATIONS

A = Abrasion
Amp = Amputation
AV = Avulsion
B = Burn (shade area) BSA% _____
C = Contusion
D = Deformity
E = Ecchymosis
L = Laceration
Fx = Fracture
P = Pain
PCt = Puncture wound
Pw = Penetrating wound
Sw = Swelling

Airway
☑ Patent ☐ Obstructed
Oxygen 10 L/min ☑ NRB ☐ NC
☐ Oral / Nasal airway
☐ Intubated
Time _____ by _____ size _____
_____ cm @ teeth
☐ BS equal after intubation
☐ Easy cap + placement
Vent FIO_2 _____ TV _____
PEEP _____ Rate _____

Breath sounds R L
Clear ☑ ☑
Diminished ☐ ☐
Wheezes ☐ ☐
Rales / Rhonchi ☐ ☐
Respiratory Effort
☑ Normal ☐ Labored
☐ Absent ☐ Assisted
Other _____

Chest R L
↓Chest expansion ☐ ☐
Penetrating trauma ☐ ☐
Flail segment ☐ ☐
SubQ air / Crepitus ☐ ☐
Equal expansion ☐ ☐
Chest tube
R Size _____ by ____ time _____
L Size _____ by ____ time _____
Other _____

Circulation 0 – Absent
Rhythm _____ 1 – Weak
Cap refill ☐ < 2 sec ☐ > 2 sec 2 – Normal
Pulse R L 3 – Strong
Carotid ____ ____ 4 – Bounding
Radial ____ ____ 5 – Doppler only
Femoral 2+ 2+
Dorsalis Pedis ____ ____
Skin
Warm ☐ Cool ☐ Dry ☐ Moist ☐
Pressure sores present PTA ☐ Yes ☐ No
Other _____

Head
Raccoon's eyes ☐
Battle sign ☐
Ear R L
Clear ☑ ☐
CSF ☐ ☐
Blood ☐ ☐
Teeth Normal
Loose site _____
Missing site _____

Neuro
LOC ☐ + ☑ -
Duration _____
R L
Pupil size ____ ____
Brisk ____ ____
Sluggish ____ ____
Non-reactive ____ ____
Pediatrics
Crying Yes ☐ No ☐
Consolable Yes ☐ No ☐ By _____

Behavior
Cooperative ☑
Uncooperative ☐
Unresponsive ☐
Chemically paralyzed ☐
Combative ☐
Restraints applied ☐
Type _____
Time _____
Reason _____

Extremities
Moves all extremities
Altered movement / sensation

	RA	LA	RL	LL
Splinted	☐	☐	☐	☐
No movement	☐	☐	☐	☐
↓Movement	☐	☐	☐	☐
No sensation	☐	☐	☐	☐
↓Sensation	☐	☐	☐	☐

Pelvis / Abd
Pelvis stable ☑ yes ☐ no
Palpation Abd
Soft ☑
Distended ☐
Firm / hard ☐
Guarding ☐
Tender ☐
Non tender ☑
Emesis ☐ yes ☑ no
NG ☐ size _____
OG ☐ time _____
by _____

GU / Rectal
Rectal tone
Present ☐
Diminished ☐
Absent ☐
Genitalia
Blood at meatus ☐
Vaginal bleeding ☐
Priapism ☐
Foley size _____
time _____
by _____
Other _____

(Time) Vascular Access
PIV Size 18 Site C/AC Init EM
0256 Size 18 Site R/AC Init SL
____ Size ____ Site ____ Init ____
____ Size ____ Site ____ Init ____
____ Size ____ Site ____ Init ____
____ Central line size ____ Site ____
By _____ MD
____ Central line size ____ Site ____
By _____ MD
____ Arterial line size Site
By _____ MD

(Time)	Lab
0300	Trauma protocol
____	Pediatric protocol
____	OB protocol
____	Type & Screen
0300	Type & Cross 6 units
____	ABG
____	Major bleed protocol
____	Other
____	Other
____	Other
____	Other

(Time)	X-Rays / Procedures
0300	Chest
____	Pelvis
____	Other x-rays
____	Other x-rays
____	CT head / C-spine / Chest / Abd / Pelvis
____	Other CT
0250	Warm blankets Bair hugger
0257	Warm fluids Level I
____	Arteriogram
____	Fast scan U / S abdomen + / - MD
____	EKG
____	C-Spine collar removed by: MD
____	C-collar applied / changed
____	Log rolled / spine board removed
____	Laceration Repair site

traumaflowsheet UP 500007 Rev. 9/09

MUSC Health

"FLOWSHEET"

Trauma Resuscitation Flowsheet

Page 3 of 4

Form Origination Date: 7/01
Version: 3

Version Date: 9/09

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

Patient Name
MRN

PATIENT IDENTIFICATION LABEL

TIME	B/P	PULSE	RESP	TEMP	O2SAT / O2	GCS	PUPILS R/L	PAIN / SEDATION
0255	183/134	90	18		99	15	/	NPA
0257	187/172	93	22		100	15	/	NPA
	/						/	/
	/						/	/
	/						/	/
	/						/	/
	/						/	/
	/						/	/
	/						/	/
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	/						/	/

PTA: SOLUTION _____ AMOUNT INFUSED mLs _____

LEVEL 1	BAG #	START TIME	AMT mLs	SOLUTION	STOP TIME	AMT INFUSED MLS	SITE	INITS
	1	0257	900	NS		200	RAC	SH

BLOOD PRODUCTS

LEVEL 1	TYPE	START	AMT	UNIT #	STOP	AMT INFUSED	INITS

TIME	MEDICATION / DOSE	ROUTE	SITE	INITS
0251	Ertapenem	2gm	IV	SH
0258	Syringe Pump	150mg	IV	SH

INTAKE

TIME	PO	IV	BLOOD	OG / NG	OTHER
PTA		100cc NS			
ED		200 cc			
TOTALS		300 cc			

START TIME	IV MED INFUSION / DOSE	STOP TIME	RATE	AMT INFUSED	SITE	INITS

OUTPUT

TIME	URINE	BLOOD	OG / NG	EMESIS	CHEST TUBES	OTHER
PTA						
ED						
TOTALS						

traumaflowsheet

UP 500007 Rev. 9/09

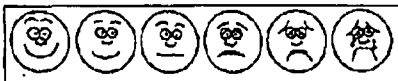
MUSC Health

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

FLOWSHEET
Trauma Resuscitation Flowsheet
Page 4 of 4

Form Origination Date: 7/01
Version: 3 Version Date: 9/09

Patient Name
MRN
PATIENT IDENTIFICATION LABEL



APP = Assume Pain Present
From Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005.

RICHMOND AGITATION SEDATION SCALE (RASS)

+4 Combative	-1 Drowsy
+3 Very agitated	-2 Light sedation
+2 Agitated	-3 Moderate sedation
+1 Restless	-4 Deep sedation
0 Alert & Calm	-5 Unarousable

FLACC Behavioral Pain Scale (1 month to 3 years of age)

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams, or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching or being talked to distractable	Difficult to console or comfort

0 = Relaxed and comfortable 1-3 = Mild discomfort 4-6 = Moderate pain 7-10 = Severe discomfort / pain

NURSES NOTES 0246 Pt. via EMS s/p GSW unknown caliber to LUQ abd, bleeding controlled c pressure dsg, GPA x 4 LOC VSS Respirations non labored, regular SOB, secretion suctioned orally. 0257 RSI meds initiated. Rapid HOB, pt. intubated 7.5 ETT 23@lip. 0300 Pt to OR via stretcher, intubated, ICT @ BS, on full monitor. VSS. ST

FAMILY
☐ NOTIFIED TIME ____ NAME ____
RELATIONSHIP TO PT ____
PHONE # ____
☐ EN-ROUTE ☐ UNABLE TO CONTACT ☐ CHILD LIFE PRESENT

VALUABLES
☑ PERSONAL EFFECTS INVENTORY DONE
☐ TO PATIENT ☐ TO FAMILY ____ ☐ OTHER ____
☑ TO SAFE ☐ RECEIPT ON CHART, ENVELOPE # ____
☐ POLICE ____ BADGE # ____

PRIMARY RN SIGNATURE ____ INIT ____
SECONDARY RN SIGNATURE ____ INIT ____
RN SIGNATURE ____ INIT ____
RN SIGNATURE [illegible] INIT ST
ORDERING MD ____
ORDERING TRAUMA / EMERGENCY ATTENDING ____ 4/26/11

@ DISPOSITION DATE 4/26/11 TIME 0300 GCS 3T VS Stable
ADMITTED RM # ____ REPORT GIVEN TO ____ RN
SERVICE / ATTENDING Trauma Sx / Leon
☐ DC'D TO HOME ☐ TRANSFERRED TO ____
☐ EXPIRED DATE ____ TIME ____
PRONOUNCED BY ____ MD
TIME TRANSPORTED TO MORGUE ____
LIFEPOINT NOTIFIED ____ CORONER NOTIFIED ____

LEFT VIA
☐ AMBULATORY ☐ WHEELCHAIR ☑ STRETCHER ☐ CARRIED
☐ POV AMBULANCE / EMS TRANSPORT COMPANY ____

TRANSPORTED WITH
☐ ID BAND ☑ SR ↑ X 2 ☑ CARDIAC MONITOR ☐ PULSE OX
☑ C-COLLAR INTACT ☐ O_2 ____ L/MIN ☐ IV X 2

traumaflowsheet 0250 1-733 UP 500007 Rev. 9/09

MUSC Health

ASCREENCRIT
Personal Belongings Inventory
Emergency Department
Page 1 of 1

Form Origination Date: 11/96
Version: 3 Version Date: 6/07

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

QTY	Item/Description	Patient	Family	Friend	ED	Safe
	Hat					
	Shirt					
	Bra					
	Dress					
	Skirt					
1	Shorts blk white gray camo flame					
	Pants					
1	Underwear blk					
1	Belt gray					
2	Socks white					
2	Shoes blk nike					
	Pajamas					
	Coat / Jacket / Sweater					
	Purse/Wallet					
	Checkbook					
	Credit Cards					
	ID / Insurance Card					
	Keys					
	Glasses / Sunglasses					
1	Cellphone / Pager					
	Dentures					
	Hearing Aid					
	Prosthetics					
	Cane / Walker / Wheelchair					
	Rings					
	Watch					
	Bracelet					
	Necklace					
	Earrings					

Money Total:			
Coins Amount =	$1 x =	$5 x =	$10 x =
$20 x =	$50 x =	$100 x =	

Medical University Hospital is not responsible for personal property retained by patient or brought to Medical University Hospital after this inventory was performed.

ADMISSION SIGNATURES	Date	Time
Patient Signature:		
Family/Friend Signature:		
Staff Signature: Shaneda / Meganthe	4/24/14	0334
DISCHARGE SIGNATURES		
Patient Signature:		
Family/Friend Signature:		
Staff Signature:		

admit to trauma

Original to Medical Record — Copy to Patient/Family

edpersonalinventory

OTC 700221 Rev. 6/07

Allergy History

Seq	Allergen	Confirmed Date/Time		Type	Onset Date	Primary Reaction	Other Reaction	Severity	Comment	Reporting Relation	Reported By	Source	Charted Date/Time	Sensitivity Class	Verified By	Verified Date	Confirmed By
1	NKA	04/26/2011 04:55	[O]	Drug	--	--	--	--	--	--	--	MEDS	04/26/2011 04:59	Allergy	Staffid, Millerdd	26-APR-11	Staffid, Millerdd

Inactive Allergy History

No Data Found

Problem History

No Data Found

Medication History

No Data Found

Clinical History

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
AdvancedDirectiv	Does the patient have a written	[ ]	NO DATA FOUND			
	Would the pt like to talk to someone re:	[ ]	NO DATA FOUND			
	Notify Hospital Chaplain?	[ ]	NO DATA FOUND			
	Notified Date/Time	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
Chart Allergy	Allergen:	[ ]	NO DATA FOUND			
	Primary Reaction:	[ ]	NO DATA FOUND			
	Severity:	[ ]	NO DATA FOUND			
	Other Reaction:	[ ]	NO DATA FOUND			
	Allergy Comment:	[ ]	NO DATA FOUND			
	Verifying RPh:	[ ]	NO DATA FOUND			
CONTACT INFO	Primary Contact	[C]	Deatra goodwin	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[M]	Deatra goodwin	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	no family yet	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Home	[C]	[redacted]	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[M]		04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Work	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN

Patient:GOODWIN,DAVON A MRN:725008 Encounter:495654253 Page 1 of 7
MUSC69 OF 519

221

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
CONTACT INFO	Phone - Cell	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Relationship	[C]	mother	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[M]	mother	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Patient lives with	[C]	Mother	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[M]	Mother	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Additional Contact	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Home	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Work	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Cell	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Relationship	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Additional Contact	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Home	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Work	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Phone - Cell	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Primary Care MD	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Comment	[C]	--	05/04/2011 11:29	05/04/2011 11:56	Stout, Jessica A., RN
		[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN

Immunizations

Patient:GOODWIN,DAVON A MRN:725008 Encounter:495654253 Page 3 of 7

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
Immunizations	Influenza	[M]	No	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	If yes, date	[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Pneumovax	[M]	No	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	If yes, date	[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Tetanus	[M]	No	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	If yes, date	[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	Varicella	[M]	No	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
	If yes, date	[C]	--	04/26/2011 17:03	04/26/2011 17:37	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:26	Askea, Meaghan E., RN
OB patients only	Gravida	[ ]	NO DATA FOUND			
	Term	[ ]	NO DATA FOUND			
	Pre-term	[ ]	NO DATA FOUND			
	Abort	[ ]	NO DATA FOUND			
	Living	[ ]	NO DATA FOUND			
	EDC	[ ]	NO DATA FOUND			
	Anesth preferred	[ ]	NO DATA FOUND			
	Last meal	[ ]	NO DATA FOUND			
	Baby up for adoption (BUFA)	[ ]	NO DATA FOUND			
	No prenatal care	[ ]	NO DATA FOUND			
	Feeding plan	[ ]	NO DATA FOUND			
	Water source	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
Patient History	Reason	[C]	GSW	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	GSW	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	High blood pressure	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Neuro	[M]	()	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Neuro select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Fainting	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN

MUSC71 OF 519

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
Patient History	Falls	[M]	()	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Faint/Falls comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Speech	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Swallow difficulty	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Spch/Swallow cmt	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	GI	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	GI select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Heart	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Heart select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Resp/Lung	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Resp/Lung select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Kidney/Bladder	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Gu select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Endocrine	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Endo select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Liver	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
Patient History	Liver select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Hepatitis type	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Bleed disorders	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Anticoagulants	[C]	Unknown	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Bld dis/anticoag cmt	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Sickle cell	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Rheumatology	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Rheum select	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Dermatology	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Cancer	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Transplant	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Psychiatric	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Psych other	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Violence	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN

Patient:GOODWIN,DAVON A MRN:725008 Encounter:495654253 Page 5 of 7
MUSC73 OF 519
225

Patient:GOODWIN,DAVON A MRN:725008 Encounter:495654253 Page 6 of 7

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
Patient History	Violence other	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	HIV	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Bld transf/react	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	OB/Gyn	[M]	()	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	OB/Gyn other	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	LNMP, if applicable	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Dev disability	[M]	No	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Failure to thrive	[C]	Unknown	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	Unknown	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Dev dis/FTT cmt	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
	Other	[C]	--	04/26/2011 17:03	04/26/2011 17:39	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:27	Askea, Meaghan E., RN
Patient History	Comment	[]	NO DATA FOUND			
	Comment	[]	NO DATA FOUND			
Substance Use	Use of Tobacco	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Daily amount	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	# of years	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Last use	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Use of Alcohol	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN

MUSC74 OF 519

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
Substance Use	Daily amount	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	# of years	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Last use	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Use of Rec Drugs	[M]	denies	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Daily amount	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	# of years	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Last use	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
	Comment	[C]	unable to obtain at this time pt sedated and intubated	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	unable to obtain at this time pt sedated and intubated	04/26/2011 05:18	04/26/2011 05:39	Askea, Meaghan E., RN
Surgical Hx	Surgical Hx	[M]	none identified	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-Neurological	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-Respiratory	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-Cardiovascular	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-GI	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-UroRenal	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-Reproductive	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-Orthopedic	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Surg Hx-Other	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
	Comment	[C]	--	04/26/2011 17:03	04/26/2011 17:40	Adams, Leslie A., RN
		[O]	--	04/26/2011 05:18	04/26/2011 05:40	Askea, Meaghan E., RN
Surgical Hx	Comment	[]	NO DATA FOUND			

Patient:GOODWIN,DAVON A MRN:725008 Encounter:495654253 Page 7 of 7
MUSC75 OF 519
227

GOODWIN, DAVON Opt Out:
MUSC - Live
Oracle Admission History Report
From: 04/26/2011 02:55 To: 05/04/2011 16:06
Rm-Bed: Admit Dt: 04/26/2011 03:16
Age: 19 yr Gender: M MD: Leon, Stuart M.
DOB: [redacted] Acct: 495654253 MRN: 002657049
Requested: 05/05/2011 03:06

Allergy History

Allergen	Type	Onset Date	Primary Reaction	Other Reaction	Severity	Comment	Confirmed By and Date/Time
NKA	Drug						Staffid, Millerdd 04/26/2011 04:55

Clinical History

Subject	Question	Response	Last Charted By and Date/Time	Confirmed By and Date/Time
CONTACT INFO	Primary Contact	Deatra goodwin	Adams, Leslie A., RN 04/26/2011 17:03	Stout, Jessica A., RN 05/04/2011 11:29
	Phone - Home	[redacted]	Adams, Leslie A., RN 04/26/2011 17:03	Stout, Jessica A., RN 05/04/2011 11:29
	Relationship	mother	Adams, Leslie A., RN 04/26/2011 17:03	Stout, Jessica A., RN 05/04/2011 11:29
	Patient lives with	Mother	Adams, Leslie A., RN 04/26/2011 17:03	Stout, Jessica A., RN 05/04/2011 11:29
Immunizations	Influenza	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Pneumovax	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Tetanus	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Varicella	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
Patient History	Reason	GSW	Askea, Meaghan E., RN 04/26/2011 05:18	Adams, Leslie A., RN 04/26/2011 17:03
	High blood pressure	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Neuro	()	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Fainting	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Falls	()	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Speech	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Swallow difficulty	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	GI	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Heart	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Resp/Lung	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Kidney/Bladder	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Endocrine	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Liver	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Bleed disorders	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Anticoagulants	Unknown	Askea, Meaghan E., RN 04/26/2011 05:18	Adams, Leslie A., RN 04/26/2011 17:03
	Sickle cell	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03

Clinical History (continued)

Subject	Question	Response	Last Charted By and Date/Time	Confirmed By and Date/Time
Patient History	Rheumatology	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Dermatology	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Cancer	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Transplant	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Psychiatric	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Violence	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	HIV	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Bld transf/react	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	OB/Gyn	()	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Dev disability	No	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Failure to thrive	Unknown	Askea, Meaghan E., RN 04/26/2011 05:18	Adams, Leslie A., RN 04/26/2011 17:03
Substance Use	Use of Rec Drugs	denies	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03
	Comment	unable to obtain at this time pt sedated and intubated	Askea, Meaghan E., RN 04/26/2011 05:18	Adams, Leslie A., RN 04/26/2011 17:03
Surgical Hx	Surgical Hx	none identified	Adams, Leslie A., RN 04/26/2011 17:03	Adams, Leslie A., RN 04/26/2011 17:03

Medication History

NO DATA FOUND

narrative

04/26/2011 00:00 TO 04/26/2011 23:59

Legend Charting

04/26/2011 05:40

ADT Detail (81149)

Pt/fam status = unavail to ans	Askea, Meaghan E., RN 04/26/2011 05:43
Fam/lguard notif = yes	Askea, Meaghan E., RN 04/26/2011 05:43
Source of info = other (specify)	Askea, Meaghan E., RN 04/26/2011 05:43
Need interpreter = no	Askea, Meaghan E., RN 04/26/2011 05:43
Admission dx = GSW	Askea, Meaghan E., RN 04/26/2011 05:43
Admit to = 4STS	Askea, Meaghan E., RN 04/26/2011 05:43
Admit via = admit via other	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: ICU bed	

narrative

04/26/2011 00:00 TO 04/26/2011 23:59

Legend Charting

04/26/2011 05:40

ADT Detail (81149)

Admit from = surgery	Askea, Meaghan E., RN 04/26/2011 05:43
Accompanied by = caregiver	Askea, Meaghan E., RN 04/26/2011 05:43
Pt/family orient = family not present	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: family not present	
ID band placed = yes	Askea, Meaghan E., RN 04/26/2011 05:43
Patient age = unknown	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unknown	

Pt Belongings (81187)

None = none	Askea, Meaghan E., RN 04/26/2011 05:43

Exposures (81190)

Isolat prev stay = unable to answer, pt intubated and sedated	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unable to answer, pt intubated and sedated	

Pneumonia vacc

Patient refuses = unable to answer at this time, pt intubated and sedated	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unable to answer at this time, pt intubated and sedated	

Adm Diabetes (18112)

Pt w/hx diabetes = unknown at this time, pt intubated and sedated	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unknown at this time, pt intubated and sedated	

Psych/Spirit/Ed (81151)

Occupation = unknown at this time, pt intubated and sedated	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unknown at this time, pt intubated and sedated	

Adm Functional (81154)

Cognition = unknown at this time, pt intubated and sedated	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unknown at this time, pt intubated and sedated	

Adm Nutrition (81147)

Consume/digest = unknown at this time, intubated and sedated	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unknown at this time, intubated and sedated	

D/C Planning (81140)

County = unknown at this time, pt intubated and sedated	Askea, Meaghan E., RN 04/26/2011 05:43
Notes: unknown at this time, pt intubated and sedated	

04/26/2011 17:27

narrative

04/26/2011 00:00 TO 04/26/2011 23:59

Legend Charting

04/26/2011 17:27

ADT Detail (81149)

Fam/lguard notif = yes	Adams, Leslie A., RN 04/26/2011 17:34
Source of info = family	Adams, Leslie A., RN 04/26/2011 17:34
Need interpreter = no	Adams, Leslie A., RN 04/26/2011 17:34
Admit to = 4STW	Adams, Leslie A., RN 04/26/2011 17:34
Admit via = stretcher	Adams, Leslie A., RN 04/26/2011 17:34
Admit from = surgery	Adams, Leslie A., RN 04/26/2011 17:34
Accompanied by = caregiver	Adams, Leslie A., RN 04/26/2011 17:34
Pt/family orient = cell phone use, GetWell Network, menu, noLatex balloon, nurse call sys, ptSafety broch, smoking policy, unit routine, visiting policy	Adams, Leslie A., RN 04/26/2011 17:34
ID band placed = yes	Adams, Leslie A., RN 04/26/2011 17:34
Patient age = 19	Adams, Leslie A., RN 04/26/2011 17:34

Adm Diabetes (18112)

Pt w/hx diabetes = no	Adams, Leslie A., RN 04/26/2011 17:34

Psych/Spirit/Ed (81151)

Occupation = not employed	Adams, Leslie A., RN 04/26/2011 17:34

Adm Functional (81154)

Swallow, speech = no alteration	Adams, Leslie A., RN 04/26/2011 17:34
Amb steady gait = WNL	Adams, Leslie A., RN 04/26/2011 17:34
Independent ADLs = WNL	Adams, Leslie A., RN 04/26/2011 17:34

Adm Nutrition (81147)

Consume/digest = food	Adams, Leslie A., RN 04/26/2011 17:34
Current dx = GSW	Adams, Leslie A., RN 04/26/2011 17:34
Notes: GSW	

D/C Planning (81140)

County = Charleston	Adams, Leslie A., RN 04/26/2011 17:34

04/30/2011 00:00 TO 04/30/2011 23:59

Legend Charting

04/30/2011 01:21

Pneumonia vacc

narrative

04/30/2011 00:00 TO 04/30/2011 23:59

Legend Charting

04/30/2011 01:21

Pneumonia vacc

Patient refuses = yes	Cottle, Jean A., RN 04/30/2011 01:22
Refuse comment = I don't want it	Cottle, Jean A., RN 04/30/2011 01:22
DO NOT administer = not given	Cottle, Jean A., RN 04/30/2011 01:22

MUSC Health

HISPHYS

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 3 Version Date: 6/10

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

PATIENT IDENTIFICATION LABEL

Date: 4/26/11 Time: Trauma Page Notification Level: ☒ A ☐ B ☐ OB

PREHOSPITAL DATA	HOSPITAL TRANSFER Hospital Name:
Hypotensive (DBP < 90 mmHg) ☐ Yes ☒ No ☐ Unknown	Injury Date: 4/26/11 Time of Injury:
Lowest recorded SBP:	Transferring Physician: Transferring Hospital:
LOC: ☐ Yes How long? _____ min ☒ No	Patient Origin: ☐ Walk-in ☒ Scene ☐ Other: _____
Mode of arrival: ☐ Helicopter ☒ Ambulance ☐ Private Vehicle ☐ Other: _____	
GCS Score: 15 Fluids: _____ mL Blood: _____ mL	Other: _____
Tetanus: ☐ Last tetanus: _____ ☒ Unknown	

HISTORY OF PRESENT ILLNESS
Source of History: ☒ EMS ☐ Patient ☐ Helicopter Flight team ☐ Police ☐ Family ☐ Other _____

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

AGE: _____ ☒ Male ☐ Female

GSW to LUQ c/o ABD pain

Patient Pregnant: ☒ N/A ☐ Unknown ☐ No ☐ Yes EDC: _____

MECHANISM OF INJURY
☐ Auto-ped ☐ Auto-bicycle ☐ MVC ☐ Motorcycle crash ☐ Burn ☒ GSW ☐ Fall ☐ Stabbing ☐ Hanging ☐ Other: _____

SAFETY EQUIPMENT

Seat belt	☐ Yes ☐ Lap belt ☐ Shoulder belt	☒ No	☐ Unknown
Ejected	☐ Yes	☒ No	☐ Unknown
Airbag	☐ Yes ☐ Front ☐ Side ☐ Unknown	☒ No	☐ Unknown
Position	☐ Driver ☐ Front seat ☐ Back seat		☐ Unknown
Crash type	☐ Front ☐ Lateral ☐ Rollover		☐ Unknown

PROTECTIVE GEAR

Helmet	☐ Yes	☒ No	☐ Unknown
Padded leather jacket	☐ Yes	☒ No	☐ Unknown
Padded leather pants	☐ Yes	☒ No	☐ Unknown

Other: _____

ALLERGIES:
☐ Penicillin ☐ Sulfa ☐ IV Contrast ☐ Aspirin ☐ Other: _____

PAST MEDICAL HISTORY ☒ **Check if complete HPI cannot be obtained due to need for urgent evaluation and / or urgent management of patient's condition**

Medical: ☐ HTN ☐ Diabetes Type: ____ ☐ Controlled ☐ Uncontrolled ☐ CHF ☐ COPD ☐ A-Fib ☐ Cirrhosis
☐ Cardiac Stents ☐ Hepatitis Type: ____ ☐ Seizure Disorder ☐ HIV ☐ Bleeding Disorder ☐ Obesity
☐ Other: _____

Surgical: ☐ Appendectomy ☐ Cholecystectomy ☐ Cardiac Stents
☐ Other: Unknown

Family Hx: Unknown

Social Hx: ☒ Unknown ☐ Suspected current ETOH intoxication ☐ Illicit drugs: _____
☐ Tobacco packs / day: _____ ☐ None

Primary Care Physician: _____ ☒ Unknown Employment: _____ ☒ Unknown

MEDICATIONS: COMPLETE MEDICATION RECONCILIATION FORM
☐ Patient on warfarin (Coumadin®)? ☐ Yes ☐ No ☒ Unknown Clopidogrel (Plavix®)? ☐ Yes ☐ No ☒ Unknown
☐ Patient on aspirin? ☐ Yes ☐ No ☒ Unknown Prasugrel (Effient®)? ☐ Yes ☐ No ☒ Unknown

Clinician Initials _____

MUSC Health

HISPHYS

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 3 Version Date: 6/10

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

PATIENT IDENTIFICATION LABEL

PRIMARY SURVEY (INITIAL FINDINGS)

AIRWAY	BREATHING	CIRCULATION	DISABILITY	GLASGOW COMA SCALE (GCS)		
☐ Stable ☐ Unstable	Equal Breath Sounds ☒ Yes ☐ No Hypoxia / Cyanosis ☐ Yes ☐ No Paradoxical Movement ☐ Yes ☐ No	Heart Rate 93 BP 183/134 Temp _____	Neuromuscular blocker, sedatives or opiates affecting exam: ☐ Yes ☒ No	Eye 4=Spontaneous 3=To Voice 2=To Pain 1=None	Verbal 5=Normal Conversation 4=Disoriented Conversation 3=Words but not coherent 2=No words only sounds 1=None	Motor 6=Normal 5=Localizes to pain 4=Withdraws to pain 3=Decorticate 2=Decerebrate 1=None
Actions taken: Intubated ☒ Yes ☐ Prior to arrival ☒ Trauma Bay ☐ No ☐ Other	Lung Sounds Right ☒ Normal ☐ Decreased ☐ None Left ☒ Normal ☐ Decreased ☐ None	Cap Refill ☒ Normal ☐ Prolonged >2 Active Bleeding ☐ Yes ☐ No ⊕ hematemesis	Focal Signs: Unequal Pupils: ☐ Yes ☐ No Lateralizing Motor Signs: ☐ Yes ☐ No	Total: 15 ☐ GCS < 8 ☐ CODE		

RESUSCITATION: (Check all that apply including actions taken during entire Emergency Department evaluation)

☒ Peripheral intravenous lines placed (see nursing notes for locations)
☐ Chest tube placed (location): _____ (See procedure note(s) for specific details; nurses notes for total output)
☐ Chest tube #2 placed (location): _____ (See procedure note(s) for specific details; 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)
☐ EKG 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: _____

SECONDARY SURVEY

EENT: (Pupils, Vision, Eye Movements, Tympanum, Facial Bones, Teeth) ☐ No abnormal findings ☒ PERRL

Gross visual acuity impaired	☐ Not evaluated ☒ No ☐ Yes		EOMs impaired	☐ Not evaluated ☒ No ☐ Yes	
Hemotympanum	☐ Not evaluated ☒ No ☐ Yes		Scalp Injury	☐ Not evaluated ☒ No ☐ Yes	
Facial Injury	☐ Not evaluated ☒ No ☐ Yes		Dental Injury	☐ Not evaluated ☒ No ☐ Yes	

Other: _____

Clinician Initials _____
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MUSC Health

"HISPHYS"

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 3 Version Date: 6/10

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

PATIENT IDENTIFICATION LABEL

SECONDARY SURVEY -- continued

CERVICAL SPINE: ☑ No abnormal findings

C-Collar in place pre-hospital: ☐ No ☐ Yes

Collar clear: ☐ Yes ☒ No Pt. with ☐ distracting injuries ☐ midline tenderness ☐ ETOH intox ☐ altered LOC ☐ neuro deficits

CHEST: (Chest Wall / Lungs / Heart) ☑ No abnormal findings

Chest Wall: ☐ Contusion ☐ Abrasion ☐ Seatbelt sign ☐ Tenderness ☐ Flail ☐ Crepitus ☐ Clinical rib fracture

Describe Positive Findings:

Lungs: ☒ Bilaterally Clear to Auscultation ☐ Other: _____

Heart: Sounds: ☐ No Murmurs, Rubs or Gallops ☐ Other: _____

BACK: ☑ No abnormal findings

Thoracic Spine: midline tenderness ☒ No ☐ Yes

Lumbar Spine: midline tenderness ☒ No ☐ Yes

Contusions: ☒ No ☐ Yes Describe: _____ Abrasions: ☐ No ☐ Yes Describe: _____

Deformity: ☒ No ☐ Yes Describe: _____ Other: _____

ABDOMEN: ☐ No abnormal findings

Tenderness: ☐ No ☑ Yes Describe: Diffuse Seatbelt sign: ☐ No ☐ Yes Describe: _____

Abrasions: ☐ No ☐ Yes Describe: _____ Distention: ☐ No ☐ Yes Describe: _____

Contusions: ☐ No ☐ Yes Describe: _____ Penetrating injuries: ☐ No ☐ Yes Location: _____

Other: GSW entry LUQ

PELVIS: ☒ No abnormal findings Tenderness: ☐ No ☐ Yes Location: _____ Other: _____

GENITOURINARY: (Perineum / Rectal / Genitalia) ☒ No abnormal findings Other: _____

Blood at meatus: ☐ No ☐ Yes Describe: _____ Vaginal Bleeding: ☐ No ☐ Yes Describe: _____

Poor sphincter tone: ☐ No ☐ Yes Describe: _____ Scrotal Hematoma: ☐ No ☐ Yes Describe: _____

GYN: ☒ Not applicable ☐ No abnormal findings Fetal Heart Tones: ☐ N/A ☐ No ☐ Yes: _____ Other: _____

Clinician Initials

MUSC Health

HISPHYS

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 3

Version Date: 6/10

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

PATIENT IDENTIFICATION LABEL

SECONDARY SURVEY – continued

EXTREMITIES: [Fractures (open / close), dislocations, range of motion] ☐ No abnormal findings

Describe Abnormalities:

Pulses (0,1+,2+)	Radial	Femoral	Dorsalis Pedis	Posterior Tibial
Right:	2+	2+	2+	
Left:	2+	2+	2+	

NEURO (Sensory, Motor Reflexes, Cranial Nerves, Specific Peripheral Nerves if Appropriate)

CN II-X11: ☒ WNL ☐ Abnormal _____

Sensory: ☒ WNL ☐ Abnormal _____

Motor: ☒ WNL ☐ Abnormal _____

Other: _____

SKIN: ☐ No abnormal findings Other: _____ (include lacerations)

Sacral Decubitus: ☒ No ☐ Yes Stage: _____ (1-4) Location: _____

ADDITIONAL PHYSICAL FINDINGS:

ANCILLARY STUDIES:

PT: _____ ☐ Not performed ☐ Pending HCG: _____ ☐ Not performed ☐ Pending

Fetal Hgb: _____ ☐ Not performed ☐ Pending PTT: _____ ☐ Not performed ☐ Pending

Platelet: _____ ☐ Not performed ☐ Pending ETOH: _____ ☐ Not performed ☐ Pending

Urinalysis: _____ EKG: _____

Other: _____

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

CXR: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
Pelvis: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
Extremities: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
CT Head: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
CT Face: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
CT Abd: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
CT Chest: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
CT C-spine: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
CTA: ☐ Not performed ☐ WNL ☐ Abnormal (describe): _____
Other: _____

Clinician Initials _____

MUSC Health

"HISPHYS"

Trauma Center Initial Patient Evaluation

Page 5 of 6

Form Origination Date: 4/04
Version: 3 Version Date: 6/10

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

PATIENT IDENTIFICATION LABEL

FAST SCAN	Positive	Negative	Equivocal
Abdomen:			
Pericardium:			
Pneumothorax:			

Study conducted by: Pager ID:

ASSESSMENT: INJURY LIST

1	GSW LUQ	14	
2		15	
3		16	
4		17	
5			
6			
7			
8			
9			
10			
11			
12			
13			

PLAN: 19 yo ♂ GSW LUQ, Bloody Emesis, Peritonitis
– OR, Ex-Lap

Management options were discussed with physicians from the following services:
☐ Orthopaedic Surgery ☐ Neurosurgery ☐ OMFS ☐ Plastics ☐ CT Surgery
☐ Others (list): _____

Clinician Signature/Initials _____ ☒ Resident ☐ Attending ☐ PA-C

Service Trauma Pager ID 5421 Date 4/26/11 Time 0400

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MUSC Health

HISPHYS

Trauma Center Initial Patient Evaluation

Form Origination Date: 4/04
Version: 3 Version Date: 6/10

P495654253 DOB: [redacted] U
TRAUMA
VICTIM PP
EAdm:12/31/11 M2657049

PATIENT IDENTIFICATION LABEL

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: _____

I have examined the patient and key findings include: _____

I have personally reviewed all available radiographic images: ☐ Yes ☐ No
I have reviewed the results of pertinent laboratory tests: ☐ Yes ☐ No
I have personally reviewed the results of additional medical testing and monitor output: ☐ Yes ☐ No
I have personally discussed this case with family: ☐ Yes ☐ No
Risk of complications/mortality: ☐ Minimal ☐ Low ☐ Moderate ☐ High

Assessment (see page 5 for complete diagnosis list): _____

Plan: _____

Patient Condition: ☐ Critical/Unstable ☐ Serious ☐ Fair ☐ Good
Admission Type: ☐ Inpatient ☐ 23-hour observation
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: _____)

Signature: _____ Attending Physician Pager ID: 14339

Date: 4/26/11 **Time:** _____

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MUSC Medical Center
HISTORY AND PHYSICAL REPORT
Patient Name: GOODWIN, DAVON
MRN: 002657049
Patcom: 495654253
Date: 04/26/2011
Service:
Attending: Stuart M. Leon, MD

CHIEF COMPLAINT: Gunshot wound to abdomen.

HISTORY OF PRESENT ILLNESS: The patient is a young, African American gentleman who sustained a gunshot wound to his left upper quadrant earlier this morning. The patient was brought to MUSC for trauma evaluation. The patient had episodes of hypotension en route. He arrives awake and alert, complaining of significant abdominal pain and was either spitting up or coughing up bright red blood. For this reason, the patient was emergency we intubated.

A complete past medical history, past surgical history, list of allergies, medications, social history, family history, and review of systems are all unable to be obtained due to urgent need for patient evaluation.

PHYSICAL EXAMINATION: The patient's airway was initially patent, though he was intubated for airway protection due to the fact that he was either coughing up or spitting up bright red blood.
LUNGS: His lungs were clear to auscultation bilaterally.
NECK: A cervical collar was in place.
CARDIOVASCULAR: He has palpable femoral pulses. His heart was tachycardic, though was a regular rhythm.
NEUROLOGIC: Glasgow coma score was 14 to 3T following intubation.
ABDOMEN: Soft, distended, tender to palpation diffusely, and the patient has a single gunshot wound located within the left upper quadrant.
PELVIS: His pelvis is stable to AP and lateral compression.
EXTREMITIES: All 4 extremities were without gross deformities.

DIAGNOSTIC IMAGING: Included obtaining a chest x-ray, as well as a flat plate of the patient's abdomen and a lateral x-ray of the patient's abdomen, and the study subsequently revealed that the bullet remained intraabdominal, it passed from left to right and anterior to posterior.

Given the patient's current clinical status, we have elected to take him emergently up to the operating at this time for exploration.

Dictated by: Stuart M. Leon, MD

_____
Stuart M. Leon, MD

_____
Stuart M. Leon, MD

Attending

731054 / 44076 /
JOB: 6040067
DD: 04/26/11 05:04 AM
DT: 04/26/11 11:46 AM

Additional CC:_____
Authenticated by STUART LEON, MD On 04/27/2011 07:21:11 AM
Authenticated by STUART LEON, MD On 04/27/2011 07:22:25 AM

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
GOODWIN, DAVON	[redacted]	36LX64533

Medical Record Number	Patient Location	Product Type
2657049	MUH 4STS 478G	FFP Thawed

Date	Time	Tech ID	Expiration Date
04/26/2011	06:44	GAGEMA	04/29/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☐ Compatible ☐ Incompatible ☐ Uncrossmatched ☒ Not Required	B POS	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE-TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present _____ applied prior to transfusion
2. Verbal identification source (check one): _____ patient _____ family member ✓ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] / Signature [signature]

Transfusion started: Date 4/26/11 Time 0730

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P	T	RR
15 minutes after start	BP	P	T	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 04/26/11 Time 0800 Amount transfused 320 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☒ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
GOODWIN, DAVON	[redacted]	36LJ13936

Medical Record Number	Patient Location	Product Type
2657049	MUH 4STS 478G	FFP Thawed

Date	Time	Tech ID	Expiration Date
04/26/2011	06:44	GAGEMA	04/29/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☐ Compatible ☐ Incompatible ☐ Uncrossmatched ☑ Not Required	B POS	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE
IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ____ patient ____ family member ✓ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] / Signature [signature]

Transfusion started: Date 4/26/11 Time 0730

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P	T	RR
15 minutes after start	BP	P Emergent	T	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/26/11 Time 0800 Amount transfused 325 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ✓ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
GOODWIN, DAVON	[redacted]	32H67376

Medical Record Number	Patient Location	Product Type
2657049	MUH 4STS 478	Red Cells, LKP

Date	Time	Tech ID	Expiration Date
04/29/2011	04:56	HAGGERH	05/11/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☒ Compatible ☐ Incompatible ☐ Uncrossmatched ☐ Not Required	B NEG	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	LKP

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE
IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ____ patient ____ family member ✓ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] RN / Signature [signature] RN

Transfusion started: Date 4/29/11 Time 0641

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P	T	RR
15 minutes after start	BP See MEWS	P	T	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/29/11 Time 0741 Amount transfused 350 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☒ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
GOODWIN, DAVON	[redacted]	36FR31999 A

Medical Record Number	Patient Location	Product Type
2657049	MUH 4STS 478	Red Cells, LKP

Date	Time	Tech ID	Expiration Date
04/29/2011	04:56	HAGGERH	05/10/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☒ Compatible ☐ Incompatible ☐ Uncrossmatched ☐ Not Required	B NEG	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	LKP

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE
IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ____ patient ____ family member ✓ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] RN / Signature [signature] RN

Transfusion started: Date 4/29/11 Time 0530

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P	T	RR
15 minutes after start	BP [illegible]	P [illegible]	T [illegible]	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA 4/29/11

Transfusion ended: Date ____ Time 0615 Amount transfused 350 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☐ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
GOODWIN, DAVON	[redacted]	12S29754 A

Medical Record Number	Patient Location	Product Type
2657049	MUH 4STS 478	Red Cells, LKP

Date	Time	Tech ID	Expiration Date
04/28/2011	04:35	ALEXIS	05/19/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☑ Compatible ☐ Incompatible ☐ Uncrossmatched ☐ Not Required	B NEG	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	LKP

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ____ patient ____ family member ✓ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] RN / Signature [signature] RN

Transfusion started: Date 4-28-11 Time 0440

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	133/51	P	106	T	38	RR 20
15 minutes after start	BP		P		T		RR
Post transfusion	BP	129/52	P	94	T	37.8	RR 24

POST TRANSFUSION DATA 4-28

Transfusion ended: Date ____ Time 0550 Amount transfused 300 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☐ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

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TRANSFUSION

Transfusion Service
Blood Tag

Name of Recipient	DOB	Unit Number
GOODWIN, DAVON	[redacted]	36J07896

Medical Record Number	Patient Location	Product Type
2657049	MUH 4STS 478G	FFP Thawed

Date	Time	Tech ID	Expiration Date
04/26/2011	06:44	GAGEMA	04/29/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☐ Compatible ☐ Incompatible ☐ Uncrossmatched ☑ Not Required	B POS	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ✓ patient ____ family member ____ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] / Signature [signature]

Transfusion started: Date 4/26/11 Time 0655

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P	T	RR
15 minutes after start	BP	[illegible]	[illegible]	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/26/11 Time 0800 Amount transfused 250 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☑ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient GOODWIN, DAVON DOB [redacted]			Unit Number 36FL43561
Medical Record Number 2657049	Patient Location MUH 4STS 478G		Product Type FFP Thawed
Date 04/26/2011	Time 06:44	Tech ID GAGEMA	Expiration Date 04/29/2011 23:59
Crossmatch Status ☐ Compatible ☐ Incompatible ☐ Uncrossmatched ☒ Not Required			Donor Blood Type B POS / Patient Blood Type B NEG
Special Donation ☐ Autologous ☐ Directed			Special Antigen Screening

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ____ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ____ patient ____ family member ____ staff member
3. Blood identification verification (check each as performed):
   - ____ Blood product matches written order
   - ____ Patient ID band matches blood tag
   - ____ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature _____ / Signature _____

Transfusion started: Date _____ Time _____

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P	T	RR
15 minutes after start	BP	P		RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/26/11 Time 0700 Amount transfused 200 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☐ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

#1

UNCROSSMATCHED BLOOD

"TRANSFUSION"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA
Discovering, Understanding, Healing

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
TRAUMA, VICTIM PP	[redacted]	36FE31001

Medical Record Number	Patient Location	Product Type
2657049	MUH 4PAV 4PAV	Red Cells, LKP

Date	Time	Tech ID	Expiration Date
04/26/2011	03:52	ALEXIS	05/23/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☐ Compatible ☐ Incompatible ☑ Uncrossmatched ☐ Not Required	B NEG	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	LKP

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present _____ applied prior to transfusion
2. Verbal identification source (check one): _____ patient _____ family member _____ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] / Signature [signature] RN

Transfusion started: Date 4/26/11 Time 04:00

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P See Anesthesia Record	T	RR
15 minutes after start	BP	P	T	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/26/2011 Time 0415 Amount transfused 300. cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☐ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

17 4

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
TRAUMA, VICTIM PP	[redacted]	32H73905

Medical Record Number	Patient Location	Product Type
2657049	MUH 4PAV 4PA	Red Cells, LKP

Date	Time	Tech ID	Expiration Date
04/26/2011	04:04	JOHNSONAD	05/26/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☐ Compatible ☐ Incompatible ☐ Uncrossmatched ☐ Not Required	B NEG	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	LKP

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE
IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ____ patient ____ family member ✓ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature [signature] MD 1404/28 / Signature [signature] Emergency CRNA

Transfusion started: Date 4/26/2011 Time 0440

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P	T	RR
15 minutes after start	BP See Anesthesia Record	P	T	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/26/2011 Time 0500 Amount transfused 300 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☑ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

17 3.

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"TRANSFUSION"

Transfusion Service Blood Tag

Name of Recipient	DOB	Unit Number
TRAUMA, VICTIM PP	[redacted]	38LX64826

Medical Record Number	Patient Location	Product Type
2657049	MUH 4PAV 4PA	Red Cells, LKP

Date	Time	Tech ID	Expiration Date
04/26/2011	04:04	JOHNSONAD	05/25/2011 23:59

Crossmatch Status	Donor Blood Type	Patient Blood Type
☐ Compatible ☐ Incompatible ☐ Uncrossmatched ☐ Not Required	B NEG	B NEG

Special Donation	Special Antigen Screening
☐ Autologous ☐ Directed	LKP

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE
IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ✓ initially present _____ applied prior to transfusion
2. Verbal identification source (check one): _____ patient _____ family member ✓ staff member
3. Blood identification verification (check each as performed):
   - ✓ Blood product matches written order
   - ✓ Patient ID band matches blood tag
   - ✓ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature Latoria Gray CRNA / Signature [signature] MD 1460 48

Transfusion started: Date 04/26/2011 Time 0430

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP See Anesthesia Record	P	T	RR
15 minutes after start	BP	P	T	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/26/2011 Time 0440 Amount transfused 300 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☒ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

2

UNCROSSMATCHED BLOOD

MYGFR4343

"TRANSFUSION"

MUSC
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Transfusion Service Blood Tag

Name of Recipient: TRAUMA, VICTIM PP DOB [redacted]			Unit Number: 32GJ09125
Medical Record Number: 2657049	Patient Location: MUH 4PAV 4PAV		Product Type: Red Cells, LKP
Date: 04/26/2011	Time: 03:52	Tech ID: ALEXIS	Expiration Date: 05/09/2011 23:59
Crossmatch Status: ☐ Compatible ☐ Incompatible ☑ Uncrossmatched ☐ Not Required			Donor Blood Type: B NEG / Patient Blood Type: B NEG
Special Donation: ☐ Autologous ☐ Directed			Special Antigen Screening: LKP

RETURN BLOOD PRODUCT TO TRANSFUSION SERVICE IMMEDIATELY IF TRANSFUSION IS DELAYED

PRE TRANSFUSION DATA

1. Patient ID band (check one): ____ initially present ____ applied prior to transfusion
2. Verbal identification source (check one): ____ patient ____ family member ____ staff member
3. Blood identification verification (check each as performed):
   - ____ Blood product matches written order
   - ____ Patient ID band matches blood tag
   - ____ Blood product label matches blood tag

The two signatures below (one must be that of the transfusionist) certify the above information has been checked in the presence of the patient.

Signature _____ / Signature McEnery CRNA

Transfusion started: Date 4/26/11 Time 0400

"Transfuse in spite of temperature elevation" order is required if patient temperature is greater than 100°F.

Pre transfusion	BP	P See Anesthesia Record	T	RR
15 minutes after start	BP	P	T	RR
Post transfusion	BP	P	T	RR

POST TRANSFUSION DATA

Transfusion ended: Date 4/26/2011 Time 0405 Amount transfused 300 cc

Did patient show symptoms of a transfusion reaction? ☐ Yes ☑ No

IF A REACTION IS SUSPECTED, THE FOLLOWING STEPS ARE TO BE TAKEN:

1. Stop the transfusion. Keep the IV access open with normal saline. Do not discard the bag and set.
2. Immediately notify the patient's physician.
3. Notify the Transfusion Service at 2-2671.
4. Refer to the Transfusion Reaction Investigation Report for further instructions.

PATIENT CHART COPY

GOODWIN, DAVON
MUSC
IV Administration Report
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 405654253 MR: 002657049
REQUESTED:05/05/11 03:07
OPT OUT:
Page: 1

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
2	IV	Routine	04/26/11 04:56	04/26/11 05:00	04/28/11 15:22

Detail - Bottle Type: 0 Begin Vol: 100 ML I/O Label: Propofol
PROPOFOL (PMX) 1000 MG
(10mg/ml)
>>NURSING: HIGH ALERT!!<< *FINAL CONCENTRATION = 10 MG/ML* **PREMIX-DO NOT ADD ANYTHING TO BAG** TUBING AND ANY UNUSED PORTION OF PROPOFOL MUST BE DISCARDE D AFTER 12 HOURS DOCUMENT TUBING CHANGE DATE: TIME: INITIALS: TITRATE Q 5

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/26 06:50	1-0	Start	antL	0 ML/HR	0 mcg/kg/min	SMT5 04/26 06:50
04/26 12:32	1-0	End	antL	0 ML/HR	0 mcg/kg/min	LAA 04/26 12:32
Wasted Amt: 100 ml						
04/26 12:32	2-0	Start	antL	0 ML/HR	0 mcg/kg/min	LAA 04/26 12:32
04/26 13:28	2-0	End	antL	0 ML/HR	0 mcg/kg/min	LAA 04/26 13:28
Wasted Amt: 100 ml						
04/26 13:28	3-0	Start	antL	0 ML/HR	0 mcg/kg/min	LAA 04/26 13:28
04/26 18:04	3-0	End	antL	0 ML/HR	0 mcg/kg/min	LAA 04/26 18:05
Wasted Amt: 100 ml						
04/26 18:04	4-0	Start	antL	0 ML/HR	0 mcg/kg/min	LAA 04/26 18:05
04/27 05:28	4-0	End	antL	0 ML/HR	0 mcg/kg/min	JLP 04/27 05:28
Wasted Amt: 100 ml						
04/27 05:28	5-0	Start	antL	0 ML/HR	0 mcg/kg/min	JLP 04/27 05:28
04/27 20:42	5-0	End	antL	0 ML/HR	0 mcg/kg/min	LZIM 04/27 20:42
Wasted Amt: 100 ml						
04/27 20:42	6-0	Start	antL	0 ML/HR	0 mcg/kg/min	LZIM 04/27 20:42
04/28 05:46	6-0	End	antL	0 ML/HR	0 mcg/kg/min	TMW1 04/28 05:46
Wasted Amt: 100 ml						
04/28 05:46	7-0	Start	antL	0 ML/HR	0 mcg/kg/min	TMW1 04/28 05:46
04/28 12:08	7-0	End	antL	0 ML/HR	0 mcg/kg/min	SACT 04/28 12:08
Wasted Amt: 100 ml						

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
3	IV	Routine	04/26/11 04:56	04/26/11 05:00	04/29/11 17:30

Detail - Bottle Type: 0 Begin Vol: 50 ML I/O Label: Fentanyl
FENTANYL (PF) (PMX) 2.5 MG
(0.05mg/ml)
>>NURSING: HIGH ALERT!!<< ***CLIPBOARD MEDICATION*** *FINAL CONCENTRATION = 50 MICROGRAMS/ML* DO NOT EXCEED MAXIMUM DOSAGE MICROGRAMS/HR TOTAL INFUSION + B OLUSES.

