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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Common Pleas

Nate Fata, Special Referee

Lower Court Case No. 2016-CP-26-8032
Court of Appeals Case No. 2017-001817

DANIEL ERIC KNIGHT, Respondent,

v.

PHILLIP RAY CAUSEY, Appellant.

RECORD ON APPEAL

VOLUME 2 OF 4

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INDEX

ORDERS

Order of Default entered February 24, 2017 2
Order of Referral entered March 22, 2017 3
Order Granting Judgment (Damages Hearing) entered May 30, 2017 5
Order Denying Defendant's Motions entered August 3, 2017 10

JUDGMENTS

Nate Fata's Letter Rendering His Decision on Damages dated April 26, 2017 39

PLEADINGS

Notice of Appeal 41
Plaintiffs Summons and Complaint filed December 16, 2016 81

TRANSCRIPTS

Transcript of Damages Hearing April 18, 2017 90
Transcript of Motions Hearing June 29, 2017 139

MOTIONS

Affidavit of Default as to Defendant Phillip Ray Causey filed February 14, 2017 321
Motion for Default Judgment and Certificate of Service filed February 16, 2017 323
Notice of Motion and Motion for Referral to Special Referee filed March 2, 2017 327
Defendant's Motion to Set Aside Default filed April 25, 2017 331

POST-JUDGMENT MOTIONS

Defendant's Post Judgment Motions and Memorandum in Support filed June 08, 2017 332
Defendant's Motion for Relief from Judgment Pursuant to SCRCP 60 filed June 13, 2017 345

EXHIBITS AND OTHER MATERIALS

Plaintiff's Exhibit 15 — Damages Hearing 347
Plaintiff's Exhibit 19 — Damages Hearing 417
Nate Fata's Letter Setting Hearing on Defendant's Motion to Set Aside Default for June 2, 2017 dated May 16, 2017 1573
Nate Fata's Email Agreeing to Reschedule Motion to Set Aside Default Hearing to June 13, 2017 dated May 18, 2017 1574
Defendant's Exhibit 1 - Motions Hearing 1577
Affidavit of Phillip Ray Causey filed June 22, 2017 1578
Affidavit of Shawana Palsey-Shaw (filed June 29, 2017 1584

MEDICAL RECORDS
Daniel Eric Knight

1	Horry County Fire Rescue
2	Conway Medical Center – *includes Conway ER Physicians, Carolina Radiology, Clinical Pathology Consultants, Hospital Physicians Services, Conway CRNA Anesthesia Services, and Conway Anesthesia records*
3	CPG Internal Medicine
4	Associates in Surgery – *includes Byrum Healthcare Center records, Conway Medical Center labs drawn on 06/08/2016*
5	Amedisys Home Health of Conway

Horry County Fire Rescue

Horry County Fire Rescue

Patient Care Record

Name: KNIGHT, DANIEL **Incident #:** FR160427017495 **Date:** 04/27/2016 Patient 1 of 1

Patient Information			
Last	KNIGHT	Address	206 ECUM SCUM
First	DANIEL	Address 2	
Middle	ERIC	City	CONWAY
Gender	Male	State	
DOB	[redacted]	Zip	29527
Age		Country	UNITED STATES
Weight	200lbs - 91kg	Tel	(830)719-5830
Pedi Color		Physician	
SSN	[redacted]	Ethnicity	
Race	White		
Advanced Directive			
Resident Status		Resident	

Clinical Impression			
Primary Impression	Traumatic injury		
Secondary Impression			
Protocol Used	Universal Patient Care		
Anatomic Position			
Chief Complaint	PELVIC PAIN		
Duration	15	Units	Minutes
Secondary Complaint			
Duration		Units	
Patient's Level of Distress			
Signs & Symptoms	Contusion - Multiple Sites		
Injury	- - -		
Medical/Trauma	Trauma		
Barriers of Care	None		
Alcohol/Drugs	Unknown		

Medication/Allergies/History	
Medications	Prozac
Allergies	Penicillin,Sulfa
History	Denies

Vital Signs

Time	AVPU	Side	POS	BP	Pulse	RR	SPO2	ETCO2	CO	BG	Temp	Pain	GCS(E+V+M)/Qualifier	RTS	PTS
17:36	A	L	Sit	130/ P	100 R	20 R						2	15=4+5+6	12	
17:46	A	L	Sit	130/82 M	84 R	16 R	98					2	15=4+5+6	12	
17:51	A	L	Sit	130/88 A	88 R	18 R	99					2	15=4+5+6	12	
18:00	A	L	Sit	117/65 A	88 R	16 R	99			82		4	15=4+5+6	12	
18:10	A	L	Sit	127/62 A	82 R	16 R	98					4	15=4+5+6	12	
18:20	A	L	Sit	118/74 A	88 R	16 R	99					4	15=4+5+6	12	

ECG

Time	3-Lead ECG	12-Lead ECG
18:00	Sinus Rhythm	
18:10	Sinus Rhythm	
18:20	Sinus Rhythm	

Flow Chart

Time	Treatment	Description	Provider
17:33	ALS Assessment	Patient Response: Improved;	Mottola, Kimberly
17:36	Spinal Immobilization	Cervical Collar; Patient Response: Improved;	Mottola, Kimberly
17:44	Spinal Immobilization	Long Spine Board; Comments REFUSED AFTER PLACED ON IT AND INTO UNIT. HAD TO REMOVE IT DUE TO PT NOT ABLE TO HANDLE DISCOMFORT. removed at 1748pm; Patient Response: Improved;	Mottola, Kimberly
17:49	Oxygen	NC; Flow Rate 3 lpm; Patient Response: Improved;	Mottola, Kimberly
17:54	3-Lead ECG	Comments nsr; Patient Response: Improved;	Mottola, Kimberly
18:00	IV Therapy	18 ga; Forearm-Left; Normal Saline; Total Fluid 10; Patient Response: Improved; Successful;	Mottola, Kimberly
18:05	BLS Assessment	Comments BGL=82; Patient Response: Improved;	Mottola, Kimberly

Initial Assessment

Category	Comments	Abnormalities		
Mental Status		Mental Status		No Abnormalities
Skin		Skin		No Abnormalities
HEENT		Head/Face		No Abnormalities
		Eyes		No Abnormalities
		Neck		No Abnormalities
Chest		Chest		No Abnormalities
		Heart Sounds		No Abnormalities
		Lung Sounds	⊕	LL: Clear, RL: Clear, RU: Clear
Abdomen		General		Not Assessed
		Left Upper		No Abnormalities

Abdomen		Right Upper		No Abnormalities
		Left Lower	⊕	Tenderness
		Right Lower	⊕	Tenderness
Back		Cervical		No Abnormalities
		Thoracic		No Abnormalities
		Lumbar/Sacral		No Abnormalities
Pelvis/GU/GI		Pelvis/GU/GI	⊕	Tenderness
Extremities	abrasion to rgt hand, and shin and knee	Left Arm		No Abnormalities
		Right Arm	⊕	Other
		Left Leg	⊕	Other
		Right Leg	⊕	Other
		Pulse	⊕	Radial: 3+ Bounding
		Capillary Refill	⊕	Left Upper: < 2 Sec, Right Upper: < 2 Sec
Neurological		Neurological		Not Assessed

Assessment Time: **4/27/2016 5:33:00 PM**

Narrative

RESPONDED TO MVA WITH ENTRAPMENT. U/A FOUND 3 CAR MVA WITH SEVERE DAMAGE TO 2 OF THE VECHICLES. PT WAS SITTING IN HIS CAR WITH FRONT END GONE AND ALL AIRBAGS EXSPOSED. PT CAOX3, SKIN W+D, LUNGS CLEAR. BLOOD NOTED ON NOSE. NO ENTRAPMENT, DOOR ABLE TO BE PULLED OUT OF THE WAY. PT C/O RGT HIP PELVIC PAIN, ABDOMEN TENDER ON PALP. SEATBELT MARKS NOTED ON LEFT SHOULDER AND RGT HIP. PT DENIES LOC, STATED THAT HE DID GET A LIL LIGHTHEADED A FEW TIMES BUT NEVER PASSED OUT. PT C SPINE OBTAINED AND THEN PLACED ON LSB AND IN TO UNIT. ONCE IN UNIT PRIOR TO LEAVING SCENE PT STATED THAT HE CANT HANDLE THE LSB, THAT IT WAS CAUSING MORE PAIN THAN WHAT HE WAS IN AND HE COULDNT RIDE THAT FAR ON IT. HE WAS EXSPLAINED THAT HE COULD REFUSE IT AND HE DID. AT THAT POINT PT SAT UPRIGHT AND STOOD SLIGHTLY AND LSB WAS REMOVED AND SAT RIGHT BACK DOWN. PT STATED THAT WAS BETTER. PT 2'EXAM NOTED PAIN AND TENDERNESS IN HIP LOWER ABDOMEN AND PEVLIS AREA. BUT ABLE TO MOVE LOWER EXTREMITIES WITH PAIN. ALSO NOTED SKIN ABRASIONS ON RGT SHIN, RGT KNEE, RGT HAND, AND CONTUSIONS ALSO TO RGT AND LEFT KNEES. PT TX WELL, IV ESTB, BP REMAINED STABLE, NO OTHER INJURIES FOUND. PT REMAINED CAOX3, SKIN W+D, LUNGS C+= BILAT, PUPILS = + REACTIVE. NO DEFORMITY NOTED. PT TX AS LEVEL 2 TO CONWAY ER FOR FURTHER EVAL.

INCIDENT STORY THAT HAPPENED WAS A TIRE CAME OFF OF A TRUCK AND SWERVED INTO HIS LANE AND HIT HIM CAUSED HIM TO HIT ANOTHER CAR (ENVOY) HEAD ON, CAUSING SEVER DAMAGE TO BOTH VECHICLES. DRIVER OF TRUCK WAVIERED. E6 OBTAINED WAVIER.

Specialty Patient - Motor Vehicle Collision

Patient Injured	Yes	Law Enforcement Case #	
Vehicle Type	Automobile	Collision Indicators	Dash Deformity,Intrusion > 12",Side Post Deformity,Steering Wheel Deformity,Windshield Spider/Star
Position In Vehicle	Driver	Damage Location	
Seat Row	1	Airbag Deployment	0
Weather	Clear	Safety Devices	Lap Belt,Other,Shoulder Belt
Extrication Required	No	Extrication Comments	
Estimated Speed	50mph\ 80 kph	Extrication Time	

Specialty Patient - Trauma Criteria

Anatomic	Pelvic Fracture	Trauma Activation	YES
Physiologic	None	Time	17:45:00
Mechanical	Intrusion > 18" (any), Intrusion>12" (occupant)	Date	04/27/2016
Other Conditions	None	Trauma level	Level 2
		Reason not Activated	

Incident Details		Destination Details		Incident Times	
Location		Disposition	Transported Lights/Siren	PSAP Call	17:20:14
Address	S HWY 701	Transport Due To	Patient	Dispatch Notified	17:21:19
Address 2		Transported To	Conway Hospital	Call Received	17:20:14
		Requested By	Other	Dispatched	17:23:15
City	Loris	Destination	Hospital ER	En Route	17:23:23
State	SC			Resp on Scene	
Zip	29569	Address	300 SINGLETON RIDGE	On Scene	17:28:55
Medic Unit	M25	Address 2		At Patient	17:29:00
Run Type	911 Response (Emergency)	City	Conway		
Priority Scene	Lights/Sirens	State	SC	Depart Scene	17:50:04
Shift	A Shift	Zip	29526	At Destination	18:24:06
Zone		Zone		Pt.Transferred	
Level of Service		Condition at Destination	Improved	Call Closed	19:00:00
EMD Complaint		Destination Record #		In District	
EMD Card Number		Trauma Registry ID			

Crew Members

Personnel	Role	Certification Level
Mottola, Kimberly	Lead	EMT-Paramedic-SC009626;
Hardwick, Bernie	Driver	EMT-Basic-SC010603;

[redacted]

Mileage		Delays		Additional Agencies
Scene	1.0	Category	Delays	Loris Fire Department
Destination	26.2			
Loaded Miles	25.2			
Start				
End				
Total Miles	0.0			

Next of Kin

Next of Kin Name	elizabeth knight	Address1	206 ECUM SCUM	City	CONWAY
Relationship to Patient	Spouse	Address2		State	
Phone		Address3		Zip	29527
				Country	UNITED STATES

Personal Items

Item	Given To	Comment
Cell Phone/Pager	PT	REMAINED WITH PT

Transfer Details

PAN		Sending Physician	
PCS		Sending Record #	
ABN		Receiving Physician	
CMS Service Level		Condition Code	
ICD-9 Code		Condition Code Modifier	
Transfer Reason			
Other/Services			
Medical Necessity			

Billing Authorization

Language	en

[redacted]

Conway Medical Center

ADMISSION RE D CO HOSPITAL AY, S.C. MEDIC/ ECORDS COPY

Unit #	Patient	Admit Date and Time	Location/Room	Visit #
M000175313	KNIGHT,DANIEL ERIC 206 ECUM CECUM DRIVE CONWAY,SC 29527 (330)719-5830	05/15/16 1103	SURE SUR232-1	V6912886
		Discharge Date and Time	Previous Admission/Visit 04/16	PTP IN / MSV ME / F/C CO
Maiden Name	Patient SS #	Physician: Rimkus, Gilbertas MD		
Sex: M / Race: CA / Marital: M	Religion: NONE	Patient Mothers Name: BETZ, ROSEMARIE		

[redacted]

Admitting Diagnosis	Healthcare Power of Attorney	Living Will
INTESTINAL PERFORATION PERITONITIS		

How Arrived	Date, Time, Place of Accident	LMD	Smoking Cessation Materials Provided.	Proration

Surgeon		Consultant

Principal Diagnosis

Secondary Diagnosis

Complications

Operations

Hospital Infections

Results of Discharge	Recovered	Improved	Not Improved	Not Treated	In For Diagnosis	Expired

MTADIN04

CASE MGT/SOCIAL WORK SVS NOTES

Occurred Date	Time	by	Author	Recorded Date	Time	by
05/18/16	1510	WC	CHICKERING,WESLYN	05/18/16	1511	WC

Abnormal? N Confidential? N

MET WITH SPOUSE- WILL CONTINUE TO FOLLOW.

05/23/16	0849	JB	BURLESON,GLORIA JEAN	05/23/16	0850	JB

Abnormal? N Confidential? N

DISCHARGE PLANNING DISCUSSED WITH PATIENT. OSTOMY NURSE IS FOLLOWING. PATIENT IS UNSURE IF HE WANTS HOME HEALTH TO FOLLOW HIM AT DISCHARGE.

05/25/16	1200	JB	BURLESON,GLORIA JEAN	05/25/16	1200	JB

Abnormal? N Confidential? N

WOUND VACC ORDER HAS BEEN PLACED. AWAITING MD SIGNATURE. REFERRAL TO AMEDISYS HOME HEALTH PER PATIENT'S CHOICE.

05/25/16	1546	JB	BURLESON,GLORIA JEAN	05/25/16	1546	JB

Abnormal? N Confidential? N

SIGNED WOUND VACC ORDER FAXED TO KCI

05/26/16	1358	JB	BURLESON,GLORIA JEAN	05/26/16	1358	JB

Abnormal? N Confidential? N

KCI HAS APPROVED HOME WOUND VACC. WILL BE PLACED DAY OF DISCHARGE.

05/27/16	1251	JB	BURLESON,GLORIA JEAN	05/27/16	1254	JB

Abnormal? N Confidential? N

HOME WOUND VACC PLACED IN PATIENT'S ROOM FOR APPLICATION AT DISCHARGE.

CM DISCHARGE PLAN

Patient: KNIGHT,DANIEL ERIC [redacted]
Account #: V00006912886 Unit #: M000175313
Admit Date: 05/15/16 Location: SURE
Status: DIS IN Room/Bed: SUR232-1
Attending: Rimkus, Gilbertas MD

CASE MANAGEMENT - Discharge Plan

D/C Date 05/29/16 DISCHARGE DISPOSITION: H DC Dispostion Status: N
PCP

SPECIFIC DISCHARGE DISPOSITION LOCATION:

SUB ACUTE REHAB	ALF	HOSPICE
HHS	ACUTE REHAB	
AMEDISYS		
PSYCHIATRIC:	DSS	DME
LTAC	NH - LONG TERM CARE	DME - Ordered Equipment:
	CLTC	:

HANDOUTS GIVEN:

Community Clinics	Long Term Care	Home Care	Transportation
Resource Directory	Social Security	Rx Assist	
Substance Abuse	Homelessness	RCF	Advance Directives

Other:

~~~~~~REFERRALS WERE MADE FOR THE FOLLOWING AGENCIES:~~~~~~

ALF (Assisted Living Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

SNF (Skilled Nursing Facility)
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

HOSPICE
TO FACILITY: Referral status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

ACUTE REHAB REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

HHS (Home Health Services) Y
TO AGENCY: AMEDISYS Referral Status: N
TO AGENCY: Referral Status:
TO AGENCY: Referral Status:

5A4D43B46E10429588C8, KNIGHT, 7
~~~~~~

CM DISCHARGE PLAN

Patient: KNIGHT,DANIEL ERIC
Account #: V00006912886
Admit Date: 05/15/16
Status: DIS IN
Attending: Rimkus, Gilbertas MD

[redacted]
Unit #: M000175313
Location: SURE
Room/Bed: SUR232-1

TO AGENCY: Referral Status:

NH-LTC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

CLTC (Community Long Term Care) Referral Status:
DSS REFERRAL:
TO WHICH SERVICE: Referral Status:

DME REFERRAL:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:
:

TO PROVIDER: Referral Status: Equipment ordered:

PSYCHIATRIC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

TRANSITIONAL CARE: Follow up Appointment:
Contact Date: Physician: Date: Time:
Contact Time: Physician: Date: Time:
Physician: Date: Time:

Follow up appointment scheduled prior to D/C.
Follow up appointment scheduled post D/C.

New Primary Care Provider Established. New Primary Care Provider:
Comments: PATIENT WAS DISCHARGED HOME WITH HIS WIFE. HE WAS DISCHARGED WITH WOUND VACC AND WILL BE FOLLOWED BY AMEDISYS HOME HEALTH.

CM DISCHARGE PLAN

Patient: KNIGHT,DANIEL ERIC [redacted]
Account #: V00006912886 Unit #: M000175313
Admit Date: 05/15/16 Location: SURE
Status: DIS IN Room/Bed: SUR232-1
Attending: Rimkus, Gilbertas MD

Occurred Date: 05/30/16 Occurred Time: 0720
Monogram: JB Initials: JBURLESON Name: BURLESON,GLORIA JEAN Nurse Type: RN

ANS-281-FRM
REV 2 01.22.16

Conway Medical Center
Conway, South Carolina

V00006912886
KNIGHT,DANIEL ERIC
CA M
[redacted]
CONWAY EMERGENCY GROUP
M000175313

Consent for Anesthesia Services

I consent to the anesthesia checked above and authorize that it be administered by a member of Conway Anesthesia Associates and/or a member of Conway Hospital Anesthesia Professional Services. I consent to an appropriate, alternate type of anesthesia, if necessary. By signing below, I certify that I have had an opportunity to ask the provider all my questions concerning risks, alternatives, and expected results of the anesthesia and had all questions answered to my satisfaction.

X _____ 5/15/16 0820 Self
(Patient or authorized person) **(Date)** **(Time)** **(Relationship if authorized person)**

_____ _____ _____ _____
(Witness) **(Date)** **(Time)** **(Reason for signature (if other than patient)**
No witness required if patient signature obtained by provider

An interpreter or other special assistance was used to assist patient in completing this form as follows:
☐ Foreign Language (specify) _____ ☐ Sign Language ☐ Patient is blind, form read to patient
☐ Other: (specify) _____
(name of interpreter or service)

CERTIFICATION OF ANESTHESIA PROVIDER:

I hereby certify that I have discussed with the individual granting consent, the anesthesia plan, risks, alternatives, and expected results of the anesthesia.

_____ 5/15/16 0820
Signature of Physician / CRNA **Date** **Time**

Transfusion Consent

I understand there are potential risks from blood transfusion including, but not limited to, transfusion reaction, hepatitis, and HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome).
I do PR _____ or do not _____ give consent to the use of blood and/or blood products as deemed necessary
Patient/ PR Initials **Patient/ PR Initials**
during this operation/procedure.

(Refusal requires completion and signature of form #28 "Refusal to Receive Blood Transfusion")

Patient acknowledgement of Anesthesia providers on day of service

I acknowledge that _____ or his/her privileged associate will provide my anesthesia.

_____ _____ _____ _____
(Patient or authorized person) (Date) (Time) (Relationship if authorized person)

ANS-281-FRM
REV 2 01.22.16

Conway Medical Center

Conway, South Carolina

V00006912886
KNIGHT,DANIEL ERIC
CA M
[redacted]
CONWAY EMERGENCY GROUP
M000175313

Consent for Anesthesia Services

I _____, acknowledge that I will have an operation, diagnostic/treatment procedure or planned vaginal delivery. I understand that anesthesia services may be needed/requested.

It has been explained to me that there are **risks** for any anesthesia planned and that no promises or guarantees can be made. Although rare, unexpected severe complications with anesthesia can occur including a remote possibility of *infection, bleeding, drug reaction, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, or death.* With present anesthesia practices these complications are extremely rare and risk may vary with my general medical health. I understand these risks apply to all forms of anesthesia and that additional or specific risks have been identified below.

I understand that the type(s) of anesthesia checked below will be used for my procedure and that the planned anesthesia is determined by many factors including my physical condition, the type of procedure and the physician's preference as well as my own desire. I understand that the planned anesthesia may not succeed completely and another technique may have to be used.

☑ General Anesthesia ☐ TIVA	Expected Result	Total unconscious state, possible placement of a tube into the windpipe
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia
☐ Spinal or Epidural Analgesia/ Anesthesia ☐ With sedation ☐ Without sedation	Expected result	Temporary decrease or loss of feeling and/or movement to lower part of body
	Technique	Drug injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal
	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, "total spinal"
☐ Major/Minor Nerve Block ☐ With sedation	Expected result	Temporary loss of feeling and /or movement of a specific limb or area of the body
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
☐ Intravenous Regional Anesthesia ☐ With sedation	Expected result	Temporary loss of feeling and/or movement of a limb
	Technique	Drug injected into veins of arm or leg while using a tourniquet
	Risks	Infection, convulsions, persistent numbness, residual pain, injury to blood vessels
☐ Monitored Anesthesia Care (with sedation)	Expected result	Reduced anxiety and pain, partial or total amnesia
	Technique	Drug injected into the bloodstream, breathed into the lungs, or administered by other routes producing a semi-conscious state
	Risks	An unconscious state, depressed breathing, injury to blood vessels
☐ Monitored Anesthesia Care (without sedation)	Expected result	Measurement of vital signs, availability of anesthesia provider for further intervention
	Technique	None
	Risks	Increased awareness, anxiety and/or discomfort

HIM-2574-FRM
REV 0 10.26.15

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006912886
M000175313
[redacted]

05/15/16

Adult Healthcare Consent Act
Emergency Department

The "Adult Healthcare Consent Act" takes effect on January 1, 2014. S.117 amends the Adult Healthcare Consent Act to require a provider to include on the patient information form an opportunity for the patient to designate an individual with whom the provider may discuss the patient's medical condition and treatment.

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

IF YES, WHOM?

Elizabeth Knight Spouse
Name of Individual

330-717-0532
Contact Number(s) (if available)

Patient Unable to Sign

IF NO,

☐ **I DO NOT WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL**

Important Right and Other Required Statements You Should Know

You can revoke this authorization at any time by writing to the Health Information Management department at Conway Medical Center at any time. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting the Health Information Management department at Conway Medical Center.

Elizabeth Knight
Signature of Individual

5-15-16
Date

HIM-465-FRM
REV 1 01.08.15

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC
V00006912886
M000175313
[redacted]
05/15/16

Patient Acknowledgement Form

Instructions: The patient or the patient's representative must acknowledge in the spaces provided the receipt of information regarding the following regulatory requirements:

HOSPITAL INFECTIONS DISCLOSURE ACT:

☑ I have been informed that all hospital infections are submitted to DHEC through the Centers for Disease Control (CDC) and National Healthcare Safety Network (NHSN). Upon request I will be provided with the appropriate information related to this subject matter. (Form 4050)

LEWIS BLACKMAN ACT INFORMATION SHEET:

☐ I acknowledge that I have received an informational sheet regarding the Lewis Blackman Act.

HEARING IMPAIRMENT / LIMITED ENGLISH ASSISTANCE:

☐ I understand that if I and/or my companion (family member, significant other, friend, driver, etc.) need assistance communicating with CMC staff, CMC will provide assistance at no charge.

PATIENT RIGHTS AND RESPONSIBILITIES:

☐ I acknowledge that I have received a copy of the Patient Rights and Responsibilities.

Patient or Patient Representative Signature

5.15.16
Date

ED-163-FRM
REV 2 10.02.14

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL ERIC [redacted]
V00006912886
M000175313
05/15/16

PATIENT INFORMATION FORM

In order to serve you in a more efficient manner, we ask that you provide us with the following information: PLEASE PRINT CLEARLY

Have you recently traveled out of the country? ☐ Yes ☑ No

Have you ever been to Conway Medical Center before? ☑ Yes ☐ No

Main reason for being here today? GI Pain

Patient Name: Knight (Last Name) Daniel (First Name) E (Middle Initial)

Current Mailing Address: 204 Quin Recm 07

Conway (City) SC (State) 29527 (Zip Code)

(843) 716 5830 (Area Code / Home Phone) ( ) [redacted] (Area Code / Work Phone)

[redacted]

( ) (Area Code / Mobile Number)

Do you or your companion (family member, significant other, friend, driver, etc.) need assistance communicating with CMC staff due to a hearing impairment or difficulty speaking English?

☐ Yes ☐ No

(There is no charge for assistance)

PLEASE RETURN THIS FORM TO THE NURSE'S DESK.

THANK YOU.

P.O. Box 829 . 300 SINGLETON RIDGE ROAD . CONWAY, S.C. 29526 (843) 347-7111

SA\AW ASW Risk Management

RSK-02-FRM
Rev 3 11.26.12

Conway Medical Center
Conway, South Carolina

KNIGHT,DANIEL E[redacted]
V00006912886
M000175313

05/15/16

Consent to Operation and Other Medical Services

I, Daniel Knight, hereby authorize Dr. Rimkus and any
(name of patient)
associates or assistants the doctor deems appropriate, to perform: Laparoscopic exploration
(Description of operation/procedure in laymen's language)
of the abdomen, possible umbilical
hernia of the intestine, possible ostomy bag

The doctor has explained the benefits of the procedure(s) to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s).

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, but not limited to, blood loss, transfusion reactions, infections, heart complications, blood clots, loss of or loss of use of body part, damage to teeth, other neurological injury or death.

I understand that during the course of the operation/procedure, unforeseen conditions may occur or be revealed that may necessitate change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I hereby authorize and request that the above-named physician and/or his associates, partners, assistants or designees perform such procedures as are necessary and desirable in the exercise of his/her professional judgment.

The doctor has explained to me the reasonable alternative(s) to the procedure(s).

I hereby authorize the doctor or hospital personnel to utilize, dispose of, or store for future testing (as ordered by your physician) removed tissues, parts or organs resulting from the procedure(s) authorized above.

I consent to any photographing or video recording of the procedure(s) that may be performed as may be necessary and appropriate for the procedure(s) and do permit such photographs/video.

I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining/providing important product information.

APPLIES TO DNR PATIENTS ONLY

I have an Advance Directive, Living Will, and/or Do Not Resuscitate Order.

I choose to suspend my Advance Directive, Living Will, and/or Do Not Resuscitate Order during my procedure or recovery from anesthesia/sedation ☐ Yes ☐ No

If No, contact physician performing the procedure prior to completing the consent

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

X [signature] 5/15/16 0820 Self

(Patient or authorized person) (Date) (Time) (Relationship if authorized person)

_____ / / _____

(Witness) (Date) (Time) Reason for signature (if other than patient)

No witness required if patient signature obtained by provider

An interpreter or other special assistance was used to assist patient in completing this form as follows:

☐ Foreign Language (specify) _____ ☐ Sign Language ☐ Patient is blind, form read to patient

☐ Other: (specify) _____ _____

(name of interpreter or service)

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the nature of the procedure(s), anticipated benefits, material risks, alternative therapies and the risks associated with the alternative of the procedure(s).

[signature] 5/15/16 8:20 AM

Signature of Physician Date Time

ADM-5172-FRM REV 3 _0.27.15

CONWAY MEDIC_ CENTER
CONWAY S.C.

Unit #	Patient	Admit Date and Time	Location/Room	Visit #		
	KNIGHT,DANIEL ERIC V00006912886 M000175313 [redacted]	Discharge Date and Time	Previous Admission/Visit	PTP	MSV	F/C
Maiden Name		Physician				
Sex / Race / Marital / Age	05/15/16	Patient Mother's Name				

CONWA_ _AL CENTER
CONSENT AND CONDITIONS OF ADMISSION AND GUARANTY

In consideration for the medical care to be provided to the patient by Conway Hospital, Inc. d/b/a Conway Medical Center ("The Hospital"), the undersigned patient, guarantor, and/or responsible party (individually and collectively hereinafter referred to as the "undersigned") hereby consent to the following conditions of treatment and admissions:

1) CONSENT FOR TREATMENT: The undersigned authorizes and consents to the admission of the patient and all medical care, treatment, services, examinations, tests and procedures, which may be performed during this hospitalization or outpatient treatment including but not limited to surgery, x-ray examination, laboratory tests, diagnostic procedures, and anesthesia, which a Physician, the Hospital, their employees, nurses, associates, assistants or assignee deem advisable to the patient. The undersigned further agrees that no guaranty has been made to the undersigned about the outcome of the care and treatment during this admission/service.

2) HOSPITAL AND PHYSICIAN: The undersigned agrees that some Physicians and the like which are providing medical care or services to the patient are not employees or agents of the Hospital or its subsidiaries, and the undersigned agrees that the Hospital is not responsible or liable for the acts or omissions of non-Hospital employees. Further, the undersigned agrees there will be a separate charge for professional services including the professional component of clinical laboratory tests, but understands that the Hospital may bill for some professional fees.

3) PAYMENT GUARANTEE: The undersigned agrees and guarantees to pay all Hospital charges to the Hospital in accordance with the regular rates and terms of the Hospital, and agrees to pay for any balance and all charges not covered by a third party payer. The Hospital files insurance as a courtesy and the undersigned is ultimately responsible for payment of the total incurred charges. The undersigned agrees that if this account is not paid timely, it may be turned over to a collection agency or attorney, and in such circumstances, the undersigned, shall be obligated to pay the amount due plus all costs of collection including reasonable attorneys fees. The undersigned agrees that overpayment collected on this account may be applied directly to any past delinquent account(s) of the patient. The undersigned patient, responsible party and guarantor, if any, hereby agrees that they are jointly and severally liable to pay the Hospital for any and all charges, any balance due and costs associated with this treatment and/or admission.

4) ASSIGNMENT OF INSURANCE BENEFITS AND THIRD PARTY CLAIMS: The undersigned hereby assigns unto the Hospital any and all rights and benefits the undersigned patient or responsible party may have under any policy of insurance (hospitalization, major medical, automobile, workers compensation, or third party liability insurance), and further directs any such insurance company to make payment of benefits directly to the Hospital or its attorney. In the event that the undersigned is entitled to any insurance or benefits covering physician services, the undersigned hereby assigns said benefits to the physicians rendering care, treatment, or service to be applied to patient's and/or the undersigned's bill. If the patient's treatment is as a result of any accident and the patient has a claim against a third party, the Hospital has the option to pursue the automobile coverage or third party liability proceeds as a primary source of payment. If the Hospital exercises this option, the patient and/or responsible party agree to assign the proceeds of any settlement or recovery in the accident claim toward the payment of any outstanding Hospital charges. This authorization is irrevocable by the undersigned.

5) AUTHORIZATION FOR RELEASE OF INFORMATION AND INSURANCE BENEFITS: The undersigned patient and or responsible party authorizes the Hospital to contact the undersigned's insurance company and its agents, the undersigned's employer or other third party payer including the patient's spouse, if applicable, to verify insurance or hospital coverage, to discuss all medical and financial information pertaining to the admission/service that may be required in processing or collecting on this claim. The undersigned authorizes and acknowledges that all medical and financial records will be accessible to all health care providers participating in the patient's care or treatment and acknowledges that patient medical records at the Hospital are stored electronically and are made available through computer networks to Hospital personnel, physicians and those health care providers involved in the patient's care. The undersigned further authorizes the Hospital, its collection agency, or attorney to obtain and review, at any time, the credit report of the patient, guarantor, and/or responsible party.

6) CHAMPUS/CHAMPVA CERTIFICATION: The undersigned requests payment of authorized benefits to the patient or on patient's behalf for medical treatment and services from the Hospital including physician services, and authorizes any holder of medical information regarding the patient to release to CHAMPUS and its agents any information needed to determine these benefits or benefits for related services.

7) MEDICARE PATIENT CERTIFICATION: The undersigned certifies that information given by the undersigned in applying for payment under the Medicare Program is correct. The undersigned hereby authorizes any holder of medical or other information about the patient to release to the Social Security Administration, its intermediaries, or carriers any information needed for this or a related Medicare claim. The undersigned authorizes the payment of the patient's benefits to the Hospital.

8) AUTHORIZATION TO CONTACT
I agree by providing you my contact information, I authorize you and your associates to contact me at those numbers. This applies to any landline or cell phone number(s) I have provided you. I understand you may contact me by sending text messages or emails, using any email address I provided. I may be contacted by a prerecorded/artificial voice message or an automatic dialing device. I understand providing my phone number(s) is not a condition of receiving services.

Daniel Knight — Patient

Elizabeth Knight Spouse — Patient's Agent/Guardian/Guarantor/Relationship — 5-15-16 Date

Cindy Barnhill — Witness

5-15-16 Date

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Ali Mansour, MD

CONSULTATION

DATE OF CONSULTATION:
05/15/2016

REFERRING PHYSICIAN:
Dr. Rimkus

REASON FOR EVALUATION:
Respiratory failure.

HISTORY:
This is a 41-year-old gentleman presenting for evaluation of abdominal pain worsening. Patient was evaluated and was found to have thickening wall, peritoneal fluid, and peritoneal gas. Patient was concerned for bowel obstruction. The patient was taken to the OR where resection of bowel and colostomy diversion was done. Currently, the patient, during his hospital stay, starting requiring more oxygen requirements. No cough. No fever. No chills. No other complaints.

PAST MEDICAL HISTORY:
Anxiety.
Recent bowel surgery for trauma.

PAST SURGICAL HISTORY:
Recent bowel surgery for trauma.

ALLERGIES:
SULFA.
PENICILLIN.

MEDICATION:
Prozac.

SOCIAL HISTORY:
Nonsmoker, no alcohol or drug abuse.

REVIEW OF SYSTEMS:
Negative 10-point review of systems.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure is 120/70, pulse is 110 sinus tach, respirations 22, T-max is 98, sats are 96% on 50% FIO2.

HEENT: Moist mucous membranes. Normal and round pupils.

NECK: No JVD. Normal cervical motion.

LUNGS: Clear to auscultation.

CARDIOVASCULAR: Regular rate and rhythm.

GASTROINTESTINAL: Soft.

LYMPHATIC SYSTEM: No edema.

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Ali Mansour, MD

CONSULTATION

NEUROLOGIC: Grossly intact.

INVESTIGATION:
ABG done this morning showed pH 7.4, pCO2 of 51, pO2 of 60. Sodium is 142, potassium 3.6, chloride 102, CO2 of 30, BUN 12, creatinine 1.1. LFTs are within normal limits. ALT slightly elevated at 72. INR is 1.4. Lactic acid 0.9. White count is 5, hemoglobin 11, hematocrit 32, platelets 230.

IMAGING:
Bilateral fluffy infiltrates involving both lungs, concerning for acute lung injury.

ASSESSMENT AND PLAN:
1. Respiratory failure, on mechanical ventilation and high-flow mask. We will switch to high-flow nasal cannula and follow clinically.
2. Acute lung injury, most likely caused post trauma. Patient will be started on low-dose steroids and follow clinically. I recommend incentive spiro. We will hold off antibiotics since all blood cultures and culturing have been negative.
3. Bowel perforation, status post surgery, improving.
4. Gastrointestinal/deep venous thrombosis prophylaxis.
5. Anxiety. Held on Prozac.

Thank you for the consult. We will follow closely.

Ali Mansour, MD Date/Time

cc: Ali Mansour, MD
AYM/4101726
DD: 05/18/2016 12:14
DT: 05/18/2016 12:46
LM File#: 201605180000043948
Job #: 4101726

Electronically Signed By:
MANSOUR,ALI MD,
May 19 2016 10:46AM

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Kenneth Santiago, MD

CONSULTATION

DATE OF CONSULTATION:
05/15/2016

REFERRING PHYSICIAN:
Dr. Rimkus from Surgery.

REASON FOR CONSULTATION:
Hypertension after surgical procedure.

HISTORY OF PRESENT ILLNESS:
This is a 41-year-old male who has a history of a motor vehicle accident 2 weeks ago. Patient went to the emergency room under trauma for evaluation where he had a CAT scan of the head, chest, and abdomen without any problems. Patient was discharged home. During the last 3 weeks the patient had been having some discomfort on the abdominal area and not eating much and not drinking much fluid. Patient went back to the emergency room secondary to severe abdominal pain. He had a CT of the abdomen that showed apparent perforated viscus with ischemic bowel. Patient was brought into the operating room where he had a resection of small bowel and ileostomy secondary to perforated terminal ileum and peritonitis. Patient was placed on aggressive IV antibiotics and transferred to the ICU for close monitoring. The patient's blood pressure during the surgery was low and he required some albumin, and also lots of fluids. Patient was admitted to the ICU.

At this time the patient is having abdominal pain. Blood pressure in the 70s systolic but his MAP had been 68. He is lethargic but oriented x3.

PAST MEDICAL HISTORY:
Anxiety.

PAST SURGICAL HISTORY:
Unremarkable.

ALLERGIES:
To SULFA and PENICILLIN.

MEDICATION:
Medication at this time includes ertapenem 1 g IV daily.
Fluconazole daily.
Hydromorphone 0.5 mg IV every 2 hours p.r.n. severe pain.
Morphine every 4 hours p.r.n. moderate pain.
Zofran p.r.n. nausea.
Pantoprazole 40 mg IV at bedtime.
Promethazine p.r.n. nausea.
Simethicone p.r.n. gas.

SOCIAL HISTORY:
No smoking or alcohol abuse. Patient lives at home.

FAMILY HISTORY:
Nobody else with abdominal pain or significant abdominal issues.

REVIEW OF SYSTEMS:

CONSULTATION

Difficult to obtain as the patient is lethargic post-surgery and uncomfortable. Patient has an ileostomy now. Positive for nausea. No vomiting. Positive for abdominal pain diffuse and not radiating anywhere. Pain started like cramping; episodes are severe; come and go. He denies any fevers or chills. No generalized weakness. No numbness or tingling. Patient is not hungry at this time. He has been having a poor p.o. intake in the last 2 weeks.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 72/51. Heart rate 130. Temperature 97.2. Respiration 18. O2 saturation 97% on 2 liters.

GENERAL: Patient is lethargic. No respiratory distress. Oriented x3.

HEENT: Moist oral mucosa. No oral thrush. White sclera bilaterally.

NECK: No masses. No JVD.

HEART: Regular rate. Tachycardic. No murmurs or gallops or rub.

LUNGS: Clear to auscultation bilaterally from the front. No wheezes.

ABDOMEN: Bowel sounds diminished. Diffuse mild tenderness. Ileostomy not draining anything at this time. Ileostomy bag in place.

EXTREMITIES: No cyanosis. No edema.

SKIN: Dry. No rash. No jaundice.

NEUROLOGIC EXAM: Cranial nerves II-XII grossly intact bilaterally. No focal sensory or motor deficits noticed. Head normocephalic. No signs of trauma or laceration.

LABORATORY DATA:
White blood cells 9.8. Hemoglobin 16.9. Hematocrit 50.4. Platelets 632. Lipase 224. Bands are 10%. Glucose 224. BUN 25. Creatinine 1.74. Sodium 140. Potassium 3.9. Chloride 106. Bicarb 22. Calcium 0.8. Albumin 2.9. T bili 1.3. Alk phos 100. AST 21. ALT 72.

IMPRESSION AND RECOMMENDATION:
1. Hypotension probably secondary to side effects from anesthetics and pain medication in combination with dehydration with hypovolemia. Patient has been having a poor p.o. intake lately. His urine is concentrated. He has a Foley catheter. His creatinine has bumped from his baseline 1.2 to 1.74.
    a. We will give 2 liters of Ringer's lactate boluses.
    b. Follow blood pressure closely in the ICU level.
    c. Adjust as needed.
    d. Patient will follow up blood pressure every 15 minutes.
    e. We consider if the patient would benefit from some Levophed if needed for his low blood pressure.
2. Abdominal pain.
    a. We will use some low-dose morphine at this time. Once the blood pressure is better we will restart maybe using the Dilaudid as ordered before.
3. Acute kidney injury, probably secondary to dehydration with hypoalbuminemia and the presence of abdominal peritonitis from perforated viscus. We will follow BUN and creatinine in the morning.

His GFR at this time is 46. We will adjust medication to that GFR. We will hold the BUN and creatinine by the morning with aggressive hydration. Follow ins and outs, too.

4. Patient is a FULL CODE.

Thank you for allowing me to participate in the care of this patient. We will follow the patient closely on a daily basis.

Kenneth Santiago, MD Date/Time

cc: Gilbertas Rimkus, MD
Kenneth Santiago, MD
KAS/3025600
DD: 05/15/2016 16:09
DT: 05/16/2016 00:12
LM File#: 201605160000036559
Job #: 3025600

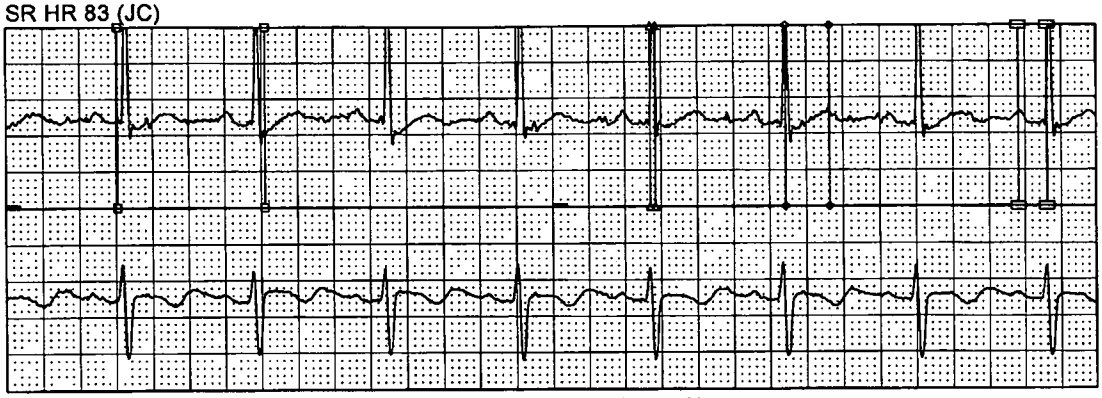
Electronically Signed By:
SANTIAGO,KENNETH MD,
Jun 20 2016 3:39PM

Patient Name: K T, D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/21/2016 3:49 PM

SR HR 83 (JC)

5/21/2016
8:13:26 AM



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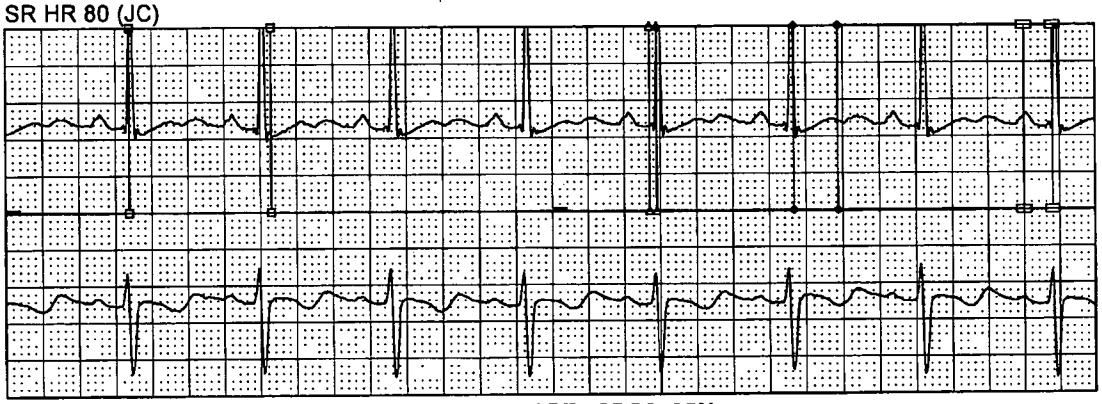
CALIPERS: ▫ Rate 83 bpm (1 interval) ▵ QRS 0.04 sec ⬨ QT 0.25 sec (QTc 0.29 sec) ▭ PR 0.17 sec
Sweep speed: 25.0 mm/s

SR HR 80 (JC)

5/21/2016
11:44:41 AM



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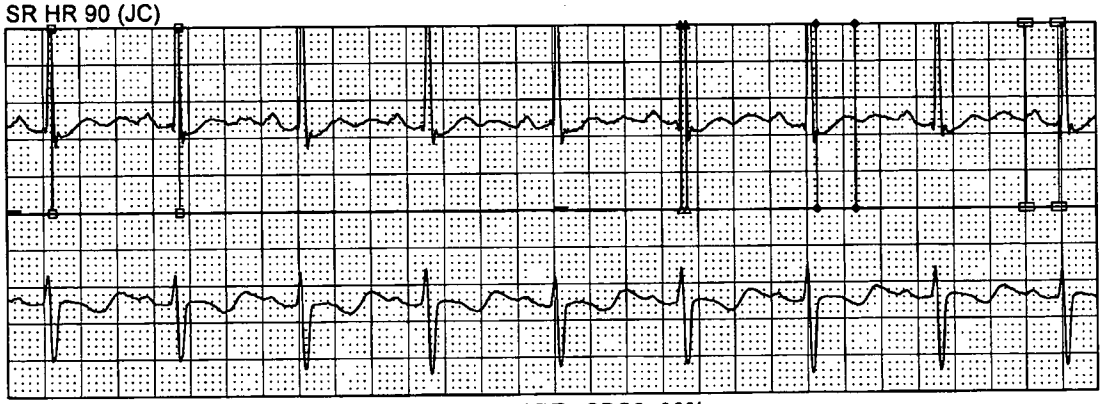
Sweep speed: 25.0 mm/s

SR HR 90 (JC)

5/21/2016
3:05:49 PM



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Sweep speed: 25.0 mm/s

--END OF REPORT--

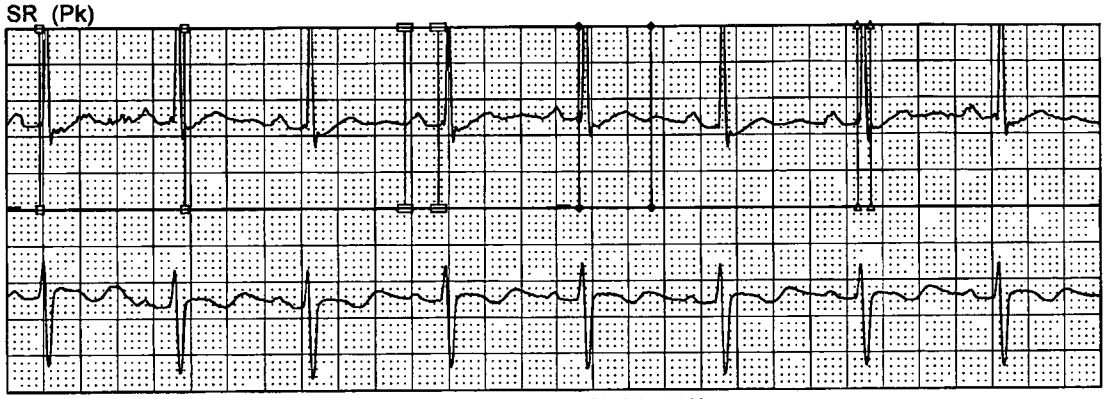
Spacelabs Healthcare
5A4D43B46E10429588C8, KNIGHT, 22

Patient Name: K. T, D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/21/2016 4:37 AM

SR (Pk)

5/20/2016
7:11:54 PM



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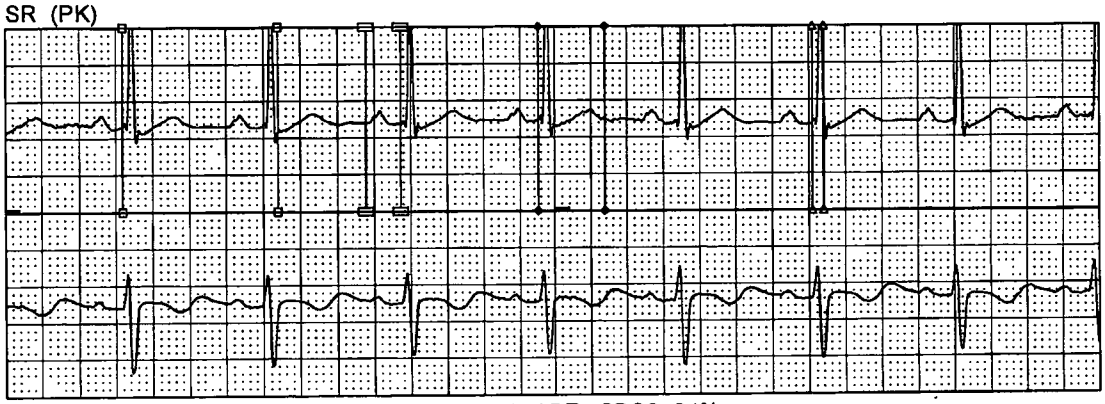
Sweep speed: 25.0 mm/s

SR (PK)

5/20/2016
11:02:04 PM



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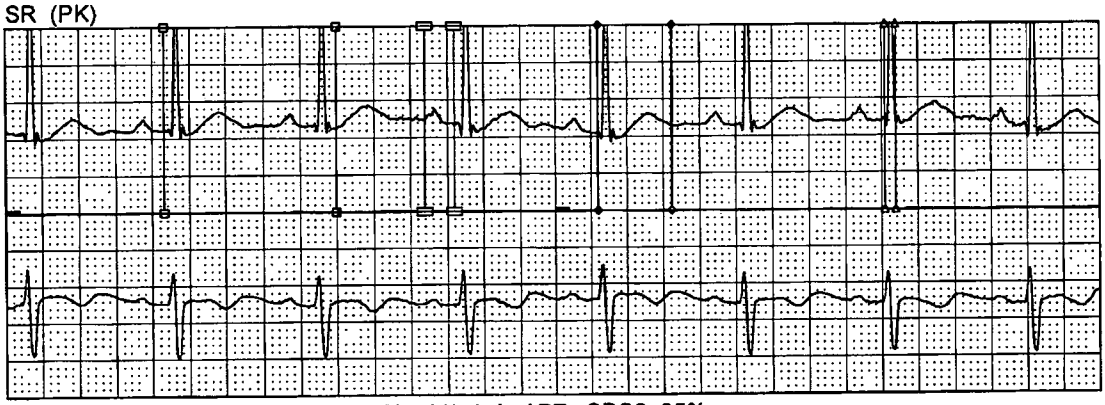
Sweep speed: 25.0 mm/s

SR (PK)

5/21/2016
3:13:32 AM



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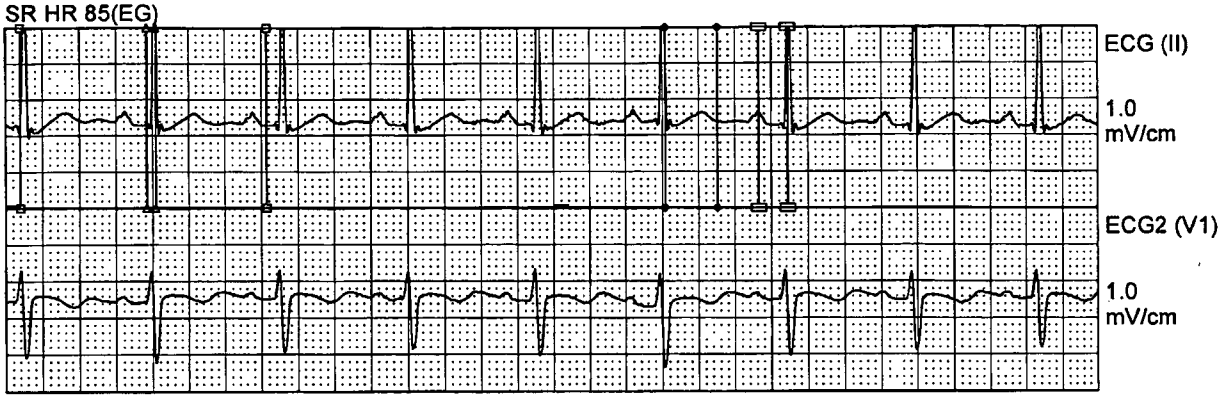
Sweep speed: 25.0 mm/s

Patient Nam GHT, D. 5/20/2016 4:26 PM
ID 1: V00006912886
ID 2:
Bed ID: CC26

SR HR 85(EG)



5/20/2016 7:00:26 AM

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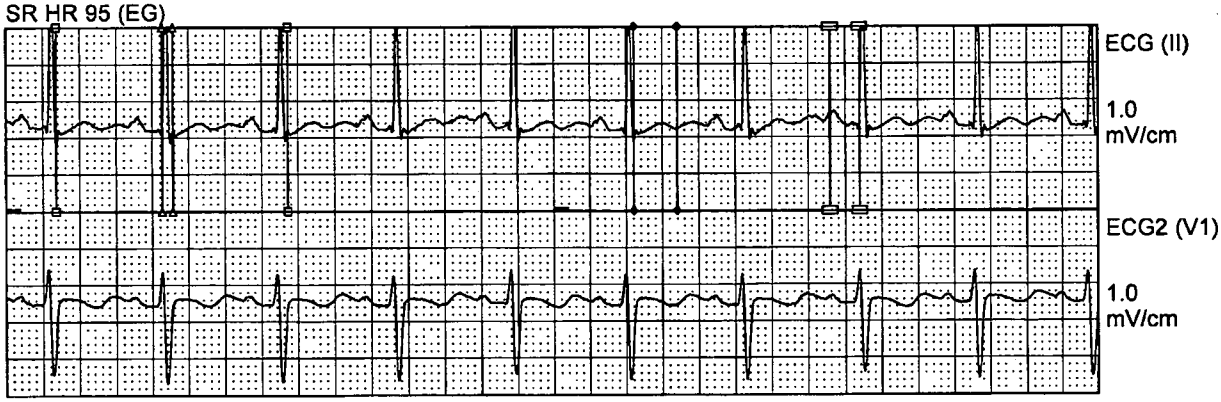
Sweep speed: 25.0 mm/s

SR HR 95 (EG)



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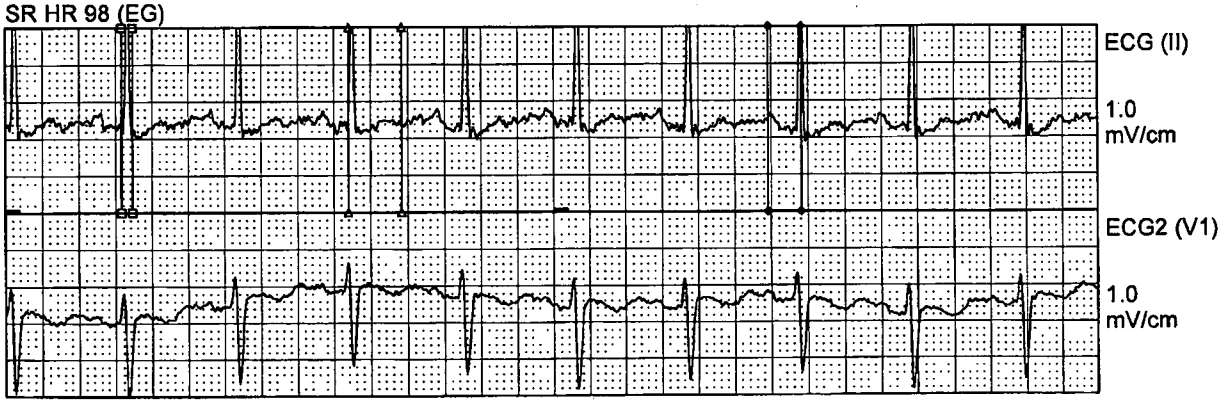
Sweep speed: 25.0 mm/s

SR HR 98 (EG)



5/20/2016 2:59:49 PM

5/20/2016 2:59:00 PM: HR=97bpm,RR=11br/min,ART=,SPO2=96%
CALIPERS: ▫ QRS 0.07 sec ▵ QT 0.30 sec (QTc 0.39 sec) ◇ PR 0.19 sec
Sweep speed: 25.0 mm/s

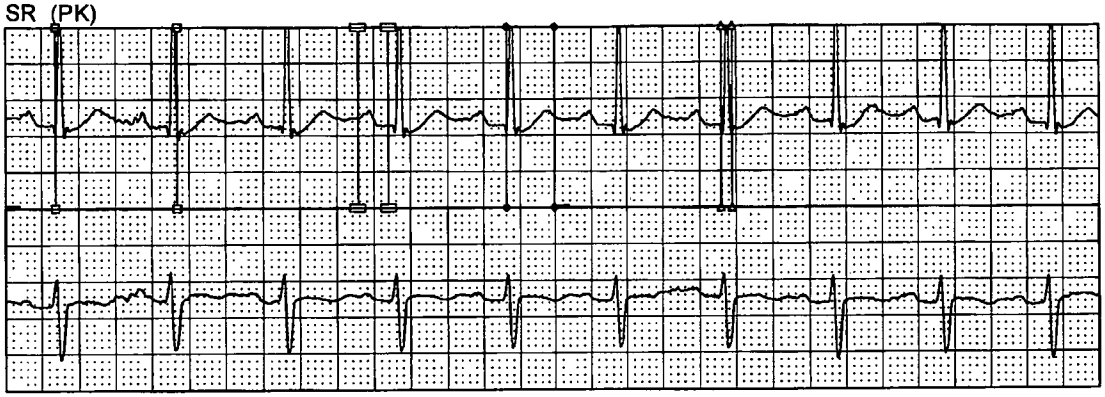
5A4D43B46E10429588C8, KNIGHT, 24

Patient Name: KN , D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/20/2016 4:59 AM

SR (PK)

5/19/2016
7:37:10 PM



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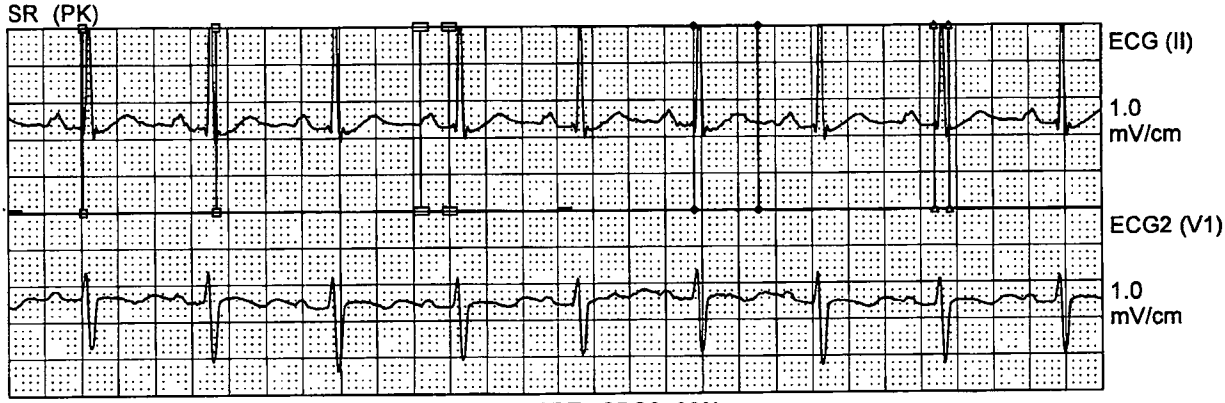
Sweep speed: 25.0 mm/s

SR (PK)

5/19/2016
11:19:27 PM



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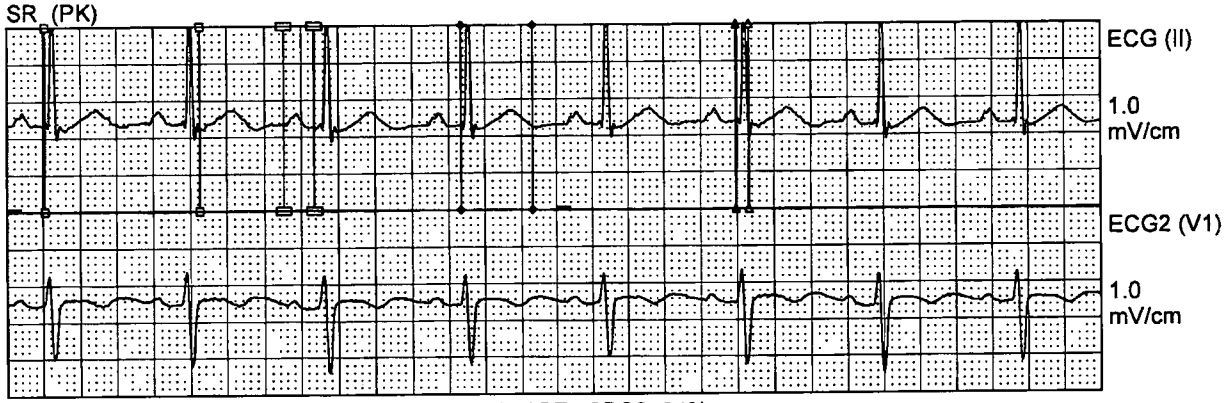
Sweep speed: 25.0 mm/s