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/26 06:50	1-0	Start	antL	0.5 ML/HR	25 mcg/hr	SMT5 04/26 06:50
04/26 18:41	1-0	End	antL	0.5 ML/HR	25 mcg/hr	LAA 04/26 18:41
Wasted Amt: 50 ml						
04/26 18:41	2-0	Start	antL	0.5 ML/HR	25 mcg/hr	LAA 04/26 18:41
04/27 13:02	2-0	End	antL	0.5 ML/HR	25 mcg/hr	BCAR 04/27 13:03
Wasted Amt: 50 ml						
04/27 13:02	3-0	Start	antL	0.5 ML/HR	25 mcg/hr	BCAR 04/27 13:02
04/27 20:36	3-0	End	antL	0.5 ML/HR	25 mcg/hr	LZIM 04/27 20:36
Wasted Amt: 50 ml						
04/27 20:36	4-0	Start	antL	0.5 ML/HR	25 mcg/hr	LZIM 04/27 20:36
04/28 05:46	4-0	End	antL	0.5 ML/HR	25 mcg/hr	TMW1 04/28 05:46
Wasted Amt: 50 ml						
04/28 05:46	5-0	Start	antL	0.5 ML/HR	25 mcg/hr	TMW1 04/28 05:46
04/29 22:06	5-0	End	antL	0.5 ML/HR	25 mcg/hr	JAC1 04/29 22:06
Wasted Amt: 50 ml						

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
4	IV	Routine	04/26/11 05:22	04/26/11 06:00	04/27/11 11:30

Detail - Bottle Type: 0 Begin Vol: 1000 ML I/O Label: Lactated Ringers
LACTATED RINGERS 1000 ML
... Until discontinued

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/26 06:50	1-0	Start	upaL	150 ML/HR		SMT5 04/26 06:50
04/26 12:32	1-0	End	upaL	150 ML/HR		LAA 04/26 12:32
Wasted Amt: 1000 ml						
04/26 12:32	2-0	Start	upaL	150 ML/HR		LAA 04/26 12:32

CONTINUED

GOODWIN, DAVON
MUSC
IV Administration Report
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002857040
REQUESTED:05/05/11 03:07
OPT OUT:
Page: 2

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
4	IV	Routine	04/26/11 05:22	04/26/11 06:00	04/27/11 11:30

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/26 13:28	2-0	End	upaL	150 ML/HR		LAA 04/26 13:28
Wasted Amt: 1000 ml						
04/26 13:28	3-0	Start	upaL	150 ML/HR		LAA 04/26 13:29
04/26 18:04	4-0	Start	upaL	150 ML/HR		LAA 04/26 18:05
04/26 18:46	4-0	End	upaL	150 ML/HR		LAA 04/26 18:46
Wasted Amt: 1000 ml						
04/26 10:46	5-0	Start	upaL	150 ML/HR		LAA 04/26 10:46
04/27 12:37	5-0	End	upaL	150 ML/HR		BCAR 04/27 12:37
Wasted Amt: 1000 ml						
04/27 16:48	3-0	End	upaL	150 ML/HR		BCAR 04/27 16:48
Wasted Amt: 1000 ml						

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
5	IV	Routine	04/26/11 05:33	04/26/11 05:32	05/01/11 09:59

Detail - Bottle Type: 1 Begin Vol: 100 ML I/O Label: Insulin
SODIUM CHLORIDE 0.9% 100 ML + INSULIN REGULAR 100 UNIT
(1unit/ml)
>>NURSING: HIGH ALERT!!<< TARGET GLUCOSE RANGE 80-110 MG /DL ** STARTING MULT IPLIER 0.03

Detail - Bottle Type: 3 Begin Vol: 100 ML I/O Label: Insulin
SODIUM CHLORIDE 0.9% 100 ML + INSULIN REGULAR 100 UNIT
(1unit/ml)
>>NURSING: HIGH ALERT!!<< TARGET GLUCOSE RANGE 80-110 MG /DL ** STARTING MULT IPLIER 0.03

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/26 06:50	1	Start	antL	0 ML/HR	0 unit/hr	SMT5 04/26 06:50
04/28 12:31	1	End	antL	0 ML/HR	0 unit/hr	SACT 04/28 12:32
Wasted Amt: 100 ml						
04/28 12:32	3	Start	antL	0 ML/HR	0 unit/hr	SACT 04/28 12:32
05/01 11:15	3	End	antL	0 ML/HR	0 unit/hr	SPS1 05/01 11:15
Wasted Amt: 100 ml						

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
6	IV	Routine	04/26/11 06:57	04/26/11 07:00	04/27/11 11:30

Detail - Bottle Type: 0 Begin Vol: 1000 ML I/O Label: Lactated Ringers
LACTATED RINGERS 1000 ML
...CC PER CC REPLACEMENT OF WOUND VAC OUTPUT - Q4H UNTIL DISCONTINUED

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/26 12:32	1-0	Start	armR	0 ML/HR		LAA 04/26 12:33
04/26 13:28	1-0	End	armR	0 ML/HR		LAA 04/26 13:29
Wasted Amt: 1000 ml						

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
7	IV	Routine	04/27/11 11:32	04/27/11 13:00	04/29/11 12:59

Detail - Bottle Type: 1 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS = PERIPHERAL; UNTIL DISCONTINUED

Detail - Bottle Type: 2 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS = PERIPHERAL; UNTIL DISCONTINUED

Detail - Bottle Type: 3 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS = PERIPHERAL; UNTIL DISCONTINUED

CONTINUED

GOODWIN, DAVON
MUSC
IV Administration Report
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 03:07
OPT OUT:
Page: 3

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
7	IV	Routine	04/27/11 11:32	04/27/11 13:00	04/29/11 12:59

Detail - Bottle Type: 4 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS - PERIPHERAL; UNTIL DISCO NTINUED

Detail - Bottle Type: 5 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS - PERIPHERAL; UNTIL DISCO NTINUED

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/27 12:37	1	Start	flaL	125 ML/HR		BCAR 04/27 12:37
04/27 20:36	1	End	flaL	125 ML/HR		L&IM 04/27 20:36
Wasted Amt: 1000 ml						
04/27 20:36	2	Start	flaL	125 ML/HR		L&IM 04/27 20:36
04/28 04:56	2	End	flaL	125 ML/HR		TMW1 04/28 04:56
Wasted Amt: 1000 ml						
04/28 04:56	3	Start	flaL	125 ML/HR		TMW1 04/28 04:56
04/28 12:08	3	End	flaL	125 ML/HR		SACT 04/28 12:08
Wasted Amt: 1000 ml						
04/28 12:08	4	Start	flaL	125 ML/HR		SACT 04/28 12:08
04/28 18:57	4	End	flaL	125 ML/HR		SACT 04/28 18:58
Wasted Amt: 1000 ml						
04/28 18:58	5	Start	flaL	125 ML/HR		SACT 04/28 18:58
04/29 13:17	5	End	flaL	125 ML/HR		SACT 04/29 13:18
Wasted Amt: 1000 ml						

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
8	IV	Routine	04/29/11 20:27	04/29/11 21:00	04/30/11 07:14

Detail - Bottle Type: 1 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS = PERIPHERAL; UNTIL DISCO NTINUED

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/29 22:06	1	Start	fraL	125 ML/HR		JAC1 04/29 22:06
04/30 09:46	1	End	fraL	125 ML/HR		JLNO 04/30 09:46
Wasted Amt: 1000 ml						

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
9	IV	Routine	04/30/11 15:44	04/30/11 15:42	05/02/11 09:26

Detail - Bottle Type: 1 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS - PERIPHERAL; UNTIL DISCO NTINUED

Detail - Bottle Type: 2 Begin Vol: 1000 ML I/O Label: D5W/NaCl.45%+KCl
D5W-NACL 0.45% & KCl 20MEQ (PMX) 1000 ML
PREMIX-DO NOT ADD ANYTHING TO BAG CONTINUOUS INFUSIONS WITH ELECTRO- LYTE ADDITIVES MUST BE RENEWED EVERY 48 HOURS. IV ACCESS - PERIPHERAL; UNTIL DISCO NTINUED

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
05/01 08:43	2	Start	antL	100 ML/HR		SPS1 05/01 08:44
05/01 20:40	1	Start	antL	100 ML/HR		JAC1 05/01 20:40
05/01 20:40	2	End	antL	100 ML/HR		JAC1 05/01 20:40
Wasted Amt: 1000 ml						
05/03 10:58	1	Admin	antL	50 ML/HR		COS0 05/03 10:58

CONTINUED

Care Providers:
BCAR CARPENTER, BROOKE, RN
COSO SLUSARSKI, CORBY, RN
JAC1 COTTLE, JEAN A, RN
JLNO NORMAN, JILL L, RN
JLP PETERSON, JENNIFER L, RN
LAA ADAMS, LESLIE A, RN
LZIM ZIMMERMAN, LAURA, RN
SACT NIKEWICZ, SARAH A, RN
SMT5 MCGLYNN, STEPHANIE, RN
SPS1 SHEFTON, SENACA P, RN
TMN1 WOMACK, TASSI M, RN

JLP PETERSON, JENNIFER L, RN
LAA ADAMS, LESLIE A, RN
BCAR CARPENTER, BROOKE, RN
LZIM ZIMMERMAN, LAURA, RN
SMT5 MCGLYNN, STEPHANIE, RN
TMW1 WOMACK, TASSI M, RN

GOODWIN, DAVON
MUSC
Medication Administration Report
FROM: 04/26/11 03:18 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 03:06
OPT OUT:
Page: 1

* see end of page for Administration Note
■ see end of page for Not-Given reason
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	start/stop	ord	04/25/11 Day:1 11 15 19 23 03	04/26/11 Day:2 11 15 19 23 03	04/27/11 Day:3 11 15 19 23 03
SCHEDULED MEDICATIONS					
FAMOTIDINE					
0 MG PO				19:36 JLP *	
20 MG/1 TAB PO EVERY 12 HOURS	04/26 09:00 04/26 12:35	5		08:07 LAA	
FAMOTIDINE (PF)					
20 MG/2 ML INJ IV EVERY 12 HOURS	**04/26 21:00** **05/04 14:05**	8		22:03 JLP	20:36 LZIM
	M:DOSAGE FORM ALERT - FOR INJECTION FOR IV PUSH-DILUTE WITH 5 TO 10 ML SODIUM C; HLORIDE 0.9% PRIOR TO ADMINISTRATION				
OPHTHALMIC LUBRICANT (ARTIFICIAL TEARS)					
1 RIBBON OINT EYE_BOTH TWICE DAILY	**04/26 08:30** **04/29 17:30**	3		08:07 LAA	22:03 JLP 20:36 LZIM
Piperacillin-Tazobactam IN D5W (ZOSYN IN DEXTROSE (ISO-OSM))					
3.375 GM/50 ML INJ IV EVERY 6 HOURS	04/26 08:00 04/27 02:01	6		07:58 SMT5 14:21 LAA	19:36 JLP 02:33 JLP
	M:**PREMIX-DO NOT ADD ANYTHING TO BAG** **REFRIGERATE**				
PRN MEDICATIONS					
CALCIUM GLUCONATE 10%					
1000 MG/60 ML INJ IV ONCALL	**04/27 15:05** **04/29 17:30**	14			16:16 BCAR * 20:36 LZIM 05:47 TMW1
	I:DEXTROSE 5% IN WATER 50 ML; M:IF USED IN AN IV BOLUS THEN IS A **NURSING HIGH ALERT** FOLLOW ICU STANDARD C; ALCIUM REPLACEMENT PROTOCOL				
DEXTROSE 50% IN WATER INJ (DEXTROSE 50% IN WATER (D50W))					
25 GM/50 ML SYRG IV ONCALL	**04/26 05:32** **05/04 14:05**	7			
10 GM IV ONCALL	04/26 05:32 05/04 14:05	7		10:04 LAA	
	M:FOR HYPOGLYCEMIA IF FSBG IS LESS THAN 70 MG/DL: 15 ML (7.5 GRAMS) FOR BLOOD ; GLUCOSE 60 - 69 MG/DL. 20 ML (10 GRAMS) FOR BLOOD GLUCOSE 50 - 59 MG/DL. 25 M; L (12.5 GRAMS) FOR BLOOD GLUCOSE 30 - 49 MG/DL. 30 ML (15 GRAMS) FOR BLOOD ; GLUCOSE LESS TH				

FAMOTIDINE
04/26 19:36 JLP * RESULT MODIFIED: Admin/qty cleared.
FAMOTIDINE (PF)
04/27 15:13 BCAR ■ Pt off unit
OPHTHALMIC LUBRICANT (ARTIFICIAL TEARS)
04/27 12:33 BCAR ■ Pt off unit
CALCIUM GLUCONATE 10%
04/27 16:16 BCAR * ionized calcium 1.04-replacing per protod

ACTIVE ALLERGIES: NKA

CONTINUED

SACT NIREWICZ, SARAH A, RN
JAC1 COTTLE, JEAN A, RN
JLNO NORMAN, JILL L, RN
SSPU SPURR, SARAH, RN

GOODWIN, DAVON
MUSC
Medication Administration Report
FROM: 04/26/11 03:18 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
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Page: 2

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	start/stop	ord	04/28/11 Day:4 11 15 19 23 03	04/29/11 Day:5 11 15 19 23 03	04/30/11 Day:6 11 15 19 23 03
SCHEDULED MEDICATIONS					
ENOXAPARIN INJ (LOVENOX)					
30 MG/0.3 ML SYRG SC EVERY 12 HOURS	04/29 09:00 05/04 14:05	16		08:15 SACT * 21:10 JAC1 *	07:57 JLNO * 21:12 JAC1 *
FAMOTIDINE (PF)					
20 MG/2 ML INJ IV EVERY 12 HOURS	04/26 21:00 05/04 14:05	8	09:22 SACT 21:08 SSPU	08:15 SACT 21:10 JAC1	07:57 JLNO 21:12 JAC1
	M:DOSAGE FORM ALERT - FOR INJECTION FOR IV PUSH-DILUTE WITH 5 TO 10 ML SODIUM C; HLORIDE 0.9% PRIOR TO ADMINISTRATION				
OPHTHALMIC LUBRICANT (ARTIFICIAL TEARS)					
1 RIBBON OINT EYE_BOTH TWICE DAILY	04/26 08:30 04/29 17:30	3	08:00 SACT * ■		
Oxymetazoline 0.05% NASAL (Decongestant NASAL SPRAY)					
2 SPRAY SPRY NASL EVERY 12 HOURS	04/30 17:04 05/02 21:01	21			18:33 JLNO 21:12 JAC1
	M:congestion				
PROTEIN SUPPLEMENT (PRO-STAT 64)					
30 ML LIQ JT DAILY	04/30 08:30 05/04 14:05	17			14:16 JLNO
	M:**OBTAIN FROM DIETARY** TO ADMINISTER VIA ENTERAL TUBE: FLUSH TUBE WITH 30ML ; WATER. ADMINISTER 30ML DOSE WITH ORAL SYRINGE. FLUSH TUBE AFTER ADMINISTRAT; ION WITH 30ML WATER **DO NOT MIX WITH OTHER MEDS OR FORMULAS**				
PRN MEDICATIONS					
DEXTROSE 50% IN WATER INJ (DEXTROSE 50% IN WATER (D50W))					
25 GM/50 ML SYRG IV ONCALL	04/26 05:32 05/04 14:05	7			
7.5 GM IV ONCALL	04/26 05:32 05/04 14:05	7			13:32 JLNO *
	M:FOR HYPOGLYCEMIA IF FSBG IS LESS THAN 70 MG/DL: 15 ML (7.5 GRAMS) FOR BLOOD ; GLUCOSE 60 - 69 MG/DL. 20 ML (10 GRAMS) FOR BLOOD GLUCOSE 50 - 59 MG/DL. 25 M; L (12.5 GRAMS) FOR BLOOD GLUCOSE 30 - 49 MG/DL. 30 ML (15 GRAMS) FOR BLOOD ; GLUCOSE LESS TH				

ENOXAPARIN INJ (LOVENOX)
04/29 08:15 SACT * S:DELTOID R
04/29 21:10 JAC1 * S:LOWER ABD QUAD R
04/30 07:57 JLNO * S:LOWER ABD QUAD L
04/30 21:12 JAC1 * S:LOWER ABD QUAD R

OPHTHALMIC LUBRICANT (ARTIFICIAL TEARS)
04/28 21:08 SSPU ■ Clinical decision
04/29 08:15 SACT ■ Clinical decision * pt awake and blinking

DEXTROSE 50% IN WATER INJ (DEXTROSE 50% IN WATER (D50W))
04/30 13:32 JLNO * musc policy

ACTIVE ALLERGIES: NKA

CONTINUED

JLNO NORMAN, JILL L, RN
JLW1 WOLFE, JESSICA L, RN
GRW WADFORD, GAYLE R, RN
SACT NIREWICZ, SARAH A, RN
SSPU SPURR, SARAH, RN
JAC1 COTTLE, JEAN A, RN

GOODWIN, DAVON
MUSC
Medication Administration Report
FROM: 04/28/11 03:18 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
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REQUESTED:05/05/11 03:06
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	start/stop	ord	04/28/11 Day:4						04/29/11 Day:5						04/30/11 Day:6					
			11	15	19	23	03		11	15	19	23	03		11	15	19	23	03	
Hydromorphone																				
0.2-0.4 MG/0.1-0.2 ML IV EVERY 2 HOURS AS NEEDED	**04/30 11:07 05/03 12:25**	19																		
0.4 MG IV	04/30 11:07 05/03 12:25	19														11:23 JLNO			01:21 JLW1	
0.2 MG IV	04/30 11:07 05/03 12:25	19														14:36 JLNO				
	M:ALERT! THIS IS *NOT* MORPHINE! *FOR:BREAKTHROUGH PAIN																			
METOPROLOL TARTRATE																				
5 MG/5 ML INJ IV EVERY 4 HOURS AS NEEDED	**04/30 15:45 05/04 14:05**	20															16:27 JLNO			
	M:For SBP >170																			
Ondansetron (PF) (Ondansetron HCl (PF))																				
4 MG/2 ML INJ IV EVERY 6 HOURS AS NEEDED	**04/29 23:45 05/04 14:05**	18													09:06 JLNO		16:04 GRW			
	M: *FOR:NAUSEA AND VOMITING																			
OXYCODONE ORAL																				
5-10 MG/5-10 ML LIQ JT EVERY 4 HOURS AS NEEDED	**04/28 15:22 05/03 12:25**	15																		
10 MG JT	04/28 15:22 05/03 12:25	15			17:59 SACT	22:17 SSPU		06:49 SSPU	10:48 SACT		16:07 SACT	20:09 JAC1	00:05 JAC1	04:07 JAC1	07:57 JLNO	13:08 JLNO		19:04 JLNO		06:21 JAC1
	M:PLEASE DISPENSE ELIXIR FORM *FOR:MODERATE PAIN																			

ACTIVE ALLERGIES: NKA

CONTINUED

PERM

SPS1 SHEFTON, SENACA P, RN
JAC1 COTTLE, JEAN A, RN
MP04 PASCARELLA, MELISSA, RN
DLRO ROBERTS, DUSTI L, RN
COS0 SLUSARSKI, COREY, RN
TMM2 MARTUCCI, TIFFANY, RN
RPGOGOLUB, RACHEL P, RN

GOODWIN, DAVON
MUSC
Medication Administration Report
FROM: 04/26/11 03:18 TO: 05/04/11 16:07
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start/stop	ord	05/01/11 Day:7					05/02/11 Day:8					05/03/11 Day:9				
		11	15	19	23	03	11	15	19	23	03	11	15	19	23	03

SCHEDULED MEDICATIONS

ENOXAPARIN INJ (LOVENOX)

30 MG/0.3 ML SYRG SC EVERY 12 HOURS	**04/29 09:00 05/04 14:05**	16	08:22 SPS1 *			20:39 JAC1 *			08:24 MP04 *			19:59 DLRO *			08:40 COS0 *			21:15 TMM2		

FAMOTIDINE (PF)

20 MG/2 ML INJ IV EVERY 12 HOURS	**04/26 21:00 05/04 14:05**	8	08:22 SPS1			20:39 JAC1			08:24 MP04			19:59 DLRO			08:40 COS0			21:15 TMM2		
M:DOSAGE FORM ALERT - FOR INJECTION FOR IV PUSH-DILUTE WITH 5 TO 10 ML SODIUM C; HLORIDE 0.9% PRIOR TO ADMINISTRATION																					

INSULIN ASPART (NOVOLOG)

2-10 UNIT/0.02-0.1 ML SC EVERY 4 HOURS	**05/01 12:00 05/04 14:05**	22																			
0 UNIT SC	05/01 12:00 05/04 14:05	22			■			■	■	■			■	■ *	■		■ *	■ *	■	■	■
2 UNIT SC	05/01 12:00 05/04 14:05	22			16:52 SPS1 *	20:39 JAC1 *			12:11 MP04 *												
4 UNIT SC	05/01 12:00 05/04 14:05	22																			04:04 TMM2 *
M:>>NURSING: HIGH ALERT!!<< MEDIUM DOSE(TDDI 40-80 UNITS INSULIN/DAY)FSBG:141-1; 70 MG/DL=2 UNITS FSBG:171-220 MG/DL=4 UNITS FSBG:221-270 MG/DL=6 UNITS FSBG:; 271-320 MG/DL=8 UNITS FSBG>320 MG/DL=10 UNITS																					

ENOXAPARIN INJ (LOVENOX)
05/01 08:22 SPS1 * S:ARM R
05/01 20:39 JAC1 * S:LOWER ABD QUAD R
05/02 08:24 MP04 * S:LOWER ABD QUAD L
05/02 19:59 DLRO * S:LOWER ABD QUAD R
05/03 08:40 COS0 * S:UPPER ABD QUAD R

INSULIN ASPART (NOVOLOG)
05/01 11:57 SPS1 ■ No insulin required
05/01 23:30 JAC1 ■ No insulin required
05/02 04:24 JAC1 ■ No insulin required
05/02 08:16 MP04 ■ No insulin required
05/02 16:15 MP04 ■ No insulin required
05/02 19:07 MP04 ■ No insulin required
05/02 23:02 DLRO ■ No insulin required * 126
05/03 03:00 DLRO ■ No insulin required
05/03 07:53 COS0 ■ No insulin required
05/03 12:10 COS0 ■ No insulin required * fs138
05/03 15:50 COS0 ■ No insulin required * fs 125
05/03 21:14 TMM2 ■ No insulin required
05/04 01:06 RPGO ■ No insulin required
05/01 16:52 SPS1 * S:ARM R
05/01 20:39 JAC1 * S:ARM R
05/02 12:11 MP04 * S:ARM L
05/04 04:04 TMM2 * S:ARM R

ACTIVE ALLERGIES: NKA

CONTINUED

SPS1 SHEFTON, SENACA P, RN
JAC1 COTTLE, JEAN A, RN
MP04 PASCARELLA, MELISSA, RN
DLRO ROBERTS, DUSTI L, RN
COS0 SLUSARSKI, COREY, RN

GOODWIN, DAVON
MUSC
Medication Administration Report
FROM: 04/26/11 03:18 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
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DOB: [redacted] ID: 495654253 MR: 002657049
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Page: 5

* see end of page for Administration Note
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HOLD: DISCONTINUED

	start/stop	ord	05/01/11 Day:7					05/02/11 Day:8					05/03/11 Day:9				
			11	15	19	23	03	11	15	19	23	03	11	15	19	23	03
Oxymetazoline 0.05% NASAL (Decongestant NASAL SPRAY)																	
2 SPRAY SPRY NASL EVERY 12 HOURS	04/30 17:04 05/02 21:01	21	08:22 SPS1		20:39 JAC1			08:24 MP04		19:56 DLRO *							
	M:congestion																
PROTEIN SUPPLEMENT (PRO-STAT 64)																	
30 ML LIQ JT DAILY	**04/30 08:30** **05/04 14:05**	17		11:57 SPS1				10:33 MP04					08:40 COS0				
	M:**OBTAIN FROM DIETARY** TO ADMINISTER VIA ENTERAL TUBE: FLUSH TUBE WITH 30ML ; WATER. ADMINISTER 30ML DOSE WITH ORAL SYRINGE. FLUSH TUBE AFTER ADMINISTRAT; ION WITH 30ML WATER **DO NOT MIX WITH OTHER MEDS OR FORMULAS**																

PRN MEDICATIONS

Hydromorphone																	
0.2-0.4 MG/0.1-0.2 ML IV EVERY 2 HOURS AS NEEDED	04/30 11:07 05/03 12:25	19															
0.4 MG IV	04/30 11:07 05/03 12:25	19	07:02 JAC1		17:45 SPS1		x2	10:33 MP04		15:34 MP04	x2	x3	x2		11:04 COS0		
	M:ALERT! THIS IS *NOT* MORPHINE! *FOR:BREAKTHROUGH PAIN																
METOPROLOL TARTRATE																	
5 MG/5 ML INJ IV EVERY 4 HOURS AS NEEDED	**04/30 15:45** **05/04 14:05**	20		11:57 SPS1					14:14 MP04			23:02 DLRO		10:22 COS0		18:08 COS0	
	M:For SBP >170																
Ondansetron (PF) (Ondansetron HCl (PF))																	
4 MG/2 ML INJ IV EVERY 6 HOURS AS NEEDED	**04/29 23:45** **05/04 14:05**	18	07:02 JAC1		18:39 SPS1		23:53 JAC1	08:43 MP04									
	M: *FOR:NAUSEA AND VOMITING																
OXYCODONE ORAL																	
5-10 MG/5-10 ML LIQ JT EVERY 4 HOURS AS NEEDED	04/28 15:22 05/03 12:25	15															

Oxymetazoline 0.05% NASAL (Decongestant NASAL SPRAY)
05/02 19:59 DLRO * It is 2001. Within time frame for admin.

Hydromorphone
05/01 23:53 JAC1 *
05/02 02:03 JAC1 *
05/02 19:07 MP04 *
05/02 21:01 DLRO *
05/02 23:02 DLRO *
05/03 00:50 DLRO *
05/03 03:00 DLRO *
05/03 04:54 DLRO *
05/03 06:46 DLRO *

ACTIVE ALLERGIES: NKA

CONTINUED

SPS1 SHEFTON, SENACA P, RN
JAC1 COTTLE, JEAN A, RN
MP04 PASCARELLA, MELISSA, RN
DLRO ROBERTS, DUSTI L, RN
COS0 SLUSARSKI, COREY, RN
MEGSSTONE, MEGAN E, RN
RPGOGOLUB, RACHEL P, RN
TMM2 MARTUCCI, TIFFANY, RN

GOODWIN, DAVON
MUSC
Medication Administration Report
FROM: 04/28/11 03:18 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 03:06
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Page: 6

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	start/stop	ord	05/01/11 Day:7 11	15	19	23	03	05/02/11 Day:8 11	15	19	23	03	05/03/11 Day:9 11	15	19	23	03
(See Previous Page) OXYCODONE ORAL																	
10 MG JT	04/28 15:22 05/03 12:25	15		↵	15:21 SPS1		23:19 JAC1	04:24 JAC1	08:24 MP04	12:11 MP04	17:09 MP04	21:01 DLRO		04:54 DLRO	08:43 COS0					
5 MG JT	04/28 15:22 05/03 12:25	15											00:50 DLRO							
	M:PLEASE DISPENSE ELIXIR FORM *FOR:MODERATE PAIN																			
5-15 MG/5-15 ML LIQ JT EVERY 3 HOURS AS NEEDED	~~05/03 12:24~~ ~~05/04 14:05~~	27																		
15 MG JT	05/03 12:24 05/04 14:05	27													12:45 COS0	x2				
5 MG JT	05/03 12:24 05/04 14:05	27															22:06 MEGS	01:07 RPGO	04:04 TMM2	
10 MG JT	05/03 12:24 05/04 14:05	27																	06:44 TMM2	
	M:PLEASE DISPENSE ELIXIR FORM, ADMINISTER IN JT *FOR:PAIN																			

OXYCODONE ORAL
05/03 15:33 COS0 *
05/03 18:13 COS0 *

ACTIVE ALLERGIES: NKA

CONTINUED

MKWI WITTENMEYER, MARIANNE K, RN

GOODWIN, DAVON
MUSC
Medication Administration Report
FROM: 04/26/11 03:18 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 03:06
OPT OUT:
Page: 7

* see end of page for Administration Note
■ see end of page for Not-Given reason
HOLD: DISCONTINUED:

	start/stop	ord	05/04/11 Day:10 11 15 19 23 03

SCHEDULED MEDICATIONS

INSULIN ASPART (NOVOLOG)

2-10 UNIT/0.02-0.1 ML SC EVERY 4 HOURS	05/01 12:00 05/04 14:05	22	
0 UNIT SC	05/01 12:00 05/04 14:05	22	
M:>>NURSING: HIGH ALERT!!<< MEDIUM DOSE(TDDI 40-80 UNITS INSULIN/DAY)FSBG:141-1; 70 MG/DL=2 UNITS FSBG:171-220 MG/DL=4 UNITS FSBG:221-270 MG/DL=6 UNITS FSBG:; 271-320 MG/DL=8 UNITS FSBG>320 MG/DL=10 UNITS			

INSULIN ASPART (NOVOLOG)
05/04 08:17 MKWI ■ No insulin required

ACTIVE ALLERGIES: NKA

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:495654253 DOB: [redacted] M
GOODWIN
DAVON
Adm:04/26/11 M:2657049

"RESUSCITATE"

Cardiopulmonary Resuscitation Event Form

Form Origination Date: 9/07
Version: 1 Version Date: 9/07

Patient Name _____
MRN _____

PATIENT IDENTIFICATION LABEL

Date 5/4/11 Time 0827 Location 1070 Wt _____ kg 2-3333 called ☒ Yes ☐ No Time 0823 Primary team notified: ☒ Yes ☐ No Time @bedside
Witnessed ☒ Yes ☐ No Patient Conscious at Onset ☐ Yes ☒ No ☐ Unknown Monitors present at onset ☐ EKG ☒ SaO_2 ☐ Apnea ☐ None
Type of Event ☐ Respiratory ☒ Respiratory leading to Cardiopulmonary ☐ Cardiopulmonary Resuscitation event ended at 0845 (time)
Reason event ended: ☐ Return of circulation ☐ Return of ventilation ☐ DNR ☐ Unresponsive to ALS ☐ Family request/restrictions Outcome Status ☒ Death ☐ Alive, in same location ☐ Alive, transferred to _____
[Resuscitated from full cardiopulmonary arrest? Consider hypothermia]

Airway / Ventilation

Initial ☐ Spontaneous ☐ Apnea ☐ Agonal ☒ Assisted
Time of first assisted ventilation 0827
Ventilation type ☐ Mouth to Mouth ☐ Mouth / Mask ☐ BVM ☒ Ambu / ET
Existing Airway ☐ ETT ☐ Tracheotomy
Airway Inserted ☒ ETT ☐ LMA Other _____
ETT Intubation Time 0832 Size 7.0 @ 23cm
By whom Anesthesia
Secondary confirmation ☒ Auscultation ☒ End-tidal CO_2

Circulation

Initial rhythm PEA
Time chest compressions started 0825
Rhythm when chest compressions started PEA
Return of circulation time N/A
AED applied ☒ Yes ☐ No ☐ N/A Time, if applied _____
AED shock ☐ Advised ☐ Delivered
Pacemaker ☒ None ☐ Permanent ☐ Transcutaneous ☐ Epicardial ☐ Transvenous ☐ Transesophageal Settings: _____

Team Members

	Name (print)
Anesthesia	
MD Mayday Leader	Patrick Fillmore
Mayday team RN	Laura Johnson
Patient's nurse	Marianne Whitmore
Pharmacist	Stephanie Whitemeyer
Respiratory Therapist	Chris Larimore
Recorder	Amanda Payne

Time	Compressions performed	Ventilations performed	Pulse	Respirations	Blood pressure	O_2 saturation	Rhythm	Heart rate	Actions / Narrative All medication doses given IV, unless specified otherwise	Defibrillation / Cardioversion Joules	Epinephrine mg	Atropine mg	Vasopressin units	Amiodarone mg	Sodium Bicarb mEq	Calcium Chloride mg	Lidocaine mg		
0827	☒ Yes ☐ No	☒ Yes ☐ No					PEA												
0830	☒ Yes ☐ No	☒ Yes ☐ No					PEA		Intubated, cordis placed										
0831	☒ Yes ☐ No	☒ Yes ☐ No					PEA		labs drawn		X								
0833	☒ Yes ☐ No	☒ Yes ☐ No					PEA		NS running			X							
0835	☒ Yes ☐ No	☒ Yes ☐ No					PEA						40						
0837	☒ Yes ☐ No	☒ Yes ☐ No					PEA				X								
0840	☒ Yes ☐ No	☒ Yes ☐ No					PEA				X								
0845	☒ Yes ☐ No	☒ Yes ☐ No					PEA		code called, pt expired										
	☐ Yes ☐ No	☐ Yes ☐ No																	
	☐ Yes ☐ No	☐ Yes ☐ No																	
	☐ Yes ☐ No	☐ Yes ☐ No																	
	☐ Yes ☐ No	☐ Yes ☐ No																	
	☐ Yes ☐ No	☐ Yes ☐ No																	
	☐ Yes ☐ No	☐ Yes ☐ No																	
	☐ Yes ☐ No	☐ Yes ☐ No																	

Recorder signature Jana Johnson RN Date / time 5/4/11
Physician signature / Pager ID [redacted] 5139 Date / time 5-4 9am
Fax completed form to Risk Management at 2-5119
cprform

Page 1 of _____
OTE 900439 Rev. 9/07

Patient:GOODWIN,DAVON A MRN:725008 Encounter:495654253 Page 1 of 1

GOODWIN, DAVON
MUSC
Interdisciplinary Plan Of Care
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 1

FLOWSHEET	04/26			04/27	
Cardiovascular	06:59	17:05	23:12	15:35	17:05
Cardiovascular		initiated	met/ongoing		
HemodynStability		in progress	in progress		
EffectvHeartRyth		in progress	in progress		
O2 meets demands		in progress	in progress		
RegainHemostasis		in progress	in progress		
Avoids DVT		in progress	in progress		
NeedAchvWellness		understands dx	understands dx undTherapRegime need demo skills		
Perform assess		active	active		
Pt/family ed		cond specific	cond specific		
Monit clin data		active	active		
Monit lab data		active	active		
Comm findings		active	active		
Med admin		monit rx	as ordered monit rx		
AssessDrains/Dsg		patency drainage char	patency security drainage char		
Eval chest pain		active	active		
Circulation		evaluate	monitor evaluate		
Admin IV fluids		active	active		
Impl restriction		fluid diet	fluid diet		
Edema		eval riskFactors avoid sknBrkdwn	eval riskFactors avoid sknBrkdwn		
Bleeding		eval riskFactors prev/control bld	eval riskFactors prev/control bld		
Admin bld prod		active	active		
Clot formation		eval riskFactors prev clot form	eval riskFactors prev clot form		
Schedule care		promote rest conserve energy	promote rest conserve energy		
Comfort	06:59	17:05	23:12	15:35	17:05
Comfort		initiated	met/ongoing		
Health Care Prob		pain itching fever/chills sleep problems	pain		
Comfort Outcomes		safePainRelief control nausea control itching maint nrmltherm improved sleep understands dx undTherapRegime	safePainRelief		
CARE PROVIDERS		LAA	JLP		

ADAMS, LESLIE A(LAA)RN PETERSON, JENNIFER L(JLP)RN

CONTINUED

GOODWIN, DAVON
MUSC
Interdisciplinary Plan Of Care
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
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Page: 2

FLOWSHEET	04/26			04/27	
Comfort-Cont.	06:59	17:05	23:12	15:35	17:05
		need demo skills			
Assess pain lvl		regular intrvls	regular intrvls		
		useApproppScales	useApproppScales		
		useApproppDscrptr	useApproppDscrptr		
Med admin		as ordered	as ordered		
		monit advEffects	monit advEffects		
InitiateNonRxInt		active	active		
Ed pain plan		patient	patient		
		family	family		
Evaluate interv		effective	effective		
		appropriate	appropriate		
		document w/in1hr	document w/in1hr		
		change plan prn	change plan prn		
Coord svcs		pain management			
Disch Planning	06:59	17:05	23:12	15:35	17:06
Disch Planning		initiated	met/ongoing	met/ongoing	
Inadeq finances					active
Perform assess Care Manager				active &	
Contact Sworker					inadeq fiances psySoc assess &
04/27/11 15:35 Care Manager(FS): s/p GSW - postop - in ICU - will have post dc needs					
04/27/11 17:06 Contact Sworker(KDW0): Pt. is 19 yo s/p GSW; pt is self-pay; social worker to refer pt for MIAP completion.					
Func/Muscuoskel	06:59	17:05	23:12	15:35	17:06
Func/Muscuoskel		initiated	met/ongoing		
Health Care Prob		difficulty w/ADL	difficulty w/ADL		
		diff w/mobility	diff w/mobility		
Baseline/ImpMob		w/o contractures	w/o neurovascomp		
Tol active level		in progress	in progress		
Participates in		ADL	ADL		
		rehab POC	rehab POC		
Comm needs		in progress	in progress		
Tol adv PO diet		in progress	in progress		
Imp func ability		in progress	in progress		
Prog2NextLvlCare		in progress	in progress		
NeedAchvWellness		understands dx	understands dx		
		undTherapRegime	undTherapRegime		
		need demo skills	need demo skills		
Perform assess		active	active		
Pt/family ed		cond specific	cond specific		
Set rehab goals		active	active		
Use,ed pt/family		therap technique	therap technique		
		assist devices	assist devices		
CARE PROVIDERS		LAA	JLP	FS	KDW0

ADAMS, LESLIE A(LAA)RN GRAHAM, KESHA(KDW0)SOCIALWORK PETERSON, JENNIFER L(JLP)RN
SIMMONS, FLORENCE(FS)NCM

CONTINUED

GOODWIN, DAVON
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OPT OUT:
Page: 3

FLOWSHEET	04/26			04/27	
Func/Muscuoskel Cont.	06:59	17:05	23:12	15:35	17:06
Set comm method		active	active		
MD consults		physical therapy	physical therapy		
		Occup Therapy	Occup Therapy		
		Speech Pathology	Speech Pathology		
Provide ROM		active	active		
MaintSafeEnviron		active	active		
Impl aspir meas		active	active		
Gastrointestinal	06:59	17:05	23:12	15:35	17:06
Gastrointestinal		initiated	met/ongoing		
Regain GI func		in progress	in progress		
Resolve GI bld		in progress	in progress		
EffectvBowelElim		in progress	in progress		
Bowel continence		in progress	in progress		
Heal mucousMem		in progress	in progress		
Perform assess		active	active		
Pt/family ed		cond specific	cond specific		
Monit clin data		active	active		
Monit lab data		active	active		
Comm findings		medical staff	medical staff		
Med admin		as ordered	as ordered		
		monit rx	monit rx		
AssessDrains/Dsg		patency	patency		
		security	security		
		drainage char	drainage char		
Weigh daily		active	active		
Monit emesis bld		active	active		
Monit stool bld		active	active		
Admin IV flds		active	active		
Resp enteralFeed		active	active		
Environ for elim		promote comfort	promote comfort		
		independence	independence		
		privacy	privacy		
Promote max fld		active	active		
MucousMem lesion		oral hygiene			
Genitourinary	06:59	17:05	23:12	15:35	17:06
Genitourinary		initiated	met/ongoing		
Fld,lyte balance		in progress	in progress		
Regain renalFunc		in progress	in progress		
EffctvElimPattrn		in progress	in progress		
BladderContinenc		in progress	in progress		
NeedAchvWellness		understands dx	understands dx		
		undTherapRegime	undTherapRegime		
			need demo skills		
Perform assess		active	active		
Pt/family ed		cond specific	disease specific		
			cond specific		
Monit clin data		active	active		
CARE PROVIDERS		LAA	JLP		

ADAMS, LESLIE A(LAA)RN PETERSON, JENNIFER L(JLP)RN

CONTINUED

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Page: 4

FLOWSHEET	04/26			04/27	
Genitourinary Cont.	06:59	17:05	23:12	15:35	17:06
Monit lab data		active	active		
Comm findings		medical staff	medical staff		
Med admin		as ordered	as ordered		
		monit rx	monit rx		
Weigh daily		active	active		
Monit strict I&O		active	active		
Admin IV fids		active	active		
Impl fldRestrict		active	active		
Environ for elim		promote comfort	promote comfort		
		independence	independence		
		privacy	privacy		
AssessDrains/Dsg		security	patency		
		drainage char	security		
			drainage char		
Neuro/EENT	06:59	17:05	23:12	15:35	17:06
Neuro/EENT		initiated	met/ongoing		
Mgmt to prevent		brain injury			
		dysfunction			
Attain		optimal orient	optimal orient		
		increase memory	increase memory		
		decr confusion	decr confusion		
Prevent compl		neurovascCompron			
NeedAchvWellness		avoidsInjSensImp			
		understands dx			
		undTherapRegime			
		need demo skills			
Perform assess		active	active		
Pt/family ed		cond specific	cond specific		
NeuroEENT chgs		identify changes	identify changes		
		report findings	report findings		
Monit clin data		active	active		
Monit lab data		active	active		
Comm findings		active	active		
Med admin		as ordered	as ordered		
			monit rx		
AssessDrains/Dsg		patency	patency		
		security	security		
		drainage char	drainage char		
MeasMinimizeRisk		seizures	neuro compromise		
		neuro compromise			
ID/MaintPatterns		sleep			
		medication use			
		elimination			
		food intake			
		self care			
		daily routine			
CARE PROVIDERS		LAA	JLP		

ADAMS, LESLIE A(LAA)RN PETERSON, JENNIFER L(JLP)RN

CONTINUED

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OPT OUT:
Page: 5

FLOWSHEET	04/26			04/27	
Neuro/EENT-Cont.	06:59	17:05	23:12	15:35	17:06
Reorient using		repetition verbal cues visual cues memory aids	repetition verbal cues visual cues memory aids		
Use Adapt Equip		active			
Nutrition	06:59	17:05	23:12	15:35	17:06
Nutrition		initiated	met/ongoing		
Tol diet regime Bld glucose lvl NeedAchvWellness		in progress 80-110 undTherapRegime need demo skills	in progress 80-110 undTherapRegime need demo skills		
Monit clin & lab Ed pt/family Meas improve PO Adv diet as tol		weight pre-albumin leve blood glucose modified diet nutrition interv oral health active active	pre-albumin leve blood glucose modified diet nutrition interv oral health active active		
Admin PN or TF		active	active		
Psy/Spirit/Ed	06:59	17:05	23:12	15:35	17:06
PsySpiritEd Eval	initiated		met/ongoing		
Respiratory	06:59	17:05	23:12	15:35	17:06
Respiratory		initiated	met/ongoing		
Attain optimalO2 AttainOptimalCO2 Patency airway NeedAchvWellness		in progress in progress in progress understands dx need demo skills	in progress in progress in progress understands dx undTherapRegime need demo skills		
Perform assess Pt/family ed Monit clin data Monit lab data Comm findings Med admin Admin IV flds Monit integ CT AssessDrains/Dsg Admin O2 therapy Admin mech vent		active cond specific active active medical staff Resp Therapy as ordered monit rx active active patency security active active	active disease specific cond specific active active medical staff Resp Therapy as ordered monit rx active active patency security drainage char active active		
CARE PROVIDERS	GMH	LAA	JLP		

ADAMS, LESLIE A(LAA)RN HUGGINS, GERIG M(GMH)CHAPLAIN PETERSON, JENNIFER L(JLP)RN

CONTINUED

GOODWIN, DAVON
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OPT OUT:
Page: 6

FLOWSHEET	04/26			04/27	
Respiratory-Cont.	06:59	17:05	23:12	15:35	17:05
ArtificialAirway		placement patency security	placement patency security		
ManageSecretions		active	active		
Impl measures		pulmonary rehab	pulmonary rehab		
Encourage PO fld		resp musc func active	resp musc func active		
SmokeCess interv		active	active		
Safety	06:59	17:05	23:12	15:35	17:05
Safety		initiated met/ongoing not met resolved/dc'ed unable to assess	met/ongoing		
Avoid injury r/t		risk factors prior deficits	risk factors prior deficits		
Avoid infection		in progress	in progress		
NeedAchvWellness		understands dx undTherapRegime	understands dx undTherapRegime		
Restraint use		need demo skills avoid injury avoid discomfort	need demo skills avoid injury avoid discomfort		
Impl safetyPrec		aspiration fall risk limited mobility seizure bleeding	limited mobility bleeding		
Pt/family ed		active	active		
Monit lab data		active	active		
Comm findings		active	active		
Monit medTherapy		response therap medLevel	response therap medLevel		
Monit compl		dx interventions therap interv	dx interventions therap interv		
Monit s/s infect		active	active		
MinRisknoscomInf		active	active		
Approp isol prec		active	active		
Impl fallProtoc		active	active		
Ed r/t restraint		patient family	patient family		
MinRestraint use		active	active		
Notify family		patient consents restraint use	patient consents restraint use		
CARE PROVIDERS		LAA	JLP		

ADAMS, LESLIE A(LAA)RN PETERSON, JENNIFER L(JLP)RN

GOODWIN, DAVON
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ROOM: *1070-A* ADM: 04/26/11 03:18
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REQUESTED:05/05/11 00:06
OPT OUT:
Page: 7

FLOWSHEET	04/26			04/27	
Skin/Wound	06:59	17:05	23:12	15:35	17:06
Skin/Wound		initiated	met/ongoing		
Risk skBreakdwn Alt skinIntegrty		in progress incision wound	in progress wound		
Maint skin integ Prog healing of NeedAchvWellness		in progress incision wound understands dx undTherapRegime need demo skills	in progress wound understands dx undTherapRegime need demo skills		
SknBreakdownPrev Reduce/rel press ReduceFric/sheer ReduceRelSkMoist ReduceRel drySkn Encourage PO fld Pt/fam ed skin		active prev mode/bed heel protect/bed use pillows heels elevated heel boots prn ReposAtLeast q4h use cushion prev mode/bed heel protect/bed lowest degreeHOB elevate knees elevate foot/bed useDevicesMovePt use moistBarrier avoid diaper use use moistCream noMassageBonyPrn active prev breakdown tx breakdown	active prev mode/bed heel protect/bed use pillows heels elevated heel boots prn ReposAtLeast q4h use cushion prev mode/bed heel protect/bed lowest degreeHOB elevate knees elevate foot/bed useDevicesMovePt contain incont use moistBarrier avoid diaper use use moistCream noMassageBonyPrn active prev breakdown tx breakdown		
Alt skinIntegrty		assess size assess depth assess drainage assess woundBase assess periwound change dsgs consult woundRN other (specify)	assess size assess depth assess drainage assess woundBase assess periwound change dsgs		
Diabetes	06:59	17:05	23:12	15:35	17:06
Diabetes		initiated			
Attain HgbA1C<9% AttainBG>70&<200 MaintanBGonIVIIC ConstCarb inDiet CARE PROVIDERS		in progress in progress in progress in progress LAA	JLP		

ADAMS, LESLIE A(LAA)RN PETERSON, JENNIFER L(JLP)RN

CONTINUED

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OPT OUT:
Page: 8

FLOWSHEET	04/26			04/27	
Diabetes Cont	06:59	17:05	23:12	15:35	17:05
Understands		diagnosis			
		theraputcRegimns			
Verbliz/demnstrt		knowledg of diet			
		SurvivlLvlKnwldg			
		useOf insulnPump			
Support Resource		in progress			
EducationResourc		in progress			
MontrA1CasOrdrd		active			
MontrFSBGasOrdrd		active			
Adm InsPerPolicy		active			
OrdApropDiabDiet		active			
InitiatRDconsult		A1C>9%			
InitiatCDEconsIt		A1C>9%			
PerfrmDiabAssess		bld gluc monitor			
Use Pt/Fam Ed		active			
SafeUseOfInsPump		consult DMS/CDE			
		complete orders			
RefrDiabMgtWksht		active			
CARE PROVIDERS		LAA			

ADAMS, LESLIE A(LAA)RN

GOODWIN, DAVON
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Interdisciplinary Plan Of Care
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 09:00
OPT OUT:
Page: 9

FLOWSHEET	04/27		04/28		04/30
Cardiovascular	18:48	20:15	09:44	20:47	01:52
Cardiovascular	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
HemodynStability	in progress	in progress			
EffectvHeartRyth	in progress	in progress			in progress
O2 meets demands	in progress	in progress			in progress
RegainHemostasis	in progress	in progress			
Avoids DVT	in progress	in progress			in progress
NeedAchvWellness	understands dx undTherapRegime	understands dx undTherapRegime			understands dx undTherapRegime need demo skills
Perform assess	active	active			active
Pt/family ed					cond specific
Monit clin data	active	active			active
Monit lab data	active	active			active
Comm findings	active	active			active
Med admin	as ordered monit rx	as ordered monit rx			as ordered monit rx
AssessDrains/Dsg	patency security drainage char	patency security			patency security drainage char
Eval chest pain	active	active			active
Circulation	monitor evaluate	monitor evaluate			monitor evaluate
Admin IV fluids	active	active			active
Impl restriction	fluid diet				fluid diet
Edema	eval riskFactors avoid sknBrkdwn	eval riskFactors avoid sknBrkdwn			eval riskFactors avoid sknBrkdwn
Bleeding	eval riskFactors prev/control bld	eval riskFactors prev/control bld			
Admin bld prod	active	active			active
Clot formation	eval riskFactors prev clot form	eval riskFactors prev clot form			eval riskFactors prev clot form
Schedule care	promote rest conserve energy				
Comfort	18:48	20:15	09:44	20:47	01:52
Comfort	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Health Care Prob	pain	pain			pain
Comfort Outcomes	safePainRelief	safePainRelief			safePainRelief understands dx undTherapRegime
Assess pain lvl	regular intrvls useApproppScales useApproppDscrptr	regular intrvls useApproppScales			regular intrvls useApproppScales useApproppDscrptr
Med admin	as ordered monit advEffects	as ordered monit advEffects			as ordered monit advEffects
InitiateNonRxInt	active	active			active
CARE PROVIDERS	BCAR	TMW1	SACT	SSPU	JAC1

CARPENTER, BROOKE(BCAR)RN
COTTLE, JEAN A(JAC1)RN
NIREWICZ, SARAH A(SACT)RN
SPURR, SARAH(SSPU)RN
WOMACK, TASSI M(TMW1)RN

CONTINUED

GOODWIN, DAVON
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OPT OUT:
Page: 10

FLOWSHEET	04/27		04/28		04/30
Comfort-Cont.	18:48	20:15	09:44	20:47	01:52
Ed pain plan Evaluate interv	patient family effective appropriate document w/in1hr change plan prn	patient family effective appropriate document w/in1hr			patient family effective appropriate document w/in1hr
Disch Planning	18:48	20:15	09:44	20:47	01:52
Disch Planning	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Inadeq finances	active	active			
Perform assess Care Manager	active	active complex d/c need			active
Contact Sworker	inadeq fiances				
Func/Muscuoskel	18:48	20:15	09:44	20:47	01:52
Func/Muscuoskel	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Health Care Prob	difficulty w/ADL diff w/mobility	difficulty w/ADL diff w/mobility			difficulty w/ADL diff w/mobility
Baseline/ImpMob Tol active level Participates in Comm needs Tol adv PO diet Imp func ability Prog2NextLvlCare NeedAchvWellness	w/o contractures w/o neurovascomp in progress ADL rehab POC in progress in progress in progress in progress understands dx undTherapRegime	w/o contractures w/o neurovascomp in progress ADL rehab POC in progress in progress in progress in progress understands dx undTherapRegime			 in progress ADL rehab POC in progress in progress in progress in progress understands dx undTherapRegime need demo skills
Perform assess Pt/family ed Set rehab goals Use,ed pt/family Set comm method MD consults Provide ROM MaintSafeEnviron	active cond specific active therap technique assist devices active physical therapy Speech Pathology & active active	active cond specific active therap technique active physical therapy active active			active cond specific active therap technique assist devices active physical therapy active active
Impl aspir meas	active	active			active

04/27/11 18:48 MD consults(BCAR): when extubated

CARE PROVIDERS	BCAR	TMW1	SACT	SSPU	JAC1

CARPENTER, BROOKE(BCAR)RN
COTTLE, JEAN A(JAC1)RN
NIREWICZ, SARAH A(SACT)RN
SPURR, SARAH(SSPU)RN
WOMACK, TASSI M(TMW1)RN

FLOWSHEET	04/27		04/28		04/30
Gastrointestinal	18:48	20:15	09:44	20:47	01:52
Gastrointestinal	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Regain GI func	in progress	in progress			in progress
Resolve GI bld	in progress				
EffectvBowelElim	in progress	in progress			in progress
Bowel continence	in progress	in progress			in progress
Heal mucousMem	in progress				
Perform assess	active	active			active
Pt/family ed	cond specific	cond specific			cond specific
Monit clin data	active	active			active
Monit lab data	active	active			active
Comm findings	medical staff	medical staff			medical staff
Med admin	as ordered	as ordered			as ordered
	monit rx	monit rx			monit rx
AssessDrains/Dsg	patency	patency			patency
	security	security			security
	drainage char	drainage char			drainage char
Weigh daily	active	active			active
Monit emesis bld	active	active			active
Monit stool bld	active	active			active
Admin IV flds	active	active			active
Resp enteralFeed	active	active			active
Environ for elim	promote comfort				promote comfort
	independence				independence
	privacy				privacy
Promote max fld	active	active			active
Genitourinary	18:48	20:15	09:44	20:47	01:52
Genitourinary	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Fld,lyte balance	in progress	in progress			
Regain renalFunc	in progress	in progress			
EffctvElimPattrn	in progress	in progress			in progress
BladderContinenc	in progress	in progress			in progress
NeedAchvWellness	understands dx	understands dx			understands dx
	undTherapRegime	undTherapRegime			undTherapRegime
					need demo skills
Perform assess	active	active			active
Pt/family ed	disease specific	disease specific			cond specific
	cond specific	cond specific			
Monit clin data	active	active			active
Monit lab data	active	active			active
Comm findings	medical staff	medical staff			medical staff
	Resp Therapy				
Med admin	as ordered	as ordered			as ordered
	monit rx	monit rx			monit rx
Weigh daily	active	active			
Monit strict I&O	active	active			active
Admin IV flds	active	active			active
Impl fldRestrict	active	active			
CARE PROVIDERS	BCAR	TMW1	SACT	SSPU	JAC1

CARPENTER, BROOKE(BCAR)RN COTTLE, JEAN A(JAC1)RN NIREWICZ, SARAH A(SACT)RN
SPURR, SARAH(SSPU)RN WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27		04/28		04/30
Genitourinary:Cont.	18:48	20:15	09:44	20:47	01:52
Environ for elim	promote comfort independence privacy	promote comfort			promote comfort independence privacy
AssessDrains/Dsg	patency security drainage char	patency security			patency security drainage char
Neuro/EENT	18:48	20:15	09:44	20:47	01:52
Neuro/EENT	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Attain	optimal orient increase memory decr confusion	optimal orient			optimal orient
Perform assess	active	active			active
Pt/family ed	cond specific	cond specific			cond specific
NeuroEENT chgs	identify changes report findings	identify changes report findings			identify changes report findings
Monit clin data	active	active			active
Monit lab data	active	active			active
Comm findings	active	active			active
Med admin	as ordered monit rx	as ordered monit rx			as ordered monit rx
AssessDrains/Dsg	patency security drainage char				
MeasMinimizeRisk	neuro compromise				
Reorient using	repetition verbal cues visual cues	repetition verbal cues visual cues			
Nutrition	18:48	20:15	09:44	20:47	01:52
Nutrition	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Tol diet regime	in progress	in progress			in progress
Bld glucose lvl	80-110	80-110			80-110
NeedAchvWellness	undTherapRegime need demo skills	undTherapRegime			
Monit clin & lab	pre-albumin leve blood glucose	pre-albumin leve blood glucose			
Ed pt/family	nutrition interv oral health				
Meas improve PO	active	active			
Adv diet as tol	active				
Admin PN or TF	active				
Psy/Spirit/Ed	18:48	20:15	09:44	20:47	01:52
PsySpiritEd Eval	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
CARE PROVIDERS	BCAR	TMW1	SACT	SSPU	JAC1

CARPENTER, BROOKE(BCAR)RN COTTLE, JEAN A(JAC1)RN NIREWICZ, SARAH A(SACT)RN
SPURR, SARAH(SSPU)RN WOMACK, TASSI M(TMW1)RN

GOODWIN, DAVON
MUSC
Interdisciplinary Plan Of Care
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 13

FLOWSHEET	04/27		04/28		04/30
Respiratory	18:48	20:15	09:44	20:47	01:52
Respiratory	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Attain optimalO2	in progress	in progress		in progress	in progress
AttainOptimalCO2	in progress	in progress		in progress	
Patency airway	in progress	in progress		in progress	in progress
NeedAchvWellness	understands dx	understands dx		understands dx	understands dx
	undTherapRegime	undTherapRegime		undTherapRegime	undTherapRegime
					need demo skills
Perform assess	active	active		active	active
Pt/family ed	disease specific	disease specific		cond specific	cond specific
	cond specific	cond specific			
Monit clin data	active	active		active	active
Monit lab data	active	active		active	active
Comm findings	medical staff	medical staff		medical staff	medical staff
	Resp Therapy	Resp Therapy		Resp Therapy	
Med admin	as ordered				as ordered
	monit rx				monit rx
Admin IV fids	active	active		active	active
Monit integ CT	active	active			
AssessDrains/Dsg	patency	patency			patency
	security	security			security
	drainage char				drainage char
Admin O2 therapy	active	active		active	active
Admin mech vent	active	active			active
ArtificialAirway	placement	placement			
	patency	patency			
	security				
ManageSecretions	active	active		active	
Impl measures	pulmonary rehab			pulmonary rehab	
	resp musc func			resp musc func	
Encourage PO fld	active				
SmokeCess interv	active				
Safety	18:48	20:15	09:44	20:47	01:52
Safety	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Avoid injury r/t	risk factors	risk factors			
	prior deficits	prior deficits			
Avoid infection	in progress	in progress			
NeedAchvWeliness	understands dx	understands dx			
	undTherapRegime	undTherapRegime			
Restraint use	avoid injury	avoid injury			
	avoid discomfort	avoid discomfort			
Impl safetyPrec	bleeding	bleeding			
Pt/family ed	active	active			
Monit lab data	active	active			
Comm findings	active	active			
Monit medTherapy	response	response			
	therap medLevel	therap medLevel			
CARE PROVIDERS	BCAR	TMW1	SACT	SSPU	JAC1

CARPENTER, BROOKE(BCAR)RN COTTLE, JEAN A(JAC1)RN NIREWICZ, SARAH A(SACT)RN
SPURR, SARAH(SSPU)RN WOMACK, TASSI M(TMW1)RN

CONTINUED

GOODWIN, DAVON
MUSC
Interdisciplinary Plan Of Care
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 14

FLOWSHEET	04/27		04/28		04/30
Safety Cont.	16:48	20:15	09:44	20:47	01:52
Monit compl	dx interventions therap interv	dx interventions therap interv			
Monit s/s infect	active	active			
MinRisknoscomInf	active	active			
Approp isol prec	active	active			
Impl fallProtoc	active	active			
Ed r/t restraint	patient family	patient family			
MinRestraint use	active	active			
Notify family	patient consents restraint use	patient consents restraint use			
Skin/Wound	16:48	20:15	09:44	20:47	01:52
Skin/Wound	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Risk skBreakdwn	in progress	in progress		in progress	
Alt skinIntegrty	wound	wound		incision	
Maint skin integ	in progress	in progress		in progress	
Prog healing of	wound	wound		incision	
NeedAchvWellness	understands dx undTherapRegime	understands dx undTherapRegime		understands dx undTherapRegime	
SknBreakdownPrev	active	active		active	
Reduce/rel press	prev mode/bed use pillows	prev mode/bed use pillows		prev mode/bed ReposAtLeast q4h	
ReduceFric/sheer	prev mode/bed	prev mode/bed		prev mode/bed elevate knees	
ReduceRelSkMoist	contain incont use moistBarrier	contain incont use moistBarrier		contain incont use moistBarrier	
ReduceRel drySkn	use moistCream	use moistCream		use moistCream	
Encourage PO fld	active	active		active	
Pt/fam ed skin	prev breakdown tx breakdown	prev breakdown tx breakdown		prev breakdown tx breakdown	
Alt skinIntegrty	change dsgs				
Diabetes	16:48	20:15	09:44	20:47	01:52
Diabetes	met/ongoing	met/ongoing	met/ongoing	met/ongoing	met/ongoing
Attain HgbA1C<8%	in progress	in progress			in progress
AttainBG>70&<200	in progress	in progress			in progress
MaintanBGonIVIIC	in progress	in progress			in progress
ConstCarb inDiet	in progress	in progress			
Understands	diagnosis theraputcRegimns				
Support Resource	in progress	in progress			in progress
EducationResourc	in progress	in progress			in progress
MontrA1CasOrdrd	active	active			active
MontrFSBGasOrdrd	active	active			active
Adm InsPerPolicy	active	active			active
OrdApropDiabDiet	active				
CARE PROVIDERS	BCAR	TMW1	SACT	SSPU	JAC1

CARPENTER, BROOKE(BCAR)RN COTTLE, JEAN A(JAC1)RN NIREWICZ, SARAH A(SACT)RN
SPURR, SARAH(SSPU)RN WOMACK, TASSI M(TMW1)RN

CONTINUED

GOODWIN, DAVON
MUSC
Interdisciplinary Plan Of Care
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 15

FLOWSHEET	04/27		04/28		04/30
Diabetes Cont.	18:48	20:15	09:44	20:47	01:52
Use Pt/Fam Ed	active				
RefrDiabMgtWksht	active				
CARE PROVIDERS	BCAR				

CARPENTER, BROOKE(BCAR)RN

GOODWIN, DAVON
MUSC
Interdisciplinary Plan Of Care
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 16

FLOWSHEET	04/30			05/01	
Cardiovascular	07:57	13:56	23:24	08:22	20:16
Cardiovascular	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Comfort	07:57	13:56	23:24	08:22	20:16
Comfort	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Disch Planning	07:57	13:56	23:24	08:22	20:16
Disch Planning	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Func/Muscuoskel	07:57	13:56	23:24	08:22	20:16
Func/Muscuoskel	met/ongoing	initiated &	met/ongoing	met/ongoing	met/ongoing
04/30/11 13:56 Func/Muscuoskel(SLC): eval complete, working on bed mobility and sit to stand transfers, limited by pain					
Gastrointestinal	07:57	13:56	23:24	08:22	20:16
Gastrointestinal	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Genitourinary	07:57	13:56	23:24	08:22	20:16
Genitourinary	met/ongoing		resolved/dc'ed		
Neuro/EENT	07:57	13:56	23:24	08:22	20:16
Neuro/EENT	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Nutrition	07:57	13:56	23:24	08:22	20:16
Nutrition	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Psy/Spirit/Ed	07:57	13:56	23:24	08:22	20:16
PsySpiritEd Eval	met/ongoing		met/ongoing	met/ongoing	resolved/dc'ed
Respiratory	07:57	13:56	23:24	08:22	20:16
Respiratory	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Safety	07:57	13:56	23:24	08:22	20:16
Safety	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Impl fallProtoc	active				
Skin/Wound	07:57	13:56	23:24	08:22	20:16
Skin/Wound	met/ongoing		met/ongoing	met/ongoing	met/ongoing
Diabetes	07:57	13:56	23:24	08:22	20:16
Diabetes	met/ongoing		met/ongoing	met/ongoing	met/ongoing
CARE PROVIDERS	JLNO	SLC	JAC1	SPS1	JAC1

CLAYTON, SHELLEY L(SLC)PT COTTLE, JEAN A(JAC1)RN NORMAN, JILL L(JLNO)RN
SHEFTON, SENACA P(SPS1)RN

CONTINUED

GOODWIN, DAVON
MUSC
Interdisciplinary Plan Of Care
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 17

FLOWSHEET	05/02		05/03
Cardiovascular	15:56	23:36	09:40
Cardiovascular	met/ongoing	met/ongoing	met/ongoing
Comfort	15:56	23:36	09:40
Comfort	met/ongoing	met/ongoing	met/ongoing
Disch Planning	15:56	23:36	09:40
Disch Planning	met/ongoing	met/ongoing	met/ongoing
Perform assess			active
Func/Muscuoskel	15:56	23:36	09:40
Func/Muscuoskel	met/ongoing	met/ongoing	met/ongoing
MaintSafeEnviron			active
Gastrointestinal	15:56	23:36	09:40
Gastrointestinal	met/ongoing	met/ongoing	met/ongoing
Neuro/EENT	15:56	23:36	09:40
Neuro/EENT	not met		met/ongoing
Nutrition	15:56	23:36	09:40
Nutrition	met/ongoing	met/ongoing	met/ongoing
Psy/Spirit/Ed	15:56	23:36	09:40
PsySpiritEd Eval	initiated		met/ongoing
Respiratory	15:56	23:36	09:40
Respiratory	met/ongoing	met/ongoing	met/ongoing
Safety	15:56	23:36	09:40
Safety	met/ongoing	met/ongoing	met/ongoing
Skin/Wound	15:56	23:36	09:40
Skin/Wound	met/ongoing	met/ongoing	met/ongoing
Diabetes	15:56	23:36	09:40
Diabetes	resolved/dc'ed		met/ongoing
CARE PROVIDERS	MP04	DLRO	COS0

PASCARELLA, MELISSA(MP04)RN ROBERTS, DUSTI L(DLRO)RN SLUSARSKI, COREY(COS0)RN

LAST PAGE

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 09:06
OPT OUT:
Page: 1

FLOWSHEET	04/26				
Neuro/EENT	05:25	05:30	06:05	06:10	06:30
Reflexes present	present				
Abs of drainage	WNL				
Norm closure Abs of swelling PERLA	WNL WNL	 WNL			
Patent nares No bleed/disch		WNL WNL			
ImplNeuroEENTPOC	done	done			
GCS eyes open GCS best verbal Best upper motor GCS total score	1=closed/swelling 1=tube/trach 4=flex/withdraw 6	1=no response 1=tube/trach 4=flex/withdraw 6			
Lvl of conscious Behavior/neuro Disoriented	sedated	sedated calm unable to assess			
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE		4=withdraws pain 4=withdraws pain 4=withdraws pain 4=withdraws pain			
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE		2=gravity elimin 2=gravity elimin 2=gravity elimin 2=gravity elimin			
Both pupilsShape Both pupilsReact Both pupils size		round brisk 3mm			
Cardiovascular	05:25	05:30	06:05	06:10	06:30
Norm sinusRhythm Rate approp/age S1S2 PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Alarms on	WNL on	WNL WNL WNL WNL WNL for race WNL on			
Implement CV POC		done			
Rhythm		NSR			
GeneralizedEdema AllPulsesPresent		+2 present			
Respiratory	05:25	05:30	06:05	06:10	06:30
Spont respers NonLaboredEffort No cough,dyspnea Suction function		WNL WNL WNL yes			
CARE PROVIDERS	MEAS	SMTS			

ASKEA, MEAGHAN E(MEAS)RN MCGLYNN, STEPHANIE(SMTS)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 2

FLOWSHEET	04/26				
Respiratory Cont.	05:25	05:30	06:05	06:10	06:30
Ambu bag/mask		present			
Implmnt Resp POC		done			
BS all lobes		rhonchi			
ETT size		7.5			
Placement @ lip		24cm			
Vent mode		PRVC			
Rate		18bpm			
FiO2		40%			
TV		500mL			
PEEP		5cm			
Oral suction		done			
Oral secretions		bloody			
Oral-consistency		thick			
ETT suction		done			
ETT secretions		&			
04/26/11 05:30 ETT secretions(SMT5): none					
Gastrointestinal	05:25	05:30	06:05	06:10	06:30
Normal dentition		WNL			
Last BM		prior to admit			
Implement GI POC		done			
BowelSndsAllQuad		absent			
Abdomen		&			
NGT location		right nare			
NGT suction		low continuous			
NGT drainage		coffee ground			
NGT interv		placement check			
04/26/11 05:30 Abdomen(SMT5): open abdomen; S/P repair following gunshot wound; See Progress notes					
Genitourinary	05:25	05:30	06:05	06:10	06:30
Adequate UOP		WNL			
ClearYellowUrine		WNL			
NoChgPattrn/Char		WNL			
NoAbn penile bld		WNL			
NoAbnPenileDisch		WNL			
Implement GU POC		done			
Catheter		foley			
Catheter size		16 FR			
DateCathInserted		04/26/2011			
CathInsertedPTA		yes			
Func/Musculoskel	05:25	05:30	06:05	06:10	06:30
Impl FuncMuscPOC		done			
Weakness		generalized			
SCD site		leg L			
		leg R			
SCD type		short leg			
CARE PROVIDERS		SMT5			

MCGLYNN, STEPHANIE(SMT5)RN

CONTINUED

FLOWSHEET	04/26				
Func/Musculoskel-Cont.	05:25	05:30	06:05	06:10	06:30
SCD assess		on operational			
Speech		unable verbalize			
Skin	05:25	05:30	06:05	06:10	06:30
Skin warm Skin dry& intact Color approp		WNL WNL to ethnicity			
Impl Skn/Wnd POC		done			
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree		2=very limited 3=occasnly moist 1=bedfast 2=very limited 2=prob adequate 2=poten.problm 12 score < 17 score1or2 in any			
Other equipment		positioningWedge			
Comfort	05:25	05:30	06:05	06:10	06:30
No c/o,no s/s of		chills fever itching nausea prob sleeping spasms sweating vomiting			
Impl Comfort POC		done			
Abnorm findings		pain			
Pain score		3 Wong-Baker(face)			
Pt relief goal		0-2			
Pain onset		ongoing			
Pain description		unable to descr			
Pain site(s)		unable to descr			
Comfort interv		cont infusion			
Observ/Treatmnts	05:25	05:30	06:05	06:10	06:30
Alarms on		done			
Bath		done			
Mouth care		done			
Linen change		done			
Turn		back			
Side rails up		x3			
CARE PROVIDERS		SMT5			

MCGLYNN, STEPHANIE(SMT5)RN

CONTINUED

FLOWSHEET	04/26				
Observ/Treatmnts-Cont.	05:25	05:30	06:05	06:10	06:30
Passive ROM		done			
HOB > 30 deg		done			
Assess reviewed		done			
Nutrition	05:25	05:30	06:05	06:10	06:30
Meal type		NPO			
Vascular Access	05:25	05:30	06:05	06:10	06:30
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions		forearm R 04/26/2011 #16 secure dry and intact flushed(see MAR) meds (see MAR)			
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions		wrist L 04/26/2011 #18 secure dry and intact flushed(see MAR) meds (see MAR)			
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions		antecubital L 04/26/2011 #16 secure dry and intact flushed(see MAR) meds (see MAR)			
Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zeroed		radial R 04/26/2011 secure dry and intact crisp done			
Safety	05:25	05:30	06:05	06:10	06:30
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on Bed press relief IV sol verified IV tbg/bag dated High alertMedsID		on done done done done on done done done			
Imple SafetyPOC		done			
AspirationRisk AspPrecautnMntn CARE PROVIDERS		yes done SMT5			

MCGLYNN, STEPHANIE(SMT5)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 03:00
OPT OUT:
Page: 5

FLOWSHEET	04/26				
Safety Cont.	05:25	05:30	06:05	06:10	06:30
InfectionHiRisk		other (specify) &			
04/26/11 05:30 InfectionHiRisk(SMT5): PIVs, Catheter, Vent, Open abdomen					
Morse Fall Risk	05:25	05:30	06:05	06:10	06:30
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score		no=0 yes=15 None Bedrest=0 yes=20 Norm BR w/c=0 OvrestFrgtLmt=15 50			
Imple Safety POC		done			
Intact Incision	05:25	05:30	06:05	06:10	06:30
Incision#1 site Incision#1 type Drain Incision#1 drAmt Incis#1 drainage Surrounding skin Dsg chg sched		abdomen other (specify) & other (specify) & moderate sanguinous intact &			
Incision#1 dsg		other (specify) &			
04/26/11 05:30 Incision#1 type(SMT5): open abdomen; S/P repair following gunshot wound					
04/26/11 05:30 Drain(SMT5): vac pack to wall suction					
04/26/11 05:30 Dsg chg sched(SMT5): per MDs only					
04/26/11 05:30 Incision#1 dsg(SMT5): loband; VacPack					
Diab Flowsheet	05:25	05:30	06:05	06:10	06:30
Insulin multiplr			.03		
Misc Events	05:25	05:30	06:05	06:10	06:30
Misc events	&	&		&	&
04/26/11 05:25 Misc events(MEAS): Pt admitted from OR, placed on central monitor, MD at bedside, fluid bolus infusing for low BP.					
04/26/11 05:30 Misc events(SMT5): Complete assessment done; Hypotensive, otherwise VSS; Dr.Leon present at bedside and stated "Lets just give him as much fluid as he needs"; Three LR boluses infusing wide open; See vitals flowsheet; Labs sent and results pending					
04/26/11 06:10 Misc events(SMT5): AM labs reviewed; INR=2.27; MDs notified and orders to follow; Otherwise no critical or significant lab values to report					
04/26/11 06:30 Misc events(SMT5): Pt. mother and stepfather brought to bedside by chaplain; Instructions to ICU given, explanation of equipement given; Family very tearful and instructed when they were ready to ask questions, Pt. placed under a confidential name of "Brown"					
CARE PROVIDERS	MEAS	SMT5	SMT5	SMT5	SMT5

ASKEA, MEAGHAN E(MEAS)RN MCGLYNN, STEPHANIE(SMT5)RN

CONTINUED

FLOWSHEET	04/26				
Chart Review	06:45	06:50	07:00	07:05	07:15
Chart check q12h					done
Neuro/EENT	06:45	06:50	07:00	07:05	07:15
Reflexes present					
Abs of drainage					
Norm closure Abs of swelling PERLA					
Patent nares No bleed/disch					
ImplNeuroEENTPOC					
GCS eyes open GCS best verbal Best upper motor GCS total score					
Lvl of conscious Behavior/neuro Disoriented					
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE					
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE					
Both pupilsShape Both pupilsReact Both pupils size					
Cardiovascular	06:45	06:50	07:00	07:05	07:15
Norm sinusRhythm Rate approp/age S1S2 PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Alarms on					
Implement CV POC					
Rhythm					
GeneralizedEdema AllPulsesPresent					
CARE PROVIDERS					SMT5, {LAA}

ADAMS, LESLIE A(LAA)RN MCGLYNN, STEPHANIE(SMT5)RN

FLOWSHEET	04/26				
Respiratory	06:45	06:50	07:00	07:05	07:15
NonLaboredEffort Suction function					
Ambu bag/mask					
Implmnt Resp POC					
BS all lobes ETT size Placement @ lip Vent mode Rate FiO2 TV PEEP Oral suction Oral secretions Oral-consistency ETT suction ETT secretions					
Gastrointestinal	06:45	06:50	07:00	07:05	07:15
Normal dentition Last BM					
BowelSndsAllQuad Abdomen NGT location NGT suction NGT drainage NGT interv					
Genitourinary	06:45	06:50	07:00	07:05	07:15
Adequate UOP ClearYellowUrine NoChgPattrn/Char NoAbn penile bld NoAbnPenileDisch					
Implement GU POC					
Catheter Catheter size DateCathInserted					
CathInsertedPTA					
Func/Musculoskel	06:45	06:50	07:00	07:05	07:15
Impl FuncMuscPOC					
Weakness					
SCD site SCD type SCD assess					
Speech					

CONTINUED

FLOWSHEET	04/26				
Skin	06:45	06:50	07:00	07:05	07:15
Skin warm Skin dry& intact Color approp					
Impl Skn/Wnd POC					
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if					
Other equipment					
Comfort	06:45	06:50	07:00	07:05	07:15
No c/o,no s/s of					
Impl Comfort POC					
Abnorm findings					
Pain score					
Comfort interv					
Observ/Treatmnts	06:45	06:50	07:00	07:05	07:15
Alarms on					
Bath					
Mouth care					
Linen change					
Turn					
Side rails up					
Passive ROM					
HOB > 30 deg					
Assess reviewed					
Nutrition	06:45	06:50	07:00	07:05	07:15
Meal type					
Vascular Access	06:45	06:50	07:00	07:05	07:15
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions					
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions					
Site#3 location					

CONTINUED

FLOWSHEET	04/26				
Vascular Access Cont.	06:45	06:50	07:00	07:05	07:15
Insertion date Gauge ' Site#3 appear Site#3 dressing Interventions					
Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zeroed					
Morse Fall Risk	06:45	06:50	07:00	07:05	07:15
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score					
Imple Safety POC					
Intact Incision	06:45	06:50	07:00	07:05	07:15
Incision#1 site Incision#1 type Drain Incision#1 drAmt Incis#1 drainage Surrounding skin					
Diab Flowsheet	06:45	06:50	07:00	07:05	07:15
Insulin mulriplr			0.04		
Misc Events	06:45	06:50	07:00	07:05	07:15
Misc events	&	&		&	
Report					(modified) &

04/26/11 06:45 Misc events(SMT5): Dr.Lundy and Dr.Rickey at bedside; Notified Dr.Lundy of bright red blood coming from Vac Pack to belly and asked if she would like another HGB soon, Dr.Lundy stated "No I do not want anymore labs"; Notified Dr.Perry and labs ordered

04/26/11 06:50 Misc events(SMT5): 4 Units of FFP ordered Stat; lst unit of FFP started

04/26/11 07:05 Misc events(SMT5): 1st unit of FFP finished infusing; 2nd unit of FFP infusing

04/26/11 07:15 Report(SMT5): Report given to Leslie RN; Notified Leslie that 2 more units of FFP still needed to be given; Transfer of pt. care

CARE PROVIDERS	SMT5	SMT5	SMT5	SMT5	SMT5

MCGLYNN, STEPHANIE(SMT5)RN

FLOWSHEET	04/26				
Neuro/EENT	08:00	09:05	09:07	10:00	10:05
Reflexes present	present		present	present	
Abs of drainage	WNL				
Norm closure Abs of swelling PERLA	WNL WNL WNL		 WNL		
Patent nares No bleed/disch	WNL WNL				
ImplNeuroEENTPOC	done				
GCS eyes open GCS best verbal Best upper motor GCS total score	3=to verbal 1=tube/trach 6=obeysVbCommand & 10		3=to verbal 1=tube/trach 5=localzes pain 9	3=to verbal 1=tube/trach 5=localzes pain 9	
Lvl of conscious Behavior/neuro Disoriented	sedated calm unable to assess			sedated calm unable to assess	
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE	6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands			5=localizToPain 5=localizToPain 4=withdraws pain 4=withdraws pain	
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE	3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity			3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity	
Both pupilsShape Both pupilsReact Both pupils size	round brisk 3mm			round brisk 3mm	
04/26/11 08:00 Best upper motor(LAA): sedation					
Special Neuro	08:00	09:05	09:07	10:00	10:05
Sedation used			Diprivan		
Pain med			Fentanyl		
Cardiovascular	08:00	09:05	09:07	10:00	10:05
Norm sinusRhythm Rate approp/age S1S2 PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Alarms on	WNL WNL WNL WNL WNL for race WNL on			WNL	
Implement CV POC	done				
Rhythm	NSR				
GeneralizedEdema AllPulsesPresent	+2 present			 present	
CARE PROVIDERS	LAA		LAA	LAA	

ADAMS, LESLIE A(LAA)RN

FLOWSHEET	04/26				
Respiratory	08:00	09:05	09:07	10:00	10:05
NonLaboredEffort	WNL				
Suction function	yes				
Ambu bag/mask	present				
Implmnt Resp POC	done				
BS all lobes	rhonchi				
ETT size	7.5				
Placement @ lip	24cm				
Vent mode	PRVC				
Rate	18bpm				
FiO2	40%				
TV	500mL				
PEEP	5cm				
Oral suction	done			done	
Oral secretions	bloody			bloody	
Oral-consistency	thick			thick	
ETT suction	done			done	
ETT secretions	clear			clear	
Gastrointestinal	08:00	09:05	09:07	10:00	10:05
Normal dentition	WNL				
Last BM	pta				
BowelSndsAllQuad	absent				
Abdomen	tender &				
NGT location	right nare			right nare	
NGT suction	low continuous				
NGT drainage	coffee ground				
NGT interv	irrigated				
	placement check			placement check	
04/26/11 08:00 Abdomen(LAA): open wound					
Genitourinary	08:00	09:05	09:07	10:00	10:05
Adequate UOP	WNL				
ClearYellowUrine	WNL				
NoChgPattrn/Char	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
Implement GU POC	done				
Catheter	foley				
Catheter size	16 FR				
DateCathInserted	04/26/2011				
CathInsertedPTA	yes				
Func/Musculoskel	08:00	09:05	09:07	10:00	10:05
Impl FuncMuscPOC	done				
Weakness	generalized				
SCD site	leg L				
	leg R				
CARE PROVIDERS	LAA			LAA	

ADAMS, LESLIE A(LAA)RN

CONTINUED

FLOWSHEET	04/26				
Func/Musculoskel-Cont.	08:00	09:05	09:07	10:00	10:05
SCD type SCD assess	short leg on operational				
Speech	unable verbalize				
Skin	08:00	09:05	09:07	10:00	10:05
Skin warm Skin dry& intact Color approp	WNL WNL to ethnicity				
Impl Skn/Wnd POC	done				
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if	2=very limited 3=occasnly moist 1=bedfast 1=complt immobil 2=prob adequate 2=poten.problm 11 score < 17 score1or2 in any				
Other equipment	positioningWedge				
Comfort	08:00	09:05	09:07	10:00	10:05
No c/o,no s/s of	itching nausea spasms sweating vomiting				
Impl Comfort POC	done				
Abnorm findings	pain recvAnalgesicTx			pain recvAnalgesicTx	
Pain score	0 Wong-Baker(fac e)			0 Wong-Baker(fac e)	
Comfort interv	cont infusion emotional supprt repositioned			cont infusion emotional supprt repositioned	
Observ/Treatmnts	08:00	09:05	09:07	10:00	10:05
Alarms on	done			done	
Bath	done				
Mouth care	done			done	
Linen change	done				
Turn	back			right side	
Side rails up	x4			x4	
Passive ROM	done				
HOB > 30 deg	done			done	
Assess reviewed	done				
CARE PROVIDERS	LAA			LAA	

ADAMS, LESLIE A(LAA)RN

CONTINUED

FLOWSHEET	04/26				
Nutrition	08:00	09:05	09:07	10:00	10:05
Meal type	NPO				
Vascular Access	08:00	09:05	09:07	10:00	10:05
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions	forearm R 04/26/2011 #16 secure dry and intact flushed(see MAR) meds (see MAR)			forearm R secure dry and intact	
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions	wrist L 04/26/2011 #18 secure dry and intact flushed(see MAR) meds (see MAR)			wrist L secure dry and intact	
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions	antecubital L 04/26/2011 #16 secure dry and intact flushed(see MAR) meds (see MAR)			antecubital L secure dry and intact	
Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zeroed	radial R 04/26/2011 secure dry and intact crisp done			radial R secure (modified) dry and intact	
Safety	08:00	09:05	09:07	10:00	10:05
Hospital ID band Bed in low posit Bed brakes on Bed press relief				on done done on	
Morse Fall Risk	08:00	09:05	09:07	10:00	10:05
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score	no=0 no=0 None Bedrest=0 yes=20 Norm BR w/c=0 OvrestFrgtLmt=15 35				
Imple Safety POC	done				
CARE PROVIDERS	LAA			LAA	

ADAMS, LESLIE A(LAA)RN

FLOWSHEET	04/26				
Intact Incision	08:00	09:05	09:07	10:00	10:05
Incision#1 site	abdomen				
Incision#1 type	other (specify) &				
Drain	other (specify) &				
Incision#1 drAmt	large				
Incis#1 drainage	&				
Surrounding skin	intact				
04/26/11 08:00 Incision#1 type(LAA): open					
04/26/11 08:00 Drain(LAA): wall vac pack @ 125mmhg					
04/26/11 08:00 Incis#1 drainage(LAA): Bloody Dr Perry and Dr crooks aware					
Diab Flowsheet	08:00	09:05	09:07	10:00	10:05
Insulin mulriplr	.04	.04			.03
CARE PROVIDERS	LAA	LAA			LAA

ADAMS, LESLIE A(LAA)RN

FLOWSHEET	04/26				
Neuro/EENT	11:00	11:10	12:00	12:11	13:14
Reflexes present	present			present	
PERLA	WNL			WNL	
GCS eyes open GCS best verbal Best upper motor GCS total score	3=to verbal 1=tube/trach 5=localzes pain 9			3=to verbal 1=tube/trach 5=localzes pain 9	
Lvl of conscious Behavior/neuro Disoriented				sedated calm unable to assess	
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE				5=localizToPain 5=localizToPain 4=withdraws pain 4=withdraws pain	
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE				3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity	
Both pupilsShape Both pupilsReact Both pupils size				round brisk 3mm	
Cardiovascular	11:00	11:10	12:00	12:11	13:14
Norm sinusRhythm AllPulsesPresent				WNL present	
Respiratory	11:00	11:10	12:00	12:11	13:14
Oral suction Oral secretions Oral-consistency ETT suction ETT secretions				done bloody thick done clear	
Gastrointestinal	11:00	11:10	12:00	12:11	13:14
NGT location NGT drainage NGT interv				right nare coffee ground irrigated placement check	
Comfort	11:00	11:10	12:00	12:11	13:14
Pain score				0 Wong-Baker(faces)	
Comfort interv				cont infusion emotional supprt repositioned	
Observ/Treatmnts	11:00	11:10	12:00	12:11	13:14
Alarms on				done	
Mouth care				done	
Turn				left side	
CARE PROVIDERS	LAA			LAA	

ADAMS, LESLIE A(LAA)RN

CONTINUED

FLOWSHEET	04/26				
Observ/Treatmnts Cont.	11:00	11:10	12:00	12:11	13:14
Side rails up				x4	
HOB > 30 deg				done	
Vascular Access	11:00	11:10	12:00	12:11	13:14
Site#1 location				forearm R	
Site#1 appear				secure	
Site#1 dressing				dry and intact	
Site#2 location				wrist L	
Site#2 appear				secure	
Site#2 dressing				dry and intact	
Site#3 location				antecubital L	
Site#3 appear				secure	
Site#3 dressing				dry and intact	
Art line loc				radial R	
Site appearance				secure	
Site dressing				dry and intact	
Safety	11:00	11:10	12:00	12:11	13:14
Hospital ID band				on	
Bed in low posit				done	
Bed brakes on				done	
Bed press relief				on	
Diab Flowsheet	11:00	11:10	12:00	12:11	13:14
Insulin mulriplr		.02	.01		.005
CARE PROVIDERS		LAA	LAA	LAA	LAA

ADAMS, LESLIE A(LAA)RN

FLOWSHEET	04/26				
Neuro/EENT	13:16	14:00	14:10	14:45	16:00
Reflexes present	present				present
PERLA	WNL	WNL			WNL
GCS eyes open GCS best verbal Best upper motor GCS total score	3=to verbal 1=tube/trach 5=localzes pain 9	3=to verbal 1=tube/trach 5=localzes pain 9			3=to verbal 1=tube/trach 5=localzes pain 9
Lvl of conscious Behavior/neuro Disoriented		sedated calm unable to assess			sedated calm unable to assess
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE		5=localizToPain 5=localizToPain 5=localizToPain 5=localizToPain			5=localizToPain 5=localizToPain 5=localizToPain 5=localizToPain
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE					3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity
Both pupilsShape Both pupilsReact Both pupils size		round brisk 3mm			round brisk 3mm
Cardiovascular	13:16	14:00	14:10	14:45	16:00
Rhythm		sinus tach			NSR
AllPulsesPresent		present			present
Respiratory	13:16	14:00	14:10	14:45	16:00
Placement @ lip Oral suction Oral secretions Oral-consistency ETT suction ETT secretions		 done bloody thick done clear			24cm done bloody creamy thick done clear
GastroIntestinal	13:16	14:00	14:10	14:45	16:00
NGT location NGT drainage NGT interv		right nare coffee ground placement check			right nare clear coffee ground irrigated placement check
Comfort	13:16	14:00	14:10	14:45	16:00
Pain score		0 Wong-Baker(face)			0 Wong-Baker(face)
Comfort interv		cont infusion emotional supprt repositioned			cont infusion emotional supprt repositioned
CARE PROVIDERS	LAA	LAA			LAA

ADAMS, LESLIE A(LAA)RN

FLOWSHEET	04/26				
Observ/Treatmnts	13:16	14:00	14:10	14:45	16:00
Alarms on		done			done
Mouth care		done &			done
Turn		right side			left side
Side rails up		x3			x4
HOB > 30 deg		done			done
04/26/11 14:00 Mouth care(LAA): teeth brushed					
Vascular Access	13:16	14:00	14:10	14:45	16:00
Site#1 location		forearm R			forearm R
Site#1 appear		secure			secure
Site#1 dressing		dry and intact			dry and intact
Site#2 location		wrist L			wrist L
Site#2 appear		secure			secure
Site#2 dressing		dry and intact			dry and intact
Site#3 location		antecubital L			antecubital L
Site#3 appear		secure			secure
Site#3 dressing		dry and intact			dry and intact
Art line loc		radial R			radial R
Site appearance		secure			
Site dressing		dry and intact			
Waveform		dampened &			dampened
Oth art interv					&
04/26/11 14:00 Waveform(LAA): RT and Dr Rickey aware					
04/26/11 16:00 Oth art interv(LAA): D/Ced					
Safety	13:16	14:00	14:10	14:45	16:00
Hospital ID band		on			on
Bed in low posit		done			done
Bed brakes on		done			done
Bed press relief		on			on
Diab Flowsheet	13:16	14:00	14:10	14:45	16:00
Insulin multiplr			.005	.02	
CARE PROVIDERS		LAA	LAA	LAA	LAA

ADAMS, LESLIE A(LAA)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 19

FLOWSHEET	04/26				
Neuro/EENT	16:05	16:38	17:10	18:00	18:01
Reflexes present					present
GCS eyes open GCS best verbal Best upper motor GCS total score					3=to verbal 1=no response 5=localzes pain 9
Lvl of conscious Behavior/neuro Disoriented					sedated calm unable to assess
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE					5=localizToPain 5=localizToPain 5=localizToPain 5=localizToPain
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE					3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity
Both pupilsShape Both pupilsReact Both pupils size					round brisk 3mm
Cardiovascular	16:05	16:38	17:10	18:00	18:01
Rhythm					NSR
AllPulsesPresent					present
Respiratory	16:05	16:38	17:10	18:00	18:01
Oral suction Oral secretions Oral-consistency ETT suction ETT secretions					done clear thick done clear
GastroIntestinal	16:05	16:38	17:10	18:00	18:01
NGT location NGT interv					right nare placement check
Comfort	16:05	16:38	17:10	18:00	18:01
Pain score					0 Wong-Baker(face)
Observ/Treatmnts	16:05	16:38	17:10	18:00	18:01
Alarms on					done
Mouth care					done
Turn					right side
Side rails up					x4
HOB > 30 deg					done
CARE PROVIDERS					LAA

ADAMS, LESLIE A(LAA)RN

CONTINUED

FLOWSHEET	04/26				
Vascular Access	16:05	16:38	17:10	18:00	18:01
Site#1 location					forearm R
Site#1 appear					secure
Site#1 dressing					dry and intact
Site#2 location					wrist L
Site#2 appear					secure
Site#2 dressing					dry and intact
Site#3 location					antecubital L
Site#3 appear					secure
Site#3 dressing					dry and intact
Art line loc		radial L			radial L
Insertion date		04/26/2011			
Site appearance		secure			secure
					sutured
Site dressing		dry and intact			dry and intact
Waveform		crisp			
Safety	16:05	16:38	17:10	18:00	18:01
Hospital ID band					on
Bed in low posit					done
Bed brakes on					done
Bed press relief					on
Diab Flowsheet	16:05	16:38	17:10	18:00	18:01
Insulin mulriplr	.02		.02	.02	
CARE PROVIDERS	LAA	LAA	LAA	LAA	LAA

ADAMS, LESLIE A(LAA)RN

FLOWSHEET	04/26				
Chart Review	18:47	19:19	20:00	20:01	22:21
Chart check q12h		done			
Neuro/EENT	18:47	19:19	20:00	20:01	22:21
Reflexes present			present		
Abs of drainage			WNL		
Norm closure Abs of swelling PERLA			WNL WNL WNL		
Patent nares No bleed/disch			WNL WNL		
ImplNeuroEENTPOC			done		
GCS eyes open GCS best verbal Best upper motor GCS total score			3=to verbal 1=tube/trach 6=obeysVbCommand 10		
Lvl of conscious Behavior/neuro Disoriented			sedated calm unable to assess		
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE			6=obeys commands 6=obeys commands 5=localizToPain 5=localizToPain		
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE			3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity		
Both pupilsShape Both pupilsReact Both pupils size			round brisk 3mm		
Cardiovascular	18:47	19:19	20:00	20:01	22:21
Norm sinusRhythm Rate approp/age S1S2 PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Alarms on			WNL WNL WNL WNL WNL for race WNL on		
Implement CV POC			done		
Rhythm			NSR		
AllPulsesPresent			present		
CARE PROVIDERS		LAA, {JLP}	JLP		

ADAMS, LESLIE A(LAA)RN PETERSON, JENNIFER L(JLP)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 22

FLOWSHEET	04/26				
Respiratory	18:47	19:19	20:00	20:01	22:21
Spont respers NonLaboredEffort Suction function			WNL WNL yes		
Ambu bag/mask			present		
Implmnt Resp POC			done		
BS all lobes ETT size Placement @ lip Vent mode Rate FiO2 TV PEEP Oral suction Oral secretions Oral-consistency ETT suction ETT secretions			rhonchi 7.5 24cm PRVC 18bpm 40% 500mL 5cm done tan thick done clear		
Gastrointestinal	18:47	19:19	20:00	20:01	22:21
Normal dentition Last BM			WNL pta		
Implement GI POC			done		
BowelSndsAllQuad Abdomen NGT location NGT suction NGT drainage NGT interv			absent tender & right nare low continuous green irrigated placement check		
04/26/11 20:00 Abdomen(JLP): open abd					
Genitourinary	18:47	19:19	20:00	20:01	22:21
Adequate UOP ClearYellowUrine NoChgPattrn/Char NoAbn penile bld NoAbnPenileDisch			WNL WNL WNL WNL WNL		
Implement GU POC			done		
Catheter Catheter size DateCathInserted			foley 16 FR 04/26/2011		
CathInsertedPTA			yes		
CARE PROVIDERS			JLP		

PETERSON, JENNIFER L(JLP)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 23

FLOWSHEET	04/26				
Func/Musculoskel	18:47	19:19	20:00	20:01	22:21
Impl FuncMuscPOC			done		
Weakness			generalized		
SCD site SCD type SCD assess			leg L leg R short leg on operational		
Speech			unable verbalize		
Skin	18:47	19:19	20:00	20:01	22:21
Skin warm Skin dry& intact Color approp			WNL WNL to ethnicity		
Impl Skn/Wnd POC			done		
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree			2=very limited 3=occasnly moist 1=bedfast 1=complt immobil 2=prob adequate 2=poten.problm 11 score < 17 score1or2 in any score1or2 in any		
Other equipment			positioningWedge		
Comfort	18:47	19:19	20:00	20:01	22:21
No c/o,no s/s of			chills fever itching nausea prob sleeping spasms sweating vomiting		
Impl Comfort POC			done		
Abnorm findings			pain recvAnalgesicTx		
Pain score			0 Wong-Baker(face)		
Pt relief goal			0-2		
Comfort interv			cont infusion meds (see MAR) repositioned		
CARE PROVIDERS			JLP		

PETERSON, JENNIFER L(JLP)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 18:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: [redacted] SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 24

FLOWSHEET	04/26				
Observ/Treatmnts	18:47	19:19	20:00	20:01	22:21
Alarms on			done		done
Mouth care			done		done
Turn			left side		back
Side rails up			x3		x3
Passive ROM			done		done
HOB > 30 deg			done		done
Assess reviewed			done		done
Nutrition	18:47	19:19	20:00	20:01	22:21
Meal type			NPO		
Vascular Access	18:47	19:19	20:00	20:01	22:21
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions			forearm R 04/26/2011 #16 secure dry and intact meds (see MAR)		
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions			wrist L 04/26/2011 #18 secure dry and intact meds (see MAR)		
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions			antecubital L 04/26/2011 #16 secure dry and intact meds (see MAR)		
Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zeroed			radial L 04/26/2011 secure dry and intact crisp done		secure
Safety	18:47	19:19	20:00	20:01	22:21
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on Bed press relief IV sol verified IV tbg/bag dated High alertMedsID			on done done done done on done done done		on done done done done on done done done
Imple SafetyPOC			done		done
CARE PROVIDERS			JLP		JLP

PETERSON, JENNIFER L(JLP)RN

CONTINUED

FLOWSHEET	04/26				
Safety-Cont.	18:47	19:19	20:00	20:01	22:21
AspirationRisk			yes		
AspPrecautnMntn			done		
Morse Fall Risk	18:47	19:19	20:00	20:01	22:21
HxFall(w/in 3mo)			no=0		
Secondary dx			no=0		
Ambulatory aid			None Bedrest=0		
IV or IV access			yes=20		
Gait			Norm BR w/c=0		
Mental status			OvrestFrgtLmt=15		
Total score			35		
Imple Safety POC			done		
Intact Incision	18:47	19:19	20:00	20:01	22:21
Incision#1 site			abdomen		
Incision#1 type			other (specify) &		
Drain			other (specify) &		
Incision#1 drAmt			large		
Incis#1 drainage			sanguinous		
Surrounding skin			intact		
04/26/11 20:00 Incision#1 type(JLP): open abd					
04/26/11 20:00 Drain(JLP): vac pack					
Diab Flowsheet	18:47	19:19	20:00	20:01	22:21
Insulin mulriplr	.02				
Misc Events	18:47	19:19	20:00	20:01	22:21
Misc events			&	&	
04/26/11 20:00 Misc events(JLP): assumed care. pt sedated on 30mcg/kg/h propofol gtt and 125mcg/h fentanyl gtt. pt weakly follows commands in BUE; localizes in BLE. PERRL pt remains on PRVC; see settings. NSR. cont to monitor for MAP>60. vac pack intact to wall sxn.					
04/26/11 20:01 Misc events(JLP): cont cc:cc replacement of abd output Q4 hr with LR. will cont to monitor.					
CARE PROVIDERS	LAA		JLP	JLP	

ADAMS, LESLIE A(LAA)RN PETERSON, JENNIFER L(JLP)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:56 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 03:06
OPT OUT:
Page: 26

FLOWSHEET	04/27				
Chart Review	00:06	02:34	05:25	06:18	07:16
Chart check q12h					done
Neuro/EENT	00:06	02:34	05:25	06:18	07:16
Reflexes present	present				
Abs of drainage	WNL				
Norm closure Abs of swelling PERLA	WNL WNL WNL				
Patent nares No bleed/disch	WNL WNL				
ImplNeuroEENTPOC	done				
GCS eyes open GCS best verbal Best upper motor GCS total score	3=to verbal 1=tube/trach 6=obeysVbCommand 10				
Lvl of conscious Behavior/neuro Disoriented	sedated calm unable to assess				
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE	5=localizToPain 5=localizToPain 5=localizToPain 5=localizToPain				
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE	3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity				
Both pupilsShape Both pupilsReact Both pupils size	round brisk 3mm				
R nare					
Special Neuro	00:06	02:34	05:25	06:18	07:16
Sedation used					
Pain med					
Cardiovescular	00:06	02:34	05:25	06:18	07:16
Rate approp/age S1S2 Angina/chestPain PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Thigh/CalfTender Alarms on					
Implement CV POC					
Rhythm					
CARE PROVIDERS	JLP				JLP, (BCAR)

CARPENTER, BROOKE(BCAR)RN PETERSON, JENNIFER L(JLP)RN

CONTINUED

FLOWSHEET	04/27				
Cardiovascular-Cont.	00:06	02:34	05:25	06:18	07:16
Monitor lead					
Heart sounds					
GeneralizedEdema R scleral edema L scleral edema					
AllPulsesPresent R radial pulse L radial pulse RdorsalisPedPuls					
LdorsalisPedPuls					
Respiratory	00:06	02:34	05:25	06:18	07:16
Suction function					
Ambu bag/mask					
Implmnt Resp POC					
RUL LUL Sputum/secretion					
Consistency					
Airway Oral airway					
ETT size Placement @ lip ETT interv Vent mode Rate FiO2 TV PEEP PIP MVe					
Oral suction Oral secretions Oral-consistency ETT suction ETT secretions					
ETT-consistency					
Gastrointestinal	00:06	02:34	05:25	06:18	07:16
Normal dentition MucousMembIntact					
Last BM					
Implement GI POC					
BowelSndsAllQuad Abdomen NGT location NGT suction NGT drainage					

CONTINUED

FLOWSHEET	04/27				
Gastrointestinal Cont.	00:06	02:34	05:25	06:18	07:16
NGT interv					
Genitourinary	00:06	02:34	05:25	06:18	07:16
Adequate UOP ClearYellowUrine NoChgPattrn/Char NoAbn penile bld NoAbnPenileDisch					
Implement GU POC					
Catheter Catheter size DateCathInserted					
CathInsertedPTA					
Func/Musculoskel	00:06	02:34	05:25	06:18	07:16
Impl FuncMuscPOC					
Weakness					
SCD site SCD type SCD assess					
Speech					
Skin	00:06	02:34	05:25	06:18	07:16
Skin warm Color approp					
Impl Skn/Wnd POC					
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree					
Turgor Temperature					
Care routine					
Other equipment					
Comfort	00:06	02:34	05:25	06:18	07:16
No c/o,no s/s of					
Impl Comfort POC					
Abnorm findings					
Pain score					
Pt relief goal					
Pain onset					
Pain description					

CONTINUED

FLOWSHEET	04/27				
Comfort-Cont.	00:06	02:34	05:25	06:18	07:16
Pain site(s)					
Comfort interv					
Observ/Treatmnte	00:06	02:34	05:25	06:18	07:16
Alarms on	done	done	done	done	
Bath			done		
Skin care			done		
Mouth care	done	done	done	done	
Linen change			done		
Turn	right side	back	right side	left side	
Side rails up	x3	x3	x3	x3	
Catheter care			done		
Peri care			done		
Passive ROM	done	done	done	done	
HOB > 30 deg	done	done	done	done	
Assess reviewed	done	done	done	done	
Nutrition	00:06	02:34	05:25	06:18	07:16
Meal type					
Vascular Access	00:06	02:34	05:25	06:18	07:16
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions					
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions					
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions					
Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zerced	secure	secure		secure	
CARE PROVIDERS	JLP	JLP	JLP	JLP	

PETERSON, JENNIFER L(JLP)RN

FLOWSHEET	04/27				
Safety	00:06	02:34	05:25	06:18	07:15
Hospital ID band	on	on		on	
CallSystm access	done	done		done	
Bed in low posit	done	done		done	
Bed brakes on	done	done		done	
Bed alarms on	done	done		done	
Bed press relief	on	on		on	
IV sol verified	done	done		done	
IV tbg/bag dated	done	done		done	
High alertMedsID	done	done		done	
Imple SafetyPOC	done	done		done	
AspirationRisk AspPrecautnMntn InfectionHiRisk RestraintUseRisk					
ElopemtRiskLevel					
Morse Fall Risk	00:06	02:34	05:25	06:18	07:15
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score					
Imple Safety POC					
Intact Incision	00:06	02:34	05:25	06:18	07:15
Incision#1 site Incision#1 type Drain Incision#1 drAmt Incis#1 drainage Surrounding skin Dsg chg sched					
Incision#1 dsg					
Misc Events	00:06	02:34	05:25	06:18	07:15
Evaluated POC					
Misc events					
CARE PROVIDERS	JLP	JLP		JLP	

PETERSON, JENNIFER L(JLP)RN

CONTINUED

FLOWSHEET	04/27				
Neuro/EENT	07:30	07:40	11:30	12:00	13:00
Reflexes present	present			present	
Abs of drainage	WNL				
PERLA	WNL				
No bleed/disch	WNL				
ImplNeuroEENTPOC	done			done	
GCS eyes open GCS best verbal Best upper motor GCS total score	3=to verbal 1=tube/trach 5=localzes pain 9			3=to verbal 1=tube/trach 4=flex/withdraw 8	
Lvl of consciou Behavior/neuro Disoriented	sedated calm unable to assess			sedated calm unable to assess	
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE	5=localizToPain 5=localizToPain 5=localizToPain 5=localizToPain			4=withdraws pain 4=withdraws pain 4=withdraws pain 4=withdraws pain	
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE	3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity			3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity	
Both pupilsShape Both pupilsReact Both pupils size	round brisk 3mm			round brisk 3mm	
R nare	other (specify) &				
04/27/11 07:30 R nare(BCAR): NG tube in place					
Special Neuro	07:30	07:40	11:30	12:00	13:00
Sedation used	Diprivan			Diprivan	
Pain med	Fentanyl			Fentanyl	
Cardiovascular	07:30	07:40	11:30	12:00	13:00
Rate approp/age S1S2 Angina/chestPain PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Thigh/CalfTender Alarms on	WNL WNL no complaints WNL WNL for race WNL none on				
Implement CV POC	done				
Rhythm	NSR sinus tach				
CARE PROVIDERS	BCAR			BCAR	

CARPENTER, BROOKE(BCAR)RN

CONTINUED

FLOWSHEET	04/27				
Cardiovascular-Cont.	07:30	07:40	11:30	12:00	13:00
Monitor lead	lead I lead II V				
Heart sounds	S1 S2				
GeneralizedEdema R scleral edema L scleral edema	+2 present present				
AllPulsesPresent R radial pulse L radial pulse RdorsalisPedPuls	present 1+=weak & 1+=weak				
LdorsalisPedPuls	1+=weak				
04/27/11 07:30 L radial pulse(BCAR): arterial line in place					
Respiratory	07:30	07:40	11:30	12:00	13:00
Suction function	yes				
Ambu bag/mask	present				
Implmnt Resp POC	done				
RUL LUL Sputum/secretion	rhonchi rhonchi clear				
Consistency	thin				
Airway Oral airway	ETT - oral @bedside				
ETT size Placement @ lip ETT interv Vent mode Rate FiO2 TV PEEP PIP MVe	7.5 24cm lip/skin care mouth care PRVC 18bpm 40% 500mL 5cm 24 8.6l/min				
Oral suction Oral secretions Oral-consistency ETT suction ETT secretions	done clear thin done clear				
ETT-consistency	thin				
Gastrointestinal	07:30	07:40	11:30	12:00	13:00
Normal dentition MucousMembIntact	WNL WNL				
Last BM	pta				
CARE PROVIDERS	BCAR				

CARPENTER, BROOKE(BCAR)RN

CONTINUED

FLOWSHEET	04/27				
Gastrointestinal-Com.	07:30	07:40	11:30	12:00	13:00
Implement GI POC	done				
BowelSndsAllQuad	absent				
Abdomen	tender &				
NGT location	right nare				
NGT suction	low continuous				
NGT drainage	green				
NGT interv	irrigated placement check				
G-tube location				LUQ	
G-tube suction				gravity	
G-tube drainage				brown green	
J-tube location				LLQ	
J-tube interv				& &	
Tube#1 type				JP	
Tube#1 location				& LUQ	
Tube#1 drainage				& bloody	
Tube#1 interv				bulb suction	
Tube#2 type				& other (specify)	
Tube#2 location				& LUQ	
Tube#2 drainage				bloody	
Tube#2 interv				&	
04/27/11 07:30 Abdomen(BCAR): open abd					
04/27/11 12:00 J-tube location(BCAR): T tube					
04/27/11 12:00 J-tube interv(BCAR): clamped per MDs					
04/27/11 12:00 Tube#1 type(BCAR): x2					
04/27/11 12:00 Tube#1 location(BCAR): and RUQ					
04/27/11 12:00 Tube#1 interv(BCAR): empty q4h					
04/27/11 12:00 Tube#2 type(BCAR): duodenostomy					
04/27/11 12:00 Tube#2 interv(BCAR): intermittent wall suction					
Genitourinary	07:30	07:40	11:30	12:00	13:00
Adequate UOP	WNL				
ClearYellowUrine	WNL				
NoChgPattrn/Char	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
Implement GU POC	done				
Catheter	foley				
Catheter size	16 FR				
CARE PROVIDERS	BCAR			BCAR	

CARPENTER, BROOKE(BCAR)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 34

FLOWSHEET	04/27				
Genitourinary-Cont.	07:30	07:40	11:30	12:00	13:00
DateCathInserted	04/26/2011				
CathInsertedPTA	yes				
Func/Musculoskel	07:30	07:40	11:30	12:00	13:00
Impl FuncMuscPOC	done				
Weakness	generalized				
SCD site SCD type SCD assess	leg L leg R short leg on operational				
Speech	unable verbalize				
Skin	07:30	07:40	11:30	12:00	13:00
Skin warm Color approp	WNL to ethnicity				
Impl Skn/Wnd POC	done				
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree	2=very limited 3=occasnly moist 1=bedfast 3=slight limited 1=very poor 2=poten.problm 12 score < 17 score1or2 in any score1or2 in any				
Turgor Temperature	tight &				
Care routine	BazaMoistBarrier CarrafoamCleansr				
Other equipment	positioningWedge				
04/27/11 07:30 Temperature(BCAR): warm					
Comfort	07:30	07:40	11:30	12:00	13:00
No c/o,no s/s of	chills fever itching nausea prob sleeping spasms sweating vomiting				
Impl Comfort POC	done				
Abnorm findings	pain				
Pain score	3 Wong-Baker(face)				
CARE PROVIDERS	BCAR				

CARPENTER, BROOKE(BCAR)RN

CONTINUED

FLOWSHEET	04/27				
Comfort Cont.	07:30	07:40	11:30	12:00	13:00
Pt relief goal	0-2				
Pain onset	ongoing				
Pain description	unable to descr				
Pain site(s)	unable to descr				
Comfort interv	meds (see MAR) relaxation				
Observ/Treatmnts	07:30	07:40	11:30	12:00	13:00
Alarms on	done			done	
Skin care	done				
Mouth care	done			done	
Linen change	done			done	
Turn	back			back	
Side rails up	x4			x4	
Catheter care	done				
Peri care	done				
Passive ROM	done			done	
HOB > 30 deg	done			done	
Assess reviewed	done			done	
Nutrition	07:30	07:40	11:30	12:00	13:00
Meal type	NPO			NPO	
Vascular Access	07:30	07:40	11:30	12:00	13:00
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions	antecubital L 04/26/2011 #18 secure dry and intact meds (see MAR)			 secure dry and intact	
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions	forearm L 04/26/2011 #16 secure dry and intact flushed(see MAR) meds (see MAR)			 secure dry and intact	
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions	forearm R 04/26/2011 #16 secure dry and intact flushed(see MAR) meds (see MAR)			 secure dry and intact	
Art line loc Insertion date CARE PROVIDERS	radial L 04/26/2011 BCAR			 BCAR	

CARPENTER, BROOKE(BCAR)RN

CONTINUED

FLOWSHEET	04/27				
Vascular Access-Cont.	07:30	07:40	11:30	12:00	13:00
Site appearance	secure				
Site dressing	dry and intact				
Waveform	crisp			dampened	
Leveled, zeroed	done			done	
Oth art interv				&	
Art line loc					
Insertion date					
Site appearance					
Site dressing					
Waveform					
Leveled, zeroed					
Oth art interv					
04/27/11 12:00 Oth art interv(BCAR): d/c'ed-not working-MDs aware-RT to place new line					
Safety	07:30	07:40	11:30	12:00	13:00
Hospital ID band	on				
Bed in low posit	done				
Bed brakes on	done				
Bed press relief	on				
IV sol verified	done				
IV tbg/bag dated	done				
High alertMedsID	done				
Imple SafetyPOC	done				
AspirationRisk	yes				
AspPrecautnMntn	done				
InfectionHiRisk	other (specify)				
	&				
RestraintUseRisk	AltrdMentalState				
ElopemtRiskLevel	3Ornted or Immob				
04/27/11 07:30 InfectionHiRisk(BCAR): ETT, foley, open abd					
Morse Fall Risk	07:30	07:40	11:30	12:00	13:00
HxFall(w/in 3mo)	no=0				
Secondary dx	yes=15				
Ambulatory aid	None Bedrest=0				
IV or IV access	yes=20				
Gait	Norm BR w/c=0				
Mental status	OvrestFrgtLmt=15				
Total score	50				
Imple Safety POC	done				
Intact Incision	07:30	07:40	11:30	12:00	13:00
Incision#1 site	abdomen			abdomen	
	&				
Incision#1 type	other (specify)			other (specity)	
				&	
Drain	other (specify)			JP	
	&			penrose	
				wound vac	
CARE PROVIDERS	BCAR			BCAR	