SR (PK)

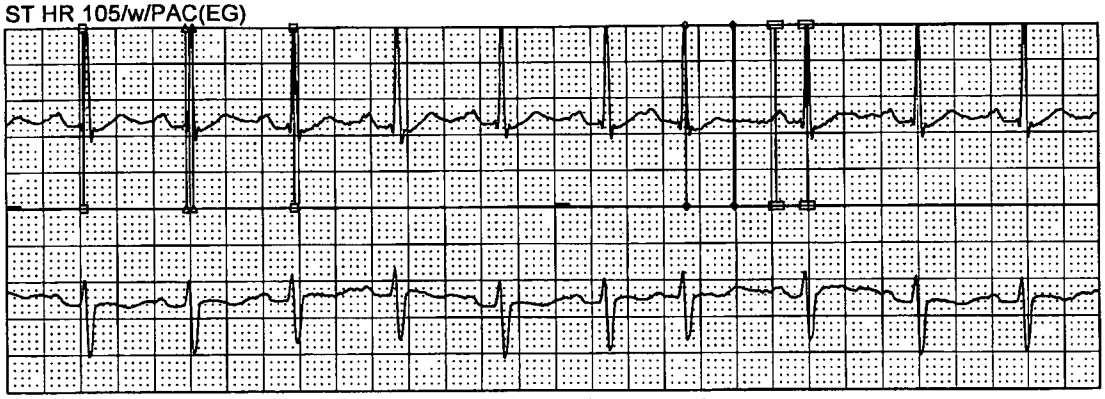
5/20/2016
3:21:50 AM



5/20/2016 3:21:00 AM: HR=78bpm,RR=20br/min,ART=,SPO2=94%
CALIPERS: ▫ Rate 80 bpm (1 interval) ▵ QRS 0.08 sec ◇ QT 0.40 sec (QTc 0.47 sec) ▭ PR 0.18 sec
Sweep speed: 25.0 mm/s

ST HR 105/w/PAC(EG)

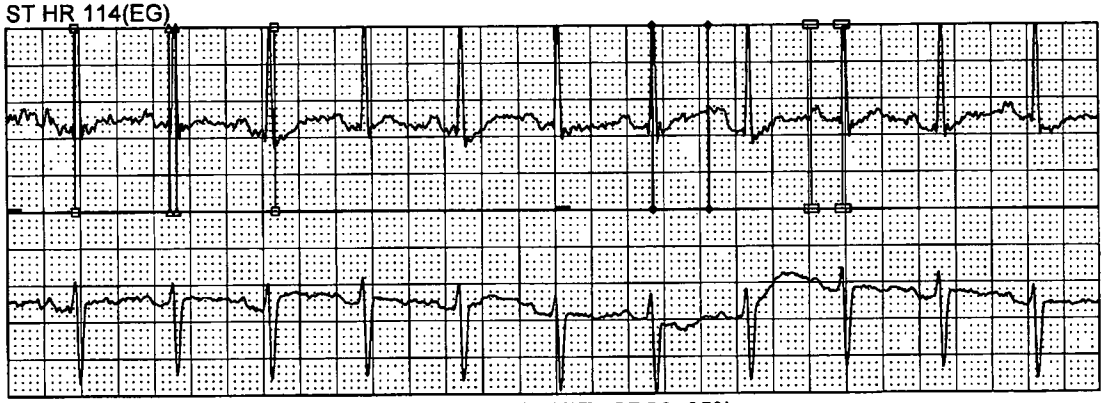
5/19/2016
7:00:22 AM



5/19/2016 7:00:00 AM: HR=105bpm,RR=25br/min,ART=,SPO2=97%
CALIPERS: ▫ Rate 105 bpm (1 interval) ▵ QRS 0.05 sec ◇ QT 0.27 sec (QTc 0.36 sec) ▭ PR 0.18 sec
Sweep speed: 25.0 mm/s

ST HR 114(EG)

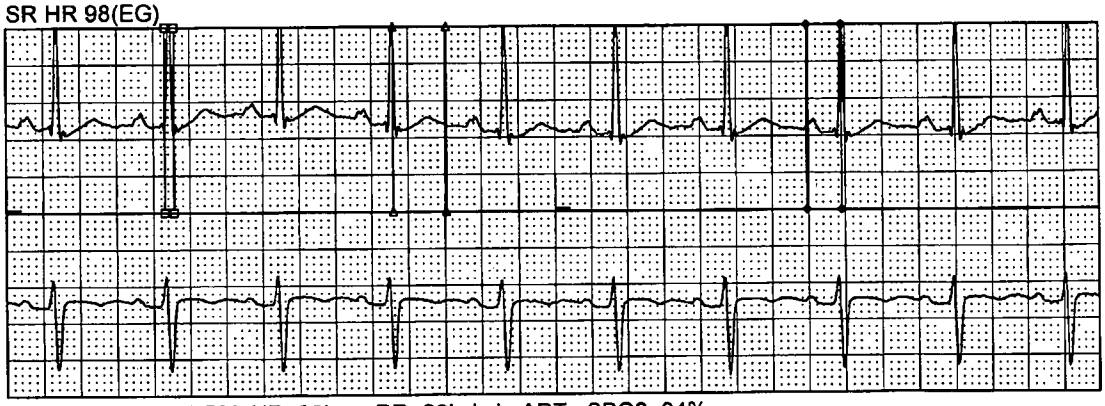
5/19/2016
11:00:08 AM



5/19/2016 11:00:00 AM: HR=117bpm,RR=19br/min,ART=,SPO2=95%
CALIPERS: ▫ Rate 114 bpm (2 intervals) ▵ QRS 0.05 sec ◇ QT 0.32 sec (QTc 0.44 sec) ▭ PR 0.18 sec
Sweep speed: 25.0 mm/s

SR HR 98(EG)

5/19/2016
3:00:34 PM



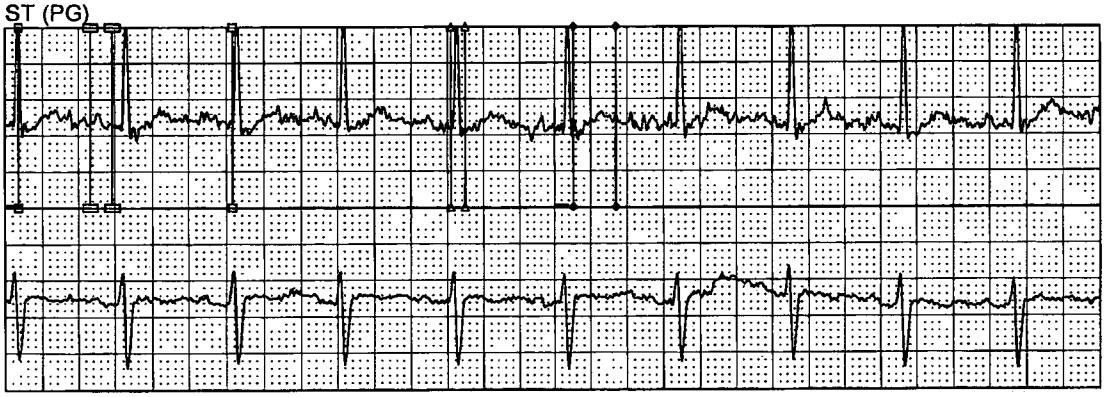
5/19/2016 3:00:00 PM: HR=96bpm,RR=23br/min,ART=,SPO2=94%
CALIPERS: ▫ QRS 0.06 sec ▵ QT 0.30 sec (QTc 0.38 sec) ◇ PR 0.20 sec
Sweep speed: 25.0 mm/s

Patient Name: KI , D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/19/2016 4:29 AM

ST (PG)

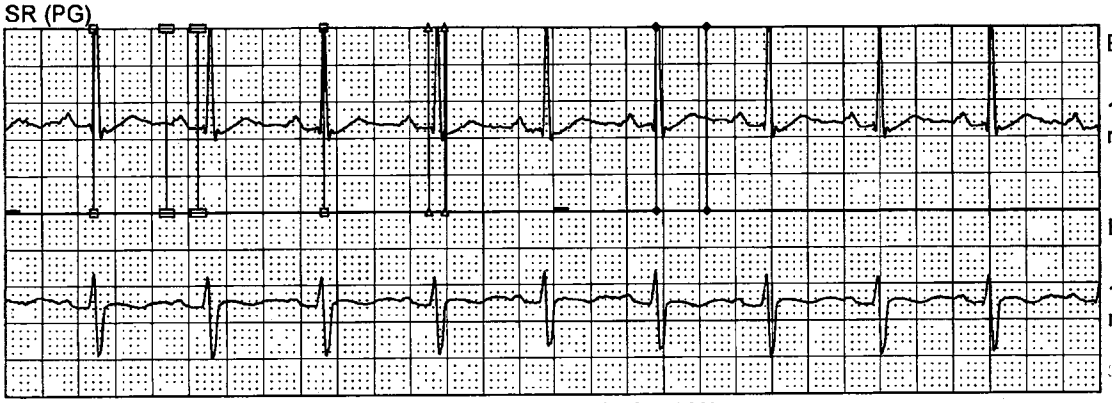
5/18/2016
7:00:19 PM



5/18/2016 7:00:00 PM: HR=102bpm,RR=39br/min,ART=,SPO2=95%
CALIPERS: ▫ Rate 102 bpm (1 interval) ▵ QRS 0.09 sec ◇ QT 0.24 sec (QTc 0.31 sec) ▭ PR 0.13 sec
Sweep speed: 25.0 mm/s

SR (PG)

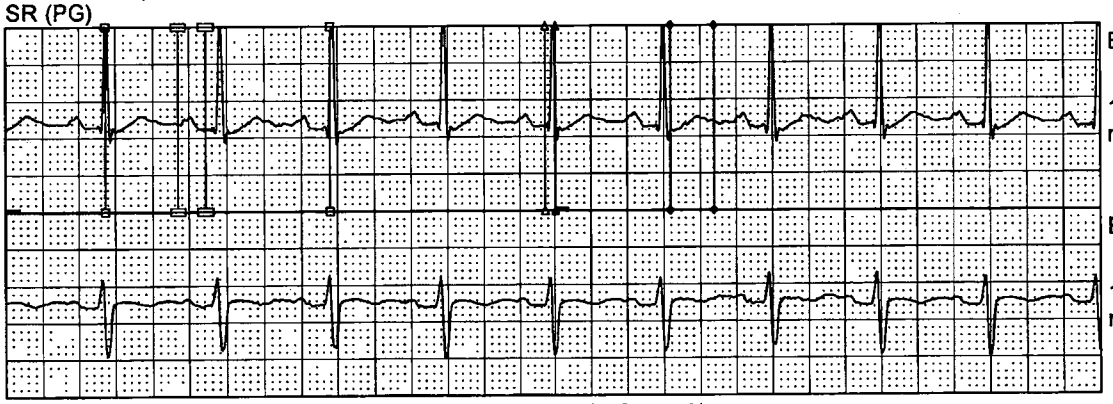
5/18/2016
11:00:35 PM



5/18/2016 11:00:00 PM: HR=98bpm,RR=21br/min,ART=,SPO2=96%
CALIPERS: ▫ Rate 97 bpm (1 interval) ▵ QRS 0.10 sec ◇ QT 0.29 sec (QTc 0.37 sec) ▭ PR 0.18 sec
Sweep speed: 25.0 mm/s

SR (PG)

5/19/2016
3:00:37 AM



5/19/2016 3:00:00 AM: HR=96bpm,RR=21br/min,ART=,SPO2=97%
CALIPERS: ▫ Rate 97 bpm (1 interval) ▵ QRS 0.07 sec ◇ QT 0.25 sec (QTc 0.32 sec) ▭ PR 0.16 sec
Sweep speed: 25.0 mm/s

--END OF REPORT--

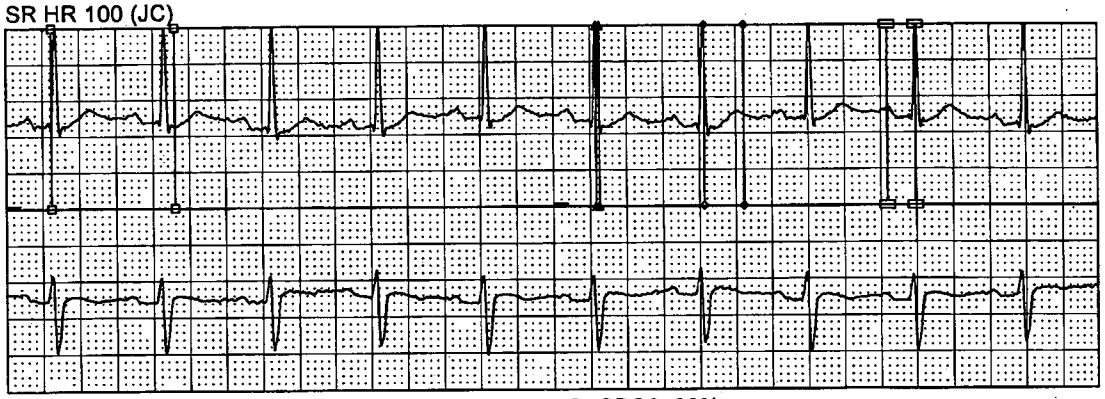
Spacelabs Healthcare
5A4D43B46E10429588C8, KNIGHT, 27

Patient Name: KN , D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/18/2016 5:26 PM

SR HR 100 (JC)

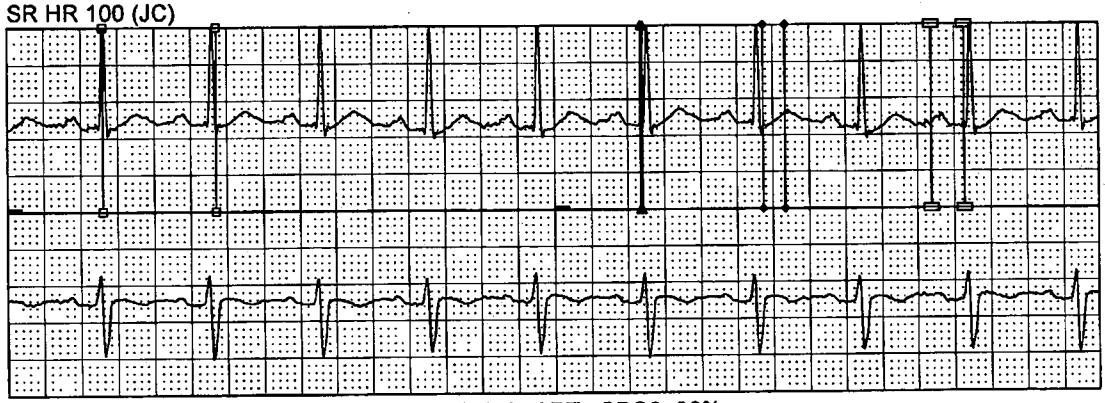
5/18/2016
8:48:38 AM



5/18/2016 8:48:00 AM: HR=105bpm,RR=21br/min,ART=,SPO2=93%
CALIPERS: ▫ Rate 101 bpm (1 interval) ▵ QRS 0.03 sec ◇ QT 0.23 sec (QTc 0.30 sec) ▭ PR 0.17 sec
Sweep speed: 25.0 mm/s

SR HR 100 (JC)

5/18/2016
4:48:36 PM



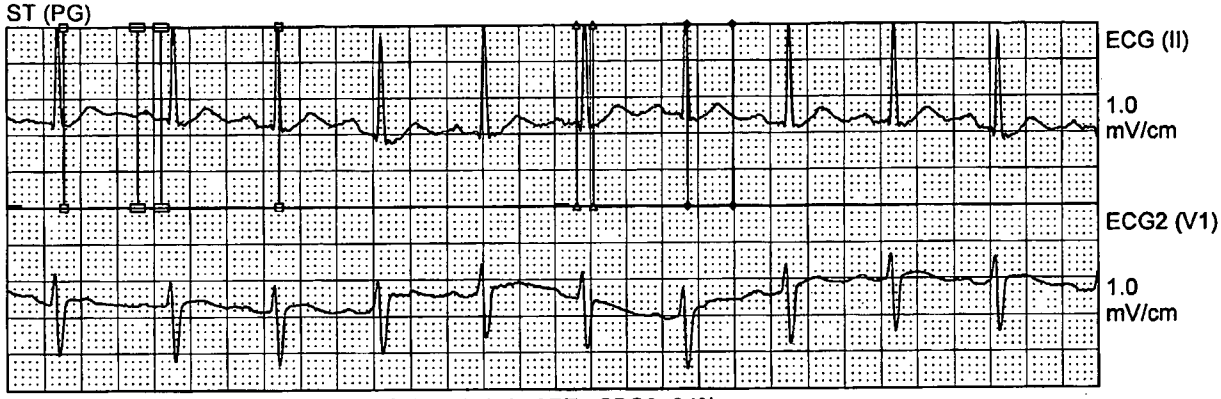
5/18/2016 4:48:00 PM: HR=101bpm,RR=31br/min,ART=,SPO2=96%
CALIPERS: ▫ Rate 101 bpm (1 interval) ▵ QRS 0.00 sec ◇ QT 0.13 sec (QTc 0.16 sec) ▭ PR 0.19 sec
Sweep speed: 25.0 mm/s

Patient Name: KNIG. J.
ID 1: V00006912886
ID 2:
Bed ID: CC26

/18/2016 5:25 AM

ST (PG)

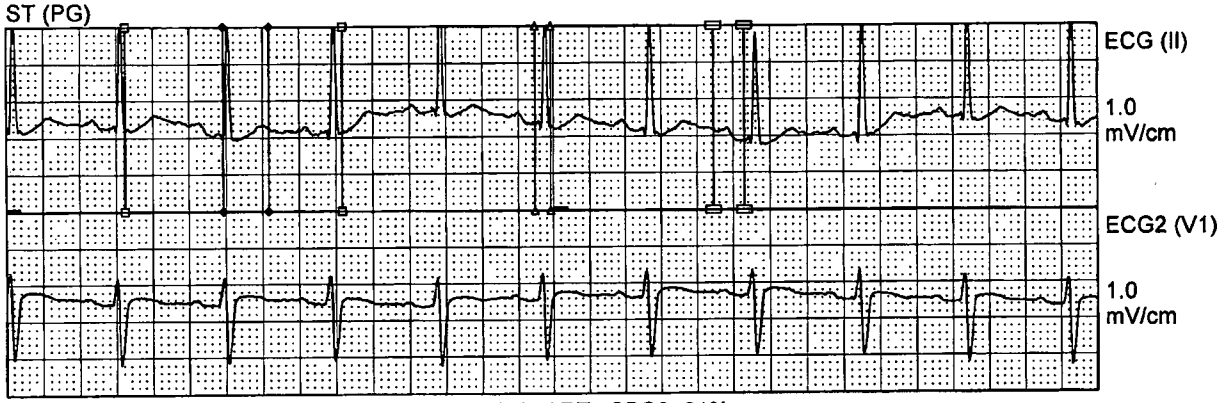
5/17/2016
7:00:37 PM



5/17/2016 7:00:00 PM: HR=110bpm,RR=27br/min,ART=,SPO2=94%
CALIPERS: ▫ Rate 106 bpm (1 interval) ▵ QRS 0.10 sec ◇ QT 0.26 sec (QTc 0.35 sec) ▭ PR 0.14 sec
Sweep speed: 25.0 mm/s

ST (PG)

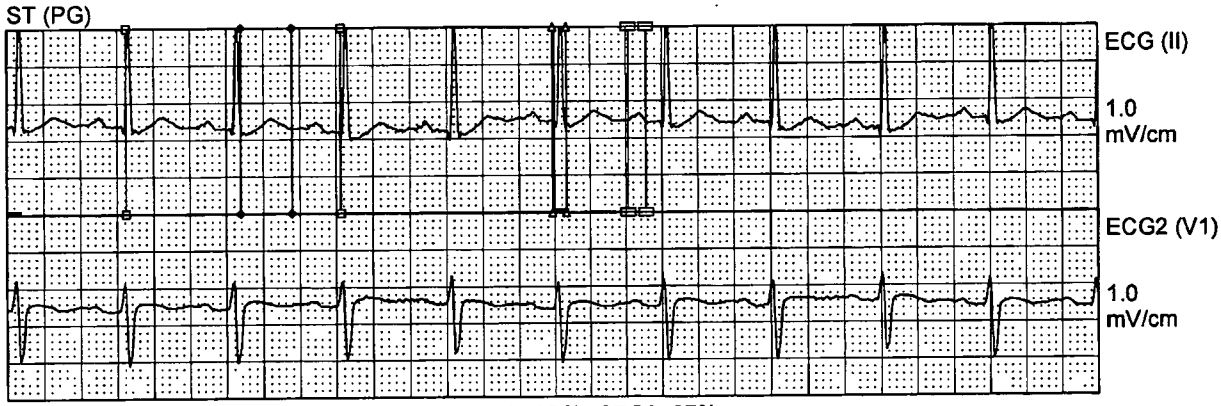
5/17/2016
11:00:29 PM



5/17/2016 11:00:00 PM: HR=103bpm,RR=21br/min,ART=,SPO2=91%
CALIPERS: ▫ Rate 103 bpm (1 interval) ▵ QRS 0.10 sec ◇ QT 0.26 sec (QTc 0.34 sec) ▭ PR 0.18 sec
Sweep speed: 25.0 mm/s

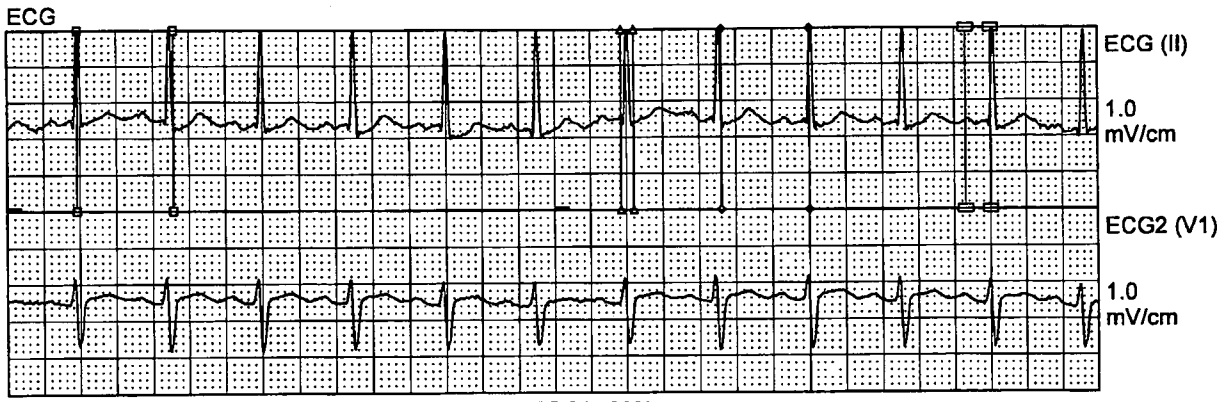
ST (PG)

5/18/2016
3:00:33 AM



5/18/2016 3:00:00 AM: HR=101bpm,RR=22br/min,ART=,SPO2=87%
CALIPERS: ▫ Rate 101 bpm (1 interval) ▵ QRS 0.09 sec ◇ QT 0.29 sec (QTc 0.37 sec) ▭ PR 0.11 sec
Sweep speed: 25.0 mm/s

Patient Name: KN[illegible]; D.
ID 1: V0000691288[illegible]
ID 2:
Bed ID: CC26



5/17/2016 8:41:00 AM: HR=121bpm,RR=25br/min,SPO2=88%
CALIPERS: ▫ Rate 119 bpm (1 interval) ▵ QRS 0.06 sec ◇ QT 0.47 sec (QTc 0.67 sec) ▭ PR 0.13 sec
Sweep speed: 25.0 mm/s

--END OF REPORT--

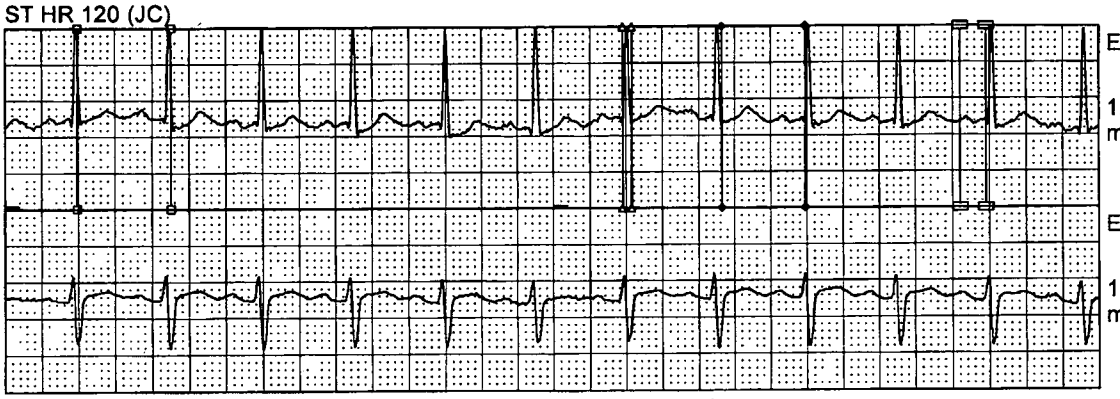
Spacelabs Healthcare
5A4D43B46E10429588C8, KNIGHT, 30

Patient Name: KN [illegible], D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/17/2016 5:20 PM

ST HR 120 (JC)

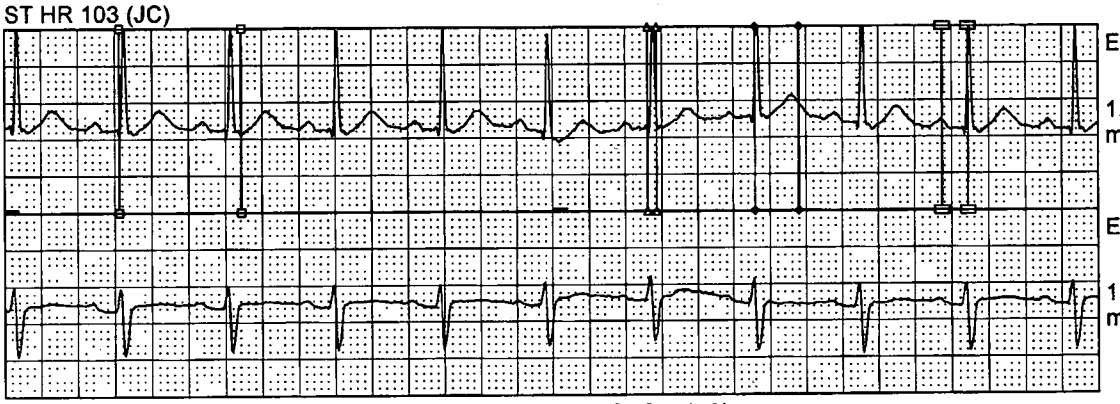
5/17/2016
8:41:59 AM



5/17/2016 8:41:00 AM: HR=121bpm,RR=25br/min,ART=,SPO2=88%
CALIPERS: ▫ Rate 119 bpm (1 interval) ▵ QRS 0.06 sec ◇ QT 0.47 sec (QTc 0.67 sec) ▭ PR 0.15 sec
Sweep speed: 25.0 mm/s

ST HR 103 (JC)

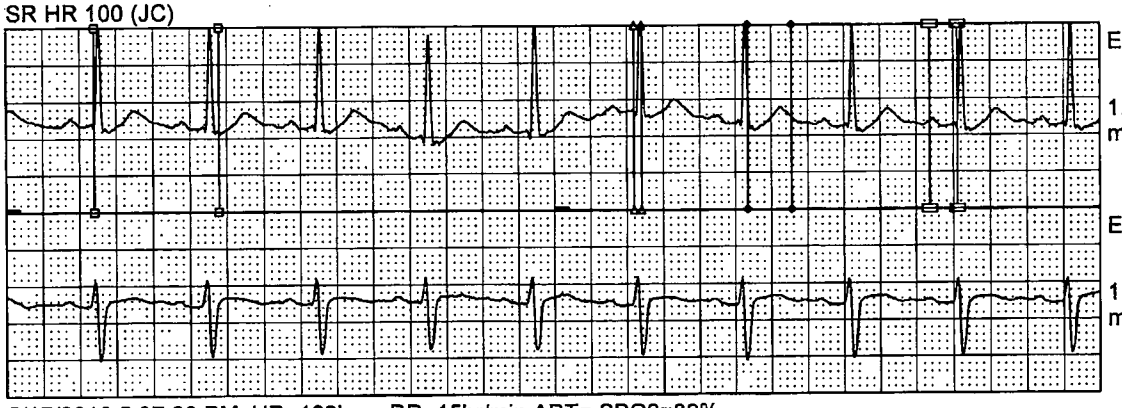
5/17/2016
12:34:10 PM



5/17/2016 12:34:00 PM: HR=103bpm,RR=14br/min,ART=,SPO2=95%
CALIPERS: ▫ Rate 103 bpm (1 interval) ▵ QRS 0.06 sec ◇ QT 0.25 sec (QTc 0.33 sec) ▭ PR 0.15 sec
Sweep speed: 25.0 mm/s

SR HR 100 (JC)

5/17/2016
5:07:43 PM



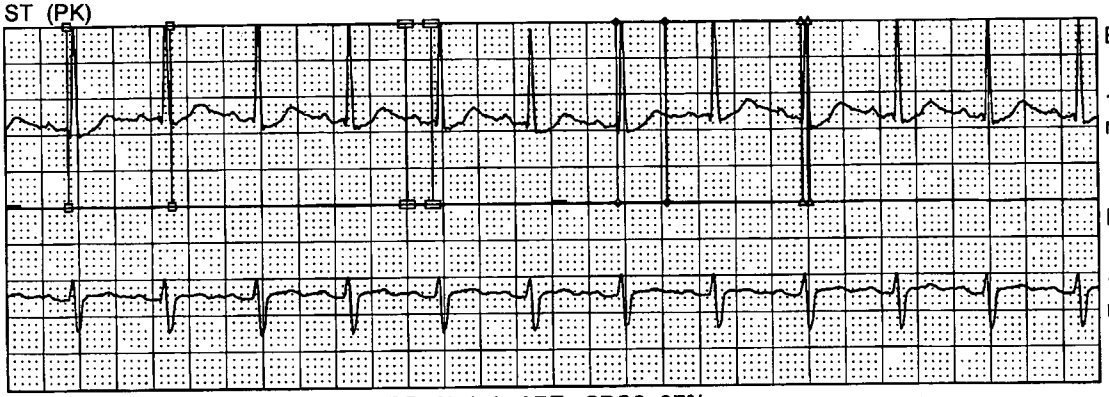
5/17/2016 5:07:00 PM: HR=102bpm,RR=15br/min,ART=,SPO2=89%
CALIPERS: ▫ Rate 100 bpm (1 interval) ▵ QRS 0.05 sec ◇ QT 0.25 sec (QTc 0.32 sec) ▭ PR 0.16 sec
Sweep speed: 25.0 mm/s

5A4D43B46E10429588C8, KNIGHT, 31

Patient Name: KNI , D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

ST (PK)

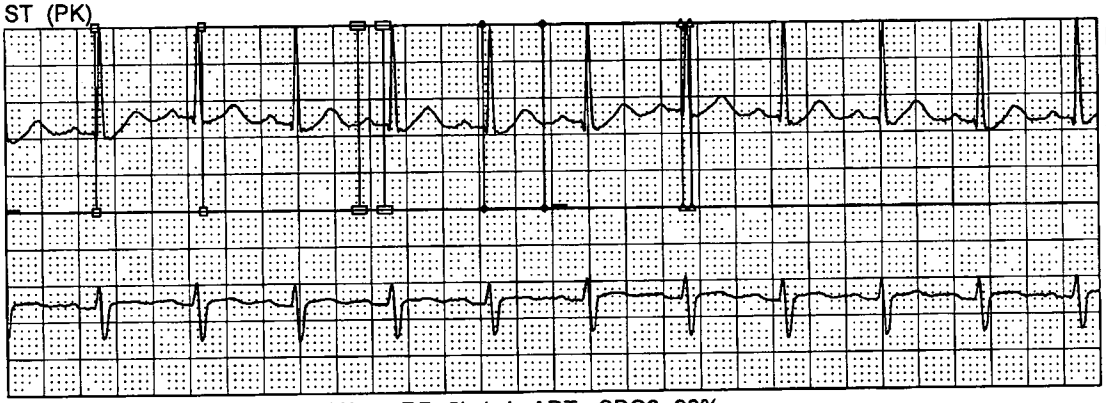
5/16/2016
7:09:17 PM



5/16/2016 7:09:00 PM: HR=120bpm,RR=8br/min,ART=,SPO2=87%
CALIPERS: ▫ Rate 119 bpm (1 interval) ▵ QRS 0.05 sec ◇ QT 0.28 sec (QTc 0.39 sec) ▭ PR 0.15 sec
Sweep speed: 25.0 mm/s

ST (PK)

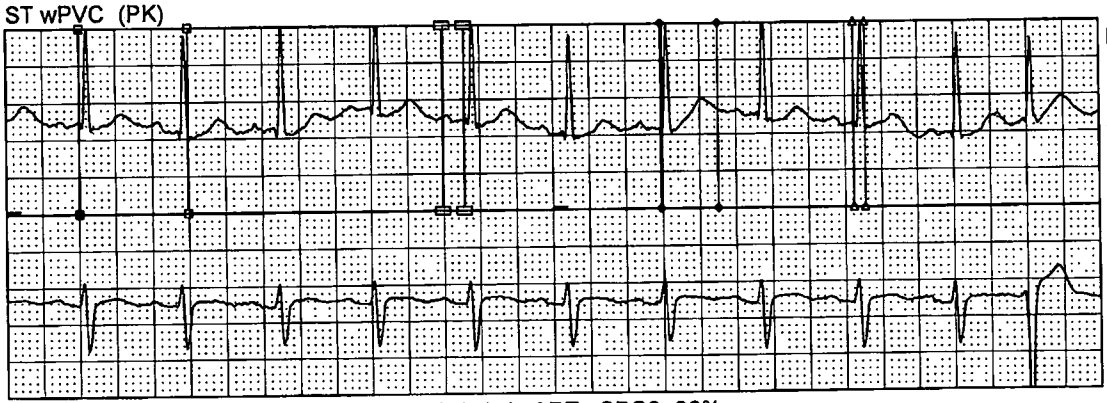
5/16/2016
11:00:32 PM



5/16/2016 11:00:00 PM: HR=110bpm,RR=6br/min,ART=,SPO2=92%
CALIPERS: ▫ Rate 112 bpm (1 interval) ▵ QRS 0.06 sec ◇ QT 0.34 sec (QTc 0.46 sec) ▭ PR 0.15 sec
Sweep speed: 25.0 mm/s

ST wPVC (PK)

5/17/2016
3:31:03 AM



5/17/2016 3:31:00 AM: HR=112bpm,RR=24br/min,ART=,SPO2=90%
CALIPERS: ▫ Rate 113 bpm (1 interval) ▵ QRS 0.07 sec ◇ QT 0.32 sec (QTc 0.44 sec) ▭ PR 0.13 sec
Sweep speed: 25.0 mm/s

--END OF REPORT--

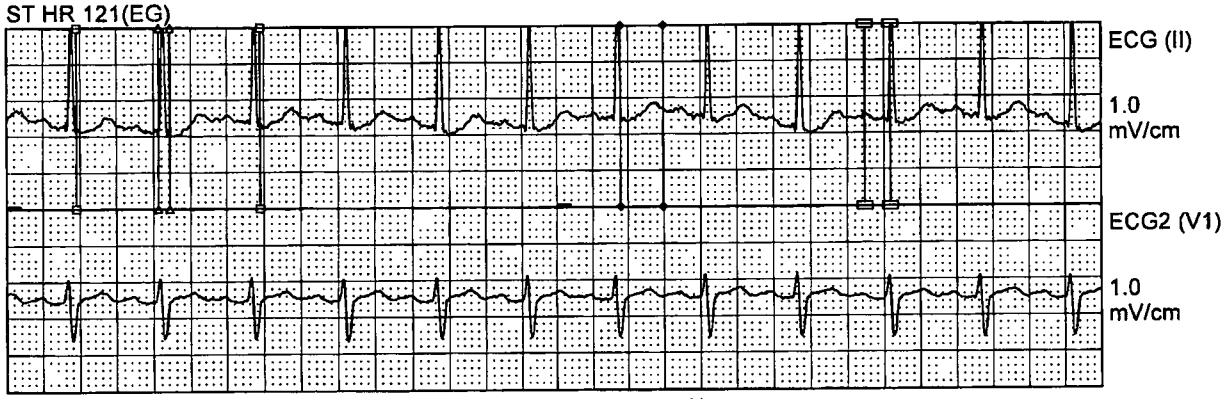
Spacelabs Healthcare
5A4D43B46E10429588C8, KNIGHT, 32

Patient Name: KN[illegible], D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/16/2016 5:00 PM

ST HR 121(EG)

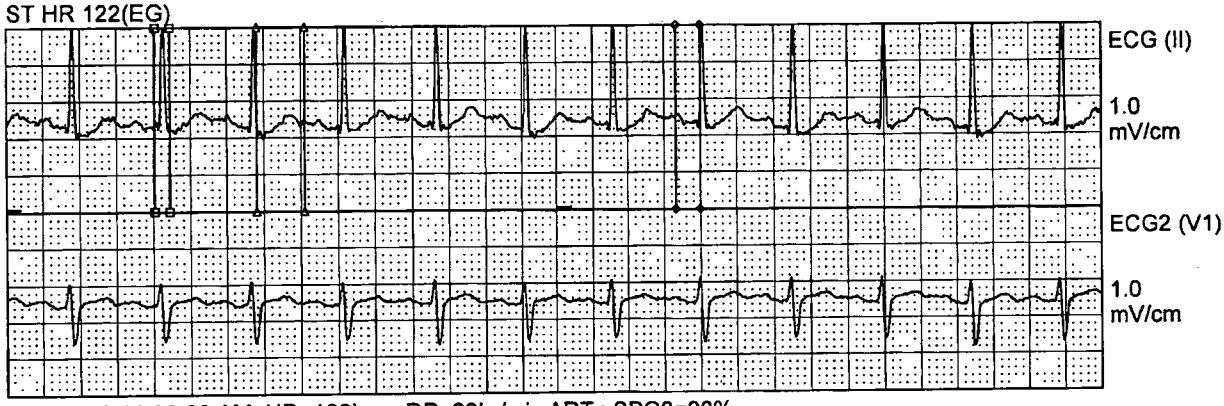
5/16/2016
7:00:06 AM



5/16/2016 7:00:00 AM: HR=121bpm,RR=0br/min,ART=,SPO2=92%
CALIPERS: ▫ Rate 121 bpm (1 interval) ▵ QRS 0.07 sec ⬨ QT 0.25 sec (QTc 0.36 sec) ▭ PR 0.15 sec
Sweep speed: 25.0 mm/s

ST HR 122(EG)

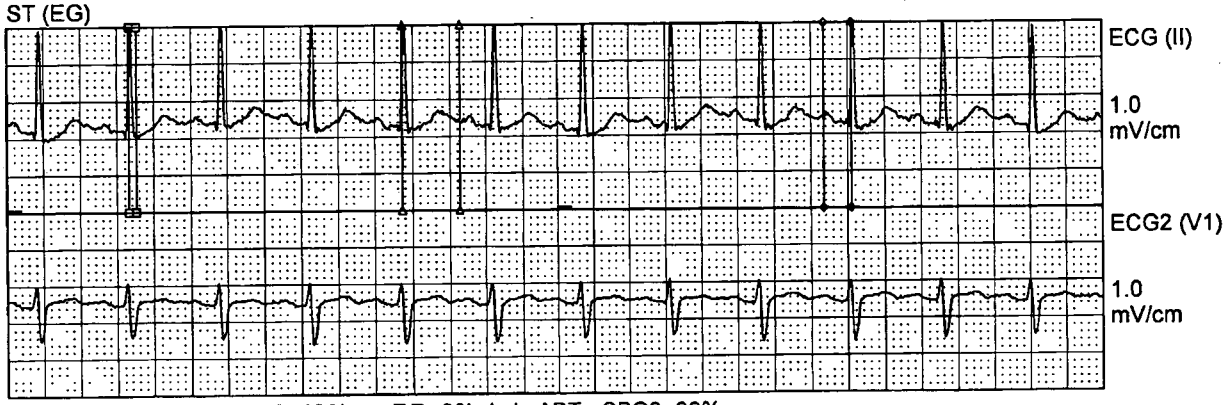
5/16/2016
11:00:41 AM



5/16/2016 11:00:00 AM: HR=122bpm,RR=29br/min,ART=,SPO2=90%
CALIPERS: ▫ QRS 0.09 sec ▵ QT 0.27 sec (QTc 0.38 sec) ⬨ PR 0.18 sec
Sweep speed: 25.0 mm/s

ST (EG)

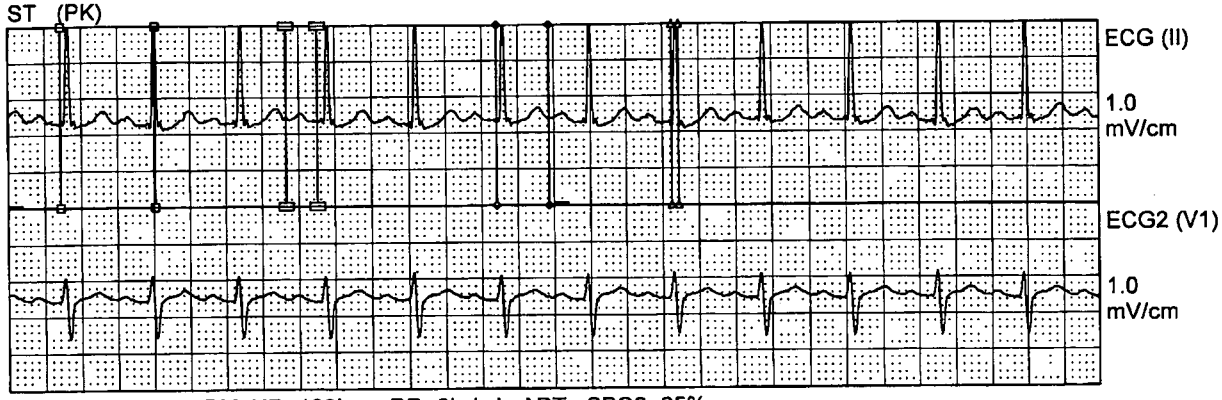
5/16/2016
3:00:50 PM



5/16/2016 3:00:00 PM: HR=122bpm,RR=30br/min,ART=,SPO2=89%
CALIPERS: ▫ QRS 0.05 sec ▵ QT 0.32 sec (QTc 0.45 sec) ⬨ PR 0.19 sec
Sweep speed: 25.0 mm/s

Patient Name: KNIGHT, D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

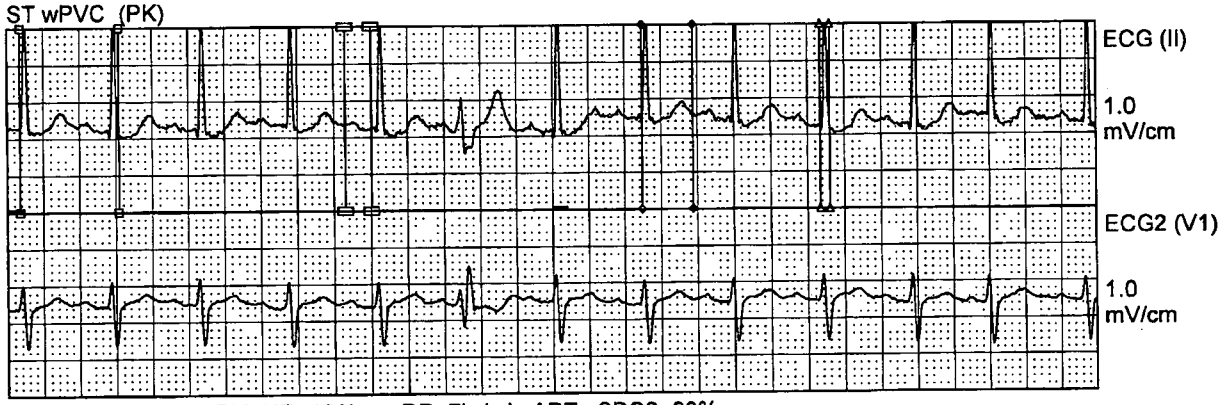
ST (PK)



5/15/2016 7:11:13 PM

5/15/2016 7:11:00 PM: HR=128bpm,RR=8br/min,ART=,SPO2=95%
CALIPERS: ▫ Rate 124 bpm (1 interval) ▵ QRS 0.05 sec ◇ QT 0.30 sec (QTc 0.43 sec) ▭ PR 0.18 sec
Sweep speed: 25.0 mm/s

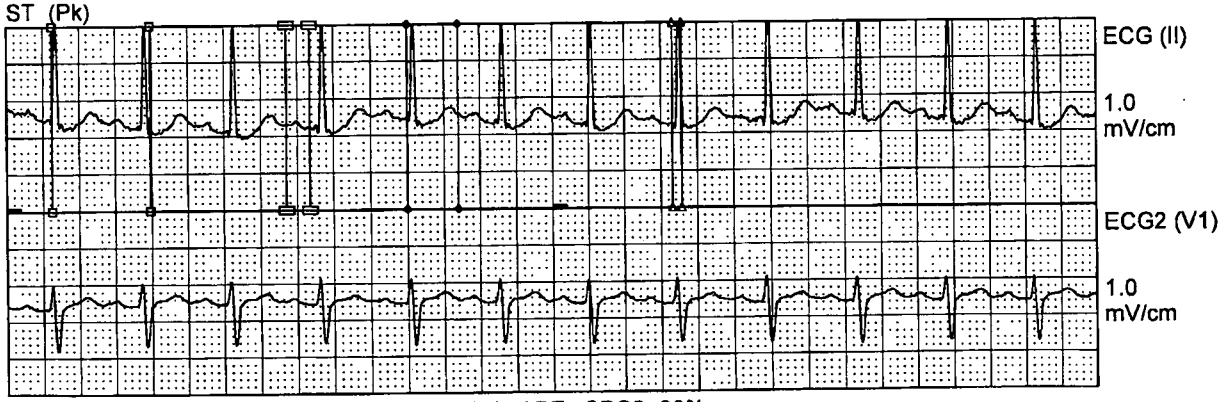
ST wPVC (PK)



5/15/2016 11:32:53 PM

5/15/2016 11:32:00 PM: HR=123bpm,RR=7br/min,ART=,SPO2=93%
CALIPERS: ▫ Rate 122 bpm (1 interval) ▵ QRS 0.06 sec ◇ QT 0.29 sec (QTc 0.42 sec) ▭ PR 0.15 sec
Sweep speed: 25.0 mm/s

ST (Pk)



5/16/2016 3:00:25 AM

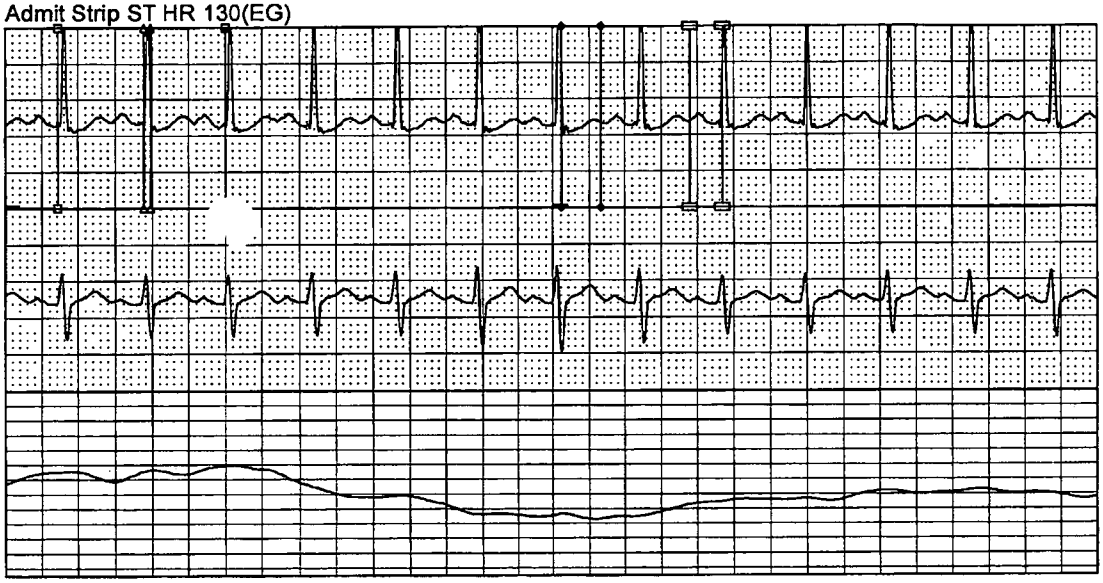
5/16/2016 3:00:00 AM: HR=122bpm,RR=0br/min,ART=,SPO2=93%
CALIPERS: ▫ Rate 122 bpm (1 interval) ▵ QRS 0.06 sec ◇ QT 0.29 sec (QTc 0.41 sec) ▭ PR 0.14 sec
Sweep speed: 25.0 mm/s

Patient Name: HT, D.
ID 1: V00006912886
ID 2:
Bed ID: CC26

5/15/2016 4:31 PM

Admit Strip ST HR 130(EG)

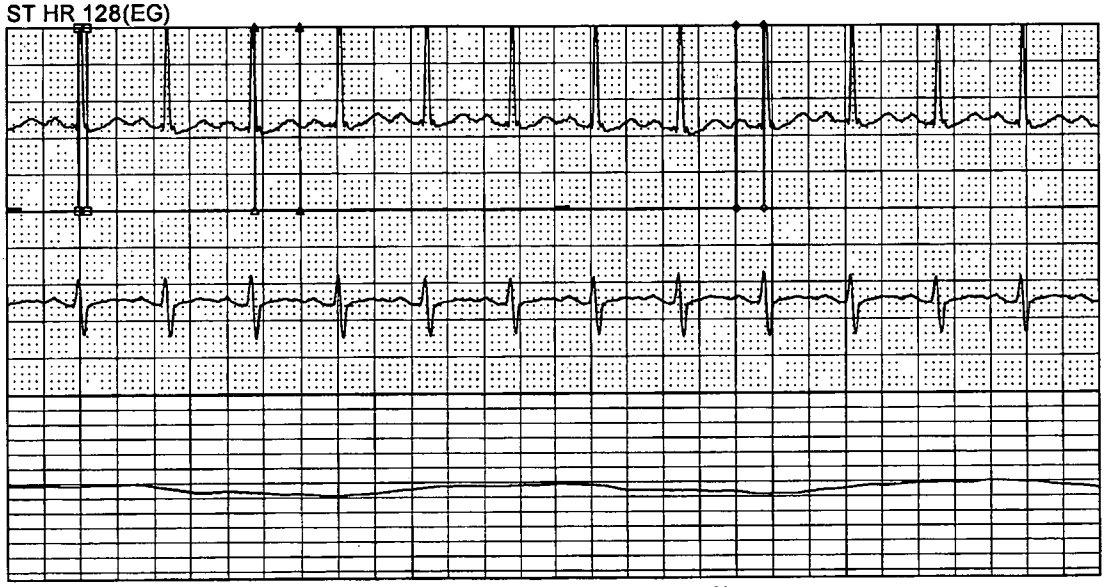
5/15/2016
10:16:38 AM



5/15/2016 10:16:00 AM: HR=133bpm,RR=10br/min,ART=,SPO2=100%
CALIPERS: ▫ Rate 133 bpm (1 interval) ▵ QRS 0.05 sec ⋄ QT 0.23 sec (QTc 0.35 sec) ▭ PR 0.19 sec
Sweep speed: 25.0 mm/s

ST HR 128(EG)

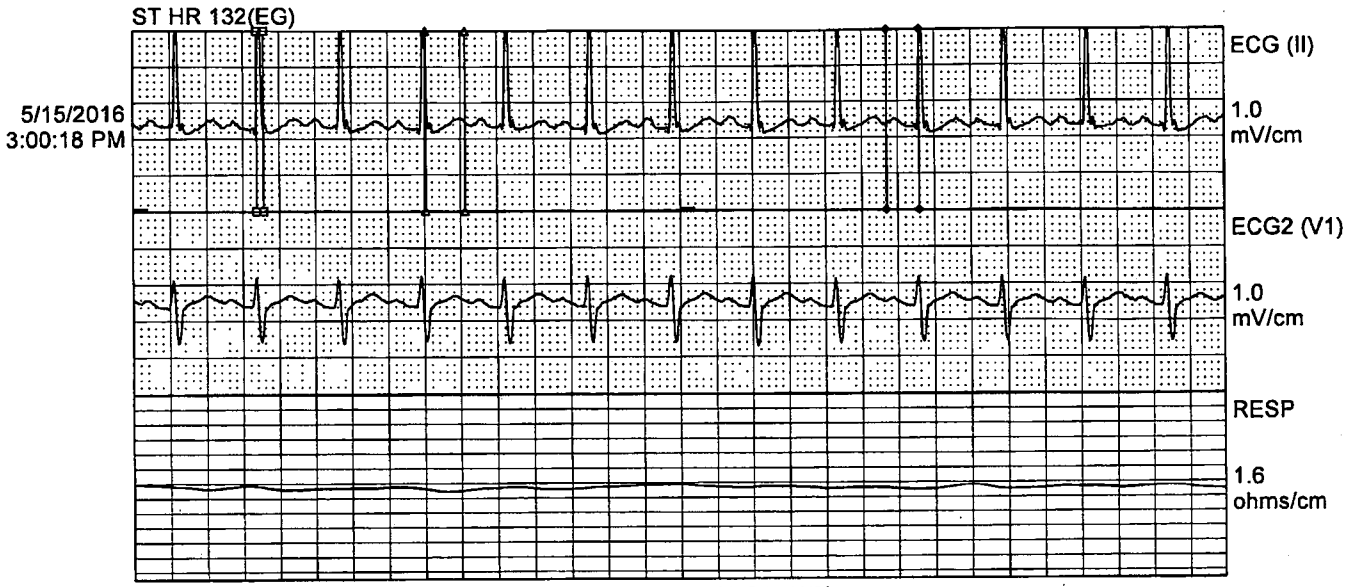
5/15/2016
11:00:51 AM



5/15/2016 11:00:00 AM: HR=128bpm,RR=17br/min,ART=,SPO2=99%
CALIPERS: ▫ QRS 0.06 sec ▵ QT 0.25 sec (QTc 0.36 sec) ⋄ PR 0.16 sec
Sweep speed: 25.0 mm/s

5A4D43B46E10429588C8, KNIGHT, 35

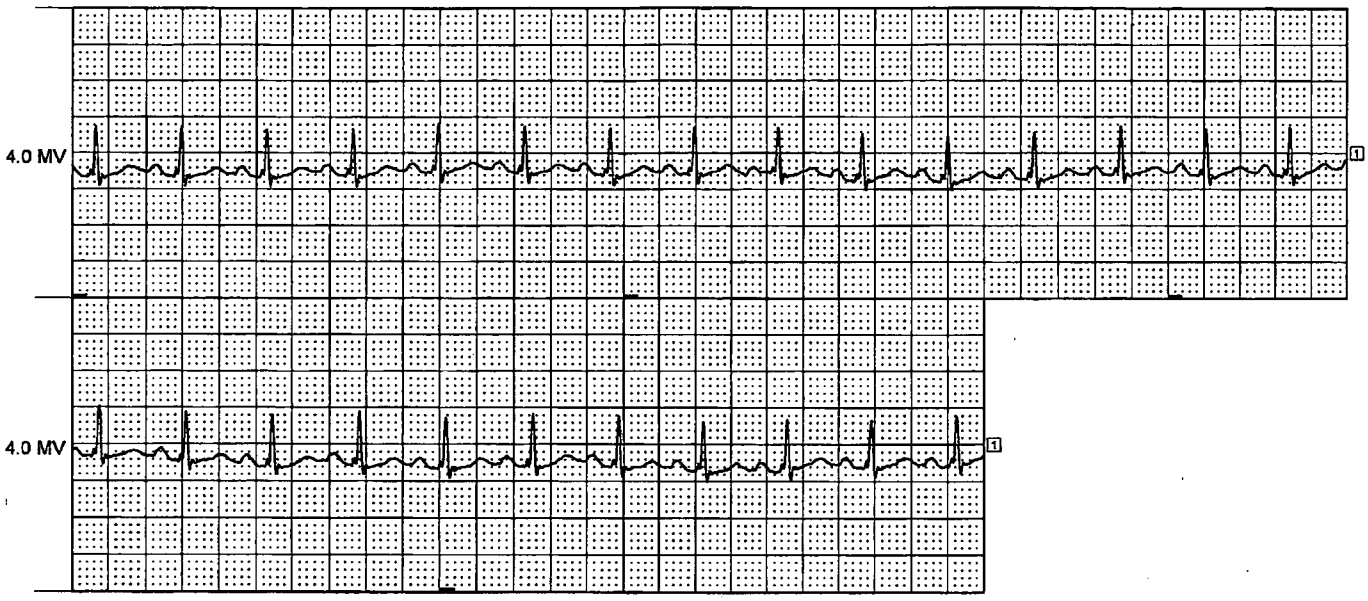
Patient Name: HT, D.
ID 1: V00006912886
ID 2:
Bed ID: CC26



5/15/2016 3:00:00 PM: HR=131bpm,RR=0br/min,ART=,SPO2=97%
CALIPERS: ▫ QRS 0.05 sec ▵ QT 0.23 sec (QTc 0.34 sec) ⬦ PR 0.19 sec
Sweep speed: 25.0 mm/s

Knight, Daniel
ED 15
07:35 15MAY2016
SPEED=25.0 MM/S

[1] II MON HR =129 VE/MIN=0
RESP=34 SPO2 96% NIBP=07:32 87/ 44(58) mmHg



KNIGHT,DANIEL ERIC
V00006912886
M000175313
[redacted]
05/15/16

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Discharge Date:	05/29/2016
Dictating Physician:	Gilbertas Rimkus, MD

DISCHARGE SUMMARY

DISCHARGE DIAGNOSES:
1. Perforation of small intestine.
2. Anxiety.

HISTORY AND HOSPITAL COURSE:
Mr. Knight is a 41-year-old patient admitted with peritonitis, free intraperitoneal area on CT. He was involved in a MVA approximately 2 weeks ago. Developed abdominal pain and the last several days progressively getting worse. He underwent urgent exploratory laparotomy and was found to have perforation of the distal small bowel with major peritoneal contamination. This was washed out. He underwent resection of small intestine and double barrel ileostomy. His wound was healing in secondary fashion with wound VAC. He had some pulmonary issues during hospital stay. Medical service was consulted, though ultimately he recovered nicely and was discharged home with Vicodin for pain as needed. He will resume his Prozac. He had home health set up for wound VAC dressing changes as well as ileostomy care.