CARPENTER, BROOKE(BCAR)RN

CONTINUED

FLOWSHEET	04/27				
Intact Incision-Cont.	07:30	07:40	11:30	12:00	13:00
Incision#1 drAmt Incis#1 drainage Surrounding skin Dsg chg sched	large sanguinous intact &			& moderate sanguinous intact twice a day	
Incision#1 dsg	other (specify) &			other (specify) &	
04/27/11 07:30 Incision#1 site(BCAR): open abd					
04/27/11 07:30 Drain(BCAR): LCWS					
04/27/11 07:30 Dsg chg sched(BCAR): per MDs					
04/27/11 07:30 Incision#1 dsg(BCAR): abd vac pack					
04/27/11 12:00 Incision#1 type(BCAR): wet to dry dressing					
04/27/11 12:00 Drain(BCAR): JP x2, 1 wall suction, Gtube to drain, Jtube clamped					
04/27/11 12:00 Incision#1 dsg(BCAR): wet to dry dressing					
Diab Flowsheet	07:30	07:40	11:30	12:00	13:00
Insulin mulriplr			.03		.03
Misc Events	07:30	07:40	11:30	12:00	13:00
Evaluated POC	done				
Misc events	&	&	&		&
04/27/11 07:30 Misc events(BCAR): report recieved, care assumed. assessment as documented. VSS at this time. pt to be taken to OR desk					
04/27/11 07:40 Misc events(BCAR): patient taken to OR desk. report given to CRNA, VSS.will monitor when patient returns					
04/27/11 11:30 Misc events(BCAR): patient returned from OR. report recieved from anesthesia staff. Lundy MD at bedside. will follow postop orders and monitor.					
04/27/11 13:00 Misc events(BCAR): Lundy MD made aware of patients BP drop-MAP high 50s-see flowsheet. will follow orders and monitor.					
CARE PROVIDERS	BCAR	BCAR	BCAR	BCAR	BCAR

CARPENTER, BROOKE(BCAR)RN

CONTINUED

FLOWSHEET	04/27				
Neuro/EENT	13:30	14:00	15:00	16:00	16:01
Reflexes present				present	
ImplNeuroEENTPOC				done	
GCS eyes open GCS best verbal Best upper motor GCS total score				3=to verbal 1=tube/trach 5=localzes pain 9	
Lvl of conscious Behavior/neuro Disoriented				sedated calm unable to assess	
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE				5=localizToPain 5=localizToPain 4=withdraws pain 4=withdraws pain	
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE				3=againstGravity 3=againstGravity 3=againstGravity 3=againstGravity	
Observ/Treatmnts	13:30	14:00	15:00	16:00	16:01
Alarms on		done		done	
Mouth care		done		done	
Linen change				done	
Turn		left side		right side	
Side rails up		x4		x4	
Passive ROM		done		done	
HOB > 30 deg		done		done	
Assess reviewed		done		done	
Vascular Access	13:30	14:00	15:00	16:00	16:01
Site#1 appear Site#1 dressing Site#2 appear Site#2 dressing Site#3 appear Site#3 dressing Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zeroed	 pedal L 04/27/2011 secure dry and intact crisp done	secure dry and intact secure dry and intact secure dry and intact secure dry and intact crisp		secure dry and intact secure dry and intact secure dry and intact secure dry and intact crisp	
Oth art interv	&				
04/27/11 13:30 Oth art interv(BCAR): placed at bedside per RT					
CARE PROVIDERS	BCAR	BCAR		BCAR	

CARPENTER, BROOKE(BCAR)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 39

FLOWSHEET	04/27				
Diab Flowsheet	13:30	14:00	15:00	16:00	16:01
Insulin mulriplr		.03	.04	.05	
Misc Events	13:30	14:00	15:00	16:00	16:01
Misc events		&		&	&
04/27/11 14:00 Misc events(BCAR): Lundy MD made aware of patients drop in BP (MAP 60s) and 1400 hgb/hct levels. will give 1 L bolus of LR per order					
04/27/11 16:00 Misc events(BCAR): Lundy MD at bedside					
04/27/11 16:01 Misc events(BCAR): pt awakes to verbal with sedation held-localizes with uppers-withdraws lowers-vitals remain stable. will continue with poc and monitor.					
CARE PROVIDERS		BCAR	BCAR	BCAR	BCAR

CARPENTER, BROOKE(BCAR)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 40

FLOWSHEET	04/27				
Chart Review	17:00	18:00	18:20	19:00	19:15
Chart check q12h					done
Observ/Treatmnts	17:00	18:00	18:20	19:00	19:15
Alarms on			done		
Skin care			done		
Mouth care			done		
Linen change			done		
Turn			back		
Side rails up			x4		
Catheter care			done		
Peri care			done		
Passive ROM			done		
HOB > 30 deg			done		
Assess reviewed			done		
Vascular Access	17:00	18:00	18:20	19:00	19:15
Site#1 appear Site#1 dressing Site#2 appear Site#2 dressing Site#3 appear Site#3 dressing Site appearance Site dressing Waveform			secure dry and intact secure dry and intact secure dry and intact secure dry and intact crisp		
Diab Flowsheet	17:00	18:00	18:20	19:00	19:15
Insulin mulriplr	.06	.07		.08	
CARE PROVIDERS	BCAR	BCAR	BCAR	BCAR	BCAR, {TMW1}

CARPENTER, BROOKE(BCAR)RN WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27				
Neuro/EENT	20:05	20:15	21:00	21:05	22:00
Reflexes present		present			
Abs of drainage		WNL			
Norm closure PERLA		WNL WNL			
Patent nares No bleed/disch		WNL WNL			
GCS eyes open GCS best verbal Best upper motor GCS total score		4=spontaneously 1=tube/trach 5=localzes pain 10			
Lvl of conscious Behavior/neuro Disoriented		sedated calm unable to assess			
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE		5=localizToPain 5=localizToPain 4=withdraws pain 4=withdraws pain			
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE		2=gravity elimin 2=gravity elimin 2=gravity elimin 2=gravity elimin			
Both pupilsShape Both pupilsReact Both pupils size		round brisk 3mm			
Special Neuro	20:05	20:15	21:00	21:05	22:00
Sedation used		Diprivan			
Pain med		Fentanyl			
Cardiovascular	20:05	20:15	21:00	21:05	22:00
Rate approp/age S1S2 Angina/chestPain PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Thigh/CalfTender Alarms on		WNL WNL no complaints WNL WNL for race WNL none on			
Rhythm		sinus tach			
Monitor lead		lead II			
Heart sounds		S1 S2			
GeneralizedEdema R scleral edema L scleral edema		+2 present present			
AllPulsesPresent CARE PROVIDERS		present TMW1			

WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27				
Cardiovascular-Cont.	20:05	20:15	21:00	21:05	22:00
R radial pulse L radial pulse RdorsalisPedPuls		1+=weak 1+=weak 1+=weak			
LdorsalisPedPuls		1+=weak			
Respiratory	20:05	20:15	21:00	21:05	22:00
Spont respers NonLaboredEffort No cough,dyspnea Suction function		WNL WNL WNL yes			
Ambu bag/mask		present			
Impimnt Resp POC		done			
BS all lobes RUL RML RLL LUL LLL		rhonchi rhonchi rhonchi decreased rhonchi rhonchi decreased rhonchi			
Sputum/secretion		clear			
Consistency		thick			
Airway Oral airway		ETT - oral @bedside			
ETT size Placement @ lip ETT interv Vent mode Rate FiO2 TV PEEP Oral suction Oral secretions Oral-consistency ETT suction ETT secretions		7.5 24cm lip/skin care mouth care PRVC 18bpm 40% 500mL 5cm done clear thin done clear			
ETT-consistency		thin			
Gastrointestinal	20:05	20:15	21:00	21:05	22:00
Normal dentition MucousMembIntact		WNL WNL			
Last BM		pta			
Implement GI POC		done			
BowelSndsAllQuad NGT location CARE PROVIDERS		absent right nare TMW1			

WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27				
Gastrointestinal-Cont.	20:05	20:15	21:00	21:05	22:00
NGT suction		low continuous			
NGT drainage		brown green			
NGT interv		placement check			
G-tube location		LUQ			
G-tube suction		gravity			
G-tube drainage		brown green			
J-tube location		LLQ			
Tube#1 type		JP &			
Tube#1 location		LUQ			
Tube#1 drainage		serosanguinous			
Tube#1 interv		bulb suction			
Tube#2 type		other (specify) &			
Tube#2 location		LUQ			
Tube#2 drainage		bloody			
Tube#2 interv		&			
04/27/11 20:15 Tube#1 type(TMW1): x2					
04/27/11 20:15 Tube#2 type(TMW1): duodenostomy					
04/27/11 20:15 Tube#2 interv(TMW1): wall suction					
Genitourinary	20:05	20:15	21:00	21:05	22:00
Adequate UOP		WNL			
ClearYellowUrine		WNL			
NoChgPattrn/Char		WNL			
NoAbn penile bld		WNL			
NoAbnPenileDisch		WNL			
Implement GU POC		done			
Catheter		foley			
Catheter size		16 FR			
DateCathInserted		04/26/2011			
CathInsertedPTA		yes			
Func/Musculoskel	20:05	20:15	21:00	21:05	22:00
Impl FuncMuscPOC		done			
Weakness		generalized			
SCD site		leg L leg R			
SCD type		short leg			
SCD assess		on operational			
Speech		unable verbalize			
CARE PROVIDERS		TMW1			

WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27				
Skin	20:05	20:15	21:00	21:05	22:00
Skin warm Color approp		WNL to ethnicity			
Impl Skn/Wnd POC		done			
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree		2=very limited 3=occasnly moist 1=bedfast 3=slight limited 1=very poor 2=poten.problm 12 score < 17 score1or2 in any score1or2 in any			
Turgor Care routine		tight BazaMoistBarrier			
Other equipment		positioningWedge			
Comfort	20:05	20:15	21:00	21:05	22:00
No c/o,no s/s of		chills fever itching			
Impl Comfort POC		done			
Abnorm findings		pain recvAnalgesicTx			
Pain score		0 Wong-Baker(face)			
Pt relief goal		0-2			
Pain onset		ongoing			
Pain description		unable to descr			
Pain site(s)		unable to descr			
Comfort interv		meds (see MAR) relaxation			
Observ/Treatmnts	20:05	20:15	21:00	21:05	22:00
Alarms on		done			done
Skin care					done
Mouth care		done			done
Turn		back	left side		back &
Side rails up		x4			x4
Passive ROM		done			done
HOB > 30 deg		done			done
Assess reviewed		done			
04/27/11 22:00 Turn(TMW1): cont turn bed					
CARE PROVIDERS		TMW1	TMW1		TMW1

WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27				
Nutrition	20:05	20:15	21:00	21:05	22:00
Meal type		NPO			
Vascular Access	20:05	20:15	21:00	21:05	22:00
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions		antecubital L 04/26/2011 #18 secure dry and intact meds (see MAR)			
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions		forearm L 04/26/2011 #16 secure dry and intact flushed(see MAR) meds (see MAR)			
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions		forearm R 04/26/2011 #16 secure dry and intact meds (see MAR)			
Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zeroed		pedal L 04/26/2011 secure dry and intact crisp done			
Safety	20:05	20:15	21:00	21:05	22:00
Hospital ID band Bed in low posit Bed brakes on Bed press relief IV sol verified IV tbg/bag dated High alertMedsID		on done done on done done done			
Imple SafetyPOC		done			
AspirationRisk AspPrecautnMntn InfectionHiRisk		yes done other (specify)			
Morse Fall Risk	20:05	20:15	21:00	21:05	22:00
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status CARE PROVIDERS		no=0 yes=15 None Bedrest=0 yes=20 Norm BR w/c=0 OvrestFrgtLmt=15 TMW1			

WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27				
Morse Fall Risk Cont.	20:05	20:15	21:00	21:05	22:00
Total score		50			
Imple Safety POC		done			
Intact Incision	20:05	20:15	21:00	21:05	22:00
Incision#1 site Incision#1 type Drain Incision#1 drAmt Incis#1 drainage Surrounding skin		abdomen other (specify) & JP other (specify) large serosanguinous intact			
Incision#1 dsg		dry gauze &			
04/27/11 20:15 Incision#1 type(TMW1): or dressing in place					
04/27/11 20:15 Incision#1 dsg(TMW1): OR dressing					
Diab Flowsheet	20:05	20:15	21:00	21:05	22:00
Insulin multiplr	.08			.09	
Restraints	20:05	20:15	21:00	21:05	22:00
Why restrained		intf w/dsgs intf w/sutures intf w/lines intf w/tubes cannotFollowDir			
Pt DevicesImpact		ETT peripheral IV drain urinary catheter ng tube oxygen/del devic			
Alt/Intervention Restraint type Restraint site No.hrs to be res Criteria for D/C		addrssdNutrition addressed pain addrssdHydration addrssdToileting addrssdPosition addrssd CallBell no alt due cond wrist foam/velcro two wrists 24hr(s) no intf w/lines no intf w/tubes no intf w/dsgs follows commands			
Pt notified Family notified CARE PROVIDERS	 LLHU	done done TMW1		 LLHU	

HURLEY, LORRI L(LLHU)RN WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27				
~~Restraints Cont.~~	20:05	20:15	21:00	21:05	22:00
Other notified		done			
Ordered		04/28/2011 20:00			
Skin checks q1h		done	done		done
Circ checks q1h		done	done		done
Restraint rel q2		done			done
ROM q2h		done			done
Position chg q2h		done			done
Orient behav q2h		done			done
Hydra needs q2h		done			done
Feed needs q2h		done			done
Toilet needs q2h		done			done
Call bell q2		done			done
Behavior q2h		continues			
CARE PROVIDERS		TMW1	TMW1		TMW1

WOMACK, TASSI M(TMW1)RN

FLOWSHEET	04/27	04/28			
Neuro/EENT	23:00	00:00	00:05	01:00	01:05
Reflexes present			present		
Abs of drainage			WNL		
Norm closure PERLA			WNL WNL		
Patent nares No bleed/disch			WNL WNL		
GCS eyes open GCS best verbal Best upper motor GCS total score			3=to verbal 1=tube/trach 5=localzes pain 9		
Lvl of conscious Behavior/neuro Disoriented			lethargic sedated calm unable to assess		
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE			5=localizToPain 5=localizToPain 4=withdraws pain 4=withdraws pain		
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE			3=againstGravity 3=againstGravity 2=gravity elimin 2=gravity elimin		
Both pupilsShape Both pupilsReact Both pupils size			round brisk 4mm		
Observ/Treatmnts	23:00	00:00	00:05	01:00	01:05
Alarms on			done		
Skin care			done		
Mouth care			done		
Turn			left side		
Side rails up			x4		
Passive ROM			done		
HOB > 30 deg			done		
Assess reviewed			done		
Diab Flowsheet	23:00	00:00	00:05	01:00	01:05
Insulin mulriplr		0.09			0.03
Restraints	23:00	00:00	00:05	01:00	01:05
Skin checks q1h Circ checks q1h Restraint rel q2 ROM q2h Position chg q2h Orient behav q2h Hydra needs q2h CARE PROVIDERS	done done TMW1	TMW1	done done done done done done done TMW1	done done TMW1	TMW1

WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/27	04/28			
Restraints-Cont.	23:00	00:00	00:05	01:00	01:05
Feed needs q2h Toilet needs q2h Call bell q2			done done done		
CARE PROVIDERS			TMW1		

WOMACK, TASSI M(TMW1)RN

FLOWSHEET	04/28				
Neuro/EENT	02:00	03:00	04:00	05:00	06:00
Reflexes present			present		
Abs of drainage			WNL		
Norm closure PERLA			WNL WNL		
Patent nares No bleed/disch			WNL WNL		
GCS eyes open GCS best verbal Best upper motor GCS total score			3=to verbal 1=tube/trach 5=localzes pain 9		
Lvl of conscious Behavior/neuro Disoriented			lethargic sedated calm unable to assess		
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE			5=localizToPain 5=localizToPain 4=withdraws pain 4=withdraws pain		
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE			3=againstGravity 3=againstGravity 2=gravity elimin 2=gravity elimin		
Both pupilsShape Both pupilsReact Both pupils size			round brisk 4mm		
Observ/Treatmnts	02:00	03:00	04:00	05:00	06:00
Alarms on	done		done		done
Skin care			done		done
Mouth care	done		done		done
Turn	right side		back &		back
Side rails up	x4		x4		x4
Peri care			done		
Passive ROM	done		done		done
HOB > 30 deg	done		done		done
Assess reviewed			done		done
04/28/11 04:00 Turn(TMW1): cont turn bed					
Diab Flowsheet	02:00	03:00	04:00	05:00	06:00
Insulin mulriplr	0.03	0.05			
CARE PROVIDERS	TMW1	TMW1	TMW1		TMW1

WOMACK, TASSI M(TMW1)RN

FLOWSHEET	04/28				
Restraints	02:00	03:00	04:00	05:00	06:00
Skin checks q1h	done	done	done	done	done
Circ checks q1h	done	done	done	done	done
Restraint rel q2	done		done		done
ROM q2h	done		done		done
Position chg q2h	done		done		done
Orient behav q2h	done		done		done
Hydra needs q2h	done		done		done
Feed needs q2h	done		done		done
Toilet needs q2h	done		done		done
Call bell q2	done		done		done
CARE PROVIDERS	TMW1	TMW1	TMW1	TMW1	TMW1

WOMACK, TASSI M(TMW1)RN

FLOWSHEET	04/28				
Chart Review	07:00	07:36	07:41	08:00	09:00
Chart check q12h		done			
Neuro/EENT	07:00	07:36	07:41	08:00	09:00
Reflexes present			present		
Abs of drainage			WNL		
Norm closure PERLA			WNL WNL		
Patent nares No bleed/disch			WNL WNL		
ImplNeuroEENTPOC			done		
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 1=tube/trach 5=localzes pain 10		
Lvl of conscious Behavior/neuro Disoriented			sedated & agitated restless & unable to assess		
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE			5=localizToPain 5=localizToPain 5=localizToPain 5=localizToPain		
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE			4=against resist 4=against resist 3=againstGravity 3=againstGravity		
Both pupilsShape Both pupilsReact Both pupils size			round brisk 3mm		
04/28/11 07:41 Lvl of conscious(SACT): paused for exam and then titrated down					
04/28/11 07:41 Behavior/neuro(SACT): when awake					
Special Neuro	07:00	07:36	07:41	08:00	09:00
Sedation used			Diprivan		
Pain med			Fentanyl		
Cardiovascular	07:00	07:36	07:41	08:00	09:00
Norm sinusRhythm Rate approp/age S1S2 PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Alarms on			WNL WNL WNL WNL WNL for race WNL on		
CARE PROVIDERS		TMW1	SACT		

NIREWICZ, SARAH A(SACT)RN WOMACK, TASSI M(TMW1)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 09:06
OPT OUT:
Page: 53

FLOWSHEET	04/28				
Cardiovascular-Cont.	07:00	07:36	07:41	08:00	09:00
Implement CV POC			done		
Rhythm			NSR		
Monitor lead			lead II		
Heart sounds			S1 S2		
GeneralizedEdema AllPulsesPresent R radial pulse L radial pulse RdorsalisPedPuls			+2 present 1+=weak 1+=weak 1+=weak		
LdorsalisPedPuls			1+=weak		
Respiratory	07:00	07:36	07:41	08:00	09:00
Suction function			yes		
Ambu bag/mask			present		
Implmnt Resp POC			done		
BS all lobes RLL LLL			rhonchi decreased rhonchi decreased rhonchi		
Sputum/secretion			frothy white		
Consistency			thin		
Airway Oral airway			ETT - oral @bedside		
ETT size Placement @ lip ETT interv Vent mode Rate FiO2 TV PEEP PIP MVe			7.5 24cm lip/skin care mouth care PRVC 18bpm 40% 500mL 5cm 23 9.1l/min		
Oral suction Oral secretions Oral-consistency ETT suction ETT secretions			done clear thin done frothy white		
ETT-consistency			thin		
CARE PROVIDERS			SACT		

NIREWICZ, SARAH A(SACT)RN

CONTINUED

FLOWSHEET	04/28				
Gastrointestinal	07:00	07:38	07:41	08:00	09:00
Normal dentition MucousMembIntact			WNL WNL		
Last BM			pta		
Implement GI POC			done		
BowelSndsAllQuad Abdomen NGT location NGT suction NGT drainage NGT interv G-tube location G-tube suction G-tube drainage J-tube location J-tube interv			absent distended rounded tender right nare low continuous green irrigated placement check LUQ gravity green LLQ &		
Tube#1 type Tube#1 location Tube#1 drainage Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage			JP & & serosanguinous bulb suction stripped & other (specify) & LUQ bloody		
Tube#2 interv			tube site care		
04/28/11 07:41 J-tube interv(SACT): clamped for future feeding					
04/28/11 07:41 Tube#1 type(SACT): x2					
04/28/11 07:41 Tube#1 location(SACT): ruq and llq					
04/28/11 07:41 Tube#1 interv(SACT): drainage recorded					
04/28/11 07:41 Tube#2 type(SACT): duodenum					
Genitourinary	07:00	07:38	07:41	08:00	09:00
Adequate UOP NoChgPattrn/Char NoAbn penile bld NoAbnPenileDisch			WNL WNL WNL WNL		
Implement GU POC			done		
Urine character			orange		
Catheter Catheter size DateCathInserted			foley 16 FR 04/26/2011		
CARE PROVIDERS			SACT		

NIREWICZ, SARAH A(SACT)RN

CONTINUED

FLOWSHEET	04/28				
Genitourinary-Cont.	07:00	07:36	07:41	08:00	09:00
CathInsertedPTA			yes		
Func/Musculoskel	07:00	07:36	07:41	08:00	09:00
Impl FunoMuscPOC			done		
Weakness			generalized		
SCD site SCD type SCD assess			leg L leg R short leg on operational		
Speech			unable verbalize		
Skin	07:00	07:36	07:41	08:00	09:00
Skin warm Color approp			WNL to ethnicity		
Impl Skn/Wnd POC			done		
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree			2=very limited 3=occasnly moist 1=bedfast 3=slight limited 1=very poor 2=poten.problm 12 score < 17 score1or2 in any score1or2 in any		
Turgor Temperature			tight cool		
Care routine			BazaMoistBarrier CarrafoamCleansr		
Other equipment			positioningWedge		
Comfort	07:00	07:36	07:41	08:00	09:00
No c/o,no s/s of			chills fever itching nausea spasms sweating vomiting		
Impl Comfort POC			done		
Abnorm findings			pain recvAnalgesicTx		
Pain score			0 Wong-Baker(face)		
Pt relief goal			0-2		
Pain onset			ongoing		
CARE PROVIDERS			SACT		

NIREWICZ, SARAH A(SACT)RN

CONTINUED

FLOWSHEET	04/28				
Comfort-Cont.	07:00	07:36	07:41	08:00	09:00
Pain description			unable to descr		
Pain site(s)			unable to descr		
Comfort interv			cont infusion emotional supprt relaxation repositioned		
Observ/Treatmnts	07:00	07:36	07:41	08:00	09:00
Alarms on			done		
Mouth care			done		
Turn			right side		
Side rails up			x4		
Passive ROM			done		
HOB > 30 deg			done		
Assess reviewed			done		
Nutrition	07:00	07:36	07:41	08:00	09:00
Meal type			NPO		
Vascular Access	07:00	07:36	07:41	08:00	09:00
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions			antecubital L 04/26/2011 #18 secure dry and intact meds (see MAR)		
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions			forearm L 04/26/2011 #18 secure dry and intact meds (see MAR)		
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions			forearm R 04/26/2011 #16 secure dry and intact meds (see MAR)		
Art line loc Insertion date Site appearance Site dressing Waveform Leveled, zeroed			pedal L 04/26/2011 secure dry and intact crisp done		
CARE PROVIDERS			SACT		

NIREWICZ, SARAH A(SACT)RN

CONTINUED

FLOWSHEET	04/28				
Safety	07:00	07:36	07:41	08:00	09:00
Hospital ID band			on		
Bed in low posit			done		
Bed brakes on			done		
Bed press relief			on		
IV sol verified			done		
IV tbg/bag dated			done		
High alertMedsID			done		
Imple SafetyPOC			done		
AspirationRisk			yes		
AspPrecautnMntn			done		
Morse Fall Risk	07:00	07:36	07:41	08:00	09:00
HxFall(w/in 3mo)			no=0		
Secondary dx			yes=15		
Ambulatory aid			None Bedrest=0		
IV or IV access			yes=20		
Gait			Norm BR w/c=0		
Mental status			OvrestFrgtLmt=15		
Total score			50		
Imple Safety POC			done		
Intact Incision	07:00	07:36	07:41	08:00	09:00
Incision#1 site			abdomen		
Incision#1 type			other (specify) &		
Drain			JP other (specify)		
Incision#1 drAmt			moderate		
Incis#1 drainage			serosanguinous		
Surrounding skin			intact		
Incision#1 dsg			dry gauze &		
04/28/11 07:41 Incision#1 type(SACT): or dsg intact					
04/28/11 07:41 Incision#1 dsg(SACT): or dsg intact					
Diab Flowsheet	07:00	07:36	07:41	08:00	09:00
Insulin mulriplr				.05	.04
Restraints	07:00	07:36	07:41	08:00	09:00
Skin checks q1h	done		done		done
Circ checks q1h	done		done		done
Restraint rel q2			done		
ROM q2h			done		
Position chg q2h			done		
Orient behav q2h			done		
Hydra needs q2h			done		
Feed needs q2h			done		
Toilet needs q2h			done		
Call bell q2			done		
CARE PROVIDERS	TMW1		SACT	SACT	SACT

NIREWICZ, SARAH A(SACT)RN WOMACK, TASSI M(TMW1)RN

CONTINUED

FLOWSHEET	04/28				
Restraints-Cont.	07:00	07:36	07:41	08:00	09:00
Behavior q2h			continues		
Misc Events	07:00	07:36	07:41	08:00	09:00
Misc events			&		
04/28/11 07:41 Misc events(SACT): shift assessment complete. pt stable. no acute issues at this time.					
CARE PROVIDERS			SACT		

NIREWICZ, SARAH A(SACT)RN

FLOWSHEET	04/28				
Neuro/EENT	10:00	10:15	11:00	12:00	12:09
GCS eyes open GCS best verbal Best upper motor GCS total score					4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE					6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE					4=against resist 4=against resist 4=against resist 4=against resist
Both pupilsShape Both pupilsReact Both pupils size					round brisk 3mm
Cardiovascular	10:00	10:15	11:00	12:00	12:09
AllPulsesPresent		present			present
Respiratory	10:00	10:15	11:00	12:00	12:09
Extubation d/t			04/28/2011 11:00 &		
04/28/11 11:00 Extubation d/t(SACT): extubated to room air, attending montgomery present					
Observ/Treatmnts	10:00	10:15	11:00	12:00	12:09
Alarms on		done			done
Mouth care		done			
Linen change					done
Turn		left side			back
Side rails up		x4			x2
Passive ROM		done			
HOB > 30 deg		done			done
Assess reviewed		done			done
Vascular Access	10:00	10:15	11:00	12:00	12:09
Site#1 appear Site#1 dressing Site#2 appear Site#2 dressing Site#3 appear Site#3 dressing Oth art interv		secure dry and intact secure dry and intact secure dry and intact &			secure dry and intact secure dry and intact secure dry and intact
04/28/11 10:15 Oth art interv(SACT): removed due to loss of waveform and blood draw					
CARE PROVIDERS		SACT	SACT		SACT

NIREWICZ, SARAH A(SACT)RN

FLOWSHEET	04/28				
Diab Flowsheet	10:00	10:15	11:00	12:00	12:09
Insulin mulriplr	.04		.05	.06	
Restraints	10:00	10:15	11:00	12:00	12:09
Skin checks q1h		done	done		
Circ checks q1h		done	done		
Restraint rel q2		done			
ROM q2h		done			
Position chg q2h		done			
Orient behav q2h		done			
Hydra needs q2h		done			
Feed needs q2h		done			
Toilet needs q2h		done			
Call bell q2		done			
Behavior q2h		continues	terminated		
Misc Events	10:00	10:15	11:00	12:00	12:09
Rounds		&			
04/28/11 10:15 Rounds(SACT): cc team at bedside. awaiting extubation					
CARE PROVIDERS	SACT	SACT	SACT	SACT	

NIREWICZ, SARAH A(SACT)RN

FLOWSHEET	04/28				
Neuro/EENT	13:00	14:00	14:07	15:00	16:00
Reflexes present					
PERLA					
GCS eyes open GCS best verbal Best upper motor GCS total score					
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE					
Both pupilsShape Both pupilsReact Both pupils size					
Cardiovascular	13:00	14:00	14:07	15:00	16:00
AllPulsesPresent			present		
Observ/Treatmnts	13:00	14:00	14:07	15:00	16:00
Alarms on			done		
Turn			right side		
Side rails up			x2		
HOB > 30 deg			done		
Assess reviewed			done		
Vascular Access	13:00	14:00	14:07	15:00	16:00
Site#1 appear Site#1 dressing Site#2 appear Site#2 dressing Site#3 appear Site#3 dressing			secure dry and intact secure dry and intact secure dry and intact		
Diab Flowsheet	13:00	14:00	14:07	15:00	16:00
Insulin multiplr	.07	.08		.09	.09
CARE PROVIDERS	SACT	SACT	SACT	SACT	SACT

NIREWICZ, SARAH A(SACT)RN

FLOWSHEET	04/28				
Chart Review	16:05	16:50	17:00	18:00	19:00
Chart check q12h					
Neuro/EENT	16:05	16:50	17:00	18:00	19:00
Reflexes present	present				
PERLA	WNL				
GCS eyes open GCS best verbal Best upper motor GCS total score	4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15				
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE	6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands				
Both pupilsShape Both pupilsReact Both pupils size	round brisk 3mm				
Cardiovascular	16:05	16:50	17:00	18:00	19:00
AllPulsesPresent	present				
Observ/Treatmnts	16:05	16:50	17:00	18:00	19:00
Alarms on	done				
Turn	back				
Side rails up	x2				
HOB > 30 deg	done				
Assess reviewed	done				
Vascular Access	16:05	16:50	17:00	18:00	19:00
Site#1 appear Site#1 dressing Site#2 appear Site#2 dressing Site#3 appear Site#3 dressing	secure dry and intact secure dry and intact secure dry and intact				
Intact Incision	16:05	16:50	17:00	18:00	19:00
Incision#1 site Incision#1 type Drain Incision#1 drAmt Incis#1 drainage Surrounding skin Dsg chg sched		abdomen staples JP other (specify) & scant serosanguinous intact every day			
Incision#1 dsg		open to air			
04/28/11 16:50 Drain(SACT): drain sponges around all abdominal drains. incision ota					
CARE PROVIDERS	SACT	SACT			

NIREWICZ, SARAH A(SACT)RN

FLOWSHEET	04/28				
Diab Flowsheet	16:05	16:50	17:00	18:00	19:00
Insulin multiplr			.1	.09	.1
CARE PROVIDERS			SACT	SACT	SACT

NIREWICZ, SARAH A(SACT)RN

FLOWSHEET	04/28				
Chart Review	19:19	19:55	20:19	21:00	22:00
Chart check q12h	done				
Neuro/EENT	19:19	19:55	20:19	21:00	22:00
Alert,orientedx3 Follows commands Reflexes present			WNL WNL present		
NormHear&/orAid Abs of drainage			WNL WNL		
Norm closure No visual impair PERLA			WNL WNL WNL		
Patent nares No bleed/disch			WNL WNL		
ImplNeuroEENTPOC			done		
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15		
Behavior/neuro Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE			calm 6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands		
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE			5=normal 5=normal 5=normal 5=normal		
Both pupilsShape Both pupilsReact Both pupils size			round brisk 3mm		
Special Neuro	19:19	19:55	20:19	21:00	22:00
Pain med			Fentanyl		
Cardiovascular	19:19	19:55	20:19	21:00	22:00
S1S2 Angina/chestPain PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Thigh/CalfTender Alarms on			WNL no complaints WNL WNL for race WNL none on		
Implement CV POC			done		
Rhythm			sinus tach		
Monitor lead			lead II		
Heart sounds			S1 S2		
CARE PROVIDERS	SACT, (SSPU)		SSPU		

NIREWICZ, SARAH A(SACT)RN SPURR, SARAH(SSPU)RN

CONTINUED

FLOWSHEET	04/28				
Cardiovascular-Cont.	19:19	19:55	20:19	21:00	22:00
RUE edema			+1		
RLE edema			+1		
LUE edema			+1		
LLE edema			+1		
GeneralizedEdema			+1		
AllPulsesPresent			present		
Respiratory	19:19	19:55	20:19	21:00	22:00
Spont respers			WNL		
NonLaboredEffort			WNL		
RegClrBreathSnds			all lobes		
Natural airway			WNL		
Suction function			yes		
Ambu bag/mask			present		
Implmnt Resp POC			done		
Cough			nonproductive		
Resp interv			deepBreatheCough incent spirometr		
Oxygen L			2LPM nasal cannula		
Gastrointestinal	19:19	19:55	20:19	21:00	22:00
No c/o N/V			WNL		
Normal dentition			WNL		
MucousMembIntact			WNL		
Last BM			pta		
Implement GI POC			done		
BowelSndsAllQuad			hypoactive		
Abdomen			distended		
			tender		
Mouth			dry		
NGT location			right nare		
NGT suction			low continuous		
NGT drainage			green		
NGT interv			irrigated		
			placement check		
G-tube location			LUQ		
G-tube suction			gravity		
G-tube drainage			green		
G-tube interv			tube site care		
J-tube location			LLQ		
J-tube interv			taped/retaped		
			&		
Tube#1 type			JP		
			&		
Tube#1 location			&		
Tube#1 drainage			serosanguinous		
CARE PROVIDERS			SSPU		

SPURR, SARAH(SSPU)RN

CONTINUED

FLOWSHEET	04/28				
Gastrointestinal-Cont.	19:19	19:55	20:19	21:00	22:00
Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage			bulb suction stripped tube site care other (specify) & LUQ serosanguinous		
Tube#2 interv			tube site care		
04/28/11 20:19 J-tube interv(SSPU): clamped- plan to start TF tmro					
04/28/11 20:19 Tube#1 type(SSPU): x 2					
04/28/11 20:19 Tube#1 location(SSPU): RUQ and LLQ					
04/28/11 20:19 Tube#2 type(SSPU): duodenostomy- to low intermittent wall suction					
Genitourinary	19:19	19:55	20:19	21:00	22:00
Adequate UOP NoChgPattrn/Char NoAbn penile bld NoAbnPenileDisch			WNL WNL WNL WNL		
Implement GU POC			done		
Urine character			amber		
Catheter Catheter size DateCathInserted			foley 16 FR 04/26/2011		
CathInsertedPTA			yes		
Func/Musculoskel	19:19	19:55	20:19	21:00	22:00
ActiveROM x4 ext Symmetry all ext Strength all ext Speech clear			WNL WNL WNL WNL		
Impl FuncMuscPOC			done		
Weakness			generalized		
SCD site SCD type SCD assess			leg L leg R short leg on operational		
Skin	19:19	19:55	20:19	21:00	22:00
Skin warm Skin dry& intact Color approp			WNL WNL to ethnicity		
Impl Skn/Wnd POC			done		
Sens perception Moisture Activity Mobility CARE PROVIDERS			4=no impairmnt 3=occasnly moist 1=bedfast 3=slight limited SSPU		

SPURR, SARAH(SSPU)RN

CONTINUED

FLOWSHEET	04/28				
Skin-Cont.	19:19	19:55	20:19	21:00	22:00
Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree			1=very poor 2=poten.problm 14 score < 17 score1or2 in any score1or2 in any		
Turgor Care routine			tight BazaMoistBarrier		
Other equipment			positioningWedge		
Comfort	19:19	19:55	20:19	21:00	22:00
No c/o,no s/s of			chills fever itching nausea prob sleeping pain sweating vomiting		
Impl Comfort POC			done		
Abnorm findings			recvAnalgesicTx		
Pain score			0 Numeric Value		
Comfort interv			cont infusion emotional supprt repositioned		
Observ/Treatmnts	19:19	19:55	20:19	21:00	22:00
Alarms on			done		
Skin care			done		
Mouth care			done		
Turn			back		
Side rails up			x4		
Deep breathe			done		
IncentiveSpir			done &		
HOB > 30 deg			done		
Assess reviewed			done		
04/28/11 20:19 IncentiveSpir(SSPU): 1000 x 10					
Nutrition	19:19	19:55	20:19	21:00	22:00
Meal type			NPO		
Vascular Access	19:19	19:55	20:19	21:00	22:00
Site#1 location Insertion date Gauge Site#1 appear CARE PROVIDERS			antecubital L 04/26/2011 #18 secure SSPU		

SPURR, SARAH(SSPU)RN

CONTINUED

FLOWSHEET	04/28				
Vascular Access-Cont.	19:19	19:55	20:19	21:00	22:00
Site#1 dressing Interventions			dry and intact meds (see MAR)		
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing Interventions			forearm L 04/26/2011 #16 secure dry and intact meds (see MAR)		
Site#3 location Insertion date Gauge Site#3 appear Site#3 dressing Interventions			forearm R 04/26/2011 #16 secure dry and intact meds (see MAR)		
Safety	19:19	19:55	20:19	21:00	22:00
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on Bed press relief IV sol verified IV tbg/bag dated High alertMedsID			on done done done done on done done done		
Imple SafetyPOC			done		
AspirationRisk AspPrecautnMntn InfectionHiRisk			yes done other (specify) &		
04/28/11 20:19 InfectionHiRisk(SSPU): invasive lines and tubes in place					
Morse Fall Risk	19:19	19:55	20:19	21:00	22:00
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score			no=0 yes=15 None Bedrest=0 yes=20 Norm BR w/c=0 Knows limits=0 35		
Imple Safety POC			done		
Intact Incision	19:19	19:55	20:19	21:00	22:00
Incision#1 site Incision#1 type Drain Incision#1 drAmt Incis#1 drainage CARE PROVIDERS			abdomen staples JP other (specify) moderate serosanguinous SSPU		

SPURR, SARAH(SSPU)RN

CONTINUED

FLOWSHEET	04/28				
Intact Incision-Cont.	**19:19**	**19:55**	**20:19**	**21:00**	**22:00**
Surrounding skin			intact		
Incision#1 dsg			open to air		
Diab Flowsheet	**19:19**	**19:55**	**20:19**	**21:00**	**22:00**
Insulin mulriplr		0.1		.09	.08
CARE PROVIDERS		SSPU	SSPU	SSPU	SSPU

SPURR, SARAH(SSPU)RN

FLOWSHEET	04/28	04/29			
Diab Flowsheet	23:10	00:10	04:00	05:10	06:10
Insulin multiplr	.07	.06	.04	.04	.03
CARE PROVIDERS	SSPU	SSPU	SSPU	SSPU	SSPU

SPURR, SARAH(SSPU)RN

FLOWSHEET	04/29				
Chart Review	07:00	07:22	08:00	09:00	10:00
Chart check q12h		done			
Neuro/EENT	07:00	07:22	08:00	09:00	10:00
Alert,orientedx3 Follows commands Reflexes present			WNL WNL present		
NormHear&/orAid Abs of drainage			WNL WNL		
Norm closure No visual impair PERLA			WNL WNL WNL		
Patent nares No bleed/disch			WNL WNL		
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15		
Behavior/neuro Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE			calm 6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands		
MotorStrengthLUE MotorStrengthRUE MotorStrengthLLE MotorStrengthRLE			5=normal 5=normal 5=normal 5=normal		
Both pupilsShape Both pupilsReact Both pupils size			round brisk 3mm		
Special Neuro	07:00	07:22	08:00	09:00	10:00
Pain med			Fentanyl		
Cardiovascular	07:00	07:22	08:00	09:00	10:00
S1S2 Angina/chestPain PalpPeriphPulses Skin warm, dry Approp skinColor Cap refill<3 sec Thigh/CalfTender Alarms on			WNL no complaints WNL WNL for race WNL none on		
Implement CV POC			done		
Rhythm			sinus tach		
Monitor lead			lead II		
Heart sounds			S1 S2		
GeneralizedEdema CARE PROVIDERS		SSPU, (SACT)	+3 SACT		

NIREWICZ, SARAH A(SACT)RN SPURR, SARAH(SSPU)RN

CONTINUED

FLOWSHEET	04/29				
Cardiovascular-Cont.	07:00	07:22	08:00	09:00	10:00
RperiorbitEdema LperiorbitEdema AllPulsesPresent			+1 +1 present		present
Respiratory	07:00	07:22	08:00	09:00	10:00
Sponl respers NonLaboredEffort RegClrBreathSnds No cough,dyspnea Natural airway			WNL WNL all lobes WNL WNL		
Suction function			yes		
Ambu bag/mask			present		
Implmnt Resp POC			done		
BS all lobes Cough			decreased productive		
Sputum/secretion			clear		
Consistency			thin		
Oxygen L			2LPM nasal cannu la		
GastroIntestinal	07:00	07:22	08:00	09:00	10:00
No c/o N/V Normal dentition MucousMembIntact			WNL WNL WNL		
Last BM			pta		
Implement GI POC			done		
BowelSndsAllQuad Abdomen G-tube location G-tube suction G-tube drainage G-tube interv J-tube location J-tube interv			absent distended tender LUQ gravity green irrigated placement check LLQ irrigated		
Tube#1 type Tube#1 location Tube#1 drainage Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage			JP & & serosanguinous bulb suction stripped other (specify) & LUQ bloody		
Tube#2 interv			&		
CARE PROVIDERS			SACT		SACT

NIREWICZ, SARAH A(SACT)RN

CONTINUED

FLOWSHEET	04/29				
Gastrointestinal-Cont	07:00	07:22	08:00	09:00	10:00
04/29/11 08:00 Tube#1 type(SACT): x2					
04/29/11 08:00 Tube#1 location(SACT): ruq and luq					
04/29/11 08:00 Tube#2 type(SACT): duodenal drain					
04/29/11 08:00 Tube#2 interv(SACT): to low wall suction					
Genitourinary	07:00	07:22	08:00	09:00	10:00
Adequate UOP NoChgPattrn/Char NoAbn penile bld NoAbnPenileDisch			WNL WNL WNL WNL		
Implement GU POC			done		
Urine character			orange		
Catheter Catheter size			foley 16 FR		
Func/Musculoskel	07:00	07:22	08:00	09:00	10:00
ActiveROM x4 ext Symmetry all ext Speech clear			WNL WNL WNL		
Impl FuncMuscPOC			done		
Weakness			generalized		
SCD site SCD type SCD assess			leg L leg R short leg on operational		
Skin	07:00	07:22	08:00	09:00	10:00
Skin warm Skin dry& intact Color approp			WNL WNL to ethnicity		
Impl Skn/Wnd POC			done		
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Implement POC if SpBed DecisnTree			4=no impairmnt 4=rarely moist 1=bedfast 3=slight limited 1=very poor 3=no app.probl 16 score < 17 score1or2 in any score1or2 in any		
Turgor Temperature			tight cool		
Care routine			BazaMoistBarrier CarrafoamCleansr		
Other equipment			positioningWedge		
CARE PROVIDERS			SACT		

NIREWICZ, SARAH A(SACT)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 74

FLOWSHEET	04/29				
Comfort	07:00	07:22	08:00	09:00	10:00
No c/o,no s/s of			chills fever itching nausea spasms sweating vomiting		
Impl Comfort POC			done		
Abnorm findings			pain recvAnalgesicTx		
Pain score			5 Numeric Value		
Pt relief goal			0-2		
Pain onset			ongoing		
Pain description			throbbing		
Pain site(s)			incisional abdomen		
Comfort interv			cont infusion emotional supprt relaxation repositioned		
Observ/Treatmnts	07:00	07:22	08:00	09:00	10:00
Alarms on			done		done
Mouth care			done		
Turn			back self		left side
Side rails up			x3		x3
Deep breathe			done		done
IncentiveSpir			done		done
HOB > 30 deg			done		done
Assess reviewed					done
Nutrition	07:00	07:22	08:00	09:00	10:00
Meal type			NPO		
Vascular Access	07:00	07:22	08:00	09:00	0:00
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions			antecubital L 04/26/2011 #18 secure dry and intact saline lock		 secure dry and intact
Site#2 location Insertion date Gauge Site#2 appear			forearm L 04/26/2011 #18 secure		 secure
CARE PROVIDERS			SACT		SACT

NIREWICZ, SARAH A(SACT)RN

CONTINUED

FLOWSHEET	04/29				
Vascular Access-Cont.	07:00	07:22	08:00	09:00	10:00
Site#2 dressing Interventions			dry and intact meds (see MAR)		dry and intact
Safety	07:00	07:22	08:00	09:00	10:00
Hospital ID band			on		
CallSystm access			done		
Bed in low posit			done		
Bed brakes on			done		
Bed alarms on			done		
Bed press relief			on		
IV sol verified			done		
IV tbg/bag dated			done		
High alertMedsID			done		
Imple SafetyPOC			done		
AspirationRisk			yes		
AspPrecautnMntn			done		
Morse Fall Risk	07:00	07:22	08:00	09:00	10:00
HxFall(w/in 3mo)			no=0		
Secondary dx			yes=15		
Ambulatory aid			None Bedrest=0		
IV or IV access			yes=20		
Gait			Norm BR w/c=0		
Mental status			Knows limits=0		
Total score			35		
Intact Incision	07:00	07:22	08:00	09:00	10:00
Incision#1 site			abdomen		
Incision#1 type			staples		
Drain			JP		
			other (specify) &		
Incision#1 drAmt			none		
Surrounding skin			intact		
Dsg chg sched			every day		
Incision#1 dsg			other (specify) &		
04/29/11 08:00 Drain(SACT): jp x2, duodenal drain, gtube, jtube					
04/29/11 08:00 Incision#1 dsg(SACT): incision ota and drain sponges around drains					
Diab Flowsheet	07:00	07:22	08:00	09:00	10:00
Insulin mulriplr	.03		.03	.04	.05
Misc Events	07:00	07:22	08:00	09:00	10:00
Misc events			&		
04/29/11 08:00 Misc events(SACT): shift assessment complete. pt stable.					
CARE PROVIDERS	SSPU		SACT	SACT	SACT

NIREWICZ, SARAH A(SACT)RN SPURR, SARAH(SSPU)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 76

FLOWSHEET	04/29				
Neuro/EENT	11:00	12:00	12:45	13:00	14:00
Alert,orientedx3 Follows commands Reflexes present			WNL WNL present		
PERLA			WNL		
GCS eyes open GCS best verbal Best upper motor GCS total score			4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15		
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE			6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands		
Both pupilsShape Both pupilsReact Both pupils size			round brisk 3mm		
Cardiovascular	11:00	12:00	12:45	13:00	14:00
AllPulsesPresent			present		
Observ/Treatmnts	11:00	12:00	12:45	13:00	14:00
Alarms on			done		
Linen change			done		
Turn			back &		
Deep breathe			done		
IncentiveSpir			done		
HOB > 30 deg			done		
Assess reviewed			done		
04/29/11 12:45 Turn(SACT): up in chair					
Vascular Access	11:00	12:00	12:45	13:00	14:00
Site#1 appear Site#1 dressing Site#2 appear Site#2 dressing			secure dry and intact secure dry and intact		
Diab Flowsheet	11:00	12:00	12:45	13:00	14:00
Insulin multiplr	.06	.07		.07	.07
CARE PROVIDERS	SACT	SACT	SACT	SACT	SACT

NIREWICZ, SARAH A(SACT)RN

GOODWIN, DAVON
MUSC
24Hour Critical Care Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 77

FLOWSHEET	04/29				
Neuro/EENT	14:15	15:00	16:00	16:30	16:54
Alert,orientedx3 Reflexes present				WNL present	
PERLA				WNL	
GCS eyes open GCS best verbal Best upper motor GCS total score				4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15	
Motor exam LUE Motor exam RUE Motor exam LLE Motor exam RLE				6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands	
Both pupilsShape Both pupilsReact Both pupils size				round brisk 3mm	
Cardiovascular	14:15	15:00	16:00	16:30	16:54
AllPulsesPresent	present			present	
Observ/Treatmnts	14:15	15:00	16:00	16:30	16:54
Alarms on	done			done	
Turn	back &			self	
Side rails up				x3	
Deep breathe	done			done	
IncentiveSpir	done			done	
HOB > 30 deg	done			done	
Assess reviewed	done			done	
04/29/11 14:15 Turn(SACT): back to bed from chair					
Vascular Access	14:15	15:00	16:00	16:30	16:54
Site#1 appear Site#1 dressing Site#2 appear Site#2 dressing	secure dry and intact secure dry and intact			secure dry and intact secure dry and intact	
Intact Incision	14:15	15:00	16:00	16:30	16:54
Drain					&
04/29/11 16:54 Drain(SACT): drain sponges changed					
Diab Flowsheet	14:15	15:00	16:00	16:30	16:54
Insulin mulriplr		.06	.06		
CARE PROVIDERS	SACT	SACT	SACT	SACT	SACT

NIREWICZ, SARAH A(SACT)RN

FLOWSHEET	04/29		
Diab Flowsheet	17:00	18:28	19:06
Insulin mulriplr	.07	.06	.05
CARE PROVIDERS	SACT	SACT	SACT

NIREWICZ, SARAH A(SACT)RN

GOODWIN, DAVON
MUSC
MUHA mod/inact
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 1

I & O

Wound drn #1
(O) Perform Date: 04/26/11 19:40 Chart Date: 04/26/11 19:45 Chart Inits.: JLP
Value: 100
(M) Perform Date: 04/26/11 19:40 Chart Date: 04/26/11 19:45 Chart Inits.: JLP
Value: (500)

InvasiveLineFlsh
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 3
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Lactated Ringers
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 30
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Foley cath
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 70
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Insulin
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 4.4
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Foley cath
(O) Perform Date: 04/29/11 19:45 Chart Date: 04/29/11 19:49 Chart Inits.: DLRO
Value: 650
(I) Inact Date: 04/29/11 19:52 Inact Inits.: DLRO

NG tube
(O) Perform Date: 05/01/11 02:00 Chart Date: 05/01/11 02:58 Chart Inits.: MGAL
Value: 150
(I) Inact Date: 05/01/11 06:44 Inact Inits.: MGAL

Urine
(O) Perform Date: 05/01/11 19:30 Chart Date: 05/01/11 19:30 Chart Inits.: BM2
Value: 1
(I) Inact Date: 05/01/11 19:30 Inact Inits.: BM2

TF residual
(O) Perform Date: 05/01/11 21:47 Chart Date: 05/01/11 22:20 Chart Inits.: ET72
Value: 15
(I) Inact Date: 05/02/11 00:38 Inact Inits.: ET72

Foley cath
(O) Perform Date: 05/02/11 22:29 Chart Date: 05/02/11 22:39 Chart Inits.: BRB5
Value: 700
(I) Inact Date: 05/03/11 04:27 Inact Inits.: BRB5

Urine(O)
(O) Perform Date: 05/04/11 01:52 Chart Date: 05/04/11 01:55 Chart Inits.: PA35
Value: 1
(I) Inact Date: 05/04/11 03:12 Inact Inits.: PA35

CONTINUED

I & O

G-tube
(O) Perform Date: 05/04/11 01:52 Chart Date: 05/04/11 01:55 Chart Inits.: PA35
Value: 0
(I) Inact Date: 05/04/11 03:12 Inact Inits.: PA35

JP #1
(O) Perform Date: 05/04/11 01:52 Chart Date: 05/04/11 01:55 Chart Inits.: PA35
Value: 0
(I) Inact Date: 05/04/11 03:12 Inact Inits.: PA35

JP #2
(O) Perform Date: 05/04/11 01:52 Chart Date: 05/04/11 01:55 Chart Inits.: PA35
Value: 0
(I) Inact Date: 05/04/11 03:12 Inact Inits.: PA35

Stool(O)
(O) Perform Date: 05/04/11 01:52 Chart Date: 05/04/11 01:55 Chart Inits.: PA35
Value: 10
Annotation: cc's
(I) Inact Date: 05/04/11 03:12 Inact Inits.: PA35

Legend Charting

Temp in C Do Not Delete
(O) Perform Date: 04/26/11 07:00 Chart Date: 04/26/11 07:38 Chart Inits.: SMT5
Value: 35.9C
(M) Perform Date: 04/26/11 07:00 Chart Date: 04/26/11 07:44 Chart Inits.: SMT5
Value: 35.9C
Annotation: (Bear hugger placed on pt.)