FOLLOWUP:
With me in the office in 1 week.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
Rachel M. Collins, CNP
GR/4103722
DD: 06/15/2016 13:03
DT: 06/15/2016 13:09
LM File#: 201606150000031237
Job #: 4103722

Electronically Signed By:
RIMKUS,GILBERTAS MD,
Jun 30 2016 11:01AM

Encounter Summary

Name: Daniel Knight
[redacted]
Sex: Male
Race: Caucasian
Martial Status: Married

[redacted]
MRN: M000175313
Account#: V00006912886
Home phone: (330)719-5830
Work phone: 843

Chief Complaint: Abdominal Pain
MOA: Walk-In
Acuity: Level 1

Arrival: 05/15/2016 04:37

Care Complete Date 05/15/2016
Care Complete Time 06:46
Departure Date 05/15/2016
Departure Time 08:22

Responsible Dept: Medical

Special Handling:
Family Waiting: No
Bed ED15

Assigned staff & roles

Name	Role	Specialty
Carcich, Emily	Primary Nurse	
Lorenzen, Darlene L	Primary Nurse	
Montgomery, Krashonda		
Rimkus, Gilbertas	Admitting Physician	Surgery - Gen
Beard, Dawn		
Tarbert, Charles	Attending Physician	Emergency Medicine

Outcome: Admit
Location: Decision by admitting physician
Condition: Critical
Chief Complaint: Abdominal Pain
Diagnosis: Bowel Perforation, Bowel Injury
Prescriptions:
Follow up:
Special Notes:
Attending Physician: Tarbert
Mid Level Provider:
Admit Physician: Rimkus
Orders: CBC W/ AUTO DIFF, CMP: CMP includes HEPAN, if HEPAN needed ORDER DBIL, LIPASE, CBC WITHOUT DIFF, LIPASE, T&S, ABDOMEN/PELVIS W CONTRAST+CT, NS 0.9%, TORadol, morphine, NS 0.9% , Diflucan, INVanz, Dilaudid, SALINE LOCK
Discharge Instruction: Medication Reconciliation, Handoff Communication Form (SBAR)

Name: Daniel Knight
[redacted]
Arrival Date: 05/15/2016 **Time:** 04:37
Bed ED15

MRN: M000175313
Account#: V00006912886
Private MD:

HPI:

05/15 05:24 (05:26) This 41 yrs old Caucasian Male presents to ED via Walk-In with complaints of **Abdominal Pain**. ct

05:24 (05:26) The patient presents with abdominal pain that is diffuse. (05:26) Onset: The symptoms/episode began/occurred ***States he was in a head on collision on April 22nd. States he had a normal workup, however has had severe abdominal pain "where the seatbelt went across". States this pain has been intermittent with three episodes occurring over the last several days. This current bout started yesterday..*** (05:26) The symptoms do not radiate. (05:26) Associated signs and symptoms: Pertinent negatives: blood in stools, constipation, diarrhea, dysuria, fever, hematuria, nausea, vomiting. (05:26) The symptoms are described as achy. (05:26) Modifying factors: The symptoms are alleviated by nothing, the symptoms are aggravated by nothing. (05:26) Severity of pain: At its worst the pain was severe in the emergency department the pain is unchanged. (05:26) The patient has experienced similar episodes in the past. (05:26) The patient has not recently seen a physician. ct

Historical:

Allergies:

04:39 (04:41) SULFA (SULFONAMIDES); (04:41) PCN; bj

Home Meds:

04:39 (04:41) 1. . Prozac Weekly oral Unknown Unknown 20 mg daily bj

PMHx:

04:39 (04:41) ANXIETY; (04:41) Whiplash (April 27, 2016); (04:41) Other - MVC (April 27, 2016); (04:41) Hand Abrasion (April 27, 2016); (04:41) Abrasion of Multiple Sites w/o Infection (April 27, 2016); (04:41) Chest Contusion (April 27, 2016); (04:41) Abdominal Wall Contusion (April 27, 2016); bj

PSHx:

04:39 (04:41) NONE; bj

Historical:

04:39 (04:41) Medication Information obtained from: Patient. (04:41) Social history Smoking status: Patient denies tobacco use. No barriers to communication noted. The patient speaks fluent English. (04:41) Immunization history: Last tetanus immunization: up to date. Pneumococcal vaccine is not up to date. Patient has never been vaccinated. Flu vaccine is up to date. (04:41) Code Status: Full code. (04:41) Do you have an Advanced Directive or Health Care Power of Attorney? No. (04:41) Family history: Not pertinent. bj

05:24 (05:26) The history from nurses notes was reviewed and my personal history differs from that reported to nursing. ct

ROS:

05:24 (05:26) **Constitutional:** Negative for fever or chills. **Neck:** Negative for pain, and swelling, **Cardiovascular:** Negative for CP or palpitations. **Respiratory:** Negative for shortness of breath, cough or wheezing. **Back:** Denies pain or injury. **GU:** Negative for dysuria, hematuria or frequency. **MS/Extremity:** Negative for pain, edema **Skin:** Negative for rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness and tingling. (05:26) **Abdomen/GI:** Positive for abdominal pain, Negative for nausea, vomiting, diarrhea, constipation. ct

Exam:

05:24 (05:27) ct

Constitutional: Awake, alert with no signs of distress.
Head/Face: Normocephalic, atraumatic.
Neck: No mass or lymphadenopathy. Neck is supple without pain with movement.
Respiratory: Lungs have equal breath sounds bilaterally, clear to auscultation. No rales, rhonchi or wheezes noted. No increased work of breathing.
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.

Skin: Warm, dry with normal turgor. Normal color with no rashes or lesions noted.
MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Full, normal range of motion. No pain with palpation and no edema.
Neuro: Awake and alert, oriented. Cranial nerves are intact. No gross motor or sensory deficits. (05:27)
Cardiovascular: Rate: tachycardic, Rhythm: regular, Pulses: no pulse deficits are appreciated, Heart sounds: normal, no murmur. (05:27)
Abdomen/GI: Inspection: abdomen appears normal, Bowel sounds: normal, in all quadrants, Palpation: soft, in all quadrants, severe abdominal tenderness, in all quadrants, mass, is not appreciated, rebound tenderness, is not appreciated, voluntary guarding, is not appreciated, no appreciated organomegaly.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
04:39 (04:42)						72.57 kg / 159.99 lbs	5 ft. 3 in. (160.02 cm)	10/10	bj
04:44 (04:45)	99 / 46	133	18	97.8(O)	98% on R/A				rb4
05:00	72 / 33	133	18						bd
05:27 (05:28)	82 / 63	112	18		98%			10/10	ec3
05:57 (05:58)	106 / 69	112	20						ec3
06:07 (06:08)	101 / 78	120	18					10/10	ec3
06:33	117 / 65	117	18		97%			9/10	ec3
06:54 (06:57)	87 / 37	123	22		97%			8/10	ec3
07:15 (07:16)	86 / 54	129	20						ec3
07:27 (07:28)	101 / 65	128	24		96% on R/A				dl
07:43	84 / 57	128	22		96% on R/A			8/10	dl
07:45 (07:46)	121 / 102	126	21		97% on R/A			8/10	dl
07:48								6/10	dl
08:03	147 / 101	126	22		96%			7/10	dl

04:39 Body Mass Index 28.34 (72.57 kg, 160.02 cm) bj

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
04:39 (04:42)	spontaneous(4)	oriented(5)	obeys commands(6)		15	bj

MDM:

04:55 Patient medically screened. cb

04:55 Financial registration complete. cb

06:45 (06:46) ct

Data reviewed: vital signs, nurses notes, old medical records, lab test result(s), radiologic studies, CT scan. (06:46)
Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology

results, the need for further work-up and treatment in the hospital. (06:46)
ED course: ***CT showed free air and likely a large amount of dead bowel. I discussed the case with Dr Rimkus who will take the patient to the OR for surgical intervention.***

Order	Status	Time	By	For
SALINE LOCK	Ordered	05/15/16 04:53	ct	ct
	Completed	05/15/16 05:00	Emily Carcich	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
CBC W/ AUTO DIFF	Ordered	05/15/16 04:53	ct	ct
	Reviewed	05/15/16 05:32	Charles Tarbert	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
CMP: CMP includes HEPAN, if HEPAN needed ORDER DBIL	Ordered	05/15/16 04:53	ct	ct
	Reviewed	05/15/16 05:37	Charles Tarbert	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
ABDOMEN/PELVIS W CONTRAST+CT	Ordered	05/15/16 04:53	ct	ct
	Reviewed	05/15/16 06:55	Charles Tarbert	
Notes: Bed Name: ED15	**Order Method:** Electronic			

Order	Status	Time	By	For
NS 0.9% 1000 mL IV at Bolus once	Ordered	05/15/16 04:53	ct	ct
	Administered	05/15/16 05:00	ec3	
Notes:	**Order Method:** Electronic			
05/15/16 05:00 **Administered:** NS 0.9% 1000 mL				ec3

Order	Status	Time	By	For
TORadol 30 mg IVP once	Ordered	05/15/16 05:23	ct	ct
	Administered	05/15/16 05:27	ec3	
Notes:	**Order Method:** Electronic			
05/15/16 05:27 **Administered:** TORadol 30 mg				ec3
05/15/16 05:57 **Follow Up:** Response: No change in condition				ec3

Order	Status	Time	By	For
LIPASE	Ordered	05/15/16 05:23	ct	ct
	Canceled	05/15/16 05:28	Dispatcher MedHost	
Notes:	**Order Method:** Electronic			

Reason for Cancellation: ADD TO C74

Order	Status	Time	By	For
CBC WITHOUT DIFF	Ordered	05/15/16 05:28	EDMS	
	Reviewed	05/15/16 05:32	Charles Tarbert	
Notes:	**Order Method:**			
	Sign off: Tarbert,Charles,MD 05/15/16 05:31			

Order	Status	Time	By	For
LIPASE	Ordered	05/15/16 05:34	EDMS	
	Reviewed	05/15/16 05:37	Charles Tarbert	
Notes:	**Order Method:**			
	Sign off: Tarbert,Charles,MD 05/15/16 05:37			

Order	Status	Time	By	For
morphine 4 mg IVP once	Ordered	05/15/16 06:01	ct	ct
	Administered	05/15/16 06:40	ec3	
Notes:	**Order Method:** Electronic			

05/15/16 06:40 **Administered:** morphine 4 mg ec3

05/15/16 06:53 **Follow Up:** Response: Blood pressure is lowered; Pain is decreased ec3

Order	Status	Time	By	For
NS 0.9% 1000 mL IV at 250 mL/h once	Ordered	05/15/16 06:04	ct	ct
	Administered	05/15/16 06:07	ec3	
Notes:	**Order Method:** Electronic			

05/15/16 06:07 **Administered:** NS 0.9% 1000 mL ec3

05/15/16 07:47 **Follow Up:** IV Status: Infusion continued dl

Order	Status	Time	By	For
Diflucan 200 mg IV at 1 Per Protocol once	Ordered	05/15/16 06:41	ct	ct
	Administered	05/15/16 07:27	dl	
Notes:	**Order Method:** Electronic			

05/15/16 07:27 **Administered:** Diflucan 200 mg dl

Order	Status	Time	By	For
INVanz 1 gram IVPB once	Ordered	05/15/16 06:41	ct	ct
	Administered	05/15/16 06:53	ec3	
Notes:	**Order Method:** Electronic			

Drug alert over ride reasons: MD discretion

05/15/16 06:53 **Administered:** INVanz 1 gram ec3

05/15/16 07:47 **Follow Up:** IV Status: Completed infusion dl

Order	Status	Time	By	For
T&S	Ordered	05/15/16 07:27	dl	ct

Physician Documentation Con't.

	Returned	05/15/16 08:09	Dispatcher MedHost
Notes:	**Order Method:** Verbal - Read back		
	Sign off:		

Order	Status	Time	By	For
Dilaudid 1 mg IVP once	Ordered	05/15/16 07:30	mj1	mj1
	Administered	05/15/16 07:40	dl	
Notes:	**Order Method:** Electronic			

05/15/16 07:40	**Administered:** Dilaudid 1 mg	dl
05/15/16 07:48	**Follow Up:** Pain 6/10 Adult	dl

Order Signatures:

Tarbert,Charles,MD	MD	ct	Conway Emergency Group		
Dispatcher MedHost		EDMS	Lorenzen, Darlene L RN	RN	dl
Jeanjaquet, Mark, MD	MD	mj1			

Dispensed Medications:

Time	Drug & Dose	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
05:00	NS 0.9% 1000 mL		IV	Bolus		left antecubital		ec3
05:27	TORadol 30 mg		IVP			left antecubital		ec3
05:57	Follow up: Response: No change in condition							ec3
06:07	NS 0.9% 1000 mL		IV	250 mL/h		left antecubital		ec3
07:47 (07:48)	Follow up: IV Status: Infusion continued							dl
06:40	morphine 4 mg		IVP			left antecubital		ec3
06:53 (06:54)	Follow up: Response: Blood pressure is lowered; Pain is decreased							ec3
06:53	INVanz 1 gram		IVPB			left antecubital		ec3
07:47	Follow up: IV Status: Completed infusion							dl
07:27	Diflucan 200 mg		IV	1 Per Protocol		right antecubital		dl
07:40 (07:41)	Dilaudid 1 mg		IVP			left antecubital		dl
07:48	Follow up: Pain 6/10 Adult							dl

Disposition:

06:45 (06:47) Disposition. (06:47) Critical Care: The time spent on critical care services is reported separate from other billable procedures. (06:47) Chart complete. ct

06:46 Aware of vital signs, to be admitted. ct

Disposition:

05/15/16 06:46 Admit ordered by Rimkus, Gilbertas. Preliminary diagnosis are Bowel Perforation, Bowel Injury.

- Bed requested for Decision by admitting physician.
- Condition is Critical.
- Problem is new.
- Symptoms are unchanged.

Critical Care Time:

06:45 Critical care time: Bedside Care: 15 minutes, Consultation: 5 minutes, Review of Old Records: 5 minutes, (06:47) Review diagnostic tests: 5 minutes, Record Phys Notes: 5 minutes. Total time: 35 minutes ct

Signatures:

Dispatcher MedHost		EDMS	Lorenzen, Darlene L RN	RN	dl
Barnhill, Cynthia		cb	Jeanjaquet, Mark, MD	MD	mj1
Beard, Dawn		db3	Tarbert,Charles,MD	MD	ct
Jaeger, Beth RN	RN	bj	Carcich, Emily RN	RN	ec3

Corrections:

05:28 ~~05:25 LIPASE+LAB ordered.~~ ~~EDMS~~ EDMS

05:28 ~~05:27 LIPASE+LAB ordered.~~ ~~EDMS~~ EDMS

CONWAY MEDICAL CENTER
P.O. BOX 829
300 SINGLETON RIDGE ROAD
CONWAY, SC 29526

Patient Name:	KNIGHT, DANIEL ERIC
Visit Number:	V00006912886
Unit Number:	M000175313
Admit Date:	05/15/2016
Room #/Location:	CC26/CCE CC26 1
Dictating Physician:	Gilbertas Rimkus, MD

PREOPERATIVE HISTORY & PHYSICAL

REASON FOR ADMISSION:
Abdominal pain, abnormal CT abdomen.

HISTORY OF PRESENT ILLNESS:
Mr. Knight is a 41-year-old patient who was involved in a collision motor vehicle accident approximately 3 weeks ago. At that time he was seen in the ER and underwent extensive workup which included CT scan of the chest and abdomen and only trace pelvic fluid was found at that time which could clearly have been physiologic. The patient presented now with increasing abdominal pain over the last several days. Work up in the emergency room again included CT scan of the abdomen and pelvis which showed tremendously distended and thickened small bowel and intraperitoneal fluid, moderate amount, and small amount of peritoneal gas suggestive of bowel obstruction with possible perforation. The patient never had any previous abdominal surgeries. I was called and asked to see the patient urgently.

PAST MEDICAL HISTORY:
Anxiety.

PAST SURGICAL HISTORY:
Unremarkable.

ALLERGIES:
SULFA, PENICILLIN.

MEDICATIONS:
Prozac.

SOCIAL HISTORY:
He does not smoke cigarettes and does not drink alcohol.

REVIEW OF SYSTEMS:
As per the ER physician's notes, reviewed with pertinent positives significant for abdominal pain getting worse the last couple of days.

PHYSICAL EXAMINATION:
VITAL SIGNS: Afebrile with heart rate of 110, blood pressure 95/60 after 2L of crystalloid.

GENERAL: A middle aged male in no distress.

HEENT: Unremarkable exam.

LUNGS: Decreased breath sounds at the bases bilaterally.

HEART: Tachycardic.

ABDOMEN: Distended. Tender diffusely with diffuse rebound tenderness.

EXTREMITIES: Atraumatic.

IMPRESSION:
A 41-year-old patient with peritonitis likely perforated viscus, possible ischemic intestine. He has been resuscitated with crystalloid and given broad spectrum IV antibiotics. We will take him to the operating

room this morning for exploratory laparotomy and possible bowel resection and possible ostomy. I discussed this with the patient and told him of the potential risks of bleeding, infection and remote possibility of having a temporary ostomy. He understood the procedure and risks and expressed written consent.

Gilbertas Rimkus, MD Date/Time

cc: Gilbertas Rimkus, MD
GR/4101506
DD: 05/15/2016 08:33
DT: 05/15/2016 08:44
LM File#: 201605150000035609
Job #: 4101506

Electronically Signed By:
RIMKUS,GILBERTAS MD,
May 18 2016 12:57PM

Medical Nutrition Therapy

Occurred Date	Time	by	Author	Recorded Date	Time	by
05/17/16	1010	SG	GUTKNECHT,SHARON	05/17/16	1021	SG

Abnormal? N Confidential? N

MNT ASSESSMENT;
ASSESSMENT;
-41 Y/O MALE ADMITTED WITH PERFORATED VISCOUS. S/P RESECTION OF SMALL BOWEL WITH ILEOSTOMY OF RLQ (5/15/16). POD #2. NGT TO SUCTION DISCONTINUED (5/16/16)
NOTED WITH ABSENT BOWEL SOUNDS. PER MD NOTATION TODAY, PT EXHIBITS WITH SOB; MILD PULMONARY EDEMA AND PLEURAL EFFUSION. IV LASIX INITIATED; PT ON OXYGEN VIA N/C.
-PT REMAINS NPO.
-PERTINENT MEDS: IV LASIX, INVANZ, DIFLUCAN, PROTONIX
-PERTINENT LAB: (5/15/16) ALBUMIN 2.9
NO RECENT ALBUMIN/PREALBUMIN LEVEL AVAILABLE
BEDSIDE GLUCOSE: (5/16/16) 100, 86, 81, 85
(5/17/16) 95
-BMI: 31.8

NUTRITION DX: RD TRIGGER
INTERVENTIONS:
NUTRITION RX:
-RECOMMENDED REQUIREMENTS:
-1950-2100 KCAL, 80-95 G PROTEIN, 1.9-2.0 L FLUID
-CONSIDER INITIATING 1 LITER PPN FOR NUTRITIONAL SUPPORT; TO PROVIDE 42.5 G PROTEIN, 510 KCAL. INITIATE CLEAR LIQUIDS WHEN BOWEL SOUNDS PRESENT WITH SUPPLEMENTATION OF RESOURCE BREEZE AT ALL MEALS FOR PO SUPPLEMENTATION.
-IF PO PROGRESSION NOT FEASIBLE, CENTRAL STANDARD TPN-2 LITERS SHOULD BE CONSIDERED TO PROVIDE 85.0 G PROTEIN, 1700 KCAL. ADD FAT EMULSION 3X WEEKLY FOR ADDITIONAL 500 KCAL.
GOALS:
-NPO < 3 DAYS
-LABS TREND WNL

MONITORING AND EVALUATION:
-MONITOR FOR PROSTAT MODULAR ON FU
-REQUEST PREALBUMIN LEVEL

COORDINATION OF CARE:
-NO D/C PLANS AT THIS TIME

POC LEVEL 1
SHARON GUTKNECHT MS RD LD

05/18/16	1306	LF	FARNAM,LARISSA	05/18/16	1318	LF

Abnormal? N Confidential? N

MNT F/U

ASSESSMENT:
- DIET ADVANCED TO CLEAR LIQUIDS
- ABLE TO TAKE IN A POPSICLE AND SOME JELLO BUT STATES NOT MUCH OF AN APPETITE
- GLUC 122, BUN 21, ALB 2.9

DIAGNOSIS:
- NO NEW DIAGNOSIS

INTERVENTION:
- NUTRITION RX: CLEARS; ADVANCE AS TOLERATED AND MEDICALLY ABLE TO A GOAL OF

Medical Nutrition Therapy

Occurred Date	Time	by	Author	Recorded Date	Time	by

05/18/16 1306 LF FARNAM,LARISSA 05/18/16 1318 LF (continued)

GI SOFT/LOW RESIDUE
GOAL: ADEQUATE P.O INTAKE
- NUTRITION EDUCATION: PROVIDED PT WITH WRITTEN AND VERBAL DIET INFORMATION ON A ILEOSTOMY DIET INCLUDING FOODS TO AVOID THAT MAY CAUSE GAS AND ABD PAIN AND ODOR; PT VERBALIZED UNDERSTANDING. RD CONTACT INFO ALSO PROVIDED IF PT OR WIFE (WHO IS NOT PRESENT IN ROOM AT TIME OF ASSESSMET) HAVE FURTHER QUESTIONS
GOAL: ADEQUATE P.O INTAKE WITH NO ABD PAIN
- COORDINATION OF CARE: NO DC NEEDS AT THIS TIME

RD TO F/U L1
LARISSA FARNAM, DHSc RD LD

05/23/16 1147 LH HARRIS,LINDSEY 05/23/16 1155 LH
Abnormal? N Confidential? N
MNT FU

ASSESSMENT
-GLU 130, BUN 24, NA 135, CA 7.7, ALB 2.0, MAG 2.5
-MED: PROTONIX, LASIX
-PT APPETITE IS POOR, WILLING TO TRY ENSURE, NO CRAZY ABOUT BREEZE. PT IS ON A 1500 CC FLUID RESTRICTION

DIAGNOSIS
-NO NEW DX

INTERVENTION
-DIET RX: REGULAR
GOAL: ADEQUATE PO INTAKE
-SUPPLEMENT: PROSTAT ONCE DAILY, ENSURE BID PO
GOAL: WT MAINTANENCE

COORDINATION OF CARE: NO DC NEEDS

FU LEVEL 1 26-28
LINDSEY HARRIS, RD LD

05/25/16 1109 LH HARRIS,LINDSEY 05/25/16 1112 LH
Abnormal? N Confidential? N
MNT FU

ASSESSMENT
-LABS: GLU 124, NA 135, CA 8, ALB 2, PHOS 2.1
-PT DOING FAIR. APPETITE REMAINS POOR. PT IS ON A FLUID RESTRICTION AND STAYS VERY THIRSTY INSTEAD OF HUNGRY. IS TOLERATING THE PROSTAT AND ENSURE DESPITE NOT LIKING THEM VERY MUCH.
-PT ASKING FOR A HAMBURGER BUT WAS SCARED ABOUT THE FAT CONTENT. ENCOURAGED PT TO MAY BE EAT ONLY HALF AND SEE HOW HE FEELS.

DIAGNOSIS
-NO NEW

INTERVENTION
-DIET RX: REGULAR, 1500 ML FLUID RESTRICTION
GOAL: ADEUQATE PO INTAKE
-SUPPLEMENT: PROSTAT BID PO, ENSURE BID PO
GOAL: IMPROVED LAB VALUES, WOUND HEALING

Medical Nutrition Therapy

Occurred Date	Time	by	Author	Recorded Date	Time	by
05/25/16	1109	LH	HARRIS,LINDSEY	05/25/16	1112	LH

(continued)

COORDINATION OF CARE: nO DC NEEDS

FU LEVEL 2 29-31
LINDSEY HARRIS, RD LD

NAME: KNIGHT,DANIEL ERIC ADMIT DATE: 05/15/16
UNIT #: M000175313 DISCHARGE DATE: 05/29/16
ACCT #: V00006912886 STATUS: DIS IN
CODED ALLERGIES Penicillins, Sulfa (Sulfonamide Antibiotics)
CODED ADRs None
UNCODED ALLERGIES Please update patient allergies
UNCODED ADRs None

ADMINISTRATION PERIOD: 0730 05/14/16 to 0729 05/15/16	START/ STOP	
Toradol (Ketorolac Tromethamine 30 MG/ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120487	05/15/16	0526 Discontinue 0527 STK MED
Morphine Sulfate (MorphINE Sulfate 4 MG/ML SYR) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120490	05/15/16	0602 Discontinue 0603 STK MED
INVanz (Ertapenem 1GM/Ns 50ML 1 GM/50 ML PREMIX) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120502	05/15/16	0645 Discontinue 0646 STK MED
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) UD XX .STK-MED/ONE RX #: 07120503	05/15/16	0646 Discontinue 0647 STK MED

ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16	START/ STOP	
Toradol (Ketorolac Tromethamine 30 MG/ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120487	05/15/16	AO 1202 STALBOT
Morphine Sulfate (MorphINE Sulfate 4 MG/ML SYR) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120490	05/15/16	AO 1202 STALBOT
INVanz (Ertapenem 1GM/Ns 50ML 1 GM/50 ML PREMIX) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120502	05/15/16	AO 1202 STALBOT

*** CONTINUED ON PAGE 2 ***
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ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) UD XX .STK-MED/ONE RX #: 07120503	05/15/16	AO 1202 STALBOT
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120518	05/15/16	0731 Discontinue 0731 STK MED AO 1202 STALBOT
Bupivacaine HCl 30 Ml (Bupivacaine HCl 0.25% 30 ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120521	05/15/16	0802 Discontinue 0803 STK MED AO 1202 STALBOT
EXPAREL Liposomal Suspension 1.3% (Bupivacaine Liposome 20 ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120535	05/15/16	0843 Discontinue 0843 STK MED AO 1202 STALBOT
Plasbumin-25% 100 Ml (Albumin Human 25 GM/100 ML BTL) 125 GM IV 0930 RX #: 07120542	05/15/16 05/15/16	Enter 0902 HGASSAWAY *0930 STALBOT at 1212 AGPACU RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: GIVEN IN PACU FDOC 05/15/16-1212 by STALBOT Discontinue 1130 SCHEDULER AO 1202 STALBOT
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) 100 MLS/HR IV Q24H Comments: PK ID: 8838622 RX #: 07120570	05/16/16 05/26/16	Enter 0955 PKPHAUSER EDIT 1006 SOWENS2 Verified 1006 SOWENS2 AO 1211 STALBOT

*** CONTINUED ON PAGE 3 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: DO NOT MIX WITH DEXTROSE CONTAINING SOLUTIONS Please specify number of doses PK ID: 8838633 RX #: 07120569	05/16/16 05/18/16	Enter 0957 PKPHAUSER EDIT 1006 SOWENS2 Verified 1006 SOWENS2 AO 1209 STALBOT 0630 LFADRI at 0558 GAVE: 50 MLS FDOC 05/16/16-0559 by LFADRI
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) 150 MLS/HR IV .Q6H40M Comments: Number of Liters Continuous PK ID: 8838635 RX #: 07120566	05/15/16 06/14/16	Enter 0958 PKPHAUSER *1000 STALBOT at 1212 AGPACU RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: STARTED IN PACU FDOC 05/15/16-1212 by STALBOT Verified 1005 HGASSAWAY AO 1208 STALBOT 1640 STALBOT at 1607 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 05/15/16-1608 by STALBOT 2320 BPAUL at 2326 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 05/15/16-2326 by BPAUL 0600 LFADRI at 0558 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 05/16/16-0559 by LFADRI
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV BEDTIME Comments: PK ID: 8838647 DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS RX #: 07120573	05/15/16 06/14/16	Enter 1002 PKPHAUSER EDIT 1009 SOWENS2 Verified 1009 SOWENS2. AO 1208 STALBOT 2100 BPAUL at 2007 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0008092351 PAN40I - Pantoprazole Sodium 40 MG/EAC... FDOC 05/15/16-2007 by BPAUL

*** CONTINUED ON PAGE 4 ***
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ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
Protonix (Pantoprazole Sodium 40 MG/EACH TAB) 40 MG OR .HS Comments: DO NOT CRUSH PK ID: 8838649 RX #: 07120574	05/15/16 06/14/16	Enter 1003 PKPHAUSER EDIT 1010 SOWENS2 Verified 1010 SOWENS2 AO 1209 STALBOT
EXPAREL Liposomal Suspension 1.3% (Bupivacaine Liposome 20 ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120600	05/15/16	1031 Discontinue 1032 STK MED AO 1202 STALBOT
EXPAREL Liposomal Suspension 1.3% (Bupivacaine Liposome 20 ML VIAL) See Dose Ins. .ROUTE .STK-MED/ONE RX #: 07120601	05/15/16	1032 Discontinue 1033 STK MED AO 1202 STALBOT
Diprivan (Propofol 10 MG/ML VIAL) 1,000 MG IV .PER PROTOCOL Comments: PER SEDATION PROTOCOL RX #: 07120636	05/15/16 06/14/16	Enter 1132 SOWENS2 AO 1209 STALBOT Hold Acknowledgement 1811 STALBOT OFF VENT Nur Request Removed 1818 HGASSAWAY Discontinue 1818 HGASSAWAY AO 1827 STALBOT
Lactated Ringer's 1000 Ml 500 ML (Lactated Ringer's 1,000 ML BAG) 1,000 MLS/HR IV .Q30M/ONE Comments: Number of Liters (bolus only) PK ID: 8842768 RX #: 07120912	05/15/16 05/15/16	Enter 1603 PKPHAUSER AO 1611 STALBOT EDIT 1611 HGASSAWAY Verified 1611 HGASSAWAY *1630 STALBOT at 1611 AG FDOC 05/15/16-1612 by STALBOT Discontinue 2059 SCHEDULER
Sodium Chloride 0.9% 10 Ml (Saline Flush Protocol 10 ML SYR) 70 ML XX .STK-MED/ONE RX #: 07121925	05/15/16 05/15/16	1115
Quelicin* (Succinylcholine Chloride 20 MG/ML VIAL) 200 MG XX .STK-MED/ONE RX #: 07122836	05/15/16 05/15/16	1720

*** CONTINUED ON PAGE 5 ***

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ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
Zemuron* (Rocuronium Bromide 10 MG/ML VIAL) 50 MG XX .STK-MED/ONE RX #: 07122837	05/15/16 05/15/16	1720
Lidocaine HCl 5 Ml (Lidocaine 1% 50 MG/5 ML AMP) 50 MG XX .STK-MED/ONE RX #: 07122838	05/15/16 05/15/16	1720
Zofran (Ondansetron 2 MG/ML SDV) 4 MG XX .STK-MED/ONE RX #: 07122839	05/15/16 05/15/16	1720
Phenylephrine HCl (Phenylephrine HCl 10 MG/ML VIAL) 10 MG XX .STK-MED/ONE RX #: 07122840	05/15/16 05/15/16	1720
Morphine Sulfate (MorphINE Sulfate 10 MG/ML SYR) See Dose Ins. IV .q2min/PRN PRN Reason: PAIN Dose Ins: May give 2 MG IV every 2 min up to 10 MG IN PACU ONLY Comments: May give 2 MG IV every 2 min up to 10 MG IN PACU ONLY PK ID: 8838381 RX #: 07120562	05/15/16 05/15/16	Admin Criterion Entered 0928 PKPHAUSER Enter 0928 PKPHAUSER Admin Criterion Edit 0934 HGASSAWAY EDIT 0934 HGASSAWAY Verified 0934 HGASSAWAY AO 1208 STALBOT Discontinue 1230 SCHEDULER
Acephen (Acetaminophen 650 MG/EACH SUP) 650 MG RE EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 8838614 RX #: 07120567	05/15/16 06/14/16	Enter 0954 PKPHAUSER EDIT 1006 HGASSAWAY Verified 1006 HGASSAWAY AO 1208 STALBOT

*** CONTINUED ON PAGE 6 ***
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ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP)	05/15/16	Admin Criterion Entered 0956 PKPHAUSER
See Dose Ins. IV EVERY 2 HOURS/PRN	05/25/16	Enter 0956 PKPHAUSER
PRN Reason: PAIN		Admin Criterion Edit 1009 SOWENS2
Dose Ins: 0.5 MG FOR PAIN </= 5; 1 MG FOR PAIN > 5 ON SCALE		EDIT 1009 SOWENS2
Comments: PK ID: 8838625		Verified 1009 SOWENS2
RX #: 07120572		AO 1208 STALBOT
		1741 CPETTY at 1741 GAVE: 0.5 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		FDOC 05/15/16-1741 by CPETTY
		DOSE changed from MG to 0.5 MG
		2007 BPAUL at 2007 GAVE: 1 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 8 Time Med Given: 2007
		Date: 05/15/16 Reassess: 2107
		Pain Location:
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/15/16-2007 by BPAUL
		DOSE changed from MG to 1 MG
		2052 REASSESS by BPAUL at 2101
		Pt Relieved Of Pain: YRe-assess Pain Scale:6 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		2326 BPAUL at 2326 GAVE: 1 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2326
		Date: 05/15/16 Reassess: 0026
		Pain Location:
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/15/16-2326 by BPAUL
		DOSE changed from MG to 1 MG
		0011 REASSESS by BPAUL at 0004
		Pt Relieved Of Pain: YRe-assess Pain Scale:5 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:

*** CONTINUED ON PAGE 7 ***

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ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
		Respiratory Quality: Respiratory Depth: Comment: 0400 LFADRI at 0400 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: Time Med Given: 0400 Date: 05/16/16 Reassess: 0500 Pain Location: Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/16/16-0401 by LFADRI DOSE changed from MG to 1 MG 0445 REASSESS by LFADRI at 0500 Pt Relieved Of Pain: Re-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment:
Mag-Al ANTACID 200-200 MG/5 Ml 30 Ml (Mag Hydrox-Al Hydrox-Sim 30 ML UDC) 30 ML OR EVERY 4 HOURS/PRN PRN Reason: INDIGESTION Comments: unless patient is NPO PK ID: 8838636 RX #: 07120578	05/15/16 06/14/16	Enter 0959 PKPHAUSER Verified 1011 SOWENS2 AO 1208 STALBOT
MYLICON-80 (Simethicone 80 MG/EACH TAB) 80 MG OR BEFORE MEALS AND BEDTIME/PRN PRN Reason: GAS/BLOATING Comments: PK ID: 8838637 RX #: 07120577	05/15/16 06/14/16	Enter 1000 PKPHAUSER Verified 1010 SOWENS2 AO 1208 STALBOT
PHENERGAN (Promethazine HCl 25 MG/ML AMP) 12.5 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: DILUTE WITH 10-20ML SALINE AND ADMINISTER OVER 10-15 MINUTES PK ID: 8838641 RX #: 07120575	05/15/16 06/14/16	Enter 1001 PKPHAUSER Verified 1010 SOWENS2 AO 1208 STALBOT

*** CONTINUED ON PAGE 8 ***

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ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
Tylenol (Acetaminophen 325 MG/EACH TAB) 650 MG OR EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 8838650 RX #: 07120568	05/15/16 06/14/16	Enter 1004 PKPHAUSER EDIT 1006 HGASSAWAY Verified 1006 HGASSAWAY AO 1209 STALBOT
Zofran (Ondansetron 2 MG/ML SDV) 4 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: PK ID: 8838653 RX #: 07120576	05/15/16 06/14/16	Enter 1005 PKPHAUSER Verified 1010 SOWENS2 AO 1209 STALBOT

*** CONTINUED ON PAGE 9 ***
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ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
Morphine Sulfate (MorphINE Sulfate 4 MG/ML SYR)	05/15/16	Admin Criterion Entered 1541 SOWENS2
See Dose Ins. IV EVERY 4 HOURS/PRN	05/25/16	Enter 1541 SOWENS2
PRN Reason: PAIN		AO 1546 CPETTY
Dose Ins: 1-2 MG		1546 CPETTY at 1546 GAVE: 2 MG
Comments: (SALA) Caution Sound-alike / Look-alike med		NDC/DIN: (SOURCE: eMAR)
RX #: 07120875		0409189101 MS4I - MorphINE Sulfate 4 MG/ML SYR
		FDOC 05/15/16-1547 by CPETTY
		DOSE changed from MG to 2 MG
		2115 BPAUL at 2115 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409189101 MS4I - MorphINE Sulfate 4 MG/ML SYR
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2115
		Date: 05/15/16 Reassess: 2215
		Pain Location:
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/15/16-2116 by BPAUL
		DOSE changed from MG to 2 MG
		2200 REASSESS by BPAUL at 2200
		Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		AO 0204 BPAUL
		0207 LFADRI at 0207 GAVE: 2 MG
		Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 0207
		Date: 05/16/16 Reassess: 0307
		Pain Location: ABDOMINAL
		Quality Of Pain: ACHING
		Onset of Pain: POST-OP
		Duration of Pain: CONTINUOUS
		FDOC 05/16/16-0208 by LFADRI
		DOSE changed from MG to 2 MG
		0252 REASSESS by LFADRI at 0307
		Pt Relieved Of Pain: Re-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 16
		Respiratory Quality: WNL Respiratory Depth: WNL
		Comment:
		0559 LFADRI at 0559 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)

*** CONTINUED ON PAGE 10 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/15/16 to 0729 05/16/16 (Continued)	START/ STOP	
		0409189101 MS4I - MorphINE Sulfate 4 MG/ML SYR Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0559 Date: 05/16/16 Reassess: 0659 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 05/16/16-0559 by LFADRI DOSE changed from MG to 2 MG 0644 REASSESS by LFADRI at 0659 Pt Relieved Of Pain: Re-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment:

ADMINISTRATION PERIOD: 0730 05/16/16 to 0729 05/17/16	START/ STOP	
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) 100 MLS/HR IV Q24H Comments: PK ID: 8838622 RX #: 07120570	05/16/16 05/26/16	0800 AWRIGHT3 at 0758 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 3600000210 FLU200PB - Fluconazole/NS 200 MG/100 ML .. FDOC 05/16/16-0758 by AWRIGHT3
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: DO NOT MIX WITH DEXTROSE CONTAINING SOLUTIONS Please specify number of doses PK ID: 8838633 RX #: 07120569	05/16/16 05/18/16	0630 SHERRINGT2 at 0525 GAVE: 50 MLS RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Per Practitioner Order RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/17/16-0526 by SHERRINGT2

*** CONTINUED ON PAGE 11 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/16/16 to 0729 05/17/16 (Continued)	START/ STOP	
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) 150 MLS/HR IV .Q6H40M Comments: Number of Liters Continuous PK ID: 8838635 RX #: 07120566	05/15/16 06/14/16	1240 AWRIGHT3 at 1302 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG FDOC 05/16/16-1302 by AWRIGHT3 1920 SHERRINGT2 at 2054 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/16/16-2054 by SHERRINGT2 *0200 SHERRINGT2 at 0123 AG FDOC 05/17/16-0123 by SHERRINGT2 0403 SHERRINGT2 at 0403 GAVE: 1,000 MLS NDC/DIN: (SOURCE: eMAR) 0338011704 LR - Lactated Ringer's 1,000 ML BAG RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/17/16-0404 by SHERRINGT2
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV BEDTIME Comments: PK ID: 8838647 DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS RX #: 07120573	05/15/16 06/14/16	2100 SHERRINGT2 at 2046 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0008092351 PAN40I - Pantoprazole Sodium 40 MG/EAC.. FDOC 05/16/16-2047 by SHERRINGT2
DIPRIVAN (Propofol 10 MG/ML VIAL) 200 MG XX .STK-MED/ONE RX #: 07121648	05/16/16 05/16/16	0928 Discontinue 0928 STK MED Enter 0928 MCARR AO 1017 AWRIGHT3
Sublimaze (FentaNYL CITRATE 50 MCG/ML AMP) 100 MCG XX .STK-MED/ONE RX #: 07121649	05/16/16 05/16/16	0928 Discontinue 0928 STK MED Enter 0928 MCARR AO 1017 AWRIGHT3
VERSED (Midazolam HCl 1 MG/ML VIAL) 4 MG XX .STK-MED/ONE RX #: 07121650	05/16/16 05/16/16	0928 Discontinue 0928 STK MED Enter 0928 MCARR AO 1017 AWRIGHT3

*** CONTINUED ON PAGE 12 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/16/16 to 0729 05/17/16 (Continued)	START/ STOP	
Sodium Chloride 0.9% 10 Ml (Saline Flush Protocol 10 ML SYR) 70 ML XX .STK-MED/ONE RX #: 07121925	05/15/16 05/15/16	Discontinue 1115 STK MED Enter 1115 PMELVIN AO 1816 AWRIGHT3
Quelicin* (Succinylcholine Chloride 20 MG/ML VIAL) 200 MG XX .STK-MED/ONE RX #: 07122836	05/15/16 05/15/16	Discontinue 1721 STK MED Enter 1721 MCARR AO 1816 AWRIGHT3
Zemuron* (Rocuronium Bromide 10 MG/ML VIAL) 50 MG XX .STK-MED/ONE RX #: 07122837	05/15/16 05/15/16	Discontinue 1721 STK MED Enter 1721 MCARR AO 1816 AWRIGHT3
Lidocaine HCl 5 Ml (Lidocaine 1% 50 MG/5 ML AMP) 50 MG XX .STK-MED/ONE RX #: 07122838	05/15/16 05/15/16	Enter 1721 MCARR Discontinue 1721 STK MED AO 1816 AWRIGHT3
Zofran (Ondansetron 2 MG/ML SDV) 4 MG XX .STK-MED/ONE RX #: 07122839	05/15/16 05/15/16	Discontinue 1721 STK MED Enter 1721 MCARR AO 1816 AWRIGHT3
Phenylephrine HCl (Phenylephrine HCl 10 MG/ML VIAL) 10 MG XX .STK-MED/ONE RX #: 07122840	05/15/16 05/15/16	Discontinue 1721 STK MED Enter 1721 MCARR AO 1816 AWRIGHT3

*** CONTINUED ON PAGE 13 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/16/16 to 0729 05/17/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) See Dose Ins. IV EVERY 2 HOURS/PRN PRN Reason: PAIN Dose Ins: 0.5 MG FOR PAIN </= 5; 1 MG FOR PAIN > 5 ON SCALE Comments: PK ID: 8838625 RX #: 07120572	05/15/16 05/25/16	0757 AWRIGHT3 at 0757 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0757 Date: 05/16/16 Reassess: 0857 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/16/16-0758 by AWRIGHT3 DOSE changed from MG to 1 MG 0842 REASSESS by AWRIGHT3 at 0842 Pt Relieved Of Pain: NRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: DR SANTIAGO NOTIFIED Discontinue Verified 0854 JBLOCKER AO 1018 AWRIGHT3
Morphine Sulfate (MorphINE Sulfate 4 MG/ML SYR) See Dose Ins. IV EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 MG Comments: (SALA) Caution Sound-alike / Look-alike med RX #: 07120875	05/15/16 05/25/16	2356 SHERRINGT2 at 2356 GAVE: 2 MG NDC/DIN: (SOURCE: eMAR) 0409189101 MS4I - MorphINE Sulfate 4 MG/ML SYR Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2356 Date: 05/16/16 Reassess: 0056 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/16/16-2357 by SHERRINGT2 DOSE changed from MG to 2 MG 0041 REASSESS by SHERRINGT2 at 0041 Pt Relieved Of Pain: YRe-assess Pain Scale:0 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 18 Respiratory Quality: WNL Respiratory Depth: WNL Comment:

*** CONTINUED ON PAGE 14 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/16/16 to 0729 05/17/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 2 MG IV EVERY 2 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8846818 RX #: 07121574	05/16/16	Admin Criterion Entered 0849 PKPHAUSER
	05/26/16	Enter 0849 PKPHAUSER
		EDIT 0854 JBLOCKER
		Verified 0854 JBLOCKER
		AO 1018 AWRIGHT3
		1022 AWRIGHT3 at 1022 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 8 Time Med Given: 1021
		Date: 05/16/16 Reassess: 1121
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/16/16-1022 by AWRIGHT3
		1107 REASSESS by AWRIGHT3 at 1107
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		1434 AWRIGHT3 at 1434 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1434
		Date: 05/16/16 Reassess: 1534
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/16/16-1434 by AWRIGHT3
		1519 REASSESS by AWRIGHT3 at 1519
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		1855 AWRIGHT3 at 1855 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 8 Time Med Given: 1855
		Date: 05/16/16 Reassess: 1955
		Pain Location: ABDOMINAL

*** CONTINUED ON PAGE 15 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/16/16 to 0729 05/17/16 (Continued)	START/ STOP	
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/16/16-1855 by AWRIGHT3
		1940 REASSESS by SHERRINGT2 at 1948
		Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		0403 SHERRINGT2 at 0403 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0403
		Date: 05/17/16 Reassess: 0503
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/17/16-0404 by SHERRINGT2
		0448 REASSESS by SHERRINGT2 at 0448
		Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		0607 SHERRINGT2 at 0607 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0606
		Date: 05/17/16 Reassess: 0706
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/17/16-0607 by SHERRINGT2
		0652 REASSESS by KBELLAM at 0720
		Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:

*** CONTINUED ON PAGE 16 ***
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ADMINISTRATION PERIOD: 0730 05/16/16 to 0729 05/17/16 (Continued)	START/ STOP	
Toradol (Ketorolac Tromethamine 30 MG/ML VIAL) 30 MG IV EVERY 6 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8853946 RX #: 07122303	05/16/16 05/21/16	Enter 1336 PKPHAUSER Verified 1348 JBLOCKER AO 1547 AWRIGHT3 2046 SHERRINGT2 at 2046 GAVE: 30 MG NDC/DIN: (SOURCE: eMAR) 0409379501 KET30I - Ketorolac Tromethamine 30 MG/... Pt C/O Pain: Y Pain Scale: 2 Time Med Given: 2046 Date: 05/16/16 Reassess: 2146 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/16/16-2047 by SHERRINGT2 2131 REASSESS by SHERRINGT2 at 2146 Pt Relieved Of Pain: YRe-assess Pain Scale:0 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16	START/ STOP	
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) 100 MLS/HR IV Q24H Comments: PK ID: 8838622 RX #: 07120570	05/16/16 05/26/16	0800 SHERRINGT2 at 0926 GAVE: 100 MLS RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/17/16-0927 by SHERRINGT2
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: DO NOT MIX WITH DEXTROSE CONTAINING SOLUTIONS Please specify number of doses PK ID: 8838633 RX #: 07120569	05/16/16 05/18/16	0630 RMESHREKI at 0506 GAVE: 50 MLS RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/18/16-0507 by RMESHREKI

*** CONTINUED ON PAGE 17 ***

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ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP	
Lactated Ringer's 1000 Ml 1,000 ML (Lactated Ringer's 1,000 ML BAG) 150 MLS/HR IV .Q6H40M Comments: Number of Liters Continuous PK ID: 8838635 RX #: 07120566	05/15/16 06/14/16	*0840 SHERRINGT2 at 0939 DC FDOC 05/17/16-1002 by SHERRINGT2 Discontinue Verified 0853 JBLOCKER AO 0939 SHERRINGT2 Dc Order Override 1002 SHERRINGT2 DC'D
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV BEDTIME Comments: PK ID: 8838647 DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS RX #: 07120573	05/15/16 06/14/16	2100 RMESHREKI at 2112 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0008092351 PAN40I - Pantoprazole Sodium 40 MG/EAC.. FDOC 05/17/16-2113 by RMESHREKI
Lasix (Furosemide 40 MG/4 ML VIAL) 20 MG IV ONE TIME ONLY/STA Comments: STAT PK ID: 8864152 RX #: 07123536	05/17/16 05/17/16	0850 SHERRINGT2 at 0959 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FUR40I - Furosemide 40 MG/4 ML VIAL RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/17/16-1002 by SHERRINGT2 Enter 0850 PKPHAUSER EDIT 0853 JBLOCKER Verified 0853 JBLOCKER AO 0959 SHERRINGT2 Discontinue 1143 SOWENS2 AO 1146 KBELLAM
Lasix (Furosemide 40 MG/4 ML VIAL) 20 MG IV Q12H Comments: PK ID: 8864474 RX #: 07123594	05/17/16 06/16/16	Enter 0900 PKPHAUSER EDIT 0920 JBLOCKER Verified 0920 JBLOCKER AO 1011 KBELLAM Discontinue 1144 SOWENS2 AO 1146 KBELLAM
Lasix (Furosemide 40 MG/4 ML VIAL) 20 MG IV ONE TIME ONLY/ONE RX #: 07123839	05/17/16 05/17/16	Enter 1143 SOWENS2 AO 1146 KBELLAM 1200 SHERRINGT2 at 1222 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FUR40I - Furosemide 40 MG/4 ML VIAL FDOC 05/17/16-1223 by SHERRINGT2 Discontinue 1401 SCHEDULER

*** CONTINUED ON PAGE 18 ***

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ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP		
Lasix (Furosemide 40 MG/4 ML VIAL) 40 MG IV EVERY 12 HOURS Comments: PK ID: 8864474 RX #: 07123840	05/17/16 06/16/16	Enter 1144 SOWENS2 AO 1146 KBELLAM 2100 RMESHREKI at 2113 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FDOC 05/17/16-2113 by RMESHREKI	FUR40I - Furosemide 40 MG/4 ML VIAL
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH FOUR TIMES A DAY RESP THERAPY RX #: 07124493	05/17/16 06/16/16	Enter 1852 NKAMDAR AO 1853 KBELLAM 1930 JWHITE7 at 1912 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/17/16-1913 by JWHITE7	ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb
Morphine Sulfate (MorphINE Sulfate 4 MG/ML SYR) See Dose Ins. IV EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 MG Comments: (SALA) Caution Sound-alike / Look-alike med RX #: 07120875	05/15/16 05/25/16	Discontinue Verified 0853 JBLOCKER AO 1011 KBELLAM	

*** CONTINUED ON PAGE 19 ***
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5A4D43B46E10429588C8, KNIGHT, 68

ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 2 MG IV EVERY 2 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8846818 RX #: 07121574	05/16/16 05/26/16	0803 SHERRINGT2 at 0803 GAVE: 2 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 8 Time Med Given: 0803 Date: 05/17/16 Reassess: 0903 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/17/16-0803 by SHERRINGT2 0848 REASSESS by SHERRINGT2 at 0927 Pt Relieved Of Pain: NRe-assess Pain Scale:6 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1041 SHERRINGT2 at 1041 GAVE: 2 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1041 Date: 05/17/16 Reassess: 1141 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/17/16-1042 by SHERRINGT2 1126 REASSESS by KBELLAM at 1126 Pt Relieved Of Pain: NRe-assess Pain Scale:4 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1616 KBELLAM at 1616 GAVE: 2 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1616 Date: 05/17/16 Reassess: 1716 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/17/16-1616 by KBELLAM 1701 REASSESS by KBELLAM at 1701

*** CONTINUED ON PAGE 20 ***

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ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP	
		Pt Relieved Of Pain: YRe-assess Pain Scale:6 Reassess:DONE
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		2112 RMESHREKI at 2112 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 2112
		Date: 05/17/16 Reassess: 2212
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/17/16-2113 by RMESHREKI
		2157 REASSESS by RMESHREKI at 2155
		Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment: PT REQUESTED TO HAVE HIS VICODEN AT 2230
		2345 RMESHREKI at 2345 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2345
		Date: 05/17/16 Reassess: 0045
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/17/16-2345 by RMESHREKI
		0030 REASSESS by RMESHREKI at 0030
		Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment: PT STATED THAT PAIN LEVEL IS TOLERABLE AT THIS TIME.
		0337 RMESHREKI at 0337 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 0337
		Date: 05/18/16 Reassess: 0437

*** CONTINUED ON PAGE 21 ***

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ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP	
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/18/16-0337 by RMESHREKI
		0422 REASSESS by RMESHREKI at 0415
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 20
		Respiratory Quality: WNL Respiratory Depth: WNL
		Comment:

*** CONTINUED ON PAGE 22 ***
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ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP	
Toradol (Ketorolac Tromethamine 30 MG/ML VIAL) 30 MG IV EVERY 6 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8853946 RX #: 07122303	05/16/16 05/21/16	1041 SHERRINGT2 at 1041 GAVE: 30 MG NDC/DIN: (SOURCE: eMAR) 6332316201 KET30I - Ketorolac Tromethamine 30 MG/.. Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1041 Date: 05/17/16 Reassess: 1141 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/17/16-1042 by SHERRINGT2 1126 REASSESS by KBELLAM at 1126 Pt Relieved Of Pain: NRe-assess Pain Scale:4 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1627 KBELLAM at 1627 GAVE: 30 MG NDC/DIN: (SOURCE: eMAR) 6332316201 KET30I - Ketorolac Tromethamine 30 MG/... Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1627 Date: 05/17/16 Reassess: 1727 Pain Location: Quality Of Pain: Onset of Pain: Duration of Pain: FDOC 05/17/16-1627 by KBELLAM 1712 REASSESS by KBELLAM at 1712 Pt Relieved Of Pain: NRe-assess Pain Scale:6 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

*** CONTINUED ON PAGE 23 ***

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ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP	
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB)	05/17/16	Admin Criterion Entered 1319 NGLODACK
See Dose Ins. PO EVERY 4 HOURS/PRN	05/27/16	Enter 1319 NGLODACK
PRN Reason: PAIN		AO 1321 KBELLAM
Dose Ins: 1-2 TABS		1321 KBELLAM at 1321 GAVE: 2 TAB
Comments: MAX APAP/24 HRS IS 4 GRAMS		NDC/DIN: (SOURCE: eMAR)
RX #: 07123965		0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 1321
		Date: 05/17/16 Reassess: 1421
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/17/16-1322 by KBELLAM
		DOSE changed from TAB to 2 TAB
		1406 REASSESS by KBELLAM at 1405
		Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		1729 KBELLAM at 1729 GAVE: 2 TAB
		NDC/DIN: (SOURCE: eMAR)
		0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1729
		Date: 05/17/16 Reassess: 1829
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/17/16-1730 by KBELLAM
		DOSE changed from TAB to 2 TAB
		1814 REASSESS by KBELLAM at 1814
		Pt Relieved Of Pain: YRe-assess Pain Scale:0 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 16
		Respiratory Quality: WNL Respiratory Depth: S
		Comment:
		2235 RMESHREKI at 2235 GAVE: 2 TAB
		NDC/DIN: (SOURCE: eMAR)
		0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB
		Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 2235
		Date: 05/17/16 Reassess: 2335
		Pain Location: ABDOMINAL

*** CONTINUED ON PAGE 24 ***

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ADMINISTRATION PERIOD: 0730 05/17/16 to 0729 05/18/16 (Continued)	START/ STOP	
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/17/16-2236 by RMESHREKI
		DOSE changed from TAB to 2 TAB
		2320 REASSESS by RMESHREKI at 2320
		Pt Relieved Of Pain: YRe-assess Pain Scale:5 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment: PT REQUESTED HIS DILAUDID
		0506 RMESHREKI at 0506 GAVE: 2 TAB
		NDC/DIN: (SOURCE: eMAR)
		0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB
		Pt C/O Pain: Y Pain Scale: 4 Time Med Given: 0506
		Date: 05/18/16 Reassess: 0606
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/18/16-0507 by RMESHREKI
		DOSE changed from TAB to 2 TAB
		0551 REASSESS by RMESHREKI at 0555
		Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:

ADMINISTRATION PERIOD: 0730 05/18/16 to 0729 05/19/16	START/ STOP	
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) 100 MLS/HR IV Q24H Comments: PK ID: 8838622 RX #: 07120570	05/16/16 05/26/16	0800 STALBOT at 0806 GAVE: 100 MLS FDOC 05/18/16-0806 by STALBOT

*** CONTINUED ON PAGE 25 ***

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ADMINISTRATION PERIOD: 0730 05/18/16 to 0729 05/19/16 (Continued)	START/ STOP			
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: DO NOT MIX WITH DEXTROSE CONTAINING SOLUTIONS Please specify number of doses PK ID: 8838633 RX #: 07120569	05/16/16 05/18/16	Discontinue 0730 SCHEDULER		
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV BEDTIME Comments: PK ID: 8838647 DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS RX #: 07120573	05/15/16 06/14/16	2100 RMESHREKI at 2115 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0008092351 FDOC 05/18/16-2116 by RMESHREKI	PAN40I	- Pantoprazole Sodium 40 MG/EAC..
Lasix (Furosemide 40 MG/4 ML VIAL) 40 MG IV EVERY 12 HOURS Comments: PK ID: 8864474 RX #: 07123840	05/17/16 06/16/16	0900 KCULCLASUR at 0943 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FDOC 05/18/16-0944 by KCULCLASUR 2100 RMESHREKI at 2115 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FDOC 05/18/16-2116 by RMESHREKI	FUR40I FUR40I	- Furosemide 40 MG/4 ML VIAL - Furosemide 40 MG/4 ML VIAL

*** CONTINUED ON PAGE 26 ***
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ADMINISTRATION PERIOD: 0730 05/18/16 to 0729 05/19/16 (Continued)	START/ STOP		
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH FOUR TIMES A DAY RESP THERAPY RX #: 07124493	05/17/16 06/16/16	0730 SESTES at 0730 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/18/16-0731 by SESTES 1130 BEPLER at 1059 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/18/16-1100 by BEPLER 1530 SESTES at 1452 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/18/16-1453 by SESTES 1930 JWILSON2 at 2024 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/18/16-2028 by JWILSON2	ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: PK ID: 8838633 RX #: 07126033	05/19/16 05/29/16	Enter 1625 SOWENS2 AO 1646 STALBOT 0600 RMESHREKI at 0611 GAVE: 50 MLS FDOC 05/19/16-0611 by RMESHREKI	

*** CONTINUED ON PAGE 27 ***

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5A4D43B46E10429588C8, KNIGHT, 76

ADMINISTRATION PERIOD: 0730 05/18/16 to 0729 05/19/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP)	05/16/16	1703 CPETTY at 1703 GAVE: 2 MG
2 MG IV EVERY 2 HOURS/PRN	05/26/16	NDC/DIN: (SOURCE: eMAR)
PRN Reason: PAIN		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
Comments: PK ID: 8846818		FDOC 05/18/16-1703 by CPETTY
RX #: 07121574		2115 RMESHREKI at 2115 GAVE: 2 MG
		NDC/DIN: (SOURCE: eMAR)
		0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP
		Pt C/O Pain: Y Pain Scale: 4 Time Med Given: 2115
		Date: 05/18/16 Reassess: 2215
		Pain Location: ABDOMINAL
		Quality Of Pain:
		Onset of Pain:
		Duration of Pain:
		FDOC 05/18/16-2116 by RMESHREKI
		2200 REASSESS by RMESHREKI at 2200
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 20
		Respiratory Quality: WNL Respiratory Depth: WNL
		Comment:

*** CONTINUED ON PAGE 28 ***
This document is part of the legal medical record.

5A4D43B46E10429588C8, KNIGHT, 77

ADMINISTRATION PERIOD: 0730 05/18/16 to 0729 05/19/16 (Continued)	START/ STOP	
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB) See Dose Ins. PO EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 TABS Comments: MAX APAP/24 HRS IS 4 GRAMS RX #: 07123965	05/17/16 05/27/16	1233 STALBOT at 1233 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1233 Date: 05/18/16 Reassess: 1333 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: FDOC 05/18/16-1234 by STALBOT DOSE changed from TAB to 2 TAB 1318 REASSESS by STALBOT at 1315 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment: 1906 STALBOT at 1906 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1905 Date: 05/18/16 Reassess: 2005 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: FDOC 05/18/16-1906 by STALBOT DOSE changed from TAB to 2 TAB 1951 REASSESS by RMESHREKI at 2000 Pt Relieved Of Pain: Re-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: SEE NURSES NOTES 0134 RMESHREKI at 0134 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0134 Date: 05/19/16 Reassess: 0234 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain:

*** CONTINUED ON PAGE 29 ***

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ADMINISTRATION PERIOD: 0730 05/18/16 to 0729 05/19/16 (Continued)	START/ STOP	
		FDOC 05/19/16-0135 by RMESHREKI DOSE changed from TAB to 2 TAB 0219 REASSESS by RMESHREKI at 0214 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 21 Respiratory Quality: WNL Respiratory Depth: WNL Comment:

ADMINISTRATION PERIOD: 0730 05/19/16 to 0729 05/20/16	START/ STOP	
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) 100 MLS/HR IV Q24H Comments: PK ID: 8838622 RX #: 07120570	05/16/16 05/26/16	0800 STALBOT at 0817 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 3600000210 FLU200PB - Fluconazole/NS 200 MG/100 ML .. FDOC 05/19/16-0817 by STALBOT
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV BEDTIME Comments: PK ID: 8838647 DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS RX #: 07120573	05/15/16 06/14/16	2100 RMESHREKI at 2213 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0008092351 PAN40I - Pantoprazole Sodium 40 MG/EAC.. RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/19/16-2214 by RMESHREKI
Lasix (Furosemide 40 MG/4 ML VIAL) 40 MG IV EVERY 12 HOURS Comments: PK ID: 8864474 RX #: 07123840	05/17/16 06/16/16	0900 TKOCH2 at 0912 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FUR40I - Furosemide 40 MG/4 ML VIAL FDOC 05/19/16-0928 by TKOCH2 2100 RMESHREKI at 2213 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FUR40I - Furosemide 40 MG/4 ML VIAL RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/19/16-2214 by RMESHREKI

*** CONTINUED ON PAGE 30 ***
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5A4D43B46E10429588C8, KNIGHT, 79

ADMINISTRATION PERIOD: 0730 05/19/16 to 0729 05/20/16 (Continued)	START/ STOP	
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH FOUR TIMES A DAY RESP THERAPY RX #: 07124493	05/17/16 06/16/16	0730 SPAITSEL at 0704 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/19/16-0704 by SPAITSEL 1130 SPAITSEL at 1047 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/19/16-1048 by SPAITSEL 1530 SPAITSEL at 1438 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/19/16-1438 by SPAITSEL 1930 JWILSON2 at 2030 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/19/16-2035 by JWILSON2
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: PK ID: 8838633 RX #: 07126033	05/19/16 05/29/16	0600 RMESHREKI at 0514 GAVE: 50 MLS FDOC 05/20/16-0515 by RMESHREKI
Solu-MEDROL (MethylPREDNISOLone SOD SUCC 40 MG/EACH VIAL) 40 MG IV EVERY 8 HOURS Comments: PK ID: 8895441 RX #: 07127130	05/19/16 05/29/16	Enter 0835 PKPHAUSER EDIT 0840 CPOSTON1 Verified 0840 CPOSTON1 AO 0856 TKOCH2 0900 TKOCH2 at 0912 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0009003930 METH40I - MethylPREDNISOLone SOD SUCC 4... FDOC 05/19/16-0928 by TKOCH2 1700 TKOCH2 at 1755 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0009003930 METH40I - MethylPREDNISOLone SOD SUCC 4... FDOC 05/19/16-1800 by TKOCH2 0100 RMESHREKI at 0124 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0009003930 METH40I - MethylPREDNISOLone SOD SUCC 4... FDOC 05/20/16-0125 by RMESHREKI

*** CONTINUED ON PAGE 31 ***
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ADMINISTRATION PERIOD: 0730 05/19/16 to 0729 05/20/16 (Continued)	START/ STOP	
Potassium Chloride 100 ML (Potassium Cl 10meq Bag 10 MEQ/100 ML PREMIX) 100 MLS/HR IV EVERY HOUR Comments: POTASSIUM CHLORIDE 10 MEQ/100 ML Total of 20 meq KCl PK ID: 8895868 RX #: 07127153	05/19/16 05/19/16	Enter 0858 PKPHAUSER 0900 TKOCH2 at 0911 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 0338070948 POT10PB - Potassium Cl 10meq Bag 10 MEQ.. FDOC 05/19/16-0928 by TKOCH2 EDIT 0908 JBLOCKER Verified 0908 JBLOCKER AO 0911 TKOCH2 Discontinue 1022 SOWENS2 AO 1027 TKOCH2
Md-Gastroview 66%-10% 120 Ml (Diatrizoate Ct Contrast 120 ML BTL) 120 ML PO ONE TIME ONLY/ONE Comments: DYE FOR CT SCAN RX #: 07127194	05/19/16 05/19/16	Enter 0928 NSKINNER 0930 TKOCH2 at 1006 GAVE: 120 ML FDOC 05/19/16-1007 by TKOCH2 AO 1001 STALBOT Discontinue 1131 SCHEDULER
Potassium Chloride 100 ML (Potassium Cl 10meq Bag 10 MEQ/100 ML PREMIX) 50 MLS/HR IV 1200 Comments: POTASSIUM CHLORIDE 10 MEQ/100 ML Total of 20 meq KCl PK ID: 8895868 RX #: 07127323	05/19/16 05/19/16	Enter 1024 SOWENS2 AO 1027 TKOCH2 1200 STALBOT at 1306 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 0338070948 POT10PB - Potassium Cl 10meq Bag 10 MEQ.. RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/19/16-1307 by STALBOT Discontinue 1400 SCHEDULER
Paxil (PARoxetine HYDROCHLORIDE 20 MG/EACH TAB) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8910722 RX #: 07128722	05/21/16 06/20/16	Enter 0720 PKPHAUSER
Paxil (PARoxetine HYDROCHLORIDE 20 MG/EACH TAB) 20 MG OR ONE TIME ONLY/ONE Comments: NOW PK ID: 8910722 RX #: 07128723	05/20/16 05/20/16	Enter 0720 PKPHAUSER