Report Do Not Delete
(O) Perform Date: 04/26/11 07:15 Chart Date: 04/26/11 07:59 Chart Inits.: SMT5
Value:
Annotation: Report given to Leslie RN; Transfer of pt. care
(M) Perform Date: 04/26/11 07:15 Chart Date: 04/26/11 08:00 Chart Inits.: SMT5
Value:
Annotation: (Report given to Leslie RN; Notified Leslie that 2 more units of FFP still needed to be given; Transfer of pt. care)

Site appearance Do Not Delete
(O) Perform Date: 04/26/11 10:00 Chart Date: 04/26/11 11:51 Chart Inits.: LAA
Value: SecureSutur
(M) Perform Date: 04/26/11 10:00 Chart Date: 04/26/11 12:14 Chart Inits.: LAA
Value: (Secure)

Temp in C Do Not Delete
(O) Perform Date: 04/28/11 13:23 Chart Date: 04/28/11 13:23 Chart Inits.: SACT
Value: 36.7C
(I) Inact Date: 04/28/11 13:23 Inact Inits.: SACT

PULSE Do Not Delete
(O) Perform Date: 04/28/11 13:23 Chart Date: 04/28/11 13:23 Chart Inits.: SACT
Value: 104
(I) Inact Date: 04/28/11 13:23 Inact Inits.: SACT

RESPIRATIONS Do Not Delete
(O) Perform Date: 04/28/11 13:23 Chart Date: 04/28/11 13:23 Chart Inits.: SACT
Value: 21

CONTINUED

GOODWIN, DAVON
MUSC
MUHA mod/inact
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 03:00
OPT OUT:
Page: 3

Legend Charting

RESPIRATIONS **Do Not Delete**
(I) Inact Date: 04/28/11 13:24 Inact Inits.: SACT

O2 SAT % **Do Not Delete**
(O) Perform Date: 04/28/11 13:23 Chart Date: 04/28/11 13:23 Chart Inits.: SACT
Value: 99%
(I) Inact Date: 04/28/11 13:24 Inact Inits.: SACT

O2 SAT % **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 97%
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

BP mean (NIBP) **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 91
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

PULSE **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 112
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Insulin **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 4.4units/hr
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Insulin mulriplr **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 0.1
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

RESPIRATIONS **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 23
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

BP (NIBP) **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 154/71
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Temp in C **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 37C
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

Glucose fs **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 104mg/dL
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

PAIN LEVEL **Do Not Delete**
(O) Perform Date: 04/29/11 06:10 Chart Date: 04/29/11 06:15 Chart Inits.: SSPU
Value: 0 Wongbk
(I) Inact Date: 04/29/11 06:35 Inact Inits.: SSPU

CONTINUED

Legend Charting

Glucose fs Do Not Delete
(C) Perform Date: 04/30/11 02:00 Chart Date: 04/30/11 02:19 Chart Inits.: MGAL
Value: 128mg/dL
(I) Inact Date: 04/30/11 02:21 Inact Inits.: MGAL

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/29/11 20:00 Chart Date: 04/30/11 03:21 Chart Inits.: JAC1
Value: .04
(C) Perform Date: 04/29/11 20:00 Chart Date: 04/30/11 03:21 Chart Inits.: JAC1
Value: .04

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/29/11 21:00 Chart Date: 04/30/11 03:21 Chart Inits.: JAC1
Value: .04
(C) Perform Date: 04/29/11 21:00 Chart Date: 04/30/11 03:21 Chart Inits.: JAC1
Value: .04

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/29/11 22:00 Chart Date: 04/30/11 03:22 Chart Inits.: JAC1
Value: .05
(C) Perform Date: 04/29/11 22:00 Chart Date: 04/30/11 03:22 Chart Inits.: JAC1
Value: .05

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/29/11 23:00 Chart Date: 04/30/11 03:22 Chart Inits.: JAC1
Value: .04
(C) Perform Date: 04/29/11 23:00 Chart Date: 04/30/11 03:22 Chart Inits.: JAC1
Value: .04

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/30/11 00:00 Chart Date: 04/30/11 03:22 Chart Inits.: JAC1
Value: .03
(C) Perform Date: 04/30/11 00:00 Chart Date: 04/30/11 03:22 Chart Inits.: JAC1
Value: .03

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/30/11 01:00 Chart Date: 04/30/11 03:23 Chart Inits.: JAC1
Value: .03
(C) Perform Date: 04/30/11 01:00 Chart Date: 04/30/11 03:23 Chart Inits.: JAC1
Value: .03

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/30/11 02:00 Chart Date: 04/30/11 03:23 Chart Inits.: JAC1
Value: .04
(C) Perform Date: 04/30/11 02:00 Chart Date: 04/30/11 03:23 Chart Inits.: JAC1
Value: .04

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/30/11 03:00 Chart Date: 04/30/11 03:23 Chart Inits.: JAC1
Value: .05
(C) Perform Date: 04/30/11 03:00 Chart Date: 04/30/11 03:23 Chart Inits.: JAC1
Value: .05

Insulin Multiplr Do Not Delete
(C) Perform Date: 04/30/11 04:00 Chart Date: 04/30/11 04:41 Chart Inits.: JAC1
Value: .06

CONTINUED

Legend Charting

Insulin Multiplr Do Not Delete
(O) Perform Date: 04/30/11 04:00 Chart Date: 04/30/11 04:41 Chart Inits.: JAC1
Value: .06

Insulin Do Not Delete
(O) Perform Date: 04/30/11 03:00 Chart Date: 04/30/11 03:20 Chart Inits.: JAC1
Value: 2.7units/hr
(I) Inact Date: 04/30/11 04:42 Inact Inits.: JAC1

Insulin Do Not Delete
(O) Perform Date: 04/30/11 02:00 Chart Date: 04/30/11 03:20 Chart Inits.: JAC1
Value: 1.4units/hr
(I) Inact Date: 04/30/11 04:42 Inact Inits.: JAC1

Insulin Do Not Delete
(O) Perform Date: 04/30/11 01:00 Chart Date: 04/30/11 03:20 Chart Inits.: JAC1
Value: 1units/hr
(I) Inact Date: 04/30/11 04:42 Inact Inits.: JAC1

Insulin Do Not Delete
(O) Perform Date: 04/30/11 00:00 Chart Date: 04/30/11 03:20 Chart Inits.: JAC1
Value: 1.2units/hr
(I) Inact Date: 04/30/11 04:43 Inact Inits.: JAC1

Insulin Do Not Delete
(O) Perform Date: 04/29/11 23:00 Chart Date: 04/30/11 03:19 Chart Inits.: JAC1
Value: 7.4units/hr
(I) Inact Date: 04/30/11 04:43 Inact Inits.: JAC1

Insulin Do Not Delete
(O) Perform Date: 04/29/11 22:00 Chart Date: 04/29/11 22:12 Chart Inits.: JAC1
Value: 1.9units/hr
(I) Inact Date: 04/30/11 04:43 Inact Inits.: JAC1

Insulin Do Not Delete
(O) Perform Date: 04/29/11 21:00 Chart Date: 04/29/11 22:12 Chart Inits.: JAC1
Value: 1.4units/hr
(I) Inact Date: 04/30/11 04:43 Inact Inits.: JAC1

Insulin Do Not Delete
(O) Perform Date: 04/29/11 20:00 Chart Date: 04/29/11 22:12 Chart Inits.: JAC1
Value: 1.6units/hr
(I) Inact Date: 04/30/11 04:43 Inact Inits.: JAC1

Insulin Multiplr Do Not Delete
(O) Perform Date: 04/30/11 05:00 Chart Date: 04/30/11 05:01 Chart Inits.: JAC1
Value: .07
(O) Perform Date: 04/30/11 05:00 Chart Date: 04/30/11 05:01 Chart Inits.: JAC1
Value: .07

Last BM Do Not Delete
(O) Perform Date: 04/30/11 07:57 Chart Date: 04/30/11 09:57 Chart Inits.: JLNO
Value: pta
(I) Inact Date: 04/30/11 10:01 Inact Inits.: JLNO

CONTINUED

Legend Charting

Tube#3 interv Do Not Delete
(O) Perform Date: 05/01/11 19:20 Chart Date: 05/01/11 20:16 Chart Inits.: JAC1
Value:
Annotation: LCWS, moderate amount green drainage
(I) Inact Date: 05/01/11 22:20 Inact Inits.: JAC1

Tube#3 type Do Not Delete
(O) Perform Date: 05/01/11 19:20 Chart Date: 05/01/11 20:16 Chart Inits.: JAC1
Value: Othdrn
Annotation: duodenal
(I) Inact Date: 05/01/11 22:21 Inact Inits.: JAC1

BP (NIBP) Do Not Delete
(O) Perform Date: 05/02/11 02:04 Chart Date: 05/02/11 02:11 Chart Inits.: ET72
Value: 161/95 Rarmly
(M) Perform Date: 05/02/11 02:04 Chart Date: 05/02/11 02:17 Chart Inits.: ET72
Value: 161/95 Rarmly
Annotation: (rn notified)

Pain score Do Not Delete
(O) Perform Date: 05/02/11 04:23 Chart Date: 05/02/11 04:25 Chart Inits.: JAC1
Value: 7 Numvlu
(I) Inact Date: 05/02/11 04:31 Inact Inits.: JAC1

Chart check q12h Do Not Delete
(O) Perform Date: 05/02/11 07:05 Chart Date: 05/02/11 07:05 Chart Inits.: JAC1
Value: Done
(O) Perform Date: 05/02/11 07:05 Chart Date: 05/02/11 07:05 Chart Inits.: JAC1
Value: Done

Drain Do Not Delete
(O) Perform Date: 05/02/11 08:05 Chart Date: 05/02/11 11:54 Chart Inits.: MP04
Value:
Annotation: miltpile drains
(M) Perform Date: 05/02/11 08:05 Chart Date: 05/02/11 11:58 Chart Inits.: MP04
Value:
Annotation: (miltpile drains; ruq jp; luq jp; g tbe to foley bag, j tube with feeding; duedonal drain.)

PainReassessScor Do Not Delete
(O) Perform Date: 05/02/11 11:40 Chart Date: 05/02/11 12:00 Chart Inits.: MP04
Value: 7 Numvlu
(M) Perform Date: 05/02/11 11:40 Chart Date: 05/02/11 12:16 Chart Inits.: MP04
Value: (6 Numvlu)

Chart check q12h Do Not Delete
(O) Perform Date: 05/02/11 19:21 Chart Date: 05/02/11 19:21 Chart Inits.: MP04
Value: Done
(O) Perform Date: 05/02/11 19:21 Chart Date: 05/02/11 19:21 Chart Inits.: MP04
Value: Done

Chart check q12h Do Not Delete
(O) Perform Date: 05/03/11 06:48 Chart Date: 05/03/11 06:48 Chart Inits.: DLRO
Value: Done
(O) Perform Date: 05/03/11 06:48 Chart Date: 05/03/11 06:48 Chart Inits.: DLRO
Value: Done

CONTINUED

Legend Charting

G-tube drainage Do Not Delete
(C) Perform Date: 05/03/11 08:43 Chart Date: 05/03/11 09:39 Chart Inits.: COS0
Value: Green
(M) Perform Date: 05/03/11 08:43 Chart Date: 05/03/11 10:00 Chart Inits.: COS0
Value: (BrownGreen)

Tube#1 drainage Do Not Delete
(C) Perform Date: 05/03/11 08:43 Chart Date: 05/03/11 09:39 Chart Inits.: COS0
Value: Ptccol
Annotation: clear/pale yellow
(I) Inact Date: 05/03/11 10:00 Inact Inits.: COS0

Tube#2 drainage Do Not Delete
(C) Perform Date: 05/03/11 08:43 Chart Date: 05/03/11 09:39 Chart Inits.: COS0
Value: Ptccol
Annotation: yellow/clear
(I) Inact Date: 05/03/11 10:01 Inact Inits.: COS0

PainReassessScor Do Not Delete
(C) Perform Date: 05/03/11 09:42 Chart Date: 05/03/11 09:43 Chart Inits.: COS0
Value: - Sleepg
(I) Inact Date: 05/03/11 10:22 Inact Inits.: COS0

ReassessComf Int Do Not Delete
(C) Perform Date: 05/03/11 12:04 Chart Date: 05/03/11 12:07 Chart Inits.: COS0
Value: EmtsupRelaxReposi
(M) Perform Date: 05/03/11 12:04 Chart Date: 05/03/11 12:15 Chart Inits.: COS0
Value: (EmtsupHeatRelaxReposi)

Chart check q12h Do Not Delete
(C) Perform Date: 05/03/11 18:54 Chart Date: 05/03/11 18:54 Chart Inits.: COS0
Value: Done
(C) Perform Date: 05/03/11 18:54 Chart Date: 05/03/11 18:54 Chart Inits.: COS0
Value: Done

Chart check q12h Do Not Delete
(C) Perform Date: 05/04/11 07:02 Chart Date: 05/04/11 07:02 Chart Inits.: TMM2
Value: Done
(C) Perform Date: 05/04/11 07:02 Chart Date: 05/04/11 07:02 Chart Inits.: TMM2
Value: Done

Misc events Do Not Delete
(C) Perform Date: 05/04/11 08:06 Chart Date: 05/04/11 08:06 Chart Inits.: MKWI
Value:
Annotation: pt up to chair
(M) Perform Date: 05/04/11 08:06 Chart Date: 05/04/11 09:20 Chart Inits.: MKWI
Value:
Annotation: (pt up to chair, Oxygen at 2l n/c started. Heat packs to neck and shoulder r/t c/o muscle pain and discomfort.)

PULSE Do Not Delete
(C) Perform Date: 05/04/11 08:06 Chart Date: 05/04/11 09:45 Chart Inits.: JTC
Value: 115
Annotation: manual pulse, the patient was sitting up in the wheelchair
(M) Perform Date: 05/04/11 08:06 Chart Date: 05/04/11 09:47 Chart Inits.: JTC
Value: 115
Annotation: (The patient was sitting up in the wheelchair when I did a manual pulse. The patient was verbal and complaining of pain. RN Marianne notified.)

CONTINUED

GOODWIN, DAVON
MUSC
MUHA mod/inact
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 8

Medication Administration

FAMOTIDINE
(O) Perform Date: 04/26/11 19:36 Chart Date: 04/26/11 19:37 Chart Inits.: JLP
Value: 20 MG
(M) Perform Date: 04/26/11 19:36 Chart Date: 04/26/11 19:37 Chart Inits.: JLP
Value: (0 MG)
Annotation: (&)

PROTEIN SUPP
(O) Perform Date: 04/30/11 13:08 Chart Date: 04/30/11 13:09 Chart Inits.: JLNO
Value: 30 ML JT
(I) Inact Date: 04/30/11 13:09 Inact Inits.: JLNO

OXYCODONE
(O) Perform Date: 05/03/11 22:06 Chart Date: 05/03/11 22:06 Chart Inits.: MEGS
Value: 15 MG JT
(I) Inact Date: 05/03/11 22:06 Inact Inits.: MEGS

OXYCODONE
(O) Perform Date: 05/04/11 00:26 Chart Date: 05/04/11 00:26 Chart Inits.: MEGS
Value: 5 MG JT
(I) Inact Date: 05/04/11 00:26 Inact Inits.: MEGS

Care Providers:
BM2 MILLS, BRETT, PCT
BRB5 BAKER, BRIAN, PCT
COS0 SLUSARSKI, COREY, RN
DLRO ROBERTS, DUSTI L, RN
ET72 TRIA, EMMANUEL, PCT
JAC1 COTTLE, JEAN A, RN
JLNO NORMAN, JILL L, RN
JLP PETERSON, JENNIFER L, RN
JTC CARSON, JOHN T, CA
LAA ADAMS, LESLIE A, RN
MEGS STONE, MEGAN E, RN
MGAL GALAMITON, MAXIMO, CA
MKWI WITTENMEYER, MARIANNE K, RN
MP04 PASCARELLA, MELISSA, RN
PA35 ALLS, PHINETHA, PCT
SACT NIREWICZ, SARAH A, RN
SMT5 MCGLYNN, STEPHANIE, RN
SSPU SPURR, SARAH, RN
TMM2 MARTUCCI, TIFFANY, RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 1

FLOWSHEET	04/29				
Neuro/EENT	20:00	20:09	21:00	22:00	23:00
Alert,orientedx3	WNL				
Follows commands	WNL				
NoSensoryDeficit	WNL				
	&				
NormHear&/orAid	WNL				
Abs of drainage	WNL				
Norm closure	WNL				
Abs of swelling	WNL				
No visual impair	WNL				
PERRLA	WNL				
Patent nares	WNL				
No bleed/disch	WNL				
04/29/11 20:00 NoSensoryDeficit(JAC1): denies tingling/numbness bil upper/lower extremities					
Special Neuro	20:00	20:09	21:00	22:00	23:00
GCS eyes open	4=spontaneously				
GCS best verbal	5=orient/verbalz				
Best upper motor	6=obeysVbCommand				
GCS total sco	15				
Motor exam LUE	6=obeys commands				
Motor exam LLE	6=obeys commands				
Motor exam RUE	6=obeys commands				
Motor exam RLE	6=obeys commands				
MotorStrengthLUE	5=normal				
MotorStrengthLLE	5=normal				
MotorStrengthRUE	5=normal				
MotorStrengthRLE	5=normal				
Cardiovascular	20:00	20:09	21:00	22:00	23:00
S1S2	WNL				
Angina/chestPain	none				
PalpPerhipPulses	WNL				
Cap refill<3 sec	WNL				
Thigh/CalfTender	none				
Implement Cv POC	done				
Rhythm	sinus tach				
RUE edema	+2				
RLE edema	+2				
LUE edema	+3				
LLE edema	+2				
GeneralizedEdema	+2				
R radial pulse	normal				
L radial pulse	normal				
R pedal pulse	normal				
L pedal pulse	normal				
CARE PROVIDERS	JAC1				

COTTLE, JEAN A(JAC1)RN

CONTINUED

FLOWSHEET	04/29				
Respiratory	20:00	20:09	21:00	22:00	23:00
Spont respers	WNL				
NonLaboredEffort	WNL				
RegClrBreathSnds	all lobes				
No cough,dyspnea	WNL				
Natural airway	WNL				
No O2 requiremnt	WNL				
	&				
04/29/11 20:00 No O2 requiremnt(JAC1): I.S. at bedside, watched pt. demonstrate use. CPO in use showing 95%					
Gastrointestinal	20:00	20:09	21:00	22:00	23:00
Continent	WNL				
No c/o N/V	WNL				
Normal dentition	WNL				
MucousMembIntact	WNL				
Last BM	pta				
Implement GI POC	done				
BowelSndsAllQuad	hypoactive				
Abdomen	distended				
	firm				
	tender				
Mouth	dry				
Tube feeding	see MAR				
Tube type	j-tube				
Tube interv	placement check				
TF interv	&				
G-tube location	LUQ				
G-tube suction	gravity				
G-tube drainage	green				
J-tube location	LUQ				
Tube#1 type	JP				
Tube#1 location	RUQ				
Tube#1 drainage	bloody				
Tube#1 interv	bulb suction				
Tube#2 type	JP				
Tube#2 location	LUQ				
Tube#2 drainage	clear				
	scant				
Tube#2 interv	bulb suction				
Tube#3 type	other (specify)				
	&				
Tube#3 location	LUQ				
Tube#3 drainage	none				
Tube#3 interv	&				
04/29/11 20:00 TF interv(JAC1): Promote increased per orders to 35cc/hr					
04/29/11 20:00 Tube#3 type(JAC1): Duodenal drain					
04/29/11 20:00 Tube#3 interv(JAC1): to LCWS					
CARE PROVIDERS	JAC1				

COTTLE, JEAN A(JAC1)RN

CONTINUED

FLOWSHEET	04/29				
Genitourinary	20:00	20:09	21:00	22:00	23:00
Adequate UOP NoAbn penile bid NoAbnPenileDisch	WNL WNL WNL				
Implement GU POC	done				
Urine character	amber				
Catheter Catheter size	foley 16 FR				
Func/Musculoskel	20:00	20:09	21:00	22:00	23:00
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear	WNL WNL WNL no devices WNL				
Impl FuncMuscPOC	done				
Weakness	generalized				
SCD site SCD type	leg L leg R short leg				
SCD assess	on operational				
Skin	20:00	20:09	21:00	22:00	23:00
Skin warm Color approp	WNL to ethnicity				
Impl Skn/Wnd POC	done				
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Bruise site(s)	4=no impairmnt 4=rarely moist 3=walks occasion & 3=slight limited 2=prob adequate 3=no app.probl 19 arm R				
04/29/11 20:00 Activity(JAC1): orders for OOB ad lib					
Psychological	20:00	20:09	21:00	22:00	23:00
Memory intact Approp affect Approp behavior Approp verbaliz	WNL & to situation to situation				
Implemnt PSE POC	done				
Abnorm findings	maladj illness				
04/29/11 20:00 Approp affect(JAC1): flat affect					
CARE PROVIDERS	JAC1				

COTTLE, JEAN A(JAC1)RN

CONTINUED

FLOWSHEET	04/29				
Comfort	20:00	20:09	21:00	22:00	23:00
No c/o,no s/s of	chills fever itching nausea prob sleeping spasms sweating vomiting				
Impl Comfort POC	done				
Abnorm findings	pain recvAnalgesicTx	pain recvAnalgesicTx			
Pain score	6 Numeric Value	6 Numeric Value			
Pt relief goal	0-4	0-4			
Pain onset	ongoing	ongoing			
Pain description	constant	constant			
Pain site(s)	incisional abdomen	incisional abdomen			
Comfort interv	distraction diversion relaxation repositioned &	meds (see MAR) &			
PainReassessScor Pt Goal Reassess				4 Numeric Value 0-4	
ReassessComf Int				distraction diversion repositioned	
04/29/11 20:00 Comfort interv(JAC1): to be medicated for pain					
04/29/11 20:09 Comfort interv(JAC1): oxycodone					
Nutrition	20:00	20:09	21:00	22:00	23:00
Meal type	NPO				
Enteral feed Schedule CurrntRate mL/hr	Promote continuous 20 &				
Goal rate mL/hr	95				
04/29/11 20:00 CurrntRate mL/hr(JAC1): increased at present time to 35cc per orders					
Vascular Access	20:00	20:09	21:00	22:00	23:00
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions	antecubital L 04/26/2011 #18 secure dry and intact saline lock				
CARE PROVIDERS	JAC1	JAC1		JAC1	

COTTLE, JEAN A(JAC1) RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:56 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 09:06
OPT OUT:
Page: 5

FLOWSHEET	04/29				
Vascular Access-Cont.	20:00	20:09	21:00	22:00	23:00
Site#2 location	forearm L				
Insertion date	04/26/2011				
Gauge	#16				
Site#2 appear	secure				
Site#2 dressing	dry and intact				
Interventions	meds (see MAR)				
Safety	20:00	20:09	21:00	22:00	23:00
Hospital ID band	on				
CallSystm access	done				
Bed in low posit	done				
Bed brakes on	done				
Bed alarms on	done				
IV sol verified	done				
IV tbg/bag dated	done				
High alertMedsID	done &				
Imple SafetyPOC	done				
04/29/11 20:00 High alertMedsID(JAC1): insulin drip					
Fall Risk	20:00	20:09	21:00	22:00	23:00
HxFall(w/in 3mo)	no=0				
Secondary dx	no=0				
Ambulatory aid	w/o NrsAssist=0				
IV or IV access	yes=20				
Gait	WeakUsesTouch=10				
Mental status	Knows limits=0				
Total score	30				
Imple SafetyPOC	done				
Intact Incision	20:00	20:09	21:00	22:00	23:00
Incision#1 site	abdomen				
Incision#1 type	staples				
Drain	other (specify) &				
Incision#1 drAmt	none				
Surrounding skin	intact				
Incision#1 dsg	open to air				
04/29/11 20:00 Drain(JAC1): multiple drains charted above					
Diab Flowsheet	20:00	20:09	21:00	22:00	23:00
Insulin Multiplr	.04		.04	.05	.04
IV rate/mL	1.4		1.9	7.4	1.2
CARE PROVIDERS	JAC1, {DLRO} JAC1		JAC1 JAC1, {DLRO}	JAC1 JAC1, {DLRO}	JAC1 JAC1, {DLRO}

COTTLE, JEAN A(JAC1)RN ROBERTS, DUSTI L(DLRO)RN

CONTINUED

FLOWSHEET	04/29				
Misc Events	20:00	20:08	21:00	22:00	23:00
Evaluated POC	done				
Misc events	&				
04/29/11 20:00 Misc events(JAC1): Received pt. from STICU @1930, assessment completed at present time. Instructed use call bell/bed controls. Placed in reach.					
CARE PROVIDERS	JAC1				

COTTLE, JEAN A(JAC1)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 7

FLOWSHEET	04/30				
Comfort	00:00	00:04	01:00	02:00	03:00
Abnorm findings		pain recvAnalgesicTx			
Pain score		7 Numeric Value			
Pt relief goal		0-4			
Pain onset		ongoing			
Pain description		constant			
Pain site(s)		incisional abdomen			
Comfort interv		meds (see MAR) &			
PainReassessScor			- sleeping		
04/30/11 00:04 Comfort interv(JAC1): oxycodone					
Diab Flowsheet	00:00	00:04	01:00	02:00	03:00
Insulin Multiplr	.03		.03	.04	.05
IV rate/mL	1		1.4	2.7	3.3
CARE PROVIDERS	JAC1 JAC1, {DLRO}	JAC1	JAC1, {DLRO} JAC1	JAC1 JAC1, {DLRO}	JAC1 JAC1, {DLRO}

COTTLE, JEAN A(JAC1)RN ROBERTS, DUSTI L(DLRO)RN

CONTINUED

FLOWSHEET	04/30				
Gastrointestinal	04:00	04:06	04:08	05:00	06:00
Stool amount Stool color Stool consistncy			small bloody liquid		
Comfort	04:00	04:06	04:08	05:00	06:00
Abnorm findings		pain recvAnalgesicTx			
Pain score		6 Numeric Value			
Pt relief goal		0-4			
Pain onset		ongoing			
Pain description		constant			
Pain site(s)		incisional abdomen			
Comfort interv		meds (see MAR) &			
PainReassessScor				- sleeping	
04/30/11 04:06 Comfort interv(JAC1): oxycodone					
Diab Flowsheet	04:00	04:06	04:08	05:00	06:00
Insulin Multiplr	.06			.07	.07
IV rate/mL	3.4			4.5	2.8
CARE PROVIDERS	JAC1 JAC1, {DLRO}	JAC1	JAC1	JAC1, {DLRO} JAC1	JAC1

COTTLE, JEAN A(JAC1)RN ROBERTS, DUSTI L(DLRC)RN

CONTINUED

FLOWSHEET	04/30				
Chart Review	06:54	07:09	07:57	08:10	08:24
Chart check q12h		done			
Neuro/EENT	06:54	07:09	07:57	08:10	08:24
Alert,orientedx3 Follows commands NormHear&/orAid Abs of drainage			WNL WNL WNL WNL		
Norm closure Abs of swelling No visual impair PERRLA			WNL WNL WNL WNL		
Patent nares No bleed/disch			WNL WNL		
ImplNeuroEENTPOC			done		
Tingling			&		
Numbness			foot L		
04/30/11 07:57 Tingling(JLNO): pt. denies					
Special Neuro	06:54	07:09	07:57	08:10	08:24
GCS eyes open GCS best verbal Best upper motor GCS total sco			4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15		
Motor exam LUE Motor exam LLE Motor exam RUE Motor exam RLE			6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands		
MotorStrengthLUE MotorStrengthLLE MotorStrengthRUE			5=normal 5=normal 5=normal		
MotorStrengthRLE			5=normal		
Cardiovascular	06:54	07:09	07:57	08:10	08:24
S1S2 Angina/chestPain PalpPerhipPulses Cap refill<3 sec Thigh/CalfTender Implement Cv POC			WNL none WNL WNL none done		
RUE edema RLE edema LUE edema LLE edema GeneralizedEdema			+2 +2 +2 +2 +2		
R radial pulse L radial pulse R pedal pulse			3+=bounding 3+=bounding normal		
CARE PROVIDERS		JLNO, {JAC1}	JLNO		

COTTLE, JEAN A(JAC1)RN NORMAN, JILL L(JLNO)RN

CONTINUED

FLOWSHEET	04/30				
Cardiovascular-Cont.	06:54	07:09	07:57	08:10	08:24
L pedal pulse			normal		
Respiratory	06:54	07:09	07:57	08:10	08:24
Spont respers NonLaboredEffort RegClrBreathSnds & No cough,dyspnea Natural airway No O2 requiremnt			WNL WNL all lobes & WNL WNL WNL		
04/30/11 07:57 RegClrBreathSnds(JLNO): pt. using IS, CPO in place					
Gastrointestinal	06:54	07:09	07:57	08:10	08:24
Continent No c/o N/V Normal dentition MucousMembIntact			WNL WNL WNL WNL		
Last BM			04/30/2011		
Implement GI POC			done		
Tube feeding Tube type Tube interv TF interv			see MAR j-tube placement check tube site care & &		
G-tube location G-tube suction G-tube drainage J-tube location			LUQ gravity green & LUQ		
Tube#1 type Tube#1 location Tube#1 drainage Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage Tube#2 interv Tube#3 type Tube#3 location Tube#3 drainage			JP RUQ bloody bulb suction JP LUQ clear scant bulb suction other (specify) & LUQ none		
Tube#3 interv			&		
04/30/11 07:57 Tube interv(JLNO): 0 residual					
04/30/11 07:57 TF interv(JLNO): promote increased to 65 cc/hour					
04/30/11 07:57 G-tube drainage(JLNO): cloudy, sediment					
CARE PROVIDERS			JLNO		

NORMAN, JILL L(JLNO)RN

CONTINUED

FLOWSHEET	04/30				
Gastrointestinal-Cont.	06:54	07:09	07:57	08:10	08:24
04/30/11 07:57 Tube#3 type(JLNO): duodenal drain					
04/30/11 07:57 Tube#3 interv(JLNO): to lows					
Genitourinary	06:54	07:09	07:57	08:10	08:24
Adequate UOP NoAbn penile bld NoAbnPenileDisch			WNL WNL WNL		
Implement GU POC			done		
Urine character			amber		
Catheter Catheter size			foley 16 FR	foley 16 FR	
Date Cath D/C'd				04/30/2011 &	
04/30/11 08:10 Date Cath D/C'd(JLNO): foley dc'd					
Func/Musculoskel	06:54	07:09	07:57	08:10	08:24
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear			WNL WNL WNL no devices WNL		
Impl FuncMuscPOC			done		
Weakness			generalized		
SCD site SCD type			leg L leg R short leg		
SCD assess			on operational		
Skin	06:54	07:09	07:57	08:10	08:24
Skin warm Color approp			WNL to ethnicity		
Impl Skn/Wnd POC			done		
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Bruise site(s)			2=very limited 4=rarely moist 3=walks occasion 3=slight limited 2=prob adequate 3=no app.probl 17 arm R		
Psychological	06:54	07:09	07:57	08:10	08:24
Memory intact Approp affect Approp behavior Approp verbaliz			WNL & to situation to situation		
CARE PROVIDERS			JLNO	JLNO	

NORMAN, JILL L(JLNO)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 12

FLOWSHEET	04/30				
Psychological-Cont.	06:54	07:09	07:57	08:10	08:24
Implemnt PSE POC			done		
04/30/11 07:57 Approp affect(JLNO): flat					
Comfort	06:54	07:09	07:57	08:10	08:24
No c/o,no s/s of			chills fever itching nausea prob sleeping spasms sweating vomiting		
Impl Comfort POC			done		
Abnorm findings			pain recvAnalgesicTx		
Pain score			7 Numeric Value		
Pt relief goal			<5		
Pain onset			ongoing		
Pain description			constant		
Pain site(s)			generalized abdomen		
Comfort interv			emotional supprt meds (see MAR)		
PainReassessScor					
Vascular Access	06:54	07:09	07:57	08:10	08:24
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions			antecubital R 04/26/2011 #18 secure dry and intact saline lock		
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing			forearm L 04/26/2011 #16 secure dry and intact		
Interventions			meds (see MAR)		
Safety	06:54	07:09	07:57	08:10	08:24
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on IV sol verified IV tbg/bag dated CARE PROVIDERS			on done done done done done done JLNO		

NORMAN, JILL L(JLNO)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 13

FLOWSHEET	04/30				
Safety Cont.	06:54	07:09	07:57	08:10	08:24
High alertMedsID			done &		
Imple SafetyPOC			done		
04/30/11 07:57 High alertMedsID(JLNO): insulin gtt					
Fall Risk	06:54	07:09	07:57	08:10	08:24
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score			no=0 no=0 w/c NrsAssist=0 yes=20 WeakUsesTouch=10 Knows limits=0 30		
Imple SafetyPOC			done		
Intact Incision	06:54	07:09	07:57	08:10	08:24
Incision#1 site Incision#1 type Drain Incision#1 drAmt Surrounding skin			abdomen staples other (specify) & none intact		
Incision#1 dsg			open to air		
04/30/11 07:57 Drain(JLNO): multiple drains					
Diab Flowsheet	06:54	07:09	07:57	08:10	08:24
Insulin Multiplr	.06				.07
IV rate/mL	2.2				4.1
Misc Events	06:54	07:09	07:57	08:10	08:24
Evaluated POC			done		
Misc events			&		
04/30/11 07:57 Misc events(JLNO): assessment complete, pt resting in bed, brother at bedside, pt using IS, pt. states pain 7 of 10, denies other needs, bed low, rails up x 3, call bell within reach					
CARE PROVIDERS	JAC1		JLNO		JLNO

COTTLE, JEAN A(JAC1)RN NORMAN, JILL L(JLNO)RN

CONTINUED

FLOWSHEET	04/30				
Comfort	08:55	09:00	09:06	09:49	10:00
Abnorm findings			nausea		
Comfort interv			meds (see MAR)		
PainReassessSoor	6 Numeric Value				
Nutrition	08:55	09:00	09:06	09:49	10:00
Meal type					diab clear liq
Breakfast amt					0%
Diab Flowsheet	08:55	09:00	09:06	09:49	10:00
Insulin Multiplr		.08			
IV rate/mL		4.8			
Misc Events	08:55	09:00	09:06	09:49	10:00
Misc events				&	
04/30/11 09:49 Misc events(JLNO): Dr.Rickey notified of pt's emesis					
CARE PROVIDERS	JLNO	JLNO	JLNO	JLNO	WCW

NORMAN, JILL L(JLNO)RN WILLIAMS, WENDY C(WCW)CA

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 15

FLOWSHEET	04/30				
Comfort	10:14	10:15	10:37	11:00	11:23
Abnorm findings					pain recvAnalgesicTx
Pain score					7 Numeric Value
Pt relief goal					<5
Pain onset					ongoing
Pain description					constant stabbing
Pain site(s)					abdomen
Comfort interv					emotional supprt meds (see MAR)
Act Daily Living	10:14	10:15	10:37	11:00	11:23
Bath Mouth care					
Amb w/assistance OOB-chair ROM joints					
Peri care					
Deep breathe					
Cough					
Diab Flowsheet	10:14	10:15	10:37	11:00	11:23
Insulin Multiplr			.09	.08	
IV rate/mL			9.8	3.0	
Misc Events	10:14	10:15	10:37	11:00	11:23
Misc events	&	&	&		
04/30/11 10:14 Misc events(JLNO): pt. re questing breakthrough medications, Dr. Rickey notified.					
04/30/11 10:15 Misc events(JLNO): Dr. Smith aware of BP 195/95					
04/30/11 10:37 Misc events(JLNO): pt requesting breakthough pain medicine, Dr. Smith notified.					
CARE PROVIDERS	JLNO	JLNO	JLNO	JLNO	JLNO

NORMAN, JILL L(JLNO)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 16

FLOWSHEET	04/30				
Comfort	11:30	11:46	12:00	12:16	12:20
PainReassessScor					6 Numeric Value
Nutrition	11:30	11:46	12:00	12:16	12:20
Lunch amt					
Act Daily Living	11:30	11:46	12:00	12:16	12:20
Bath Mouth care	dependent independent				
Amb w/assistance OOB-chair ROM joints	assist assist independent				
Peri care	dependent				
Deep breathe	independent				
Cough	independent				
Vascular Access	11:30	11:46	12:00	12:16	12:20
Site#2 location Gauge Site#2 appear Site#2 dressing				forearm L #16 dislodged loose	
Interventions				dc'ed/RN	
Diab Flowsheet	11:30	11:46	12:00	12:16	12:20
Insulin Multiplr			.9		
IV rate/mL			4.8		
Misc Events	11:30	11:46	12:00	12:16	12:20
Misc events		&			
04/30/11 11:46 Misc events(JLNO): 0.04 IV dialudid administered, pt vomited again, TF stopped, Dr. Smith notifed.					
CARE PROVIDERS	WCW	JLNO	JLNO	JLNO	JLNO

NORMAN, JILL L(JLNO)RN WILLIAMS, WENDY C(WCW)CA

CONTINUED

FLOWSHEET	04/30				
Comfort	12:35	13:00	13:08	14:00	14:35
Abnorm findings			pain recvAnalgesicTx		pain recvAnalgesicTx
Pain score			5 Numeric Value		5 Numeric Value
Pt relief goal			<5		<5
Pain onset			ongoing		ongoing
Pain description			constant stabbing		constant stabbing
Pain site(s)			abdomen		abdomen
Comfort interv			emotional supprt meds (see MAR)		emotional supprt meds (see MAR)
PainReassessScor				5 Numeric Value	
Nutrition	12:35	13:00	13:08	14:00	14:35
Lunch amt	0%				
Diab Flowsheet	12:35	13:00	13:08	14:00	14:35
Insulin Multiplr		.08		.07	
IV rate/mL		0.2		2.6	
CARE PROVIDERS	WCW	JLNO	JLNO	JLNO	JLNO

NORMAN, JILL L(JLNO)RN WILLIAMS, WENDY C(WCW)CA

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 18

FLOWSHEET	04/30				
Comfort	15:00	15:30	15:35	16:00	16:31
PainReassessScor		4 Numeric Value			
Vascular Access	15:00	15:30	15:35	16:00	16:31
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing					
Interventions					
Diab Flowsheet	15:00	15:30	15:35	16:00	16:31
Insulin Multiplr	.07			.07	
IV rate/mL	2.8			2.9	
Misc Events	15:00	15:30	15:35	16:00	16:31
Misc events			&		&
04/30/11 15:35 Misc events(JLNO): Pt. Goodwin in 1070 has 80 cc bloody residual from J-Tube, frank blood in stool x 2, BP 190 over 80, HR 104, 99% on 2L, 18 respirations, Dr. Smith notified.					
04/30/11 16:31 Misc events(JLNO): decongestant requested from dr. m. smith					
CARE PROVIDERS	JLNO	JLNO	JLNO	JLNO	JLNO

NORMAN, JILL L(JLNO)RN

CONTINUED

FLOWSHEET	04/30				
Chart Review	17:00	18:00	19:00	19:04	19:12
Chart check q12h					done
Comfort	17:00	18:00	19:00	19:04	19:12
Abnorm findings				pain recvAnalgesicTx	
Pain score				4 Numeric Value	
Pt relief goal				<5	
Pain onset				ongoing	
Pain description				constant	
Pain site(s)				abdomen	
Comfort interv				emotional supprt meds (see MAR)	
PainReassessScor					
Vascular Access	17:00	18:00	19:00	19:04	19:12
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing	forearm L 04/30/2011 #20 secure dry and intact				
Interventions	IV inserted				
Diab Flowsheet	17:00	18:00	19:00	19:04	19:12
Insulin Multiplr	.07	.03	.05		
IV rate/mL	3.2	1.6	1.4		
CARE PROVIDERS	JLNO	JLNO	JLNO	JLNO	JAC1, {JLNO}

COTTLE, JEAN A(JAC1)RN NORMAN, JILL L(JLNO)RN

CONTINUED

FLOWSHEET	04/30				
Neuro/EENT	20:00	20:20	21:00	22:00	23:00
Alert,orientedx3 Follows commands NoSensoryDeficit		WNL WNL WNL &			
NormHear&/orAid Abs of drainage		WNL WNL			
Norm closure Abs of swelling No visual impair PERRLA		WNL WNL WNL WNL			
Patent nares No bleed/disch		WNL WNL			
ImplNeuroEENTPOC		done			
Tingling		&			
Numbness		&			
04/30/11 20:20 NoSensoryDeficit(JAC1): denies tingling/numbness bil upper/lower extremities					
04/30/11 20:20 Tingling(JAC1): denies					
04/30/11 20:20 Numbness(JAC1): denies					
Special Neuro	20:00	20:20	21:00	22:00	23:00
GCS eyes open GCS best verbal Best upper motor GCS total sco		4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15			
Motor exam LUE Motor exam LLE Motor exam RUE Motor exam RLE		6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands			
MotorStrengthLUE MotorStrengthLLE MotorStrengthRUE		5=normal 5=normal 5=normal			
MotorStrengthRLE		5=normal			
Cardiovascular	20:00	20:20	21:00	22:00	23:00
S1S2 Angina/chestPain PalpPerhipPulses Cap refill<3 sec Thigh/CalfTender Implement Cv POC		WNL none WNL WNL none done			
RUE edema RLE edema LUE edema LLE edema GeneralizedEdema		+2 +2 +2 +2 +2			
R radial pulse CARE PROVIDERS		normal JAC1			

COTTLE, JEAN A(JAC1)RN

CONTINUED

FLOWSHEET	04/30				
Cardiovascular-Cont.	20:00	20:20	21:00	22:00	23:00
L radial pulse R pedal pulse		normal normal			
L pedal pulse		normal			
Respiratory	20:00	20:20	21:00	22:00	23:00
Spont respers NonLaboredEffort RegClrBreathSnds Natural airway No O2 requiremnt		WNL WNL all lobes WNL WNL			
Implmnt Resp POC		done			
Cough		nonproductive			
Oxygen L		2LPM nasal cannula &			
04/30/11 20:20 Oxygen L(JAC1): CPO in use sats @98%, IS @ BS					
Gastrointestinal	20:00	20:20	21:00	22:00	23:00
Continent No c/o N/V Normal dentition MucousMembIntact		WNL WNL WNL WNL			
Last BM		04/30/2011 &			
Implement GI POC		done			
BowelSndsAllQuad Tube type Tube interv TF interv		hypoactive j-tube placement check TF held			
G-tube location G-tube suction G-tube drainage J-tube location		LUQ gravity green LUQ			
Tube#1 type Tube#1 location Tube#1 drainage Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage Tube#2 interv Tube#3 type Tube#3 location Tube#3 drainage		JP RUQ bloody scant bulb suction JP LUQ clear scant bulb suction other (specify) & LUQ serosanguinous			
CARE PROVIDERS		JAC1			

COTTLE, JEAN A(JAC1)RN

FLOWSHEET	04/30				
Gastrointestinal-Cont.	20:00	20:20	21:00	22:00	23:00
Tube#3 interv		&			
04/30/11 20:20 Last BM(JAC1): assisted pt. to BR					
04/30/11 20:20 Tube#3 type(JAC1): duodenal drain					
04/30/11 20:20 Tube#3 interv(JAC1): to LCWS					
Genitourinary	20:00	20:20	21:00	22:00	23:00
Continent		WNL &			
NoAbn penile bld NoAbnPenileDisch		WNL WNL			
Implement GU POC		done			
Urine character		amber			
04/30/11 20:20 Continent(JAC1): denies pain/burning on urination since foley dc'd					
Func/Musculoskel	20:00	20:20	21:00	22:00	23:00
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear		WNL WNL WNL no devices WNL			
Impl FuncMuscPOC		done			
Weakness		generalized			
SCD site SCD type		leg L leg R short leg			
SCD assess		on operational			
Skin	20:00	20:20	21:00	22:00	23:00
Skin warm Color approp		WNL to ethnicity			
Impl Skn/Wnd POC		done			
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Bruise site(s)		4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 2=prob adequate 3=no app.probl 19 arm R			
Psychological	20:00	20:20	21:00	22:00	23:00
Memory intact Approp affect Approp behavior Approp verbaliz		WNL & to situation to situation			
Implemnt PSE POC		done			
CARE PROVIDERS		JAC1			

COTTLE, JEAN A(JAC1)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 23

FLOWSHEET	04/30				
Psychological-Cont.	20:00	20:20	21:00	22:00	23:00
Abnorm findings		maladj illness &			
04/30/11 20:20 Approp affect(JAC1): flat					
04/30/11 20:20 Abnorm findings(JAC1): appears to be move motivated tonight than last night					
Comfort	20:00	20:20	21:00	22:00	23:00
No c/o,no s/s of		chills fever itching nausea prob sleeping pain spasms sweating vomiting			
Impl Comfort POC		done			
Pain score		2 Numeric Value			
PainReassessScor	2 Numeric Value				
Vascular Access	20:00	20:20	21:00	22:00	23:00
Site#1 location Gauge Site#1 appear Interventions		antecubital L #18 dislodged dc'ed/RN			
Site#2 location Insertion date Gauge Site#2 appear Site#2 dressing		forearm L 04/30/2011 #20 secure dry and intact			
Interventions		meds (see MAR)			
Safety	20:00	20:20	21:00	22:00	23:00
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on IV sol verified IV tbg/bag dated High alertMedsID		on done done done done done done done &			
Imple SafetyPOC		done			
04/30/11 20:20 High alertMedsID(JAC1): insulin drip					
Fall Risk	20:00	20:20	21:00	22:00	23:00
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access CARE PROVIDERS	JAC1	no=0 no=0 w/c NrsAssist=0 yes=20 JAC1			

COTTLE, JEAN A(JAC1),RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 24

FLOWSHEET	04/30				
Fall Risk Cont.	20:00	20:20	21:00	22:00	23:00
Gait Mental status Total score		WeakUsesTouch=10 Knows limits=0 30			
Imple SafetyPOC		done			
Intact Incision	20:00	20:20	21:00	22:00	23:00
Incision#1 site Incision#1 type Drain Incision#1 drAmt Surrounding skin		abdomen staples other (specify) & none intact			
Incision#1 dsg		open to air			
04/30/11 20:20 Drain(JAC1): multiple drains already charted					
Diab Flowsheet	20:00	20:20	21:00	22:00	23:00
Insulin Multiplr	.05		.04	.03	.03
IV rate/mL	2.1		1.6	1.1	1.4
Misc Events	20:00	20:20	21:00	22:00	23:00
Evaluated POC		done			
Misc events		&			
04/30/11 20:20 Misc events(JAC1): Received report, assumed care. Assessment complete. denies needs. Call bell in reach.					
CARE PROVIDERS	JAC1	JAC1	JAC1	JAC1	JAC1

COTTLE, JEAN A(JAC1)RN

FLOWSHEET	05/01				
Comfort	00:00	01:00	01:20	02:00	03:00
Abnorm findings			pain recvAnalgesicTx		
Pain score			6 Numeric Value		
Pt relief goal			0-4		
Pain onset			ongoing		
Pain description			constant		
Pain site(s)			incisional abdomen		
Comfort interv			meds (see MAR) &		
PainReassessScor				3 Numeric Value	
05/01/11 01:20 Comfort interv(JAC1): dilaudid					
Diab Flowsheet	00:00	01:00	01:20	02:00	03:00
Insulin Multiplr	.03	.02		.01	.01
IV rate/mL	1.3	.7		.2	.5
CARE PROVIDERS	JAC1	JAC1	JAC1	JAC1	JAC1

COTTLE, JEAN A(JAC1)RN

FLOWSHEET	05/01				
Comfort	04:00	05:00	06:00	06:20	06:59
Abnorm findings				pain recvAnalgesicTx	
Pain score				6 Numeric Value	
Pt relief goal				0-4	
Pain onset				ongoing	
Pain description				constant	
Pain site(s)				incisional abdomen	
Comfort interv				meds (see MAR) &	
05/01/11 06:20 Comfort interv(JAC1): oxycodone					
Diab Flowsheet	04:00	05:00	06:00	06:20	06:59
Insulin Multiplr.	.02	.03	.03		.03
IV rate/mL	1.1	1.6	1.3		1.3
CARE PROVIDERS	JAC1	JAC1	JAC1	JAC1	JAC1

COTTLE, JEAN A(JAC1)RN

FLOWSHEET	05/01				
Chart Review	07:02	07:45	07:55	08:00	08:22
Chart check q12h		done			
Neuro/EENT	07:02	07:45	07:55	08:00	08:22
Alert,orientedx3 Follows commands NoSensoryDeficit					WNL WNL WNL
NormHear&/orAid Abs of drainage					WNL WNL
Norm closure Abs of swelling No visual impair PERRLA					WNL WNL WNL WNL
Patent nares No bleed/disch					WNL WNL
ImplNeuroEENTPOC					done
Tingling					&
Numbness					&
05/01/11 08:22 Tingling(SPS1): denies					
05/01/11 08:22 Numbness(SPS1): denies					
Special Neuro	07:02	07:45	07:55	08:00	08:22
GCS eyes open GCS best verbal Best upper motor GCS total sco					4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15
Motor exam LUE Motor exam LLE Motor exam RUE Motor exam RLE					6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands
MotorStrengthLUE MotorStrengthLLE MotorStrengthRUE					5=normal 5=normal 5=normal
MotorStrengthRLE					5=normal
Cardiovascular	07:02	07:45	07:55	08:00	08:22
S1S2 Angina/chestPain PalpPerhipPulses Cap refill<3 sec Thigh/CalfTender Implement Cv POC					WNL none WNL WNL none done
RUE edema RLE edema LUE edema LLE edema GeneralizedEdema					+2 +2 +2 +2 +2
R radial pulse CARE PROVIDERS		SPS1, {JAC1}			normal SPS1

COTTLE, JEAN A(JAC1)RN SHEFTON, SENACA P(SPS1)RN

FLOWSHEET	05/01				
Cardiovascular-Cont.	07:02	07:45	07:55	08:00	08:22
L radial pulse					normal
R pedal pulse					normal
L pedal pulse					normal
Respiratory	07:02	07:45	07:55	08:00	08:22
Spont respers					WNL
NonLaboredEffort					WNL
RegClrBreathSnds					all lobes
Natural airway					WNL
No O2 requiremnt					WNL
Implmnt Resp POC					done
Cough					nonproductive
Gastrointestinal	07:02	07:45	07:55	08:00	08:22
Continent					WNL
No c/o N/V					WNL
Normal dentition					WNL
MucousMembIntact					WNL
Last BM					04/30/2011
Implement GI POC					done
BowelSndsAllQuad					hypoactive
Tube feeding					see MAR
Tube type					j-tube
Tube interv					irrigated
TF interv					TF bag changed
					TF restarted
G-tube location					LUQ
G-tube suction					gravity
G-tube drainage					green
J-tube location					LUQ
Tube#1 type					JP
Tube#1 location					RUQ
Tube#1 drainage					bloody
					scant
Tube#1 interv					bulb suction
Tube#2 type					JP
Tube#2 location					LUQ
Tube#2 drainage					clear
					scant
Tube#2 interv					bulb suction
Tube#3 type					other (specify)
					&
Tube#3 location					LUQ
Tube#3 drainage					purulent
Tube#3 interv					&
05/01/11 08:22 Tube#3 type(SPS1): duodenal drain					
05/01/11 08:22 Tube#3 interv(SPS1): LCWS					
CARE PROVIDERS					SPS1

SHEFTON, SENACA P(SPS1)RN

CONTINUED

FLOWSHEET	05/01				
Genitourinary	07:02	07:45	07:55	08:00	08:22
Continent					WNL
NoAbn penile bld					WNL
NoAbnPenileDisch					WNL
Implement GU POC					done
Urine character					amber
Func/Musculoskel	07:02	07:45	07:55	08:00	08:22
ActiveROM x4 ext					WNL
Symmetry all ext					WNL
No act restrict					WNL
No use of device					no devices
Speech clear					WNL
Impl FuncMuscPOC					done
Weakness					generalized
SCD site					leg L
					leg R
SCD type					short leg
SCD assess					on
					operational
Skin	07:02	07:45	07:55	08:00	08:22
Skin warm					WNL
Color approp					to ethnicity
Impl Skn/Wnd POC					done
Sens perception					4=no impairmnt
Moisture					4=rarely moist
Activity					3=walks occasion
Mobility					3=slight limited
Nutrition					2=prob adequate
Friction & shear					3=no app.probl
Total Score					19
Bruise site(s)					arm R
Psychological	07:02	07:45	07:55	08:00	08:22
Memory intact					WNL
Approp affect					&
Approp behavior					to situation
Approp verbaliz					to situation
Implemnt PSE POC					done
Abnorm findings					maladj illness
05/01/11 08:22 Approp affect(SPS1): flat					
Comfort	07:02	07:45	07:55	08:00	08:22
No c/o,no s/s of					chills
					fever
					itching
					nausea
					prob sleeping
CARE PROVIDERS					SPS1

SHEFTON, SENACA P(SPS1)RN

CONTINUED

FLOWSHEET	05/01				
Comfort-Cont.	07:02	07:45	07:55	08:00	08:22
					spasms sweating vomiting
Impl Comfort POC					done
Abnorm findings	nausea pain recvAnalgesicTx vomiting				pain
Pain score	6 Numeric Value				6 Numeric Value
Pt relief goal	0-4				<4
Pain onset	ongoing				ongoing
Pain description	constant				constant
Pain site(s)	incisional abdomen				incisional abdomen
Comfort interv	meds (see MAR) &				emotional supprt
PainReassessScor			- sleeping		
05/01/11 07:02 Comfort interv(JAC1): dilaudid & zofran					
Nutrition	07:02	07:45	07:55	08:00	08:22
Meal type					clear liquid
Vascular Access	07:02	07:45	07:55	08:00	08:22
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions					forearm L 04/30/2011 #20 secure dry and intact meds (see MAR)
Safety	07:02	07:45	07:55	08:00	08:22
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on IV sol verified IV tbg/bag dated High alertMedsID					on done done done done done done done &
Imple SafetyPOC					done
05/01/11 08:22 High alertMedsID(SPS1): Insulin					
Fall Risk	07:02	07:45	07:55	08:00	08:22
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access CARE PROVIDERS	JAC1		SPS1		no=0 no=0 w/c NrsAssist=0 yes=20 SPS1

COTTLE, JEAN A(JAC1)RN SHEFTON, SENACA P(SPS1)RN

FLOWSHEET	05/01				
Fall Risk Cont	07:02	07:45	07:55	08:00	08:22
Gait Mental status Total score					WeakUsesTouch=1 Knows limits=0 0
Imple SafetyPOC					done
Intact Incision	07:02	07:45	07:55	08:00	08:22
Incision#1 site Incision#1 type Drain Incision#1 drAmt Surrounding skin					abdomen staples other (specify) & none intact
Incision#1 dsg					open to air
05/01/11 08:22 Drain(SPS1): multiple drains already charted above					
Diab Flowsheet	07:02	07:45	07:55	08:00	08:22
Insulin Multipl				0.02	
IV rate/mL				0.9	
Misc Events	07:02	07:45	07:55	08:00	08:22
Evaluated POC					done
Misc events					&
05/01/11 08:22 Misc events(SPS1): Received report and assumed care of pt. Assessment complete and will continue to monitor.					
CARE PROVIDERS				SPS1	SPS1

SHEFTON, SENACA P(SPS1)RN

FLOWSHEET	05/01				
Chart Review	09:00	15:21	16:15	17:45	18:43
Chart check q12h					
Comfort	09:00	15:21	16:15	17:45	18:43
Abnorm findings		pain recvAnalgesicTx		pain recvAnalgesicTx	
Pain score		5 Numeric Value		5 Numeric Value	
Pt relief goal		<4		<4	
Pain onset		ongoing		ongoing	
Pain description		constant		constant	
Pain site(s)		incisional abdomen		incisional abdomen	
Comfort interv		emotional supprt meds (see MAR)		emotional supprt meds (see MAR)	
PainReassessScor Pt Goal Reassess			- sleeping		3 Numeric Value <4
ReassessComf Int					emotional supprt
Diab Flowsheet	09:00	15:21	16:15	17:45	18:43
Insulin Multiplr	0.02				
IV rate/mL	1.1				
CARE PROVIDERS	SPS1	SPS1	SPS1	SPS1	SPS1

SHEFTON, SENACA P(SPS1)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 09:06
OPT OUT:
Page: 33

FLOWSHEET	05/01				05/02
Chart Review	19:00	19:20	23:18	23:52	00:45
Chart check q12h	done				
Neuro/EENT	19:00	19:20	23:18	23:52	00:45
Alert,orientedx3 Follows commands NoSensoryDeficit		WNL WNL WNL			
NormHear&/orAid Abs of drainage		WNL WNL			
Norm closure Abs of swelling No visual impair PERRLA		WNL WNL WNL & WNL			
Patent nares No bleed/disch		WNL WNL			
ImplNeuroEENTPOC		done			
Tingling		&			
Numbness		&			
05/01/11 19:20 No visual impair(JAC1): sclera yellow					
05/01/11 19:20 Tingling(JAC1): denies					
05/01/11 19:20 Numbness(JAC1): denies					
Cardiovascular	19:00	19:20	23:18	23:52	00:45
Reg rate, rhythm S1S2 Angina/chestPain PalpPerhipPulses Cap refill<3 sec Thigh/CalfTender Implement Cv POC		WNL WNL none WNL WNL none done			
RUE edema RLE edema LUE edema LLE edema GeneralizedEdema		+2 +2 +2 +2 +2			
Respiratory	19:00	19:20	23:18	23:52	00:45
Spont respers NonLaboredEffort Natural airway No O2 requiremnt		WNL WNL WNL WNL			
Implmnt Resp POC		done			
Abnorm findings		tachypneic			
Cough		productive			
Sputum/Secretion		clear			
CARE PROVIDERS	SPS1, {JAC1}	JAC1			

COTTLE, JEAN A(JAC1)RN SHEFTON, SENACA P(SPS1)RN

CONTINUED

FLOWSHEET	05/01				05/02
Gastrointestinal	19:00	19:20	23:18	23:52	00:45
Continent		WNL			
No c/o N/V		WNL			
Normal dentition		WNL			
MucousMembIntact		WNL			
Last BM		05/01/2011			
Implement GI POC		done			
BowelSndsAllQuad		hypoactive			
Tube feeding		see MAR			
Tube type		j-tube			
Tube interv		irrigated placement check			
G-tube location		LUQ			
G-tube suction		gravity			
G-tube drainage		green			
J-tube location		LUQ			
Tube#1 type		JP			
Tube#1 location		RUQ			
Tube#1 drainage		none			
Tube#1 interv		bulb suction			
Tube#2 type		JP			
Tube#2 location		LUQ			
Tube#2 drainage		none			
Tube#2 interv		bulb suction			
Tube#3 type		other (specify) &			
Tube#3 location		LUQ			
Tube#3 drainage		amber			
05/01/11 19:20 Tube#3 type(JAC1): duodenal, LCWS					
Genitourinary	19:00	19:20	23:18	23:52	00:45
Continent		WNL			
Adequate UOP		WNL			
NoAbn penile bld		WNL			
NoAbnPenileDisch		WNL			
Urine character		amber			
Func/Musculoskel	19:00	19:20	23:18	23:52	00:45
ActiveROM x4 ext		WNL			
Symmetry all ext		WNL			
No act restrict		WNL			
No use of device		no devices			
Speech clear		WNL			
Impl FuncMuscPOC		done			
Weakness		generalized			
SCD site		leg L leg R			
SCD type		short leg			
CARE PROVIDERS		JAC1			

COTTLE, JEAN A(JAC1)RN

CONTINUED

FLOWSHEET	05/01				05/02
Func/Musculoskel-Cont.	19:00	19:20	23:18	23:52	00:45
SCD assess		on operational			
Skin	19:00	19:20	23:18	23:52	00:45
Skin warm Color approp		WNL to ethnicity			
Impl Skn/Wnd POC		done			
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Bruise site(s)		4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 2=prob adequate 3=no app.probl 19 arm R			
Psychological	19:00	19:20	23:18	23:52	00:45
Memory intact Approp affect Approp behavior Approp verbaliz		WNL & to situation to situation			
05/01/11 19:20 Approp affect(JAC1): flat					
Comfort	19:00	19:20	23:18	23:52	00:45
No c/o,no s/s of		chills fever itching nausea prob sleeping spasms sweating vomiting			
Impl Comfort POC		done			
Abnorm findings		pain recvAnalgesicTx	pain recvAnalgesicTx	pain recvAnalgesicTx	
Pain score		3 Numeric Value	7 Numeric Value	5 Numeric Value	
Pt relief goal		0-4	0-4	0-4	
Pain onset		ongoing		ongoing	
Pain description		constant	constant	constant cramping	
Pain site(s)		incisional abdomen	incisional abdomen	incisional abdomen	
Comfort interv		distraction diversion repositioned	meds (see MAR) &	meds (see MAR) &	
PainReassessScor					- sleeping
05/01/11 23:18 Comfort interv(JAC1): oxycodone					
CARE PROVIDERS		JAC1	JAC1	JAC1	JAC1

COTTLE, JEAN A(JAC1)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 36

FLOWSHEET	05/01				05/02
Comfort-Cont.	19:00	19:20	23:18	23:52	00:45
05/01/11 23:52 Comfort interv(JAC1): dilaudid, pre medicate with zofran, pt. advises dilaudid makes him nauseated.					
Nutrition	19:00	19:20	23:18	23:52	00:45
Meal type		clear liquid			
Vascular Access	19:00	19:20	23:18	23:52	00:45
Site#1 location		forearm L			
Insertion date		04/30/2011			
Gauge		#20			
Site#1 appear		secure			
Site#1 dressing		dry and intact			
Interventions		meds (see MAR)			
Safety	19:00	19:20	23:18	23:52	00:45
Hospital ID band		on			
CallSystm access		done			
Bed in low posit		done			
Bed brakes on		done			
Bed alarms on		done			
IV sol verified		done			
IV tbg/bag dated		done			
Imple SafetyPOC		done			
Fall Risk	19:00	19:20	23:18	23:52	00:45
HxFall(w/in 3mo)		no=0			
Secondary dx		no=0			
Ambulatory aid		w/c NrsAssist=0			
IV or IV access		yes=20			
Gait		WeakUsesTouch=10			
Mental status		Knows limits=0			
Total score		30			
Imple SafetyPOC		done			
Intact Incision	19:00	19:20	23:18	23:52	00:45
Incision#1 site		abdomen			
Incision#1 type		staples			
Drain		other (specify) &			
Incision#1 drAmt		none			
Surrounding skin		intact			
Incision#1 dsg		open to air			
05/01/11 19:20 Drain(JAC1): multiple drains already charted					
Misc Events	19:00	19:20	23:18	23:52	00:45
Evaluated POC		done			
Misc events		&			
05/01/11 19:20 Misc events(JAC1): Received report, assumed care. Assessment complete. Denies needs. Call bell in reach.					
CARE PROVIDERS		JAC1			

COTTLE, JEAN A(JAC1)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 37

FLOWSHEET	05/02				
Chart Review	02:02	02:55	04:23	05:00	07:05
Chart check q12h					done
Neuro/EENT	02:02	02:55	04:23	05:00	07:05
Alert,orientedx3 Follows commands NoSensoryDeficit					
NormHear&/orAid Abs of drainage					
Norm closure Abs of swelling No visual impair PERRLA					
Patent nares No bleed/disch					
ImplNeuroEENTPOC					
Tingling					
Numbness					
Cardiovascular	02:02	02:55	04:23	05:00	07:05
Reg rate, rhythm S1S2 Angina/chestPain PalpPerhipPulses Cap refill<3 sec Thigh/CalfTender Implement Cv POC					
RUE edema RLE edema LUE edema LLE edema GeneralizedEdema					
R radial pulse L radial pulse R pedal pulse					
L pedal pulse					
Respiratory	02:02	02:55	04:23	05:00	07:05
Sponf respers NonLaboredEffort Natural airway No O2 requiremnt					
Implmnt Resp POC					
Abnorm findings					
Cough					
Sputum/Secretion					
CARE PROVIDERS					JAC1, {MP04}

COTTLE, JEAN A(JAC1)RN PASCARELLA, MELISSA(MP04)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 38

FLOWSHEET	05/02				
GastroIntestinal	02:02	02:55	04:23	05:00	07:05
Continent No c/o N/V Normal dentition MucousMembIntact					
Last BM					
Implement GI POC					
BowelSndsAllQuad Tube feeding Tube type Tube interv G-tube location G-tube suction G-tube drainage J-tube location					
Tube#1 type Tube#1 location Tube#1 drainage Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage Tube#2 interv Tube#3 type Tube#3 location Tube#3 drainage					
Genitourinary	02:02	02:55	04:23	05:00	07:05
Continent Adequate UOP NoAbn penile bld NoAbnPenileDisch					
Urine character					
Func/Musculoskel	02:02	02:55	04:23	05:00	07:05
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear					
Impl FuncMuscPOC					
Weakness					
SCD site SCD type					
SCD assess					
Skin	02:02	02:55	04:23	05:00	07:05
Skin warm Color approp					
Impl Skn/Wnd POC					
Sens perception					

CONTINUED

FLOWSHEET	05/02				
Skin-Cont.	02:02	02:55	04:23	05:00	07:05
Moisture Activity Mobility Nutrition Friction & shear Total Score Bruise site(s)					
Psychological	02:02	02:55	04:23	05:00	07:05
Memory intact Approp affect Approp behavior Approp verbaliz					
Comfort	02:02	02:55	04:23	05:00	07:05
No c/o,no s/s of					
Impl Comfort POC					
Abnorm findings	pain recvAnalgesicTx		pain recvAnalgesicTx		
Pain score	5 Numeric Value		4 Numeric Value		
Pt relief goal	0-4		0-4		
Pain onset	ongoing		ongoing		
Pain description	constant		constant		
Pain site(s)	incisional abdomen		incisional abdomen		
Comfort interv	meds (see MAR) &		meds (see MAR) &		
PainReassessScor		- sleeping		- sleeping	
05/02/11 02:02 Comfort interv(JAC1): dilaudid					
05/02/11 04:23 Comfort interv(JAC1): oxycodone					
Vascular Access	02:02	02:55	04:23	05:00	07:05
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions					
Safety	02:02	02:55	04:23	05:00	07:05
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on					
CARE PROVIDERS	JAC1	JAC1	JAC1	JAC1	

COTTLE, JEAN A(JAC1)RN

CONTINUED

FLOWSHEET	05/02				
Fall Risk	02:02	02:55	04:23	05:00	07:05
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score					
Intact Incision	02:02	02:55	04:23	05:00	07:05
Incision#1 site Incision#1 type Drain Incision#1 drAmt Surrounding skin					
Incision#1 dsg					
Misc Events	02:02	02:55	04:23	05:00	07:05
Evaluated POC					

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 18:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 41

FLOWSHEET	05/02				
Neuro/EENT	08:05	08:25	09:20	10:40	11:40
Alert,orientedx3	WNL				
Follows commands	WNL				
NoSensoryDeficit	WNL				
NormHear&/orAid	WNL				
Abs of drainage	WNL				
Norm closure	WNL				
Abs of swelling	WNL				
No visual impair	WNL				
PERRLA	WNL				
Patent nares	WNL				
No bleed/disch	WNL				
ImplNeuroEENTPOC	done				
Tingling	&				
Numbness	&				
05/02/11 08:05 Tingling(MP04): denies					
05/02/11 08:05 Numbness(MP04): denies					
Cardiovascular	08:05	08:25	09:20	10:40	11:40
Reg rate, rhythm	WNL				
S1S2	WNL				
Angina/chestPain	none				
PalpPerhipPulses	WNL				
Cap refill<3 sec	WNL				
Thigh/CalfTender	none				
Implement Cv POC	done				
RUE edema	+2				
RLE edema	+2				
LUE edema	+2				
LLE edema	+2				
GeneralizedEdema	+2				
R radial pulse	normal				
L radial pulse	normal				
R pedal pulse	normal				
L pedal pulse	normal				
Respiratory	08:05	08:25	09:20	10:40	11:40
Spont respers	WNL				
NonLaboredEffort	WNL				
Natural airway	WNL				
No O2 requiremnt	WNL				
Implmnt Resp POC	done				
Abnorm findings	tachypneic				
Cough	nonproductive				
Sputum/Secretion	clear				
CARE PROVIDERS	MP04				

PASCARELLA, MELISSA(MP04)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 42

FLOWSHEET	05/02				
Gastrointestinal	08:05	08:25	09:20	10:40	11:40
Continent	WNL				
No c/o N/V	WNL				
Normal dentition	WNL				
MucousMembIntact	WNL				
Last BM	5/1/11				
Implement GI POC	done				
BowelSndsAllQuad	hypoactive				
Tube feeding	see MAR				
Tube type	j-tube				
Tube interv	irrigated tube site care				
G-tube location	LUQ				
G-tube suction	gravity				
G-tube drainage	green				
J-tube location	LUQ				
Tube#1 type	JP				
Tube#1 location	RUQ				
Tube#1 drainage	none				
Tube#1 interv	bulb suction				
Tube#2 type	JP				
Tube#2 location	LUQ				
Tube#2 drainage	none				
Tube#2 interv	bulb suction				
Tube#3 type	&				
Tube#3 location	LUQ				
Tube#3 drainage	amber				
05/02/11 08:05 Tube#3 type(MP04): duodenal bulb					
Genitourinary	08:05	08:25	09:20	10:40	11:40
Continent	WNL				
Adequate UOP	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
Urine character	amber				
Func/Musculoskel	08:05	08:25	09:20	10:40	11:40
ActiveROM x4 ext	WNL				
Symmetry all ext	WNL				
No act restrict	WNL				
No use of device	no devices				
Speech clear	WNL				
Impl FuncMuscPOC	done				
Weakness	generalized				
SCD site	leg L leg R				
SCD type	short leg				
CARE PROVIDERS	MP04				

PASCARELLA, MELISSA(MP04)RN

CONTINUED

FLOWSHEET	05/02				
Func/Musculoskel-Cont.	08:05	08:25	09:20	10:40	11:40
SCD assess	on operational				
Skin	08:05	08:25	09:20	10:40	11:40
Skin warm Color approp	WNL to ethnicity				
Impl Skn/Wnd POC	done				
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Bruise site(s)	4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 3=adequate 3=no app.probl 20 arm R				
Psychological	08:05	08:25	09:20	10:40	11:40
Memory intact Approp affect Approp behavior Approp verbaliz	WNL to situation to situation to situation				
Comfort	08:05	08:25	09:20	10:40	11:40
No c/o,no s/s of	chills fever itching prob sleeping spasms				
Impl Comfort POC	done				
Abnorm findings	nausea	pain		pain	
Pain score	6 Numeric Value	5 Numeric Value		5 Numeric Value	
Pain onset	ongoing				
Pain site(s)	back				
Comfort interv	relaxation repositioned other (specify)				
PainReassessScor			- sleeping		6 Numeric Value (modified)
Vascular Access	08:05	08:25	09:20	10:40	11:40
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions	forearm L 04/30/2011 #20 secure dry and intact meds (see MAR)				
CARE PROVIDERS	MP04	MP04	MP04	MP04	MP04

PASCARELLA, MELISSA(MP04)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 44

FLOWSHEET	05/02				
Safety	08:05	08:25	09:20	10:40	11:40
Hospital ID band	on				
CallSystm access	done				
Bed in low posit	done				
Bed brakes on	done				
Bed alarms on	done				
Fall Risk	08:05	08:25	09:20	10:40	11:40
HxFall(w/in 3mo)	no=0				
Secondary dx	no=0				
Ambulatory aid	w/c NrsAssist=0				
IV or IV access	yes=20				
Gait	WeakUsesTouch=10				
Mental status	Knows limits=0				
Total score	30				
Intact Incision	08:05	08:25	09:20	10:40	11:40
Incision#1 site	abdomen				
Incision#1 type	staples				
Drain	(modified) &				
Incision#1 drAmt	none				
Surrounding skin	intact				
Incision#1 dsg	open to air				
05/02/11 08:05 Drain(MP04): miltpile drains; ruq jp; luq jp; g tbe to foley bag, j tube with feeding; duedonal drain.					
Misc Events	08:05	08:25	09:20	10:40	11:40
Evaluated POC	done				
CARE PROVIDERS	MP04				

PASCARELLA, MELISSA(MP04)RN

FLOWSHEET	05/02				
Comfort	12:15	13:13	14:10	15:30	16:09
Abnorm findings	pain			pain	
Pain score	6 Numeric Value			4 Numeric Value	
PainReassessSoor		5 Numeric Value			
Nutrition	12:15	13:13	14:10	15:30	16:09
Meal type			clear liquid		
Breakfast amt			0%		
Lunch amt			0%		
Act Daily Living	12:15	13:13	14:10	15:30	16:09
Bath Mouth care					assist & assist
Amb w/assistance OOB-chair ROM joints					assist assist assist
Peri care					independent
Deep breathe					independent
Cough					independent
05/02/11 16:09 Bath(ALB3): Pt. requested bath both day and night shift.					
CARE PROVIDERS	MP04	MP04	ALB3	MP04	ALB3

BOSTER, ALIX(ALB3)PCT PASCARELLA, MELISSA(MP04)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 46

FLOWSHEET	05/02				
Chart Review	16:15	17:09	17:48	19:08	19:21
Chart check q12h					done
Comfort	16:15	17:09	17:48	19:08	19:21
Abnorm findings		pain	:	pain	
Pain score		7 Numeric Value		9 Numeric Value	
Pain description				burning sharp stabbing throbbing	
Pain site(s)				abdomen	
PainReassessScor	3 Numeric Value		- sleeping		
Nutrition	16:15	17:09	17:48	19:08	19:21
Dinner amt					
CARE PROVIDERS	MP04	MP04	MP04	MP04	MP04, {DLRO}

PASCARELLA, MELISSA(MP04)RN ROBERTS, DUSTI L(DLRO)RN

FLOWSHEET	05/02				
Neuro/EENT	19:29	20:08	21:01	22:01	23:02
Alert,orientedx3 Follows commands NoSensoryDeficit		WNL WNL WNL			
NormHear&/orAid Abs of drainage		WNL WNL			
Norm closure Abs of swelling No visual impair PERRLA		WNL WNL WNL & WNL			
Patent nares No bleed/disch		WNL WNL			
Tingling		&			
Numbness		&			
05/02/11 20:08 No visual impair(DLRO): yellow sclera					
05/02/11 20:08 Tingling(DLRO): Denies					
05/02/11 20:08 Numbness(DLRO): Denies					
Special Neuro	19:29	20:08	21:01	22:01	23:02
GCS eyes open GCS best verbal Best upper motor GCS total sco		4=spontaneously 5=orient/verbalz 6=obeysVbCommand 15			
Motor exam LUE Motor exam LLE Motor exam RUE Motor exam RLE		6=obeys commands 6=obeys commands 6=obeys commands 6=obeys commands			
MotorStrengthLUE MotorStrengthLLE MotorStrengthRUE		5=normal 5=normal 5=normal			
MotorStrengthRLE		5=normal			
Cardiovascular	19:29	20:08	21:01	22:01	23:02
Reg rate, rhythm S1S2 Angina/chestPain PalpPerhipPulses Cap refill<3 sec Thigh/CalfTender Implement Cv POC		WNL WNL none WNL WNL none done			
RUE edema RLE edema LUE edema LLE edema GeneralizedEdema		+1 +1 +2 +1 +1			
R radial pulse L radial pulse CARE PROVIDERS		normal normal DLRO			

ROBERTS, DUSTI L(DLRO)RN

CONTINUED

FLOWSHEET	05/02				
Cardiovascular-Cont.	19:29	20:08	21:01	22:01	23:02
R pedal pulse		normal			
L pedal pulse		normal			
Respiratory	19:29	20:08	21:01	22:01	23:02
Spont respers NonLaboredEffort RegClrBreathSnds No cough,dyspnea Natural airway No O2 requiremnt		WNL WNL all lobes WNL WNL WNL			
Implmnt Resp POC		done			
Abnorm findings		shallow			
Cough		nonproductive &			
05/02/11 20:08 Cough(DLRO): per pt report.					
Gastrointestinal	19:29	20:08	21:01	22:01	23:02
Continent No c/o N/V Normal dentition MucousMembIntact		WNL WNL WNL WNL			
Last BM		05/01/2011			
Implement GI POC		done			
BowelSndsAllQuad Abdomen Tube feeding Tube type Tube interv G-tube location G-tube suction G-tube drainage J-tube location		hypoactive muscle guarding tender see MAR j-tube irrigated tube site care LUQ gravity green LUQ			
Tube#1 type Tube#1 location Tube#1 drainage Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage Tube#2 interv Tube#3 type Tube#3 location Tube#3 drainage		JP RUQ scant bulb suction JP LUQ none bulb suction & LUQ other (specify) &			
05/02/11 20:08 Tube#3 type(DLRO): Duodenal drain					
CARE PROVIDERS		DLRO			

ROBERTS, DUSTI L(DLRO)RN

FLOWSHEET	05/02				
Gastrointestinal-Cont	19:29	20:08	21:01	22:01	23:02
05/02/11 20:08 Tube#3 drainage(DLRO): yellow					
Genitourinary	19:29	20:08	21:01	22:01	23:02
Continent Adequate UOP NoAbn penile bld NoAbnPenileDisch		WNL WNL WNL WNL			
Urine character		amber			
Func/Musculoskel	19:29	20:08	21:01	22:01	23:02
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear		WNL WNL WNL no devices WNL			
Impl FuncMuscPOC		done			
Weakness		generalized			
SCD site SCD type		leg L leg R short leg			
SCD assess		on operational			
Skin	19:29	20:08	21:01	22:01	23:02
Skin warm Color approp		WNL to ethnicity			
Impl Skn/Wnd POC		done			
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score		4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 3=adequate 3=no app.probl 20			
Psychological	19:29	20:08	21:01	22:01	23:02
Memory intact Approp affect Approp behavior Approp verbaliz		WNL to situation to situation to situation			
Abnorm findings		excess anxiety maladj illness			
Comfort	19:29	20:08	21:01	22:01	23:02
Abnorm findings			pain recvAnalgesicTx		pain recvAnalgesicTx
Pain score			7 Numeric Value		5 Numeric Value
Pt relief goal			0		0
CARE PROVIDERS		DLRO	DLRO		DLRO

ROBERTS, DUSTI L(DLRO)RN

CONTINUED

FLOWSHEET	05/02				
Comfort-Cont.	19:29	20:08	21:01	22:01	23:02
Pain onset			ongoing		ongoing
Pain description			constant		constant
Pain site(s)			abdomen		abdomen
Comfort interv			meds (see MAR)		meds (see MAR)
PainReassessScor Pt Goal Reassess		6 Numeric Value 0		- sleeping	
ReassessComf Int		emotional supprt			
Nutrition	19:29	20:08	21:01	22:01	23:02
Dinner amt	0%				
Vascular Access	19:29	20:08	21:01	22:01	23:02
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions		forearm L 04/30/2011 #20 secure dry and intact meds (see MAR)			
Safety	19:29	20:08	21:01	22:01	23:02
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on IV sol verified IV tbg/bag dated High alertMedsID		on done done done done done done done &			
Imple SafetyPOC		done			
05/02/11 20:08 High alertMedsID(DLRO): FSBS Q4hr					
Fall Risk	19:29	20:08	21:01	22:01	23:02
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score		no=0 no=0 None Bedrest=0 yes=20 WeakUsesTouch=10 Knows limits=0 30			
Imple SafetyPOC		done			
Intact Incision	19:29	20:08	21:01	22:01	23:02
Incision#1 site Incision#1 type Drain Incision#1 drAmt Surrounding skin		abdomen staples & none intact			
Incision#1 dsg		open to air			
CARE PROVIDERS	ALB3	DLRO	DLRO	DLRO	DLRO

BOSTER, ALIX(ALB3)PCT ROBERTS, DUSTI L(DLRO)RN

CONTINUED

FLOWSHEET	05/02				
Intact Incision-Cont.	19:29	20:08	21:01	22:01	23:02
05/02/11 20:08 Drain(DLRO): Multiple drains. See previous charting.					
Misc Events	19:29	20:08	21:01	22:01	23:02
Evaluated POC		done			
Misc events		&			
05/02/11 20:08 Misc events(DLRO): Assessment complete. Patient alert and oriented x 3 rating pain 6/10. Family at bedside. Call bell within reach. Will continue to monitor.					
CARE PROVIDERS		DLRO			

ROBERTS, DUSTI L(DLRO)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 52

FLOWSHEET	05/02	05/03			
Comfort	23:59	00:50	01:50	03:00	03:38
Abnorm findings		pain recvAnalgesicTx		pain recvAnalgesicTx	
Pain score		5 Numeric Value		8 Numeric Value	
Pt relief goal		0		0	
Pain onset		ongoing		ongoing	
Pain description		constant		constant	
Pain site(s)		abdomen		abdomen	
Comfort interv		meds (see MAR)		meds (see MAR)	
PainReassessScor Pt Goal Reassess	- sleeping		8 Numeric Value & 0		- sleeping
ReassessComf Int			emotional supprt		
05/03/11 01:50 PainReassessScor(DLRO): New family member arrived.					
CARE PROVIDERS	DLRO	DLRO	DLRO	DLRO	DLRO

ROBERTS, DUSTI L(DLRO)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 53

FLOWSHEET	05/03				
Chart Review	04:54	05:54	06:47	06:48	07:47
Chart check q12h				done	
Neuro/EENT	04:54	06:54	06:47	06:48	07:47
Alert,orientedx3 Follows commands NoSensoryDeficit					
NormHear&/orAid Abs of drainage					
Norm closure Abs of swelling No visual impair PERRLA					
Patent nares No bleed/disch					
ImplNeuroEENTPOC					
Tingling					
Numbness					
Special Neuro	04:54	05:54	06:47	06:48	07:47
GCS eyes open GCS best verbal Best upper motor GCS total soo					
Motor exam LUE Motor exam LLE Motor exam RUE Motor exam RLE					
MotorStrengthLUE MotorStrengthLLE MotorStrengthRUE					
MotorStrengthRLE					
Cardiovascular	04:54	05:54	06:47	06:48	07:47
Reg rate, rhythm S1S2 Angina/chestPain PalpPerhipPulses Cap refill<3 sec Thigh/CalfTender Absence of edema					
Implement Cv POC					
Respiratory	04:54	05:54	06:47	06:48	07:47
Spont respers NonLaboredEffort RegClrBreathSnds No cough,dyspnea Natural airway					
CARE PROVIDERS				DLRO, {COS0}	

ROBERTS, DUSTI L(DLRO)RN SLUSARSKI, COREY(COS0)RN

CONTINUED

FLOWSHEET	05/03				
Respiratory-Cont.	04:54	05:54	06:47	06:48	07:47
No O2 requiremnt					
Gastrointestinal	04:54	05:54	06:47	06:48	07:47
Continent No c/o N/V Normal dentition Last BM					
Implement GI POC					
BowelSndsAllQuad Abdomen Tube feeding Tube type Tube interv G-tube location G-tube suction G-tube drainage J-tube location					
Tube#1 type Tube#1 location Tube#1 drainage Tube#1 interv Tube#2 type Tube#2 location Tube#2 drainage Tube#2 interv Tube#3 type Tube#3 location Tube#3 drainage					
Genitourinary	04:54	05:54	06:47	06:48	07:47
Continent Adequate UOP NoAbn penile bld NoAbnPenileDisch					
Implement GU POC					
Urine character					
Func/Musculoskel	04:54	05:54	06:47	06:48	07:47
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear					
Impl FuncMuscPOC					
Weakness					
SCD site SCD type					
SCD assess					

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 55

FLOWSHEET	05/03				
Skin	04:54	05:54	06:47	06:48	07:47
Skin warm Color approp					
Impl Skn/Wnd POC					
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Color					
Psychological	04:54	05:54	06:47	06:48	07:47
Memory intact Approp behavior Approp verbaliz					
Implemnt PSE POC					
Abnorm findings					
Comfort	04:54	05:54	06:47	06:48	07:47
No c/o,no s/s of					
Impl Comfort POC					
Abnorm findings	pain recvAnalgesicTx		pain recvAnalgesicTx		
Pain score	5 Numeric Value		4 Numeric Value		
Pt relief goal	0		0		
Pain onset	ongoing		ongoing		
Pain description	constant		constant		
Pain site(s)	abdomen		abdomen		
Comfort interv	meds (see MAR)		meds (see MAR)		
PainReassessScor		- sleeping			- sleeping
Vascular Access	04:54	05:54	06:47	06:48	07:47
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions					
Safety	04:54	05:54	06:47	06:48	07:47
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on IV sol verified IV tbg/bag dated					
CARE PROVIDERS	DLRO	DLRO	DLRO		COSO

ROBERTS, DUSTI L(DLRO)RN SLUSARSKI, COREY(COSO)RN

CONTINUED

PERM

FLOWSHEET	05/03				
Safety-Cont.	04:54	05:54	06:47	06:48	07:47
High alertMedsID					
Imple SafetyPOC					
Fall Risk	04:54	05:54	06:47	06:48	07:47
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score					
Imple SafetyPOC					
Intact Incision	04:54	05:54	06:47	06:48	07:47
Incision#1 site Incision#1 type Drain Incision#1 drAmt Surrounding skin					
Incision#1 dsg					
Misc Events	04:54	05:54	06:47	06:48	07:47
Evaluated POC					
Misc events					

FLOWSHEET	05/03				
Neuro/EENT	08:43	09:43	10:34	11:04	12:04
Alert,orientedx3	WNL				
Follows commands	WNL				
NoSensoryDeficit	WNL				
NormHear&/orAid	WNL				
Abs of drainage	WNL				
Norm closure	WNL				
Abs of swelling	WNL				
No visual impair	WNL				
PERRLA	WNL				
Patent nares	WNL				
No bleed/disch	WNL				
ImplNeuroEENTPOC	done				
Tingling	&				
Numbness	&				
05/03/11 08:43 Tingling(COS0): denies					
05/03/11 08:43 Numbness(COS0): denies					
Special Neuro	08:43	09:43	10:34	11:04	12:04
GCS eyes open	4=spontaneously				
GCS best verbal	5=orient/verbalz				
Best upper motor	6=obeysVbCommand				
GCS total soo	15				
Motor exam LUE	6=obeys commands				
Motor exam LLE	6=obeys commands				
Motor exam RUE	6=obeys commands				
Motor exam RLE	6=obeys commands				
MotorStrengthLUE	5=normal				
MotorStrengthLLE	5=normal				
MotorStrengthRUE	5=normal				
MotorStrengthRLE	5=normal				
Cardiovascular	08:43	09:43	10:34	11:04	12:04
Reg rate, rhythm	WNL				
S1S2	WNL				
Angina/chestPain	none				
PalpPerhipPulses	WNL				
Cap refill<3 sec	WNL				
Thigh/CalfTender	none				
Absence of edema	WNL				
Implement Cv POC	done				
Respiratory	08:43	09:43	10:34	11:04	12:04
Spont respers	WNL				
NonLaboredEffort	WNL				
RegClrBreathSnds	all lobes				
No cough,dyspnea	WNL				
Natural airway	WNL				
CARE PROVIDERS	COS0				

SLUSARSKI, COREY(COS0)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 58

FLOWSHEET	05/03				
Respiratory-Cont.	08:43	09:43	10:34	11:04	12:04
No O2 requiremnt	WNL				
Gastrointestinal	08:43	09:43	10:34	11:04	12:04
Continent	WNL				
No c/o N/V	WNL				
Normal dentition	WNL				
Last BM	5/1/11				
Implement GI POC	done				
BowelSndsAllQuad	hypoactive				
Abdomen	muscle guarding				
	tender				
	&				
Tube feeding	see MAR				
	&				
Tube type	j-tube				
Tube interv	irrigated				
	tube site care				
G-tube location	LUQ				
G-tube suction	gravity				
G-tube drainage	brown				
	green				
	(modified)				
J-tube location	LUQ				
Tube#1 type	JP				
Tube#1 location	RUQ				
Tube#1 drainage	purulent				
Tube#1 interv	bulb suction				
Tube#2 type	JP				
Tube#2 location	LUQ				
Tube#2 drainage	green				
Tube#2 interv	bulb suction				
Tube#3 type	other (specify)				
	&				
Tube#3 location	LUQ				
Tube#3 drainage	other (specify)				
	&				
05/03/11 08:43 Abdomen(COS0): +Flatus					
05/03/11 08:43 Tube feeding(COS0): promote @95ml/hr					
05/03/11 08:43 Tube#3 type(COS0): duodenal drain					
05/03/11 08:43 Tube#3 drainage(COS0): yellow					
Genitourinary	08:43	09:43	10:34	11:04	12:04
Continent	WNL				
Adequate UOP	WNL				
NoAbn penile bld	WNL				
NoAbnPenileDisch	WNL				
Implement GU POC	done				
Urine character	amber				
CARE PROVIDERS	COS0				

SLUSARSKI, COREY(COS0)RN

CONTINUED

FLOWSHEET	05/03				
Func/Musculoskel	08:43	09:43	10:34	11:04	12:04
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear	WNL WNL WNL no devices WNL				
Impl FuncMuscPOC	done				
Weakness	generalized				
SCD site SCD type	leg L leg R short leg				
SCD assess	on operational				
Skin	08:43	09:43	10:34	11:04	12:04
Skin warm Color approp	WNL to ethnicity				
Impl Skn/Wnd POC	done				
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score Color	4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 3=adequate 3=no app.probl 20 jaundice &				
05/03/11 08:43 Color(COS0): eyes					
Psychological	08:43	09:43	10:34	11:04	12:04
Memory intact Approp behavior Approp verbaliz	WNL to situation to situation				
Implemnt PSE POC	done				
Abnorm findings	excess anxiety				
Comfort	08:43	09:43	10:34	11:04	12:04
No c/o,no s/s of	chills fever itching nausea prob sleeping spasms sweating vomiting				
Impl Comfort POC	done				
Abnorm findings	pain recvAnalgesicTx			pain recvAnalgesicTx	
CARE PROVIDERS	COS0			COS0	

SLUSARSKI, COREY(COS0)RN

FLOWSHEET	05/03				
Comfort-Cont.	08:43	09:43	10:34	11:04	12:04
Pain score	10 Numeric Value			6 Numeric Value	
Pt relief goal	0-3			0-3	
Pain onset	ongoing			ongoing	
Pain description	constant			constant	
Pain site(s)	incisional abdomen			abdomen	
Comfort interv	emotional supprt meds (see MAR) relaxation			emotional supprt meds (see MAR) relaxation	
PainReassessSoor Pt Goal Reassess		4 Numeric Value 0-3			5 Numeric Value 0-3
ReassessComf Int		relaxation			emotional supprt heat relaxation repositioned (modified)
Nutrition	08:43	09:43	10:34	11:04	12:04
Meal type			clear liquid		
Breakfast amt			0%		
Act Daily Living	08:43	09:43	10:34	11:04	12:04
Bath Mouth care			assist independent		
Amb w/assistance OOB-chair ROM joints			assist assist independent		
Peri care			independent		
Deep breathe			independent		
Cough			independent		
Vascular Access	08:43	09:43	10:34	11:04	12:04
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions	forearm L 04/30/2011 #20 secure dry and intact meds (see MAR)				
Safety	08:43	09:43	10:34	11:04	12:04
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on IV sol verified IV tbg/bag dated	on done done done done done done				
CARE PROVIDERS	COSO	COSO	JTC	COSO	COSO

CARSON, JOHN T(JTC)CA SLUSARSKI, COREY(COSO)RN

CONTINUED

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 61

FLOWSHEET	05/03				
Safety-Cont.	08:43	09:43	10:34	11:04	12:04
High alertMedsID	done &				
Imple SafetyPOC	done				
05/03/11 08:43 High alertMedsID(COS0): insulin					
Fall Risk	08:43	09:43	10:34	11:04	12:04
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score	no=0 no=0 w/c NrsAssist=0 yes=20 WeakUsesTouch=10 Knows limits=0 30				
Imple SafetyPOC	done				
Intact Incision	08:43	09:43	10:34	11:04	12:04
Incision#1 site Incision#1 type Drain Incision#1 drAmt Surrounding skin	abdomen staples other (specify) & none intact				
Incision#1 dsg	open to air				
05/03/11 08:43 Drain(COS0): x4					
Misc Events	08:43	09:43	10:34	11:04	12:04
Evaluated POC	done				
Misc events	&				
05/03/11 08:43 Misc events(COS0): pt A/Ox3, assessment complete. Pt c/o pain to abd meds given as ordered. Denies nausea, Staples OTA, hypo BS +Flatus. Family at bedside call bell w/in reach will cont to monitor					
CARE PROVIDERS	COS0				

SLUSARSKI, COREY(COS0)RN

CONTINUED

FLOWSHEET	05/03				
Gastrointestinal	12:45	13:45	14:09	15:33	16:09
Last BM					5/3
Stool amount Stool color Stool consistncy					small & liquid
05/03/11 16:09 Stool color(COS0): cream colored					
Comfort	12:45	13:45	14:09	15:33	16:09
Abnorm findings	pain recvAnalgesicTx			pain recvAnalgesicTx	
Pain score	7 Numeric Value			6 Numeric Value	
Pt relief goal	0-3			0-3	
Pain onset	ongoing			ongoing	
Pain description	constant			constant	
Pain site(s)	abdomen			incisional abdomen	
Comfort interv	emotional supprt meds (see MAR) relaxation			emotional supprt meds (see MAR) relaxation	
PainReassessScor		- sleeping			
Nutrition	12:45	13:45	14:09	15:33	16:09
Lunch amt			10%		
Misc Events	12:45	13:45	14:09	15:33	16:09
Misc events			&		
05/03/11 14:09 Misc events(COS0): M.Mosteller aware of pt BP. No new orders at this time will cont to monitor					
CARE PROVIDERS	COS0	COS0	COS0 JTC	COS0	COS0

CARSON, JOHN T(JTC)CA SLUSARSKI, COREY(COS0)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: [redacted] SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 63

FLOWSHEET	05/03				
Chart Review	16:33	18:13	18:54	18:59	19:20
Chart check q12h			done		
Neuro/EENT	16:33	18:13	18:54	18:59	19:20
Alert,orientedx3					WNL
Follows commands					WNL
NoSensoryDeficit					WNL
NormHear&/orAid					WNL
Abs of drainage					WNL
Norm closure					WNL
Abs of swelling					WNL
No visual impair					WNL
PERRLA					WNL
Patent nares					WNL
No bleed/disch					WNL
Behavior/neuro					calm
Orientation					situation
					to person
					to place
					to time
Special Neuro	16:33	18:13	18:54	18:59	19:20
GCS eyes open					4=spontaneously
GCS best verbal					5=orient/verbalz
Best upper motor					6=obeysVbCommand
GCS total sco					15
Motor exam LUE					6=obeys commands
Motor exam LLE					6=obeys commands
Motor exam RUE					6=obeys commands
Motor exam RLE					6=obeys commands
MotorStrengthLUE					5=normal
MotorStrengthLLE					5=normal
MotorStrengthRUE					5=normal
MotorStrengthRLE					5=normal
Cardiovascular	16:33	18:13	18:54	18:59	19:20
Reg rate, rhythm					&
S1S2					WNL
Angina/chestPain					none
PalpPerhipPulses					WNL
Cap refill<3 sec					WNL
Thigh/CalfTender					none
Absence of edema					WNL
Implement Cv POC					done
R pedal pulse					normal
L pedal pulse					normal
05/03/11 19:20 Reg rate, rhythm(TMM2): 120					
CARE PROVIDERS			COS0, (TMM2)		TMM2

MARTUCCI, TIFFANY(TMM2)RN SLUSARSKI, COREY(COS0)RN

CONTINUED

FLOWSHEET	05/03				
Respiratory	16:33	18:15	18:54	18:59	19:20
Spont respers					WNL
NonLaboredEffort					WNL
RegClrBreathSnds					all lobes
No cough,dyspnea					WNL
Natural airway					WNL
No O2 requiremnt					WNL
Gastrointestinal	16:33	18:15	18:54	18:59	19:20
Continent					&
No c/o N/V					WNL
Normal dentition					WNL
MucousMembIntact					WNL
Last BM					5/3/2011
Implement GI POC					done
BowelSndsAllQuad					hypoactive
Abdomen					distended
					muscle guarding
					tender
Tube feeding					see MAR
Tube type					j-tube
Tube interv					irrigated
TF interv					&
G-tube location					LUQ
G-tube suction					gravity
G-tube drainage					clear
					green
J-tube location					LLQ
Tube#1 type					JP
Tube#1 location					RUQ
Tube#1 drainage					&
Tube#1 interv					bulb suction
Tube#2 type					JP
Tube#2 location					LUQ
Tube#2 drainage					clear
Tube#2 interv					bulb suction
Tube#3 type					other (specify)
					&
Tube#3 location					LUQ
Tube#3 drainage					clear
					green
					&
Tube#3 interv					&
05/03/11 19:20 Continent(TMM2): continent at times.					
05/03/11 19:20 TF interv(TMM2): tube feed replenished.					
05/03/11 19:20 Tube#1 drainage(TMM2): greyish liquid					
05/03/11 19:20 Tube#3 type(TMM2): Duodenal tube					
05/03/11 19:20 Tube#3 drainage(TMM2): yellowish					
CARE PROVIDERS					TMM2

MARTUCCI, TIFFANY(TMM2)RN

CONTINUED

FLOWSHEET	05/03				
Gastrointestinal-Cont.	16:33	18:13	18:54	18:59	19:20
05/03/11 19:20 Tube#3 interv(TMM2): continous low wall suction					
Genitourinary	16:33	18:13	18:54	18:59	19:20
Continent Adequate UOP NoAbn penile bld NoAbnPenileDisch					WNL WNL WNL WNL
Urine character					&
05/03/11 19:20 Urine character(TMM2): clear amber					
Func/Musculoskel	16:33	18:13	18:54	18:59	19:20
ActiveROM x4 ext Symmetry all ext No act restrict No use of device Speech clear					WNL WNL WNL & WNL
Impl FuncMuscPOC					done
Weakness					generalized
SCD site SCD type					leg L leg R short leg
SCD assess					on operational
05/03/11 19:20 No use of device(TMM2): trapeze					
Skin	16:33	18:13	18:54	18:59	19:20
Skin warm Color approp					WNL to ethnicity
Impl Skn/Wnd POC					done
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total Score SpBed DecisnTree					4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 3=adequate 3=no app.probl 20 score1or2 in any
Color					jaundice
Other equipment					trapeze
Psychological	16:33	18:13	18:54	18:59	19:20
Memory intact Approp verbaliz					WNL to situation
Abnorm findings					excess anxiety maladj illness
CARE PROVIDERS					TMM2

MARTUCCI, TIFFANY(TMM2)RN

FLOWSHEET	05/03				
Comfort	16:33	18:13	18:54	18:59	19:20
No c/o,no s/s of					chills fever itching nausea prob sleeping spasms sweating vomiting
Impl Comfort POC		done			done
Abnorm findings		pain recvAnalgesicTx			pain
Pain score		8 Numeric Value			6 Numeric Value
Pt relief goal		0-3			0-3
Pain onset		ongoing			ongoing
Pain description		constant			constant
Pain site(s)		abdomen			abdomen &
Comfort interv		meds (see MAR)			diversion emotional supprt relaxation repositioned
PainReassessScor Pt Goal Reassess	- sleeping		7 Numeric Value 0-3		
ReassessComf Int			relaxation		
05/03/11 19:20 Pain site(s)(TMM2): posterior neck					
Nutrition	16:33	18:13	18:54	18:59	19:20
Meal type					clear liquid
Dinner amt				0%	
Vascular Access	16:33	18:13	18:54	18:59	19:20
Site#1 location Insertion date Gauge Site#1 appear Site#1 dressing Interventions					forearm L 04/30/2011 #20 secure dry and intact meds (see MAR)
Safety	16:33	18:13	18:54	18:59	19:20
Hospital ID band CallSystm access Bed in low posit Bed brakes on Bed alarms on Bed press relief					on done done done done on
CARE PROVIDERS	COS0	COS0	COS0	JTC	RPGO TMM2

CARSON, JOHN T(JTC)CA
SLUSARSKI, COREY(COS0)RN
GOLUB, RACHEL P(RPGO)RN
MARTUCCI, TIFFANY(TMM2)RN

FLOWSHEET	05/03				
Safety-Cont.	16:33	18:13	18:54	18:59	19:20
IV sol verified IV tbg/bag dated High alertMedsID					done done done
Imple SafetyPOC					done
Fall Risk	16:33	18:13	18:54	18:59	19:20
HxFall(w/in 3mo) Secondary dx Ambulatory aid IV or IV access Gait Mental status Total score					no=0 no=0 w/c NrsAssist=0 yes=20 WeakUsesTouch=10 OvrestFrgtLmt=15 45
Imple SafetyPOC					done
Intact Incision	16:33	18:13	18:54	18:59	19:20
Incision#1 site Incision#1 type Incision#1 drAmt Surrounding skin					abdomen staples none intact
Incision#1 dsg					open to air
Misc Events	16:33	18:13	18:54	18:59	19:20
Evaluated POC					done
Misc events					&
Misc events					&
05/03/11 19:20 Misc events(TMM2): Assumed patient care, assessment as noted. Patient showing signs of anxiety, states 6/10 pain rating. POC and medication dosing schedule explained to patient. Patient stated understanding, Call bell in reach, will continue to monitor.					
05/03/11 19:20 Misc events(RPGO): agree with above assessment. call light in reach. will continue to monitor for comfort and safety.					
CARE PROVIDERS					RPGO TMM2

GOLUB, RACHEL P(RPGO)RN MARTUCCI, TIFFANY(TMM2)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 09:00
OPT OUT:
Page: 68

FLOWSHEET	05/03				
Misc Events	21:30	21:45	21:50	22:06	23:45
Misc events	&	&	&	&	&
Misc events		&	&		&

05/03/11 21:30 Misc events(TMM2): Patient showing signs of pain, states painful, medication for pain offered and patient refused at this time. States he will call if medication needed.

05/03/11 21:45 Misc events(RPGO): Pt mother came to RN station stating that no one had come to room when pt called for temperature to be changed. Secretary attempted to explain that she had called control room for temp to be changed, however mother yelling at secretary "I wasnt

05/03/11 21:45 Misc events(RPGO): talking to you!" Charge RN Megan S. states will come to room to try to help change temperature. Megan to room with pt mother.

05/03/11 21:50 Misc events(MEGS): I followed pt. mother to room, where she closed the door, to try and adjust temp from thermastat, mother continued to approach and speak to me in a threating mannor, She continued in this mannor for approximatley 5 min.

05/03/11 21:50 Misc events(MEGS): I tried to answer her questions and calm her down but she continued to raise her voice in a threatening tone, addressed pt. neck pain and explained that to mother that he denied pain meds, I then fixed his SCDs and exited the room.

05/03/11 22:06 Misc events(MEGS): pt. states that he wants pain meds that go through his J tube, when offered 15mg Oxycodone elixor he stated that he only wanted 5mg, 5mg Oxycodone administered per J tube, will continue to monitor for safety

05/03/11 23:45 Misc events(RPGO): Pt mother entered floor states going to pt room. Charge RN Megan Stone asked if mother aware of visiting policy as now 2 guests in room past visiting hours. Mother very rudely addressed Charge stating that she already knows the policy and continued

05/03/11 23:45 Misc events(RPGO): to pt room. Charge RN on phone w/ HSC at the time, HSC aware of escalating tone.

CARE PROVIDERS	TMM2	RPGO	MEGS	MEGS	RPGO

GOLUB, RACHEL P(RPGO)RN MARTUCCI, TIFFANY(TMM2)RN STONE, MEGAN E(MEGS)RN

GOODWIN, DAVON
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FROM: 04/28/11 02:55 TO: 05/04/11 16:07
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AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 69

FLOWSHEET	05/03	05/04			
Comfort	23:50	00:00	00:15	01:07	02:05
Abnorm findings				pain recvAnalgesicTx	
Pain score				5 Numeric Value	
Pt relief goal				<4	
Pain onset				ongoing	
Pain description				constant cramping	
Pain site(s)				abdomen	
Comfort interv				emotional supprt meds (see MAR) relaxation repositioned	
Misc Events	23:50	00:00	00:15	01:07	02:05
Misc events	&	&	&	&	&
Misc events		&	&		

05/03/11 23:50 Misc events(RPGO): Mother called desk for assistance in room, when entered room mother upset that it took staff over 1 min to enter room. Mother speaking very loudly to staff and states family will be bringing pillow for pt and that she will spend night w/ pt.

05/04/11 00:00 Misc events(RPGO): HSC made aware of mother spending night with pt and threatening tone she has taken w/ staff, HSC advised for security to come to floor for implemetation fo safety plan for staff and pt. Security arrived to floor and asked for HSC presence. HSC Angela on

05/04/11 00:00 Misc events(RPGO): floor to discuss w/ family safety policy.

05/04/11 00:15 Misc events(RPGO): HSC angela, security and Charge RN Megan S. to room addressing mother about threatening tone toward staff and verbal aggression. Angela HSC explained to mother that she may not speak to staff in this manner and if it continues she will be escorted off th

05/04/11 00:15 Misc events(RPGO): the floor. Mother continued to argu w/ HSC but states understanding.

05/04/11 01:07 Misc events(RPGO): Pt requesting pain medication, asked pt if he woould like 5mg again or up to 15mg. Pt requesting 5mg only at this time. admistered med per pt request. will continue to monitor

05/04/11 02:05 Misc events(TMM2): patient requesting to get OOB to wheelchair. States "I want to be wheeled around in the halls" Staff assisted patient OOB, disconnected tube feeding, IV fluids and helped into the wheel chair. Patients mother pushed him down hall.

CARE PROVIDERS	RPGO	RPGO	RPGO	RPGO	TMM2

GOLUB, RACHEL P(RPGO)RN MARTUCCI, TIFFANY(TMM2)RN

CONTINUED

FLOWSHEET	05/04				
Chart Review	02:08	04:04	04:50	06:38	06:42
Chart check q12h					
Comfort	02:08	04:04	04:50	06:38	06:42
Pain score		8 Numeric Value			8 Numeric Value
Pt relief goal		0-4			
Pain onset		ongoing			
Pain description		constant cramping			throbbing
Pain site(s)		&			neck shoulder R
Comfort interv		emotional supprt meds (see MAR) relaxation			meds (see MAR)
PainReassessScor			- sleeping		

05/04/11 04:04 Pain site(s)(TMM2): abdomen

Misc Events	02:08	04:04	04:50	06:38	06:42
Misc events	&			&	
Misc events	&				

05/04/11 02:08 Misc events(TMM2): Patient rang call bell minutes later stating he wanted to be put back to bed and staff responded. Patient was in bed as staff entered the room. IV fluids, tube feed and drains were reconnected, bed in low position, call bell in reach, will continue

05/04/11 02:08 Misc events(TMM2): to monitor per MUSC policy.

05/04/11 06:38 Misc events(TMM2): Patient requesting muscle relaxers as promised by MD. No orders pending at this time, will page MD to inquire.