*** CONTINUED ON PAGE 32 ***
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5A4D43B46E10429588C8, KNIGHT, 81

ADMINISTRATION PERIOD: 0730 05/19/16 to 0729 05/20/16 (Continued)	START/ STOP		
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 2 MG IV EVERY 2 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8846818 RX #: 07121574	05/16/16 05/26/16	1316 CPETTY at 1316 GAVE: 2 MG NDC/DIN: (SOURCE: eMAR) 0409255201 FDOC 05/19/16-1316 by CPETTY	HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP

*** CONTINUED ON PAGE 33 ***

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ADMINISTRATION PERIOD: 0730 05/19/16 to 0729 05/20/16 (Continued)	START/ STOP	
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB) See Dose Ins. PO EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 TABS Comments: MAX APAP/24 HRS IS 4 GRAMS RX #: 07123965	05/17/16 05/27/16	0911 TKOCH2 at 0911 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0911 Date: 05/19/16 Reassess: 1011 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 05/19/16-0928 by TKOCH2 DOSE changed from TAB to 2 TAB 0956 REASSESS by TKOCH2 at 0956 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1422 TKOCH2 at 1422 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1422 Date: 05/19/16 Reassess: 1522 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 05/19/16-1423 by TKOCH2 DOSE changed from TAB to 2 TAB 1507 REASSESS by TKOCH2 at 1507 Pt Relieved Of Pain: NRe-assess Pain Scale:5 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2213 RMESHREKI at 2213 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2213 Date: 05/19/16 Reassess: 2313 Pain Location: ABDOMINAL Quality Of Pain: Onset of Pain: Duration of Pain:

*** CONTINUED ON PAGE 34 ***

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ADMINISTRATION PERIOD: 0730 05/19/16 to 0729 05/20/16 (Continued)	START/ STOP	
		FDOC 05/19/16-2214 by RMESHREKI DOSE changed from TAB to 2 TAB 2258 REASSESS by RMESHREKI at 2250 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 19 Respiratory Quality: WNL Respiratory Depth: WNL Comment:

ADMINISTRATION PERIOD: 0730 05/20/16 to 0729 05/21/16	START/ STOP			
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) 100 MLS/HR IV Q24H Comments: PK ID: 8838622 RX #: 07120570	05/16/16 05/26/16	0800 STALBOT at 0729 GAVE: 100 MLS FDOC 05/20/16-0729 by STALBOT		
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV BEDTIME Comments: PK ID: 8838647 DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS RX #: 07120573	05/15/16 06/14/16	2100 CBARKER4 at 2138 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0008092351 FDOC 05/20/16-2140 by CBARKER4	PAN40I	- Pantoprazole Sodium 40 MG/EAC..
Lasix (Furosemide 40 MG/4 ML VIAL) 40 MG IV EVERY 12 HOURS Comments: PK ID: 8864474 RX #: 07123840	05/17/16 06/16/16	0900 RGASQUE at 0905 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FDOC 05/20/16-0920 by RGASQUE Discontinue Verified 1314 EKNIGHT AO 1350 STALBOT	FUR40I	- Furosemide 40 MG/4 ML VIAL

*** CONTINUED ON PAGE 35 ***

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ADMINISTRATION PERIOD: 0730 05/20/16 to 0729 05/21/16 (Continued)	START/ STOP		
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH FOUR TIMES A DAY RESP THERAPY RX #: 07124493	05/17/16 06/16/16	0730 SPAITSEL at 0711 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/20/16-0712 by SPAITSEL 1130 SPAITSEL at 1055 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/20/16-1055 by SPAITSEL 1530 SPAITSEL at 1436 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/20/16-1437 by SPAITSEL 1930 CGRAVES at 1954 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/20/16-1955 by CGRAVES	ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: PK ID: 8838633 RX #: 07126033	05/19/16 05/29/16	0600 CBARKER4 at 0611 GAVE: 50 MLS FDOC 05/21/16-0611 by CBARKER4	
Solu-MEDROL (MethylPREDNISOLone SOD SUCC 40 MG/EACH VIAL) 40 MG IV EVERY 8 HOURS Comments: PK ID: 8895441 RX #: 07127130	05/19/16 05/29/16	0900 RGASQUE at 0906 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0009003930 FDOC 05/20/16-0920 by RGASQUE Discontinue Verified 1314 EKNIGHT AO 1350 STALBOT	METH40I - MethylPREDNISOLone SOD SUCC 4..
Paxil (PARoxetine HYDROCHLORIDE 20 MG/EACH TAB) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8910722 RX #: 07128722	05/21/16 06/20/16	EDIT 0730 JBLOCKER Verified 0730 JBLOCKER AO 0751 STALBOT Discontinue 0922 RBEVERLY AO 0929 STALBOT	

*** CONTINUED ON PAGE 36 ***
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ADMINISTRATION PERIOD: 0730 05/20/16 to 0729 05/21/16 (Continued)	START/ STOP	
Paxil (PARoxetine HYDROCHLORIDE 20 MG/EACH TAB) 20 MG OR ONE TIME ONLY/ONE Comments: NOW PK ID: 8910722 RX #: 07128723	05/20/16 05/20/16	EDIT 0730 JBLOCKER Verified 0730 JBLOCKER AO 0732 STALBOT 0900 STALBOT at 0732 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 6838209801 PAR20T - PARoxetine HYDROCHLORIDE 20 M... RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/20/16-0733 by STALBOT Discontinue 0922 RBEVERLY AO 0929 STALBOT
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07128854	05/21/16 06/20/16	Enter 0854 PKPHAUSER EDIT 0900 RBEVERLY Verified 0900 RBEVERLY AO 0912 STALBOT
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR ONE TIME ONLY/ONE Comments: NOW PK ID: 8912971 RX #: 07128855	05/20/16 05/20/16	Enter 0854 PKPHAUSER EDIT 0901 RBEVERLY Verified 0901 RBEVERLY AO 0911 STALBOT 1000 STALBOT at 1058 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/20/16-1059 by STALBOT Discontinue 1401 SCHEDULER
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	Enter 0933 PKPHAUSER EDIT 0946 JBLOCKER Now Dose 0946 JBLOCKER Keep Next Dose 0946 JBLOCKER Verified 0946 JBLOCKER AO 1010 STALBOT 1100 STALBOT at 1058 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M... FDOC 05/20/16-1059 by STALBOT

*** CONTINUED ON PAGE 37 ***

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ADMINISTRATION PERIOD: 0730 05/20/16 to 0729 05/21/16 (Continued)	START/ STOP	
Lasix (Furosemide 40 MG/4 ML VIAL) 40 MG IV Q24H Comments: PK ID: 8917422 RX #: 07129259	05/21/16 06/20/16	Enter 1309 PKPHAUSER EDIT 1315 EKNIGHT Verified 1315 EKNIGHT AO 1350 STALBOT
Solu-MEDROL (MethylPREDNISOLone SOD SUCC 40 MG/EACH VIAL) 40 MG IV Q12H Comments: PK ID: 8917424 RX #: 07129260	05/20/16 05/30/16	Enter 1310 PKPHAUSER EDIT 1315 EKNIGHT Verified 1315 EKNIGHT AO 1350 STALBOT 2100 CBARKER4 at 2138 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0009003930 METH40I - MethylPREDNISOLone SOD SUCC 4... FDOC 05/20/16-2140 by CBARKER4
Toradol (Ketorolac Tromethamine 30 MG/ML VIAL) 30 MG IV EVERY 6 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8853946 RX #: 07122303	05/16/16 05/21/16	Discontinue Verified 0946 JBLOCKER AO 1010 STALBOT

*** CONTINUED ON PAGE 38 ***
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ADMINISTRATION PERIOD: 0730 05/20/16 to 0729 05/21/16 (Continued)	START/ STOP	
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB) See Dose Ins. PO EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 TABS Comments: MAX APAP/24 HRS IS 4 GRAMS RX #: 07123965	05/17/16 05/27/16	0733 STALBOT at 0733 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0733 Date: 05/20/16 Reassess: 0833 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: FDOC 05/20/16-0733 by STALBOT DOSE changed from TAB to 2 TAB 0818 REASSESS by STALBOT at 0833 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1637 STALBOT at 1637 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1637 Date: 05/20/16 Reassess: 1737 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: FDOC 05/20/16-1638 by STALBOT DOSE changed from TAB to 2 TAB 1722 REASSESS by STALBOT at 1725 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2139 CBARKER4 at 2139 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2139 Date: 05/20/16 Reassess: 2239 Pain Location: INCISIONAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS

*** CONTINUED ON PAGE 39 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/20/16 to 0729 05/21/16 (Continued)	START/ STOP	
		FDOC 05/20/16-2140 by CBARKER4 DOSE changed from TAB to 2 TAB 2224 REASSESS by CBARKER4 at 2300 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 0352 CBARKER4 at 0352 GAVE: 2 TAB NDC/DIN: (SOURCE: eMAR) 0406012323 VIC5T - HYDROcodone 5MG/APAP 325MG TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0352 Date: 05/21/16 Reassess: 0452 Pain Location: INCISIONAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: CONTINUOUS FDOC 05/21/16-0353 by CBARKER4 DOSE changed from TAB to 2 TAB 0437 REASSESS by CBARKER4 at 0546 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

ADMINISTRATION PERIOD: 0730 05/21/16 to 0729 05/22/16	START/ STOP	
Diflucan 200MG/100ML IV 100 ML (Fluconazole/NS 200 MG/100 ML PREMIX) 100 MLS/HR IV Q24H Comments: PK ID: 8838622 RX #: 07120570	05/16/16 05/26/16	UNDOC 0800 MWILLIAMS at 0844 GAVE: 100 MLS FDOC 05/21/16-0845 by MWILLIAMS UNDOC 05/21/16-0915 by MWILLIAMS New Comments: DR BUDHOO IN ROOM, VO TO D/C *0800 MWILLIAMS at 0915 DC PER DR BUDHOO D/C RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Per Practitioner Order FDOC 05/21/16-0916 by MWILLIAMS Discontinue Verified 0958 HGASSAWAY AO 1006 MWILLIAMS

*** CONTINUED ON PAGE 40 ***
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ADMINISTRATION PERIOD: 0730 05/21/16 to 0729 05/22/16 (Continued)	START/ STOP	
Protonix (Pantoprazole Sodium 40 MG/EACH VIAL) 40 MG IV BEDTIME Comments: PK ID: 8838647 DILUTE VIAL WITH 10 ML OF NORMAL SALINE AND ADMINISTER SLOW IV PUSH OVER 2 MINS RX #: 07120573	05/15/16 06/14/16	Discontinue Verified 1457 NGLODACK AO 1529 MWILLIAMS
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH FOUR TIMES A DAY RESP THERAPY RX #: 07124493	05/17/16 06/16/16	0730 MSANDERS at 0747 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/21/16-0749 by MSANDERS 1130 MSANDERS at 1110 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/21/16-1111 by MSANDERS Discontinue 1459 NGLODACK AO 1529 MWILLIAMS 1530 FSLOAN at 1437 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/21/16-1439 by FSLOAN
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) INVanz 1 GM (Ertapenem Sodium 1 GM/EACH VIAL) 50 MLS/HR IV Q24H Comments: PK ID: 8838633 RX #: 07126033	05/19/16 05/29/16	Discontinue Verified 0958 HGASSAWAY AO 1006 MWILLIAMS
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07128854	05/21/16 06/20/16	0900 MWILLIAMS at 0844 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/21/16-0845 by MWILLIAMS Discontinue 1127 NGLODACK AO 1133 MWILLIAMS

*** CONTINUED ON PAGE 41 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/21/16 to 0729 05/22/16 (Continued)	START/ STOP			
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 MWILLIAMS at 0844 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 FDOC 05/21/16-0845 by MWILLIAMS EDIT 1458 NGLODACK AO 1528 MWILLIAMS AO 1529 MWILLIAMS	ENOX40I	- Enoxaparin Sodium 40 MG/0.4 M..
Lasix (Furosemide 40 MG/4 ML VIAL) 40 MG IV Q24H Comments: PK ID: 8917422 RX #: 07129259	05/21/16 06/20/16	0900 MWILLIAMS at 0844 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0409610204 FDOC 05/21/16-0845 by MWILLIAMS Discontinue Verified 0958 HGASSAWAY AO 1006 MWILLIAMS	FUR40I	- Furosemide 40 MG/4 ML VIAL
Solu-MEDROL (MethylPREDNISOLone SOD SUCC 40 MG/EACH VIAL) 40 MG IV Q12H Comments: PK ID: 8917424 RX #: 07129260	05/20/16 05/30/16	0900 MWILLIAMS at 0844 GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0009003930 FDOC 05/21/16-0845 by MWILLIAMS Discontinue Verified 0958 HGASSAWAY AO 1006 MWILLIAMS	METH40I	- MethylPREDNISOLone SOD SUCC 4..
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	Enter 0955 PKPHAUSER EDIT 1000 HGASSAWAY Now Dose 1000 HGASSAWAY Keep Next Dose 1000 HGASSAWAY Verified 1000 HGASSAWAY AO 1006 MWILLIAMS 1100 MWILLIAMS at 1046 GAVE: 50 MLS FDOC 05/21/16-1046 by MWILLIAMS 1700 PSKINNER2 at 1624 GAVE: 50 MLS FDOC 05/21/16-1625 by PSKINNER2 0100 MGODWIN at 0041 GAVE: 50 MLS NDC/DIN: (SOURCE: eMAR) 0338055311 6050507491 FDOC 05/22/16-0041 by MGODWIN	NS50A KEF1I	- Sodium Chloride 0.9% 50 ML MINI - CeFAZolin Sodium 1 GM/EACH VIAL

*** CONTINUED ON PAGE 42 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/21/16 to 0729 05/22/16 (Continued)	START/ STOP	
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07130514	05/21/16 05/31/16	Enter 0956 PKPHAUSER EDIT 1000 HGASSAWAY Now Dose 1000 HGASSAWAY Verified 1000 HGASSAWAY Keep Next Dose 1000 HGASSAWAY AO 1006 MWILLIAMS 1100 MWILLIAMS at 1046 GAVE: 100 MLS FDOC 05/21/16-1046 by MWILLIAMS 1700 PSKINNER2 at 1624 GAVE: 100 MLS FDOC 05/21/16-1625 by PSKINNER2 0100 MGODWIN at 0159 GAVE: 100 MLS FDOC 05/22/16-0159 by MGODWIN
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	Enter 1126 NGLODACK AO 1133 MWILLIAMS
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 1 MG IV EVERY 4 HOURS Comments: PK ID: 8931778 RX #: 07130796	05/21/16 05/31/16	Admin Criterion Entered 1447 PKPHAUSER Enter 1447 PKPHAUSER EDIT 1458 NGLODACK Verified 1458 NGLODACK AO 1528 MWILLIAMS Discontinue 1542 NGLODACK AO 1602 MWILLIAMS
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY Comments: PK ID: 8931749 RX #: T00388660	05/21/16 06/20/16	Enter 1448 PKPHAUSER Cancel 1500 NGLODACK AO 1529 MWILLIAMS
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC Q24H Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8931751 RX #: T00388661	05/21/16 06/20/16	Enter 1449 PKPHAUSER Cancel 1500 NGLODACK AO 1529 MWILLIAMS

*** CONTINUED ON PAGE 43 ***
This document is part of the legal medical record.

5A4D43B46E10429588C8, KNIGHT, 92

ADMINISTRATION PERIOD: 0730 05/21/16 to 0729 05/22/16 (Continued)	START/ STOP		
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	Enter 1459 NGLODACK AO 1528 MWILLIAMS AO 1529 MWILLIAMS 1930 JWHITE7 at 1958 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/21/16-2000 by JWHITE7 0130 JWHITE7 at 0140 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/22/16-0142 by JWHITE7	ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb
Acephen (Acetaminophen 650 MG/EACH SUP) 650 MG RE EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 8838614 RX #: 07120567	05/15/16 06/14/16	Discontinue Verified 0958 HGASSAWAY AO 1006 MWILLIAMS	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 2 MG IV EVERY 2 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8846818 RX #: 07121574	05/16/16 05/26/16	Discontinue Verified 1457 NGLODACK AO 1529 MWILLIAMS	
VICODIN/LORCET 5/325 (HYDROcodone 5MG/APAP 325MG TAB) See Dose Ins. PO EVERY 4 HOURS/PRN PRN Reason: PAIN Dose Ins: 1-2 TABS Comments: MAX APAP/24 HRS IS 4 GRAMS RX #: 07123965	05/17/16 05/27/16	Discontinue Verified 0958 HGASSAWAY AO 1006 MWILLIAMS	

*** CONTINUED ON PAGE 44 ***
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ADMINISTRATION PERIOD: 0730 05/21/16 to 0729 05/22/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	Admin Criterion Entered 1224 PKPHAUSER Enter 1224 PKPHAUSER AO 1227 MWILLIAMS Admin Criterion Edit 1229 NGLODACK EDIT 1229 NGLODACK Verified 1229 NGLODACK AO 1233 MWILLIAMS 1233 MWILLIAMS at 1233 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1233 Date: 05/21/16 Reassess: 1333 Pain Location: ABDOMINAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: FDOC 05/21/16-1234 by MWILLIAMS DOSE changed from MG to 10 MG 1318 REASSESS by PSKINNER2 at 1318 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1758 PSKINNER2 at 1758 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 1758 Date: 05/21/16 Reassess: 1858 Pain Location: ABDOMINAL INCISIONAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/21/16-1759 by PSKINNER2 DOSE changed from MG to 10 MG 1843 REASSESS by PSKINNER2 at 1843 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 0040 MGODWIN at 0040 GAVE: 10 MG

*** CONTINUED ON PAGE 45 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/21/16 to 0729 05/22/16 (Continued)	START/ STOP	
		NDC/DIN: (SOURCE: eMAR)
		6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0040
		Date: 05/22/16 Reassess: 0140
		Pain Location: ABDOMINAL
		INCISIONAL
		Quality Of Pain: ACHING
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/22/16-0041 by MGODWIN
		DOSE changed from MG to 10 MG
		0125 REASSESS by MGODWIN at 0140
		Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP)	05/21/16	Admin Criterion Entered 1542 NGLODACK
1 MG IV EVERY 4 HOURS/PRN	05/31/16	Enter 1542 NGLODACK
PRN Reason: PAIN		AO 1602 MWILLIAMS
Comments: PK ID: 8931778		
RX #: 07130854		

ADMINISTRATION PERIOD: 0730 05/22/16 to 0729 05/23/16	START/ STOP	
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR)	05/20/16	0900 MMAPLES at 0840 SITE: L ABD - Left Abdomen GAVE: 40 MG
40 MG SC EVERY 24 HRS IN AM	05/31/16	NDC/DIN: (SOURCE: eMAR)
Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE		0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M..
PK ID: 8913585		FDOC 05/22/16-0842 by MMAPLES
RX #: 07128948		

*** CONTINUED ON PAGE 46 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/22/16 to 0729 05/23/16 (Continued)	START/ STOP	
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 MMAPLES at 0833 GAVE: 50 MLS FDOC 05/22/16-0842 by MMAPLES 1700 MMAPLES at 1841 GAVE: 50 MLS RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/22/16-1851 by MMAPLES 0100 MGODWIN at 0036 GAVE: 50 MLS FDOC 05/23/16-0037 by MGODWIN
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07130514	05/21/16 05/31/16	0900 MMAPLES at 0834 GAVE: 100 MLS FDOC 05/22/16-0842 by MMAPLES 1700 MMAPLES at 1705 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 0338105548 FLA500PB - MetroNIDAZOLE 500MG/NS 100ML .. FDOC 05/22/16-1713 by MMAPLES 0100 MGODWIN at 0116 GAVE: 100 MLS FDOC 05/23/16-0116 by MGODWIN
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 MMAPLES at 0834 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/22/16-0842 by MMAPLES
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	0730 FSLOAN at 0703 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/22/16-0704 by FSLOAN *1330 CGRAVES at 1843 NOT GIVEN RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/22/16-1844 by CGRAVES 1930 CGRAVES at 1910 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/22/16-1910 by CGRAVES 0130 CGRAVES at 0157 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/23/16-0158 by CGRAVES

*** CONTINUED ON PAGE 47 ***

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ADMINISTRATION PERIOD: 0730 05/22/16 to 0729 05/23/16 (Continued)	START/ STOP			
Dakins Solution (Dakins Solution 0.125% 473 ML BTL) See Dose Ins. IR TWICE DAILY Dose Ins: USE BID FOR WOUND CARE Comments: DAKINS SOLUTION QUARTER STRENGTH RX #: 07131735	05/22/16 06/21/16	Enter 1313 HGASSAWAY AO 1524 MMAPLES 1524 MMAPLES at 1524 GAVE: 1 SOL RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/22/16-1557 by MMAPLES DOSE changed from SOL to 1 SOL 2100 MGODWIN at 2134 GAVE: 1 SOL FDOC 05/22/16-2135 by MGODWIN DOSE changed from SOL to 1 SOL		
Potassium Chloride (Potassium Chloride 20 MEQ/EACH TAB) 40 MEQ OR ONE TIME ONLY/ONE Comments: PK ID: 8945882 RX #: 07132054	05/22/16 05/22/16	Enter 1754 PKPHAUSER EDIT 1806 NGLODACK Verified 1806 NGLODACK 1830 MMAPLES at 1842 GAVE: 40 MEQ NDC/DIN: (SOURCE: eMAR) 0781572001 FDOC 05/22/16-1851 by MMAPLES AO 1842 MMAPLES Discontinue 2231 SCHEDULER	POT20T	- Potassium Chloride 20 MEQ/EAC...
MYLICON-80 (Simethicone 80 MG/EACH TAB) 80 MG OR BEFORE MEALS AND BEDTIME/PRN PRN Reason: GAS/BLOATING Comments: PK ID: 8838637 RX #: 07120577	05/15/16 06/14/16	2113 MGODWIN at 2113 GAVE: 80 MG NDC/DIN: (SOURCE: eMAR) 6373922510 FDOC 05/22/16-2113 by MGODWIN	M80T	- Simethicone 80 MG/EACH TAB

*** CONTINUED ON PAGE 48 ***
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ADMINISTRATION PERIOD: 0730 05/22/16 to 0729 05/23/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	0939 MMAPLES at 0939 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 0939 Date: 05/22/16 Reassess: 1039 Pain Location: ABDOMINAL INCISIONAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/22/16-0940 by MMAPLES DOSE changed from MG to 10 MG 1024 REASSESS by MMAPLES at 1024 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment: 1707 MMAPLES at 1707 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 1707 Date: 05/22/16 Reassess: 1807 Pain Location: ABDOMINAL INCISIONAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/22/16-1713 by MMAPLES DOSE changed from MG to 10 MG 1752 REASSESS by MMAPLES at 1750 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 0327 MGODWIN at 0327 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 8 Time Med Given: 0327 Date: 05/23/16 Reassess: 0427 Pain Location: ARM,LEFT Quality Of Pain: ACHING

*** CONTINUED ON PAGE 49 ***

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NAME: KNIGHT,DANIEL ERIC UNIT #: M000175313 ACCT #: V00006912886

ADMINISTRATION PERIOD: 0730 05/22/16 to 0729 05/23/16 (Continued)	START/ STOP	
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/23/16-0327 by MGODWIN
		DOSE changed from MG to 10 MG
		0412 REASSESS by MGODWIN at 0417
		Pt Relieved Of Pain: Re-assess Pain Scale:0 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 16
		Respiratory Quality: WNL Respiratory Depth: WNL
		Comment:

*** CONTINUED ON PAGE 50 ***
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ADMINISTRATION PERIOD: 0730 05/22/16 to 0729 05/23/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 1 MG IV EVERY 4 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8931778 RX #: 07130854	05/21/16 05/31/16	1454 MMAPLES at 1454 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1454 Date: 05/22/16 Reassess: 1554 Pain Location: ABDOMINAL INCISIONAL Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/22/16-1501 by MMAPLES 1539 REASSESS by MMAPLES at 1539 Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2104 MGODWIN at 2104 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 8 Time Med Given: 2104 Date: 05/22/16 Reassess: Pain Location: ARM,LEFT Quality Of Pain: ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/22/16-2105 by MGODWIN 2149 REASSESS by MGODWIN at 2153 Pt Relieved Of Pain: YRe-assess Pain Scale:0 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 0611 MGODWIN at 0611 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 8 Time Med Given: 0610 Date: 05/23/16 Reassess: 0710 Pain Location: OTHER Quality Of Pain: SHARP Onset of Pain: SUDDEN Duration of Pain: CONTINUOUS FDOC 05/23/16-0611 by MGODWIN

*** CONTINUED ON PAGE 51 ***

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ADMINISTRATION PERIOD: 0730 05/22/16 to 0729 05/23/16 (Continued)	START/ STOP	
		0656 REASSESS by MGODWIN at 0653 Pt Relieved Of Pain: YRe-assess Pain Scale:6 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

ADMINISTRATION PERIOD: 0730 05/23/16 to 0729 05/24/16	START/ STOP	
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 PSKINNER2 at 0852 SITE: R ABD - Right Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M.. FDOC 05/23/16-0856 by PSKINNER2
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 PSKINNER2 at 0853 GAVE: 50 MLS FDOC 05/23/16-0856 by PSKINNER2 1700 PSKINNER2 at 1639 GAVE: 50 MLS FDOC 05/23/16-1640 by PSKINNER2 0100 MGODWIN at 0035 GAVE: 50 MLS FDOC 05/24/16-0035 by MGODWIN
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07130514	05/21/16 05/31/16	0900 PSKINNER2 at 0853 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 0338105548 FLA500PB - MetroNIDAZOLE 500MG/NS 100ML .. FDOC 05/23/16-0856 by PSKINNER2 1700 PSKINNER2 at 1639 GAVE: 100 MLS FDOC 05/23/16-1640 by PSKINNER2 0100 MGODWIN at 0102 GAVE: 100 MLS FDOC 05/24/16-0102 by MGODWIN

*** CONTINUED ON PAGE 52 ***
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ADMINISTRATION PERIOD: 0730 05/23/16 to 0729 05/24/16 (Continued)	START/ STOP	
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 PSKINNER2 at 0853 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/23/16-0856 by PSKINNER2
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	0730 BEPLER at 0757 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/23/16-0757 by BEPLER 1330 BEPLER at 1350 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/23/16-1352 by BEPLER 1930 KODOM2 at 1949 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/23/16-1951 by KODOM2 0130 KODOM2 at 0214 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/24/16-0222 by KODOM2
Dakins Solution (Dakins Solution 0.125% 473 ML BTL) See Dose Ins. IR TWICE DAILY Dose Ins: USE BID FOR WOUND CARE Comments: DAKINS SOLUTION QUARTER STRENGTH RX #: 07131735	05/22/16 06/21/16	0900 PSKINNER2 at 0854 GAVE: 1 SOL FDOC 05/23/16-0856 by PSKINNER2 DOSE changed from SOL to 1 SOL 2100 MGODWIN at 2314 GAVE: 1 SOL NDC/DIN: (SOURCE: eMAR) 3932806412 DAK125S - Dakins Solution 0.125% 473 ML... RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/23/16-2314 by MGODWIN DOSE changed from SOL to 1 SOL

*** CONTINUED ON PAGE 53 ***

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ADMINISTRATION PERIOD: 0730 05/23/16 to 0729 05/24/16 (Continued)	START/ STOP	
Lasix (Furosemide 40 MG/4 ML VIAL) 40 MG IV EVERY 8 HOURS Comments: PK ID: 8951993 RX #: 07132785	05/23/16	Enter 1014 PKPHAUSER
	05/23/16	EDIT 1020 EKNIGHT
		Verified 1020 EKNIGHT
		AO 1053 PSKINNER2
		1200 PSKINNER2 at 1057 GAVE: 40 MG
		NDC/DIN: (SOURCE: eMAR)
		0409610204 FUR40I - Furosemide 40 MG/4 ML VIAL
		RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care
		FDOC 05/23/16-1059 by PSKINNER2
		2000 MGODWIN at 2045 GAVE: 40 MG
		NDC/DIN: (SOURCE: eMAR)
		0409610204 FUR40I - Furosemide 40 MG/4 ML VIAL
		FDOC 05/23/16-2045 by MGODWIN
		Discontinue 2001 SCHEDULER

*** CONTINUED ON PAGE 54 ***
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ADMINISTRATION PERIOD: 0730 05/23/16 to 0729 05/24/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	0854 PSKINNER2 at 0854 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0853 Date: 05/23/16 Reassess: 0953 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/23/16-0856 by PSKINNER2 DOSE changed from MG to 10 MG 0939 REASSESS by PSKINNER2 at 0939 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: PAIN LEVEL HIGHER DURING DRSG CHANGE. 1410 PSKINNER2 at 1410 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1410 Date: 05/23/16 Reassess: 1510 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/23/16-1410 by PSKINNER2 DOSE changed from MG to 10 MG 1455 REASSESS by PSKINNER2 at 1455 Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

*** CONTINUED ON PAGE 55 ***
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ADMINISTRATION PERIOD: 0730 05/23/16 to 0729 05/24/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 1 MG IV EVERY 4 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8931778 RX #: 07130854	05/21/16 05/31/16	2204 MGODWIN at 2204 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 2204 Date: 05/23/16 Reassess: 2304 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/23/16-2204 by MGODWIN 2249 REASSESS by MGODWIN at 2249 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

ADMINISTRATION PERIOD: 0730 05/24/16 to 0729 05/25/16	START/ STOP	
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 BLEWIS5 at 0848 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M.. FDOC 05/24/16-0849 by BLEWIS5
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 BLEWIS5 at 0948 GAVE: 50 MLS FDOC 05/24/16-0949 by BLEWIS5 1700 BLEWIS5 at 1728 GAVE: 50 MLS FDOC 05/24/16-1728 by BLEWIS5 0100 SSARVIS4 at 0017 GAVE: 50 MLS FDOC 05/25/16-0022 by SSARVIS4

*** CONTINUED ON PAGE 56 ***
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ADMINISTRATION PERIOD: 0730 05/24/16 to 0729 05/25/16 (Continued)	START/ STOP	
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07130514	05/21/16 05/31/16	Discontinue 0857 EKNIGHT 0900 BLEWIS5 at 0847 GAVE: 100 MLS FDOC 05/24/16-0849 by BLEWIS5 AO 0901 BLEWIS5
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 BLEWIS5 at 0847 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/24/16-0849 by BLEWIS5
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	0730 BEPLER at 0748 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/24/16-0749 by BEPLER 1330 APRUITT at 1309 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/24/16-1310 by APRUITT *1930 KODOM2 at 2136 RT.EMERG RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: ppc FDOC 05/24/16-2137 by KODOM2 0130 KODOM2 at 0035 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/25/16-0036 by KODOM2
Dakins Solution (Dakins Solution 0.125% 473 ML BTL) See Dose Ins. IR TWICE DAILY Dose Ins: USE BID FOR WOUND CARE Comments: DAKINS SOLUTION QUARTER STRENGTH RX #: 07131735	05/22/16 06/21/16	0900 BLEWIS5 at 0948 GAVE: 1 SOL FDOC 05/24/16-0949 by BLEWIS5 DOSE changed from SOL to 1 SOL Hold Acknowledgement 1941 BLEWIS5 dc...wound vac applied Nur Request Removed 1946 AWRIGHT1 AO 1952 BLEWIS5 Discontinue 2002 AWRIGHT1 AO 2155 SSARVIS4

*** CONTINUED ON PAGE 57 ***

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ADMINISTRATION PERIOD: 0730 05/24/16 to 0729 05/25/16 (Continued)	START/ STOP	
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07134550	05/24/16 06/03/16	Enter 0857 EKNIGHT AO 0901 BLEWIS5 1000 BLEWIS5 at 0900 GAVE: 100 MLS FDOC 05/24/16-0925 by BLEWIS5 1800 BLEWIS5 at 1810 GAVE: 100 MLS FDOC 05/24/16-1810 by BLEWIS5 0200 SSARVIS4 at 0119 GAVE: 100 MLS FDOC 05/25/16-0120 by SSARVIS4

*** CONTINUED ON PAGE 58 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/24/16 to 0729 05/25/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	1458 BLEWIS5 at 1458 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1458 Date: 05/24/16 Reassess: 1558 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/24/16-1458 by BLEWIS5 DOSE changed from MG to 10 MG 1543 REASSESS by BLEWIS5 at 1540 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: UP IN CHAIR 2105 SSARVIS4 at 2105 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 2105 Date: 05/24/16 Reassess: 2205 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/24/16-2106 by SSARVIS4 DOSE changed from MG to 10 MG 2150 REASSESS by SSARVIS4 at 2150 Pt Relieved Of Pain: YRe-assess Pain Scale:0 Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 18 Respiratory Quality: WNL Respiratory Depth: WNL Comment:

*** CONTINUED ON PAGE 59 ***

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ADMINISTRATION PERIOD: 0730 05/24/16 to 0729 05/25/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 1 MG IV EVERY 4 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8931778 RX #: 07130854	05/21/16 05/31/16	1105 BLEWIS5 at 1105 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1105 Date: 05/24/16 Reassess: 1205 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/24/16-1105 by BLEWIS5 1150 REASSESS by BLEWIS5 at 1150 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: Y Sleeping Resp: 18 Respiratory Quality: WNL Respiratory Depth: WNL Comment:

ADMINISTRATION PERIOD: 0730 05/25/16 to 0729 05/26/16	START/ STOP	
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 NROBERTS2 at 0858 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M.. FDOC 05/25/16-0859 by NROBERTS2
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 NROBERTS2 at 0858 GAVE: 50 MLS FDOC 05/25/16-0859 by NROBERTS2 1700 NROBERTS2 at 1730 GAVE: 50 MLS FDOC 05/25/16-1732 by NROBERTS2 0100 MGODWIN at 0110 GAVE: 50 MLS FDOC 05/26/16-0113 by MGODWIN

*** CONTINUED ON PAGE 60 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/25/16 to 0729 05/26/16 (Continued)	START/ STOP	
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 NROBERTS2 at 0859 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/25/16-0859 by NROBERTS2
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	0730 BEPLER at 0717 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/25/16-0717 by BEPLER 1330 BEPLER at 1304 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/25/16-1306 by BEPLER 1930 KODOM2 at 2119 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: ppc FDOC 05/25/16-2120 by KODOM2 0130 KODOM2 at 0032 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/26/16-0032 by KODOM2
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07134550	05/24/16 06/03/16	1000 NROBERTS2 at 1003 GAVE: 100 MLS FDOC 05/25/16-1004 by NROBERTS2 1800 CWHITE7 at 1813 GAVE: 100 MLS FDOC 05/25/16-1819 by CWHITE7 0200 MGODWIN at 0150 GAVE: 100 MLS FDOC 05/26/16-0150 by MGODWIN
Mag-Al ANTACID 200-200 MG/5 Ml 30 Ml (Mag Hydrox-Al Hydrox-Sim 30 ML UDC) 30 ML OR EVERY 4 HOURS/PRN PRN Reason: INDIGESTION Comments: unless patient is NPO PK ID: 8838636 RX #: 07120578	05/15/16 06/14/16	1854 NROBERTS2 at 1854 GAVE: 30 ML NDC/DIN: (SOURCE: eMAR) 01211761130 MAALP - Mag Hydrox-Al Hydrox-Sim 30 M.. FDOC 05/25/16-1854 by NROBERTS2 2250 MGODWIN at 2250 GAVE: 30 ML NDC/DIN: (SOURCE: eMAR) 01211761130 MAALP - Mag Hydrox-Al Hydrox-Sim 30 M... FDOC 05/25/16-2251 by MGODWIN

*** CONTINUED ON PAGE 61 ***
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NAME: KNIGHT,DANIEL ERIC UNIT #: M000175313 ACCT #: V00006912886

ADMINISTRATION PERIOD: 0730 05/25/16 to 0729 05/26/16 (Continued)	START/ STOP			
MYLICON-80 (Simethicone 80 MG/EACH TAB)	05/15/16	1813 CWHITE7 at 1813 GAVE: 80 MG		
80 MG OR BEFORE MEALS AND BEDTIME/PRN	06/14/16	NDC/DIN: (SOURCE: eMAR)		
PRN Reason: GAS/BLOATING		6373922510	M80T	- Simethicone 80 MG/EACH TAB
Comments: PK ID: 8838637		FDOC 05/25/16-1819 by CWHITE7		
RX #: 07120577		2249 MGODWIN at 2249 GAVE: 80 MG		
		NDC/DIN: (SOURCE: eMAR)		
		6373922510	M80T	- Simethicone 80 MG/EACH TAB
		FDOC 05/25/16-2251 by MGODWIN		

*** CONTINUED ON PAGE 62 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/25/16 to 0729 05/26/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	0812 CWHITE7 at 0812 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 0812 Date: 05/25/16 Reassess: 0912 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/25/16-0814 by CWHITE7 DOSE changed from MG to 10 MG 0857 REASSESS by NROBERTS2 at 0858 Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1416 NROBERTS2 at 1416 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1416 Date: 05/25/16 Reassess: 1516 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/25/16-1417 by NROBERTS2 DOSE changed from MG to 10 MG 1501 REASSESS by NROBERTS2 at 1501 Pt Relieved Of Pain: YRe-assess Pain Scale:6 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1813 CWHITE7 at 1813 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB

*** CONTINUED ON PAGE 63 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/25/16 to 0729 05/26/16 (Continued)	START/ STOP	
		Pt C/O Pain: Y Pain Scale: 7 Time Med Given: 1813
		Date: 05/25/16 Reassess: 1913
		Pain Location: OTHER
		ABDOMINAL
		Quality Of Pain: SORE
		ACHING
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/25/16-1819 by CWHITE7
		DOSE changed from MG to 10 MG
		1858 REASSESS by CWHITE7 at 1857
		Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: N Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		2250 MGODWIN at 2250 GAVE: 10 MG
		NDC/DIN: (SOURCE: eMAR)
		6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB
		Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 2250
		Date: 05/25/16 Reassess: 2350
		Pain Location: OTHER
		ABDOMINAL
		Quality Of Pain: SORE
		ACHING
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/25/16-2251 by MGODWIN
		DOSE changed from MG to 10 MG
		2335 REASSESS by MGODWIN at 2350
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 16
		Respiratory Quality: WNL Respiratory Depth: WNL
		Comment:
		0254 MGODWIN at 0254 GAVE: 10 MG
		NDC/DIN: (SOURCE: eMAR)
		6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0254
		Date: 05/26/16 Reassess: 0354
		Pain Location: OTHER
		ABDOMINAL
		Quality Of Pain: SORE
		ACHING

*** CONTINUED ON PAGE 64 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/25/16 to 0729 05/26/16 (Continued)	START/ STOP	
		Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/26/16-0255 by MGODWIN DOSE changed from MG to 10 MG 0339 REASSESS by MGODWIN at 0354 Pt Relieved Of Pain: Re-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Y Sleeping Resp: 16 Respiratory Quality: WNL Respiratory Depth: WNL Comment:

ADMINISTRATION PERIOD: 0730 05/26/16 to 0729 05/27/16	START/ STOP	
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 NROBERTS2 at 0832 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M.. FDOC 05/26/16-0834 by NROBERTS2
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 NROBERTS2 at 0832 GAVE: 50 MLS FDOC 05/26/16-0834 by NROBERTS2 1700 NROBERTS2 at 1652 GAVE: 50 MLS FDOC 05/26/16-1652 by NROBERTS2 0100 MGODWIN at 0106 GAVE: 50 MLS FDOC 05/27/16-0111 by MGODWIN
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 NROBERTS2 at 0833 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/26/16-0834 by NROBERTS2

*** CONTINUED ON PAGE 65 ***
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ADMINISTRATION PERIOD: 0730 05/26/16 to 0729 05/27/16 (Continued)	START/ STOP	
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	0730 FSLOAN at 0747 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/26/16-0748 by FSLOAN 1330 FSLOAN at 1333 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/26/16-1334 by FSLOAN *1930 BEPLER at 05/27/16 - 0739 NOT GIVEN BY NIGHTSHIFT RT RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: NOT GIVEN BY NIGHTSHIFT FDOC 05/27/16-0740 by BEPLER *0130 BEPLER at 0740 NOT GIVEN NOT GIVEN BY NIGHTSHIFT RT RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: NOT GIVEN BY NIGHTSHIFT FDOC 05/27/16-0740 by BEPLER
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07134550	05/24/16 06/03/16	1000 PSKINNER2 at 0944 GAVE: 100 MLS FDOC 05/26/16-0945 by PSKINNER2 1800 NROBERTS2 at 1819 GAVE: 100 MLS FDOC 05/26/16-1822 by NROBERTS2 0200 MGODWIN at 0133 GAVE: 100 MLS FDOC 05/27/16-0133 by MGODWIN
Mag-Al ANTACID 200-200 MG/5 Ml 30 Ml (Mag Hydrox-Al Hydrox-Sim 30 ML UDC) 30 ML OR EVERY 4 HOURS/PRN PRN Reason: INDIGESTION Comments: unless patient is NPO PK ID: 8838636 RX #: 07120578	05/15/16 06/14/16	1241 PSKINNER2 at 1241 GAVE: 30 ML NDC/DIN: (SOURCE: eMAR) 0121176130 MAALP - Mag Hydrox-Al Hydrox-Sim 30 M.. FDOC 05/26/16-1241 by PSKINNER2 1652 NROBERTS2 at 1652 GAVE: 30 ML NDC/DIN: (SOURCE: eMAR) 0121176130 MAALP - Mag Hydrox-Al Hydrox-Sim 30 M... FDOC 05/26/16-1652 by NROBERTS2

*** CONTINUED ON PAGE 66 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/26/16 to 0729 05/27/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	0833 NROBERTS2 at 0833 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0833 Date: 05/26/16 Reassess: 0933 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/26/16-0834 by NROBERTS2 DOSE changed from MG to 10 MG 0918 REASSESS by PSKINNER2 at 0918 Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1650 NROBERTS2 at 1650 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1650 Date: 05/26/16 Reassess: 1750 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/26/16-1652 by NROBERTS2 DOSE changed from MG to 10 MG 1735 REASSESS by PSKINNER2 at 1735 Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2131 MGODWIN at 2131 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB

*** CONTINUED ON PAGE 67 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/26/16 to 0729 05/27/16 (Continued)	START/ STOP	
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 2131
		Date: 05/26/16 Reassess: 2231
		Pain Location: OTHER
		ABDOMINAL
		Quality Of Pain: SORE
		ACHING
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/26/16-2132 by MGODWIN
		DOSE changed from MG to 10 MG
		2216 REASSESS by MGODWIN at 2231
		Pt Relieved Of Pain: YRe-assess Pain Scale:0 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		0135 MGODWIN at 0135 GAVE: 10 MG
		NDC/DIN: (SOURCE: eMAR)
		6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0135
		Date: 05/27/16 Reassess: 0235
		Pain Location: OTHER
		ABDOMINAL
		Quality Of Pain: SORE
		ACHING
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/27/16-0146 by MGODWIN
		DOSE changed from MG to 10 MG
		0220 REASSESS by MGODWIN at 0235
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Y Sleeping Resp: 16
		Respiratory Quality: WNL Respiratory Depth: WNL
		Comment:

ADMINISTRATION PERIOD: 0730 05/27/16 to 0729 05/28/16	START/ STOP	

*** CONTINUED ON PAGE 68 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/27/16 to 0729 05/28/16 (Continued)	START/ STOP	
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 PSKINNER2 at 0851 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M.. FDOC 05/27/16-0853 by PSKINNER2
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 PSKINNER2 at 0851 GAVE: 50 MLS FDOC 05/27/16-0853 by PSKINNER2 1700 PSKINNER2 at 1633 GAVE: 50 MLS FDOC 05/27/16-1634 by PSKINNER2 0100 BGORDON at 0024 GAVE: 50 MLS FDOC 05/28/16-0027 by BGORDON
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 PSKINNER2 at 0851 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FLU20C - FLUoxetine HCl 20 MG/EACH CAP FDOC 05/27/16-0853 by PSKINNER2
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	0730 JELLIOTT at 0652 GAVE: 3 ML FDOC 05/27/16-0654 by JELLIOTT 1330 JELLIOTT at 1359 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/27/16-1359 by JELLIOTT 1930 AHENDERSON at 2020 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb FDOC 05/27/16-2021 by AHENDERSON *0130 AHENDERSON at 0045 PRT wants to sleep FDOC 05/28/16-0046 by AHENDERSON

*** CONTINUED ON PAGE 69 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/27/16 to 0729 05/28/16 (Continued)	START/ STOP		
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07134550	05/24/16 06/03/16	1000 PSKINNER2 at 0927 GAVE: 100 MLS FDOC 05/27/16-0930 by PSKINNER2 1800 PSKINNER2 at 1727 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 0338105548 FDOC 05/27/16-1728 by PSKINNER2 0200 BGORDON at 0206 GAVE: 100 MLS FDOC 05/28/16-0209 by BGORDON	FLA500PB - MetroNIDAZOLE 500MG/NS 100ML ..

*** CONTINUED ON PAGE 70 ***
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ADMINISTRATION PERIOD: 0730 05/27/16 to 0729 05/28/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	0853 PSKINNER2 at 0853 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 4 Time Med Given: 0852 Date: 05/27/16 Reassess: 0952 Pain Location: OTHER ABDOMINAL Quality Of Pain: SORE ACHING Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/27/16-0853 by PSKINNER2 DOSE changed from MG to 10 MG 0938 REASSESS by PSKINNER2 at 0938 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 1400 PSKINNER2 at 1400 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 4 Time Med Given: 1400 Date: 05/27/16 Reassess: 1500 Pain Location: ABDOMINAL Quality Of Pain: SORE Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/27/16-1400 by PSKINNER2 DOSE changed from MG to 10 MG 1445 REASSESS by PSKINNER2 at 1445 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 2044 BGORDON at 2044 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 2044 Date: 05/27/16 Reassess: 2144 Pain Location: ABDOMINAL

*** CONTINUED ON PAGE 71 ***
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ADMINISTRATION PERIOD: 0730 05/27/16 to 0729 05/28/16 (Continued)	START/ STOP	
		Quality Of Pain: SORE
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/27/16-2045 by BGORDON
		DOSE changed from MG to 10 MG
		2129 REASSESS by BGORDON at 2138
		Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		0643 BGORDON at 0643 GAVE: 10 MG
		NDC/DIN: (SOURCE: eMAR)
		6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0643
		Date: 05/28/16 Reassess: 0743
		Pain Location: ABDOMINAL
		Quality Of Pain: SORE
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/28/16-0644 by BGORDON
		DOSE changed from MG to 10 MG
		0728 REASSESS by BGORDON at 0738
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:

*** CONTINUED ON PAGE 72 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/27/16 to 0729 05/28/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 1 MG IV EVERY 4 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8931778 RX #: 07130854	05/21/16 05/31/16	0930 PSKINNER2 at 0930 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 3 Time Med Given: 0930 Date: 05/27/16 Reassess: 1030 Pain Location: ABDOMINAL Quality Of Pain: SORE Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/27/16-0930 by PSKINNER2 1015 REASSESS by PSKINNER2 at 0938 Pt Relieved Of Pain: YRe-assess Pain Scale:3 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SORE DULL Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

ADMINISTRATION PERIOD: 0730 05/28/16 to 0729 05/29/16	START/ STOP	
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 PLESLIE2 at 0801 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M.. RULE: REQ OVR FOR EMAR TIME VARIANCE OVR CMT: Prioritizing Patient Care FDOC 05/28/16-0802 by PLESLIE2
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 PLESLIE2 at 0800 GAVE: 50 MLS FDOC 05/28/16-0802 by PLESLIE2 1700 PLESLIE2 at 1732 GAVE: 50 MLS FDOC 05/28/16-1734 by PLESLIE2 0100 TBOSSE2 at 0028 GAVE: 50 MLS FDOC 05/29/16-0034 by TBOSSE2

*** CONTINUED ON PAGE 73 ***

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ADMINISTRATION PERIOD: 0730 05/28/16 to 0729 05/29/16 (Continued)	START/ STOP		
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 PLESLIE2 at 0800 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FDOC 05/28/16-0802 by PLESLIE2	FLU20C - FLUoxetine HCl 20 MG/EACH CAP
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	*0730 ACAMPBELL2 at 0830 PRT FDOC 05/28/16-0830 by ACAMPBELL2 1330 MSANDERS at 1341 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/28/16-1341 by MSANDERS 1930 AHENDERSON at 1932 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/28/16-1933 by AHENDERSON *0130 AHENDERSON at 0126 PRT FDOC 05/29/16-0127 by AHENDERSON	ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07134550	05/24/16 06/03/16	1000 PLESLIE2 at 1001 GAVE: 100 MLS NDC/DIN: (SOURCE: eMAR) 0338105548 FDOC 05/28/16-1005 by PLESLIE2 1800 PLESLIE2 at 1857 GAVE: 100 MLS FDOC 05/28/16-1858 by PLESLIE2 0200 TBOSSE2 at 0146 GAVE: 100 MLS FDOC 05/29/16-0148 by TBOSSE2	FLA500PB - MetroNIDAZOLE 500MG/NS 100ML ..
Mag-Al ANTACID 200-200 MG/5 Ml 30 Ml (Mag Hydrox-Al Hydrox-Sim 30 ML UDC) 30 ML OR EVERY 4 HOURS/PRN PRN Reason: INDIGESTION Comments: unless patient is NPO PK ID: 8838636 RX #: 07120578	05/15/16 06/14/16	0759 PLESLIE2 at 0759 GAVE: 30 ML NDC/DIN: (SOURCE: eMAR) 0121176130 FDOC 05/28/16-0802 by PLESLIE2 1734 PLESLIE2 at 1734 GAVE: 30 ML NDC/DIN: (SOURCE: eMAR) 0121176130 FDOC 05/28/16-1734 by PLESLIE2	MAALP - Mag Hydrox-Al Hydrox-Sim 30 M.. MAALP - Mag Hydrox-Al Hydrox-Sim 30 M...

*** CONTINUED ON PAGE 74 ***
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ADMINISTRATION PERIOD: 0730 05/28/16 to 0729 05/29/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	1139 PLESLIE2 at 1139 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1138 Date: 05/28/16 Reassess: 1238 Pain Location: ABDOMINAL Quality Of Pain: SHARP Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/28/16-1139 by PLESLIE2 DOSE changed from MG to 10 MG 1224 REASSESS by PLESLIE2 at 1230 Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: DULL Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: STATES NO ADDITIONAL MEDS AT THIS TIME. REVIEW OF PAIN SCORE/MEDICATION REVIEWED. 1600 PLESLIE2 at 1600 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 5 Time Med Given: 1600 Date: 05/28/16 Reassess: 1700 Pain Location: ABDOMINAL Quality Of Pain: SHARP Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/28/16-1601 by PLESLIE2 DOSE changed from MG to 10 MG 1645 REASSESS by PLESLIE2 at 1659 Pt Relieved Of Pain: YRe-assess Pain Scale:4 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SHARP Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: 0033 TBOSSE2 at 0033 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0033 Date: 05/29/16 Reassess: 0133 Pain Location: ABDOMINAL Quality Of Pain: SHARP Onset of Pain: POST-OP

*** CONTINUED ON PAGE 75 ***

This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/28/16 to 0729 05/29/16 (Continued)	START/ STOP	
		Duration of Pain: INTERMITTENT
		FDOC 05/29/16-0034 by TBOSSE2
		DOSE changed from MG to 10 MG
		0118 REASSESS by TBOSSE2 at 0118
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:
		0548 TBOSSE2 at 0548 GAVE: 10 MG
		NDC/DIN: (SOURCE: eMAR)
		6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB
		Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 0548
		Date: 05/29/16 Reassess: 0648
		Pain Location: ABDOMINAL
		Quality Of Pain: SHARP
		Onset of Pain: POST-OP
		Duration of Pain: INTERMITTENT
		FDOC 05/29/16-0549 by TBOSSE2
		DOSE changed from MG to 10 MG
		0633 REASSESS by TBOSSE2 at 0633
		Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE
		Pain Location:
		Quality Of Pain:
		Patient Sleeping: Sleeping Resp:
		Respiratory Quality: Respiratory Depth:
		Comment:

*** CONTINUED ON PAGE 76 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/28/16 to 0729 05/29/16 (Continued)	START/ STOP	
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 1 MG IV EVERY 4 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8931778 RX #: 07130854	05/21/16 05/31/16	1931 CWHITE6 at 1931 GAVE: 1 MG NDC/DIN: (SOURCE: eMAR) 0409255201 HYDR1I - HYDROmorphONE HCl 1 MG/ML AMP Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1931 Date: 05/28/16 Reassess: 2031 Pain Location: ABDOMINAL Quality Of Pain: SHARP Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/28/16-1932 by CWHITE6 2016 REASSESS by TBOSSE2 at 2016 Pt Relieved Of Pain: YRe-assess Pain Scale: Reassess:DONE Pain Location: Quality Of Pain: Patient Sleeping: Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment:

ADMINISTRATION PERIOD: 0730 05/29/16 to 0729 05/30/16	START/ STOP	
Protonix (Pantoprazole Sodium 40 MG/EACH TAB) 40 MG OR .HS Comments: DO NOT CRUSH PK ID: 8838649 RX #: 07120574	05/15/16 06/14/16	Discontinue 1318 DISCHARGE
Lovenox (Enoxaparin Sodium 40 MG/0.4 ML SYR) 40 MG SC EVERY 24 HRS IN AM Comments: NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE PK ID: 8913585 RX #: 07128948	05/20/16 05/31/16	0900 PLESLIE2 at 0848 SITE: L ABD - Left Abdomen GAVE: 40 MG NDC/DIN: (SOURCE: eMAR) 0075062040 ENOX40I - Enoxaparin Sodium 40 MG/0.4 M.. FDOC 05/29/16-0850 by PLESLIE2 Discontinue 1318 DISCHARGE

*** CONTINUED ON PAGE 77 ***
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ADMINISTRATION PERIOD: 0730 05/29/16 to 0729 05/30/16 (Continued)	START/ STOP		
Sodium Chloride 50 Ml 50 ML (Sodium Chloride 0.9% 50 ML MINI) KEFZOL/ANCEF 1 GM (CeFAZolin Sodium 1 GM/EACH VIAL) 100 MLS/HR IV EVERY 8 HOURS Comments: #1 O: Provider Aware - Continue as ordered ALL: The use of Kefzol/ancef SolR (cefazolin) may result in an allergic reaction based on a reported history of allergy to Drug: Penicillins PK ID: 8928573 RX #: 07130516	05/21/16 05/31/16	0900 PLESLIE2 at 0847 GAVE: 50 MLS FDOC 05/29/16-0850 by PLESLIE2 Discontinue 1318 DISCHARGE	
PROzac (FLUoxetine HCl 20 MG/EACH CAP) 20 MG OR EVERY 24 HRS IN AM Comments: PK ID: 8912971 RX #: 07130588	05/22/16 06/21/16	0900 PLESLIE2 at 0848 GAVE: 20 MG NDC/DIN: (SOURCE: eMAR) 5011164801 FDOC 05/29/16-0850 by PLESLIE2 Discontinue 1318 DISCHARGE	FLU20C - FLUoxetine HCl 20 MG/EACH CAP
Duoneb 3 mL Nebs (IPRATROPIUM/ALBUTEROL 3 ML NEB) 3 ML INH EVERY 6 HOURS RESP THERAPY RX #: 07130799	05/21/16 06/20/16	0730 MSANDERS at 0706 GAVE: 3 ML NDC/DIN: (SOURCE: eMAR) 0487020101 FDOC 05/29/16-0706 by MSANDERS Discontinue 1318 DISCHARGE	ALBU3SOL30 - Ipratropium/Albuterol 3 Ml Neb
Flagyl 500MG/100ML Bag 100 ML (MetroNIDAZOLE 500MG/NS 100ML 500 MG/100 ML PREMIX) 100 MLS/HR IV EVERY 8 HOURS Comments: FLAGYL 500MG/100ML PK ID: 8928570 RX #: 07134550	05/24/16 06/03/16	1000 PLESLIE2 at 1044 GAVE: 100 MLS FDOC 05/29/16-1046 by PLESLIE2 Discontinue 1318 DISCHARGE	
Mag-Al ANTACID 200-200 MG/5 Ml 30 Ml (Mag Hydrox-Al Hydrox-Sim 30 ML UDC) 30 ML OR EVERY 4 HOURS/PRN PRN Reason: INDIGESTION Comments: unless patient is NPO PK ID: 8838636 RX #: 07120578	05/15/16 06/14/16	Discontinue 1318 DISCHARGE	

*** CONTINUED ON PAGE 78 ***

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ADMINISTRATION PERIOD: 0730 05/29/16 to 0729 05/30/16 (Continued)	START/ STOP	
MYLICON-80 (Simethicone 80 MG/EACH TAB) 80 MG OR BEFORE MEALS AND BEDTIME/PRN PRN Reason: GAS/BLOATING Comments: PK ID: 8838637 RX #: 07120577	05/15/16 06/14/16	Discontinue 1318 DISCHARGE
PHENERGAN (Promethazine HCl 25 MG/ML AMP) 12.5 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: DILUTE WITH 10-20ML SALINE AND ADMINISTER OVER 10-15 MINUTES PK ID: 8838641 RX #: 07120575	05/15/16 06/14/16	Discontinue 1318 DISCHARGE
Tylenol (Acetaminophen 325 MG/EACH TAB) 650 MG OR EVERY 4 HOURS/PRN PRN Reason: FEVER > 101.5 Comments: MAX APAP/24 HRS IS 4 GRAMS PK ID: 8838650 RX #: 07120568	05/15/16 06/14/16	Discontinue 1318 DISCHARGE
Zofran (Ondansetron 2 MG/ML SDV) 4 MG IV Q3H/PRN PRN Reason: NAUSEA Comments: PK ID: 8838653 RX #: 07120576	05/15/16 06/14/16	Discontinue 1318 DISCHARGE

*** CONTINUED ON PAGE 79 ***
This document is part of the legal medical record.

ADMINISTRATION PERIOD: 0730 05/29/16 to 0729 05/30/16 (Continued)	START/ STOP	
Percolone (OxyCODONE HCl 5 MG/EACH TAB) See Dose Ins. OR EVERY 4 HOURS/PRN PRN Reason: pain Dose Ins: 5-10 MG Comments: IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN PK ID: 8930094 RX #: 07130645	05/21/16 05/31/16	1043 PLESLIE2 at 1043 GAVE: 10 MG NDC/DIN: (SOURCE: eMAR) 6830850547 OXYC5T - OxyCODONE HCl 5 MG/EACH TAB Pt C/O Pain: Y Pain Scale: 6 Time Med Given: 1043 Date: 05/29/16 Reassess: 1143 Pain Location: ABDOMINAL Quality Of Pain: SHARP Onset of Pain: POST-OP Duration of Pain: INTERMITTENT FDOC 05/29/16-1046 by PLESLIE2 DOSE changed from MG to 10 MG 1128 REASSESS by PLESLIE2 at 1151 Pt Relieved Of Pain: YRe-assess Pain Scale:2 Reassess:DONE Pain Location: ABDOMINAL Quality Of Pain: SHARP Patient Sleeping: N Sleeping Resp: Respiratory Quality: Respiratory Depth: Comment: Discontinue 1318 DISCHARGE
Dilaudid (HYDROmorphONE HCl 1 MG/ML AMP) 1 MG IV EVERY 4 HOURS/PRN PRN Reason: PAIN Comments: PK ID: 8931778 RX #: 07130854	05/21/16 05/31/16	Discontinue 1318 DISCHARGE

ADMINISTRATION PERIOD: 0730 05/30/16 to 0729 05/31/16	START/ STOP	

*** CONTINUED ON PAGE 80 ***

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NAME: KNIGHT,DANIEL ERIC UNIT #: M000175313 ACCT #: V00006912886

ADMINISTRATION PERIOD:	START/ STOP
0730 05/30/16 to 0729 05/31/16 (Continued)	

LEGENDS

ACTIVITY CODES
* - Not Administered
AO - Nursing Acknowledged Order
CAN - Canceled Order
DC - Pharmacy Discontinue
ED - Pharmacy Edit or Verification
ENTER - Order Entry
FDOC - File Document
OVDC - DC Order Override
REASSESS - Nursing Reassessment
UNDOC - Nursing Undo Document
nHA - Nursing Hold Acknowledgement
nREM - Nursing Request Removed

REASON CODES
AG - ALREADY GIVEN
AGPACU - ALREADY GIVEN IN PACU
DC - ORDER DISCONTINUED
NOT GIVEN - NOT GIVEN
PRT - PT REFUSED/Declined
RT.EMERG - RT Involved in Emergengy

SITE CODES
L ABD - Left Abdomen
R ABD - Right Abdomen

ELECTRONICALLY SIGNED BY

USER	USER NAME/TYPE
ACAMPBELL2	CAMPBELL,AMY RRT
BEPLER	EPLER,BRANDY RTLPN
CBARKER4	BARKER,CANDACE RN
CWHITE7	WHITE,CORAZON RN
JWILSON2	WILSON,JESSIE RRT
LFADRI	FADRI,LOURDES RN
MWILLIAMS	WILLIAMS,MARSHA RN
RGASQUE	GASQUE,RACHEL RN
SPAITSEL	PAITSEL,SUSANNA RRT
TKOCH2	KOCH,THOMAS RN

USER	USER NAME/TYPE
AHENDERSON	EDGE-HENDERSON,ABRAN RRT
BGORDON	GORDON,BRITTANY RN
CGRAVES	GRAVES,CHARLENE CRT
FSLOAN	SLOAN,FRED CRT
KBELLAM	BELLAM,KATIE RN
MGODWIN	GODWIN,MELISSA RN
NROBERTS2	ROBERTS,NATALIE RN
RMESHREKI	MESHREKI,RAFIK RN
SSARVIS4	SARVIS,SABRINA RN

USER	USER NAME/TYPE
APRUITT	PRUITT,APRIL RRT
BLEWIS5	LEWIS,BETHANY RN
CPETTY	PETTY,CHERYL RN
JELLIOTT	ELLIOTT,JOETTA RCP
KCULCLASUR	CULCLASURE,KELLI RN
MMAPLES	MAPLES,MICHELE RN
PLESLIE2	LESLIE,PRISCILLA RN
SESTES	ESTES,SUSAN CRT
STALBOT	TALBOT,SUSIE LPN

USER	USER NAME/TYPE
AWRIGHT3	WRIGHT,ANTHONY RN
BPAUL	PAUL,BETSY RN
CWHITE6	WHITE,CASEY RN
JWHITE7	WHITE,JENNIFER CRT
KODOM2	ODOM,KIM RRT
MSANDERS	SANDERS,MICHELE E CRT
PSKINNER2	SKINNER,PAMELA RN
SHERRINGT2	HERRINGTON,SHERRY RN
TBOSSE2	BOSSE,TRICIA RN

OTHER USERS

USER	USER NAME
AWRIGHT1	WRIGHT,ANDREW
HGASSAWAY	GASSAWAY,HUGH
NKAMDAR	KAMDAR,NIKITA
RBEVERLY	BEVERLY,ROGER

USER	USER NAME
BLEWIS5	LEWIS,BETHANY
JBLOCKER	BLOCKER,JANE
NSKINNER	SKINNER,NICOLE
SHERRINGT2	HERRINGTON,SHERRY

USER	USER NAME
CPOSTON1	POSTON,CATHY
MCARR	CARR,MICHELLE
PKPHAUSER	PK PHARMACY USER
SOWENS2	OWENS,SALLY

USER	USER NAME
EKNIGHT	KNIGHT,ELIZABETH
NGLODACK	GLODACK,NATALIE
PMELVIN	MELVIN,PATRICIA
STALBOT	TALBOT,SUSIE

COMBINED ALLERGY HISTORY

DATE	MODULE	USER	ALLERGY DETAILS	
05/15/16 1005	PHA	SOWENS2 - OWENS,SALLY	ADDED Penicillins OLD: NEW: Penicillins added.	by SOWENS2

*** CONTINUED ON PAGE 81 ***

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ADMINISTRATION PERIOD: 0730 05/30/16 to 0729 05/31/16 (Continued)	START/ STOP	

ADDED by SOWENS2
Sulfa (Sulfonamide Antibiotics)
OLD:
NEW: Sulfa (Sulfonamide Antibiotics) added.

05/15/16 1104 ADM CANDERSON - ANDERSON,CYNTHIA FILED by CANDERSON

TEXT:
User filed without changing allergy record.

Conway Medical Center
Conway, South Carolina

Physician's Orders
Medication Renewal Notices for 05/31/16

Team Health # 1

V00006912886
KNIGHT,DANIEL ERIC
[redacted]
M000175313 05/15/16

Rimkus, Gilbertas MD

Rx #	START	MEDICATION/DOSE		ROUTE	Renew	Stop
07128948	05/20	Enoxaparin Sodium	40 MG/0.4 ML INJ (40 MG)	SC	☐	☐
	SIG:	EVERY 24 HRS IN AM				
	LABEL COMMENT:	NOTIFY MD FOR PLT < 100,000 OR 50% DROP FROM BASELINE				
	ORDERING DOCTOR:	Budhoo, David MD				
07130516	05/21	CeFAZolin Sodium	1 GM/EACH IV (1 GM)	IV	☐	☐
		IN: Sodium Chloride 0.9%	50 ML IV (50 ML)			
	SIG:	EVERY 8 HOURS				
	LABEL COMMENT:	#1 O: Provider Aware - Continue as ordered ALL: The use of				
	ORDERING DOCTOR:	Budhoo, David MD				
07130645	05/21	OxyCODONE HCl	5 MG/EACH TAB (5-10 MG	OR	☐	☐
	SIG:	EVERY 4 HOURS PRN				
	LABEL COMMENT:	IMMEDIATE RELEASE TABLET - DO NOT CONFUSE WITH OXYCONTIN				
	ORDERING DOCTOR:	Budhoo, David MD				
07130854	05/21	HYDROmorphONE Hydrochlori	1 MG/ML AMP (1 MG)	IV	☐	☐
	SIG:	EVERY 4 HOURS PRN				
	LABEL COMMENT:	PK ID: 8931778				
	ORDERING DOCTOR:	Ellis, Michael H. MD				

[redacted]

The above order(s) are due to expire on: 05/31/16
Please check renew or stop box above and sign.

Physician Signature: _____ **Date/Time:** _____

** Fax order to pharmacy **

Physician not required to sign

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 0647

000000 MEDHOST (ER) Info A CP
- Document 05/15/16 0647 M 05/15/16 0648 M
Tobacco Use/Hx Of Use Past Year: N Tobacco Type+:

Alcohol Use: Type Alcohol Used:
Substance Use: Type Substance Used:

Code Status+: Full Code

Reason For Visit: INTESTINAL PERFORATION PERITONITIS

Previous Medical Hx: ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Surgical History <Esc>: NONE

Weight (lbs): 160 (Oz): kg: Height (ft): 5 (in): 3

Advance Directive: On File Here:

Activity Date: 05/15/16 Time: 0648

000000 MEDHOST (ER) Info A CP
- Create 05/15/16 0648 05/15/16 0648

Activity Date: 05/15/16 Time: 1012

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1012 ST 05/15/16 1110 ST
Critical Care Flowsheet Time: 1012

Temperature: 97.4
Temperature Source+: Tympanic
Pulse: 132
Pulse Source+: MONITOR
Respirations: 26
SPON:
Vent Resp:
Blood Pressure: 134/75
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 99
%/L of O2: 40
ETCO2:
A-LINE BP:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 1012 (continued)

120000 Critical Care Flowsheet (continued)
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1015

010 RESP THERAPY - VENTILATOR DOCUMENTATION A Q4H CP
- Document 05/15/16 1015 AC2 05/15/16 1111 AC2
VENT NUMBER: 6 Time: 1015 ETT: Y Trach:
Mode APV/SIMV FiO2 40
Rate Set/Time High-APRV: 10 ETT AT Teeth: 20 ETT R/L/M: RT
RATE ACTUAL: 23 Tube Size: 8.0 Cuff Pressure:
VT SET/Insp Pres(PC)/Pres High-APRV: 500 Target VT
VT EXHALED/Time Low-APRV: 564 HR: 98 ETCO2: 28 O2 Sat: 100
VT SPON: VE: 11.5 Blood Pressure:
PEEP/CPAP/Pres Low-APRV: 5 Breath Sounds: CLEAR
P.S.: 10 Peak Airway Pressure: 16
Auto Peep: Mean Airway Pressure: 7.6 Resuscitation Bag at BS: Y Vent Day: 1
SENSITIVITY/Flow Trig: 4 I:E 1:2.8 Suction: Y
I TIME/FLOW RATE: 0.8 Pplat: 16 CHARGES
VE%: VE Set: MECHANICS Vent I: Y
ALARMS WORKING: Y High PAP: 40 RSBI: Vent Day:
Low PAP: 5 NIF: Intubation:
High RR: 40 Low VE: 3 SPON VT: PVCS:
Low RR: 5 High VE: 20 RR: CPR:
VE: ETCO2: Y
Comment: PT ARRIVED FROM OR, REMAINS INTUBATED. PLAN TO EXTUBATE WHEN HE WAKES UP. PLAN TO WEAN TO PS VC: VC:
Pul Compliance: Pul Comp:
WEANING VE <15lpm: PEEP < 5: PaO2/FiO2 > 200:
FIO2 < 0.5: RSBI (< 105/copd < 130):
PaO2 > 60:
Peep < 10:
BP Stable:
Temp < 101:
Pt Free Pathology: Temp > 97.6:
Follows Commands: Pass Screen:
Pass Screen 1:
Weaning Protocol Ordered:
Cough/Gag Reflex Present: If No, Contact MD/DO:
Off Sedation:
Off Vasopressors:
Patient Notes: Nursing Notes
- Create 05/15/16 1015 ST 05/15/16 1232 ST
Abnormal? N Confidential? N
pt admitted via bed to CC26, on vent, on spond mode, cardiac monitor showing ST hr 132, resp 26 and wnl. LR infusing via pump at 150cc/hr. foley patent to bsd. abd dsg c/d/i with jp drain draining large amts of serous fluid. nodding head yes and no to answer questions. no sedation, alert and following all

5A4D43B46E10429588C8, KNIGHT, 133

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 1015 (continued)

Patient Notes: Nursing Notes (continued)
commands.

Note Type	Description
No Type	None

Activity Date: 05/15/16 Time: 1030

120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/15/16 1030 ST 05/15/16 1200 ST

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative
Site:

Speech/Cry+: ET Tube

Vision Impairment:
Responsive To+: Sound
Hearing Impairment:

Mental Status: Alert

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented:	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 10

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 1030 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Peripheral/pedal pulses present. Skin warm and dry.
Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: Sticker:
Chest Pain: N Heart Rate: 132 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: Normal Transvenous Pacemaker: N Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal	Radial Rt+: Normal
Dorsalis Rt+: Normal	Radial Lt+: Normal
Post Tib Lt+:	Femoral Rt+:
Post Tib Rt+:	Femoral Lt+:
Carotid Rt+:	Cap Refill RUE+: Brisk
Carotid Lt+:	Cap Refill LUE+: Brisk
Brachial Rt+:	Cap Refill RLE+: Brisk
Brachial Lt+:	Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 26 O2 Sat: 99 &/L of O2: 40 Cyanosis: N Pallor: Y

O2 Mode+: Vent
RR Description+: WNL

Breath Sounds
LUL+: Clear

Resp Pattern+: WNL
Chest Expansions+: Symmetrical

LLL+: Clear

5A4D43B46E10429588C8, KNIGHT, 134

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1030 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

RUL+: Clear
RML+: Clear
RLL+: Clear

COPD Educational Video:
Airway: ETT Secured at 19 cm @ TEETH Position: M Size 8.0 F

VENTILATOR DOCUMENTATION:
Vent type: HAMILTON
Tidal Volume Vent Set Rate:
Pressure Support 10 Mode SPONT
FiO2 40 Peep: 5

VAP BUNDLE:
HOB > 30 degrees YES
DVT Prophylaxis YES
PUD Prophylaxis YES
Sedation Vacation CONTRA
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction Y

Modified Ramsey Score 2 Cooperatv/Orlant/Tranquil
TOF

Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull:

Comment
MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:
Paralysis+:
Joint Swelling+:
Amputations+:
Muscle Spasms+:
Contractures+:
Deformities+:
Weakness+:

Transfer, Lift, or Ambulation equipment TRANS BRD
Musc-Skel Comment <Esc>:

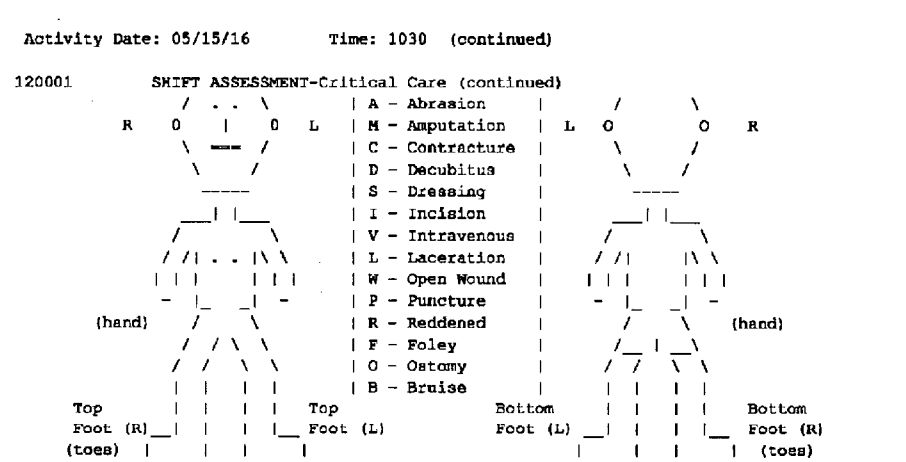
FRONT VIEW ---WOUND TYPES--- **BACK VIEW**
| Lesion Location |

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1030 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)



COMMENT:
Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Pale
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+:

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: FOLEY, JP DRAIN

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast: 1	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate:
No Impairment: 4	Walks Frequently:	Excellent: 4

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:

5A4D43B46E1042958C8, KNIGHT, 135

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1030 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Very Moist: Very Limited: Potential Problem:
Occasionally Moist: Slightly Limited: 3 No Apparent Problem: 3
Rarely Moist: 4 No Limitations:

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: Incontinent Stool:
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness MIDDLE Tubes+: NG Tube
Abd Appearance+: Tube Drainage: N Tube To Suction: N
OGT/NGT is secured at 63 cm
RUQ+: HYPOACTIVE Stoma Present: Location:
LUQ+: HYPOACTIVE Appearance:
RLQ+: HYPOACTIVE Ostomy Appliance:
LLQ+: HYPOACTIVE Drainage Characteristics:
GI Comment <Esc>: Rectal Tube:

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems:
Urine Odor+: Normal
Character+: CLOUDY ***Dialysis***
Incontinent Bladder: CAPD: Peritoneal Dialysis:
Suprapubic Catheter: Hemodialysis:
Urostomy: Hemo Site Description+:
Stoma Appearance Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1030 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Pt C/O Pain: N Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: UNSTABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn:
Ability To Understand Verbal Instructions:
Ability To Understand Written Instruction:
Learning Preference+:
Knowledge of Educational Needs/Treatment Plan:
Appropriate teaching for disease process utilized:

Specific Barriers To Learning

Physical:	Language:	Visual:	Motivation:	Cultural:	Cognitive:
Reading:	Age Related:	Auditory:	Emotional:	Religious:	Finances:

EDUCATION/INTERVENTION: PT SEDATED ON VENT
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/15/16 1030 ST 05/15/16 1201 ST
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics,

5A4D43B46E10429588C8, KNIGHT, 136

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1030 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Ambulatory and/or incontinent
****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing
*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs
****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt) 9
RN Judgement (4pt)

Total Score: 17

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart Y
Remain W/patient whenever OOB Y
If OOB to chair, q30min monitoring Y
Assess q1hr 7A-7P Y
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: ON VENT

Fall Score Ranking: HIGH Level of Care: TOTAL

010 RESP THERAPY - VENTILATOR DOCUMENTATION A Q4H CP
- Document 05/15/16 1030 AC2 05/15/16 1112 AC2
VENT NUMBER: 6 Time: 1030 ETT: Trach:
Mode SPONT FiO2 40
Rate Set/Time High-APRV: ETT AT Teeth: ETT R/L/M:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1030 (continued)

010 RESP THERAPY - VENTILATOR DOCUMENTATION (continued)

RATE ACTUAL: 22 Tube Size: Cuff Pressure:
VT SET/Insp Pres(PC)/Pres High-APRV: Target VT
VT EXHALED/Time Low-APRV: HR: 96 ETCO2: 30 O2 Sat: 100
VT SPON: 526 VE: Blood Pressure:
PEEP/CPAP/Pres Low-APRV: 5 Breath Sounds:
P.S.: 10 Peak Airway Pressure:
Auto Peep: Mean Airway Pressure: 7.5 Resuscitation Bag at BS: Vent Day:
SENSITIVITY/Flow Trig: I:E Suction:
I TIME/FLOW RATE: Pplat:
VE%: VE Set: MECHANICS CHARGES
ALARMS WORKING: High PAP: RSBI: Vent I:
Low PAP: NIF: Vent Day:
High RR: Low VE: SPON VT: Intubation:
Low RR: High VE: PVCS:
RR: CPR:
VE: ETCO2:
Comment: VC: VC:
Pul Compliance: Pul Comp:
WEANING VE <15lpm: PEEP < 5: PaO2/FiO2 > 200:
FIO2 < 0.5: RSBI (< 105/copd < 130):
PaO2 > 60:
Peep < 10:
BP Stable:
Temp < 101:
Pt Free Pathology: Temp > 97.6:
Follows Commands: Pass Screen:
Pass Screen 1:
Weaning Protocol Ordered:
Cough/Gag Reflex Present: If No, Contact MD/DO:
Off Sedation:
Off Vasopressors:

Activity Date: 05/15/16 Time: 1100

5500011 Purposeful Rounding A CP
- Document 05/15/16 1100 SF 05/15/16 1112 SF
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
Patient Notes: Nursing Notes
- Create 05/15/16 1100 ST 05/15/16 1233 ST
Abnormal? N Confidential? N
wife at bedside, pt resting quietly at this time. continues to nod head yes and no. resp even nonlabored. no sedation, follows all commands.

5A4D43B46E1042958C8, KNIGHT, 137

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/15/16 Time: 1100 (continued)										
Patient Notes: Nursing Notes (continued) Note Type Description										
No Type None										
Activity Date: 05/15/16 Time: 1108 (continued)										
Problem: Critical Care Plan of Care (continued)										
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
Outcome: RESPIRATORY STATUS-Critical Care							C			
Definition: Maintenance of adequate ventilation thru a patent airway to maintain arterial blood gas concentration, oximetry reading, and/or capnography reading WNL										
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
120004 Ventilator Documentation-Critical Care							A	Q4H		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
- Document	05/15/16	1108	ST	05/15/16	1109	ST				
VENTILATOR DOCUMENTATION:										
Vent type: HAMILTON										
Tidal Volume Vent Set Rate:										
Pressure Support 10 Mode SPONT										
FiO2 40 Peep: 5										
HOB > 30 degrees YES Subglottic Suction Y										
Comment:										
120039 Sedation/Paralysis Scale-Critical Care							A	Q4H		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
Outcome: CARDIOVASCULAR STATUS-Critical Care							C			
Definition: Cardiac Pump effectiveness to provide adequate systemic and coronary perfusion pressure										
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
120009 Telemetry Monitoring - Critical Care							A	Q4H		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
150035 Hemodynamic Monitoring (Crit Care)							A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
Outcome: NEUROLOGICAL STATUS-Critical Care							C			
Definition: Ability of the peripheral and central nervous system to receive, process, and respond to internal & external stimuli as demonstrated by appropriate arousal, orientation, and attention to the environment										
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6954 STROKE EDUCATION							A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/15/16 Time: 1108										
Outcome: GI/GU STATUS-Critical Care							C			
Definition: Adequate urine output, bowel elimination, and nutritional status										
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
Outcome: Critical Care Interventions							C			
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
0840 Positioning							A	Q2H		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
10026 DISCHARGE PATIENT-Escorted							A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
108 CHF/AMI/STROKE/DVT HQI Screen							A			CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
1160 Nutritional Monitoring							A	08,12,18		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
120000 Critical Care Flowsheet							A	Q1H		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
1200008 Oral Care - Critical Care							A	Q4H		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
120001 SHIFT ASSESSMENT-Critical Care							A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
120003 Goals/Outcomes - Critical Care							A	08,18,20,06		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
1200041 IV Pump Totals - Critical Care							A	01,05,09,13,17,21		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
120040 Bedside Procedure Doc - Critical Care							A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
125 CRITICAL CARE REPORT							A	05,17		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
150011 Weight, Monitor Daily							A	DAILY@0600		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
150012 Intake/Output (No IVs) Critical Care							A	01,05,09,13,17,21		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
1661 Foot Drop Boots - ON							A	05		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
1662 Foot Drop Boots - OFF							A	17		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
1663 IPC, TED, VFP Documentation							A			CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
2380 Medication Management							A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
275051 VTE Prophylaxis Orders Complete?							A	08,20		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
3592 TED/HEEL PROTECTORS/IPC Skin Assessment							A	04,16		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
400002 Wound Care/Dressing Change							A	AD		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
525002 IV THERAPY ASSESSMENT							A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				

5A4D43B46E10429588C8, KNIGHT, 138

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/15/16		**Time: 1108**								
525003	IV Site Check						A	06,18		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
5500	Off-Unit for Test/Procedure						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
5500010	Rounds Surveillance						A	06,18		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
5500011	Purposeful Rounding						A			CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6409	FALLS SCREEN - FOLLOW-UP						A	02,14		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6421	ISOLATION Patient Type						A	08,20		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6680	Vital Signs						A	AD		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6901	PATIENT LINEN CHANGE						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6902	PATIENT TURNED						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6903	PATIENT FED						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6907	PATIENT BATH - Critical Care						A	DAILY		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6910	Last BM						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6911	Transfer/Nursing Report Record						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6922	Nursing Report (Hand Off)						A	07,19		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6952	RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)						A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
6955	Anticoagulant Educ Materials Provided						A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
7370	Discharge Planning Assessment						A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
7371	Discharge Information for PATIENT						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
750006	PAIN ASSESSMENT						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
75015	Discharge Med Rec via RXM						A			CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
7900	Flu Vaccination Received						A	PRN		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
800001	Education/Teaching Assessment						A	04,16		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
9610	Fall Risk Assessment/Interventions						A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				
99	SEPSIS Documentation						A	QS		CP
- Create	05/15/16	1108	CP	05/15/16	1108	CP				

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/15/16		**Time: 1108**								
Problem: RT - RESPIRATORY FAILURE							A			
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
Outcome: ADEQUATE VENTILATION							A			
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
010	RESP THERAPY - VENTILATOR DOCUMENTATION						A	Q4H		CP
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
011	PULMONARY CONSULT DOC - RESP THERAPY						A	Q48H		CP
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
016	RESP THERAPY - EQUIPMENT CHANGE OUT						A	QD@1130		CP
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
020	RESP THERAPY - Change Flow Sensor						A	Q5D@11		CP
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
08	RESP THERAPY - PATIENT EVALUATION						A	Q72H@0800		CP
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
09	RESP THERAPY - TREATMENT						A	AD		CP
- Create	05/15/16	1108	AC2	05/15/16	1108	AC2				
Activity Date: 05/15/16		**Time: 1109**								
120039	Sedation/Paralysis Scale-Critical Care						A	Q4H		CP
- Document	05/15/16	1109	ST	05/15/16	1109	ST				
Modified Ramsey Score	2	Cooperatv/Orient/Tranquil								
		TOF								
120009	Telemetry Monitoring - Critical Care						A	Q4H		CP
- Document	05/15/16	1109	ST	05/15/16	1109	ST				
Telemetry Rhythm: SINUS TACHYCARDIA										
Low Rate: 115										
High Rate: 132										
Change From Baseline: N										
Notify MD: N		Check Alarm: Y								
Comment:										
Activity Date: 05/15/16		**Time: 1110**								
120003	Goals/Outcomes - Critical Care						A	08,18,20,06		CP
- Document	05/15/16	1110	ST	05/15/16	1111	ST				
CRITICAL CARE GOALS/OUTCOMES										
Goal #1: HEMODYNAMICALLY STABLE :										
Goal #2: MAINTAIN, COMFORT, SAFETY :										
Goal #3: MAINTAIN PATENT AIRWAY :										
COMMENT:										

5A4D43B46E1042958C8, KNIGHT, 139

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/15/16		**Time: 1111**								
1661	Foot Drop Boots - ON						A	PRN		CP
- Ed Directs	05/15/16 1111	ST		05/15/16 1111	ST			05/15 1108 05	=>	05/15 1108 05
										05/15 1111 PRN
1662	Foot Drop Boots - OFF						A	PRN		CP
- Ed Directs	05/15/16 1111	ST		05/15/16 1111	ST			05/15 1108 17	=>	05/15 1108 17
										05/15 1111 PRN
Activity Date: 05/15/16		**Time: 1112**								
1200041	IV Pump Totals - Critical Care						A	05,17		CP
- Ed Directs	05/15/16 1112	ST		05/15/16 1112	ST					
	05/15 1108 01,05,09,13,17,21								=>	05/15 1108 01,05,09,13,17,21
									=>	05/15 1112 05,17
150012	Intake/Output (No IVs) Critical Care						A	05,17		CP
- Ed Directs	05/15/16 1112	ST		05/15/16 1112	ST					
	05/15 1108 01,05,09,13,17,21								=>	05/15 1108 01,05,09,13,17,21
									=>	05/15 1112 05,17
011	PULMONARY CONSULT DOC - RESP THERAPY						A	Q48H		CP
- Document	05/15/16 1112 AC2			05/15/16 1112 AC2						

PULMONARY CONSULT DOCUMENTATION

VENTILATOR

Greater than 48 hrs N
Has Pulmonary Consult been initiated? N
If No, start now N

***All vents need a pulmonary consult if on > 48 hours.

HIGH FLOW NASAL CANNULA

Palliative Care Consult?
Has pulmonary consult been initiated?
Start Pulmonary Consult now

***All Hi Flow NC need a Pulmonary Consult unless followed by Palliative Care.

016	RESP THERAPY - EQUIPMENT CHANGE OUT						A	QD@1130		CP
- Document	05/15/16 1112 AC2			05/15/16 1112 AC2						

EQUIPMENT CHANGE OUT

Closed Suction System (PRN)
HME (24-48HRS)
Nebs (Every Wed)
O2 Humidifiers (Every Wed)
NRB (Every Wed)
Venturi (Every Wed)

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/15/16		**Time: 1113**								
120000	Critical Care Flowsheet						A	Q1H		CP
- Document	05/15/16 1113	ST		05/15/16 1320	ST					

Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 129
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 105/70
BP Location+:
BP Position+:
O2 Sat: 99
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 79
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/15/16 **Time: 1119**

6952	RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)						A	PRN		CP
- Ed Directs	05/15/16 1119	ST		05/15/16 1119	ST			05/15 1108 QS	=>	05/15 1108 QS
										05/15 1119 PRN
- Document	05/15/16 1119	ST		05/15/16 1119	ST					

Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

Activity Date: 05/15/16 **Time: 1128**

120000	Critical Care Flowsheet						A	Q1H		CP
- Document	05/15/16 1128	ST		05/15/16 1320	ST					

Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 129
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 104/71
BP Location+:
BP Position+:
O2 Sat: 99
%/L of O2:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

5A4D43B46E10429588C8, KNIGHT, 140

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 1128 (continued)

120000 Critical Care Flowsheet (continued)

ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 81
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1140

Patient Notes: Nursing Notes
- Create 05/15/16 1140 ST 05/15/16 1235 ST
Abnormal? N Confidential? N
Dr Rimkus in to see pt and update given. verbal order to extubate when pt is stable.
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 1142

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1142 ST 05/15/16 1320 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 129 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 104/65 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 99 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 76
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1158

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1158 ST 05/15/16 1320 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 1158 (continued)

120000 Critical Care Flowsheet (continued)

Pulse: 129 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 98/64 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 99 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 74
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1200

0840 Positioning A Q2H CP
- Document 05/15/16 1200 ST 05/15/16 1213 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/15/16 1200 ST 05/15/16 1213 ST
Diet Ordered: NPO
Meal:
% Diet Taken:
Oral Supplemsnt:
PO Supplement: cc (Total Intake)
Comment:
120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1200 ST 05/15/16 1213 ST
Critical Care Flowsheet Time: 1200

Temperature: 97.2 Nursing Note:
Temperature Source+: Tympanic
Pulse: 129 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 26 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 92/62 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 99 Calibrate: Void (ml): ml
%/L of O2: 40
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:

5A4D43B46E1042958C8, KNIGHT, 141

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1200 (continued)

120000 Critical Care Flowsheet (continued)
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

1200008 Oral Care - Critical Care A Q4H CP
- Document 05/15/16 1200 ST 05/15/16 1213 ST

Activity Date: 05/15/16 Time: 1213

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1213 ST 05/15/16 1320 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 129 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 92/62 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 99 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 74
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/15/16 Time: 1220

Patient Notes: Nursing Notes
- Create 05/15/16 1220 ST 05/15/16 1238 ST
Abnormal? N Confidential? N
extubated per R.T., placed on NC at 2/1 with sats 98%. LR infusing via pump site w/o problems. jp drain to bulb suction. pt awake and asking questions, denies pain at this time. will continue to monitor closely.
Note Type Description
No Type None

Patient Notes: Respiratory Therapy Notes
- Create 05/15/16 1220 MES 05/15/16 1247 MES
Abnormal? N Confidential? N
EXTUBATED PT WITHOUT DIFFICULTY TO 2L NC
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1228

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1228 ST 05/15/16 1320 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 133 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 95/65 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 76
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/15/16 Time: 1243

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1243 ST 05/15/16 1320 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 130 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 89/63 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 98 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 70
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

5A4D43B46E1042958BC8, KNIGHT, 142

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change
Activity Date: 05/15/16 Time: 1248									
Problem: RT - RESPIRATORY FAILURE							C		
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
Outcome: ADEQUATE VENTILATION							C		
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
010 RESP THERAPY - VENTILATOR DOCUMENTATION							C	Q4H	CP
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
011 PULMONARY CONSULT DOC - RESP THERAPY							C	Q48H	CP
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
016 RESP THERAPY - EQUIPMENT CHANGE OUT							C	QD@1130	CP
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
020 RESP THERAPY - Change Flow Sensor							C	Q5D@11	CP
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
08 RESP THERAPY - PATIENT EVALUATION							C	Q72H@0800	CP
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
09 RESP THERAPY - TREATMENT							C	AD	CP
- Ed Status	05/15/16	1248	MES	05/15/16	1248	MES			A => C
Activity Date: 05/15/16 Time: 1259									
120000 Critical Care Flowsheet							A	Q1H	CP
- Document	05/15/16	1259	ST	05/15/16	1320	ST			

Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 131 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 93/65 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 98 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 72
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1300

120000 Critical Care Flowsheet							A	Q1H	CP
- Document	05/15/16	1300	ST	05/15/16	1317	ST			

Critical Care Flowsheet Time: 1300

Temperature: Nursing Note:
Temperature Source+:
Pulse: 133 PCWP: Glycemic Protocol:

Problem/Outcome/Intervention Description

Activity Date: 05/15/16 Time: 1300 (continued)

120000 Critical Care Flowsheet (continued)

Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 87/65 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 98 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 72
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

- Document	05/15/16	1300	ST	05/15/16	1839	ST			

Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 130 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 93/65 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 98 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 72
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

5500011 Purposeful Rounding								A	CP
- Document	05/15/16	1300	SF	05/15/16	1336	SF			

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E1042958C8, KNIGHT, 143

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/15/16		Time: 1315								
120000	Critical Care Flowsheet							A	Q1H	CP
- Document	05/15/16	1315	ST	05/15/16	1839	ST				
	Critical Care Flowsheet				Time:					

Temperature:
Temperature Source+:
Pulse: 130
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 87/65
BP Location+:
BP Position+:
O2 Sat: 98
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 72
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/15/16		Time: 1330								
120000	Critical Care Flowsheet							A	Q1H	CP
- Document	05/15/16	1330	ST	05/15/16	1839	ST				
	Critical Care Flowsheet				Time:					

Temperature:
Temperature Source+:
Pulse: 131
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 85/63
BP Location+:
BP Position+:
O2 Sat: 98
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 70
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/15/16		Time: 1344								
120000	Critical Care Flowsheet							A	Q1H	CP
- Document	05/15/16	1344	ST	05/15/16	1839	ST				
	Critical Care Flowsheet				Time:					

Temperature:
Temperature Source+:
Pulse: 131
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 91/66
BP Location+:
BP Position+:
O2 Sat: 98
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 74
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/15/16		Time: 1359								
120000	Critical Care Flowsheet							A	Q1H	CP
- Document	05/15/16	1359	ST	05/15/16	1839	ST				
	Critical Care Flowsheet				Time:					

Temperature:
Temperature Source+:
Pulse: 133
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 77/61
BP Location+:
BP Position+:
O2 Sat: 98
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 66
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

5A4D43B46E1042958C8, KNIGHT, 144

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/15/16 Time: 1400										
0840	Positioning						A	Q2H		CP
- Document	05/15/16	1400	ST	05/15/16	1400	ST				
120000	Critical Care Flowsheet						A	Q1H		CP
- Document	05/15/16	1400	ST	05/15/16	1408	ST				

Critical Care Flowsheet Time: 1406

Temperature:
Temperature Source+:
Pulse: 133
Pulse Source+: MONITOR
Respirations: 18
SPON:
Vent Resp:
Blood Pressure: 80/52
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 98
%/L of O2: 2
ETCO2:
A-LINE BP:
MAP: 59
Intra-Abd Pressure:

Nursing Note:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

6409	FALLS SCREEN - FOLLOW-UP						A	02,14		CP
- Document	05/15/16	1400	ST	05/15/16	1406	ST				

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: Y

Change in Meds: Y

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/15/16 Time: 1400 (continued)										
6409	FALLS SCREEN - FOLLOW-UP (continued)									

Interm confusion or change in LOC
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (3pt)
RN Judgement (4pt)

Total Score: 0

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach

Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

5A4D43B46E1042958C8, KNIGHT, 145

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/15/16 Time: 1402

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1402 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 133 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 80/52 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 98 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 59
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1408

Patient Notes: Nursing Notes
- Create 05/15/16 1408 ST 05/15/16 1410 ST
Abnormal? N Confidential? N
awake and alert, asking "what happened", pt instructed on surgery and why, verbalizes understanding. oral care provided.
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 1414

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1414 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 131 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1414 (continued)

120000 Critical Care Flowsheet (continued)
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 83/50 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 71
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1423

Patient Notes: Nursing Notes
- Create 05/15/16 1423 ST 05/15/16 1424 ST
Abnormal? N Confidential? N
bp 83/50, Dr Santiago awaren NS bolus infusing at this time.
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 1424

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1424 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 133 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 86/56 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 68
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

5A4D43B46E10429588C8, KNIGHT, 146

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1428

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1428 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 133 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 81/59 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 68
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1445

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1445 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 133 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 81/47 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 56
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1459

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1459 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 131 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 72/51 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 55
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1500

5500011 Purposeful Rounding A CP
- Document 05/15/16 1500 SF 05/15/16 1520 SF
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/15/16 Time: 1502

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1502 ST 05/15/16 1502 ST
Critical Care Flowsheet Time: 1500

Temperature: Nursing Note:
Temperature Source+:
Pulse: 131 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:

5A4D43B46E1042958C8, KNIGHT, 147

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1502 (continued)

120000 Critical Care Flowsheet (continued)

Vent Resp:
Blood Pressure: 72/51
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 97
%/L of O2: 2
ETCO2:
A-LINE BP:
MAP: 55
Intra-Abd Pressure:
Comment:

CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Activity Date: 05/15/16 Time: 1514

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1514 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 131
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 87/64
BP Location+:
BP Position+:
O2 Sat: 98
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 69
Intra-Abd Pressure:
Comment:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Patient Notes: Nursing Notes
- Create 05/15/16 1514 ST 05/15/16 1514 ST
Abnormal? N Confidential? N
wife at bedside and update given, bolus infuisng with bp 87/64 (69).
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 1528

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1528 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 1528 (continued)

120000 Critical Care Flowsheet (continued)

Temperature:
Temperature Source+:
Pulse: 133
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 82/62
BP Location+:
BP Position+:
O2 Sat: 96
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 67
Intra-Abd Pressure:
Comment:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Activity Date: 05/15/16 Time: 1529

Patient Notes: Nursing Notes
- Create 05/15/16 1529 ST 05/15/16 1529 ST
Abnormal? N Confidential? N
ngt remains to lis with no drainage at this time, ostomy bag intact with no drainage at this time. ns bolus completed, will continue to monitor closely.
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 1543

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1543 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 133
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 78/62
BP Location+:
BP Position+:
O2 Sat: 96
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 68

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

5A4D43B46E10429588C8, KNIGHT, 148

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/15/16 Time: 1543 (continued)

120000 Critical Care Flowsheet (continued)
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1558

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1558 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 131 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 83/56 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 64
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1609

120004 Ventilator Documentation-Critical Care A PRN CP
- Ed Directs 05/15/16 1609 ST 05/15/16 1609 ST 05/15 1108 Q4H => 05/15 1108 Q4H
05/15 1300 PRN
120039 Sedation/Paralysis Scale-Critical Care A PRN CP
- Ed Directs 05/15/16 1609 ST 05/15/16 1609 ST 05/15 1108 Q4H => 05/15 1108 Q4H
05/15 1300 PRN
120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/15/16 1609 ST 05/15/16 1610 ST
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate: 115
High Rate: 132
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/15/16 Time: 1609

150035 Hemodynamic Monitoring (Crit Care) A PRN CP
- Ed Directs 05/15/16 1609 ST 05/15/16 1609 ST 05/15 1108 QS => 05/15 1108 QS
05/15 1300 PRN
0840 Positioning A Q2H CP
- Document 05/15/16 1609 ST 05/15/16 1609 ST
120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1609 ST 05/15/16 1610 ST
Critical Care Flowsheet Time: 1600

Temperature: 98.4 Nursing Note:
Temperature Source+: Tympanic
Pulse: 125 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 83/56 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 64
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:
1200008 Oral Care - Critical Care A Q4H CP
- Document 05/15/16 1609 ST 05/15/16 1611 ST
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/15/16 1609 ST 05/15/16 1609 ST
TED Hose - removed for skin assessment and reapplied.

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied.

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/15/16 1609 ST 05/15/16 1611 ST
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
diet, physician follow-up, medications, what to do if Comment
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:

5A4D43B46E10429588C8, KNIGHT, 149

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented From	Comment	Units	Change

Activity Date: 05/15/16 Time: 1609 (continued)

800001 Education/Teaching Assessment (continued)
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chgea or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
Material Codes: VERBAL
Comment: UNDERSTANDS
Comment: UNDERSTANDS

EDUCATION/INTERVENTION: POC, ALL CARE EXPLAINED WHEN PROVIDED

Outcome: VERBAL

Non-Surgical Open Wound: Date Began:

New Surgical Flap or Graft: Y Date of Surgery: 05/15/16

Activity Date: 05/15/16 Time: 1614

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1614 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 130
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 83/41
BP Location+:
BP Position+:
O2 Sat: 96
%/L of O2:
ETCO2:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented From	Comment	Units	Change

Activity Date: 05/15/16 Time: 1614 (continued)

120000 Critical Care Flowsheet (continued)
A-LINE BP: Secured at cm
MAP: 60
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1624

Patient Notes: Nursing Notes
- Create 05/15/16 1624 ST 05/15/16 1625 ST
Abnormal? N Confidential? N
states that morhine is "starting to help with the pain". map remains at 60.
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 1629

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1629 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 131
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 86/58
BP Location+:
BP Position+:
O2 Sat: 97
%/L of O2:
ETCO2:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 65
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1644

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1644 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 130
Pulse Source+:
PCWP:
CVP:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:

5A4D43B46E10429588C8, KNIGHT, 150

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1644 (continued)

120000 Critical Care Flowsheet (continued)

Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 86/52 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 68
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1658

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1658 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 130 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 80/54 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 68
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1700

5500011 Purposeful Rounding A CP
- Document 05/15/16 1700 SF 05/15/16 1707 SF
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1700 (continued)

5500011 Purposeful Rounding (continued)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/15/16 Time: 1713

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1713 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 130 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 80/63 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 69
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1715

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1715 ST 05/15/16 1718 ST
Critical Care Flowsheet Time: 1700

Temperature: Nursing Note:
Temperature Source+:
Pulse: 129 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 80/63 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:

5A4D43B46E10429588C8, KNIGHT, 151

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1715 (continued)

120000 Critical Care Flowsheet (continued)
A-LINE BP: Secured at cm
MAP: 69
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:
1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/15/16 1715 ST 05/15/16 1718 ST
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): LR + NS BOLUS IV Fluids (A): 2350
Medication (B): IV Fluids (B):
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 2350 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/15/16 1715 ST 05/15/16 1717 ST
Primary Diagnosis:
Sec Diag/Comorbidities:
Previous Medical Hx: ANXIETY
<Esc> Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU Y PCU TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N

K/MG Protocol: NO
Last K: Covered: Blood Pressure: 83/56
Last MG: Covered: Temperature: 98.4

Pacemaker: N Sensitivity: Rate: Cooling Blanket:
Defibrillator: N Demand: Asynchronous: Warming Blanket:
Transvenous Pacemaker: N Atrial: Ventricular:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 1715 (continued)

125 CRITICAL CARE REPORT (continued)
Secured at cm
Mental Status: Alert

Respirations: 18 VENTILATOR DOCUMENTATION:
O2 Sat: 97 Vent type:
%/L of O2: 2 Tidal Volume Vent Set Rate:
O2 Mode+: Vent Pressure Support Mode
FiO2 Peep:

Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:
COMMENT:

Tubes+: NG Tube Urinary Catheter Inserted:
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+:
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation:
Drainage Characteristics: Suprapubic Catheter: Foley Dc'd:

Abd Appearance+: Last BM:

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS:
Last Dialysis Treatment: Frequency:
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure:

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG

Pulm Art Cath: Zeroed: CVP Line: Zeroed:
Location: Location:
Secured at cm Dressing:
Dressing: Appearance:
Appearance: Phlebostatic Axis Marked:
Phlebostatic Axis Marked: Waveform:

5A4D43B46E10429588C8, KNIGHT, 152

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 1715 (continued)

125 CRITICAL CARE REPORT (continued)

Waveform:
Date Flush Change:
Date Tubing Change:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment:

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: LR 150CC/HR
Date Insert/DC #1: 05/15/16
IV #1 Comment:

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment:

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/15/16 1715 ST 05/15/16 1716 ST
INTAKE

PO: 0
IV FLUIDS: Y
PO Supplement:
TF Tube:
Blood Products:
NG Irrigation:
TF Flush:
***Use PUMP TOTALS intervention to document IV/Blood fluids.
Foley Irrigation (CBI):
Dialysis (Intake):
OUTPUT
Void (ml):
Foley: 700
SP Catheter:
Foley (Residual):
Bladder Incont Episodes:
Bowel Incont Episodes:
Void Episodes:
Stool Episodes:
Diapers:
Emesis:
T Tube:
NG/PEG TUBE:
Duodenal Tube:
Liquid Stool:
Colostomy:
Ileostomy:
Urostomy:
Ileoconduit:
#1 JP: 220
#2 JP:
#1 Chest Tube:
#2 Chest Tube:
Left Ureteral:
Right Ureteral:
Dialysis (Output):
Thoracentesis:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 1715 (continued)

150012 Intake/Output (No IVs) Critical Care (continued)

#3 JP:
OTHER:
#1 Hemovac:
#2 Hemovac:
Left Nephrostomy:
Right Nephrostomy:
Paracentesis:
Wound Vac:
Pericardial Dng (Output):
Comment:

Activity Date: 05/15/16 Time: 1728

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1728 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 129
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 85/62
BP Location+:
BP Position+:
O2 Sat: 96
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 67
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1743

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1743 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 128
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 86/61
BP Location+:
BP Position+:
O2 Sat: 97
%/L of O2:
ETCO2:
A-LINE BP:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

5A4D43B46E10429588C8, KNIGHT, 153

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/15/16 Time: 1743 (continued)

120000 Critical Care Flowsheet (continued)
MAP: 67
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1745

120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1745 ST 05/15/16 1839 ST
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 129 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 86/61 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 95 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 67
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/15/16 Time: 1753

Patient Notes: Nursing Notes
- Create 05/15/16 1753 ST 05/15/16 1753 ST
Abnormal? N Confidential? N
states that pain has returned, medicated see e-mar.
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 1805

0840 Positioning A Q2H CP
- Document 05/15/16 1805 ST 05/15/16 1805 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/15/16 1805 ST 05/15/16 1805 ST
Diet Ordered: NPO
Meal:
% Diet Taken:

Oral Supplement:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/15/16 Time: 1805 (continued)

1160 Nutritional Monitoring (continued)
PO Supplement: cc (Total Intake)
Comment:
120000 Critical Care Flowsheet A Q1H CP
- Document 05/15/16 1805 ST 05/15/16 1806 ST
Critical Care Flowsheet Time: 1800

Temperature: Nursing Note:
Temperature Source+:
Pulse: 126 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 85/59 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 67
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:
525003 IV Site Check A 06,18 CP
- Document 05/15/16 1805 ST 05/15/16 1806 ST
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/15/16 1805 ST 05/15/16 1806 ST

5A4D43B46E10429588C8, KNIGHT, 154

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/15/16		Time: 1813								
120000 Critical Care Flowsheet							A	Q1H		CP
- Document	05/15/16	1813	ST	05/15/16	1839	ST				
Critical Care Flowsheet		Time:								

Temperature:
Temperature Source+:
Pulse: 128
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 84/61
BP Location+:
BP Position+:
O2 Sat: 96
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 69
Intra-Abd Pressure:
Comment:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/15/16		Time: 1828								
120000 Critical Care Flowsheet							A	Q1H		CP
- Document	05/15/16	1828	ST	05/15/16	1839	ST				
Critical Care Flowsheet		Time:								

Temperature:
Temperature Source+:
Pulse: 126
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 91/62
BP Location+:
BP Position+:
O2 Sat: 95
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 68
Intra-Abd Pressure:
Comment:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/15/16		Time: 1900								
5500011 Purposeful Rounding							A			CP
- Document	05/15/16	1900	BD	05/16/16	0649	BD				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

6922 Nursing Report (Hand Off)							A	07,19	CP
- Document	05/15/16	1900	BW	05/15/16	2105	BW			

****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From BETSY/SUSIE

Comment

Activity Date: 05/15/16		Time: 2000							
120009 Telemetry Monitoring - Critical Care							A	Q4H	CP
- Document	05/15/16	2000	BW	05/15/16	2226	BW			

Telemetry Rhythm:

Low Rate: 115
High Rate: 132
Change From Baseline: N
Notify MD: N Check Alarm:

Comment:

0840 Positioning							A	Q2H	CP
- Document	05/15/16	2000	BW	05/15/16	2155	BW			
120000 Critical Care Flowsheet							A	Q1H	CP
- Document	05/15/16	2000	BW	05/15/16	2157	BW			
Critical Care Flowsheet		Time: 2000							

Temperature: 99.3
Temperature Source+: Tympanic
Pulse: 130
Pulse Source+: MONITOR
Respirations: 26
SPON:
Vent Resp:
Blood Pressure: 97/67
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml

5A4D43B46E10429588C8, KNIGHT, 155

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

120000 Critical Care Flowsheet (continued)

O2 Sat: 95 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 74
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

1200008	Oral Care - Critical Care					A	Q4H		CP
- Document	05/15/16 2000	BW	05/15/16 2201	BW					
120001	SHIFT ASSESSMENT-Critical Care					A	QS		CP
- Document	05/15/16 2000	BW	05/15/16 2201	BW					

Neurological WNL: WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative Site:

Speech/Cry+: Clear

Vision Impairment:
Responsive To+: Sound Hearing Impairment:

Mental Status: Alert & Oriented ***Continued On Next Page***

Glasgow Coma Scale

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Cardiovascular WNL: WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: Sticker:
Chest Pain: N Heart Rate: 130 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: Defibrillator:
Heart Sounds+: Normal Transvenous Pacemaker: Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal	Radial Rt+: Normal
Dorsalis Rt+: Normal	Radial Lt+: Normal
Post Tib Lt+:	Femoral Rt+:
Post Tib Rt+:	Femoral Lt+:
Carotid Rt+:	Cap Refill RUE+: Brisk
Carotid Lt+:	Cap Refill LUE+: Brisk
Brachial Rt+: Normal	Cap Refill RLE+: Brisk
Brachial Lt+: Normal	Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 26 O2 Sat: 95 %/L of O2: 2 Cyanosis: N Pallor: Y

O2 Mode+: NASAL CANNULA ***Breath Sounds***

5A4D43B46E10429588C8, KNIGHT, 156

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

RR Description+: Tachypnea
Resp Pattern+: Shallow
Chest Expansions+: Symmetrical
Cough+: Productive
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

LUL+: Clear
LLL+: Clear
RUL+: Clear
RML+: Clear
RLL+: Clear

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull:

Comment
MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:
Paralysis+:
Joint Swelling+:
Amputations+:
Muscle Spasms+:
Contractures+:
Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment MAXI SLIDE

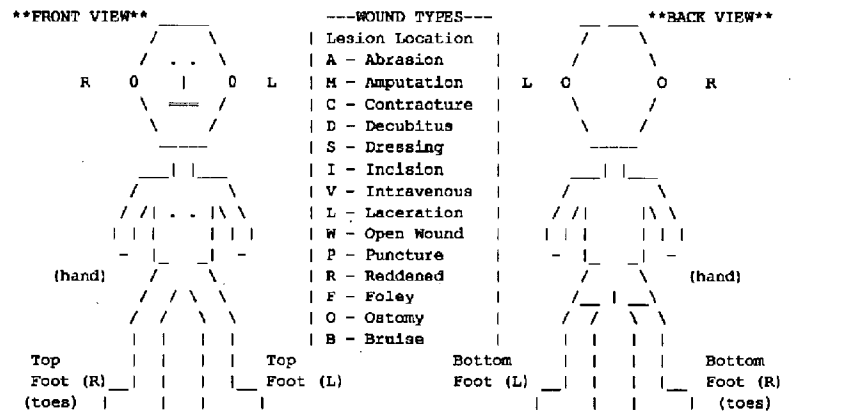
Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Musc-Skel Comment <Esc>:



COMMENT:
Skin WNL: WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Pale
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+:
Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed:
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains:

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast: 2	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally:	Adequate: 3

5A4D43B46E10429588C8, KNIGHT, 157

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

No Impairment: Walks Frequently: Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist: 3
Rarely Moist:

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited: 3
No Limitations:

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Total Braden Score: 17

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: Incontinent Stool:
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness Tubes+: NG Tube
Abd Appearance+: Tube Drainage: Tube To Suction:
OGT/NGT is secured at cm
RUQ+: HYPOACTIVE Stoma Present: Location:
LUQ+: HYPOACTIVE Appearance:
RLQ+: HYPOACTIVE Ostomy Appliance:
LLQ+: HYPOACTIVE Drainage Characteristics:
GI Comment <Esc>: Rectal Tube:

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems:
Urine Odor+: Normal
Character+: CLOUDY ***Dialysis***
Incontinent Bladder: CAPD: Peritoneal Dialysis:
Suprapubic Catheter: Hemodialysis:
Urostomy: Hemo Site Description+:
Stoma Appearance Last Dialysis Treatment:

GU Comment <Esc>:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: 5 pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: SEE EMAR

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: UNSTABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn:
Ability To Understand Verbal Instructions:
Ability To Understand Written Instruction:
Learning Preference+:
Knowledge of Educational Needs/Treatment Plan:
Appropriate teaching for disease process utilized:

Specific Barriers To Learning

Physical:	Language:	Visual:	Motivation:	Cultural:	Cognitive:
Reading:	Age Related:	Auditory:	Emotional:	Religious:	Finances:

EDUCATION/INTERVENTION:
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/15/16 2000 BW 05/15/16 2226 BW
VTE Prophylaxix Orders Complete?
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/15/16 2000 BW 05/15/16 2227 BW
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT FOREARM IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Jelco Type of Cath #3:
Cath Gauge #1: 18 Cath Gauge #3:
Fluid/Rate #1: LR 150CC/HR Fluid/Rate #3:

5A4D43B46E10429588C8, KNIGHT, 158

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

525002 IV THERAPY ASSESSMENT (continued)
Date Insert/DC #1: 05/15/16 Date Insert/DC #3:
IV #1 Comment: IV #3 Comment:
<Esc> <Esc>

IV Site #2: LEFT FOREARM IV Site #4:
Site Appear #2: NORMAL Site Appear #4:
Type of Cath #2: Jelco Type of Cath #4:
Cath Gauge #2: 18 Cath Gauge #4:
Fluid/Rate #2: SL Fluid/Rate #4:
Date Insert/DC #2: 05/15/16 Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/15/16 2000 BW 05/15/16 2155 BW
Type of Isolation: NONE Tissue Test:

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/15/16 2000 BW 05/15/16 2155 BW
Anticoagulant Educ Material provided to Patient &/or Family?
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

7370 Discharge Planning Assessment A QS CP
- Document 05/15/16 2000 BW 05/15/16 2155 BW
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY EDUCATION

NEEDS IDENTIFIED:
Home Health: Wound Care:
Medical Equipment: Nursing Home/Rehab Placement:

FLU VACCINE (within last year)

Who will be taking you home from the hospital?
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

7370 Discharge Planning Assessment (continued)

Social Services Consult Requested: Date Requested:

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment:
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/15/16 2000 BW 05/15/16 2157 BW
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern 1
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 6

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

5A4D43B46E1042958BC8, KNIGHT, 159

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: HIGH Level of Care: TOTAL

99 SEPSIS Documentation A QS CP
- Document 05/15/16 2000 BW 05/15/16 2155 BW
Temperature: 99.3
Temperature Source+: Tympanic
Pulse: 130
Respirations: 26
Blood Pressure: 97/67
MAP: 74
Mental Status: Alert
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 2
Sepsis Result: Possible Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: Y
If NO, Reason:
Patient Notes: Nursing Notes
- Create 05/15/16 2000 BW 05/15/16 2235 BW
Abnormal? N Confidential? N
PATIENT ALT. PIV X2 WITHOUT REDNESS OR SWELLING. OSTOMY IN PLACE WITH RED STOMA NOTED. ABD DRESSING IN PLACE WITH MONTGOMERY STRAPS. C/D AT THIS TIME. PT STATES PAIN TO ABD. HYPO BOWEL SOUNDS NOTED. HEART RATE NOTED. SKIN WARM AND DRY. WILL CONTINUE TO MONITOR PATIENT STATUS.

Addendum: 05/15/16 at 2236 by BW PAUL,BETSY RN

FOLEY CATH IN PLACE WITH ORANGE COLOR LIQUID IN GRAVITY DRAINAGE BAG.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/15/16 Time: 2100

5500011 Purposeful Rounding A CP
- Document 05/15/16 2100 BD 05/16/16 0649 BD
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/15/16 Time: 2106

120000 Critical Care Flowsheet A Q4H CP
- Ed Directs 05/15/16 2106 BW 05/15/16 2106 BW 05/15 1108 Q1H -> 05/15 1108 Q4H
120003 Goals/Outcomes - Critical Care A 18,06 CP
- Ed Directs 05/15/16 2106 BW 05/15/16 2106 BW
05/15 1108 08,18,20,06 ==> 05/15 1108 18,06

Activity Date: 05/15/16 Time: 2200

0840 Positioning A Q2H CP
- Document 05/15/16 2200 BW 05/15/16 2227 BW

Activity Date: 05/15/16 Time: 2236

Patient Notes: Nursing Notes
- Create 05/15/16 2236 BW 05/15/16 2237 BW
Abnormal? N Confidential? N
PATIENT IN ROOM WITH EYES CLOSED. CONTINUING TO WATCH PRESSURE AND HR. PATIENT VERBALIZES ATTEMPTS TO TAKE DEEP BREATH. WILL CONTINUE TO MONITOR CLOSE.
Note Type Description
No Type None

Activity Date: 05/15/16 Time: 2300

5500011 Purposeful Rounding A CP
- Document 05/15/16 2300 BD 05/16/16 0649 BD
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:

5A4D43B46E10429588C8, KNIGHT, 160

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/15/16 Time: 2300 (continued)

5500011 Purposeful Rounding (continued)
<Esc>

Activity Date: 05/15/16 Time: 2339

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/15/16 2339 BW 05/15/16 2340 BW
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate: 115
High Rate: 132
Change From Baseline: N
Notify MD: Check Alarm:

Comment:

0840 Positioning A Q2H CP
- Document 05/15/16 2339 BW 05/15/16 2339 BW

120000 Critical Care Flowsheet A Q4H CP
- Document 05/15/16 2339 BW 05/15/16 2340 BW
Critical Care Flowsheet Time: 2339

Temperature: Nursing Note:
Temperature Source+:
Pulse: 122 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 26 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 106/63 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 95 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 75
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

1200008 Oral Care - Critical Care A Q4H CP
- Document 05/15/16 2339 BW 05/15/16 2340 BW

Activity Date: 05/16/16 Time: 0004

Patient Notes: Nursing Notes
- Create 05/16/16 0004 BW 05/16/16 0004 BW
Abnormal? N Confidential? N
PATIENT IN ROOM WITHOUT COMPLICATION AT THIS TIME
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 0013

120000 Critical Care Flowsheet A Q4H CP
- Document 05/16/16 0013 SH2 05/17/16 0118 SH2
Critical Care Flowsheet Time:

Temperature: 98.4 Nursing Note:
Temperature Source+: Tympanic
Pulse: 122 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 103/62 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 94 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 71
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/16/16 Time: 0030

Patient Notes: Nursing Notes
- Create 05/16/16 0030 LF 05/16/16 0223 LF
Abnormal? N Confidential? N
SEEN PT RESTING IN BED WITH EYES CLOSED.RESPIRATION WNL.FOLEY CATHETER PATENT.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/16/16 Time: 0043

120000 Critical Care Flowsheet A Q4H CP
- Document 05/16/16 0043 SH2 05/17/16 0118 SH2
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 124 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 100/63 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 94 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:

5A4D43B46E10429588C8, KNIGHT, 161

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/16/16 Time: 0043 (continued)

120000 Critical Care Flowsheet (continued)
A-LINE BP: Secured at cm
MAP: 74
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/16/16 Time: 0100

120000 Critical Care Flowsheet A Q4H CP
- Document 05/16/16 0100 LF 05/16/16 0222 LF
Critical Care Flowsheet Time: 0100

Temperature: Nursing Note:
Temperature Source+:
Pulse: 123 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 98/65 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 93 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

5500011 Purposeful Rounding A CP
- Document 05/16/16 0100 BD 05/16/16 0649 BD
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 0200

0840 Positioning A Q2H CP
- Document 05/16/16 0200 LF 05/16/16 0221 LF

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/16/16 Time: 0200

120000 Critical Care Flowsheet A Q4H CP
- Document 05/16/16 0200 LF 05/16/16 0223 LF
Critical Care Flowsheet Time: 0200

Temperature: Nursing Note:
Temperature Source+:
Pulse: 125 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 114/64 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 94 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/16/16 0200 LF 05/16/16 0221 LF

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern

5A4D43B46E10429588C8, KNIGHT, 162

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 0

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/16/16 Time: 0207

Patient Notes: Nursing Notes
- Create 05/16/16 0207 LF 05/16/16 0224 LF
Abnormal? N Confidential? N
MORPHINE 2MG IV GIVEN FOR PAIN.SEE EMAR AND FOR REASSESSMENT.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/16/16 Time: 0221

120000 Critical Care Flowsheet					A	Q1H		CP
- Ed Directe	05/16/16 0221	LF	05/16/16 0221	LF	05/15 1108 Q4H	=>	05/15 1108 Q4H 05/16 0221 Q1H	

Activity Date: 05/16/16 Time: 0245

Patient Notes: Nursing Notes
- Create 05/16/16 0245 LF 05/16/16 0436 LF
Abnormal? N Confidential? N
MOUTH CARE PROVIDED.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/16/16 Time: 0300

120000 Critical Care Flowsheet					A	Q1H		CP
- Document	05/16/16 0300	LF	05/16/16 0426	LF				

Critical Care Flowsheet Time: 0300

Temperature:			Nursing Note:
Temperature Source+:			
Pulse:	122	PCWP:	Glycemic Protocol:
Pulse Source+:	MONITOR	CVP:	Fingerstick BS:
Respirations:	20	MPA:	Frequency:
SPO2:		PAP:	
Vent Resp:		CO:	Cooling Blanket:
Blood Pressure:	99/60	CI:	Warming Blanket:
BP Location+:	L Arm	SVR:	
BP Position+:	SEMI-FOWLER'S	PVR:	Foley: ml
O2 Sat:	93	Calibrate:	Void (ml): ml
%/L of O2:	2		
ETCO2:		Transvenous Pacer Setting:	V Output mA Set Rate:
A-LINE BP:			Secured at cm
MAP:			
Intra-Abd Pressure:		Weight (lbs):	(Oz): kg:
		Weight Source:	

5A4D43B46E10429588C8, KNIGHT, 163

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0300 (continued)

120000 Critical Care Flowsheet (continued)
Comment:
5500011 Purposeful Rounding A CP
- Document 05/16/16 0300 BD 05/16/16 0649 BD
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 0350

Patient Notes: Nursing Notes
- Create 05/16/16 0350 LF 05/16/16 0435 LF
Abnormal? N Confidential? N
MOUTH CARE PROVIDED.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/16/16 Time: 0400

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/16/16 0400 LF 05/16/16 0427 LF
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate: 120
High Rate: 122
Change From Baseline:
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/16/16 0400 LF 05/16/16 0426 LF
120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 0400 LF 05/16/16 0427 LF
Critical Care Flowsheet Time: 0400

Temperature: 98.8 Nursing Note:
Temperature Source+: Tympanic
Pulse: 122 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 106/63 CI: Warming Blanket:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0400 (continued)

120000 Critical Care Flowsheet (continued)
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 92 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
1200008 Oral Care - Critical Care A Q4H CP
- Document 05/16/16 0400 LF 05/16/16 0429 LF
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/16/16 0400 LF 05/16/16 0427 LF
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/16/16 0400 LF 05/16/16 0428 LF
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
diet, physician follow-up, medications, what to do if Comment
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS

5A4D43B46E10429588C8, KNIGHT, 164

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From / Change

Activity Date: 05/16/16 Time: 0400 (continued)

800001 Education/Teaching Assessment (continued)
ACTIVITY
Comment: Comment:

EDUCATION/INTERVENTION: CARE AS PROVIDED.