CARE PROVIDERS	TMM2	TMM2	TMM2	TMM2	TMM2

MARTUCCI, TIFFANY(TMM2)RN

GOODWIN, DAVON
MUSC
24Hour Adult Patient Record
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 71

FLOWSHEET	05/04				
Chart Review	07:02	08:06	08:16	08:20	08:25
Chart check q12h	done				
Misc Events	07:02	08:06	08:16	08:20	08:25
Mayday					seeMaydayRecord
Misc events		(modified) &	&	&	&
Misc events					
05/04/11 08:06 Misc events(MKWI): pt up to chair, Oxygen at 2l n/c started. Heat packs to neck and shoulder r/t c/o muscle pain and discomfort.					
05/04/11 08:16 Misc events(MKWI): pt called to get back in bed.					
05/04/11 08:20 Misc events(MKWI): PCT John in room, pt not responsive, nurse called.					
05/04/11 08:25 Misc events(MKWI): pt unresponsive, called charge nurse and mayday, lifted pt back to bed, started CPR.					
CARE PROVIDERS	TMM2, {MKWI}	MKWI	MKWI	MKWI	MKWI

MARTUCCI, TIFFANY(TMM2)RN WITTENMEYER, MARIANNE K(MKWI)RN

FLOWSHEET	05/04				
Misc Events	08:26	09:20	09:21	09:50	11:45
Critical lab res			&	&	
Lifepoint called Date/time call Call made by LifepointContact					done 05/04/2011 11:45 & &
Misc events	&	&			
Misc events	&				
05/04/11 08:26 Misc events(MKWI): Mayday team at bedside, labs drawn, Femoral IV access started.					
05/04/11 08:26 Misc events(MKWI): Mayday team took over, paper charting started					
05/04/11 09:20 Misc events(MKWI): dr. Montgomeray at bedside with family					
05/04/11 09:21 Critical lab res(JSTO): Sharon Dean from lab called for a critical Potassium of 8.5.					
05/04/11 09:50 Critical lab res(MKWI): Trinindad from lab called, platelet count clumps in lab smear, lab cancelled					
05/04/11 11:45 Call made by(JSTO): Jessica Stout, RN					
05/04/11 11:45 LifepointContact(JSTO): Abbi Reed					
CARE PROVIDERS	MKWI	MKWI	JSTO	MKWI	JSTO

STOUT, JESSICA A(JSTO)RN WITTENMEYER, MARIANNE K(MKWI)RN

FLOWSHEET	05/04	
Misc Events	12:47	13:45
Misc events	&	&
05/04/11 12:47 Misc events(JSTO): Lifepoint called to say they realeased the body.		
05/04/11 13:45 Misc events(MKWI): Patients body to morgue		
CARE PROVIDERS	JSTO	MKWI

STOUT, JESSICA A(JSTO)RN

WITTENMEYER, MARIANNE K(MKWI)RN

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 1

FLOWSHEET	04/26							
Vital Signs	05:15	05:30	05:45	06:05	06:15	06:29	06:30	06:45
Temp in C	36.6C Rectal	36.6C			36.1C		36.0C	36.0C
PULSE	87	91	86	93	88		96	92
RESPIRATIONS	5 Visual		23	18	18		16	18
Vent resp	18							
O2 SAT %	100% O2			100% O2				
O2 flow	40 Prcent							
O2 equipment	Vent							
BP (NIBP)	94/48							
BP mean (NIBP)	60							
Arterial BP	119/55	126/46	121/52	108/62	106/66		89/63	119/53
Arterial mean	69	63	71	75	78		73	68
Glucose fs				273mg/dL				
Insulin mulriplr				.03				
RASS	-3			-3				
CAM-ICU	Ngatve							
PAIN LEVEL	1 Wongbk			3				
WEIGHT in Kg	94.5kg							
Glucose	05:15	05:30	05:45	06:05	06:15	06:29	06:30	06:45
GLUCOSE POC, WHO		**212 H**				**273 H**		
Medicated Drips	05:15	05:30	05:45	06:05	06:15	06:29	06:30	06:45
Fentanyl				50mcg/hr				
Insulin				6.39units/hr				
Propofol				30mcg/kg/min				
I&O SUMMARY	05:15	05:30	05:45	06:05	06:15	06:29	06:30	06:45
Intake Total	1003			2028.39				
Output Total	75			100				
NET	928			1928.39				
INTAKE	05:15	05:30	05:45	06:05	06:15	06:29	06:30	06:45
InvasiveLineFlsh	3			3				
Lactated Ringers	1000			2000				
Fentanyl				1				
Insulin				6.39				
Propofol				18				
Intake Total	1003			2028.39				
CARE PROVIDERS	MEAS	SID SMT5	SMT5	SMT5	SMT5	SID	SMT5	SMT5

ASKEA, MEAGHAN E(MEAS)RN CC SYSTEM, ID(SID) MCGLYNN, STEPHANIE(SMT5)RN

Ngatve negative
Prcent percent
Rectal rectal
Vent ventilator
Visual visual
Wongbk Wong-Baker(face)

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 2

FLOWSHEET	04/26							
OUTPUT	05:15	05:30	05:45	06:05	06:15	06:29	06:30	06:45
Foley cath	25			100				
NG tube	&							
Wound drn #1	50&							
Output Total	75			100				
04/26/11 05:15 NG tube(MEAS): R nare								
04/26/11 05:15 Wound drn #1(MEAS): to wall suction								
CARE PROVIDERS	MEAS			SMT5				

ASKEA, MEAGHAN E(MEAS)RN MCGLYNN, STEPHANIE(SMT5)RN

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 3

FLOWSHEET	04/26						
Vital Signs	06:50	07:00	07:24	08:00	09:02	09:05	10:00
Temp in C		(35.9C&)		35.9C		36.3C	
PULSE		87		94		87	
RESPIRATIONS		18		18		18	
Vent resp				18		18	
O2 SAT %		100% O2		100% O2		100%	
Arterial BP		137/66		142/68		155/76	
Arterial mean		83		86		95	
Glucose fs		185mg/dL		186mg/dL		85mg/dL	
Insulin mulriplr		0.04		.04		.04	
PAIN LEVEL				0 App		0 App	
04/26/11 07:00 Temp in C(SMT5): Bear hugger placed on pt.							
Glucose	06:50	07:00	07:24	08:00	09:02	09:05	10:00
GLUCOSE POC, WHO			**185 H**		85		
Medicated Drips	06:50	07:00	07:24	08:00	09:02	09:05	10:00
Fentanyl		50mcg/hr		50mcg/hr		100mcg/hr	
Insulin		8.5units/hr		8.5units/hr		.8units/hr	
Propofol		30mcg/kg/min		30mcg/kg/min		20mcg/kg/min	
I&O SUMMARY	06:50	07:00	07:24	08:00	09:02	09:05	10:00
Intake Total	0	1630.5		178.4		795.5	50
Output Total		1050		960		325	
NET	0	580.5		-781.6		470.5	50
INTAKE	06:50	07:00	07:24	08:00	09:02	09:05	10:00
IVPB							50
InvasiveLineFlsh		3		3		3	
Lactated Ringers	0	1000		150		150	
Fentanyl	0	1		1		2	
Insulin	0	8.5		6.4		8.5	
Propofol	0	18		18		12	
FFP		600				620	
Intake Total	0	1630.5		178.4		795.5	50
OUTPUT	06:50	07:00	07:24	08:00	09:02	09:05	10:00
Foley cath		150		60		125	
NG tube				300			
Wound drn #1		900		600&		200	
Output Total		1050		960		325	
04/26/11 08:00 Wound drn #1(LAA): Dr perry aware							
CARE PROVIDERS	SMT5	SMT5	SID	LAA	SID	LAA	LAA

ADAMS, LESLIE A(LAA)RN CC SYSTEM, ID(SID) MCGLYNN, STEPHANIE(SMT5)RN
App AssumePainPresnt

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 4

FLOWSHEET	04/26						
Vital Signs	10:01	10:05	10:26	11:01	11:10	11:58	12:00
Temp in C		36.7C			37.0C		37.2C
PULSE		91			95		97
RESPIRATIONS		18			18		18
Vent resp		18			18		18
O2 SAT %		100%			100%		100%
BP (NIBP)		114/62			121/58		
BP mean (NIBP)		75			70		
Arterial BP		128/64			134/52		142/64
Arterial mean		81			73		83
Glucose fs		**55mg/dL&**			88mg/dL		90mg/dL
Insulin mulriplr		.03			.02		.01
PAIN LEVEL		0 App			0 App		0 App
04/26/11 10:05 Glucose fs(LAA): D50 given as per protocol							
Glucose	10:01	10:05	10:26	11:01	11:10	11:58	12:00
GLUCOSE POC, WHO	**55 L**		97	88		90	
Medicated Drips	10:01	10:05	10:26	11:01	11:10	11:58	12:00
Fentanyl		100mcg/hr			100mcg/hr		125mcg/hr
Insulin		&			.3units/hr		.2units/hr
Propofol		20mcg/kg/min			12mcg/kg/min		60mcg/kg/min
04/26/11 10:05 Insulin(LAA): off as per protocol							
I&O SUMMARY	10:01	10:05	10:26	11:01	11:10	11:58	12:00
Intake Total		417.8			417.7		441.8
Output Total		30			120		620
NET		387.8			297.7		-178.2
INTAKE	10:01	10:05	10:26	11:01	11:10	11:58	12:00
InvasiveLineFlsh		3			3		3
Lactated Ringers		150			150		150
OTHER PRIMARY IV		250&			250		250
Fentanyl		2			2		2.5
Insulin		0.8			0.7		0.3
Propofol		12			12		36
Intake Total		417.8			417.7		441.8
04/26/11 10:05 OTHER PRIMARY IV(LAA): cc for cc wound vac replacement							
OUTPUT	10:01	10:05	10:26	11:01	11:10	11:58	12:00
Foley cath		30			120		120
NG tube							0
Wound drn #1							500
Output Total		30			120		620
CARE PROVIDERS	SID	LAA	SID	SID	LAA	SID	LAA

ADAMS, LESLIE A(LAA)RN CC SYSTEM, ID(SID)
App AssumePainPresnt

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 5

FLOWSHEET	04/26						
Vital Signs	12:32	13:12	13:14	13:28	14:00	14:10	14:15
Temp in C			37.7C			38.0C	
PULSE			107			110	
RESPIRATIONS			18			19	
O2 SAT %			100% O2				
BP (NIBP)						127/71	
BP mean (NIBP)						82	
Arterial BP			140/75				
Arterial mean			92				
Glucose fs			104mg/dL			115mg/dL	
Insulin multiplr			.005			.005	
PAIN LEVEL			0 Wongbk			0 App	
Glucose	12:32	13:12	13:14	13:28	14:00	14:10	14:15
GLUCOSE POC, WHO		**104 H**					**115 H**
Medicated Drips	12:32	13:12	13:14	13:28	14:00	14:10	14:15
Fentanyl			125mcg/hr			125mcg/hr	
Insulin			.2units/hr			1.1units/hr	
Propofol			60mcg/kg/min			60mcg/kg/min	
I&O SUMMARY	12:32	13:12	13:14	13:28	14:00	14:10	14:15
Intake Total	0		316.7	0	50	316.7	
Output Total			35			270	
NET	0		281.7	0	50	46.7	
INTAKE	12:32	13:12	13:14	13:28	14:00	14:10	14:15
IVPB					50		
InvasiveLineFlsh			3			3	
Lactated Ringers	0		150	0		150	
OTHER PRIMARY IV			125			125	
Fentanyl			2.5			2.5	
Insulin			0.2			0.2	
Propofol	0		36	0		36	
Intake Total	0		316.7	0	50	316.7	
OUTPUT	12:32	13:12	13:14	13:28	14:00	14:10	14:15
Foley cath			35			120	
NG tube						150	
Output Total			35			270	
CARE PROVIDERS	LAA	SID	LAA	LAA	LAA	LAA	SID

ADAMS, LESLIE A(LAA)RN CC SYSTEM, ID(SID)
App AssumePainPresent Wongbk Wong-Baker(face)

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 09:06
OPT OUT:
Page: 6

FLOWSHEET	04/26							
Vital Signs	14:45	14:52	14:54	16:05	16:08	16:39	17:10	17:56
Temp in C	38.2C		38.2C	38.1C			37.9C	
PULSE	112		112	98			94	
RESPIRATIONS	18		17	18			18	
Vent resp				18			18	
O2 SAT %	100%		100%	100% O2			100% O2	
BP (NIBP)	84/49&			105/48				
BP mean (NIBP)	58			61				
Arterial BP	84/57						114/57	
Arterial mean	65						73	
Glucose fs	139mg/dL			86mg/dL				
Insulin mulriplr	.02			.02			.02	
PAIN LEVEL	0 App			0 App			0 App	
04/26/11 14:45 BP (NIBP)(LAA): Labs sent early								
Glucose	14:45	14:52	14:54	16:05	16:08	16:39	17:10	17:56
GLUCOSE POC, WHO		**139 H**			86			**101 H**
Medicated Drips	14:45	14:52	14:54	16:05	16:08	16:39	17:10	17:56
Fentanyl	125mcg/hr			125mcg/hr			125mcg/hr	
Insulin	2.4units/hr			.5units/hr			.5units/hr	
Propofol	40mcg/kg/min			&			30mcg/kg/min	
04/26/11 16:05 Propofol(LAA): on hold due to low BP								
I&O SUMMARY	14:45	14:52	14:54	16:05	16:08	16:39	17:10	17:56
Intake Total	180.6			294.9		1000	274	
Output Total	35			755			100	
NET	145.6			-460.1		1000	174	
INTAKE	14:45	14:52	14:54	16:05	16:08	16:39	17:10	17:56
InvasiveLineFlsh	3			3			3	
Lactated Ringers	150			150		1000	150	
OTHER PRIMARY IV				125			100	
Fentanyl	2.5			2.5			2.5	
Insulin	1.1			2.4			0.5	
Propofol	24			12			18	
Intake Total	180.6			294.9		1000	274	
OUTPUT	14:45	14:52	14:54	16:05	16:08	16:39	17:10	17:56
Foley cath	35			115			100	
NG tube				240				
Wound drn #1				400				
Output Total	35			755			100	
CARE PROVIDERS	LAA	SID	LAA	LAA	SID	LAA	LAA	SID

ADAMS, LESLIE A(LAA)RN CC SYSTEM, ID(SID)
App AssumePainPresnt

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 18:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB[redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 7

FLOWSHEET	04/26						
Vital Signs	18:00	18:04	18:41	18:44	18:46	18:47	18:56
Temp in C	37.9C					37.8C	
PULSE	98					95	
RESPIRATIONS	18					18	
Vent resp	18					18	
O2 SAT %	100% O2					100% O2	
BP (NIBP)						102/51	
BP mean (NIBP)						64	
Arterial BP	115/58					93/48	
Arterial mean	73					61	
Glucose fs	101mg/dL					104mg/dL	
Insulin mulriplr	.02					.02	
PAIN LEVEL	0 App					0 App	
Glucose	18:00	18:04	18:41	18:44	18:46	18:47	18:56
GLUCOSE POC, WHO				**104 H**			
Medicated Drips	18:00	18:04	18:41	18:44	18:46	18:47	18:56
Fentanyl	125mcg/hr					125mcg/hr	
Insulin	.8units/hr					.9units/hr	
Propofol	18mcg/kg/min					30mcg/kg/min	
I&O SUMMARY	18:00	18:04	18:41	18:44	18:46	18:47	18:56
Intake Total	274	0	0		0	274.3	250
Output Total	100					100	
NET	174	0	0		0	174.3	250
INTAKE	18:00	18:04	18:41	18:44	18:46	18:47	18:56
IVPB							
InvasiveLineFlsh	3					3	
Lactated Ringers	150	0			0	150	250
OTHER PRIMARY IV	100					100	
Fentanyl	2.5		0			2.5	
Insulin	0.5					0.8	
Propofol	18	0				18	
Intake Total	274	0	0		0	274.3	250
OUTPUT	18:00	18:04	18:41	18:44	18:46	18:47	18:56
Foley cath	100					100	
NG tube							
Wound drn #1							
Output Total	100					100	
CARE PROVIDERS	LAA	LAA	LAA	SID	LAA	LAA	LAA

ADAMS, LESLIE A(LAA)RN CC SYSTEM, ID(SID)
App AssumePainPresnt

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 8

FLOWSHEET	04/26					
Vital Signs	19:40	19:41	19:53	21:00	21:02	22:06
Temp in C	37.5C			37.6C		37.6C
PULSE	96			98		95
RESPIRATIONS	19			18		9
O2 SAT %		100% O2		100% O2		100% O2
BP (NIBP)	103/59					
BP mean (NIBP)	66					
Arterial BP	93/50			106/53		106/52
Arterial mean	62			67		67
Glucose fs			117mg/dL	95mg/dL		87mg/dL
PAIN LEVEL	0 Wongbk			0 Wongbk		0 Wongbk
Glucose	19:40	19:41	19:53	21:00	21:02	22:06
GLUCOSE PCX, WHO			**117 H**		95	87
Medicated Drips	19:40	19:41	19:53	21:00	21:02	22:06
Fentanyl	125mcg/hr					
Insulin	.9units/hr			1.7units/hr		.7units/hr
Propofol	30mcg/kg/min			20mcg/kg/min		
I&O SUMMARY	19:40	19:41	19:53	21:00	21:02	22:06
Intake Total	249.4			294.2		293.2
Output Total	800			175		100
NET	-550.6			119.2		193.2
INTAKE	19:40	19:41	19:53	21:00	21:02	22:06
IVPB	50					
InvasiveLineFlsh	3			3		3
Lactated Ringers	175			275		275
Fentanyl	2.5			2.5		2.5
Insulin	0.9			1.7		0.7
Propofol	18			12		12
Intake Total	249.4			294.2		293.2
OUTPUT	19:40	19:41	19:53	21:00	21:02	22:06
Foley cath	200			175		100
NG tube	100					
Wound drn #1	(500)					
Output Total	800			175		100
CARE PROVIDERS	JLP	JLP	SID JLP	JLP	SID	SID JLP

CC SYSTEM, ID(SID)
Wongbk Wong-Baker(face)

PETERSON, JENNIFER L(JLP)RN

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 9

FLOWSHEET	04/26		04/27				
Vital Signs	23:05	23:15	00:00	00:05	01:17	02:05	02:16
Temp in C	37.6C		37.8C			38.0C	
PULSE	98		100			107	
RESPIRATIONS	19		18			18	
O2 SAT %	100% O2		100% O2			100%	
Arterial BP	121/57		121/56			116/66	
Arterial mean	74		73			80	
Glucose fs	104mg/dL		97mg/dL			150mg/dL	
PAIN LEVEL	0 Wongbk		0 Wongbk			0 Wongbk	
Glucose	23:05	23:15	00:00	00:05	01:17	02:05	02:16
GLUCOSE POC, WHO		**104 H**		97	88		**150 H**
Medicated Drips	23:05	23:15	00:00	00:05	01:17	02:05	02:16
Insulin	.3units/hr		.3units/hr			.3units/hr	
Propofol	25mcg/kg/min						
I&O SUMMARY	23:05	23:15	00:00	00:05	01:17	02:05	02:16
Intake Total	295.8		295.8			345.8	
Output Total	100		550			50	
NET	195.8		-254.2			295.8	
INTAKE	23:05	23:15	00:00	00:05	01:17	02:05	02:16
IVPB						50	
InvasiveLineFlsh	3		3			3	
Lactated Ringers	275		275			275	
Fentanyl	2.5		2.5			2.5	
Insulin	0.3		0.3			0.3	
Propofol	15		15			15	
Intake Total	295.8		295.8			345.8	
OUTPUT	23:05	23:15	00:00	00:05	01:17	02:05	02:16
Foley cath	100		50			50	
NG tube			100				
Wound drn #1			400				
Output Total	100		550			50	
CARE PROVIDERS	JLP	SID	JLP	SID	SID	JLP	SID

CC SYSTEM, ID(SID)
Wongbk Wong-Baker(face)

PETERSON, JENNIFER L(JLP)RN

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 10

FLOWSHEET	04/27							
Vital Signs	03:10	03:26	04:06	04:11	05:10	05:28	06:10	06:16
Temp in C	38.0C		37.9C		37.9C		38.1C	
PULSE	108		108		105		108	
RESPIRATIONS	18		8				18	
Vent resp								
O2 SAT %	100%		100%		100%		100% O2	
Arterial BP	118/63		118/55		114/51		113/58	
Arterial mean	78		72		69		74	
Glucose fs	113mg/dL						92mg/dL	
PAIN LEVEL	0 Wongbk		0 Wongbk		0 Wongbk		0 Wongbk	
Glucose	03:10	03:26	04:06	04:11	05:10	05:28	06:10	06:16
GLUCOSE PCX, WHO		**113 H**		86				92
Medicated Drips	03:10	03:26	04:06	04:11	05:10	05:28	06:10	06:16
Fentanyl								
Insulin	1.8units/hr		1.8units/hr		1units/hr		1units/hr	
Propofol								
I&O SUMMARY	03:10	03:26	04:06	04:11	05:10	05:28	06:10	06:16
Intake Total	297.3		297.3		271.5	0	271.5	
Output Total	75		500		100		100	
NET	222.3		-202.7		171.5	0	171.5	
INTAKE	03:10	03:26	04:06	04:11	05:10	05:28	06:10	06:16
InvasiveLineFlsh	3		3		3		3	
Lactated Ringers	275		275		250		250	
Fentanyl	2.5		2.5		2.5		2.5	
Insulin	1.8		1.8		1		1	
Propofol	15		15		15	0	15	
Intake Total	297.3		297.3		271.5	0	271.5	
OUTPUT	03:10	03:26	04:06	04:11	05:10	05:28	06:10	06:16
Foley cath	75		100		100		100	
NG tube			100					
Wound drn #1			300					
Output Total	75		500		100		100	
CARE PROVIDERS	JLP	SID	JLP	SID	JLP	JLP	JLP	SID

CC SYSTEM, ID(SID)
Wongbk Wong-Baker(face)

PETERSON, JENNIFER L(JLP)RN

FLOWSHEET	04/27					
Vital Signs	07:25	11:30	11:37	12:00	12:37	12:49
Temp in C	38.2C	37C		37.0C		
PULSE	106	105		107		
RESPIRATIONS				19		
Vent resp	18	18				
O2 SAT %	100% O2	100%		100%		
BP (NIBP)		131/95		130/55		
BP mean (NIBP)		103		71		
Arterial BP	118/64					
Arterial mean	79					
Glucose fs	92mg/dL	164mg/dL				
Insulin mulriplr		.03				
RASS		0				
CAM-ICU		Ngatve				
PAIN LEVEL	4 App	3 App		3 App		
Glucose	07:25	11:30	11:37	12:00	12:37	12:49
GLUCOSE POC, WHO			**164 H**			97
Medicated Drips	07:25	11:30	11:37	12:00	12:37	12:49
Fentanyl	125mcg/hr	125mcg/hr		125mcg/hr		
Insulin	.2units/hr	3.1units/hr		3.2units/hr		
Propofol	25mcg/kg/min	25mcg/kg/min		25mcg/kg/min		
I&O SUMMARY	07:25	11:30	11:37	12:00	12:37	12:49
Intake Total	270.7	270.6		270.7	0	
Output Total	100	125		50		
NET	170.7	145.6		220.7	0	
INTAKE	07:25	11:30	11:37	12:00	12:37	12:49
InvasiveLineFlsh	3					
D5W/NaCl.45%+KCl					0	
Lactated Ringers	250	250		250	0	
Fentanyl	2.5	2.5		2.5		
Insulin	0.2	3.1		3.2		
Propofol	15	15		15		
Intake Total	270.7	270.6		270.7	0	
OUTPUT	07:25	11:30	11:37	12:00	12:37	12:49
Foley cath	100	125		50		
G-tube						
Output Total	100	125		50		
CARE PROVIDERS	BCAR	BCAR	SID	BCAR	BCAR	SID

CARPENTER, BROOKE(BCAR)RN CC SYSTEM, ID(SID)
App AssumePainPresnt Ngatve negative

CONTINUED

FLOWSHEET	04/27					
Vital Signs	13:00	13:02	14:00	14:57	15:00	15:53
Temp in C	37.0C		36.9C		37.1C	
PULSE	95		103		104	
RESPIRATIONS					18	
Vent resp	18		18		18	
O2 SAT %	100%		100% O2		100% O2	
BP (NIBP)	112/52		114/66		116/67	
BP mean (NIBP)	65		72		79	
Arterial BP	106/58		105/60		94/61	
Arterial mean	71		72		72	
Glucose fs	97mg/dL		151mg/dL		161mg/dL	
Insulin mulriplr	.03		.03		.04	
RASS					0	
CAM-ICU					Ngatve	
PAIN LEVEL	3 App		3 App		3 App	
CO			5.9		6.4	
CI			2.9		3.1	
SVI			27		29	
SVV			18		22	
Glucose	13:00	13:02	14:00	14:57	15:00	15:53
GLUCOSE POC, WHO			**151 H**	**161 H**		**158 H**
Medicated Drips	13:00	13:02	14:00	14:57	15:00	15:53
Fentanyl	100mcg/hr		100mcg/hr		100mcg/hr	
Insulin	.7units/hr		2.7units/hr		4units/hr	
Propofol	15mcg/kg/min		15mcg/kg/min		25mcg/kg/min	
I&O SUMMARY	13:00	13:02	14:00	14:57	15:00	15:53
Intake Total	1138.7	0	140.7		1149	
Output Total	140		100		55	
NET	998.7	0	40.7		1094	
INTAKE	13:00	13:02	14:00	14:57	15:00	15:53
InvasiveLineFlsh	3		3		3	
D5W/NaCl.45%+KCl	125		125		125	
Lactated Ringers	1000				1000	
Fentanyl	2	0	2		2	
Insulin	0.7		2.7		4	
Propofol	8		8		15	
Intake Total	1138.7	0	140.7		1149	
CARE PROVIDERS	BCAR	BCAR	SID BCAR	SID	BCAR	SID

CARPENTER, BROOKE(BCAR)RN CC SYSTEM, ID(SID)

App AssumePainPresnt Ngatve negative

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 13

FLOWSHEET	04/27					
OUTPUT	13:00	13:02	14:00	14:57	15:00	15:53
Foley cath	100		100		50	
NG tube						
G-tube	40				5	
JP #1						
JP #2						
Wound drn #1						
Output Total	140		100		55	
CARE PROVIDERS	BCAR		BCAR		BCAR	

CARPENTER, BROOKE(BCAR)RN

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 14

FLOWSHEET	04/27						
Vital Signs	16:00	16:48	16:59	17:00	18:00	18:15	18:54
Temp in C	37.2C			37.2C	37.4C		
PULSE	98			98	105		
RESPIRATIONS	16			18			
Vent resp	18			18	18		
O2 SAT %	100% O2			100% O2	100% O2		
BP (NIBP)	118/69				112/59		
BP mean (NIBP)	77				71		
Arterial BP	105/59			130/69	116/60		
Arterial mean	73			87	75		
Glucose fs	158mg/dL			138mg/dL	122mg/dL		
Insulin mulriplr	.05			.06	.07		
RASS	0				0		
CAM-ICU	Ngatve				Ngatve		
PAIN LEVEL	3 App			3 App	3 App		
CO				9.3	9.8		
CI				4.5	4.7		
SVI	48			46	45		
SVV	19			17	17		
Glucose	16:00	16:48	16:59	17:00	18:00	18:15	18:54
GLUCOSE POC, WHO			**138 H**			**122 H**	**117 H**
Medicated Drips	16:00	16:48	16:59	17:00	18:00	18:15	18:54
Fentanyl	100mcg/hr			100mcg/hr	100mcg/hr		
Insulin	4.9units/hr			4.7units/hr	4.3units/hr		
Propofol	25mcg/kg/min			25mcg/kg/min	25mcg/kg/min		
I&O SUMMARY	16:00	16:48	16:59	17:00	18:00	18:15	18:54
Intake Total	149.9	0		159.7	159.3		
Output Total	330			75	63		
NET	-180.1	0		84.7	96.3		
INTAKE	16:00	16:48	16:59	17:00	18:00	18:15	18:54
InvasiveLineFlsh	3			3	3		
D5W/NaCl.45%+KCl	125			125	125		
Lactated Ringers		0		10	10		
Fentanyl	2			2	2		
Insulin	4.9			4.7	4.3		
Propofol	15			15	15		
Intake Total	149.9	0		159.7	159.3		
CARE PROVIDERS	BCAR	BCAR	SID	BCAR	BCAR	SID	SID

CARPENTER, BROOKE(BCAR)RN CC SYSTEM, ID(SID)

App AssumePainPresnt Ngatve negative

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 15

FLOWSHEET	04/27						
OUTPUT	16:00	16:48	16:59	17:00	18:00	18:15	18:54
Foley cath	45			75	60		
NG tube	100						
G-tube	7				3		
JP #1	28&						
JP #2	100&						
Wound drn #1	50&						
Output Total	330			75	63		
04/27/11 16:00 JP #1(BCAR): pancreas							
04/27/11 16:00 JP #2(BCAR): duodenal							
04/27/11 16:00 Wound drn #1(BCAR): duodenostomy-wall suction							
CARE PROVIDERS	BCAR			BCAR	BCAR		

CARPENTER, BROOKE(BCAR)RN

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 16

FLOWSHEET	04/27							
Vital Signs	19:00	19:44	20:05	20:36	20:42	21:02	21:05	21:57
Temp in C	37.5C		37.6C				37.6C	
PULSE	102		98				97	
RESPIRATIONS			25				19	
Vent resp	18							
O2 SAT %	100% O2		100% O2				100% O2	
O2 flow								
O2 equipment								
BP (NIBP)	128/73							
BP mean (NIBP)	87							
Arterial BP	127/68		130/69				149/70	
Arterial mean	85		87				90	
Glucose fs	117mg/dL		116mg/dL				119mg/dL	
Insulin mulriplr	.08		.08				.09	
RASS	0							
CAM-ICU	Ngatve							
PAIN LEVEL	3 App		0 Wongbk				0 Wongbk	
CO	8.9							
CI	4.3							
SVI	42							
SVV	16							
Glucose	19:00	19:44	20:05	20:36	20:42	21:02	21:05	21:57
GLUCOSE POC, WHO		**116 H**				**119 H**		**118 H**
Medicated Drips	19:00	19:44	20:05	20:36	20:42	21:02	21:05	21:57
Fentanyl	100mcg/hr							
Insulin	4.5units/hr		5units/hr				5.9units/hr	
Propofol	25mcg/kg/min							
I&O SUMMARY	19:00	19:44	20:05	20:36	20:42	21:02	21:05	21:57
Intake Total	159.5		160	0	0		145.9	
Output Total	45		30				310	
NET	114.5		130	0	0		-164.1	
INTAKE	19:00	19:44	20:05	20:36	20:42	21:02	21:05	21:57
InvasiveLineFlsh	3		3				3	
D5W/NaCl.45%+KCl	125		125	0			125	
Lactated Ringers	10		10				10	
Fentanyl	2		2	0			2	
Insulin	4.5		5				5.9	
Propofol	15		15		0			
Intake Total	159.5		160	0	0		145.9	
CARE PROVIDERS	BCAR	SID	LLHU	LZIM	LZIM	SID	LLHU	SID

CARPENTER, BROOKE(BCAR)RN CC SYSTEM, ID(SID) HURLEY, LORRI L(LLHU)RN
ZIMMERMAN, LAURA(LZIM)RN
App AssumePainPresnt Ngatve negative Wongbk Wong-Baker(face)

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 17

FLOWSHEET	04/27							
OUTPUT	19:00	19:44	20:05	20:36	20:42	21:02	21:05	21:57
Foley cath	45		30				100	
NG tube							25	
G-tube							40	
JP #1							15	
JP #2							105	
Wound drn #1							25	
Output Total	45		30				310	
CARE PROVIDERS	BCAR		LLHU				LLHU	

CARPENTER, BROOKE(BCAR)RN HURLEY, LORRI L(LLHU)RN

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 18

FLOWSHEET	04/27				04/28	
Vital Signs	22:00	23:00	23:02	23:57	00:00	01:05
Temp in C	37.7C	37.7C			37.7C	38.0C
PULSE	104	96			98	97
RESPIRATIONS	18	18			18	18
O2 SAT %	100%	100% O2			99% O2	100% O2
O2 flow	40 Prcent	40 Prcent			40 Prcent	40 Prcent
O2 equipment	Vent	Vent			Vent	Vent
Arterial BP	162/75	126/60			149/64	141/61
Arterial mean	97	78			87	81
Insulin mulriplr					0.09	0.03
RASS	-2	-2			-2	-2
PAIN LEVEL	4 Wongbk	0 Wongbk			0 Wongbk	0 Wongbk
Glucose	22:00	23:00	23:02	23:57	00:00	01:05
GLUCOSE POC, WHO			86	79		**104 H**
Medicated Drips	22:00	23:00	23:02	23:57	00:00	01:05
Fentanyl	100mcg/hr	100mcg/hr			100mcg/hr	100mcg/hr
Insulin	5.8units/hr	2.3units/hr			0units/hr	1.3units/hr
Propofol	25mcg/kg/min	25mcg/kg/min			35mcg/kg/min	35mcg/kg/min
I&O SUMMARY	22:00	23:00	23:02	23:57	00:00	01:05
Intake Total	161.8	158.3			161	162.3
Output Total	40	50			265	40
NET	121.8	108.3			-104	122.3
INTAKE	22:00	23:00	23:02	23:57	00:00	01:05
InvasiveLineFlsh	3	3			3	3
D5W/NaCl.45%+KCl	125	125			125	125
Lactated Ringers	10	10			10	10
Fentanyl	2	2			2	2
Insulin	5.8	2.3			0	1.3
Propofol	16	16			21	21
Intake Total	161.8	158.3			161	162.3
OUTPUT	22:00	23:00	23:02	23:57	00:00	01:05
Foley cath	40	50			75	40
NG tube					25	
G-tube					60	
JP #1					20	
JP #2					85	
Wound drn #1					0	
Output Total	40	50			265	40
CARE PROVIDERS	TMW1	TMW1	SID	SID	TMW1	SID TMW1

CC SYSTEM, ID(SID) WOMACK, TASSI M(TMW1)RN
Prcent percent Vent ventilator Wongbk Wong-Baker(face)

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 19

FLOWSHEET	04/28						
Vital Signs	02:00	02:06	03:00	03:06	03:57	04:00	04:05
Temp in C	38.0C		38.0C				38.0C
PULSE	101		102				107
RESPIRATIONS	18		18				**28**
O2 SAT %	100% O2		100% O2				100% O2
O2 flow	40 Prcent		40 Prcent				40 Prcent
O2 equipment	Vent		Vent				Vent
Arterial BP	149/57		140/56			146/65	155/63
Arterial mean	79		78				87
Insulin mulriplr	0.03		0.05				
RASS	-2		0				0
PAIN LEVEL	0 Numvlu		0 Wongbk				0 Wongbk
SVV			17				
Glucose	02:00	02:06	03:00	03:06	03:57	04:00	04:05
GLUCOSE POC, WHO		**121 H**		**123 H**	**107 H**		
Medicated Drips	02:00	02:06	03:00	03:06	03:57	04:00	04:05
Fentanyl	100mcg/hr		100mcg/hr				100mcg/hr
Insulin	3.1units/hr		3.1units/hr				2.2units/hr
Propofol	35mcg/kg/min		35mcg/kg/min				35mcg/kg/min
I&O SUMMARY	02:00	02:06	03:00	03:06	03:57	04:00	04:05
Intake Total	164.1		155.1				163.2
Output Total	120		50				245
NET	44.1		105.1				-81.8
INTAKE	02:00	02:06	03:00	03:06	03:57	04:00	04:05
InvasiveLineFlsh	3		3				3
D5W/NaCl.45%+KCl	125		125				125
Lactated Ringers	10						10
Fentanyl	2		2				2
Insulin	3.1		3.1				2.2
Propofol	21		22				21
Intake Total	164.1		155.1				163.2
OUTPUT	02:00	02:06	03:00	03:06	03:57	04:00	04:05
Foley cath	120		50				60
NG tube							0
G-tube							80
JP #1							15
JP #2							90
Wound drn #1							0
Output Total	120		50				245
CARE PROVIDERS	TMW1	SID	TMW1	SID	SID	TMW1	TMW1

CC SYSTEM, ID(SID) WOMACK, TASSI M(TMW1)RN
Numvlu Numeric Value Prcent percent Vent ventilator Wongbk Wong-Baker(face)

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 , MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 20

FLOWSHEET	04/28						
Vital Signs	04:51	04:56	05:05	05:46	06:00	06:10	07:05
Temp in C			38.0C		37.8C		37.6C
PULSE			99		97		92
RESPIRATIONS			24		28		
O2 SAT %			100% O2		100% O2		100% O2
O2 flow			40 Prcent		40 Prcent		40 Prcent
O2 equipment			Vent		Vent		Vent
Arterial BP			151/54		135/56		123/53
Arterial mean			78		76		72
RASS			0		0		0
PAIN LEVEL			0 Wongbk		0 Wongbk		0 Wongbk
Glucose	04:51	04:56	05:05	05:46	06:00	06:10	07:05
GLUCOSE PCX, WHO	**107 H**					**106 H**	
Medicated Drips	04:51	04:56	05:05	05:46	06:00	06:10	07:05
Fentanyl			125mcg/hr		125mcg/hr		125mcg/hr
Insulin			2.3units/hr		2.2units/hr		2.3units/hr
Propofol					35mcg/kg/min		35mcg/kg/min
I&O SUMMARY	04:51	04:56	05:05	05:46	06:00	06:10	07:05
Intake Total		0	138	0	163.7		232.2
Output Total			50		35		50
NET		0	88	0	128.7		182.2
INTAKE	04:51	04:56	05:05	05:46	06:00	06:10	07:05
IVPB							50
InvasiveLineFlsh			3		3		3
D5W/NaCl.45%+KCl		0	125		125		125
Lactated Ringers			10		10		10
Fentanyl				0	2.5		2
Insulin					2.2		2.2
Propofol				0	21		40
Intake Total		0	138	0	163.7		232.2
OUTPUT	04:51	04:56	05:05	05:46	06:00	06:10	07:05
Foley cath			50		35		50
Output Total			50		35		50
CARE PROVIDERS	SID	TMW1	TMW1	TMW1	TMW1	SID	TMW1

CC SYSTEM, ID(SID)
WOMACK, TASSI M(TMW1)RN

Prcent percent Vent ventilator Wongbk Wong-Baker(face)

CONTINUED

FLOWSHEET	04/28						
Vital Signs	07:07	07:57	08:00	09:00	09:13	10:00	10:04
Temp in C			37.6C	37.6C		37.4C	
PULSE			108	97		100	
RESPIRATIONS			16	12		15	
O2 SAT %			100%	100%		100%	
BP (NIBP)				136/66		131/73	
BP mean (NIBP)				83		87	
Arterial BP			146/66	94/78			
Arterial mean			90	86			
Glucose fs			102mg/dL	91 mg/dL		105mg/dL	
Insulin multiplr			.05	.04		.04	
RASS			-2				
CAM-ICU			Ngatve				
PAIN LEVEL			0 Wongbk	2 Wongbk		2 Wongbk	
Glucose	07:07	07:57	08:00	09:00	09:13	10:00	10:04
GLUCOSE PCX, WHO	**103 H**	**102 H**			91		**105 H**
Medicated Drips	07:07	07:57	08:00	09:00	09:13	10:00	10:04
Fentanyl			125mcg/hr	125mcg/hr		200mcg/hr	
Insulin			2.3units/hr	2.1units/hr		1.2units/hr	
Propofol			35mcg/kg/min	20mcg/kg/min			
I&O SUMMARY	07:07	07:57	08:00	09:00	09:13	10:00	10:04
Intake Total			163.8	154.6		140.2	
Output Total			250	85		50	
NET			-86.2	69.6		90.2	
INTAKE	07:07	07:57	08:00	09:00	09:13	10:00	10:04
InvasiveLineFlsh			3	3			
D5W/NaCl.45%+KCl			125	125		125	
Lactated Ringers			10	10		10	
Fentanyl			2.5	2.5		4	
Insulin			2.3	2.1		1.2	
Propofol			21	12			
Intake Total			163.8	154.6		140.2	
OUTPUT	07:07	07:57	08:00	09:00	09:13	10:00	10:04
Foley cath			75	85		50	
G-tube			75				
JP #1			10				
JP #2			90				
Output Total			250	85		50	
CARE PROVIDERS	SID	SID	SACT	SACT	SID	SACT	SID

CC SYSTEM, ID(SID) NIREWICZ, SARAH A(SACT)RN

Ngatve negative Wongbk Wong-Baker(face)

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUCGTCD:05/05/11 09:06
OPT OUT:
Page: 22

FLOWSHEET	04/28							
Vital Signs	11:00	11:05	12:00	12:02	12:08	12:31	12:32	13:00
Temp in C	37.0C		37.3C					36.9C
PULSE	115		116					107
RESPIRATIONS	21		**26**					23
O2 SAT %	98%		94%					99%
BP (NIBP)	**164/74**		158/71					153/70
BP mean (NIBP)	96		91					91
Glucose fs	146mg/dL		154mg/dL					146mg/dL
Insulin mulriplr	.05		.06					.07
PAIN LEVEL	7		4 Numvlu					0 Sleepg
Glucose	11:00	11:05	12:00	12:02	12:08	12:31	12:32	13:00
GLUCOSE PCX, WHO		**146 H**		**154 H**				
Medicated Drips	11:00	11:05	12:00	12:02	12:08	12:31	12:32	13:00
Fentanyl	50mcg/hr		50mcg/hr					50mcg/hr
Insulin	1.8units/hr		4.3units/hr					5.6units/hr
I&O SUMMARY	11:00	11:05	12:00	12:02	12:08	12:31	12:32	13:00
Intake Total	137.8		140.3		0	0	0	141.6
Output Total	75		460					150
NET	62.8		-319.7		0	0	0	-8.4
INTAKE	11:00	11:05	12:00	12:02	12:08	12:31	12:32	13:00
D5W/NaCl.45%+KCl	125		125		0			125
Lactated Ringers	10		10					10
Fentanyl	1		1					1
Insulin	1.8		4.3			0	0	5.6
Propofol					0			
Intake Total	137.8		140.3		0	0	0	141.6
OUTPUT	11:00	11:05	12:00	12:02	12:08	12:31	12:32	13:00
Foley cath	75		100					150
NG tube			50					
G-tube			200					
JP #1			10					
JP #2			100					
Output Total	75		460					150
CARE PROVIDERS	SACT	SID	SACT	SID	SACT	SACT	SACT	SACT

CC SYSTEM, ID(SID) NIREWICZ, SARAH A(SACT)RN
Numvlu Numeric Value Sleepg sleeping

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 09:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 23

FLOWSHEET	04/28						
Vital Signs	13:07	14:00	15:00	15:08	15:58	16:00	17:00
Temp in C		36.3C					
PULSE		107	117			113	113
RESPIRATIONS		22	23			**26**	**27**
O2 SAT %		99%	99%			97%	97%
BP (NIBP)		141/70	160/79			160/76	145/68
BP mean (NIBP)		87	98			96	87
Glucose fs		142mg/dL	151mg/dL			128mg/dL	127mg/dL
Insulin mulriplr		.08	.09			.09	.1
PAIN LEVEL		0 Sleepg	4 Numvlu			0 Sleepg	0 Sleepg
Glucose	13:07	14:00	15:00	15:08	15:58	16:00	17:00
GLUCOSE PCX, WHO	**146 H**	**142 H**		**151 H**	**128 H**		
Medicated Drips	13:07	14:00	15:00	15:08	15:58	16:00	17:00
Fentanyl		50mcg/hr	75mcg/hr				75mcg/hr
Insulin		6units/hr	6.6units/hr			8.2units/hr	6.1units/hr
I&O SUMMARY	13:07	14:00	15:00	15:08	15:58	16:00	17:00
Intake Total		142	143.1			143.2	142.6
Output Total		100	125			325	150
NET		42	18.1			-181.8	-7.4
INTAKE	13:07	14:00	15:00	15:08	15:58	16:00	17:00
D5W/NaCl.45%+KCl		125	125			125	125
Lactated Ringers		10	10			10	10
Fentanyl		1	1.5				1.5
Insulin		6	6.6			8.2	6.1
Intake Total		142	143.1			143.2	142.6
OUTPUT	13:07	14:00	15:00	15:08	15:58	16:00	17:00
Foley cath		100	125			100	150
G-tube						125	
JP #1						15	
JP #2						85	
Output Total		100	125			325	150
CARE PROVIDERS	SID	SID SACT	SACT	SID	SID	SACT	SACT

CC SYSTEM, ID(SID) NIREWICZ, SARAH A(SACT)RN
Numvlu Numeric Value Sleepg sleeping

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 24

FLOWSHEET	04/28							
Vital Signs	17:04	18:00	18:02	18:57	18:58	18:59	19:00	19:55
PULSE		**121**					118	115
RESPIRATIONS		**28**					**27**	**28**
O2 SAT %		96%					95%	100%
O2 flow								2 Liters
O2 equipment								Naslcn
BP (NIBP)		157/77					160/73	147/59 Larm
BP mean (NIBP)		96					91	80
Glucose fs		74mg/dL					114mg/dL	101mg/dL
Insulin multiplr		.09					.1	0.1
PAIN LEVEL		2 Numvlu					4 Numvlu	0 Numvlu
Glucose	17:04	18:00	18:02	18:57	18:58	18:59	19:00	19:55
GLUCOSE PCX, WHO	**127 H**		74			**114 H**		
Medicated Drips	17:04	18:00	18:02	18:57	18:58	18:59	19:00	19:55
Fentanyl		75mcg/hr					75mcg/hr	75mcg/hr
Insulin		6.7units/hr					1.3units/hr	4.1units/hr
I&O SUMMARY	17:04	18:00	18:02	18:57	18:58	18:59	19:00	19:55
Intake Total		141.7		0	0		137.8	141.9
Output Total		75					125	420
NET		66.7		0	0		12.8	-278.1
INTAKE	17:04	18:00	18:02	18:57	18:58	18:59	19:00	19:55
D5W/NaCl.45%+KCl		125		0	0		125	125
Lactated Ringers		10					10	10
Fentanyl							1.5	1.5
Insulin		6.7					1.3	5.4
Intake Total		141.7		0	0		137.8	141.9
OUTPUT	17:04	18:00	18:02	18:57	18:58	18:59	19:00	19:55
Foley cath		75					125	130
NG tube								0
G-tube								200
JP #1								10
JP #2								80
Wound drn #1								0
Output Total		75					125	420
CARE PROVIDERS	SID	SACT	SID	SACT	SACT	SID	SACT	SSPU

CC SYSTEM, ID(SID)
NIREWICZ, SARAH A(SACT)RN
SPURR, SARAH(SSPU)RN

Larm arm L
Liters liter(s)
Naslcn nasal cannula
Numvlu Numeric Value

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 25

FLOWSHEET	04/28							
Vital Signs	20:01	20:58	21:00	22:00	22:03	22:14	22:17	23:00
PULSE			116	115				
RESPIRATIONS			**29**	**29**				
O2 SAT %			96% Rmair	94% Rmair				
BP (NIBP)			156/66	156/75 Larm				
BP mean (NIBP)			84	95				
Glucose fs			83mg/dL	74mg/dL				90mg/dL
Insulin mulriplr			.09	.08				
PAIN LEVEL			0 Numvlu	5 Numvlu				
Glucose	20:01	20:58	21:00	22:00	22:03	22:14	22:17	23:00
GLUCOSE PCX, WHO	**101 H**	83			74			
Medicated Drips	20:01	20:58	21:00	22:00	22:03	22:14	22:17	23:00
Fentanyl			75mcg/hr	75mcg/hr				
Insulin			2.1units/hr	1.1units/hr				
I&O SUMMARY	20:01	20:58	21:00	22:00	22:03	22:14	22:17	23:00
Intake Total			140.6	138.6			30	
Output Total			125	160		100		
NET			15.6	-21.4		-100	30	
INTAKE	20:01	20:58	21:00	22:00	22:03	22:14	22:17	23:00
Meds per tube							30	
D5W/NaCl.45%+KCl			125	125				
Lactated Ringers			10	10				
Fentanyl			1.5	1.5				
Insulin			4.1	2.1				
Intake Total			140.6	138.6			30	
OUTPUT	20:01	20:58	21:00	22:00	22:03	22:14	22:17	23:00
Foley cath			125	160				
JP #2						100		
Output Total			125	160		100		
CARE PROVIDERS	SID	SID	SSPU	SSPU	SID	SSPU	SSPU	MGAL

CC SYSTEM, ID(SID)
Larm arm L
GALAMITON, MAXIMO(MGAL)CA
Numvlu Numeric Value
SPURR, SARAH(SSPU)RN
Rmair room air

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 26

FLOWSHEET	04/28			04/29				
Vital Signs	23:06	23:10	23:57	00:10	01:15	01:16	02:03	02:10
Temp in C				38C Oral				
PULSE		118		115	114			111
RESPIRATIONS		30		**33**	**32**			**30**
O2 SAT %		94% Rmair		98%	95%			95%
O2 flow				2 Liters				
O2 equipment				Naslcn				
BP (NIBP)		156/81 Larm		128/61	136/64 Rarm			157/54
BP mean (NIBP)		94		72	77			81
Glucose fs		84mg/dL		77mg/dL				
Insulin multiplr		.07		.06				
PAIN LEVEL				0 Numvlu				
Glucose	23:06	23:10	23:57	00:10	01:15	01:16	02:03	02:10
GLUCOSE POC, WHO	84		77			81	88	
Medicated Drips	23:06	23:10	23:57	00:10	01:15	01:16	02:03	02:10
Fentanyl		75mcg/hr		75mcg/hr	75mcg/hr			75mcg/hr
Insulin		1.7units/hr		1units/hr				1units/hr
I&O SUMMARY	23:06	23:10	23:57	00:10	01:15	01:16	02:03	02:10
Intake Total		137.6		135	127.5			127.5
Output Total		150		375	200			75
NET		-12.4		-240	-72.5			52.5
INTAKE	23:06	23:10	23:57	00:10	01:15	01:16	02:03	02:10
D5W/NaCl.45%+KCl		125		125	125			125
Lactated Ringers				10				
OTHER PRIMARY IV		10						
Fentanyl		1.5			1.5			1.5
Insulin		1.1			1			1
Intake Total		137.6		135	127.5			127.5
OUTPUT	23:06	23:10	23:57	00:10	01:15	01:16	02:03	02:10
Foley cath		150		175	100			75
G-tube				200				
JP #2					100			
Output Total		150		375	200			75
CARE PROVIDERS	SID	SSPU	SID	SSPU	SSPU	SID	SID	SSPU

CC SYSTEM, ID(SID)
SPURR, SARAH(SSPU)RN

Larm arm L
Liters liter(s)
Naslcn nasal cannula
Numvlu Numeric Value
Oral oral
Rarm arm R
Rmair room air

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 27

FLOWSHEET	04/29							
Vital Signs	03:01	03:04	04:00	04:11	05:03	05:10	05:22	05:58
Temp in C			38.3C Oral					
PULSE		119	117			114		
RESPIRATIONS		28	**29**			**30**		
O2 SAT %		93% Rmair	95%			97%		
O2 flow			2 Liters					
O2 equipment			Naslcn					
BP (NIBP)		158/73	160/68 Larm			147/62		
BP mean (NIBP)		92	89			82		
Glucose fs			82mg/dL			96mg/dL		
Insulin multiplr			.04			.04		
PAIN LEVEL								
Glucose	03:01	03:04	04:00	04:11	05:03	05:10	05:22	05:58
GLUCOSE POC, WHO	95			82	96			**106 H**
Medicated Drips	03:01	03:04	04:00	04:11	05:03	05:10	05:22	05:58
Fentanyl		75mcg/hr	75mcg/hr			125mcg/hr		
Insulin		1units/hr	0.9units/hr			1units/hr		
I&O SUMMARY	03:01	03:04	04:00	04:11	05:03	05:10	05:22	05:58
Intake Total		127.5	128.3			127.5	350	
Output Total		100	305			225		
NET		27.5	-176.7			-97.5	350	
INTAKE	03:01	03:04	04:00	04:11	05:03	05:10	05:22	05:58
D5W/NaCl.45%+KCl		125	125			125		
Fentanyl		1.5	1.5			1.5		
Insulin		1	1.8			1		
PRBC							350	
Intake Total		127.5	128.3			127.5	350	
OUTPUT	03:01	03:04	04:00	04:11	05:03	05:10	05:22	05:58
Foley cath		100	30			225		
G-tube			175					
JP #1			30					
JP #2			70					
Wound drn #1			0					
Output Total		100	305			225		
CARE PROVIDERS	SID	SSPU	SSPU	SID	SID	SSPU	SSPU	SID

CC SYSTEM, ID(SID) SPURR, SARAH(SSPU)RN

Larm arm L
Liters liter(s)
Naslcn nasal cannula
Oral oral
Rmair room air

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 09:06
OPT OUT:
Page: 28

FLOWSHEET	04/29						
Vital Signs	06:10	06:42	07:00	08:00	08:07	09:00	09:01
Temp in C				37.9C Oral			
PULSE	112		110	103		103	
RESPIRATIONS	23		**30**	24		**33**	
O2 SAT %	97%		97%	97%		95%	
O2 flow			2 Liters				
O2 equipment			Naslcn				
BP (NIBP)	154/71			**164/82**		**174/95**	
BP mean (NIBP)	91			101		114	
Glucose fs	106mg/dL		102mg/dL	121mg/dL		129mg/dL	
Insulin mulriplr	.03		.03	.03		.04	
PAIN LEVEL	0 Numvlu			5 Numvlu		6 Numvlu	
WEIGHT in Kg		116.2kg					
Glucose	06:10	06:42	07:00	08:00	08:07	09:00	09:01
GLUCOSE POC, WHO			**102 H**		**108 H**		**129 H**
Medicated Drips	06:10	06:42	07:00	08:00	08:07	09:00	09:01
Fentanyl	50mcg/hr		50mcg/hr	50mcg/hr		50mcg/hr	
Insulin	1.4units/hr		1.3units/hr	1.3units/hr		1.4units/hr	
I&O SUMMARY	06:10	06:42	07:00	08:00	08:07	09:00	09:01
Intake Total	127.4		536.4	127.3		127.4	
Output Total	125		60	335		100	
NET	2.4		476.4	-207.7		27.4	
INTAKE	06:10	06:42	07:00	08:00	08:07	09:00	09:01
Meds per tube			60				
D5W/NaCl.45%+KCl	125		125	125		125	
Fentanyl	1.5			1		1	
Insulin	0.9		1.4	1.3		1.4	
PRBC			350				
Intake Total	127.4		536.4	127.3		127.4	
OUTPUT	06:10	06:42	07:00	08:00	08:07	09:00	09:01
Foley cath	125		60	100		100	
G-tube				150			
JP #1				5			
JP #2				80			
Output Total	125		60	335		100	
CARE PROVIDERS	SSPU	SSPU	SID SSPU	SACT	SID	SACT	SID

CC SYSTEM, ID(SID)
Liters liter(s)
NIREWICZ, SARAH A(SACT)RN
Naslcn nasal cannula
Numvlu Numeric Value
SPURR, SARAH(SSPU)RN
Oral oral

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 29

FLOWSHEET	04/29						
Vital Signs	09:59	10:00	10:10	11:00	11:15	12:00	12:11
Temp in C						37C Oral	
PULSE		102	107	101		101	
RESPIRATIONS		**31**	**27**	**31**		**30**	
O2 SAT %		97%	95%	93% O2		96% O2	
BP (NIBP)		160/71	160/71	149/70		155/83	
BP mean (NIBP)		92	92	89		100	
Glucose fs		123mg/dL		131mg/dL		115mg/dL	
Insulin mulriplr		.05		.06		.07	
PAIN LEVEL		5 Numvlu		5 Numvlu		5 Numvlu	
Glucose	09:59	10:00	10:10	11:00	11:15	12:00	12:11
GLUCOSE POC, WHO	**123 H**				**131 H**		**115 H**
Medicated Drips	09:59	10:00	10:10	11:00	11:15	12:00	12:11
Fentanyl						50mcg/hr	
Insulin		2.8units/hr		3.2units/hr		4.3units/hr	
I&O SUMMARY	09:59	10:00	10:10	11:00	11:15	12:00	12:11
Intake Total		127.8		128.2		130.3	
Output Total		75		125		365	
NET		52.8		3.2		-234.7	
INTAKE	09:59	10:00	10:10	11:00	11:15	12:00	12:11
D5W/NaCl.45%+KCl		125		125		125	
Fentanyl						1	
Insulin		2.8		3.2		4.3	
Intake Total		127.8		128.2		130.3	
OUTPUT	09:59	10:00	10:10	11:00	11:15	12:00	12:11
Foley cath		75		125		150	
G-tube						125	
JP #1						10	
JP #2						80	
Output Total		75		125		365	
CARE PROVIDERS	SID	SACT	SACT	SACT	SID	SACT	SID

CC SYSTEM, ID(SID) NIREWICZ, SARAH A(SACT)RN
Numvlu Numeric Value Oral oral

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 30

FLOWSHEET	04/29						
Vital Signs	13:00	13:01	13:17	14:00	14:04	15:00	15:11
PULSE	96			96		103	
RESPIRATIONS	17			21		**31**	
O2 SAT %	100%			100%		100%	
BP (NIBP)	155/78			144/75		**173/83**	
BP mean (NIBP)	95			92		105	
Glucose fs	105mg/dL			101mg/dL		97mg/dL	
Insulin mulriplr	.07			.07		.06	
PAIN LEVEL	5 Numvlu			5 Numvlu		0 Sleepg	
Glucose	13:00	13:01	13:17	14:00	14:04	15:00	15:11
GLUCOSE POC, WHO		**105 H**			**101 H**		97
Medicated Drips	13:00	13:01	13:17	14:00	14:04	15:00	15:11
Fentanyl	50mcg/hr			50mcg/hr		50mcg/hr	
Insulin	3.9units/hr			3.2units/hr		2.9units/hr	
I&O SUMMARY	13:00	13:01	13:17	14:00	14:04	15:00	15:11
Intake Total	129.9		0	149.2		148.9	
Output Total	60			75		125	
NET	69.9		0	74.2		23.9	
INTAKE	13:00	13:01	13:17	14:00	14:04	15:00	15:11
Tube feeding				20		20	
Tube feed flush							
D5W/NaCl.45%+KCl	125		0	125		125	
Fentanyl	1			1		1	
Insulin	3.9			3.2		2.9	
Intake Total	129.9		0	149.2		148.9	
OUTPUT	13:00	13:01	13:17	14:00	14:04	15:00	15:11
Foley cath	60			75		125	
G-tube							
JP #1							
JP #2							
Output Total	60			75		125	
CARE PROVIDERS	SACT	SID	SACT	SACT	SID	SACT	SID

CC SYSTEM, ID(SID) NIREWICZ, SARAH A(SACT)RN
Numvlu Numeric Value Sleepg sleeping