Outcome: VERBAL

Non-Surgical Open Wound: Date Began:

New Surgical Flap or Graft: Y Date of Surgery: 05/15/16

Patient Notes: Nursing Notes
- Create 05/16/16 0400 LF 05/16/16 0435 LF
Abnormal? N Confidential? N
DILAUDID 1MG IV GIVEN BY B PAUL,RN.SEE EMAR.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/16/16 Time: 0500

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 0500 LF 05/16/16 0712 LF
Critical Care Flowsheet Time: 0500

Temperature: Nursing Note:
Temperature Source+:
Pulse: 121 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 102/67 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 92 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/16/16 0500 LF 05/16/16 0636 LF
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): LR IV Fluids (A): 1700

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From / Change

Activity Date: 05/16/16 Time: 0500 (continued)

1200041 IV Pump Totals - Critical Care (continued)

Medication (B): INVANZ IV Fluids (B): 50
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 1750 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/16/16 0500 LF 05/16/16 0525 LF
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx: ANXIETY
<Esc> Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:
STATUS: ICU Y PCU TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N
K/MG Protocol: NO
Last K: Covered: Blood Pressure: 106/63
Last MG: Covered: Temperature: 98.8
Pacemaker: N Sensitivity: Rate: Cooling Blanket:
Defibrillator: N Demand: Asynchronous: Warming Blanket:
Transvenous Pacemaker: N Atrial: Ventricular:
Secured at cm
Mental Status: Alert & Oriented
Respirations: 20 VENTILATOR DOCUMENTATION:
O2 Sat: 92 Vent type:
%/L of O2: 2 Tidal Volume Vent Set Rate:
O2 Mode+: NASAL CANNULA Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score

5A4D43B46E1042958BC8, KNIGHT, 165

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:

COMMENT:

Tubes+: NG Tube Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+:
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd:

Abd Appearance+: Last BM:

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist

Dressing changed:	Date:	Change:
CAP Changed:	Date:	Change:
IV Tube Change:	Date:	Change:
Huber Needle Size:		Date:

Procedure:

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN

Pulm Art Cath: Zeroed: CVP Line: Zeroed:
Location: Location:
Secured at cm Dressing:
Dressing: Appearance:
Appearance: Phlebostatic Axis Marked:
Phlebostatic Axis Marked: Waveform:
Waveform: Date Flush Change:
Date Flush Change: Date Tubing Change:
Date Tubing Change:

A-Line: IABP: Zeroed: Phlebostatic Axis Marked:
Location: Waveform:
Dressing: Date Flush Change:
Appearance: Date Tubing Change:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

Comment:

IV Site #1: RIGHT FOREARM IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Jelco Type of Cath #3:
Cath Gauge #1: 18 Cath Gauge #3:
Fluid/Rate #1: LR 150CC/HR Fluid/Rate #3:
Date Insert/DC #1: 05/15/16 Date Insert/DC #3:
IV #1 Comment: WNL IV #3 Comment:

IV Site #2: LEFT FOREARM IV Site #4:
Site Appear #2: NORMAL Site Appear #4:
Type of Cath #2: Jelco Type of Cath #4:
Cath Gauge #2: 18 Cath Gauge #4:
Fluid/Rate #2: SL Fluid/Rate #4:
Date Insert/DC #2: 05/15/16 Date Insert/DC #4:
IV #2 Comment: WNL IV #4 Comment:

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/16/16 0500 LF 05/16/16 0635 LF
INTAKE

PO: 0 IV FLUIDS: Y PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI):
Dialysis (Intake):

OUTPUT

Void (ml):	Bladder Incont Episodes:	Emesis:		Colostomy:
Foley: 1000	Bowel Incont Episodes:	T Tube:		Ileostomy: 30
SP Catheter:	Void Episodes:	NG/PEG TUBE:		Urostomy:
Foley (Residual):	Stool Episodes:	Duodenal Tube:		Ileoconduit:
	Diapers:	Liquid Stool:		
#1 JP: 80	#1 Chest Tube:	Left Ureteral:		Dialysis (Output):
#2 JP:	#2 Chest Tube:	Right Ureteral:		Thoracentesis:
#3 JP:	#1 Hemovac:	Left Nephrostomy:		Paracentesis:
OTHER:	#2 Hemovac:	Right Nephrostomy:		Wound Vac:
				Pericardial Drg (Output):

Comment:
5500011 Purposeful Rounding A CP
- Document 05/16/16 0500 BD 05/16/16 0649 BD
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

5A4D43B46E10429588C8, KNIGHT, 166

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 0500 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 0600

0840 Positioning A Q2H CP
- Document 05/16/16 0600 LF 05/16/16 0636 LF
120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 0600 LF 05/16/16 0712 LF
Critical Care Flowsheet Time: 0600

Temperature: Nursing Note:
Temperature Source+:
Pulse: 120 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 100/62 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 92 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/16/16 0600 LF 05/16/16 0636 LF
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: MAINTAIN, COMFORT, SAFETY : MET MET

Goal #3: MAINTAIN PATENT AIRWAY : MET MET

COMMENT:
150011 Weight, Monitor Daily A DAILY@0600 CP
- Document 05/16/16 0600 LF 05/16/16 0636 LF
Weight (lbs):
(Oz):

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 0600 (continued)

150011 Weight, Monitor Daily (continued)
kg:
Weight Source:
- Document 05/16/16 0600 LF 05/16/16 0638 LF
Weight (lbs): 180
(Oz): 0
kg: 81.647
Weight Source: Bedscale
525003 IV Site Check A 06,18 CP
- Document 05/16/16 0600 LF 05/16/16 0636 LF
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/16/16 0600 LF 05/16/16 0636 LF
Patient Notes: Nursing Notes
- Create 05/16/16 0600 LF 05/16/16 0658 LF
Abnormal? N Confidential? N
NGT TO LOW INTERMITTENT SUCTION DRAIN 154 CC YELLOWISH FLUID.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/16/16 Time: 0642

Patient Notes: Nursing Notes
- Create 05/16/16 0642 LF 05/16/16 0645 LF
Abnormal? N Confidential? N
JP DRAIN OUTPUT 80 ML APPEARS YELLOW/BROWNISH IN COLOR AS WELL AS ILEOSTOMY FLUID WITH 30 ML.
Note Type Description
Intervention Rounds Surveillance

5A4D43B46E10429588C8, KNIGHT, 167

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 0646

5500011 Purposeful Rounding A CP
- Document 05/16/16 0646 BD 05/16/16 0649 BD
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 0700

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 0700 LF 05/16/16 0713 LF
Critical Care Flowsheet Time: 0700

Temperature: Nursing Note:
Temperature Source+:
Pulse: 118 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 105/68 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 94 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
5500011 Purposeful Rounding A CP
- Document 05/16/16 0700 JM 05/16/16 0804 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 0700

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/16/16 0700 AW3 05/16/16 1033 AW3
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From TONY

Comment

Activity Date: 05/16/16 Time: 0715

Patient Notes: Nursing Notes
- Create 05/16/16 0715 AW3 05/16/16 1053 AW3
Abnormal? N Confidential? N
PT INITIAL ASSESSMENT COMPLETED. PT IS RESTING IN BED AT THIS TIME WITH COMPLIANTS OF ABD PAIN. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT INSTRUCTED TO CALL FOR ANY ASSISTANCE NEEDED.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 0757

Patient Notes: Nursing Notes
- Create 05/16/16 0757 AW3 05/16/16 1054 AW3
Abnormal? N Confidential? N
PT COMPLAINING OF PAIN AT THIS TIME IN ABD. PT GIVEN 1 MG DILAUDID IV PER ORDER. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT WIFE AT THE BEDSIDE.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 0800

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/16/16 0800 AW3 05/16/16 1043 AW3
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate:
Change From Baseline:
Notify MD: Check Alarm:

Comment: RATE 117
0840 Positioning A Q2H CP
- Document 05/16/16 0800 AW3 05/16/16 1036 AW3
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/16/16 0800 AW3 05/16/16 1037 AW3
Diet Ordered: NPO
Meal:
% Diet Taken:

5A4D43B46E1042958C8, KNIGHT, 168

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

1160 Nutritional Monitoring (continued)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 0800 AW3 05/16/16 1038 AW3
Critical Care Flowsheet Time: 0800

Temperature: 98.0
Temperature Source+: Tympanic
Pulse: 117
Pulse Source+: MONITOR
Respirations: 22
SPON:
Vent Resp:
Blood Pressure: 104/61
BP Location+: R Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 94
&/L of O2: 2
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

1200008 Oral Care - Critical Care A Q4H CP
- Document 05/16/16 0800 AW3 05/16/16 1043 AW3

120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/16/16 0800 AW3 05/16/16 1042 AW3

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Behavior+: Calm/Cooperative

Speech/Cry+: Clear

Responsive To+: Sound

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Site:

Vision Impairment:
Hearing Impairment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Mental Status: Alert & Oriented ***Continued On Next Page***
Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: Sticker:
Chest Pain: N Heart Rate: 117 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator:
Heart Sounds+: Normal Transvenous Pacemaker: Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+:
Loc 1+:
Pitting:
Edema 2+:
Loc 2+:
Pitting:
TED Hose: N
IPC: Y
Venous Foot Pump: N
Edema 3+:
Loc 3+:
Pitting:
Edema 4+:
Loc 4+:
Pitting:

Peripheral Pulses

5A4D43B46E10429588C8, KNIGHT, 169

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

120001 SKIFT ASSESSMENT-Critical Care (continued)

Dorsalis Lt+:
Dorsalis Rt+:
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal
Femoral Rt+:
Femoral Lt+:
Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 22 O2 Sat: 94 %/L of O2: 2 Cyanosis: N Pallor: Y

O2 Mode+: NASAL CANNULA
RR Description+: Tachypnea

Resp Pattern+: Shallow
Chest Expansions+: Symmetrical
Cough+: Productive
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Clear
RUL+: Clear
RML+: Clear
RLL+: Clear

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

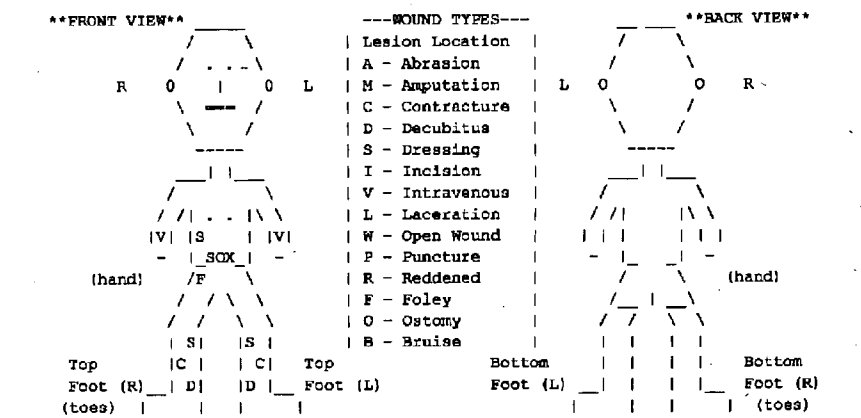
Activity Date: 05/16/16 Time: 0800 (continued)

120001 SKIFT ASSESSMENT-Critical Care (continued)

Comment
MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:
Paralysis+:
Joint Swelling+:
Amputations+:
Muscle Spasms+:
Contractures+:
Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment MAXI SLIDE
Musc-Skel Comment <Esc>:



COMMENT: X-JP DRAIN

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Pale
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Pale

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

5A4D43B46E10429588C8, KNIGHT, 170

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 0000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti:
Location/Size<Esc>:
Stage+:

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP RIGHT ABD

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally: 3	Adequate: 3
No Impairment:	Walks Frequently:	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: Incontinent Stool:
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness
Abd Appearance+: SOFT
DISTENDED
RUQ+: HYPOACTIVE
LUQ+: HYPOACTIVE
RLQ+: HYPOACTIVE
LLQ+: HYPOACTIVE
GI Comment <Esc>:

Tubes+: NG Tube
Tube Drainage: N Tube To Suction: N
OGT/NGT is secured at 63 cm
Stoma Present: Location:
Appearance:
Ostomy Appliance:
Drainage Characteristics:
Rectal Tube:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y
Urine Color+: Amber
Urine Odor+: Normal
Character+: CLOUDY
Incontinent Bladder:
Suprapubic Catheter: N
Urostomy:
Stoma Appearance

Currently Menses:
LMP:
Prostate Problems:
Dialysis
CAPD: Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: 8 pain management this shift:
Pain Location+: ABDOMINAL
Quality Of Pain+:
Onset/Duration:
Pain Med Given<Esc>:

Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment:

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

5A4D43B46E10429588C8, KNIGHT, 171

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Specific Barriers To Learning

Physical: N Language: N Visual: N Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: N Religious: N Finances: N

EDUCATION/INTERVENTION: DISCUSSED POC, DIET AND SAFETY

275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/16/16 0800 AW3 05/16/16 1043 AW3
VTE Prophylaxix Orders Complete? Y

525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/16/16 0800 AW3 05/16/16 1043 AW3
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: LR 150CC/HR
Date Insert/DC #1: 05/15/16
IV #1 Comment:
<Esc>

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment:
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/16/16 0800 AW3 05/16/16 1037 AW3
Type of Isolation: NONE Tissue Test:

6907 PATIENT BATH - Critical Care A DAILY CP
- Document 05/16/16 0800 AW3 05/16/16 1037 AW3
Hygiene: Sitz Bath Date: 05/16/16

CHG Bath given: Y If no, Reason:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)

Patient Refused (Bath): Nurse Notified (Bath):

Hygiene Comment:

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/16/16 0800 AW3 05/16/16 1037 AW3
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

6955 Anticoagulant Educ Materials Provided (continued)
CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

7370 Discharge Planning Assessment A QS CP
- Document 05/16/16 0800 AW3 05/16/16 1037 AW3
----------DISCHARGE PLANNING ASSESSMENT----------

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY EDUCATION

NEEDS IDENTIFIED:
Home Health: Wound Care:
Medical Equipment: Nursing Home/Rehab Placement:

FLU VACCINE (within last year)

Who will be taking you home from the hospital?
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet?

Social Services Consult Requested: Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment:

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/16/16 0800 AW3 05/16/16 1038 AW3
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning

5A4D43B46E10429588C8, KNIGHT, 172

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)

No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present 2
3 or more present

Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs
****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated 2
Consistantly demonstrated
RN Judgement (9pt) 9
RN Judgement (4pt)

Total Score: 18

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart Y

Remain W/patient whenever OOB Y
If OOB to chair, q30min monitoring Y
Assess q1hr 7A-7P Y
Assess q1hr 7P-7A Y
Reinforce Call Light Use Y
Frequent Re-orientation Y
Bed/Chair Alarm in Use Y
Friction Footwear when OOB Y
In Room when Pt OOB to BSC, BR, Shower, etc. Y

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/16/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Fall Score Ranking: HIGH Level of Care: TOTAL

99 SEPSIS Documentation A QS CP
- Document 05/16/16 0800 AW3 05/16/16 1036 AW3
Temperature: 98.0
Temperature Source+: Tympanic
Pulse: 117
Respirations: 22
Blood Pressure: 104/61
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? Y
Sepsis Criteria Count: 2
Sepsis Result: Possible Sepsis Risk
Physician Notified: Y
If NO, Reason:

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Activity Date: 05/16/16 Time: 0900

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 0900 AW3 05/16/16 1051 AW3
Critical Care Flowsheet Time: 0900

Temperature:
Temperature Source+:
Pulse: 118
Pulse Source+: MONITOR
Respirations: 22
SPON:
Vent Resp:
Blood Pressure: 109/64
BP Location+: R Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 92
%/L of O2: 2
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

5500011 Purposeful Rounding A CP
- Document 05/16/16 0900 JM 05/16/16 1018 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

5A4D43B46E10429588C8, KNIGHT, 173

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 0900 (continued)

5500011 Purposeful Rounding (continued)
Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 1000

0840 Positioning A Q2H CP
- Document 05/16/16 1000 AW3 05/16/16 1051 AW3
120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1000 AW3 05/16/16 1051 AW3
Critical Care Flowsheet Time: 1000

Temperature: Nursing Note:
Temperature Source+:
Pulse: 118 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 112/65 CI: Warming Blanket:
BP Location+: R Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 92 Calibrate: Void (ml): ml
%/L of O2: 2
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/16/16 Time: 1015

Patient Notes: Nursing Notes
- Create 05/16/16 1015 AW3 05/16/16 1015 AW3
Abnormal? N Confidential? N
NG TUBE PULLED PER DR RIMKUS ORDER. PT TOLERATED WELL.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 1021

Patient Notes: Nursing Notes
- Create 05/16/16 1021 AW3 05/16/16 1033 AW3
Abnormal? N Confidential? N
PT COMPLAINING OF ABD PAIN AT THIS TIME. PT BP 112/65. PT GIVEN 2 MG DILAUDID IV PER ORDER. PT ENCOURAGED TO USE INCENTIVE SPIROMETRY AT LEAST 10 TIMES PER HOUR WHEN AWAKE. PT WIFE IS AT THE BEDSIDE. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT AND WIFE INSTRUCTED TO CALL FOR ANY

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 1021 (continued)

Patient Notes: Nursing Notes (continued)
ASSISTANCE NEEDED.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 1051

Patient Notes: Nursing Notes
- Create 05/16/16 1051 AW3 05/16/16 1052 AW3
Abnormal? N Confidential? N
* UNDONE *
PT INITIAL ASSESSMENT COMPLETED. PT IS RESTING IN BED AT THIS TIME WITH COMPLIANTS OF ABD PAIN. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT INSTRUCTED TO CALL FOR ANY ASSISTANCE NEEDED.

Undone: 05/16/16 at 1053 by WRIGHT,ANTHONY RN
Reason: WRONG TIME

Note Type Description
No Type None

Activity Date: 05/16/16 Time: 1100

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1100 AW3 05/16/16 1106 AW3
Critical Care Flowsheet Time: 1100

Temperature: 98.0 Nursing Note:
Temperature Source+: Tympanic
Pulse: 116 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 116/63 CI: Warming Blanket:
BP Location+: R Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 91 Calibrate: Void (ml): ml
%/L of O2: 3
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
5500011 Purposeful Rounding A CP
- Document 05/16/16 1100 JM 05/16/16 1357 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

5A4D43B46E10429588C8, KNIGHT, 174

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 1100 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 1112

108 CHF/AMI/STROKE/DVT HQI Screen A CP
- Document 05/16/16 1112 SO 05/16/16 1112 SO
CHF/AMI HQI Date Screen

CHF? N ---------^ EF: BNP: ACE/ARB:

AMI? N ---------^ Asa within 24 hours of admit? Beta Blocker within 24 hours?

VTE: DVT N PE N ---------^ Venous Thromboembolism (VTE) Warfarin EDUCATION N

STROKE? N---------^ STROKE/TIA EDUCATION N

Date Flu Vaccination Received: NFS

Comment:
:

Reviewed: SO Date: 05/16/16 Monitor: Y

Activity Date: 05/16/16 Time: 1200

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/16/16 1200 AW3 05/16/16 1619 AW3
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate:
Change From Baseline:
Notify MD: Check Alarm:

Comment: RATE 118
0840 Positioning A Q2H CP
- Document 05/16/16 1200 AW3 05/16/16 1618 AW3
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/16/16 1200 AW3 05/16/16 1618 AW3
Diet Ordered: NPO
Meal:
% Diet Taken:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 1200 (continued)

1160 Nutritional Monitoring (continued)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:
120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1200 AW3 05/16/16 1619 AW3
Critical Care Flowsheet Time: 1200

Temperature: 99.2 Nursing Note:
Temperature Source+: Tympanic
Pulse: 118 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 22 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 114/69 CI: Warming Blanket:
BP Location+: R Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 90 Calibrate: Void (ml): ml
%/L of O2: 3
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
1200008 Oral Care - Critical Care A Q4H CP
- Document 05/16/16 1200 AW3 05/16/16 1619 AW3

Activity Date: 05/16/16 Time: 1300

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1300 AW3 05/16/16 1620 AW3
Critical Care Flowsheet Time: 1300

Temperature: Nursing Note:
Temperature Source+:
Pulse: 111 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 108/68 CI: Warming Blanket:
BP Location+: R Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 91 Calibrate: Void (ml): ml
%/L of O2: 3
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm

5A4D43B46E10429588C8, KNIGHT, 175

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 1300 (continued)

120000 Critical Care Flowsheet (continued)
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

5500011 Purposeful Rounding A CP
- Document 05/16/16 1300 JM 05/16/16 1358 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 1400

0840 Positioning A Q2H CP
- Document 05/16/16 1400 AW3 05/16/16 1620 AW3
120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1400 AW3 05/16/16 1621 AW3
Critical Care Flowsheet Time: 1400

Temperature: 99.1
Temperature Source+: Tympanic
Pulse: 120
Pulse Source+: MONITOR
Respirations: 20
SPON:
Vent Resp:
Blood Pressure: 111/63
BP Location+: R Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 92
&/L of O2: 3
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:
Comment:

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/16/16 1400 AW3 05/16/16 1620 AW3

FALL SCREEN FOLLOW-UP

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Recent Fall: N (Falls since last FALL ASSESSMENT)
Condition Changed: N
Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

5A4D43B46E10429588C8, KNIGHT, 176

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/16/16 Time: 1434

Patient Notes: Nursing Notes
- Create 05/16/16 1434 AW3 05/16/16 1627 AW3
Abnormal? N Confidential? N
PT COMPLAINING OF ABD PAIN AT THIS TIME RATED AT A 7 OUT OF 10 ON PAIN SCALE. PT GIVEN 2 MG DILAUDID IV PER ORDER. PT BP 111/63. PT BED IN LOWEST LOCKED POS, CALL LIGHT IN REACH, AND SIDE RAILS UP X 2. PT INSTRUCTED TO CALL FOR ANY ASSISTANCE NEEDED.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 1500

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1500 AW3 05/16/16 1624 AW3
Critical Care Flowsheet Time: 1500

Temperature: Nursing Note:
Temperature Source+:
Pulse: 121 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 1500 (continued)

120000 Critical Care Flowsheet (continued)
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 116/63 CI: Warming Blanket:
BP Location+: R Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 91 Calibrate: Void (ml): ml
%/L of O2: 3
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/16/16 Time: 1600

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/16/16 1600 AW3 05/16/16 1625 AW3
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate:
Change From Baseline:
Notify MD: Check Alarm:

Comment: RATE 120
0840 Positioning A Q2H CP
- Document 05/16/16 1600 AW3 05/16/16 1624 AW3
120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1600 AW3 05/16/16 1625 AW3
Critical Care Flowsheet Time: 1600

Temperature: 99.2 Nursing Note:
Temperature Source+: Tympanic
Pulse: 120 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 108/64 CI: Warming Blanket:
BP Location+: R Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 90 Calibrate: Void (ml): ml
%/L of O2: 3
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

5A4D43B46E10429588C8, KNIGHT, 177

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/16/16		**Time: 1600**								
1200008 Oral Care - Critical Care							A	Q4H		CP
- Document	05/16/16	1600	AW3	05/16/16	1625	AW3				
3592 TED/HEEL PROTECTORS/IPC Skin Assessment							A	04,16		CP
- Document	05/16/16	1600	AW3	05/16/16	1624	AW3				

TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

800001 Education/Teaching Assessment							A	04,16		CP
- Document	05/16/16	1600	AW3	05/16/16	1625	AW3				

Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions.
Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
Material Codes: VERBAL
Comment:
Comment:

EDUCATION/INTERVENTION: CARE AS PROVIDED.

Outcome: VERBAL

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/16/16		**Time: 1600 (continued)**								
800001 Education/Teaching Assessment (continued)										

Non-Surgical Open Wound: Date Began:

New Surgical Flap or Graft: Y Date of Surgery: 05/15/16

Activity Date: 05/16/16		**Time: 1700**								
120000 Critical Care Flowsheet							A	Q1H		CP
- Document	05/16/16	1700	AW3	05/16/16	1818	AW3				

Critical Care Flowsheet Time: 1700

Temperature:
Temperature Source+:
Pulse: 122
Pulse Source+: MONITOR
Respirations: 16
SPON:
Vent Resp:
Blood Pressure: 115/72
BP Location+: R Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 90
%/L of O2: 3
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

1200041 IV Pump Totals - Critical Care							A	05,17		CP
- Document	05/16/16	1700	AW3	05/16/16	1819	AW3				

IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): LR	IV Fluids (A): 1500
Medication (B):	IV Fluids (B):
Medication (C):	IV Fluids (C):
Medication (D):	IV Fluids (D):
Medication (E):	IV Fluids (E):
Medication (F):	IV Fluids (F):
Medication (G):	IV Fluids (G):
Medication (H):	IV Fluids (H):

PUMP TOTAL 1500 cc

5A4D43B46E1042958C8, KNIGHT, 178

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 1700

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/16/16 1700 AW3 05/16/16 1818 AW3
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU Y PCU TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N

K/MG Protocol: NO
Last K: Covered: Blood Pressure: 106/63
Last MG: Covered: Temperature: 98.8

Pacemaker: N Sensitivity: Rate: Cooling Blanket:
Defibrillator: N Demand: Asynchronous: Warming Blanket:
Transvenous Pacemaker: N Atrial: Ventricular:
Secured at cm

Mental Status: Alert & Oriented

Respirations: 20 VENTILATOR DOCUMENTATION:
O2 Sat: 92 Vent type:
%/L of O2: 2 Tidal Volume Vent Set Rate:
O2 Mode+: NASAL CANNULA Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:

COMMENT:

Tubes+: NG Tube Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+:
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Do'd:

Abd Appearance+: Last BM:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 1700 (continued)

125 CRITICAL CARE REPORT (continued)
Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure:

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS

Pulm Art Cath: Zeroed: CVP Line: Zeroed:
Location: Location:
Secured at cm Dressing:
Dressing: Appearance:
Appearance: Phlebostatic Axis Marked:
Phlebostatic Axis Marked: Waveform:
Waveform: Date Flush Change:
Date Flush Change: Date Tubing Change:
Date Tubing Change:

A-Line: IABP: Zeroed: Phlebostatic Axis Marked:
Location: Waveform:
Dressing: Date Flush Change:
Appearance: Date Tubing Change:

Comment:

IV Site #1: RIGHT FOREARM IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Jelco Type of Cath #3:
Cath Gauge #1: 18 Cath Gauge #3:
Fluid/Rate #1: LR 150CC/HR Fluid/Rate #3:
Date Insert/DC #1: 05/15/16 Date Insert/DC #3:
IV #1 Comment: WNL IV #3 Comment:

5A4D43B46E1042958C8, KNIGHT, 179

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 1700 (continued)

125 CRITICAL CARE REPORT (continued)

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment: WNL

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/16/16 1700 AW3 05/16/16 1819 AW3
INTAKE

PO: 10 IV FLUIDS: Y PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI):
Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: 950 Bowel Incont Episodes: T Tube: Ileostomy:
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: 30 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Dng (Output):

Comment:

Activity Date: 05/16/16 Time: 1800

0840 Positioning A Q2H CP
- Document 05/16/16 1800 AW3 05/16/16 1902 AW3
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/16/16 1800 AW3 05/16/16 1903 AW3
Diet Ordered: NPO
Meal:
% Diet Taken:

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 1800

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1800 AW3 05/16/16 1903 AW3
Critical Care Flowsheet Time: 1800

Temperature:
Temperature Source+:
Pulse: 120
Pulse Source+: MONITOR
Respirations: 22
SPON:
Vent Resp:
Blood Pressure: 128/77
BP Location+: R Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 90
%/L of O2: 3
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/16/16 1800 AW3 05/16/16 1903 AW3
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: MAINTAIN, COMFORT, SAFETY : MET MET

Goal #3: MAINTAIN PATENT AIRWAY : MET MET

COMMENT:

525003 IV Site Check A 06,18 CP
- Document 05/16/16 1800 AW3 05/16/16 1904 AW3
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type:
Dressing clean, dry, & intact:
Tenderness of the Site:

Unused lumens capped, locked, & covered:
Dressing changed: Date: Change:
BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:

CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)

5A4D43B46E10429588C8, KNIGHT, 180

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 1800 (continued)

525003 IV Site Check (continued)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5500010 Rounds Surveillance A 06,18 CP
- Document 05/16/16 1800 AW3 05/16/16 1904 AW3

Activity Date: 05/16/16 Time: 1845

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1845 SH2 05/17/16 0134 SH2

Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 123 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 128/77 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 88 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 91
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/16/16 Time: 1855

Patient Notes: Nursing Notes
- Create 05/16/16 1855 AW3 05/16/16 1905 AW3
Abnormal? N Confidential? N
PT COMPLAINING OF PAIN AT THIS TIME IN ABD. PT GIVEN 2 MG DILAUDID IV PER ORDER.

Note Type Description
No Type None

Activity Date: 05/16/16 Time: 1900

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1900 SH2 05/16/16 2242 SH2

Critical Care Flowsheet Time:

Temperature: 99.7 Nursing Note:
Temperature Source+: Temporal Artery

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 1900 (continued)

120000 Critical Care Flowsheet (continued)
Pulse: PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

5500011 Purposeful Rounding A CP
- Document 05/16/16 1900 NW 05/17/16 0636 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/16/16 1900 SH2 05/16/16 2232 SH2
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From TONY RN/SHERRY RN

Comment

Activity Date: 05/16/16 Time: 1913

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1913 SH2 05/16/16 2242 SH2

Critical Care Flowsheet Time:

Temperature: 99.7 Nursing Note:
Temperature Source+: Temporal Artery
Pulse: PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:

5A4D43B46E1042958C8, KNIGHT, 181

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 1913 (continued)

120000 Critical Care Flowsheet (continued)

SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/16/16 Time: 1930

Patient Notes: Nursing Notes
- Create 05/16/16 1930 SH2 05/16/16 2159 SH2
Abnormal? N Confidential? N
RECEIVED BEDSIDE REPORT FROM TONYRN,PM ASSESSMENT COMPLETED,VS 99.7-125-16 118/65 SAO2 91% ON O2 3LNC,BS REPORT PT SAO2 IN 80'S WHILE PT USING IS THUS O2 BUMPED TO 3LNC,THEN SAO2 INCREASED,PT PULLING UP ON IS TO 500,LUNGS DEMIN POSTERIOR,CLEAR ANTERIOR,TELE ST,PT REPORTED EXPECTORATING YELLOW SPUTUM TODAY.ABD DISTENDED BUT SOFT,BS HEARD IN ALL QUAD EXCEPT LLQ,ABD DRESSING D&I,JP DRAINING YELLOW COLORED DRAINAGE,APPROX 40ML,ILEOSTOMY WITH SMALL AMT OF TEA COLORED LIQ,F/C DRAINING DARK AMBER URINE,REPORTED THAT THE DILAUDID GIVEN AT AROUND 1900 WAS EFFECTIVE FOR PAIN,PAIN 2/10.18G RH AND 18G LAC,SITE HEALTHY,LR INFUSING 150ML/HR TO RH,ICE CHIP AT BS,SEE ASSESSMENT FOR DETAILS.PT SAID HE THINKS HE HAS PASSED GAS,PT DENIES NEEDS.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 1944

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 1944 SH2 05/16/16 2242 SH2
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 121 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 111/69 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 88 Calibrate: Void (ml): ml
%/L of O2:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/16/16 Time: 1944 (continued)

120000 Critical Care Flowsheet (continued)

ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 81
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/16/16 Time: 2000

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/16/16 2000 SH2 05/16/16 2251 SH2
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate:
Change From Baseline:
Notify MD: Check Alarm:

Comment:

0840 Positioning A Q2H CP
- Document 05/16/16 2000 SH2 05/16/16 2244 SH2
1200008 Oral Care - Critical Care A Q4H CP
- Document 05/16/16 2000 SH2 05/16/16 2300 SH2
120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/16/16 2000 SH2 05/16/16 2251 SH2
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils ***Strength Of Extremities***
Size Right+: 2mm RUE+: WNL
Rt Reaction To Light+: Reactive LUE+: WNL
RLE+: WNL
Size Left+: 2mm LLE+: WNL
Lt Reaction To Light+: Reactive
Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative Site:

Speech/Cry+: Clear
Vision Impairment:
Responsive To+: Sound Hearing Impairment:

Mental Status: Alert & Oriented ***Continued On Next Page***
Glasgow Coma Scale

Eye Opening ***Best Verbal Response*** ***Best Motor Response***
Spontaneously: 4 Converses/Oriented: 5 Obeys Command: 6
To Speech: Converses/Disoriented: Localizes Pain:

5A4D43B46E1042958C8, KNIGHT, 182

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

To Pain: Inappropriate Words: Withdraws To Pain:
No Response: Incomprehensible: Abnormal Flexion:
No Response: Abnormal Extension:
No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: Sticker:
Chest Pain: N Heart Rate: 125 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: Normal Transvenous Pacemaker: N Secured at cm
Telemetry Pattern+: Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal Radial Rt+: Normal
Dorsalis Rt+: Normal Radial Lt+: Normal
Post Tib Lt+: Femoral Rt+:
Post Tib Rt+: Femoral Lt+:
Carotid Rt+: Cap Refill RUE+: Brisk
Carotid Lt+: Cap Refill LUE+: Brisk

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Brachial Rt+: Cap Refill RLE+: Brisk
Brachial Lt+: Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 16 O2 Sat: 91 &/L of O2: 3 Cyanosis: Pallor:

O2 Mode+: NASAL CANNULA ***Breath Sounds***
RR Description+: WNL LUL+: Clear
Resp Pattern+: Shallow LLL+: Diminished
Chest Expansions+: Symmetrical
Cough+: Productive RUL+: Clear
Sputum Amount+: Small
Sputum Consistency+: RML+: Diminished
Sputum Color+: Yellow
Airway Suctioned+: RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees YES
DVT Prophylaxis
PUD Prophylaxis YES
Sedation Vacation CONTRA
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

Chest Tube: CT Size:
CT Type: Incentive Spirometer Volume pull:
CT Location:
CT Drainage:

Comment
MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

5A4D43B46E1042958BC8, KNIGHT, 183

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

ROM Limitations+: Paralysis+:

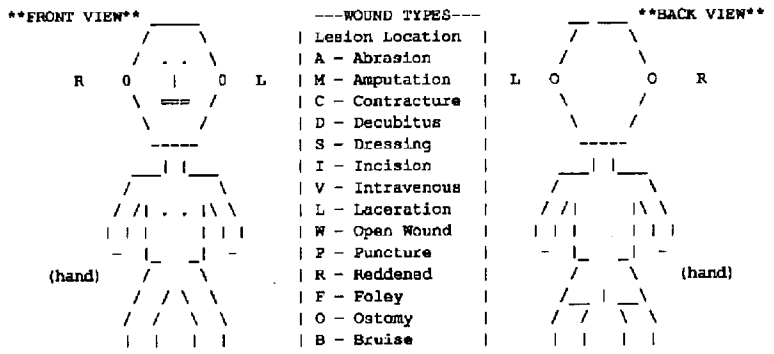
Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment MAXI SLIDE

Musc-Skel Comment <Esc>:



COMMENT:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Pale
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Pale

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Stage+:

Tubes/Drains:

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate: 2
Slightly Limited:	Walks Occasionally:	Adequate:
No Impairment: 4	Walks Frequently: 4	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited: 2	Potential Problem:
Occasionally Moist:	Slightly Limited:	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: Incontinent Stool:
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness MIDDLE Tubes+:
Abd Appearance+: SOFT Tube Drainage: Tube To Suction:
DISTENDED OGT/NGT is secured at cm
RUQ+: HYPOACTIVE Stoma Present: Location:
LUQ+: HYPOACTIVE Appearance:
RLQ+: HYPOACTIVE Ostomy Appliance:
LLQ+: ABSENT Drainage Characteristics:
GI Comment <Esc>: Rectal Tube:

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

5A4D43B46E1042958C8, KNIGHT, 184

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Does Patient have a Foley Catheter? Y
Currently Menses:
LMP:
Urine Color+: Amber
Prostate Problems:
Urine Odor+: Normal
Character+: CLOUDY
Dialysis
Incontinent Bladder:
CAPD: Peritoneal Dialysis:
Suprapubic Catheter: N
Hemodialysis:
Urostomy:
Hemo Site Description+:
Stoma Appearance
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+:
Sleeping Resp:
Respiratory Quality:
Onset/Duration:
Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: 2
REPORTED DILUADID EFFECTIVE.

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: UNSTABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning

Physical: N Language: N Visual: N Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: N Religious: N Finances: N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
EDUCATION/INTERVENTION: CARE AS PROVIDED.
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/16/16 2000 SH2 05/16/16 2251 SH2
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/16/16 2000 SH2 05/16/16 2300 SH2
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT FOREARM
IV Site #3:
Site Appear #1: NORMAL
Site Appear #3:
Type of Cath #1: Jelco
Type of Cath #3:
Cath Gauge #1: 18
Cath Gauge #3:
Fluid/Rate #1: LR 150CC/HR
Fluid/Rate #3:
Date Insert/DC #1: 05/15/16
Date Insert/DC #3:
IV #1 Comment:
IV #3 Comment:
<Esc>
<Esc>

IV Site #2:
IV Site #4:
Site Appear #2:
Site Appear #4:
Type of Cath #2:
Type of Cath #4:
Cath Gauge #2:
Cath Gauge #4:
Fluid/Rate #2:
Fluid/Rate #4:
Date Insert/DC #2:
Date Insert/DC #4:
IV #2 Comment:
IV #4 Comment:
<Esc>
<Esc>
6421 ISOLATION Patient Type A 08,20 CP
- Document 05/16/16 2000 SH2 05/16/16 2244 SH2
Type of Isolation: NONE Tissue Test:
6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/16/16 2000 SH2 05/16/16 2244 SH2
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website--THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<
7370 Discharge Planning Assessment A QS CP
- Document 05/16/16 2000 SH2 05/16/16 2244 SH2
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY EDUCATION

NEEDS IDENTIFIED:
Home Health:
Wound Care:
Medical Equipment:
Nursing Home/Rehab Placement:

5A4D43B46E10429588C8, KNIGHT, 185

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

7370 Discharge Planning Assessment (continued)

FLU VACCINE (within last year)

Who will be taking you home from the hospital?
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet?

Social Services Consult Requested: Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment:
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/16/16 2000 SH2 05/16/16 2245 SH2
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing
*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking 1
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs
****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt) 9

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/16/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)
1-2 present RN Judgement (4pt)
3 or more present
Total Score: 12

*****Interventions*****

Bed Wheels Locked Y	Fall assessment completed Y
Bed in Low Position Y	Patient needs Assessed q2hr Y
Call Light within reach Y	Environment Assessed Fall Risk Y
	Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P Y	Remain W/patient whenever OOB
Assess q1hr 7P-7A Y	If OOB to chair, q30min monitoring
Frequent Re-orientation Y	Assess q1hr 7A-7P
Reinforce Call Light use Y	Assess q1hr 7P-7A
Bed/Chair Alarm in use Y	Reinforce Call Light Use
Friction Footwear when OOB Y	Frequent Re-orientation
In Rm when pt OOB to BSC, BR, Shower,etc. Y	Bed/Chair Alarm in Use
	Friction Footwear when OOB
	In Room when Pt OOB to BSC, BR, Shower, etc.

HIGH RISK (>14) RED Sign on door/chart

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care: Assist
99 SEPSIS Documentation A QS CP
- Document 05/16/16 2000 SH2 05/16/16 2244 SH2
Temperature: 97.9
Temperature Source+: Tympanic
Pulse: 125
Respirations: 16
Blood Pressure: 118/65
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? Y
Sepsis Criteria Count: 2
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: NA
If NO, Reason: Protocol in Place

5A4D43B46E10429588C8, KNIGHT, 186

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 2013

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 2013 SH2 05/16/16 2242 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 122
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 118/65
BP Location+:
BP Position+:
O2 Sat: 89
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 77
Intra-Abd Pressure:
Comment:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Activity Date: 05/16/16 Time: 2043

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 2043 SH2 05/16/16 2242 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 122
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 114/69
BP Location+:
BP Position+:
O2 Sat: 90
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 85
Intra-Abd Pressure:
Comment:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 2045

Patient Notes: Nursing Notes
- Create 05/16/16 2045 SH2 05/16/16 2231 SH2
Abnormal? N Confidential? N
TORADOL IV GIVEN,TEMP AND MILD PAIN.SEE MAR.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 2100

5500011 Purposeful Rounding A CP
- Document 05/16/16 2100 NW 05/17/16 0636 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/16/16 Time: 2113

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 2113 SH2 05/16/16 2242 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 115
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 107/64
BP Location+:
BP Position+:
O2 Sat: 91
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 77
Intra-Abd Pressure:
Comment:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

5A4D43B46E10429588C8, KNIGHT, 187

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 2130

Patient Notes: Nursing Notes
- Create 05/16/16 2130 SH2 05/16/16 2211 SH2
Abnormal? N Confidential? N
PT ASSISTED WITH ADL,BRUSH TEETH,BS 85,DECLINED PAIN MEDICATIONS,WIFE CALLED TO CHECK ON PT,GIVEN CONFID # PER PT CONSENT.NO CHANGE IN ASSESSMENT,ASSESSED ABD,JP AND ILEOSTOMY,NO CHANGES,DRESSING D&I.PT TAKING FEW ICE CHIPS INTERMITTENTLY.
Note Type Description
No Type None

Activity Date: 05/16/16 Time: 2143

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 2143 SH2 05/16/16 2242 SH2
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 112 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 106/61 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 91 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 82
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/16/16 Time: 2200

0840 Positioning A Q2H CP
- Document 05/16/16 2200 SH2 05/16/16 2300 SH2

Activity Date: 05/16/16 Time: 2213

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 2213 SH2 05/16/16 2242 SH2
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 112 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/16/16 Time: 2213 (continued)

120000 Critical Care Flowsheet (continued)
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 110/62 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 92 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 76
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/16/16 Time: 2300

120000 Critical Care Flowsheet A Q1H CP
- Document 05/16/16 2300 SH2 05/17/16 0127 SH2
Critical Care Flowsheet Time: 2300

Temperature: Nursing Note:
Temperature Source+:
Pulse: PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 111/65 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 76
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:
5500011 Purposeful Rounding A CP
- Document 05/16/16 2300 NW 05/17/16 0636 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:

5A4D43B46E1042958BC8, KNIGHT, 188

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/16/16 Time: 2300 (continued)

5500011 Purposeful Rounding (continued)
<Esc>

Activity Date: 05/17/16 Time: 0000

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/17/16 0000 SH2 05/17/16 0114 SH2
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate:
Change From Baseline:
Notify MD: Check Alarm:

Comment:

0840 Positioning A Q2H CP
- Document 05/17/16 0000 SH2 05/17/16 0113 SH2

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0000 SH2 05/17/16 0114 SH2
Critical Care Flowsheet Time: 0000

Temperature: 98.4 Nursing Note:
Temperature Source+: Tympanic
Pulse: 113 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 111/65 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 91 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

1200008 Oral Care - Critical Care A Q4H CP
- Document 05/17/16 0000 SH2 05/17/16 0114 SH2
Patient Notes: Nursing Notes
- Create 05/17/16 0000 SH2 05/17/16 0151 SH2
Abnormal? N Confidential? N
VS 98.4-113/20 111/65 SAO2 91% OFFERED PAIN MEDICATION,PT SAID OK,MORPHINE GIVEN FOR ABD PAIN 5/10.NO OTHER NEEDS,RESTING WELL,OFFERED TO REPOSITION PT,HE DECLINED.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 0013

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0013 SH2 05/17/16 0129 SH2
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 111 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 108/66 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 91 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 77
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/17/16 Time: 0043

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0043 SH2 05/17/16 0129 SH2
Critical Care Flowsheet Time:

Temperature: Nursing Note:
Temperature Source+:
Pulse: 112 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 113/69 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 91 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 83
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

5A4D43B46E10429588C8, KNIGHT, 189

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/17/16		**Time: 0100**								
5500011	Purposeful Rounding							A		CP
- Document	05/17/16	0100	NW	05/17/16	0636	NW				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/17/16		**Time: 0113**								
120000	Critical Care Flowsheet							A	Q1H	CP
- Document	05/17/16	0113	SH2	05/17/16	0129	SH2				

Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 112
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 120/63
BP Location+:
BP Position+:
O2 Sat: 90
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 84
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/17/16		**Time: 0148**								
0840	Positioning							A	Q2H	CP
- Document	05/17/16	0148	SH2	05/17/16	0148	SH2				
6409	FALLS SCREEN - FOLLOW-UP							A	02,14	CP
- Document	05/17/16	0148	SH2	05/17/16	0148	SH2				

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/17/16		**Time: 0148 (continued)**								
6409	FALLS SCREEN - FOLLOW-UP (continued)									

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed

5A4D43B46E10429588C8, KNIGHT, 190

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0148 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

or dosage within the last 24 hrs
MODERATE Risk (9-14) YELLOW sign on door HIGH RISK (>14) RED Sign on door/chart

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/17/16 Time: 0151

Patient Notes: Nursing Notes
- Create 05/17/16 0151 SH2 05/17/16 0152 SH2
Abnormal? N Confidential? N
SUPINE,RESP EVEN UNLABORED,TELE ST 115,SAO2 90% ON 3L NC.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 0200

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0200 SH2 05/17/16 0212 SH2
Critical Care Flowsheet Time: 0200

Temperature: 98.4
Temperature Source+: Tympanic
Pulse: 115
Pulse Source+: MONITOR
Respirations: 18
SPON:
Vent Resp:
Blood Pressure: 127/75
BP Location+:
BP Position+:
O2 Sat: 90

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0200 (continued)

120000 Critical Care Flowsheet (continued)
%/L of O2: 4
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 87
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/17/16 Time: 0212

Patient Notes: Nursing Notes
- Create 05/17/16 0212 SH2 05/17/16 0216 SH2
Abnormal? N Confidential? N
PT CALLED REPORTED FEELING SOB,SAO2 88-89% ON 3L NC,O2 INCREASED TO 4LNC,SAO2 INCREASES TO 90%,PT SAID THIS IS NEW FOR HIM,"I DON'T UNDERSTAND MY VS ARE THE BEST ALL DAY"LUNGS CLEAR ANTERIOR,LEFT POSTERIOR BASE
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 0215

Patient Notes: Nursing Notes
- Create 05/17/16 0215 SH2 05/17/16 0229 SH2
Abnormal? N Confidential? N
LEFT LOWER POSTERIOR BASE VERY DEMINISHED,VS 127/75 RESP 18 EVEN,SHALLOW O2 INCREASED TO 90% ON 4LNC.DR HAYES CALLED AND NO NEW ORDERS EXCEPT FOR O2 TO BE TITRATED TO KEEP SAO2 UP.DR.HAYES AWARE OF IVF,POC,CHEST XRAY RESULTS ECT.PT INSTRUCTED THAT DR.HAYES CALLED BACK AND POC.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 0300

5500011 Purposeful Rounding A CP
- Document 05/17/16 0300 NW 05/17/16 0636 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E1042958C8, KNIGHT, 191

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/17/16 Time: 0313

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0313 SH2 05/17/16 0416 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 113
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 127/74
BP Location+:
BP Position+:
O2 Sat: 90
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 86
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/17/16 Time: 0314

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0314 SH2 05/17/16 0416 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 113
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 127/74
BP Location+:
BP Position+:
O2 Sat: 90
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 86
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/17/16 Time: 0343

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0343 SH2 05/17/16 0416 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 114
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 119/72
BP Location+:
BP Position+:
O2 Sat: 91
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 94
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/17/16 Time: 0400

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/17/16 0400 SH2 05/17/16 0438 SH2
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate:
Change From Baseline:
Notify MD: Check Alarm:

Comment:

0840 Positioning A Q2H CP
- Document 05/17/16 0400 SH2 05/17/16 0438 SH2

1200008 Oral Care - Critical Care A Q4H CP
- Document 05/17/16 0400 SH2 05/17/16 0439 SH2

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/17/16 0400 SH2 05/17/16 0438 SH2
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

5A4D43B46E1042958C8, KNIGHT, 192

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/17/16 Time: 0400

800001 Education/Teaching Assessment A 04,16 CP
- Document 05/17/16 0400 SH2 05/17/16 0439 SH2
Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
Comment: Comment:

EDUCATION/INTERVENTION: CARE AS PROVIDED.

Outcome: VERBAL

Non-Surgical Open Wound: Date Began:

New Surgical Flap or Graft: Y Date of Surgery: 05/15/16

Activity Date: 05/17/16 Time: 0405

Patient Notes: Nursing Notes
- Create 05/17/16 0405 SH2 05/17/16 0425 SH2
Abnormal? N Confidential? N
SAO2 MAINTAINING AROUND 90-91% ON 4LNC,VS 99.1-114-24 121/75 SAO2 92% AT TIME.TELE ST,DILUADID 2MG IV GIVEN SLOWLY FOR ABD PAIN 6/10 WITH GOOD EFFECT,JP EMPTIED WITH 60ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID,F/C DRAINED 545ML AMBER URINE,ABD DRSSING D&I,PT STATED HIS BREATHING

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/17/16 Time: 0405 (continued)

Patient Notes: Nursing Notes (continued)
IS ABOUT THE SAME,HE STILL FEELS SOB,NO DISTRESS,RESP 22-24 EVEN UNLABORED,MINT SWABS GIVEN,PT USED,ICE CHIPS GIVEN.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 0410

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0410 SH2 05/17/16 0416 SH2
Critical Care Flowsheet Time:

Temperature: 99.1 Nursing Note:
Temperature Source+: Tympanic
Pulse: 115 PCWP: Glycemic Protocol:
Pulse Source+: CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 121/75 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 90 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 91
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/17/16 Time: 0439

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0439 SH2 05/17/16 0447 SH2
Critical Care Flowsheet Time: 0400

Temperature: 99.1 Nursing Note:
Temperature Source+: Tympanic
Pulse: 115 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 121/75 CI: Warming Blanket:
BP Location+: SVR:
BP Position+: PVR: Foley: ml
O2 Sat: 92 Calibrate: Void (ml): ml
%/L of O2: 4
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm

5A4D43B46E10429588C8, KNIGHT, 193

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0439 (continued)

120000 Critical Care Flowsheet (continued)
MAP: 91
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/17/16 0439 SH2 05/17/16 0449 SH2
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): LR IV Fluids (A): 1800
Medication (B): INVANZ IV Fluids (B): 50
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 1850 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/17/16 0439 SH2 05/17/16 0446 SH2
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU Y PCU TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N

K/MG Protocol: NO
Last K: Covered: Blood Pressure: 121/75
Last MG: Covered: Temperature: 99.1

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0439 (continued)

125 CRITICAL CARE REPORT (continued)
Pacemaker: N Sensitivity: Rate: Cooling Blanket:
Defibrillator: N Demand: Asynchronous: Warming Blanket:
Transvenous Pacemaker: N Atrial: Ventricular:
Secured at cm
Mental Status: Alert & Oriented

Respirations: 24 VENTILATOR DOCUMENTATION:
O2 Sat: 92 Vent type:
%/L of O2: 4 Tidal Volume Vent Set Rate:
O2 Mode+: NASAL CANNULA Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:

COMMENT:

Tubes+: NG Tube Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+:
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd:

Abd Appearance+: Last BM:

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure:

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60 ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C 545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILUADID IV X1

5A4D43B46E10429588C8, KNIGHT, 194

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/17/16 Time: 0439 (continued)

125 CRITICAL CARE REPORT (continued)
DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment:

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: LR 150CC/HR
Date Insert/DC #1: 05/15/16
IV #1 Comment: WNL

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment: WNL

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/17/16 0439 SH2 05/17/16 0448 SH2
INTAKE

PO: 50 IV FLUIDS: Y PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI):
Dialysis (Intake):

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/17/16 Time: 0439 (continued)

150012 Intake/Output (No IVs) Critical Care (continued)
OUTPUT

Void (ml):
Foley: 545
SP Catheter:
Foley (Residual):
Bladder Incont Episodes:
Bowel Incont Episodes:
Void Episodes:
Stool Episodes:
Diapers:
Emesis: 0
T Tube:
NG/PEG TUBE:
Duodenal Tube:
Liquid Stool:
Colostomy:
Ileostomy: 150
Urostomy:
Ileoconduit:

#1 JP: 60
#2 JP:
#3 JP:
OTHER:
#1 Chest Tube:
#2 Chest Tube:
#1 Hemovac:
#2 Hemovac:
Left Ureteral:
Right Ureteral:
Left Nephrostomy:
Right Nephrostomy:
Dialysis (Output):
Thoracentesis:
Paracentesis:
Wound Vac:
Pericardial Dng (Output):

Comment:

Activity Date: 05/17/16 Time: 0443

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0443 SH2 05/17/16 0510 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 115
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 113/68
BP Location+:
BP Position+:
O2 Sat: 90
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 79
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

Activity Date: 05/17/16 Time: 0500

5500011 Purposeful Rounding A CP
- Document 05/17/16 0500 NW 05/17/16 0636 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

5A4D43B46E10429588C8, KNIGHT, 195

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 0500 (continued)

5500011 Purposeful Rounding (continued)
Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/17/16 Time: 0511

0840 Positioning A Q2H CP
- Document 05/17/16 0511 SH2 05/17/16 0511 SH2
120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0511 SH2 05/17/16 0511 SH2
Critical Care Flowsheet Time: 0500

Temperature: 99.1
Temperature Source+: Tympanic
Pulse: 115
Pulse Source+: MONITOR
Respirations: 24
SPON:
Vent Resp:
Blood Pressure: 113/68
BP Location+: R Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 90
%/L of O2: 4
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:
120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/17/16 0511 SH2 05/17/16 0512 SH2
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: MAINTAIN, COMFORT, SAFETY : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >91% : MET MET

COMMENT:
150011 Weight, Monitor Daily A DAILY@0600 CP
- Document 05/17/16 0511 SH2 05/17/16 0512 SH2
Weight (lbs): 191
(Oz): 0
kg: 86.636
Weight Source:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 0511

525003 IV Site Check A 06,18 CP
- Document 05/17/16 0511 SH2 05/17/16 0512 SH2
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type:
Dressing clean, dry, & intact:
Tenderness of the Site:
Unused lumens capped, locked, & covered:
Dressing changed: Date: Change:
BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/17/16 0511 SH2 05/17/16 0512 SH2

Activity Date: 05/17/16 Time: 0513

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0513 SH2 05/17/16 0753 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 121
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 125/77
BP Location+:
BP Position+:
O2 Sat: 90
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 88
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

5A4D43B46E1042958BC8, KNIGHT, 196

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 0543

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0543 SH2 05/17/16 0753 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 112
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 120/73
BP Location+:
BP Position+:
O2 Sat: 89
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 87
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

Activity Date: 05/17/16 Time: 0609

Patient Notes: Nursing Notes
- Create 05/17/16 0609 KK 05/17/16 0744 KK
Abnormal? N Confidential? N
DILUADID 2MG IV GIVEN GOT ABD PAIN 5/10.VSS.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 0614

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0614 SH2 05/17/16 0753 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 114
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 121/80
BP Location+:
BP Position+:
O2 Sat: 89
%/L of O2:
ETCO2:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 0614 (continued)

120000 Critical Care Flowsheet (continued)
A-LINE BP: Secured at cm
MAP: 92
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/17/16 Time: 0634

5500011 Purposeful Rounding A CP
- Document 05/17/16 0634 NW 05/17/16 0636 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complate: Y

Comment:
<Esc>

Activity Date: 05/17/16 Time: 0645

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0645 SH2 05/17/16 0753 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 114
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 124/65
BP Location+:
BP Position+:
O2 Sat: 88
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 87
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

5A4D43B46E10429588C8, KNIGHT, 197

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/17/16		Time: 0700								
6922 Nursing Report (Hand Off)							A	07,19		CP
- Document	05/17/16	0700	KK	05/17/16	1012	KK				

****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From KATIE/SHERRY

Comment

Activity Date: 05/17/16 Time: 0715

120000 Critical Care Flowsheet							A	Q1H		CP
- Document	05/17/16	0715	SH2	05/17/16	0753	SH2				

Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 112
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 111/69
BP Location+:
BP Position+:
O2 Sat: 89
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 84
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/17/16 Time: 0720

Patient Notes: Nursing Notes
- Create 05/17/16 0720 SH2 05/17/16 0746 SH2
Abnormal? N Confidential? N
RESTING IN BED,REPORTED OFF TO KATIE RN.O2 INCREASE TO 5 L DUE TO SAO2 89%,SAO2 INCREASED TO 91%.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 0735

Patient Notes: Nursing Notes
- Create 05/17/16 0735 KK 05/17/16 1140 KK
Abnormal? N Confidential? N
REPORT RECEIVED FROM SHERRY, RN. PATIENT IS RESTING IN BED. AM ASSESMENT

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/17/16 Time: 0735 (continued)

Patient Notes: Nursing Notes (continued)
COMPLETE. A+OX3, BEDSIDE MONITOR ST 110'S. AFEBRILE. 02 SATS 88% ON 5L NC. WILL HUMIDIFY THIS SHIFT. ALSO WILL NOTIFY DR SANTIAGO OF 02 SATS. FINE CRACKLES HEARD ON AUSCULTATION. AFEBRILE. IV SITE PATENT, IVF INFUSING. ILIOSTOMY INTACT AND DRAINING CLOUDY GRAY LIQUID COLORED STOOL INTO COLLECTION BAG. WAFFER INTACT, STOMA PINK. JP DRAIN CHARGED AND DRAINING YELLOW COLORED DRAINAGE INTO COLLECTION BULB. MEDIAL ABD INCISION C/D/I. HYPOACTIVE BS HEARD. PT STATES "IS NOT PASSING GAS. FOLEY CATHETER INTACT AND DRAINING CLEAR AMBER COLORED URINE. SCDS REMOVED FOR SKIN INSPECTION, NO FINDINGS NOTED, REAPPLIED. PATIENT C/O PAIN, WILL MEDICATE PRN PER ORDERS. DISCUSSED PLAN OF CARE WITH PATIENT AND WIFE ELIZABETH, VERBALIZES UNDERSTANDING. PATIENT DEMONSTRATED USE OF IS,500. RE-ENCOURAGEMENT NEEDED. CALL LIGHT WITHIN REACH. CONTINUE WITH PLAN OF CARE.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 0800

120009 Telemetry Monitoring - Critical Care							A	Q4H		CP
- Document	05/17/16	0800	KK	05/17/16	1013	KK				

Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate: 114
Change From Baseline:
Notify MD: Check Alarm:

Comment:

0840 Positioning							A	Q2H		CP
- Document	05/17/16	0800	KK	05/17/16	1012	KK				
1160 Nutritional Monitoring							A	08,12,18		CP
- Document	05/17/16	0800	KK	05/17/16	1012	KK				

Diet Ordered: ICE CHIPS
Meal: BREAKFAST
% Diet Taken: NPO

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:

1200008 Oral Care - Critical Care							A	Q4H		CP
- Document	05/17/16	0800	KK	05/17/16	1013	KK				
120001 SHIFT ASSESSMENT-Critical Care							A	QS		CP
- Document	05/17/16	0800	KK	05/17/16	1112	KK				

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm

Strength Of Extremities
RUE+: WNL

5A4D43B46E10429588C8, KNIGHT, 198

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:
Vision Impairment: GLASSES
Hearing Impairment:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Sound
Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>: A+OX3.

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: 114 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: S1,S2 Transvenous Pacemaker: N Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: N Asynchronous: N
Pulse Rhythm+: Regular Atrial: N Ventricular: N
Dizziness/Syncope+:
JVD+: Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Edema 1+:
Loc 1+:
Pitting:
Edema 2+:
Loc 2+:
Pitting:
TED Hose: N
IPC: Y
Venous Foot Pump: N
Edema 3+:
Loc 3+:
Pitting:
Edema 4+:
Loc 4+:
Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal	Radial Rt+: Normal
Dorsalis Rt+: Normal	Radial Lt+: Normal
Post Tib Lt+:	Femoral Rt+:
Post Tib Rt+:	Femoral Lt+:
Carotid Rt+:	Cap Refill RUE+: Brisk
Carotid Lt+:	Cap Refill LUE+: Brisk
Brachial Rt+:	Cap Refill RLE+: Brisk
Brachial Lt+:	Cap Refill LLE+: Brisk

Cardio Comment <Esc>: ST 110'S.

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 25 O2 Sat: 88 %/L of O2: 5 Cyanosis: N Pallor: N

O2 Mode+: NASAL CANNULA
RR Description+: Tachypnea
Resp Pattern+: Rapid
Chest Expansions+: Symmetrical
Cough+: Non-effective
Sputum Amount+: None
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Diminished
RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation

5A4D43B46E1042958C8, KNIGHT, 199

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

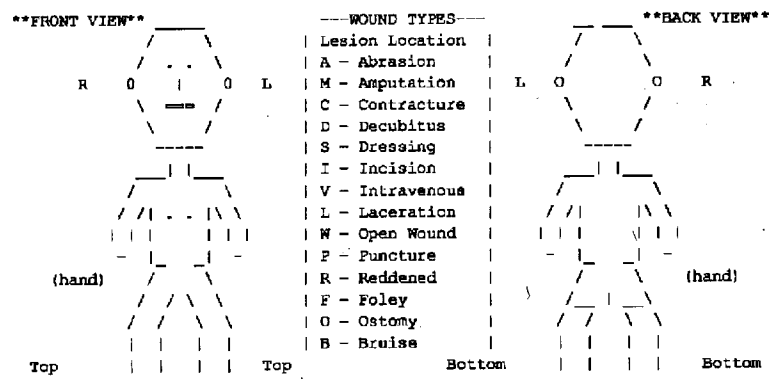
Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull: 500

Comment
MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:
Paralysis+:
Joint Swelling+:
Amputations+:
Muscle Spasms+:
Contractures+:
Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>: ONE PERSON ASSIST REPOSOTION OOB TO CHAIR.



Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Foot (R) (toes) Foot (L) Foot (L) (toes) Foot (R)

COMMENT: X-JP DRAIN, F-FOLEY, I-MEDIAL ABD

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Pale
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Pale
Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1:
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains: JP DRAIN, PIV X2, FOLEY

Skin Comment <Esc>: ILIOSTOMMY DRAINING CLOUDY LIGHT GRAY COLORED LIQUID STOOL.
Is Pt At Risk For Immobility Or Skin Breakdown: Y

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor: 1
Very Limited:	Chairfast: 2	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate:
No Impairment: 4	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 17

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/17/16 Incontinent Stool: Y

5A4D43B46E10429588C8, KNIGHT, 200

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Emesis: N Diarrhea: N Stool Amount+: Moderate
By C-Diff Protocol - Watery loose stool: N Stool Color+: Light Gray
Stool Consistency+: Liquid

Abd Girth: cm Tenderness Tubes+:
Abd Appearance+: SOFT Tube Drainage: Y Tube To Suction: N
DISTENDED OGT/NGT is secured at cm
RUQ+: HYPOACTIVE Stoma Present: Y Location: RT ABD
LUQ+: HYPOACTIVE Appearance: PINK
RLQ+: HYPOACTIVE Ostomy Appliance: Y
LLQ+: HYPOACTIVE Drainage Characteristics: CLOUDY GRAY
GI Comment <Esc>: ILIOSTOMY NOTED TO RT ABD, WAFFER C/D/I. GRAY Rectal Tube: N
LIQUID STOOL DRAINING INTO COLLECTION BAG. PT IS
NOT PASSING GAS.
Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems:
Urine Odor+: Normal
Character+: CLEAR ***Dialysis***
Incontinent Bladder: N CAPD: Peritoneal Dialysis:
Suprapubic Catheter: N Hemodialysis:
Urostomy: N Hemo Site Description+:
Stoma Appearance Last Dialysis Treatment:

GU Comment <Esc>: FOLEY CATHETER INTACT AND DRAINING TO GRAVITY.

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: 6 pain management this shift: 0
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>: DILAUDID

Time Med Given: 1041 Date: 05/17/16 Reassess: 1141 (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: DILAUDID GIVEN Q2HRS.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning

Physical: N	Language: N	Visual: Y	Motivation: N	Cultural: N	Cognitive: N
Reading: N	Age Related: N	Auditory: N	Emotional: Y	Religious: N	Finances: N

EDUCATION/INTERVENTION: DISCUSSED PLAN OF CARE, VERBALIZES UNDERSTANDING.
- Edit Results 05/17/16 0800 KK 05/17/16 1202 KK
LLL+: Fine Crackles [Diminished]
RLL+: Fine Crackles [Diminished]
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/17/16 0800 KK 05/17/16 1013 KK
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/17/16 0800 KK 05/17/16 1028 KK
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT WRIST IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Jelco Type of Cath #3:
Cath Gauge #1: 18 Cath Gauge #3:
Fluid/Rate #1: SL Fluid/Rate #3:
Date Insert/DC #1: 05/15/16 Date Insert/DC #3:
IV #1 Comment: WNL IV #3 Comment:
<Esc> <Esc>

IV Site #2: LEFT ANTECUBITAL SPACE IV Site #4:
Site Appear #2: NORMAL Site Appear #4:
Type of Cath #2: Jelco Type of Cath #4:
Cath Gauge #2: 18 Cath Gauge #4:
Fluid/Rate #2: ABX Fluid/Rate #4:
Date Insert/DC #2: 05/15/16 Date Insert/DC #4:
IV #2 Comment: WNL IV #4 Comment:
<Esc> <Esc>

5A4D43B46E10429588C8, KNIGHT, 201

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/17/16		**Time: 0800**								
6421 ISOLATION Patient Type								A	08,20	CP
- Document	05/17/16	0800	KK	05/17/16	1012	KK				
Type of Isolation: NONE								Tissue Test: N		
6907 PATIENT BATH - Critical Care								A	DAILY	CP
- Document	05/17/16	0800	KK	05/17/16	1013	KK				
Hygiene: Assisted								Date: 05/17/16		
CHG Bath given: Y				If no, Reason:						
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)										
Patient Refused (Bath):				Nurse Notified (Bath):						
Hygiene Comment:										
6955 Anticoagulant Educ Materials Provided								A	QS	CP
- Document	05/17/16	0800	KK	05/17/16	1024	KK				
Anticoagulant Educ Material provided to Patient &/or Family? Y										
Comment:										
CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)										
>>>>>>COMPLETE Intervention after Filing<<<<<<										
7370 Discharge Planning Assessment								A	QS	CP
- Document	05/17/16	0800	KK	05/17/16	1025	KK				
==========DISCHARGE PLANNING ASSESSMENT==========										
...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...										
Can you think of any needs you may have when that happens?										
OSTOMY EDUCATION										
NEEDS IDENTIFIED:										
Home Health: Y								Wound Care: N		
Medical Equipment: N								Nursing Home/Rehab Placement: N		
FLU VACCINE (within last year)										
Who will be taking you home from the hospital? WIFE ELIZABETH										
Name and Phone number....										
[redacted]										
Would you like a dietitian to talk with you about your diet? N										
Social Services Consult Requested: N				Date Requested: 05/16/16						

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/17/16		**Time: 0800 (continued)**								
7370 Discharge Planning Assessment (continued)										
Physical Therapy Consult Needed-Make note on PURPLE SHEET										
Comment: WILL CONTINUE TO ASSESS NEEDS.										
9610 Fall Risk Assessment/Interventions								A	QS	CP
- Document	05/17/16	0800	KK	05/17/16	1025	KK				

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 4

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation Y

5A4D43B46E1042958BC8, KNIGHT, 202

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)
MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/17/16 0800 SH2 05/17/16 1051 SH2
Temperature: 98.2
Temperature Source+: Tympanic
Pulse: 116
Respirations: 25
Blood Pressure: 129/72
MAP: 88
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? Y
Sepsis Criteria Count: 2
Sepsis Result: Possible Sepsis Risk

Physician Notified: N
If NO, Reason: Physician Already Aware

(May use most recent VITAL SIGNS taken if they are WNL and no greater than 3hrs)

Activity Date: 05/17/16 Time: 0807

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0807 KK 05/17/16 1020 KK
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 114
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 115/78
BP Location+:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 0807 (continued)

120000 Critical Care Flowsheet (continued)
BP Position+:
O2 Sat: 89
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 90
Intra-Abd Pressure:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Foley: ml
Void (ml): ml
Comment:

Activity Date: 05/17/16 Time: 0913

120000 Critical Care Flowsheet A Q1H CP
- Document 05/17/16 0913 KK 05/17/16 1020 KK
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 118
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 123/78
BP Location+:
BP Position+:
O2 Sat: 89
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 92
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Foley: ml
Void (ml): ml
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Comment:

Activity Date: 05/17/16 Time: 0930

Patient Notes: Nursing Notes
- Create 05/17/16 0930 KK 05/17/16 1146 KK
Abnormal? N Confidential? N
DR SANTIAGO NOTIFIED OF PATIENTS O2 STATS 88-90% ON 5L NC HUMIDIFIED AFTER BEIING REPOSITIONED OOB TO CHAIR. NEW ORDERS RECEIVED FOR IV LASIX TO BE GIVEN.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 203

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/17/16 Time: 1000										
0840 Positioning							A	Q2H		CP
- Document	05/17/16	1000	KK	05/17/16	1013	KK				
Activity Date: 05/17/16 Time: 1010										
Patient Notes: Medical Nutrition Therapy										
- Create	05/17/16	1010	SG	05/17/16	1021	SG				

Abnormal? N Confidential? N

MNT ASSESSMENT;
ASSESSMENT;
-41 Y/O MALE ADMITTED WITH PERFORATED VISCOUS. S/P RESECTION OF SMALL BOWEL WITH ILEOSTOMY OF RLQ (5/15/16). POD #2. NGT TO SUCTION DISCONTINUED (5/16/16)
NOTED WITH ABSENT BOWEL SOUNDS. PER MD NOTATION TODAY, PT EXHIBITS WITH SOB; MILD PULMONARY EDEMA AND PLEURAL EFFUSION. IV LASIX INITIATED; PT ON OXYGEN VIA N/C.
-PT REMAINS NPO.
-PERTINENT MEDS: IV LASIX, INVANZ, DIFLUCAN, PROTONIX
-PERTINENT LAB: (5/15/16) ALBUMIN 2.9
NO RECENT ALBUMIN/PREALBUMIN LEVEL AVAILABLE
BEDSIDE GLUCOSE: (5/16/16) 100, 86, 81, 85
(5/17/16) 95
-BMI: 31.8

NUTRITION DX: RD TRIGGER
INTERVENTIONS:
NUTRITION RX:
-RECOMMENDED REQUIREMENTS:
-1950-2100 KCAL, 80-95 G PROTEIN, 1.9-2.0 L FLUID
-CONSIDER INITIATING 1 LITER PPN FOR NUTRITIONAL SUPPORT; TO PROVIDE 42.5 G PROTEIN, 510 KCAL. INITIATE CLEAR LIQUIDS WHEN BOWEL SOUNDS PRESENT WITH SUPPLEMENTATION OF RESOURCE BREEZE AT ALL MEALS FOR PO SUPPLEMENTATION.
-IF PO PROGRESSION NOT FEASIBLE, CENTRAL STANDARD TPN-2 LITERS SHOULD BE CONSIDERED TO PROVIDE 85.0 G PROTEIN, 1700 KCAL. ADD FAT EMULSION 3X WEEKLY FOR ADDITIONAL 500 KCAL.
GOALS:
-NPO < 3 DAYS
-LABS TREND WNL

MONITORING AND EVALUATION:
-MONITOR FOR PROSTAT MODULAR ON FU
-REQUEST PREALBUMIN LEVEL

COORDINATION OF CARE:
-NO D/C PLANS AT THIS TIME

POC LEVEL 1
SHARON GUTKNECHT MS RD LD

Note Type	Description
No Type	None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/17/16 Time: 1013										
1200008 Oral Care - Critical Care							A	DAILY		CP
- Ed Directs	05/17/16	1013	KK	05/17/16	1013	KK		05/15 1108 Q4H	=>	05/15 1108 Q4H
										05/17 1013 DAILY
Activity Date: 05/17/16 Time: 1023										
Patient Notes: Nursing Notes										
- Create	05/17/16	1023	KK	05/17/16	1023	KK				

Abnormal? N Confidential? N

DR SANTIGO PAGED AND NOTIFIED OF PATIENTS C/O PAIN 6/10 AFTER MEDICATED PRN PER ORDERS. NO NEW ORDERS RECEIVED.

Note Type	Description
No Type	None

Activity Date: 05/17/16 Time: 1031										
120000 Critical Care Flowsheet							A	Q4H		CP
- Ed Directs	05/17/16	1031	KK	05/17/16	1031	KK		05/15 1108 Q4H	=>	05/15 1108 Q4H
								05/16 0221 Q1H		05/16 0221 Q1H
										05/17 1031 Q4H
Activity Date: 05/17/16 Time: 1044										
120000 Critical Care Flowsheet							A	Q4H		CP
- Document	05/17/16	1044	KK	05/17/16	1102	KK				

Critical Care Flowsheet Time:

Temperature:			Nursing Note:
Temperature Source+:			
Pulse:	108	PCWP:	Glycemic Protocol:
Pulse Source+:		CVP:	Fingerstick BS:
Respirations:		MPA:	Frequency:
SPON:		PAP:	
Vent Resp:		CO:	Cooling Blanket:
Blood Pressure:	111/75	CI:	Warming Blanket:
BP Location+:		SVR:	
BP Position+:		PVR:	Foley: ml
O2 Sat:	93	Calibrate:	Void (ml): ml
%/L of O2:			
ETCO2:		Transvenous Pacer Setting:	V Output mA Set Rate:
A-LINE BP:			Secured at cm
MAP:	86		
Intra-Abd Pressure:		Weight (lbs):	(Oz): kg:
		Weight Source:	

Comment:

5A4D43B46E10429588C8, KNIGHT, 204

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 1125

Patient Notes: Nursing Notes
- Create 05/17/16 1125 KK 05/17/16 1126 KK
Abnormal? N Confidential? N
DR SANTIAGO PAGED AND NOTIFIED OF PATIENTS HOP AFTER GIVEN LASIX 300ML. ALSO NOTIFIED OF ILIOSTOMY AND PATIENT NEEDING WOUND CARE CONSULT FOR EDUCATION/TEACHING AS WELL AS SUPPLIES FOR HOME. NEW ORDERS RECEIVED.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 1200

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/17/16 1200 KK 05/17/16 1201 KK
Telemetry Rhythm: SINUS TACHYCARDIA
Low Rate:
High Rate: 112
Change From Baseline:
Notify MD: Check Alarm:
Comment:

0840 Positioning A Q2H CP
- Document 05/17/16 1200 KK 05/17/16 1200 KK

1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/17/16 1200 KK 05/17/16 1201 KK
Diet Ordered: ICE CHIPS
Meal: LUNCH
% Diet Taken: NPO
Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:

Activity Date: 05/17/16 Time: 1213

120000 Critical Care Flowsheet A Q4H CP
- Document 05/17/16 1213 SH2 05/17/16 1228 SH2
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 112
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 102/67
BP Location+:
BP Position+:
O2 Sat: 94

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 1213 (continued)

120000 Critical Care Flowsheet (continued)
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 77
Intra-Abd Pressure:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/17/16 Time: 1307

Patient Notes: Nursing Notes
- Create 05/17/16 1307 KK 05/17/16 1308 KK
Abnormal? N Confidential? N
DR RIMKUS INTO SEE PATIENT, NEW ORDERS RECEIVED TO ADVANCE DIET TO CLEAR LIQUIDS AND ALSO NOTIFIED OF PATIENTS C/O PAIN 6/10, NEW ORDERS RECEIVED.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 1400

0840 Positioning A Q2H CP
- Document 05/17/16 1400 KK 05/17/16 1413 KK

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/17/16 1400 KK 05/17/16 1414 KK

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: Y

FALL SCREEN Y NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning

5A4D43B46E10429588C8, KNIGHT, 205

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present 2
3 or more present

Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 10

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y

Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P Y
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

or dosage within the last 24 hrs 1
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Fall Score Ranking: Moderate Patient on Anticoagulants? Y

Activity Date: 05/17/16 Time: 1420

7322	CASE MANAGEMENT EVALUATION/DC						A	PRN	AS
- Create	05/17/16	1420	WC	05/17/16	1421	WC			
- Document	05/17/16	1420	WC	05/17/16	1421	WC			

CASE MANAGEMENT-Evaluation/DC

Reason For Referral: OTHER

Pt Interview: Y Family Interview: Y Other:

Admitted From: HOME Type Of Facility:

Bed Held At Trans Fac: Level Of Care: 10th Day:

Person To Notify:
Relationship To Pt:
Home Telephone #:
Alternate Telephone #:

Person to Notify:
Relationship to Pt:
Home Telephone #:
Alternate Telephone#:

Hospitalization within last 30 days N
Known/suspected substance abuse N
Knowledge/cognitive deficit N

Behavioral Health Issues N
Abuse/neglect/domestic violence N
Cultural/religious Issues N

EVALUATION:

Living Status: LIVES W/SPOUSE ADL Status: AMBULATORY

Durable Medical Equipment

HH Services At Home:
HH Provider:

DME Provider:

Other Cmty Services:
Funding Source:

Discharge Risk: Evaluation Notes:

5A4D43B46E10429588C8, KNIGHT, 206

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/17/16 Time: 1420 (continued)

7322 CASE MANAGEMENT EVALUATION/DC (continued)
OSTOMY AFTER A CAR WRECK. LIVES WITH SPOUSE, WORKS AND IS INDEPENDENT. WILL FOLLOW FOR ANY NEEDS.
<Esc>
PLAN

Return to pre-hospital setting Y YES PPD ordered

Anticipated Needs for Discharge:
Home Health DME Transportation ALF SNF LTAC
Rx Assist Financial Assist Other

Pt/family agree with plan Pt/family do NOT agree with plan

Reassessment & Alterations to Plans

<Esc>

Activity Date: 05/17/16 Time: 1531

Patient Notes: Wound Care Note
- Create 05/17/16 1531 KM 05/17/16 1536 KM
Abnormal? N Confidential? N
CONSULTED ON PT FOR NEW ILEOSTOMY. LOOP ILESOTOMY S/P PERFORATION AFTER CAR ACCIDENT. SURGERY WAS THIS WEEKEND. R UPPER QUADRANT STOMA PINK, SLIGHTLY EDEMATOUS, MEASURES ABOUT 32 MM IN DIAMETER. 45 MM POUCHING SYSTEM IN PLACE, NO LEAKS NOTED. HAS BEEN ON SINCE SURGERY. DRAINING LARGE AMOUNTS GRAY/GREEN LIQUID EFFLUENT. PT ON ONLY CLEAR LIQUIDS AT THIS TIME. PT DROWSY FROM PAIN MEDS BUT INTERESTED IN LEARNING, LOOKING AT STOMA. SPOUSE, ELIZABETH, IN ROOM AND VERY INVOLVED IN CARE. REVIEWED GENERAL INFORMATION, CARE. DEMONSTRATED HOW TO USE MOLDABLE WAFER, HOW TO OPERATE CLAMP AND EMPTY POUCHING SYSTEM. BOTH ABLE TO RETURN DEMO. SETTING UP PT WITH CONVATEC CONCIERGE SERVICE AND WILL SET UP SUPPLIES WITH BYRUM HEALTHCARE. PT WILL PROBABLY NOT NEED HOME HEALTH SERVICES BUT DID DISCUSS THE POSSIBILITY. PLAN TO MEET ELIZABETH IN THE ROOM 0745 TOMORROW TO DO A POUCHING SYSTEM CHANGE. WILL REQUEST DIETICIAN TO TEACH ABOUT ILEOSTOMY DIET.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 1546

Patient Notes: Nursing Notes
- Create 05/17/16 1546 KK 05/17/16 1547 KK
Abnormal? N Confidential? N
WOCN INTO SEE PATIENT TO DO ILIOSTOMY TEACHING FOR PATIENT AND WIFE, VERBALIZES UNDERSTANDING. NEW ORDERS RECEIVED FOR DIETARY CONSULT.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/17/16 Time: 1600

Patient Notes: Wound Care Note
- Create 05/17/16 1600 KM 05/18/16 1633 KM
Abnormal? N Confidential? N
DUE TO PT'S FREQUENT LIQUID EFFLUENT AND NEEDING FREQUENT NEARLY Q 1 HOUR EMPTYING OF POUCHING SYSTEM, PT'S NURSE KATIE AND I DECIDED TO SWITCH HIM TO A SYSTEM WITH A UROSTOMY POUCH TO ATTACH TO BEDSIDE DRAINAGE TO ALLOW HIM SOME TIME TO REST BETWEEN EMPTYING. REMOVED ENTIRE SYSTEM, PERISTOMAL SKIN INTACT, NO S/S IRRITATION. STOMA BRIGHT PINK, MOIST, PROTRUDING ABOUT 1 CM WITH EFFLUENT COMING FROM CENTER. SOME STAPLES/SUTURES VISIBLE. PT'S ABDOMEN TENDER. HE DID VISUALIZE THE STOMA AND ASK IF IT WAS NORMAL LOOKING. REASSURANCE PROVIDED. REAPPLIED 45 MM MOLDABLE DURAHESIVE WAFER WITH UROSTOMY POUCHING SYSTEM TO BEDSIDE DRAINAGE. TOLERATED WELL.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 1613

120000 Critical Care Flowsheet A Q4H CP
- Document 05/17/16 1613 KK 05/17/16 1620 KK
Critical Care Flowsheet Time:

Temperature:
Temperature Source+:
Pulse: 103
Pulse Source+:
Respirations:
SPON:
Vent Resp:
Blood Pressure: 111/80
BP Location+:
BP Position+:
O2 Sat: 89
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 92
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Comment:

Activity Date: 05/17/16 Time: 1615

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/17/16 1615 KK 05/17/16 1615 KK
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate:
High Rate: 103
Change From Baseline:
Notify MD: Check Alarm:

5A4D43B46E10429588C8, KNIGHT, 207

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 1615 (continued)

120009 Telemetry Monitoring - Critical Care (continued)
Comment:
0840 Positioning A Q2H CP
- Document 05/17/16 1615 KK 05/17/16 1615 KK
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/17/16 1615 KK 05/17/16 1615 KK
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

Activity Date: 05/17/16 Time: 1620

800001 Education/Teaching Assessment A 04,16 CP
- Document 05/17/16 1620 KK 05/17/16 1621 KK
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
diet, physician follow-up, medications, what to do if Comment
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
Comment: Comment:

EDUCATION/INTERVENTION: DISCUSSED POC, VBERALIZES UNDERSTANDING

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 1620 (continued)

800001 Education/Teaching Assessment (continued)

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/17/16 Time: 1705

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/17/16 1705 KK 05/17/16 1707 KK
INTAKE

PO: 575 IV FLUIDS: Y PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention Foley Irrigation (CBI):
to document IV/Blood fluids. Dialysis (Intake):
OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: 1250 Bowel Incont Episodes: T Tube: Ileostomy: 1325
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: 20 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Dng (Output):
Comment:
- Edit Results 05/17/16 1705 KK 05/17/16 1737 KK
PO: 1075 [575]

Activity Date: 05/17/16 Time: 1708

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/17/16 1708 KK 05/17/16 1710 KK
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): LR IV Fluids (A): 450
Medication (B): ABX IV Fluids (B): 106
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):

5A4D43B46E10429588C8, KNIGHT, 208

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 1708 (continued)

1200041 IV Pump Totals - Critical Care (continued)

Medication (F): IV Fluids (F):

Medication (G): IV Fluids (G):

Medication (H): IV Fluids (H):

PUMP TOTAL 556 cc

Activity Date: 05/17/16 Time: 1711

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/17/16 1711 KK 05/17/16 1719 KK
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N

K/MG Protocol: NO
Last K: 3.9 Covered: NO Blood Pressure: 111/80
Last MG: NOT DONE Covered: Temperature: 98.2

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm

Mental Status: Alert & Oriented

Respirations: 19 VENTILATOR DOCUMENTATION:
O2 Sat: 92 Vent type:
%/L of O2: 40 Tidal Volume Vent Set Rate:
O2 Mode+: VENI-MASK Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score
cm @ TOF

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 1711 (continued)

125 CRITICAL CARE REPORT (continued)
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:
COMMENT:

Tubes+: NG Tube Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+: 16
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd:

Abd Appearance+: Last BM: 05/17/16

Tube Feeding Type: CC/HR: FREE H20 FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60 ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C 545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILUADID IV X1 DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES. PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT 20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED. O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.

Pulm Art Cath: Zeroed: CVP Line: Zeroed:
Location: Location:
Secured at cm Dressing:
Dressing: Appearance:
Appearance: Phlebostatic Axis Marked:

5A4D43B46E10429588C8, KNIGHT, 209

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 1711 (continued)

125 CRITICAL CARE REPORT (continued)
Phlebostatic Axis Marked: Waveform:
Waveform: Date Flush Change:
Date Flush Change: Date Tubing Change:
Date Tubing Change:

A-Line: IABP: Zeroed: Phlebostatic Axis Marked:
Location: Waveform:
Dressing: Date Flush Change:
Appearance: Date Tubing Change:

Comment: NA

IV Site #1: RIGHT FOREARM — IV Site #3:
Site Appear #1: NORMAL — Site Appear #3:
Type of Cath #1: Jelco — Type of Cath #3:
Cath Gauge #1: 18 — Cath Gauge #3:
Fluid/Rate #1: SL — Fluid/Rate #3:
Date Insert/DC #1: 05/15/16 — Date Insert/DC #3:
IV #1 Comment: WNL — IV #3 Comment:

IV Site #2: LEFT FOREARM — IV Site #4:
Site Appear #2: NORMAL — Site Appear #4:
Type of Cath #2: Jelco — Type of Cath #4:
Cath Gauge #2: 18 — Cath Gauge #4:
Fluid/Rate #2: SL — Fluid/Rate #4:
Date Insert/DC #2: 05/15/16 — Date Insert/DC #4:
IV #2 Comment: WNL — IV #4 Comment:

- Edit Results 05/17/16 1711 KK 05/17/16 1815 KK
%/L of O2: 50 [40]

Activity Date: 05/17/16 Time: 1737

120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/17/16 1737 KK 05/17/16 1739 KK
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >91% : PM PARTIALLY MET

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 1737 (continued)

120003 Goals/Outcomes - Critical Care (continued)
COMMENT: 1. PT'S O2 WEANED TO 45% VENTI-MASK TO MAINTAIN SATS >92%
525003 IV Site Check A 06,18 CP
- Document 05/17/16 1737 KK 05/17/16 1739 KK
IV Site WNL: Y If No:

Comment: PIV X2

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/17/16 1737 KK 05/17/16 1739 KK

Activity Date: 05/17/16 Time: 1739

0840 Positioning A Q2H CP
- Document 05/17/16 1739 KK 05/17/16 1739 KK
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/17/16 1739 KK 05/17/16 1740 KK
Diet Ordered: CLEAR LIQUIDS
Meal: DINNER
% Diet Taken: 0% - 25% (POOR)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:

Activity Date: 05/17/16 Time: 1741

09 RESP THERAPY - TREATMENT A AD PS
- Create 05/17/16 1741 SE 05/17/16 1741 SE
- Document 05/17/16 1741 SE 05/17/16 1742 SE
RESPIRATORY THERAPY TREATMENT

%/L of O2: 45 LPM 10 NC O2 Sat: 90 FIO2 VM Y PRB NRB
O2 24 hrs Y CPO in use BIPAP I: E: RATE:
R/A NPPV

5A4D43B46E10429588C8, KNIGHT, 210

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 1741 (continued)

09 RESP THERAPY - TREATMENT (continued)

Hand Held Nebulizer Install
Neb Induced Sputum
HHN Sub
Demo and Eval

MDI Install
MDI Subsequent
MDI Additional Tx:

Incentive Install
Pt Instructed
Pt Achieves ml
Pt Understands/will use on own
Pt unable to comprehend or perform TX
Nurse Notified Nurse will follow-up

Metaneb/IPPB Install
Metaneb/IPPB Sub

Continous Neb 1st Hour
Continous Neb Sub

Pulse Ox Single
Pulse Ox over-noc
Pulse Ox Continuous

CPT Initial
CPT Subsequent
CPT w/Bed:
Oscillating PEP
NT Suction

MODE: M/P Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List MDI Medication List

Medication stable, not discolored, not expired

PRE ASSESSMENT: Pre-Assessment HR: Pre-Assessment RR:

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: Post-Assessment RR:

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Adverse Reactions:
Comment:

COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood

Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment PT SATS 86-88% ON 6LM NC/CHANGED TO 45% VENTRI MAS
<Esc> K

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 1741 (continued)

09 RESP THERAPY - TREATMENT (continued)

Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend
Reinforcement Needed Y

Activity Date: 05/17/16 Time: 1834

Patient Notes: Nursing Notes
- Create 05/17/16 1834 KK 05/17/16 1848 KK
Abnormal? N Confidential? N
PATIENT REPOSITIONED BACK INTO BED. PATIENT HAD A POOR INTAKE FOR DINNER. DENIES NAUSEA. PATIENT C/O PAIN, MEDICATED PRN PER ORDERS. RELIEF NOTED. PATIENT TURNED AND REPOSITIONED AT INTERVALS FOR COMFORT. PATIENTS O2 WEANED TO 50% VENT-MASK TO MAINTAIN SATS >92%. DR SANTIAGO PAGED X3 TO NOTIFY. NOTIFIED OF PATIENTS IS PULL 500-750 THIS SHIFT. SHALLOW RESPIRATORY NOTED. PATIENT NOT WANTING TO USE SPLINTING AND TCDB. NO EFFORT NOTED. ALSO NOTIFIED OF PATIENTS HR AND BP AFTER MEDICATED PRN PER ORDERS FOR PAIN SR/ST 99/100. 111/80. NEW ORDERS RECEIVED. RESPIRATORY THERAPIST AWARE. NO OTHER NEEDS VOICED AT THIS TIME. SAFETY MAINTAINED. SEE EMR AND MAR FOR FURTHER DETAILS. REPORT TO BE GIVEN TO ONCOMING RN TO RESUME PLAN OF CARE.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 1856

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/17/16 1856 KK 05/17/16 1856 KK
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From RAFIKE/KATIE

Comment

Activity Date: 05/17/16 Time: 1900

5500011 Purposeful Rounding A CP
- Document 05/17/16 1900 NW 05/17/16 2126 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:

5A4D43B46E1042958C8, KNIGHT, 211

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 1900 (continued)

5500011 Purposeful Rounding (continued)
<Esc>

Activity Date: 05/17/16 Time: 1916

Problem: RT - BRONCHOSPASM/INADEQUATE VENTILATION A
- Create 05/17/16 1916 JF7 05/17/16 1916 JF7
Outcome: ADEQUATE VENTILATION A
- Create 05/17/16 1916 JF7 05/17/16 1916 JF7
016 RESP THERAPY - EQUIPMENT CHANGE OUT A QD@1130 CP
- Create 05/17/16 1916 JF7 05/17/16 1916 JF7
08 RESP THERAPY - PATIENT EVALUATION A Q72H@0800 CP
- Create 05/17/16 1916 JF7 05/17/16 1916 JF7
09 RESP THERAPY - TREATMENT A AD CP
- Create 05/17/16 1916 JF7 05/17/16 1916 JF7
- Document 05/17/16 1916 JF7 05/17/16 1917 JF7
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM 10 NC O2 Sat: 93 FIO2 VM Y PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Y Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/F Mask Y Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 102 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 101 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 1916 (continued)

09 RESP THERAPY - TREATMENT (continued)
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/17/16 Time: 2000

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/17/16 2000 RM 05/18/16 0204 RM
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate: 110
High Rate: 100
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/17/16 2000 RM 05/18/16 0111 RM
120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/17/16 2000 RM 05/18/16 0203 RM
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils ***Strength Of Extremities***
Size Right+: 3mm RUE+: WNL
Rt Reaction To Light+: Reactive LUE+: WNL

5A4D43B46E10429588C8, KNIGHT, 212

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency Documented Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Size Left+: 3mm
Lt Reaction To Light+: Reactive

Behavior+: Calm/Cooperative

Speech/Cry+: Clear

Responsive To+: Spontaneous

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Response***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: S1,S2 Transvenous Pacemaker: Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency Documented Comment	Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Site:

Vision Impairment:
Hearing Impairment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal	Radial Rt+: Normal
Dorsalis Rt+: Normal	Radial Lt+: Normal
Post Tib Lt+: Normal	Femoral Rt+:
Post Tib Rt+: Normal	Femoral Lt+:
Carotid Rt+:	Cap Refill RUE+: Brisk
Carotid Lt+:	Cap Refill LUE+: Brisk
Brachial Rt+:	Cap Refill RLE+: Brisk
Brachial Lt+:	Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 20 O2 Sat: 94 %/L of O2: 50 Cyanosis: N Pallor: N

O2 Mode+: VENI-MASK
RR Description+: Tachypnea
Resp Pattern+: Rapid
Chest Expansions+: Symmetrical
Cough+: Non-effective
Sputum Amount+: None
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

Breath Sounds

LUL+: Diminished
LLL+: Diminished
RUL+: Diminished
RML+: Diminished
RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation
Weaning Parameter Completed RT

5A4D43B46E1042958C8, KNIGHT, 213

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

120001 SKIFT ASSESSMENT-Critical Care (continued)

Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull:

Comment
MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

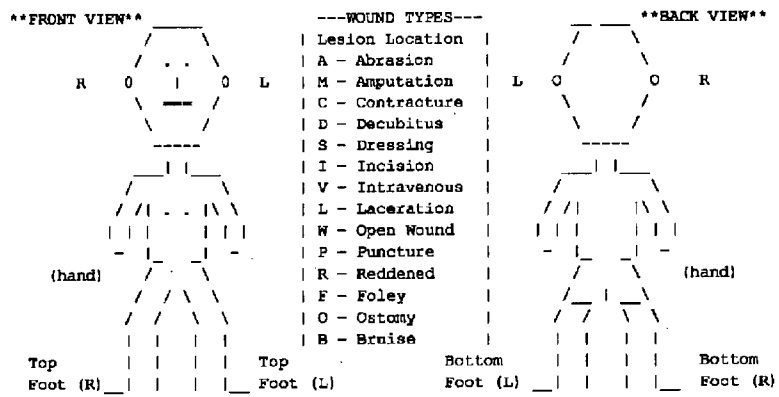
ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>: GENRALIZED WEAKNESS NOTED



Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

120001 SKIFT ASSESSMENT-Critical Care (continued)
(toes) | | | | | | | | (toes)

COMMENT:
Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed:
Decubiti:
Location/Size<Esc>:

Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains:

Skin Comment <Esc>: PT HAS MID LINE ABD INCISION THAT IS DRY AND INTACT. PT HAS JP DRAIN ON THE LT SIDE AND ILIOSTOMY ON THE RT SIDE. NO SIGNS OF INFECTION NOTED AROUND THE STOMA
Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast: 2	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

5A4D43B46E10429588C8, KNIGHT, 214

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Nausea: N Constipation: N Last BM: 05/17/16 Incontinent Stool:
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness MIDDLE Tubes+:
Abd Appearance+: SOFT Tube Drainage: Tube To Suction:
DISTENDED OGT/NGT is secured at cm
RUQ+: HYPOACTIVE Stoma Present: Y Location: RT ABD
LUQ+: HYPOACTIVE Appearance: PINK
RLQ+: HYPOACTIVE Ostomy Appliance: Y
LLQ+: HYPOACTIVE Drainage Characteristics: CLOUDY GRAY
GI Comment <Esc>: ILIOSTOMY NOTED TO RT ABD, WAFFER C/D/I. GRAY LIQUID STOOL DRAINING INTO COLLECTION BAG. PT IS NOT PASSING GAS. Rectal Tube: N
Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems:
Urine Odor+: Normal
Character+: CLEAR ***Dialysis***
Incontinent Bladder: CAPD: Peritoneal Dialysis:
Suprapubic Catheter: Hemodialysis:
Urostomy: Hemo Site Description+:
Stoma Appearance Last Dialysis Treatment:

GU Comment <Esc>: FOLEY CATHETER INTACT AND DRAINING TO GRAVITY.

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: SEE NURSES NOTES

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPALINED AS PROVIDED
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/17/16 2000 RM 05/18/16 0204 RM
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/17/16 2000 RM 05/18/16 0204 RM
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT FOREARM IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Jelco Type of Cath #3:
Cath Gauge #1: 18 Cath Gauge #3:
Fluid/Rate #1: SL Fluid/Rate #3:
Date Insert/DC #1: 05/15/16 Date Insert/DC #3:
IV #1 Comment: WNL IV #3 Comment:
<Esc> <Esc>

IV Site #2: LEFT FOREARM IV Site #4:
Site Appear #2: NORMAL Site Appear #4:
Type of Cath #2: Jelco Type of Cath #4:
Cath Gauge #2: 18 Cath Gauge #4:
Fluid/Rate #2: SL Fluid/Rate #4:
Date Insert/DC #2: 05/15/16 Date Insert/DC #4:
IV #2 Comment: WNL IV #4 Comment:
<Esc> <Esc>

5500011 Purposeful Rounding A CP
- Document 05/17/16 2000 NW 05/17/16 2126 NW
Pain
Potty
Position

5A4D43B46E1042958BC8, KNIGHT, 215

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

5500011 Purposeful Rounding (continued)
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/17/16 2000 RM 05/18/16 0141 RM
Type of Isolation: NONE Tissue Test:

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/17/16 2000 RM 05/18/16 0141 RM
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

7370 Discharge Planning Assessment A QS CP
- Document 05/17/16 2000 RM 05/18/16 0141 RM
----------DISCHARGE PLANNING ASSESSMENT----------

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY EDUCATION

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/16/16

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

7370 Discharge Planning Assessment (continued)
Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL CONTINUE TO ASSESS NEEDS.

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/17/16 2000 RM 05/18/16 0142 RM

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs 1

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 13

*****Interventions*****

Bed Wheels Locked Y	Fall assessment completed Y
Bed in Low Position Y	Patient needs Assessed q2hr Y
Call Light within reach Y	Environment Assessed Fall Risk Y
	Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y HIGH RISK (>14) RED Sign on door/chart

5A4D43B46E10429588C8, KNIGHT, 216

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Assess q2hr 7A-7P		Remain W/patient whenever OOB	
Assess q1hr 7P-7A	Y	If OOB to chair, q30min monitoring	
Frequent Re-orientation	Y	Assess q1hr 7A-7P	
Reinforce Call Light use	Y	Assess q1hr 7P-7A	
Bed/Chair Alarm in use	Y	Reinforce Call Light Use	
Friction Footwear when OOB	Y	Frequent Re-orientation	
In Rm when pt OOB to BSC, BR, Shower,etc.	Y	Bed/Chair Alarm in Use	
		Friction Footwear when OOB	
		In Room when Pt OOB to BSC, BR, Shower, etc.	

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/17/16 2000 RM 05/18/16 0137 RM

Temperature:	98.7	
Temperature Source+:	Tympanic	(May use most recent
Pulse:	101	VITAL SIGNS taken
Respirations:	20	if they are WNL and
Blood Pressure:	111/80	no greater then 3hrs)
MAP:	85	
Mental Status:	Alert & Oriented	
Clinical Suspicion of Infection?	N	
Sepsis Criteria Count:	2	
Sepsis Result:	Possible Sepsis Risk	
Physician Notified:	N	
If NO, Reason:	Physician Already Aware	

Patient Notes: Nursing Notes
- Create 05/17/16 2000 RM 05/18/16 0014 RM
Abnormal? N Confidential? N
REPORT GIVEN. ASSESSMENY COMPLETE. SEE SHIFT ASESSMENT. PT IS AOX3. PT COMAPLAINED OF PAIN 5/10 IN HIS ABDOMEN. HE STATED THAT HE WOULD LIKE HIS PAIN MEDICINE AROUND 2100 WITH HIS NOGHT MEDS. NO OTHER SIGNS OF DISTRESS NOTED. WILL CONTIUE TO MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 2013

120000 Critical Care Flowsheet A Q4H CP
- Document 05/17/16 2013 RM 05/18/16 0113 RM
Critical Care Flowsheet Time:

Temperature: 98.7
Temperature Source+: Tympanic
Nursing Note:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/17/16 Time: 2013 (continued)

120000 Critical Care Flowsheet (continued)

Pulse:	106	PCWP:	Glycemic Protocol:
Pulse Source+:	MONITOR	CVP:	Fingerstick BS:
Respirations:		MPA:	Frequency:
SPON:		PAP:	
Vent Resp:		CO:	Cooling Blanket:
Blood Pressure:	111/80	CI:	Warming Blanket:
BP Location+:	L Arm	SVR:	
BP Position+:	SEMI-FOWLER'S	PVR:	Foley: ml
O2 Sat:	92	Calibrate:	Void (ml): ml
%/L of O2:			
ETCO2:		Transvenous Pacer Setting:	V Output mA Set Rate:
A-LINE BP:			Secured at cm
MAP:	85		
Intra-Abd Pressure:		Weight (lbs):	(Oz): kg:
		Weight Source:	

Comment:

Activity Date: 05/17/16 Time: 2100

Patient Notes: Nursing Notes
- Create 05/17/16 2100 RM 05/17/16 2231 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 7/10, DILAUDID IV GIVEN. SEE EMAR.
Note Type Description
No Type None

Activity Date: 05/17/16 Time: 2109

5500011 Purposeful Rounding A CP
- Document 05/17/16 2109 NW 05/17/16 2126 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/17/16 Time: 2157

Problem: RT - INADEQUATE VENTILATION/OXYGENATION A
- Create 05/17/16 2157 JW2 05/17/16 2157 JW2
Outcome: ADEQUATE VENTILATION C
- Create 05/17/16 2157 JW2 05/17/16 2157 JW2

5A4D43B46E1042958C8, KNIGHT, 217

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/17/16		**Time: 2157**								
012 RESP THERAPY - NON-INVASIVE VENTILATION							A	AD		CP
- Create	05/17/16	2157	JW2	05/17/16	2157	JW2				
016 RESP THERAPY - EQUIPMENT CHANGE OUT							A	QD@1130		CP
- Create	05/17/16	2157	JW2	05/17/16	2157	JW2				
08 RESP THERAPY - PATIENT EVALUATION							A	Q72H@0800		CP
- Create	05/17/16	2157	JW2	05/17/16	2157	JW2				
09 RESP THERAPY - TREATMENT							A	AD		CP
- Create	05/17/16	2157	JW2	05/17/16	2157	JW2				
Activity Date: 05/17/16		**Time: 2158**								
Problem: RT - BRONCHOSPASM/INADEQUATE VENTILATION							C			
- Ed Status	05/17/16	2158	JW2	05/17/16	2158	JW2				A => C
Outcome: ADEQUATE VENTILATION							C			
- Ed Status	05/17/16	2158	JW2	05/17/16	2158	JW2				A => C
016 RESP THERAPY - EQUIPMENT CHANGE OUT							C	QD@1130		CP
- Ed Status	05/17/16	2158	JW2	05/17/16	2158	JW2				A => C
08 RESP THERAPY - PATIENT EVALUATION							C	Q72H@0800		CP
- Ed Status	05/17/16	2158	JW2	05/17/16	2158	JW2				A => C
09 RESP THERAPY - TREATMENT							C	AD		CP
- Ed Status	05/17/16	2158	JW2	05/17/16	2158	JW2				A => C
012 RESP THERAPY - NON-INVASIVE VENTILATION							A	AD		CP
- Document	05/17/16	2158	JW2	05/17/16	2159	JW2				
NON-INVASIVE VENTILATION										

Time: 2158 Number: 38 Ventilator: N
IPAP: 12 EPAP: 6
PS: Mode: BIPAP SP ALARMS Apnea:
Set Rate/Back up: Low VE:
FiO2/LPM: 10 High RR:
Low Pressure:

PATIENT DATA
Blood Pressure: Pulse: 105 Respirations: 18 O2 Sat: 93
Sensitivity: VT: VE: I Time:

Breath Sounds: DIM

Mask Size: MED Mask Type: FULL

Skin Integrity (of mask area): INTACT

Action Taken: PLACED PT ON BIPAP

CHARGES
BiPAP with RR Install:
BiPAP with RR Day:
BiPAP with out Rate Install: Y
BiPAP with out Rate Day:

Activity Date: 05/17/16		**Time: 2200**								
0840 Positioning							A	Q2H		CP
- Document	05/17/16	2200	RM	05/18/16	0204	RM				
5500011 Purposeful Rounding							A			CP
- Document	05/17/16	2200	NW	05/18/16	0522	NW				
Pain										
Potty										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/17/16		**Time: 2200 (continued)**								
5500011 Purposeful Rounding (continued)										CP
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										

Purposeful Rounding complete: Y ,

Comment:
<Esc>

Activity Date: 05/17/16		**Time: 2230**								
Patient Notes: Nursing Notes										A => C
- Create	05/17/16	2230	RM	05/18/16	0018	RM				
Abnormal? N Confidential? N										
PT COMPLAINED OF ABDOMINAL PAIN 7/10. VICODEN PO GIVEN, SEE EMAR. WILL CONTIUE										
TO MONITOR PT.										
Note Type Description										
No Type None										
Activity Date: 05/17/16		**Time: 2300**								
5500011 Purposeful Rounding							A			CP
- Document	05/17/16	2300	NW	05/18/16	0522	NW				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/18/16		**Time: 0000**								
120009 Telemetry Monitoring - Critical Care							A	Q4H		CP
- Document	05/18/16	0000	RM	05/18/16	0205	RM				
Telemetry Rhythm: SINUS TACHYCARDIA										

Low Rate: 110
High Rate: 100
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:

5A4D43B46E10429588C8, KNIGHT, 218

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/18/16 Time: 0000										
0840 Positioning							A	Q2H		CP
- Document	05/18/16	0000	RM	05/18/16	0205	RM				
Patient Notes: Nursing Notes										
- Create	05/18/16	0000	RM	05/18/16	0019	RM				
Abnormal? N Confidential? N										
PT COMPLAINED OF ABDOMINAL PAIN 5/10, DILAUDID IV GIVEN. SEE EMAR. WILL CONTIUE TO MONITOR PT.										
Note Type Description										
No Type None										
Activity Date: 05/18/16 Time: 0013										
120000 Critical Care Flowsheet							A	Q4H		CP
- Document	05/18/16	0013	RM	05/18/16	0205	RM				
Critical Care Flowsheet Time:										
Temperature: 98.8								Nursing Note:		
Temperature Source+: Tympanic										
Pulse: 101								PCWP:		Glycemic Protocol:
Pulse Source+: MONITOR								CVP:		Fingerstick BS:
Respirations:								MPA:		Frequency:
SPON:								PAP:		
Vent Resp:								CO:		Cooling Blanket:
Blood Pressure: 108/81								CI:		Warming Blanket:
BP Location+: L Arm								SVR:		
BP Position+: SEMI-FOWLER'S								PVR:		Foley: ml
O2 Sat: 94								Calibrate:		Void (ml): ml
%/L of O2:										
ETCO2:								Transvenous Pacer Setting: V Output	mA	Set Rate:
A-LINE BP:								Secured at	cm	
MAP: 90										
Intra-Abd Pressure:								Weight (lbs):	(Oz):	kg:
								Weight Source:		
Comment:										
Activity Date: 05/18/16 Time: 0021										
012 RESP THERAPY - NON-INVASIVE VENTILATION							A	AD		CP
- Document	05/18/16	0021	JW2	05/18/16	0021	JW2				
NON-INVASIVE VENTILATION										
Time: 0021 Number: 38 Ventilator: N										
IPAP: 12 EPAP: 6										
PS: Mode: BIPAP SP ALARMS Apnea:										
Set Rate/Back up: Low VE:										
FiO2/LPM: 10 High RR:										
Low Pressure:										
PATIENT DATA										
Blood Pressure: Pulse: 86 Respirations: 18 O2 Sat: 92										
Sensitivity: VT: VE: I Time:										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/18/16 Time: 0021 (continued)										
012 RESP THERAPY - NON-INVASIVE VENTILATION (continued)										
Breath Sounds:										
										CHARGES
Mask Size: Mask Type:										BiPAP with RR Install:
										BiPAP with RR Day:
Skin Integrity (of mask area):										BiPAP with out Rate Install:
										BiPAP with out Rate Day: Y
Action Taken:										
- Edit Results 05/18/16 0021 JW2 05/18/16 0022 JW2										
Pulse: 101 [86]										
O2 Sat: 94 [92]										
Activity Date: 05/18/16 Time: 0100										
5500011 Purposeful Rounding							A			CP
- Document	05/18/16	0100	NW	05/18/16	0522	NW				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment:										
<Esc>										
Activity Date: 05/18/16 Time: 0200										
0840 Positioning							A	Q2H		CP
- Document	05/18/16	0200	RM	05/18/16	0206	RM				
6409 FALLS SCREEN - FOLLOW-UP							A	02,14		CP
- Document	05/18/16	0200	RM	05/18/16	0206	RM				
FALL SCREEN FOLLOW-UP										
Recent Fall: N (Falls since last FALL ASSESSMENT)										
Condition Changed: N										
Change in Meds: N										
FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!										

5A4D43B46E1042958C8, KNIGHT, 219

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?
Patient Notes: Nursing Notes
- Create 05/18/16 0200 RM 05/18/16 0207 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CAHNGE IN CONDITION NOTED AT THIS TIME.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 0300

5500011 Purposeful Rounding A CP
- Document 05/18/16 0300 NW 05/18/16 0522 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Parsonal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/18/16 Time: 0314

012 RESP THERAPY - NON-INVASIVE VENTILATION A AD CP
- Document 05/18/16 0314 JW2 05/18/16 0316 JW2
NON-INVASIVE VENTILATION

Time: 0314 Number: 38 Ventilator: N
IPAP: 12 EPAP: 6
PS: Mode: BIPAP SP ALARMS Apnea:
Set Rate/Back up: Low VE:
FiO2/LPM: 10 High RR:
Low Pressure:
PATIENT DATA
Blood Pressure: Pulse: 101 Respirations: 21 O2 Sat: 90

5A4D43B46E10429588C8, KNIGHT, 220

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0314 (continued)

012 RESP THERAPY - NON-INVASIVE VENTILATION (continued)
Sensitivity: VT: VE: I Time:

Breath Sounds:

Mask Size: Mask Type:

Skin Integrity (of mask area):

Action Taken:

CHARGES
BiPAP with RR Install:
BiPAP with RR Day:
BiPAP with out Rate Install:
BiPAP with out Rate Day:

Activity Date: 05/18/16 Time: 0400

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/18/16 0400 RM 05/18/16 0536 RM
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate: 110
High Rate: 100
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/18/16 0400 RM 05/18/16 0515 RM
120000 Critical Care Flowsheet A Q4H CP
- Document 05/18/16 0400 RM 05/18/16 0536 RM
Critical Care Flowsheet Time: 0400

Temperature: 98.6
Temperature Source+: Tympanic
Pulse: 106
Pulse Source+: MONITOR
Respirations: 22
SPON:
Vent Resp:
Blood Pressure: 112/77
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 90
%/L of O2: 50
ETCO2:
A-LINE BP:
MAP: 87
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Comment:
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/18/16 0400 RM 05/18/16 0535 RM
TED Hose - removed for skin assessment and reapplied. NA

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0400 (continued)

3592 TED/HEEL PROTECTORS/IPC Skin Assessment (continued)
IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/18/16 0400 RM 05/18/16 0536 RM
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
Comment:

Material Codes: VERBAL
Comment:

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:
New Surgical Flap or Graft: N Date of Surgery: 05/15/16

5A4D43B46E10429588C8, KNIGHT, 221

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0400

Patient Notes: Nursing Notes
- Create 05/18/16 0400 RM 05/18/16 0407 RM
Abnormal? N Confidential? N
PT COMPLAINED OF PAIN 5/10, DILAUDID IV GIVEN. SEE EMAR.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 0500

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/18/16 0500 RM 05/18/16 0538 RM
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): ABX IV Fluids (A): 50
Medication (B): IV Fluids (B):
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 50 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/18/16 0500 RM 05/18/16 0537 RM
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:
STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)
K/MG Protocol: NO
Last K: Covered: Blood Pressure: 112/77
Last MG: Covered: Temperature: 98.6

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm
Mental Status: Alert & Oriented

Respirations: 22 VENTILATOR DOCUMENTATION:
O2 Sat: 90 Vent type:
%/L of O2: 50 Tidal Volume Vent Set Rate:
O2 Mode+: VENI-MASK Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:
COMMENT:

Tubes+: NG Tube Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+: 16
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd:

Abd Appearance+: Last BM: 05/18/16

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN

5A4D43B46E10429588C8, KNIGHT, 222

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60 ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C 545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILUADID IV X1 DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES. PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT 20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED. O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:

Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment: NA

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: SL
Date Insert/DC #1: 05/15/16
IV #1 Comment: WNL

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment: WNL

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/18/16 0500 RM 05/18/16 0538 RM
INTAKE

PO: 500 IV FLUIDS: PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI):
Dialysis (Intake):
OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: 1200 Bowel Incont Episodes: T Tube: Ileostomy: 2075
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Drg (Output):

Comment:

Activity Date: 05/18/16 Time: 0507

Patient Notes: Nursing Notes
- Create 05/18/16 0507 RM 05/18/16 0508 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABD PAIN 4/10. PT REQUESTED 2 TAB OF VOCODAN SEE EMAR.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 0519

5500011 Purposeful Rounding A CP
- Document 05/18/16 0519 NW 05/18/16 0522 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E1042958BC8, KNIGHT, 223

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/18/16 Time: 0538

150011 Weight, Monitor Daily A DAILY@0600 CP
- Document 05/18/16 0538 RM 05/18/16 0539 RM
Weight (lbs): 180
(Oz): 6
kg: 81.817
Weight Source: Bedscale

Activity Date: 05/18/16 Time: 0557

Patient Notes: Respiratory Therapy Notes
- Create 05/18/16 0557 JW2 05/18/16 0557 JW2
Abnormal? N Confidential? N
PT ON BIPAP THROUGH NIGHT 12/6 WITH 15LPM BLEED IN.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 0600

0840 Positioning A Q2H CP
- Document 05/18/16 0600 RM 05/18/16 0612 RM
120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/18/16 0600 RM 05/18/16 0612 RM
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >90% : PM PARTIALLY MET

COMMENT:
525003 IV Site Check A 06,18 CP
- Document 05/18/16 0600 RM 05/18/16 0613 RM
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/18/16 Time: 0600 (continued)

525003 IV Site Check (continued)
Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/18/16 0600 RM 05/18/16 0613 RM
5500011 Purposeful Rounding A CP
- Document 05/18/16 0600 NW 05/18/16 0724 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
Patient Notes: Nursing Notes
- Create 05/18/16 0600 RM 05/18/16 0621 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED ATTHIS TIME.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 0700

5500011 Purposeful Rounding A CP
- Document 05/18/16 0700 JM 05/18/16 0813 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
- Document 05/18/16 0700 JM 05/18/16 1244 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

5A4D43B46E10429588C8, KNIGHT, 224

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/18/16 Time: 0700 (continued)

5500011 Purposeful Rounding (continued)
Comment:
<Esc>

Activity Date: 05/18/16 Time: 0717

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/18/16 0717 ST 05/18/16 0717 ST
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From SUSIE / RAFIK

Comment

Activity Date: 05/18/16 Time: 0718

275051 VTE Prophylaxis Orders Complete? A PRN CP
- Ed Directs 05/18/16 0718 ST 05/18/16 0718 ST 05/15 1108 08,20 => 05/15 1108 08,20
05/18 0718 PRN
6955 Anticoagulant Educ Materials Provided A PRN CP
- Ed Directs 05/18/16 0718 ST 05/18/16 0718 ST 05/15 1108 QS -> 05/15 1108 QS
05/18 0718 PRN

Activity Date: 05/18/16 Time: 0723

5500011 Purposeful Rounding A CP
- Document 05/18/16 0723 NW 05/18/16 0724 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/18/16 Time: 0734

012 RESP THERAPY - NON-INVASIVE VENTILATION A AD CP
- Document 05/18/16 0734 SE 05/18/16 0734 SE
NON-INVASIVE VENTILATION

Time: 0734 Number: 38 Ventilator: N
IPAP: EPAP:
PS: Mode: ALARMS Apnea:
Set Rate/Back up: Low VE:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/18/16 Time: 0734 (continued)

012 RESP THERAPY - NON-INVASIVE VENTILATION (continued)
FiO2/LPM: High RR:
Low Pressure:
PATIENT DATA
Blood Pressure: Pulse: Respirations: O2 Sat:
Sensitivity: VT: VE: I Time:
Breath Sounds:

CHARGES
Mask Size: Mask Type: BiPAP with RR Install:
BiPAP with RR Day:
Skin Integrity (of mask area): BiPAP with out Rate Install:
BiPAP with out Rate Day:
Action Taken: PT ON 50% VM.

Activity Date: 05/18/16 Time: 0735

09 RESP THERAPY - TREATMENT C AD PS
- Ed Status 05/18/16 0735 SE 05/18/16 0735 SE A => C
09 RESP THERAPY - TREATMENT A AD CP
- Document 05/18/16 0735 SE 05/18/16 0736 SE
RESPIRATORY THERAPY TREATMENT

%/L of O2: 50 LPM 12 NC O2 Sat: 91 FIO2 VM Y PRB NRB
O2 24 hrs Y CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Y Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 103 Pre-Assessment RR: 38

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Y Rales Diminished Audible
Comment:

5A4D43B46E1042958C8, KNIGHT, 225

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 0735 (continued)

09 RESP THERAPY - TREATMENT (continued)
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 106 Post-Assessment RR: 26

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Y Rales Diminished Adverse Reactions:
Comment:
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend
Reinforcement Needed Y

Activity Date: 05/18/16 Time: 0800

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/18/16 0800 ST 05/18/16 0824 ST
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate: 100
High Rate: 108
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/18/16 0800 ST 05/18/16 0819 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/18/16 0800 ST 05/18/16 0819 ST
Diet Ordered: CLEAR LIQUIDS
Meal: BREAKFAST
% Diet Taken: >75% (GOOD)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

1160 Nutritional Monitoring (continued)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:
120000 Critical Care Flowsheet A Q4H CP
- Document 05/18/16 0800 ST 05/18/16 0821 ST
Critical Care Flowsheet Time: 0800

Temperature: 97.7
Temperature Source+: Tympanic
Pulse: 106
Pulse Source+: MONITOR
Respirations: 22
SPON:
Vent Resp:
Blood Pressure: 120/73
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 91
%/L of O2: 50
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:
1200008 Oral Care - Critical Care A DAILY CP
- Document 05/18/16 0800 ST 05/18/16 0825 ST
120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/18/16 0800 ST 05/18/16 0824 ST
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupila
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Size Left+: 3mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous

Vision Impairment: GLASSES
Hearing Impairment:

5A4D43B46E1042958C8, KNIGHT, 226

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Mental Status: Alert & Oriented ***Continued On Next Page***

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: 106 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: Normal Transvenous Pacemaker: N Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Dorsalis Lt+:	Normal	Radial Rt+:	Normal
Dorsalis Rt+:	Normal	Radial Lt+:	Normal
Post Tib Lt+:		Femoral Rt+:	
Post Tib Rt+:		Femoral Lt+:	
Carotid Rt+:		Cap Refill RUE+:	Brisk
Carotid Lt+:		Cap Refill LUE+:	Brisk
Brachial Rt+:		Cap Refill RLE+:	Brisk
Brachial Lt+:		Cap Refill LLE+:	Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 22 O2 Sat: 91 %/L of O2: 50 Cyanosis: N Pallor: N

O2 Mode+: VENI-MASK ***Breath Sounds***
RR Description+: Tachypnea LUL+: Diminished
Resp Pattern+: Rapid LLL+: Diminished
Chest Expansions+: Symmetrical
Cough+: Productive RUL+: Diminished
Sputum Amount+: Moderate
Sputum Consistency+: Thick RML+: Diminished
Sputum Color+: Beige
Airway Suctioned+: RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION: VAP BUNDLE:
Vent type: HOB > 30 degrees
Tidal Volume Vent Set Rate: DVT Prophylaxis
Pressure Support Mode PUD Prophylaxis
FiO2 Peep: Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Modified Ramsey Score Subglottic Suction
TOF

Chest Tube: CT Size:
CT Type: Incentive Spirometer Volume pull:
CT Location:
CT Drainage:

5A4D43B46E1042958BC8, KNIGHT, 227

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Comment

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized Paralysis+:

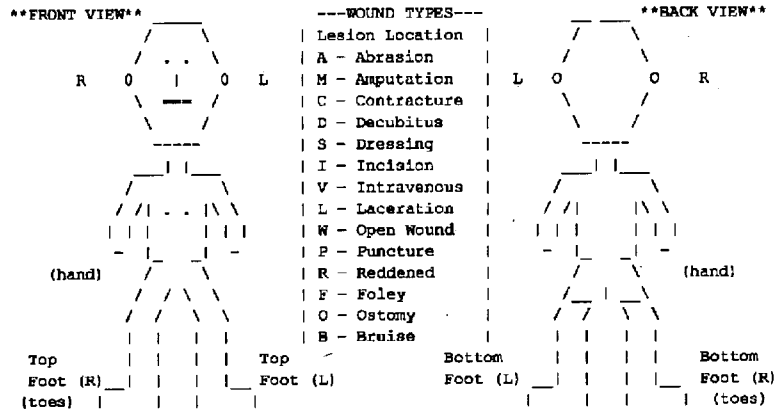
Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI

Musc-Skel Comment <Esc>:



COMMENT:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and turgor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, FOLEY

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast: 2	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N
Emesis: N Diarrhea: N
By C-Diff Protocol - Watery loose stool: N

Last BM: 05/18/16 Incontinent Stool:
Stool Amount+:
Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness
Abd Appearance+: SOFT
DISTENDED
RUQ+: HYPOACTIVE
LUQ+: HYPOACTIVE
RLQ+: HYPOACTIVE
LLQ+: HYPOACTIVE
GI Comment <Esc>:

Tubes+:
Tube Drainage: Tube To Suction:
OGT/NGT is secured at cm
Stoma Present: Y Location: RT ABD
Appearance: PINK
Ostomy Appliance: Y
Drainage Characteristics: CLOUDY GRAY
Rectal Tube:

5A4D43B46E10429588C8, KNIGHT, 228

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y
Currently Menses:
LMP:
Urine Color+: Amber
Prostate Problems:
Urine Odor+: Normal
Character+: CLEAR
Dialysis
Incontinent Bladder:
CAPD: Peritoneal Dialysis:
Suprapubic Catheter:
Hemodialysis:
Urostomy:
Hemo Site Description+:
Stoma Appearance
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: N Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+:
Sleeping Resp:
Respiratory Quality:
Onset/Duration:
Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preferance+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: POC, OSTOMY NURSE TEACHING AT BEDSIDE TO PT AND WIFE
120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/18/16 0800 ST 05/18/16 0851 ST
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE :

Goal #2: SAFETY MAINTAINED :

Goal #3: TITRATE O2 TO KEEP SAO2 >90% :

COMMENT:
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/18/16 0800 ST 05/18/16 0825 ST
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT WRIST	IV Site #3:
Site Appear #1: NORMAL	Site Appear #3:
Type of Cath #1: Jelco	Type of Cath #3:
Cath Gauge #1: 18	Cath Gauge #3:
Fluid/Rate #1: SL	Fluid/Rate #3:
Date Insert/DC #1: 05/15/16	Date Insert/DC #3:
IV #1 Comment: <Esc>	IV #3 Comment: <Esc>
IV Site #2: LEFT FOREARM	IV Site #4:
Site Appear #2: NORMAL	Site Appear #4:
Type of Cath #2: Jelco	Type of Cath #4:
Cath Gauge #2: 18	Cath Gauge #4:
Fluid/Rate #2: SL	Fluid/Rate #4:
Date Insert/DC #2: 05/15/16	Date Insert/DC #4:
IV #2 Comment: <Esc>	IV #4 Comment: <Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/18/16 0800 ST 05/18/16 0819 ST
Type of Isolation: NONE Tissue Test:
6907 PATIENT BATH - Critical Care A DAILY CP
- Document 05/18/16 0800 ST 05/18/16 0819 ST
Hygiene: Assisted Date: 05/18/16

CHG Bath given: Y If no, Reason:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)

5A4D43B46E10429588C8, KNIGHT, 229

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/18/16 Time: 0800 (continued)

6907 PATIENT BATH - Critical Care (continued)
Patient Refused (Bath): Nurse Notified (Bath):

Hygiene Comment:

7370 Discharge Planning Assessment A QS CP
- Document 05/18/16 0800 ST 05/18/16 0819 ST

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NONE AT THIS TIME

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

Do you have questions about insurance or need to speak to a financial counselor? N

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL CONTINUE TO ASSESS NEEDS.