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 31

FLOWSHEET	04/29						
Vital Signs	16:00	16:02	17:00	17:10	18:23	18:28	19:07
PULSE	94		105			100	
RESPIRATIONS	**29**		22			**27**	
O2 SAT %	98%		99%			99%	
BP (NIBP)	**173/93**		**177/81**			**184/85**	
BP mean (NIBP)	107		104			106	
Glucose fs	104mg/dL		117mg/dL			96mg/dL	
Insulin mulriplr	.06		.07			.06	
PAIN LEVEL	5 Numvlu		3 Numvlu			0 Sleepg	
Glucose	16:00	16:02	17:00	17:10	18:23	18:28	19:07
GLUCOSE POC, WHO		**104 H**		**117 H**	96		91
Medicated Drips	16:00	16:02	17:00	17:10	18:23	18:28	19:07
Fentanyl	50mcg/hr		50mcg/hr			50mcg/hr	
Insulin	2.2units/hr		2.6units/hr			4units/hr	
I&O SUMMARY	16:00	16:02	17:00	17:10	18:23	18:28	19:07
Intake Total	178.2		148.6			150	
Output Total	300		175			275	
NET	-121.8		-26.4			-125	
INTAKE	16:00	16:02	17:00	17:10	18:23	18:28	19:07
Tube feeding	20		20			20	
Tube feed flush	30						
D5W/NaCl.45%+KCl	125		125			125	
Fentanyl	1		1			1	
Insulin	2.2		2.6			4	
Intake Total	178.2		148.6			150	
OUTPUT	16:00	16:02	17:00	17:10	18:23	18:28	19:07
Foley cath	100		175			275	
G-tube	125						
JP #1	5						
JP #2	70						
Output Total	300		175			275	
CARE PROVIDERS	SACT	SID	SACT	SID	SID	SACT	SID

CC SYSTEM, ID(SID) NIREWICZ, SARAH A(SACT)RN
Numvlu Numeric Value Sleepg sleeping

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB[redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 09:06
OPT OUT:
Page: 32

FLOWSHEET	04/29						
Vital Signs	19:08	19:50	19:54	20:00	20:15	20:57	20:59
TEMP #1 in F				100.9F Oral			
PULSE				108 Radial			
RESPIRATIONS				20 Visual			
O2 SAT %				93% O2			
O2 flow				2 Liters			
O2 equipment				Nasln			
BP (NIBP)				192/90 Rlowlg&			
Glucose fs	91mg/dL			94mg/dL			107mg/dL
Insulin Multiplr				.04			
Insulin mulriplr	.05						
PAIN LEVEL				8 App			
HEIGHT WEIGHT in Kg				79.38kg	185.4cm		
04/29/11 20:00 BP (NIBP)(MGAL): pt. arrived on floor							
Glucose	19:08	19:50	19:54	20:00	20:15	20:57	20:59
GLUCOSE POC, WHO			94			**107 H**	
Medicated Drips	19:08	19:50	19:54	20:00	20:15	20:57	20:59
Insulin	2.2units/hr			1.4units/hr			
I&O SUMMARY	19:08	19:50	19:54	20:00	20:15	20:57	20:59
Intake Total	147.2			60			
Output Total	150	1700		650			
NET	-2.8	-1700		-590			
INTAKE	19:08	19:50	19:54	20:00	20:15	20:57	20:59
Tube feeding	20			20&			
Meds per tube				40			
D5W/NaCl.45%+KCl	125						
Insulin	2.2						
Intake Total	147.2			60			
04/29/11 20:00 Tube feeding(JAC1): zero residual, increased to 35 cc to reach goal of 95							
OUTPUT	19:08	19:50	19:54	20:00	20:15	20:57	20:59
Foley cath	150	1700					
G-tube				650			
Output Total	150	1700		650			
CARE PROVIDERS	SACT	DLRO	SID	JAC1 JAC1, {DLRO} MGAL	MGAL	SID	MGAL

CC SYSTEM, ID(SID)
NIREWICZ, SARAH A(SACT)RN
COTTLE, JEAN A(JAC1)RN
ROBERTS, DUSTI L(DLRO)RN
GALAMITON, MAXIMO(MGAL)CA

App AssumePainPresnt
Liters liter(s)
Nasln nasal cannula
Oral oral
Radial radial
Rlowlg right lower leg
Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 33

FLOWSHEET	04/29						04/30
Vital Signs	21:00	22:00	22:03	22:06	23:00	23:03	00:00
TEMP #1 in F		101.5F Oral&			**101.6F Oral**		**101.7F Oral**
PULSE		106 Radial					
RESPIRATIONS		20 Visual					
O2 SAT %		95% O2					
O2 flow		2 Liters					
BP (NIBP)		197/85 Rarmly					
Glucose fs		208mg/dL			90mg/dL		92mg/dL
Insulin Multiplr	.04	.05			.04		.03
04/29/11 22:00 TEMP #1 in F(MGAL): Ordered pt. use i.s. while awake							
Glucose	21:00	22:00	22:03	22:06	23:00	23:03	00:00
GLUCOSE PCX, WHO			**208 H**			90	
Medicated Drips	21:00	22:00	22:03	22:06	23:00	23:03	00:00
Insulin	1.9units/hr	7.4units/hr			1.2units/hr		1units/hr
I&O SUMMARY	21:00	22:00	22:03	22:06	23:00	23:03	00:00
Intake Total	35			0			770
NET	35			0			770
INTAKE	21:00	22:00	22:03	22:06	23:00	23:03	00:00
Tube feeding	35						105
Tube feed flush							30
Meds per tube							60
D5W/NaCl.45%+KCl				0			575
Fentanyl				0			
Intake Total	35			0			770
CARE PROVIDERS	JAC1 JAC1, {DLRO}	JAC1 JAC1, {DLRO} MGAL	SID	JAC1	JAC1, {DLRO} JAC1	SID	JAC1, {DLRO} MGAL JAC1

CC SYSTEM, ID(SID) COTTLE, JEAN A(JAC1)RN GALAMITON, MAXIMO(MGAL)CA
ROBERTS, DUSTI L(DLRO)RN

Liters liter(s) Radial radial Visual visual
Oral oral Rarmly Rt arm lying

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 34

FLOWSHEET	04/30						
Vital Signs	00:07	00:54	01:00	01:06	02:00	02:08	02:52
TEMP #1 in F					100.7F Oral		
PULSE					111 Radial		
RESPIRATIONS					18 Visual		
O2 SAT %					97% O2		
O2 flow					2 Liters		
O2 equipment					Naslcn		
BP (NIBP)					188/80 Rarmly		
Glucose fs			108mg/dL		128mg/dL		
Insulin Multiplr			.03		.04		
PAIN LEVEL					2 Sleepg		
Glucose	00:07	00:54	01:00	01:06	02:00	02:08	02:52
GLUCOSE POC, WHO	92	**108 H**				**128 H**	**126 H**
Medicated Drips	00:07	00:54	01:00	01:06	02:00	02:08	02:52
Insulin			1.4units/hr		2.7units/hr		
I&O SUMMARY	00:07	00:54	01:00	01:06	02:00	02:08	02:52
Intake Total					70		
Output Total				880			
NET				-880	70		
INTAKE	00:07	00:54	01:00	01:06	02:00	02:08	02:52
Tube feeding					70&		
Intake Total					70		
04/30/11 02:00 Tube feeding(JAC1): increased to 50cc/hr, residual 10cc							
OUTPUT	00:07	00:54	01:00	01:06	02:00	02:08	02:52
Foley cath				600			
G-tube				200			
JP #1				0			
JP #2				80			
Output Total				880			
CARE PROVIDERS	SID	SID	JAC1, {DLRO} JAC1	MGAL	JAC1, {DLRO} JAC1 MGAL	SID	SID

CC SYSTEM, ID(SID) COTTLE, JEAN A(JAC1)RN GALAMITON, MAXIMO(MGAL)CA
ROBERTS, DUSTI L(DLRO)RN

Liters liter(s) Oral oral Rarmly Rt arm lying Visual visual
Naslcn nasal cannula Radial radial Sleepg sleeping

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 35

FLOWSHEET	04/30						
Vital Signs	03:00	04:00	04:06	04:56	05:00	05:02	06:00
Glucose fs	126mg/dL	117mg/dL			124mg/dL		101mg/dL
Insulin Multiplr	.05	.06			.07		.07
Glucose	03:00	04:00	04:06	04:56	05:00	05:02	06:00
GLUCOSE PCX, WHO			**117 H**	**124 H**			
Medicated Drips	03:00	04:00	04:06	04:56	05:00	05:02	06:00
Insulin	3.3units/hr	3.4units/hr			4.5units/hr		2.9units/hr
I&O SUMMARY	03:00	04:00	04:06	04:56	05:00	05:02	06:00
Intake Total		90				150	175
Output Total		986					
NET		-896				150	175
INTAKE	03:00	04:00	04:06	04:56	05:00	05:02	06:00
Tube feeding						150	50
Tube feed flush		30					
Meds per tube		60					
D5W/NaCl.45%+KCl							125
Intake Total		90				150	175
OUTPUT	03:00	04:00	04:06	04:56	05:00	05:02	06:00
Foley cath		800					
Stool		1&					
G-tube		150					
JP #1		5					
JP #2		30					
Output Total		986					
04/30/11 04:00 Stool(MGAL): pt. stool wasa bloody shown to th nurse							
CARE PROVIDERS	JAC1,JAC1, (DLRO) MGAL	JAC1,JAC1, (DLRO) MGAL	SID	SID	JAC1,JAC1, (DLRO) MGAL	JAC1	JAC1

CC SYSTEM, ID(SID)
ROBERTS, DUSTI L(DLRO)RN
COTTLE, JEAN A(JAC1)RN
GALAMITON, MAXIMO(MGAL)CA

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 36

FLOWSHEET	04/30								
Vital Signs	06:01	06:53	06:54	07:57	08:00	08:08	08:10	08:24	09:00
Insulin Multiplr			.06					.07	.08
Glucose	06:01	06:53	06:54	07:57	08:00	08:08	08:10	08:24	09:00
GLUCOSE POC, WHO	**101 H**	97				**119 H**			
Medicated Drips	06:01	06:53	06:54	07:57	08:00	08:08	08:10	08:24	09:00
Insulin		2.2units/hr						4.1units/hr	
I&O SUMMARY	06:01	06:53	06:54	07:57	08:00	08:08	08:10	08:24	09:00
Intake Total				90	80				120
Output Total					0		650		
NET				90	80		-650		120
INTAKE	06:01	06:53	06:54	07:57	08:00	08:08	08:10	08:24	09:00
Oral									120
Tube feeding					50				
Tube feed flush					30				
Meds per tube				30					
InvasiveLineFlsh				60					
Intake Total				90	80				120
OUTPUT	06:01	06:53	06:54	07:57	08:00	08:08	08:10	08:24	09:00
Foley cath							650&		
Emesis									1
TF residual					0				
Output Total					0		650		
04/30/11 08:10 Foley cath(WCW): foely d'cd									
CARE PROVIDERS	SID	JAC1 SID	JAC1	JLNO	JLNO	SID	WCW	JLNO	JLNO

CC SYSTEM, ID(SID)
COTTLE, JEAN A(JAC1)RN
NORMAN, JILL L(JLNO)RN
WILLIAMS, WENDY C(WCW)CA

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 37

FLOWSHEET	04/30						
Vital Signs	09:04	09:11	09:46	10:00	10:05	10:22	10:37
TEMP #1 in F				98.7F Oral			
PULSE				106 Radial			
RESPIRATIONS				18 Visual			
BP (NIBP)				**195/95 Rarmly&**			
Insulin Multiplr							.09
PAIN LEVEL				6 Numvlu			
04/30/11 10:00 BP (NIBP)(WCW): RN aware							
Glucose	09:04	09:11	09:46	10:00	10:05	10:22	10:37
GLUCOSE PCX, WHO	**120 H**				**128 H**	**169 H**	
Medicated Drips	09:04	09:11	09:46	10:00	10:05	10:22	10:37
Insulin		4.8units/hr		9.8units/hr			
I&O SUMMARY	09:04	09:11	09:46	10:00	10:05	10:22	10:37
Intake Total			0				
Output Total				445			
NET			0	-445			
INTAKE	09:04	09:11	09:46	10:00	10:05	10:22	10:37
D5W/NaCl.45%+KCl			0				
Intake Total			0				
OUTPUT	09:04	09:11	09:46	10:00	10:05	10:22	10:37
Foley cath				0			
Stool				0			
G-tube				400			
JP #1				30			
JP #2				15			
Output Total				445			
CARE PROVIDERS	SID	JLNO	JLNO	JLNO WCW	SID	SID	JLNO

CC SYSTEM, ID(SID) NORMAN, JILL L(JLNO)RN WILLIAMS, WENDY C(WCW)CA

Numvlu Numeric Value
Oral oral
Radial radial
Rarmly Rt arm lying
Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/28/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 38

FLOWSHEET	04/30							
Vital Signs	11:00	11:35	11:37	12:00	12:08	12:30	13:00	13:23
Insulin Multiplr	.08			.9			.08	
Glucose	11:00	11:35	11:37	12:00	12:08	12:30	13:00	13:23
GLUCOSE PCX, WHO		98			**113 H**			**63 L**
Medicated Drips	11:00	11:35	11:37	12:00	12:08	12:30	13:00	13:23
Insulin	3.0units/hr			4.8units/hr			.2units/hr	
I&O SUMMARY	11:00	11:35	11:37	12:00	12:08	12:30	13:00	13:23
Intake Total				290				
Output Total			60			650		
NET			-60	290		-650		
INTAKE	11:00	11:35	11:37	12:00	12:08	12:30	13:00	13:23
Tube feeding				260&				
Tube feed flush				30				
Intake Total				290				
04/30/11 12:00 Tube feeding(JLNO): tf stopped								
OUTPUT	11:00	11:35	11:37	12:00	12:08	12:30	13:00	13:23
Urine						650		
Emesis			60					
TF residual								
Output Total			60			650		
CARE PROVIDERS	JLNO	SID	JLNO	JLNO	SID	WCW	JLNO	SID

CC SYSTEM, ID(SID) NORMAN, JILL L(JLNO)RN WILLIAMS, WENDY C(WCW)CA

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 39

FLOWSHEET	04/30						
Vital Signs	14:00	14:10	14:20	14:26	15:00	15:24	16:00
TEMP #1 in F			98.2F				
PULSE			104 Radial				
RESPIRATIONS			18 Visual				
O2 SAT %			99% O2				
O2 flow			2 Liters				
O2 equipment			Naslcn				
Manual BP			**190/80 Rarmly&**				
Insulin Multipir	.07				.07		.07
PAIN LEVEL			5 Numvlu				
04/30/11 14:20 Manual BP(WCW): RN aware							
Glucose	14:00	14:10	14:20	14:26	15:00	15:24	16:00
GLUCOSE PCX, WHO		97				100	
Medicated Drips	14:00	14:10	14:20	14:26	15:00	15:24	16:00
Insulin	2.6units/hr				2.8units/hr		
I&O SUMMARY	14:00	14:10	14:20	14:26	15:00	15:24	16:00
Intake Total				95			
Output Total	65		315				
NET	-65		-315	95			
INTAKE	14:00	14:10	14:20	14:26	15:00	15:24	16:00
Meds per tube				30			
InvasiveLineFlsh				65			
Intake Total				95			
OUTPUT	14:00	14:10	14:20	14:26	15:00	15:24	16:00
Stool			0				
G-tube			300				
TF residual	65						
JP #1			15				
JP #2			0				
Wound drn #1			0				
Output Total	65		315				
CARE PROVIDERS	JLNO	SID	WCW	JLNO	JLNO	SID	JLNO

CC SYSTEM, ID(SID) NORMAN, JILL L(JLNO)RN WILLIAMS, WENDY C(WCW)CA

Liters liter(s) Numvlu Numeric Value Rarmly Rt arm lying
Naslcn nasal cannula Radial radial Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 40

FLOWSHEET	04/30					
Vital Signs	16:20	16:22	16:26	16:30	17:00	17:08
PULSE					93	
BP (NIBP)					**186/92 Larmly**	
Manual BP			**180/80 Larmly**			
Insulin Multiplr					.07	
Glucose	16:20	16:22	16:26	16:30	17:00	17:08
GLUCOSE PCX, WHO	**101 H**					**106 H**
Medicated Drips	16:20	16:22	16:26	16:30	17:00	17:08
Insulin		2.9units/hr			3.2units/hr	
OUTPUT	16:20	16:22	16:26	16:30	17:00	17:08
Stool				1		
CARE PROVIDERS	SID	JLNO	JLNO	WCW	JLNO	SID

CC SYSTEM, ID(SID)
Larmly Lt arm lying
NORMAN, JILL L(JLNO)RN
WILLIAMS, WENDY C(WCW)CA

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 18:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 41

FLOWSHEET	04/30						
Vital Signs	17:15	17:35	18:00	18:18	18:41	19:00	19:01
TEMP #1 in F			99.6F Oral				
PULSE	90	89 Radial	93 Radial				
RESPIRATIONS			18 Visual				
O2 SAT %			97% O2				
O2 flow			2 Liters				
O2 equipment			Naslcn				
BP (NIBP)	**179/89 Larmly**	**177/86 Rarmly**	**162/80 Rarmly**				
Insulin Multiplr			.03			.05	
PAIN LEVEL			0 Numvlu				
Glucose	17:15	17:35	18:00	18:18	18:41	19:00	19:01
GLUCOSE PCX, WHO				87			88
Medicated Drips	17:15	17:35	18:00	18:18	18:41	19:00	19:01
Insulin			1.6units/hr				
I&O SUMMARY	17:15	17:35	18:00	18:18	18:41	19:00	19:01
Intake Total						300	
Output Total					581		
NET					-581	300	
INTAKE	17:15	17:35	18:00	18:18	18:41	19:00	19:01
Meds per tube							
InvasiveLineFlsh							
D5W/NaCl.45%+KCl						300	
Intake Total						300	
OUTPUT	17:15	17:35	18:00	18:18	18:41	19:00	19:01
Stool					1		
G-tube					550		
JP #1					30		
Output Total					581		
CARE PROVIDERS	JLNO	BM2	JLNO WCW	SID	WCW	JLNO	SID

CC SYSTEM, ID(SID) MILLS, BRETT(BM2)PCT NORMAN, JILL L(JLNO)RN
WILLIAMS, WENDY C(WCW)CA

Larmly Lt arm lying Nasicn nasal cannula Oral oral Rarmly Rt arm lying
Liters liter(s) Numvlu Numeric Value Radial radial Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 42

FLOWSHEET	04/30						
Vital Signs	19:04	19:25	20:00	20:04	21:00	21:12	21:51
TEMP #1 in F							
PULSE							
RESPIRATIONS							
O2 SAT %							
O2 flow							
O2 equipment							
BP (NIBP)							
Glucose fs			101mg/dL		99mg/dL		
Insulin Multiplr			.05		.04		
Glucose	19:04	19:25	20:00	20:04	21:00	21:12	21:51
GLUCOSE PCX, WHO				**101 H**		99	97
Medicated Drips	19:04	19:25	20:00	20:04	21:00	21:12	21:51
Insulin		1.4units/hr	2.1units/hr		1.6units/hr		
I&O SUMMARY	19:04	19:25	20:00	20:04	21:00	21:12	21:51
Intake Total	90						
Output Total							
NET	90						
INTAKE	19:04	19:25	20:00	20:04	21:00	21:12	21:51
Meds per tube	30						
InvasiveLineFlsh	60						
Intake Total	90						
OUTPUT	19:04	19:25	20:00	20:04	21:00	21:12	21:51
Urine							
Output Total							
CARE PROVIDERS	JLNO	JLNO	JAC1 MGAL	SID	JAC1 MGAL	SID	SID

CC SYSTEM, ID(SID)
NORMAN, JILL L(JLNO)RN
COTTLE, JEAN A(JAC1)RN
GALAMITON, MAXIMO(MGAL)CA

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 43

FLOWSHEET	04/30			05/01			
Vital Signs	22:00	23:00	23:08	00:00	00:04	00:57	01:00
TEMP #1 in F	98.7F Oral						
PULSE	87 Radial						
RESPIRATIONS	20 Visual						
O2 SAT %	100% O2						
O2 flow	2 Liters						
O2 equipment	Naslcn						
BP (NIBP)	159/82 Rarmly						
Glucose fs	97mg/dL	106mg/dL		102mg/dL			97mg/dL
Insulin Multiplr	.03	.03		.03			.02
PAIN LEVEL							
Glucose	22:00	23:00	23:08	00:00	00:04	00:57	01:00
GLUCOSE POX, WHO			**106 H**		**102 H**	97	
Medicated Drips	22:00	23:00	23:08	00:00	00:04	00:57	01:00
Insulin	1.1units/hr	1.4units/hr		1.3units/hr			.7units/hr
I&O SUMMARY	22:00	23:00	23:08	00:00	00:04	00:57	01:00
Intake Total				500			
Output Total	-400						
NET	-400			500			
INTAKE	22:00	23:00	23:08	00:00	00:04	00:57	01:00
Oral							
D5W/NaCl.45%+KCl				500			
Intake Total				500			
OUTPUT	22:00	23:00	23:08	00:00	00:04	00:57	01:00
Urine	400						
G-tube							
JP #1							
JP #2							
Output Total	400						
CARE PROVIDERS	JAC1 MGAL	JAC1	SID	JAC1	SID	SID	JAC1

CC SYSTEM, ID(SID) COTTLE, JEAN A(JAC1)RN GALAMITON, MAXIMO(MGAL)CA

Liters liter(s) Oral oral Rarmly Rt arm lying
Naslcn nasal cannula Radial radial Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:56 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB[redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:00
OPT OUT:
Page: 44

FLOWSHEET	05/01						
Vital Signs	02:00	02:06	03:00	03:09	04:00	04:02	05:00
TEMP #1 in F	99.5F Oral						
PULSE	105 Radial						
RESPIRATIONS	20 Visual						
O2 SAT %	100% O2						
O2 flow	2 Liters						
O2 equipment	Nasion						
BP (NIBP)	**162/82**						
Glucose fs	75mg/dL		105mg/dL		114mg/dL		113mg/dL
Insulin Multiplr	.01		.01		.02		.03
PAIN LEVEL	3 Numvlu						
Glucose	02:00	02:06	03:00	03:09	04:00	04:02	05:00
GLUCOSE POC, WHO		75		**105 H**		**114 H**	
Medicated Drips	02:00	02:06	03:00	03:09	04:00	04:02	05:00
Insulin	.2units/hr		.5units/hr		1.1units/hr		1.6units/hr
I&O SUMMARY	02:00	02:06	03:00	03:09	04:00	04:02	05:00
Intake Total	0						500
Output Total	803						150
NET	-803						350
INTAKE	02:00	02:06	03:00	03:09	04:00	04:02	05:00
Oral	0						
D5W/NaCl.45%+KCl							500
Intake Total	0						500
OUTPUT	02:00	02:06	03:00	03:09	04:00	04:02	05:00
Urine	400						
G-tube	400						
JP #1	0						
JP #2	3						
Wound drn #1							150
Output Total	803						150
CARE PROVIDERS	JAC1 MGAL	SID	JAC1	SID	JAC1 MGAL	SID	JAC1

CC SYSTEM, ID(SID) COTTLE, JEAN A(JAC1)RN GALAMITON, MAXIMO(MGAL)CA

Liters liter(s) Numvlu Numeric Value Radial radial
Nasion nasal cannula Oral oral Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: [redacted] SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 45

FLOWSHEET	05/01						
Vital Signs	05:10	06:00	06:12	06:26	06:56	06:58	06:59
TEMP #1 in F				97.8F Oral			
PULSE				97 Radial			
RESPIRATIONS				20 Visual			
O2 SAT %				98% O2			
O2 flow				2 Liters			
O2 equipment				Nasln			
BP (NIBP)				151/82 Rarmly			
Glucose fs		103mg/dL				104mg/dL	
Insulin Multiplr		.03					.03
PAIN LEVEL				5 Numvlu			
Glucose	05:10	06:00	06:12	06:26	06:56	06:58	06:59
GLUCOSE PCX, WHO	**113 H**		**103 H**		**104 H**		
Medicated Drips	06:10	06:00	06:12	06:26	06:56	06:58	06:59
Insulin		1.3units/hr					1.3units/hr
I&O SUMMARY	05:10	06:00	06:12	06:26	06:56	06:58	06:59
Output Total		600					
NET		-600					
OUTPUT	05:10	06:00	06:12	06:26	06:56	06:58	06:59
Urine		600					
Output Total		600					
CARE PROVIDERS	SID	JAC1	SID	MGAL	SID	JAC1	JAC1

CC SYSTEM, ID(SID)
COTTLE, JEAN A(JAC1)RN
GALAMITON, MAXIMO(MGAL)CA

Liters liter(s)
Nasln nasal cannula
Numvlu Numeric Value
Oral oral
Radial radial
Rarmly Rt arm lying
Visual visual

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 46

FLOWSHEET	05/01								
Vital Signs	08:00	08:03	08:43	09:00	09:06	10:00	10:53	11:00	11:15
TEMP #1 in F						100.6F Oral			
PULSE						104 Radial			
RESPIRATIONS						**26 Visual&**			
O2 SAT %						98% Rmair			
BP (NIBP)						**177/88 Rarmly&**			
Insulin Multiplr	0.02			0.02					
PAIN LEVEL						0 Sleepg			
05/01/11 10:00 RESPIRATIONS(BM2): rn aware									
05/01/11 10:00 BP (NIBP)(BM2): rn aware									
Glucose	08:00	08:03	08:43	09:00	09:06	10:00	10:53	11:00	11:15
GLUCOSE PCX, WHO		**109 H**			**117 H**				
I&O SUMMARY	08:00	08:03	08:43	09:00	09:06	10:00	10:53	11:00	11:15
Intake Total			0				0	400	0
Output Total							0		
NET			0				0	400	0
INTAKE	08:00	08:03	08:43	09:00	09:06	10:00	10:53	11:00	11:15
Oral							0		
D5W/NaCl.45%+KCl			0					400	
Insulin									0
Intake Total			0				0	400	0
OUTPUT	08:00	08:03	08:43	09:00	09:06	10:00	10:53	11:00	11:15
Urine							0		
Output Total							0		
CARE PROVIDERS	SPS1	SID	SPS1	SPS1	SID	BM2	BM2	SPS1	SPS1

CC SYSTEM, ID(SID) MILLS, BRETT(BM2)PCT SHEFTON, SENACA P(SPS1)RN

Oral oral
Radial radial
Rarmly Rt arm lying
Rmair room air
Sleepg sleeping
Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 09:06
OPT OUT:
Page: 47

FLOWSHEET	05/01							
Vital Signs	11:36	12:00	14:12	15:00	15:37	18:21	18:23	18:32
TEMP #1 in F			99.3F Oral			99.3F Oral		
PULSE			97 Radial			100 Radial		
RESPIRATIONS			25 Visual			25 Visual		
O2 SAT %			99% Rmair			100% Rmair		
BP (NIBP)			158/86 Rarmly			**162/89 Rarmly**		
PAIN LEVEL			4 Numvlu			4 Numvlu		
Glucose	11:36	12:00	14:12	15:00	15:37	18:21	18:23	18:32
GLUCOSE PCX, WHO	**116 H**				**151 H**			
I&O SUMMARY	11:36	12:00	14:12	15:00	15:37	18:21	18:23	18:32
Intake Total		120	100	880			150	
Output Total			2075				350	400
NET		120	-1975	880			-200	-400
INTAKE	11:36	12:00	14:12	15:00	15:37	18:21	18:23	18:32
Oral			100				150	
Tube feeding				380				
Tube feed flush		90		90				
Meds per tube		30		10				
D5W/NaCl.45%+KCl				400				
Intake Total		120	100	880			150	
OUTPUT	11:36	12:00	14:12	15:00	15:37	18:21	18:23	18:32
Urine			1000				350	
Stool			1&					
G-tube			325					400
JP #1			10					
JP #2			15					
Wound drn #1			725					
Output Total			2075				350	400
05/01/11 14:12 Stool(BM2): Liquid, BLoody, substantial								
CARE PROVIDERS	SID	SPS1	BM2	SPS1	SID	BM2	BM2	BM2

CC SYSTEM, ID(SID) MILLS, BRETT(BM2)PCT SHEFTON, SENACA P(SPS1)RN

Numvlu Numeric Value Radial radial Rmair room air
Oral oral Rarmly Rt arm lying Visual visual

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 18:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 09:06
OPT OUT:
Page: 48

FLOWSHEET	05/01						05/02	
Vital Signs	18:50	19:30	19:33	20:40	21:47	23:28	00:00	02:04
TEMP #1 in F					99.7F			100.7F Oral
PULSE					111 Brachl			112 Brachl
RESPIRATIONS					24 Visual			22 Visual
O2 SAT %					99% Rmair			99% Rmair
BP (NIBP)					159/95 Larmly			**(161/95 Rarmly&)**
PAIN LEVEL					4 Numvlu			5 Numvlu
05/02/11 02:04 BP (NIBP)(ET72): rn notified								
Glucose	18:50	19:30	19:33	20:40	21:47	23:28	00:00	02:04
GLUCOSE PCX, WHO			**158 H**			**111 H**		
I&O SUMMARY	18:50	19:30	19:33	20:40	21:47	23:28	00:00	02:04
Intake Total	810			0			1065	0
Output Total		400			465			0
NET	810	-400		0	-465		1065	0
INTAKE	18:50	19:30	19:33	20:40	21:47	23:28	00:00	02:04
Oral								0
Tube feeding	380						475	
Tube feed flush	30						30	
Meds per tube							60	
D5W/NaCl.45%+KCl	400			0			500	
Intake Total	810			0			1065	0
OUTPUT	18:50	19:30	19:33	20:40	21:47	23:28	00:00	02:04
Urine					0			0
Urine		1			0			0
Foley cath					325			0
Stool		1&			1			
G-tube					125			0
JP #1					15			0
JP #2								0
Wound drn #1		400						
Output Total		400			465			0
05/01/11 19:30 Stool(BM2): Bloody, liquid, substantial								
CARE PROVIDERS	SPS1	BM2	SID	JAC1	ET72	SID	JAC1	ET72

CC SYSTEM, ID(SID) COTTLE, JEAN A(JAC1)RN MILLS, BRETT(BM2)PCT
SHEFTON, SENACA P(SPS1)RN TRIA, EMMANUEL(ET72)PCT

Brachl brachial Numvlu Numeric Value Rarmly Rt arm lying Visual visual
Larmly Lt arm lying Oral oral Rmair room air

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 49

FLOWSHEET	05/02							
Vital Signs	04:18	05:57	06:00	06:16	07:58	08:00	08:38	09:00
TEMP #1 in F				99.8F Oral				
PULSE				89 Brachl				
RESPIRATIONS				22 Visual				
O2 SAT %				99% Rmair				
BP (NIBP)				**161/93 Larmly**				
PAIN LEVEL				4 Numvlu				
Glucose	04:18	05:57	06:00	06:16	07:58	08:00	08:38	09:00
GLUCOSE PCX, WHO	**117 H**				**134 H**			
I&O SUMMARY	04:18	05:57	06:00	06:16	07:58	08:00	08:38	09:00
Intake Total		1260						240
Output Total			500	555		1	400	
NET		1260	-500	-555		-1	-400	240
INTAKE	04:18	05:57	06:00	06:16	07:58	08:00	08:38	09:00
Oral								240
Tube feeding		570						
Tube feed flush		30						
Meds per tube		60						
D5W/NaCl.45%+KCl		600						
Intake Total		1260						240
OUTPUT	04:18	05:57	06:00	06:16	07:58	08:00	08:38	09:00
Urine							400	
Foley cath				555				
Emesis						1		
Wound drn #1			500					
Output Total			500	555		1	400	
CARE PROVIDERS	SID	JAC1	JAC1	ET72	SID	MP04	MP04	MP04

CC SYSTEM, ID(SID)
COTTLE, JEAN A(JAC1)RN
PASCARELLA, MELISSA(MP04)RN
TRIA, EMMANUEL(ET72)PCT

Brachl	brachial	Numvlu	Numeric Value	Rmair	room air
Larmly	Lt arm lying	Oral	oral	Visual	visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 50

FLOWSHEET	05/02							
Vital Signs	10:00	12:00	12:05	14:00	14:11	14:12	15:00	15:59
TEMP #1 in F	98.1F Oral			98.4F Oral				
PULSE	85 Radial			90 Radial				
RESPIRATIONS	20 Visual			20 Visual				
O2 SAT %	98% Rmair			99% Rmair				
BP (NIBP)	**167/92 Rarmly&**			**172/95 Rarmly&**				
PAIN LEVEL	6 Numvlu			4 Numvlu				
WEIGHT in Kg								
05/02/11 10:00 BP (NIBP)(ALB3): RN Missy aware								
05/02/11 14:00 BP (NIBP)(ALB3): RN Missy aware								
Glucose	10:00	12:00	12:05	14:00	14:11	14:12	15:00	15:59
GLUCOSE POC, WHO			**141 H**					**107 H**
I&O SUMMARY	10:00	12:00	12:05	14:00	14:11	14:12	15:00	15:59
Intake Total		240				120	240	
Output Total					25			
NET		240			-25	120	240	
INTAKE	10:00	12:00	12:05	14:00	14:11	14:12	15:00	15:59
Oral		240				120	240	
Intake Total		240				120	240	
OUTPUT	10:00	12:00	12:05	14:00	14:11	14:12	15:00	15:59
JP #2					25			
Output Total					25			
CARE PROVIDERS	ALB3	MP04	SID	ALB3	ALB3	ALB3	MP04	SID

BOSTER, ALIX(ALB3)PCT CC SYSTEM, ID(SID) PASCARELLA, MELISSA(MP04)RN

Numvlu Numeric Value Radial radial Rmair room air
Oral oral Rarmly Rt arm lying Visual visual

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 51

FLOWSHEET	05/02								
Vital Signs	16:22	16:23	16:24	17:18	17:21	18:00	19:04	19:29	20:00
TEMP #1 in F						95.5F Oral			
PULSE						97 Radial			
RESPIRATIONS						24 Visual			
O2 SAT %						99% Rmair			
BP (NIBP)						160/96 Rarmly			
PAIN LEVEL						10 Numvlu			
WEIGHT in Kg	92.2kg								
Glucose	16:22	16:23	16:24	17:18	17:21	18:00	19:04	19:29	20:00
GLUCOSE PCX, WHO									
I&O SUMMARY	16:22	16:23	16:24	17:18	17:21	18:00	19:04	19:29	20:00
Intake Total					360				610
Output Total		950	0	700			950		
NET		-950	0	-700	360		-950		610
INTAKE	16:22	16:23	16:24	17:18	17:21	18:00	19:04	19:29	20:00
Oral					360				
Tube feeding									380
Tube feed flush									30
D5W/NaCl.45%+KCl									200
Intake Total					360				610
OUTPUT	16:22	16:23	16:24	17:18	17:21	18:00	19:04	19:29	20:00
Foley cath		950					950		
Emesis								1	
JP #1			0						
Wound drn #1				700					
Output Total		950	0	700			950		
CARE PROVIDERS	ALB3	ALB3	ALB3	MP04	MP04	ALB3	ALB3	ALB3	DLRO

BOSTER, ALIX(ALB3)PCT PASCARELLA, MELISSA(MP04)RN ROBERTS, DUSTI L(DLRO)RN

Numvlu Numeric Value Radial radial Rmair room air
Oral oral Rarmly Rt arm lying Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 52

FLOWSHEET	05/02					05/03	
Vital Signs	20:02	22:29	22:30	23:00	23:31	00:00	01:00
TEMP #1 in F		95.3F Oral					
PULSE		97 Radial			88 Radial		
RESPIRATIONS		20 Visual					
O2 SAT %		100% Rmair					
BP (NIBP)		**186/97 Rarmly**			**167/97 Rarmly**		
PAIN LEVEL		5 Numvlu					
Glucose	20:02	22:29	22:30	23:00	23:31	00:00	01:00
GLUCOSE PCX, WHO	**125 H**			**126 H**			
I&O SUMMARY	20:02	22:29	22:30	23:00	23:31	00:00	01:00
Intake Total						610	
Output Total			700				400
NET			-700			610	-400
INTAKE	20:02	22:29	22:30	23:00	23:31	00:00	01:00
Tube feeding						360	
Tube feed flush						30	
D5W/NaCl.45%+KCl						200	
Intake Total						610	
OUTPUT	20:02	22:29	22:30	23:00	23:31	00:00	01:00
Urine							400
G-tube			700				
Output Total			700				400
CARE PROVIDERS	SID	BRB5	DLRO	SID	BRB5	DLRO	DLRO

BAKER, BRIAN(BRB5)PCT CC SYSTEM, ID(SID) ROBERTS, DUSTI L(DLRO)RN

Numvlu Numeric Value Radial radial Rmair room air
Oral oral Rarmly Rt arm lying Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 53

FLOWSHEET	05/03						
Vital Signs	01:32	03:00	03:04	04:00	04:26	05:05	05:24
TEMP #1 in F	98.9F Oral						96.7F Oral
PULSE	97 Brachl						93 Brachl
RESPIRATIONS	18 Visual						18 Visual
O2 SAT %	99% Rmair						99% Rmair
BP (NIBP)	**185/96 Larmly**	162/88 Larm&					**187/95 Larmly**
PAIN LEVEL	5 Numvlu						6 Numvlu
05/03/11 03:00 BP (NIBP)(DLRO): Manual							
Glucose	01:32	03:00	03:04	04:00	04:26	05:05	05:24
GLUCOSE PCX, WHO			**116 H**				
I&O SUMMARY	01:32	03:00	03:04	04:00	04:26	05:05	05:24
Intake Total				610			
Output Total		200			500	250	1610
NET		-200		610	-500	-250	-1610
INTAKE	01:32	03:00	03:04	04:00	04:26	05:05	05:24
Tube feeding				380			
Tube feed flush				30			
D5W/NaCl.45%+KCl				200			
Intake Total				610			
OUTPUT	01:32	03:00	03:04	04:00	04:26	05:05	05:24
Urine		200			500		
G-tube							1600
JP #2							10
Wound drn #1						250	
Output Total		200			500	250	1610
CARE PROVIDERS	BRB5	DLRO	SID	DLRO	BRB5	DLRO	BRB5

BAKER, BRIAN(BRB5)PCT CC SYSTEM, ID(SID) ROBERTS, DUSTI L(DLRO)RN

Brachl brachial Larmly Lt arm lying Oral oral Visual visual
Larm arm L Numvlu Numeric Value Rmair room air

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 18Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 54

FLOWSHEET	05/03						
Vital Signs	07:48	07:57	08:43	10:00	10:19	10:30	10:58
TEMP #1 in F				97.9F Oral			
PULSE				116 Radial	114 Radial	98 Radial	
RESPIRATIONS				22 Visual			
O2 SAT %				99% Rmair			
BP (NIBP)				157/106 Rarmly&			
Manual BP					**170/100**	158/96 Larm	
Glucose fs		125mg/dL					
FSBGreportedToRN		Done					
PAIN LEVEL				4 Numvlu			
05/03/11 10:00 BP (NIBP)(JTC): RN Corey aware							
Glucose	07:48	07:57	08:43	10:00	10:19	10:30	10:58
GLUCOSE PCX, WHO	**125 H**						
I&O SUMMARY	07:48	07:57	08:43	10:00	10:19	10:30	10:58
Intake Total				120			0
Output Total			750	670			
NET			-750	-550			0
INTAKE	07:48	07:57	08:43	10:00	10:19	10:30	10:58
Oral				120			
Tube feeding							
Tube feed flush							
D5W/NaCl.45%+KCl							0
Intake Total				120			0
OUTPUT	07:48	07:57	08:43	10:00	10:19	10:30	10:58
Urine				1			
Stool				1&			
G-tube			750	650			
JP #2				20			
Output Total			750	670			
05/03/11 10:00 Stool(JTC): small loose stool							
CARE PROVIDERS	SID	JTC	JTC	COS0 JTC	COS0	COS0	COS0

CARSON, JOHN T(JTC)CA — CC SYSTEM, ID(SID) — SLUSARSKI, COREY(COS0)RN

Done done
Larm arm L
Numvlu Numeric Value
Oral oral
Radial radial
Rarmly Rt arm lying
Rmair room air
Visual visual

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/28/11 02:55 TO: 05/04/11 18:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:06
OPT OUT:
Page: 55

FLOWSHEET	05/03						
Vital Signs	11:00	11:07	12:00	12:09	12:30	14:00	14:15
TEMP #1 in F						97F Oral	
PULSE	90 Radial					112 Brachl	
RESPIRATIONS						20 Visual	
O2 SAT %						99% Rmair	
BP (NIBP)						**187/100 Rarmly&**	
Manual BP	160/98 Larm						**164/100 Rarm**
FSBGreportedToRN			Done				
PAIN LEVEL						5 Numvlu	
05/03/11 14:00 BP (NIBP)(JTC): RN Corey aware							
Glucose	11:00	11:07	12:00	12:09	12:30	14:00	14:15
GLUCOSE POX, WHO				**138 H**			
I&O SUMMARY	11:00	11:07	12:00	12:09	12:30	14:00	14:15
Intake Total	410	200				240	
Output Total					850	50	
NET	410	200			-850	190	
INTAKE	11:00	11:07	12:00	12:09	12:30	14:00	14:15
Oral						240	
Tube feeding	380						
Tube feed flush	30						
D5W/NaCl.45%+KCl		200					
Intake Total	410	200				240	
OUTPUT	11:00	11:07	12:00	12:09	12:30	14:00	14:15
G-tube					850		
JP #2							
Wound drn #1						50	
Output Total					850	50	
CARE PROVIDERS	COS0	COS0	JTC	SID	JTC	COS0 JTC	COS0

CARSON, JOHN T(JTC)CA — CC SYSTEM, ID(SID) — SLUSARSKI, COREY(COS0)RN

Brachl brachial
Done done
Larm arm L
Numvlu Numeric Value
Oral oral
Radial radial
Rarm arm R
Rarmly Rt arm lying
Rmair room air
Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 00:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 56

FLOWSHEET	05/03								
Vital Signs	14:28	15:00	15:12	15:50	16:09	16:19	17:08	17:54	18:00
TEMP #1 in F									96.5F Oral
PULSE									**125 Brachl&**
RESPIRATIONS									22 Visual
O2 SAT %									99% Rmair
BP (NIBP)									**203/101 Rarmly&**
Manual BP									
PAIN LEVEL									5 Numvlu
05/03/11 18:00 PULSE(JTC): RN Corey aware									
05/03/11 18:00 BP (NIBP)(JTC): RN Corey aware									
Glucose	14:28	15:00	15:12	15:50	16:09	16:19	17:08	17:54	18:00
GLUCOSE PCX, WHO				**125 H**					
I&O SUMMARY	14:28	15:00	15:12	15:50	16:09	16:19	17:08	17:54	18:00
Intake Total	120	670					640		240
Output Total	460					5		100	800
NET	-340	670				-5	640	-100	-560
INTAKE	14:28	15:00	15:12	15:50	16:09	16:19	17:08	17:54	18:00
Oral	120								240
Tube feeding		380					380		
Tube feed flush		30					30		
Meds per tube		60					30		
D5W/NaCl.45%+KCl		200					200		
Intake Total	120	670					640		240
OUTPUT	14:28	15:00	15:12	15:50	16:09	16:19	17:08	17:54	18:00
Urine			1						
Stool			1&		1				
G-tube	450								800
JP #1						5			
JP #2	10								
Wound drn #1								100	
Output Total	460					5		100	800
05/03/11 15:12 Stool(JTC): small bm									
CARE PROVIDERS	JTC	COS0	JTC	SID	COS0	JTC	COS0	COS0	JTC

CARSON, JOHN T(JTC)CA CC SYSTEM, ID(SID) SLUSARSKI, COREY(COS0)RN

Brachl brachial Oral oral Rmair room air
Numvlu Numeric Value Rarmly Rt arm lying Visual visual

CONTINUED

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED:05/05/11 00:00
OPT OUT:
Page: 57

FLOWSHEET	05/03						05/04
Vital Signs	18:08	18:20	18:59	20:15	22:00	23:36	01:52
TEMP #1 in F					99.7F Oral		98.3F Oral
PULSE	116 Radial	100 Radial			**126 Brachl**		**125 Brachl**
RESPIRATIONS					24 Visual		22 Visual
O2 SAT %					99% Rmair		100% Rmair
BP (NIBP)					150/65 Larm		
Manual BP	**174/98 Rarm**	160/98 Rarm					
PAIN LEVEL					5 Numvlu		7 Numvlu
Glucose	18:08	18:20	18:59	20:15	22:00	23:36	01:52
GLUCOSE PCX, WHO				**121 H**		99	
I&O SUMMARY	18:08	18:20	18:59	20:15	22:00	23:36	01:52
Output Total					560		0
NET					-560		0
OUTPUT	18:08	18:20	18:59	20:15	22:00	23:36	01:52
Urine			1		3		
Stool			1		3		
G-tube					550		
JP #1					5		
JP #2					5		
Wound drn #1							0
Output Total					560		0
CARE PROVIDERS	COS0	COS0	JTC	SID	PA35	SID	PA35

ALLS, PHINETHA(PA35)PCT CARSON, JOHN T(JTC)CA CC SYSTEM, ID(SID)
SLUSARSKI, COREY(COS0)RN

Brachl	brachial	Numvlu	Numeric Value	Radial	radial	Rmair	room air
Larm	arm L	Oral	oral	Rarm	arm R	Visual	visual

GOODWIN, DAVON
MUSC
Vital Signs, I&O
FROM: 04/26/11 02:55 TO: 05/04/11 16:07
ROOM: *1070-A* ADM: 04/26/11 03:18
AGE: 19Y SEX: M : LEON, STUART M
DOB: [redacted] ID: 495654253 MR: 002657049
REQUESTED: 05/05/11 00:06
OPT OUT:
Page: 58

FLOWSHEET	05/04								
Vital Signs	02:00	03:47	04:14	04:15	06:51	06:55	07:29	08:05	08:06
TEMP #1 in F					95.1F Oral				
PULSE					113 Brachl				(115&)
RESPIRATIONS					24 Visual				
O2 SAT %					99% Rmair				
PAIN LEVEL					7 Numvlu				
05/04/11 08:06 PULSE(JTC): The patient was sitting up in the wheelchair when I did a manual pulse. The patient was verbal and complaining of pain. RN Marianne notified.									
Glucose	02:00	03:47	04:14	04:15	06:51	06:55	07:29	08:05	08:06
GLUCOSE POC, WHO		**180 H**					**117 H**		
I&O SUMMARY	02:00	03:47	04:14	04:15	06:51	06:55	07:29	08:05	08:06
Intake Total						2960			
Output Total	1600		905		0			2100	
NET	-1600		-905		0	2960		-2100	
INTAKE	02:00	03:47	04:14	04:15	06:51	06:55	07:29	08:05	08:06
Oral						1050			
Tube feeding						1140			
Tube feed flush						120			
Meds per tube						50			
D5W/NaCl.45%+KCl						600			
Intake Total						2960			
OUTPUT	02:00	03:47	04:14	04:15	06:51	06:55	07:29	08:05	08:06
Urine					0				
Urine				1					
Stool					0				
G-tube	1600		800					2100	
JP #1			5						
Wound drn #1			100						
Output Total	1600		905		0			2100	
CARE PROVIDERS	RPGO	SID	TMM2	TMM2	PA35	TMM2	SID	MKWI	JTC

ALLS, PHINETHA(PA35)PCT
GOLUB, RACHEL P(RPGO)RN
CARSON, JOHN T(JTC)CA
MARTUCCI, TIFFANY(TMM2)RN
CC SYSTEM, ID(SID)
WITTENMEYER, MARIANNE K(MKWI)RN

Brachl brachial Oral oral
Numvlu Numeric Value Rmair room air
Visual visual

LAST PAGE

Ex: Nursing Records, Physician Orders, Progress Notes, etc.

MRN	DOS	MISSING DOCUMENT(S)	DATE MISSING	DATE SCANNED	INITIALS
		Triage		4-28-11	

P:495654253 DOB [redacted] U
TRAUMA
VICTIM PP
Adm:04/26/11 M:2657049

This form is used to indicate documents that were not received (in Health Information Services) with the medical record at the time of discharge.

4-5 laps ib

MUSC Health

INTRAOPNOTE

POST-PROCEDURE / OPERATIVE NOTE

Page 1 of 1

Form Origination Date: 1/00
Version: 8 Version Date: 1/10

P:495654253 DOB: [redacted]
TRAUMA
VICTIM PP
Adm:04/26/11 M:2657049

Patient Name
MRN

PATIENT IDENTIFICATION LABEL

ALL STARRED (*) ELEMENTS OF THIS FORM MUST BE COMPLETED

UMA Providers: To effectively track the clinic location where the patient originated from, check the following (other than MUSC Campus Clinics).
☐ Beaufort ☐ E. Cooper ☐ Florence ☐ Greenville ☐ N. Chas ☐ Trident ☐ W. Ashley ☐ Other:

PRE-OP DIAGNOSIS, POST-OP DIAGNOSIS AND PROCEDURE MUST BE WRITTEN OUT

* **DATE:** 4/26/11
* **PRE-OP DIAGNOSIS:** GSW to Abdomen
* **POST-OP DIAGNOSIS:** same
* **PROCEDURE:** Damage Control Laparotomy, Repair of [illegible]

POST-OP DIAGNOSIS: ICD-9 Code wounds to SMA, SMV, through & through duodenal injury (D3/4) & repair, through & through IVC (liver)

1.	2.	3.	4.	5.

* **CPT Code**

Procedure 1	Procedure 2	Procedure 3	Procedure 4	Procedure 5	Procedure 6	Procedure 7	Procedure 8
Procedure 9	**Procedure 10**	**Procedure 11**	**Procedure 12**	**Procedure 13**	**Procedure 14**	**Procedure 15**	**Procedure 16**

MODIFIERS: Put modifier with procedure number in above box(es)

-22 unusual	-50 bilateral	-51 multiple	-52 reduced service	-53 discontinued
-54 surgery only	-55 postop mgmt only	-56 preop mgmt only	-58 staged / related	-59 distinct procedure
-62 two surgeons	-66 team	-78 repeat / same MD	-77 repeat / different MD	-78 return to OR
-79 unrelated / same MD	-82 asst surgeon, no resident available			

* **ATTENDING SURGEON:** [illegible] MD — **ASSISTANT:** C. Selander MD
CO-SURGEON: — **ANESTHESIA:** CRNA

* **SPECIMEN REMOVED:** ☐ None ☐ Yes, (specify) Lap packs (4 w/ 5)
RETAINED ITEM(S) TO BE REMOVED: ☒ N/A ☐ Lap packs (4 w/ 5) **DATE TO BE REMOVED:**
* **ESTIMATED BLOOD LOSS:** ☐ None ☒ Amount 1500 cc 8 800cc crystalloid 400 cc wu
COMPLICATIONS: ☐ No ☒ Yes, indicate Hypothermia 4 u PRBC
* **FINDINGS:** Cardiac GSW to chest, through the hepatic Se 3 bullet passed through

DICTATION JOB NUMBER: 6040068 Penetrating injuries to SMV & SMA through D3/4, through IVC

☒ I was present for the entire procedure.
☐ I was present for the key portions of the procedure and immediately available for the entire procedure.
☐ I was present for the key portions of the procedure and either I or Dr. _____ was immediately available for the entire procedure.
☐ Overlapping Procedures:
You must indicate what the Key Portions of the procedure were, and Dr. _____ was immediately available.
Key Portions:

As attending physician, I verify that this represents an accurate description of services rendered.

*Attending Signature [signature] Doctor # 72639 *Pager ID 14339 *Date 4/26/11 *Time 0500 AM/PM

intraop1

OTE 700194 Rev. 1/10

MUSC Health

INTRAOPNOTE

POST-PROCEDURE / OPERATIVE NOTE

Page 1 of 1

Form Origination Date: 1/00
Version: 8 Version Date: 1/10

P:495654253 DOB: [redacted] B M
GOODWIN
DAVON
Adm:04/26/11 M:2657049

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

ALL STARRED (*) ELEMENTS OF THIS FORM MUST BE COMPLETED

UMA Providers: To effectively track the clinic location where the patient originated from, check the following (other than MUSC Campus Clinics).
☐ Beaufort ☐ E. Cooper ☐ Florence ☐ Greenville ☐ N. Chas ☐ Trident ☐ W. Ashley ☐ Other:

PRE-OP DIAGNOSIS, POST-OP DIAGNOSIS AND PROCEDURE MUST BE WRITTEN OUT

* DATE: 4/27/11
* PRE-OP DIAGNOSIS: Acute abdomen
* POST-OP DIAGNOSIS: Same
* PROCEDURE: Laparoscopic lysis of adhesions, Appendectomy, Peritoneal lavage, Placement of abdominal drain

POST-OP DIAGNOSIS: ICD-9 Code (primary, then secondary), Placement of abdominal drain

1.	2.	3.	4.	5.

* CPT Code

Procedure 1	Procedure 2	Procedure 3	Procedure 4	Procedure 5	Procedure 6	Procedure 7	Procedure 8
Procedure 9	**Procedure 10**	**Procedure 11**	**Procedure 12**	**Procedure 13**	**Procedure 14**	**Procedure 15**	**Procedure 16**

MODIFIERS: Put modifier with procedure number in above box(es)

-22 unusual	-50 bilateral	-51 multiple	-52 reduced service	-53 discontinued
-54 surgery only	-55 postop mgmt only	-56 preop mgmt only	-58 staged / related	-59 distinct procedure
-62 two surgeons	-66 team	-76 repeat / same MD	-77 repeat / different MD	-78 return to OR
-79 unrelated / same MD	-82 asst surgeon, no resident available			

* ATTENDING SURGEON: Marcus ASSISTANT: Peace, Crosby
CO-SURGEON: _____ ANESTHESIA: CRNA
* SPECIMEN REMOVED: ☑ None ☐ Yes, (specify) _____
RETAINED ITEM(S) TO BE REMOVED: ☐ N/A ☑ Multiple Jackson Salomon DATE TO BE REMOVED: TBD
* ESTIMATED BLOOD LOSS: ☐ None ☑ Amount Minimal
COMPLICATIONS: ☑ No ☐ Yes, indicate _____
* FINDINGS: Bowel viable. Subhepatic on duodenum to hepatic flexure = base of mesocolon making 2 layer closure impossible. Area extensively dissected. Appendix not injured @ ileocecal junction.
DICTATION JOB NUMBER: 6040 339

☑ I was present for the entire procedure.
☐ I was present for the key portions of the procedure and immediately available for the entire procedure.
☐ I was present for the key portions of the procedure and either I or Dr. _____ was immediately available for the entire procedure.
☐ Overlapping Procedures:
You must indicate what the Key Portions of the procedure were, and Dr. _____ was immediately available.
Key Portions:

As attending physician, I verify that this represents an accurate description of services rendered.

*Attending Signature _____ Doctor # 10716 *Pager ID 14223 *Date 4/27/11 *Time 12:30 AM PM

intraop1

OTE 700194 Rev. 1/10