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/18/16 0800 ST 05/18/16 0820 ST

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/18/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 9

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y
Assess q2hr 7A-7P Y
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use Y
Bed/Chair Alarm in use
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower, etc.

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: BED IN LOWEST POSITION AND LOCKED, CALL BELL W/I REACH, PT DOES NOT ATTEMPT TO GET OOB UNASSISTED

5A4D43B46E10429588C8, KNIGHT, 230

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP

- Document 05/18/16 0800 ST 05/18/16 0819 ST

Temperature: 97.7
Temperature Source+: Tympanic (May use most recent
Pulse: 106 VITAL SIGNS taken
Respirations: 22 if they are WNL and
Blood Pressure: 120/73 no greater then 3hrs)
MAP: 90
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 2
Sepsis Result: Possible Sepsis Risk

Physician Notified: N
If NO, Reason: Physician Already Aware

Patient Notes: Nursing Notes

- Create 05/18/16 0800 ST 05/18/16 0857 ST

Abnormal? N Confidential? N
assessment completed, pt resting quietly in high fowlers with ostomy nurse at bedside teaching to pt and wife. o2 sat 88-89% on 50% NRM, pt encouraged to TCDB and use I.S.

Note Type Description
No Type None

Patient Notes: Wound Care Note

- Create 05/18/16 0800 KM 05/18/16 1637 KM

Abnormal? N Confidential? N
MET PT'S SPOUSE AT BEDSIDE THIS AM. HE IS HAVING SOME DIFFICULTY BREATHING, NEEDING O2 MASK. ENC DEEP BREATHING, SPLINTING BELLY. DUE TO HAVING CHANGED APPLIANCE YESTERDAY EVENING WILL NOT REMOVE AT THIS TIME. NO EVIDENCE OF LEAKING. DOES HAVE SMALL BLISTER TO R GROIN, NURSE TO PUT SOME DRY GAUZE THERE TO KEEP SKIN DRY AND ABSORB EXCESS MOISTURE. STOMA VISIBLE THROUGH POUCH, REMAINS PINK, SHINY, PROTRUDES STILL ABOUT 1 CM. DRAINAGE GRAYISH BROWN, MOSTLY LIQUID INTO BEDSIDE DRAINAGE. PROVIDED MORE HANDOUTS FOR PATIENT. REVIEWED HOW TO USE STOMA BELT IF NEEDED ONCE PATIENT MORE MOBILE. REVIEWED HOW TO CARE FOR SKIN, HOW TO APPLY MOLDABLE WAFER. DISCUSSED DIFFERENT POUCHING SYSTEMS (2 VERSUS 1 PIECE) AND I AM ORDERING THEM THE 2 PIECE WITH SAMPLES OF THE ONE PIECE TO BE SENT TO THEM. UTILIZING BYRAM HEALTHCARE FOR THEIR SUPPLIES. ORDER SENT. COPY OF ORDER WITH REORDER NUMBERS PROVIDED TO SPOUSE.

Note Type Description
No Type None

Activity Date: 05/18/16 Time: 0820

Patient Notes: Nursing Notes

- Create 05/18/16 0820 ST 05/18/16 0857 ST

Abnormal? N Confidential? N
pt placed on high flow o2 at 80% with sats 92% at this time.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 0820 (continued)

Patient Notes: Nursing Notes (continued)

Note Type Description
No Type None

Activity Date: 05/18/16 Time: 0828 (continued)

014 RESP THERAPY - OXYHOOD (continued)

- Create 05/18/16 0828 KK* 05/18/16 0828 KK*
- Document 05/18/16 0828 KK* 05/18/16 0828 KK*

OXYHOOD/Hi Flow
Time: 0828
Interface: MED
Set FiO2: 80
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 29.0
Temp in Hood:
Water Level: 1000
Respirations: 22 --Charges--
Pulse: 89 Oxyhood/Hi Flow Install: Y
O2 Sat: 95 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 0900

5500011 Purposeful Rounding A CP

- Document 05/18/16 0900 JM 05/18/16 0931 JM

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

- Document 05/18/16 0900 JM 05/18/16 1244 JM

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E10429588C8, KNIGHT, 231

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 0941

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 0941 SE 05/18/16 0942 SE

OXYHOOD/Hi Flow
Time: 0941
Interface: MED
Set FiO2: 70
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.9
Temp in Hood:
Water Level: 900
Respirations: 24 --Charges--
Pulse: 106 Oxyhood/Hi Flow Install:
O2 Sat: 92 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 0945

Patient Notes: Nursing Notes
- Create 05/18/16 0945 ST 05/18/16 1018 ST
Abnormal? N Confidential? N
Dr Rimkus in to see pt and removed dsg, area c/d/i with good blood supply, no drainage noted. dry dsg applied per verbal order.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 1000

0840 Positioning A Q2H CP
- Document 05/18/16 1000 ST 05/18/16 1000 ST

Activity Date: 05/18/16 Time: 1100

5500011 Purposeful Rounding A CP
- Document 05/18/16 1100 JM 05/18/16 1104 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment: y
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 1102

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/18/16 1102 BE 05/18/16 1109 BE
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM 40 NC O2 Sat: 96 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 100 Pre-Assessment RR: 19

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Y Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 102 Post-Assessment RR: 20

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Y Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

5A4D43B46E1042958BC8, KNIGHT, 232

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 1102 (continued)

09 RESP THERAPY - TREATMENT (continued)
DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/18/16 Time: 1109

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 1109 BE 05/18/16 1111 BE
OXYHOOD/Hi Flow
Time: 1109
Interface:
Set FiO2: 70
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31.0
Temp in Hood:
Water Level: 850
Respirations: 20
Pulse: 108
O2 Sat: 96
--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 1132

Patient Notes: Nursing Notes
- Create 05/18/16 1132 ST 05/18/16 1133 ST
Abnormal? N Confidential? N
pt consult written and in room to see pt, up to recliner with minimal assist and tolerated well.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 1147

016 RESP THERAPY - EQUIPMENT CHANGE OUT A QD@1130 CP
- Document 05/18/16 1147 SE 05/18/16 1147 SE
EQUIPMENT CHANGE OUT

Closed Suction System (PRN) N
HME (24-48HRS) N
Nebs (Every Wed) N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 1147 (continued)

016 RESP THERAPY - EQUIPMENT CHANGE OUT (continued)
O2 Humidifiers (Every Wed) N
NRB (Every Wed) N
Venturi (Every Wed) N

Comment:

Activity Date: 05/18/16 Time: 1200

120000 Critical Care Flowsheet A Q4H CP
- Document 05/18/16 1200 ST 05/18/16 1224 ST
Critical Care Flowsheet Time: 1200

Temperature: 98.0
Temperature Source+: Tympanic
Pulse: 104
Pulse Source+: MONITOR
Respirations: 20
SPON:
Vent Resp:
Blood Pressure: 104/74
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 95
%/L of O2: 80
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/18/16 Time: 1205

10 PT: Intial Evaluation A AS
- Create 05/18/16 1205 CG 05/18/16 1209 CG
- Document 05/18/16 1205 CG 05/18/16 1209 CG
Reason For Visit: INTESTINAL PERFORATION PERITONITIS
Past Medical History: anxiety

Past Surgical History:

Precautions:

Residence: House
Lives Alone: N Number of Stairs: Railing: Ramp

Previous Functional Level: Independent Device:

RUE - Weight Bearing Status: Full Weight Bearing

5A4D43B46E10429588C8, KNIGHT, 233

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/18/16 Time: 1205 (continued)

10 PT: Intial Evaluation (continued)
LUE - Weight Bearing Status: Full Weight Bearing
RLE - Weight Bearing Status: Full Weight Bearing
LLE - Weight Bearing Status: Full Weight Bearing

Comment: Mental Status: Alert-Oriented x 3

OBJECTIVE****

	ROM		MMT	describe if not 5/5
RUE WFL	:		RUE: 3/5	: 3+/5
LUE WFL	:		LUE: 3/5	: "
RLE WFL	:		RLE: 3/5	: "
LLE WFL	:		LLE: 3/5	: "

FUNCTIONAL MOBILITY***
Supine<-->Sit: Minimal of 1
Sit<-->Stand: Minimal of 1 Device:
Bed<-->Chair: Minimal of 1 Device:
Stand-Pivot-Transfer:

Gait Ambulated (ft): Assist: Device:
Gait Ambulated (ft): Assist: Device:
O2 L/min:

Comment: Unable to ambulate patient due to him being on high-flow O2

Coordination: Not Impaired :
Tone: Not Impaired :
Sensation: Not Impaired :

BALANCE
Sitting Static: Fair Standing Static:
Dynamic: Dynamic: Poor
Describe: Describe:

Endurance: Dec from Baseline Problems Identified: Dec Functional Mobility
Impaired Balance
Impaired Endurance
Impaired Gait
Impaired Strength

Tx Today: Patient received initial eval and transfer to bedside chair. Pt left in bed with all needs in place, call bell in reach and nursing notified.

STG: To Be Met in 3 days

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/18/16 Time: 1205 (continued)

10 PT: Intial Evaluation (continued)

: Y Supine<-->Sit with: Contact Guard assist.
: Y Sit<-->Stand with: Contact Guard assist with: device
: Y Gait: 50 feet with: Minimal of 1 assit using: device
Additional ST Goal #1
Additional ST Goal #2
Other STG:

LTG: To Be Met in 7 Days.

: Supine<-->Sit with: assit.
: Sit<-->Stand with: assist with: device.
: Y Gait: 150 feet with: Contact Guard assist using: device.
Additional LT Goal #1 Standing Balance Good
Additional LT Goal #2
Other LTG

PLAN
Frequency x Length of Stay: Daily Monday-Friday
Discharge PT as Therapy is not warranted at this time: Date of Re-Eval: 05/25/16

Discharge Planning: Follow for DC Planning
Discharge Equipment: Walker Rolling Walker Cane Quad Cane BSC Wheelchair

Other

Additional PT Comments:

#1 G CODES: G CODES Modifier
#2 G CODES: G CODES Modifier
#3 G CODES: G CODES Modifier

Activity Date: 05/18/16 Time: 1212

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/18/16 1212 ST 05/18/16 1212 ST
Telemetry Rhythm: SINUS TACHYCARDIA

Low Rate: 100
High Rate: 108
Change From Baseline: N
Notify MD: N Check Alarm: Y

5A4D43B46E10429588C8, KNIGHT, 234

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/18/16 Time: 1212 (continued)										
120009 Telemetry Monitoring - Critical Care (continued)										
Comment:										
0840 Positioning							A	Q2H		CP
- Document	05/18/16	1212	ST	05/18/16	1212	ST				
1160 Nutritional Monitoring							A	08,12,18		CP
- Document	05/18/16	1212	ST	05/18/16	1212	ST				
Diet Ordered: CLEAR LIQUIDS										
Meal: LUNCH										
% Diet Taken: >75% (GOOD)										
Oral Supplement:										
PO Supplement: co (Total Intake)										
Comment:										
Activity Date: 05/18/16 Time: 1237										
Patient Notes: Nursing Notes										
- Create	05/18/16	1237	ST	05/18/16	1304	ST				
Abnormal? N Confidential? N										
back to bed, encouraged to stay up longer, po med given for pain, see e-mar.										
Note Type Description										
No Type None										
Activity Date: 05/18/16 Time: 1245										
6901 PATIENT LINEN CHANGE							A	PRN		CP
- Document	05/18/16	1245	JM	05/18/16	1245	JM				
Linen Change 05/18/16										
Patient Refused (Linen): Nurse Notified (Linen):										
6907 PATIENT BATH - Critical Care							A	DAILY		CP
- Document	05/18/16	1245	JM	05/18/16	1245	JM				
Hygiene: Date: 05/18/16										
CHG Bath given: Y If no, Reason:										
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)										
Patient Refused (Bath): Nurse Notified (Bath):										
Hygiene Comment:										
Activity Date: 05/18/16 Time: 1300										
5500011 Purposeful Rounding							A			CP
- Document	05/18/16	1300	JM	05/18/16	1308	JM				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/18/16 Time: 1300 (continued)										
5500011 Purposeful Rounding (continued)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										CP
Purposeful Rounding complete: Y										
Comment:										
<Esc>										
Activity Date: 05/18/16 Time: 1306										
Patient Notes: Medical Nutrition Therapy										
- Create	05/18/16	1306	LF*	05/18/16	1318	LF*				
Abnormal? N Confidential? N										
MNT F/U										
ASSESSMENT:										
- DIET ADVANCED TO CLEAR LIQUIDS										
- ABLE TO TAKE IN A POPSICLE AND SOME JELLO BUT STATES NOT MUCH OF AN APPETITE										
- GLUC 122, BUN 21, ALB 2.9										
DIAGNOSIS:										
- NO NEW DIAGNOSIS										
INTERVENTION:										
- NUTRITION RX: CLEARS; ADVANCE AS TOLERATED AND MEDICALLY ABLE TO A GOAL OF GI SOFT/LOW RESIDUE										CP
GOAL: ADEQUATE P.O INTAKE										
- NUTRITION EDUCATION: PROVIDED PT WITH WRITTEN AND VERBAL DIET INFORMATION ON A ILEOSTOMY DIET INCLUDING FOODS TO AVOID THAT MAY CAUSE GAS AND ABD PAIN AND ODOR; PT VERBALIZED UNDERSTANDING. RD CONTACT INFO ALSO PROVIDED IF PT OR WIFE (WHO IS NOT PRESENT IN ROOM AT TIME OF ASSESSMET) HAVE FURTHER QUESTIONS										CP
GOAL: ADEQUATE P.O INTAKE WITH NO ABD PAIN										
- COORDINATION OF CARE: NO DC NEEDS AT THIS TIME										
RD TO F/U L1										
LARISSA FARNAM, DESc RD LD										
Note Type Description										
No Type None										
Activity Date: 05/18/16 Time: 1340										
Patient Notes: Nursing Notes										
- Create	05/18/16	1340	ST	05/18/16	1355	ST				
Abnormal? N Confidential? N										
pt resting quietly at this time with eyes closed, no s/s of any distress noted at this time. vss.										CP
Note Type Description										
No Type None										

5A4D43B46E10429588C8, KNIGHT, 235

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 1350

014	RESP THERAPY - OXYHOOD							A	Q2H	PS
- Document	05/18/16	1350	SE	05/18/16	1353	SE				

OXYHOOD/Hi Flow
Time: 1350
Interface: MED
Sat FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.9
Temp in Hood:
Water Level: 800
Respirations: 27
Pulse: 100
O2 Sat: 95

--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment: OXYGEN DECREASED 60%.

Activity Date: 05/18/16 Time: 1400

0840	Positioning							A	Q2H	CP
- Document	05/18/16	1400	ST	05/18/16	1422	ST				
6409	FALLS SCREEN - FOLLOW-UP							A	02,14	CP
- Document	05/18/16	1400	ST	05/18/16	1422	ST				

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

No falls in past 12 months
1-2 falls in past 12 months
Requires assistive device

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)
Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach

Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

or dosage within the last 24 hrs
MODERATE Risk (9-14) YELLOW sign on door
HIGH RISK (>14) RED Sign on door/chart

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

5A4D43B46E10429588C8, KNIGHT, 236

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/18/16 Time: 1454

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/18/16 1454 SE 05/18/16 1455 SE
RESPIRATORY THERAPY TREATMENT

%/L of O2: 60 LPM 40 NC Y O2 Sat: 92 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 107 Pre-Assessment RR: 13

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 98 Post-Assessment RR: 20

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 1454 (continued)

09 RESP THERAPY - TREATMENT (continued)

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend
Reinforcement Needed Y

Activity Date: 05/18/16 Time: 1456

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 1456 SE 05/18/16 1456 SE
OXYHOOD/Hi Flow
Time: 1456
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.9
Temp in Hood:
Water Level: 600
Respirations: 20 --Charges--
Pulse: 100 Oxyhood/Hi Flow Install:
O2 Sat: 96 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 1500

5500011 Purposeful Rounding A CP
- Document 05/18/16 1500 JM 05/18/16 1500 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:

5A4D43B46E1042958C8, KNIGHT, 237

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 1500 (continued)

5500011 Purposeful Rounding (continued)
<Esc>

Activity Date: 05/18/16 Time: 1510

Patient Notes: CASE MGT/SOCIAL WORK SVS NOTES
- Create 05/18/16 1510 WC 05/18/16 1511 WC
Abnormal? N Confidential? N
MET WITH SPOUSE- WILL CONTINUE TO FOLLOW.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 1607

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/18/16 1607 ST 05/18/16 1610 ST
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 95
High Rate: 101
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/18/16 1607 ST 05/18/16 1607 ST
120000 Critical Care Flowsheet A Q4H CP
- Document 05/18/16 1607 ST 05/18/16 1609 ST
Critical Care Flowsheet Time: 1600

Temperature: 98.1
Temperature Source+: Tympanic
Pulse: 97
Pulse Source+: MONITOR
Respirations: 18
SPON:
Vent Resp:
Blood Pressure: 104/74
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 96
%/L of O2: 60
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 1607

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/18/16 1607 ST 05/18/16 1607 ST
TED Hose - removed for skin assessment and reapplied.

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied.

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/18/16 1607 ST 05/18/16 1621 ST
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
Comment: UNDERSTANDS

Material Codes: VERBAL
Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED., POC, DSG CHANGES

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

5A4D43B46E10429588C8, KNIGHT, 238

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 1607 (continued)

800001 Education/Teaching Assessment (continued)
New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/18/16 Time: 1627

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 1627 SE 05/18/16 1628 SE
OXYHOOD/Hi Flow
Time: 1627
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.9
Temp in Hood:
Water Level: 500
Respirations: 22 --Charges--
Pulse: 100 Oxyhood/Hi Flow Install:
O2 Sat: 14 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 1700

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/18/16 1700 ST 05/18/16 1724 ST
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): ABX IV Fluids (A): 100
Medication (B): IV Fluids (B):
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 100 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/18/16 1700 ST 05/18/16 1724 ST
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:

<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 1700 (continued)

125 CRITICAL CARE REPORT (continued)

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N
K/MG Protocol: NO
Last K: Covered: Blood Pressure: 104/74
Last MG: Covered: Temperature: 98.1

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm
Mental Status: Alert & Oriented

Respirations: 22 VENTILATOR DOCUMENTATION:
O2 Sat: 90 Vent type:
%/L of O2: 50 Tidal Volume Vent Set Rate:
O2 Mode+: VENI-MASK Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:
COMMENT:

Tubes+: NG Tube Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+: 16
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd:

Abd Appearance+: Last BM: 05/18/16
Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y

5A4D43B46E10429588C8, KNIGHT, 239

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 1700 (continued)

125 CRITICAL CARE REPORT (continued)

Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist

Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60 ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C 545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILUADID IV X1 DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES. PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT 20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED. O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:

Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment: NA

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco

IV Site #3:
Site Appear #3:
Type of Cath #3:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 1700 (continued)

125 CRITICAL CARE REPORT (continued)

Cath Gauge #1: 18
Fluid/Rate #1: SL
Date Insert/DC #1: 05/15/16
IV #1 Comment: WNL

Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment: WNL

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/18/16 1700 ST 05/18/16 1724 ST
INTAKE

PO: 480 IV FLUIDS: Y PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI):
Dialysis (Intake):

OUTPUT
Void (ml):
Foley: 850
SP Catheter:
Foley (Residual):
Bladder Incont Episodes:
Bowel Incont Episodes:
Void Episodes:
Stool Episodes:
Diapers:
Emesis:
T Tube:
NG/PEG TUBE:
Duodenal Tube:
Liquid Stool:
Colostomy:
Ileostomy: 1150
Urostomy:
Ileoconduit:

#1 JP: 5
#2 JP:
#3 JP:
OTHER:
#1 Chest Tube:
#2 Chest Tube:
#1 Hemovac:
#2 Hemovac:
Left Ureteral:
Right Ureteral:
Left Nephrostomy:
Right Nephrostomy:
Dialysis (Output):
Thoracentesis:
Paracentesis:
Wound Vac:
Pericardial Drg (Output):

Comment:

5500011 Purposeful Rounding A CP
- Document 05/18/16 1700 JM 05/18/16 1826 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:

5A4D43B46E10429588C8, KNIGHT, 240

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change	

Activity Date: 05/18/16 Time: 1700 (continued)

5500011 Purposeful Rounding (continued)
<Esc>

Activity Date: 05/18/16 Time: 1709

Patient Notes: Respiratory Therapy Notes
- Create 05/18/16 1709 SE 05/18/16 1711 SE
Abnormal? N Confidential? N
0805-ABG DONE
0820-PT SET UP ON HIGH FLOW:80% ON 40LPM.
0930-DECREASED OXYGEN TO 70% ON 40LPM.
1350-DECREASED OXYGEN TO 60% ON 40LPM.

Note Type	Description
No Type	None

Activity Date: 05/18/16 Time: 1806

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 1806 SE 05/18/16 1806 SE
OXYHOOD/Hi Flow
Time: 1806
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31.0
Temp in Hood:
Water Level: 400
Respirations: 22
Pulse: 98
O2 Sat: 92
--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 1808

0840 Positioning A Q2H CP
- Document 05/18/16 1808 ST 05/18/16 1809 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/18/16 1808 ST 05/18/16 1809 ST
Diet Ordered: CLEAR LIQUIDS
Meal: DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change	

Activity Date: 05/18/16 Time: 1808

120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/18/16 1808 ST 05/18/16 1809 ST
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >90% : MET MET

COMMENT:
525003 IV Site Check A 06,18 CP
- Document 05/18/16 1808 ST 05/18/16 1809 ST
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/18/16 1808 ST 05/18/16 1809 ST

Activity Date: 05/18/16 Time: 1900

5500011 Purposeful Rounding A CP
- Document 05/18/16 1900 NW 05/19/16 0016 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E10429588C8, KNIGHT, 241

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/18/16 Time: 1900										
6922 Nursing Report (Hand Off)							A	07,19		CP
- Document	05/18/16	1900	RM	05/18/16	2218	RM				

****Nursing Report (Hand Off)****

Report Received/Care Assumed Report Given Bedside:

To/From TO RAFIK

Comment

Activity Date: 05/18/16 Time: 2000

120009 Telemetry Monitoring - Critical Care							A	Q4H		CP
- Document	05/18/16	2000	RM	05/18/16	2313	RM				
0840 Positioning							A	Q2H		CP
- Document	05/18/16	2000	RM	05/18/16	2308	RM				
120001 SHIFT ASSESSMENT-Critical Care							A	QS		CP
- Document	05/18/16	2000	RM	05/18/16	2313	RM				

Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 95
High Rate: 105
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Size Left+: 3mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Vision Impairment:
Hearing Impairment:

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/18/16 Time: 2000 (continued)										
120001 SHIFT ASSESSMENT-Critical Care (continued)										

To Pain: Inappropriate Words: Withdraws To Pain:
No Response: Incomprehensible: Abnormal Flexion:
No Response: Abnormal Extension:
No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: S1,S2 Transvenous Pacemaker: Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal Radial Rt+: Normal
Dorsalis Rt+: Normal Radial Lt+: Normal
Post Tib Lt+: Normal Femoral Rt+:
Post Tib Rt+: Normal Femoral Lt+:
Carotid Rt+: Cap Refill RUE+: Brisk
Carotid Lt+: Cap Refill LUE+: Brisk

5A4D43B46E10429588C8, KNIGHT, 242

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Brachial Rt+: Cap Refill RLE+: Brisk
Brachial Lt+: Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 21 O2 Sat: 96 %/L of O2: 80 Cyanosis: N Pallor: N

O2 Mode+: Hi-flow NASAL CANNULA ***Breath Sounds***
RR Description+: Tachypnea LUL+: Diminished

Resp Pattern+: Shallow LLL+: Diminished
Chest Expansions+: Symmetrical
Cough+: Non-effective RUL+: Diminished
Sputum Amount+:
Sputum Consistency+: RML+: Diminished
Sputum Color+:
Airway Suctioned+: RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION: VAP BUNDLE:
Vent type: HOB > 30 degrees
Tidal Volume Vent Set Rate: DVT Prophylaxis
Pressure Support Mode PUD Prophylaxis
FiO2 Peep: Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Modified Ramsey Score Subglottic Suction
TOF

Chest Tube: CT Size:
CT Type: Incentive Spirometer Volume pull:
CT Location:
CT Drainage:

Comment
MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Documented Comment	Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

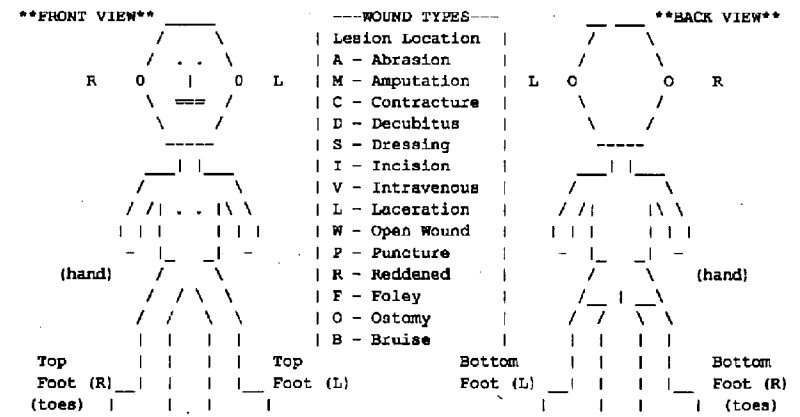
ROM Limitations+: Generalized Paralysis+:

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>: GENRALIZED WEAKNESS NOTED



COMMENT:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal Wound Site #1: ABD
Skin Temp+: Warm Wound Appear #1+: CLEAN/DRY
Skin To Touch+: Dry Closure Type #1+:
Skin Condition+: Warm & Dry Dressing Type #1:
Dress Appear #1: C/D/I

Turgor+: GOOD
Mucous Membranes+: Moist & Intact Wound Site #2:
Specialty Bed: Y Wound Appear #2+:
Decubiti: N Closure Type #2+:
Location/Size<Esc>: Dressing Type #2:
Dress Appear #2:

5A4D43B46E1042958BC8, KNIGHT, 243

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Stage+:

Tubes/Drains:

Skin Comment <Esc>: PT HAS MID LINE ABD INCISION THAT IS DRY AND INTACT. PT HAS JP DRAIN ON THE LT SIDE AND ILIOSTOMY ON THE RT SIDE. NO SIGNS OF INFECTION NOTED AROUND THE STOMA

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally: 3	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: Constipation: Last BM: 05/18/16 Incontinent Stool:
Emesis: Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness Tubes+:
Abd Appearance+: SOFT Tube Drainage: Tube To Suction:
DISTENDED OGT/NGT is secured at cm
RUQ+: HYPOACTIVE Stoma Present: Y Location: RT ABD
LUQ+: HYPOACTIVE Appearance: PINK
RLQ+: HYPOACTIVE Ostomy Appliance: Y
LLQ+: HYPOACTIVE Drainage Characteristics: CLOUDY GRAY
GI Comment <Esc>: ILIOSTOMY NOTED TO RT ABD, WAFFER C/D/I. GRAY LIQUID STOOL DRAINING INTO COLLECTION BAG. PT IS NOT PASSING GAS. Rectal Tube:

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Does Patient have a Foley Catheter? Y Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems:
Urine Odor+: Normal
Character+: CLEAR ***Dialysis***
Incontinent Bladder: CAPD: Peritoneal Dialysis:
Suprapubic Catheter: Hemodialysis:
Urostomy: Hemo Site Description+:
Stoma Appearance Last Dialysis Treatment:

GU Comment <Esc>: FOLEY CATHETER INTACT AND DRAINING TO GRAVITY.

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT pain management this shift:
Pain Scale:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: SEE NURSES NOTES

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N

5A4D43B46E1042958C8, KNIGHT, 244

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/18/16 2000 RM 05/18/16 2313 RM
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: SL
Date Insert/DC #1: 05/15/16
IV #1 Comment: WNL
<Esc>

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment: WNL
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/18/16 2000 RM 05/18/16 2308 RM
Type of Isolation: NONE Tissue Test:

7370 Discharge Planning Assessment A QS CP
- Document 05/18/16 2000 RM 05/18/16 2308 RM

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NONE AT THIS TIME

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

7370 Discharge Planning Assessment (continued)
Do you have questions about insurance or need to speak to a financial counselor? N

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL CONTINUE TO ASSESS NEEDS.
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/18/16 2000 RM 05/18/16 2309 RM
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs 1

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 11

*****Interventions*****
Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

5A4D43B46E10429588C8, KNIGHT, 245

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/18/16 2000 RM 05/18/16 2308 RM
Temperature: 98.2
Temperature Source+: Tympanic
Pulse: 97
Respirations: 21
Blood Pressure: 127/75
MAP: 91
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 2
Sepsis Result: Possible Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: N
If NO, Reason: Physician Already Aware
Patient Notes: Nursing Notes
- Create 05/18/16 2000 RM 05/18/16 2033 RM
Abnormal? N Confidential? N
REPORT GIVEN. ASSESSMENT COMPLETE. SEE SHIFT ASSESSMENT. PT IS AOX3. PT STATING THAT HIS PAIN LEVEL IS TOLERABLE AT THIS TIME. TRANSFERED PT FROM THE CHAIR TO THE BED. PT TOLERATED WITH MINAML DISTRESS. REASSESSED PT PAIN, HE STATED THAT HE WOULD LIKE TO HOLD OFF ON TAKING SEVERAL PAIN MEDS AND THAT HE WANTS HIS DILAUDID WITH HIS NIGHT MEDICINE AROUND 2100. PT ALSO WAS ADVICED TO ASK FOR PAIN MEDICINE WHEN HURTING AND NOT TO WAIT UNTILL PAIN LEVL IS

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/18/16 Time: 2000 (continued)

Patient Notes: Nursing Notes (continued)
UNTOLERABLE.NO SIGNS OF DISTRESS NOTED AT THIS TIME. WLL CONTIUE TO MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 2015

120000 Critical Care Flowsheet A Q4H CP
- Document 05/18/16 2015 RM 05/18/16 2220 RM
Critical Care Flowsheet Time:

Temperature: 98.2
Temperature Source+: Tympanic
Pulse: 106
Pulse Source+: MONITOR
Respirations:
SPON:
Vent Resp:
Blood Pressure: 127/75
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 93
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 91
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

Activity Date: 05/18/16 Time: 2024

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/18/16 2024 JW2 05/18/16 2031 JW2
RESPIRATORY THERAPY TREATMENT

%/L of O2: 60 LPM 40 NC Y O2 Sat: 93 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install
Neb Induced Sputum
HHN Sub Y
Demo and Eval
MDI Install
MDI Subsequent
MDI Additional Tx:
Incentive Install
Pt Instructed
Metaneb/IPPB Install
Metaneb/IPPB Sub
Continous Neb 1st Hour
Continous Neb Sub
Pulse Ox Single
Pulse Ox over-noc
Pulse Ox Continuous
CPT Initial

5A4D43B46E10429588C8, KNIGHT, 246

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 2024 (continued)

09 RESP THERAPY - TREATMENT (continued)

Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Inline Y A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 105 Pre-Assessment RR: 20

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 105 Post-Assessment RR: 20

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/18/16 Time: 2028

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 2028 JW2 05/18/16 2029 JW2
OXYHOOD/Hi Flow

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/18/16 Time: 2028 (continued)

014 RESP THERAPY - OXYHOOD (continued)

Time: 2028
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.8
Temp in Hood:
Water Level: 1000
Respirations: 20 --Charges--
Pulse: 105 Oxyhood/Hi Flow Install:
O2 Sat: 93 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 2100

5500011 Purposeful Rounding A CP
- Document 05/18/16 2100 NW 05/19/16 0016 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/18/16 Time: 2115

Patient Notes: Nursing Notes
- Create 05/18/16 2115 RM 05/18/16 2122 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 4/10. DILAUDID GIVEN AS PT REQUESTED. WILL CONTIUE TO MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 2200

0840 Positioning A Q2H CP
- Document 05/18/16 2200 RM 05/18/16 2314 RM
5500011 Purposeful Rounding A CP
- Document 05/18/16 2200 NW 05/19/16 0023 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

5A4D43B46E1042958BC8, KNIGHT, 247

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 2200 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
Patient Notes: Nursing Notes
- Create 05/18/16 2200 RM 05/18/16 2211 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS O DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/18/16 Time: 2254

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 2254 JW2 05/18/16 2255 JW2
OXYHOOD/Hi Flow
Time: 2254
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31
Temp in Hood:
Water Level: 900
Respirations: 20 --Charges--
Pulse: 101 Oxyhood/Hi Flow Install:
O2 Sat: 94 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/18/16 Time: 2306

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/18/16 2306 JW2 05/18/16 2307 JW2
OXYHOOD/Hi Flow
Time: 2306
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31
Temp in Hood:
Water Level: 900
Respirations: 21 --Charges--
Pulse: 97 Oxyhood/Hi Flow Install:
O2 Sat: 96 Oxyhood/Hi Flow Day:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/18/16 Time: 2306 (continued)

014 RESP THERAPY - OXYHOOD (continued)

Comment:

Activity Date: 05/19/16 Time: 0000

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/19/16 0000 RM 05/19/16 0151 RM
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 95
High Rate: 105
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/19/16 0000 RM 05/19/16 0150 RM
120000 Critical Care Flowsheet A Q4H CP
- Document 05/19/16 0000 RM 05/19/16 0151 RM
Critical Care Flowsheet Time: 0000

Temperature: 98.3 Nursing Note:
Temperature Source+: Tympanic
Pulse: 98 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 22 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 109/67 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2: 80
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 81
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
Patient Notes: Nursing Notes
- Create 05/19/16 0000 RM 05/19/16 0153 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THSI TIME. WILL CONTIUE TO MONITOR PT.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 248

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/19/16 Time: 0022										
5500011 Purposeful Rounding							A			CP
- Document	05/19/16	0022	NW	05/19/16	0023	NW				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 05/19/16 Time: 0143										
014 RESP THERAPY - OXYHOOD							A	Q2H		PS
- Document	05/19/16	0143	JW2	05/19/16	0143	JW2				
OXYHOOD/Hi Flow										
Time: 0143										
Interface: MED										
Set FiO2: 60										
Analyzed FiO2:										
Liter Flow: 40										
Temp on Heater: 30.9										
Temp in Hood:										
Water Level: 600										
Respirations: 21 --Charges--										
Pulse: 97 Oxyhood/Hi Flow Install:										
O2 Sat: 96 Oxyhood/Hi Flow Day:										
Comment:										
Activity Date: 05/19/16 Time: 0151										
Patient Notes: Nursing Notes										
- Create	05/19/16	0151	RM	05/19/16	0152	RM				
Abnormal? N Confidential? N										
PT COMPLAINED OF ABD PAIN 6/10. VICODAN PO GIVEN. SEE EMAR. WILL CONTIUR TO MONITOR PT.										
Note Type Description										
No Type None										
Activity Date: 05/19/16 Time: 0200										
0840 Positioning							A	Q2H		CP
- Document	05/19/16	0200	RM	05/19/16	0200	RM				
5500011 Purposeful Rounding							A			CP
- Document	05/19/16	0200	NW	05/19/16	0715	NW				
Pain										
Potty										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/19/16 Time: 0200 (continued)										
5500011 Purposeful Rounding (continued)										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment: <Esc>										
6409 FALLS SCREEN - FOLLOW-UP							A	02,14		CP
- Document	05/19/16	0200	RM	05/19/16	0200	RM				

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

5A4D43B46E10429588C8, KNIGHT, 249

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/19/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Drop >20mmHG lying->standing
*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking:
Patient on Anticoagulants?

Activity Date: 05/19/16 Time: 0305

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/19/16 0305 JW2 05/19/16 0305 JW2
OXYHOOD/Hi Flow
Time: 0305
Interface: MED
Set FiO2: 60
Analyzed FiO2:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/19/16 Time: 0305 (continued)

014 RESP THERAPY - OXYHOOD (continued)
Liter Flow: 40
Temp on Heater: 31
Temp in Hood:
Water Level: 600
Respirations: 20
Pulse: 107
O2 Sat: 97

--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day: Y

Comment:

Activity Date: 05/19/16 Time: 0400

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/19/16 0400 RM 05/19/16 0455 RM
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 95
High Rate: 105
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:

0840 Positioning A Q2H CP
- Document 05/19/16 0400 RM 05/19/16 0451 RM

120000 Critical Care Flowsheet A Q4H CP
- Document 05/19/16 0400 RM 05/19/16 0455 RM
Critical Care Flowsheet Time: 0400

Temperature: 98.6
Temperature Source+: Tympanic
Pulse: 108
Pulse Source+: MONITOR
Respirations: 18
SPON:
Vent Resp:
Blood Pressure: 121/91
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 96
%/L of O2: 80
ETCO2:
A-LINE BP:
MAP: 107
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/19/16 0400 RM 05/19/16 0454 RM
TED Hose - removed for skin assessment and reapplied. NA

5A4D43B46E10429588C8, KNIGHT, 250

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0400 (continued)

3592 TED/HEEL PROTECTORS/IPC Skin Assessment (continued)
IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
5500011 Purposeful Rounding A CP
- Document 05/19/16 0400 NW 05/19/16 0715 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/19/16 0400 RM 05/19/16 0455 RM
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
diet, physician follow-up, medications, what to do if Comment
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
Comment: UNDERSTANDS Comment: UNDERSTANDS

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0400 (continued)

800001 Education/Teaching Assessment (continued)

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16
Patient Notes: Nursing Notes
- Create 05/19/16 0400 RM 05/19/16 0620 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHNAGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 0455

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/19/16 0455 RM 05/19/16 0456 RM
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N
K/MG Protocol: NO
Last K: Covered: Blood Pressure: 121/91
Last MG: Covered: Temperature: 98.6

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm

5A4D43B46E10429588C8, KNIGHT, 251

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0455 (continued)

125 CRITICAL CARE REPORT (continued)

Mental Status: Alert & Oriented

Respirations: 18
O2 Sat: 96
%/L of O2: 80
O2 Mode+: Hi-flow NASAL CANNULA

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume
Vent Set Rate:
Pressure Support
Mode
FiO2
Peep:

Airway:
Secured at
cm @
Position:
Size

Modified Ramsey Score
TOF

Chest Tube:
CT Type:
CT Size:
CT Drainage:

COMMENT:

Tubes+: NG Tube
Tube Drainage: N Tube To Suction: N
Ostomy Appliance:
Rectal Tube:
Drainage Characteristics:

Urinary Catheter Inserted: 05/15/16
Urinary Catheter Size+: 16
Urinary Catheter Irrigation: N
Suprapubic Catheter: N
Foley Dc'd:

Abd Appearance+:

Last BM: 05/18/16

Tube Feeding Type:
CC/HR:
FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

Glycemic Protocol:
Fingerstick BS: Y
Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist

Dressing changed:	Date:	Change:
CAP Changed:	Date:	Change:
IV Tube Change:	Date:	Change:
Huber Needle Size:		Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60 ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C 545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILUADID IV X1 DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0455 (continued)

125 CRITICAL CARE REPORT (continued)
PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT 20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED. O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:

Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment: NA

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: SL
Date Insert/DC #1: 05/15/16
IV #1 Comment: WNL

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment: WNL

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

Activity Date: 05/19/16 Time: 0511

014 RESP THERAPY - OXYHOOD A Q2H PS
- Document 05/19/16 0511 JW2 05/19/16 0512 JW2
OXYHOOD/Hi Flow

5A4D43B46E10429588C8, KNIGHT, 252

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 0511 (continued)

014 RESP THERAPY - OXYHOOD (continued)
Time: 0511
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.9
Temp in Hood:
Water Level: 500
Respirations: 19
Pulse: 101
O2 Sat: 96
--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/19/16 Time: 0600

0840 Positioning A Q2H CP
- Document 05/19/16 0600 RM 05/19/16 0619 RM
120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/19/16 0600 RM 05/19/16 0619 RM
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >90% : MET MET

COMMENT:
1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/19/16 0600 RM 05/19/16 0619 RM
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): ABX IV Fluids (A): 100
Medication (B): IV Fluids (B):
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 0600 (continued)

1200041 IV Pump Totals - Critical Care (continued)
PUMP TOTAL 100 cc
150011 Weight, Monitor Daily A DAILY@0600 CP
- Document 05/19/16 0600 RM 05/19/16 0612 RM
Weight (lbs): 166
(Oz): 9
kg: 75.551
Weight Source: Bedscale
150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/19/16 0600 RM 05/19/16 0619 RM
INTAKE

PO: IV FLUIDS: PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention Foley Irrigation (CBI):
to document IV/Blood fluids. Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: 1050 Bowel Incont Episodes: T Tube: Ileostomy: 2150
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Drg (Output):

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/19/16 0600 RM 05/19/16 0619 RM
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5A4D43B46E10429588C8, KNIGHT, 253

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/19/16		**Time: 0600**								
5500010 Rounds Surveillance							A	06,18		CP
- Document	05/19/16	0600	RM	05/19/16	0620	RM				
5500011 Purposeful Rounding							A			CP
- Document	05/19/16	0600	NW	05/19/16	0715	NW				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
Patient Notes: Nursing Notes
- Create 05/19/16 0600 RM 05/19/16 0624 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR PT.

Note Type	Description
No Type	None

Activity Date: 05/19/16 **Time: 0605**

Patient Notes: Respiratory Therapy Notes
- Create 05/19/16 0605 JW2 05/19/16 0606 JW2
Abnormal? N Confidential? N
PT ON HIFLOW NC THROUGH NIGHT. BIPAP ON STANDBY.

Note Type	Description
No Type	None

Activity Date: 05/19/16 **Time: 0700**

5500011 Purposeful Rounding							A			CP
- Document	05/19/16	0700	SF	05/19/16	0737	SF				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/19/16		**Time: 0706**								
014 RESP THERAPY - OXYHOOD							A	Q2H		PS
- Document	05/19/16	0706	SP	05/19/16	0707	SP				

OXYHOOD/Hi Flow
Time: 0706
Interface: MED
Set FiO2: 60
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.9
Temp in Hood:
Water Level: 400
Respirations: 17
Pulse: 105
O2 Sat: 97

--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/19/16 **Time: 0707**

012 RESP THERAPY - NON-INVASIVE VENTILATION							A	AD		CP
- Document	05/19/16	0707	SP	05/19/16	0707	SP				

NON-INVASIVE VENTILATION

Time: 0707 Number: 38 Ventilator: N
IPAP: EPAP:
PS: Mode:
Set Rate/Back up:
FiO2/LPM:

ALARMS Apnea:
Low VE:
High RR:
Low Pressure:

PATIENT DATA
Blood Pressure: Pulse: Respirations: O2 Sat:
Sensitivity: VT: VE: I Time:

Breath Sounds:

Mask Size: Mask Type:

Skin Integrity (of mask area):

CHARGES
BiPAP with RR Install:
BiPAP with RR Day:
BiPAP with out Rate Install:
BiPAP with out Rate Day:

Action Taken: STANDBY HIGH FLOW ON

016 RESP THERAPY - EQUIPMENT CHANGE OUT							A	QD@1130		CP
- Document	05/19/16	0707	SP	05/19/16	0707	SP				

EQUIPMENT CHANGE OUT

Closed Suction System (PRN) N
HME (24-48HRS) N
Nebs (Every Wed) N
O2 Humidifiers (Every Wed) N
NRB (Every Wed) N
Venturi (Every Wed) N

5A4D43B46E10429588C8, KNIGHT, 254

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 0707 (continued)

016 RESP THERAPY - EQUIPMENT CHANGE OUT (continued)
Comment:
09 RESP THERAPY - TREATMENT A AD CP
- Document 05/19/16 0707 SP 05/19/16 0709 SP
RESPIRATORY THERAPY TREATMENT

%/L of O2: 60 LPM NC Y O2 Sat: 97 FIO2 VM PRB NRB
O2 24 hrs Y CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Inline Y A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 105 Pre-Assessment RR: 17

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Y Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 107 Post-Assessment RR: 16

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Y Rales Diminished Y Adverse Reactions: N
Comment:
COUGH Y Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment HIGH FLOW ON AT 60% 02
<Esc>

PATIENT EDUCATION TOPIC:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 0707 (continued)

09 RESP THERAPY - TREATMENT (continued)
THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/19/16 Time: 0709

09 RESP THERAPY - TREATMENT A RT-QID CP
- Ed Directs 05/19/16 0709 SP 05/19/16 0710 SP
05/17 2157 AD ==> 05/17 2157 AD
==> 05/19 0630 RT-QID

Activity Date: 05/19/16 Time: 0714

5500011 Purposeful Rounding A CP
- Document 05/19/16 0714 NW 05/19/16 0715 NW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/19/16 Time: 0727

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/19/16 0727 ST 05/19/16 0727 ST
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From SUSIE / RAFIK

Comment

5A4D43B46E1042958BC8, KNIGHT, 255

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/19/16 Time: 0800										
120009 Telemetry Monitoring - Critical Care							A	Q4H		CP
- Document	05/19/16	0800	ST	05/19/16	0828	ST				
Telemetry Rhythm: SINUS TACHYCARDIA										
Low Rate: 100										
High Rate: 110										
Change From Baseline: N										
Notify MD: N Check Alarm: Y										
Comment:										
0840 Positioning							A	Q2H		CP
- Document	05/19/16	0800	ST	05/19/16	0823	ST				
1160 Nutritional Monitoring							A	08,12,18		CP
- Document	05/19/16	0800	ST	05/19/16	0823	ST				
Diet Ordered: CLEAR LIQUIDS										
Meal: BREAKFAST										
% Diet Taken: >75% (GOOD)										
Oral Supplement:										
PO Supplement: cc (Total Intake)										
Comment:										
120000 Critical Care Flowsheet							A	Q4H		CP
- Document	05/19/16	0800	ST	05/19/16	0824	ST				
Critical Care Flowsheet Time: 0800										

Temperature: 98.4
Temperature Source+: Tympanic
Pulse: 108
Pulse Source+: MONITOR
Respirations: 16
SPON:
Vent Resp:
Blood Pressure: 110/81
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 97
%/L of O2: 60
ETCO2:
A-LINE BP:
MAP: 88
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:										
1200008 Oral Care - Critical Care							A	DAILY		CP
- Document	05/19/16	0800	ST	05/19/16	0828	ST				
120001 SHIFT ASSESSMENT-Critical Care							A	QS		CP
- Document	05/19/16	0800	ST	05/19/16	0828	ST				

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/19/16 Time: 0800 (continued)										
120001 SHIFT ASSESSMENT-Critical Care (continued)										

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Size Left+: 3mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented

Vision Impairment: GLASSES
Hearing Impairment:

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: 108 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: Normal Transvenous Pacemaker: N Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:

5A4D43B46E10429588C8, KNIGHT, 256

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency	Documented Comment	Documented Units	From Change

Activity Date: 05/19/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal Radial Rt+: Normal
Dorsalis Rt+: Normal Radial Lt+: Normal
Post Tib Lt+: Femoral Rt+:
Post Tib Rt+: Femoral Lt+:
Carotid Rt+: Cap Refill RUE+: Brisk
Carotid Lt+: Cap Refill LUE+: Brisk
Brachial Rt+: Cap Refill RLE+: Brisk
Brachial Lt+: Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 16 O2 Sat: 97 %/L of O2: 60 Cyanosis: N Pallor: N

O2 Mode+: Hi-flow NASAL CANNULA ***Breath Sounds***
RR Description+: WNL LUL+: Diminished
Resp Pattern+: Shallow LLL+: Diminished
Chest Expansions+: Symmetrical
Cough+: Non-effective RUL+: Diminished
Sputum Amount+:
Sputum Consistency+: RML+: Diminished
Sputum Color+:
Airway Suctioned+: RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION: VAP BUNDLE:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency	Documented Comment	Documented Units	From Change

Activity Date: 05/19/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Vent type: HOB > 30 degrees
Tidal Volume: Vent Set Rate: DVT Prophylaxis
Pressure Support Mode PUD Prophylaxis
FiO2 Peep: Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Modified Ramsey Score Subglottic Suction
TOF

Chest Tube: CT Size:
CT Type: Incentive Spirometer Volume pull:
CT Location:
CT Drainage:

Comment
MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

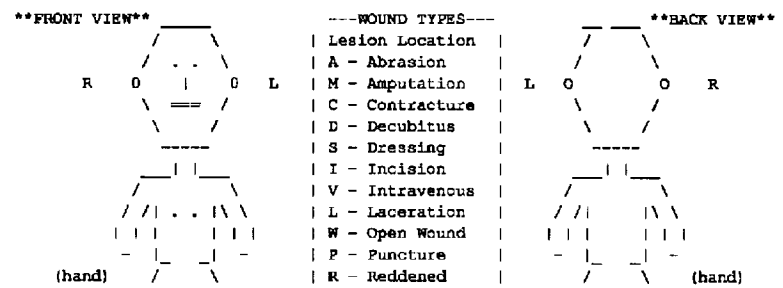
ROM Limitations+: Generalized Paralysis+:

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>:



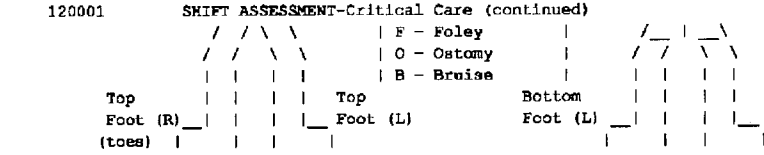
5A4D43B46E10429588C8, KNIGHT, 257

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)



COMMENT:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and turgor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, FOLEY, OSTOMY

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast: 2	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate:
No Impairment: 4	Walks Frequently:	Excellent: 4
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited: 2	Potential Problem:
Occasionally Moist:	Slightly Limited:	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: Y WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/19/16 Incontinent Stool:
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness
Abd Appearance+: SOFT
DISTENDED
RUQ+: HYPOACTIVE
LUQ+: HYPOACTIVE
RLQ+: HYPOACTIVE
LLQ+: HYPOACTIVE
GI Comment <Esc>:

Tubes+:
Tube Drainage: Tube To Suction:
OGT/NGT is secured at cm
Stoma Present: Y Location: RT ABD
Appearance: PINK
Ostomy Appliance: Y
Drainage Characteristics: CLOUDY GRAY
Rectal Tube: N

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y

Urine Color+: Amber
Urine Odor+: Normal
Character+: CLEAR
Incontinent Bladder:
Suprapubic Catheter:
Urostomy:
Stoma Appearance

Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD: Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: N Acceptable Scale/Goal for EXCELLENT pain management this shift:
Pain Scale:
Pain Location+:
Quality Of Pain+:
Onset/Duration:
Pain Med Given<Esc>:

Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

5A4D43B46E10429588C8, KNIGHT, 258

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/19/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: POC, ACTIVITY, ABD DSG, ALL CARE EXPLAINED AS PROVIDED.
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/19/16 0800 ST 05/19/16 0828 ST
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: SL
Date Insert/DC #1: 05/15/16
IV #1 Comment:
<Esc>

IV Site #2: LEFT FOREARM
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/15/16
IV #2 Comment:
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/19/16 0800 ST 05/19/16 0823 ST
Type of Isolation: NONE Tissue Test:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/19/16 Time: 0800

6907 PATIENT BATH - Critical Care A DAILY CP
- Document 05/19/16 0800 ST 05/19/16 0823 ST
Hygiene: Assisted Date: 05/19/16

CHG Bath given: Y If no, Reason:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)

Patient Refused (Bath): Nurse Notified (Bath):

Hygiene Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/19/16 0800 ST 05/19/16 0823 ST
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NONE AT THIS TIME

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....
[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL CONTINUE TO ASSESS NEEDS.

5A4D43B46E10429588C8, KNIGHT, 259

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0800

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/19/16 0800 ST 05/19/16 0824 ST

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking 1
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 10

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P Y
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: BED IN LOWEST POSITION AND LOCKED, CALL BELL W/I REACH, PT DOES NOT ATTEMPT TO GET OOB UNASSISTED

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/19/16 0800 ST 05/19/16 0823 ST
Temperature: 98.4
Temperature Source+: Tympanic
Pulse: 108
Respirations: 16
Blood Pressure: 110/81
MAP: 88
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:
If NO, Reason:
Patient Notes: Nursing Notes
- Create 05/19/16 0800 ST 05/19/16 0922 ST
Abnormal? N Confidential? N
assessment completed, pt resting quietly with eyes closed, awakens easily, pt teaching on TCDB and increasing activity / ambulating, using I.S. and he verbalizes understanding. vss. remains on high flow o2 with sats 94-95%.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 0802

014 RESP THERAPY - OXYHOOD C Q2H PS
- Ed Status 05/19/16 0802 SP 05/19/16 0802 SP A => C
Problem: RT - INADEQUATE OXYGEN A
- Create 05/19/16 0802 SP 05/19/16 0802 SP
Outcome: ADEQUATE OXYGENATION A
- Create 05/19/16 0802 SP 05/19/16 0802 SP
011 PULMONARY CONSULT DOC - RESP THERAPY A Q48H CP
- Create 05/19/16 0802 SP 05/19/16 0802 SP
014 RESP THERAPY - OXYHOOD A Q2H CP
- Create 05/19/16 0802 SP 05/19/16 0802 SP

5A4D43B46E10429588C8, KNIGHT, 260

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/19/16	Time: 0803									
011	PULMONARY CONSULT DOC - RESP THERAPY							A	Q48H	CP
- Document	05/19/16	0803	SP	05/19/16	0803	SP				
	PULMONARY CONSULT DOCUMENTATION									
VENTILATOR										
	Greater than 48 hrs N									
Has Pulmonary Consult been initiated?										
	If No, start now									
***All vents need a pulmonary consult if on > 48 hours.										
HIGH FLOW NASAL CANNULA										
	Palliative Care Consult?									
Has pulmonary consult been initiated?										
	Start Pulmonary Consult now									
***All Hi Flow NC need a Pulmonary Consult unless followed by Palliative Care.										
Activity Date: 05/19/16	Time: 0830									
Patient Notes: Nursing Notes										
- Create	05/19/16	0830	ST	05/19/16	0922	ST				
Abnormal? N Confidential? N										
Dr Budhoo in to see pt, update given, wife at bedside.										
Note Type Description										
No Type None										
Activity Date: 05/19/16	Time: 0900									
5500011	Purposeful Rounding							A		CP
- Document	05/19/16	0900	SF	05/19/16	0918	SF				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 05/19/16	Time: 0916									
6907	PATIENT BATH - Critical Care							A	DAILY	CP
- Document	05/19/16	0916	SF	05/19/16	0917	SF				
Hygiene:							Date: 05/19/16			

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/19/16	Time: 0916 (continued)									
6907	PATIENT BATH - Critical Care (continued)									
	CHG Bath given: N If no, Reason: REFUSED									
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)										
	Patient Refused (Bath): Y Nurse Notified (Bath): 0									
Hygiene Comment:										
Activity Date: 05/19/16	Time: 0918									
1699	Prostat Supplement							A	08,20	OE
- Create	05/19/16	0918	MB4	05/19/16	0918	MB4				
Activity Date: 05/19/16	Time: 0922									
Patient Notes: Nursing Notes										
- Create	05/19/16	0922	ST	05/19/16	0923	ST				
Abnormal? N Confidential? N										
pt given prostat, verbalizes understanding, Dr Monsour in to see pt and update given.										
Note Type Description										
No Type None										
Activity Date: 05/19/16	Time: 1000									
0840	Positioning							A	Q2H	CP
- Document	05/19/16	1000	TK2	05/19/16	1020	TK2				
Patient Notes: Nursing Notes										
- Create	05/19/16	1000	TK2	05/19/16	1020	TK2				
Abnormal? N Confidential? N										
ASSISTED WITH TRANSFER FROM BED TO CHAIR. ABLE TO TRANSFER WITH MINIMAL ASSIST.										
Note Type Description										
No Type None										
Activity Date: 05/19/16	Time: 1009									
014	RESP THERAPY - OXYHOOD							A	Q2H	CP
- Document	05/19/16	1009	SP	05/19/16	1010	SP				
OXYHOOD/Hi Flow										
Time: 1009										
Interface: MED										
Set FiO2: 40										
Analyzed FiO2:										
Liter Flow: 40										
Temp on Heater: 31.0										
Temp in Hood:										
Water Level: 1000										
Respirations: 27							--Charges--			
Pulse: 113							Oxyhood/Hi Flow Install:			

5A4D43B46E1042958BC8, KNIGHT, 261

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 1009 (continued)

014 RESP THERAPY - OXYHOOD (continued)
O2 Sat: 92 Oxyhood/Hi Flow Day:

Comment: O2 DOWN TO 50% AT 9AM THEN 40%
Patient Notes: Nursing Notes
- Create 05/19/16 1009 TK2 05/19/16 1019 TK2
Abnormal? N Confidential? N
RECEIVED ACAPPELA WITH INSTRUCTION FROM S ESTES, RT.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 1049

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/19/16 1049 SP 05/19/16 1051 SP
RESPIRATORY THERAPY TREATMENT

%/L of O2: 40 LPM NC O2 Sat: 96 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install Pulse Ox Single
MDI Subsequent Pulse Ox over-noc
MDI Additional Tx: Pulse Ox Continuous
Incentive Install CPT Initial
Pt Instructed CPT Subsequent
Pt Achieves ml CPT w/Bed:
Pt Understands/will use on own Oscillating PEP Y
Pt unable to comprehend or perform TX NT Suction
Nurse Notified Nurse will follow-up
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 106 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 106 Post-Assessment RR: 17

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 1049 (continued)

09 RESP THERAPY - TREATMENT (continued)
Comment:
COUGH Y Productive: Sputum: Scant Thick Thin Blood Tinged
COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment ENCOURAGED I.S. AND ACCAPELLA USAGE
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella Y IS Y O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Y Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/19/16 Time: 1100

5500011 Purposeful Rounding A CP
- Document 05/19/16 1100 SF 05/19/16 1105 SF
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/19/16 Time: 1130

25 PT: Daily Documentation A PS
- Document 05/19/16 1130 JW 05/19/16 1405 JW

S: Pt in bedside chair, reports feeling a little better today. Press ESC to get out of text boxes.

5A4D43B46E10429588C8, KNIGHT, 262

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/19/16 Time: 1130 (continued)

25 PT: Daily Documentation (continued)

O: Performed sit to stand with min Ax1
Gt amb ~ 15'with RW, hi-flow O2, and CGAx1
Stand to sit in bedside chair with min Ax1

A: Pt amb fairly well with walker, limited by hi-flow O2 connection.

P: Cont POC

Activity Date: 05/19/16 Time: 1152

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/19/16 1152 SP 05/19/16 1152 SP
OXYHOOD/Hi Flow
Time: 1152
Interface: MED
Set FiO2: 40
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.9
Temp in Hood:
Water Level: 900
Respirations: 26
Pulse: 103
O2 Sat: 97
--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/19/16 Time: 1200

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/19/16 1200 ST 05/19/16 1227 ST
Telemetry Rhythm: SINUS TACHYCARDIA
Low Rate: 100
High Rate: 110
Change From Baseline: N
Notify MD: N
Check Alarm: Y

Comment:

0840 Positioning A Q2H CP
- Document 05/19/16 1200 ST 05/19/16 1226 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/19/16 1200 ST 05/19/16 1227 ST
Diet Ordered: MECH SOFT
Meal:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/19/16 Time: 1200 (continued)

1160 Nutritional Monitoring (continued)
% Diet Taken:

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:
120000 Critical Care Flowsheet A Q4H CP
- Document 05/19/16 1200 TK2 05/19/16 1249 TK2
Critical Care Flowsheet Time: 1247

Temperature: 98.5
Temperature Source+: Tympanic
Pulse: 111
Pulse Source+: MONITOR
Respirations: 12
SPO2:
Vent Resp:
Blood Pressure: 101/70
BP Location+: L Arm
BP Position+: SITTING
O2 Sat: 96
%/L of O2: 40
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:

Comment:
Patient Notes: Nursing Notes
- Create 05/19/16 1200 ST 05/19/16 1344 ST
Abnormal? N Confidential? N
remains in recliner with much encouragement, tolerating well. o2 sat 97% on high flow at 40%. encouraged to cough and deep breath, tolerating well. no s/s of any distress noted at this time.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 1300

5500011 Purposeful Rounding A CP
- Document 05/19/16 1300 SF 05/19/16 1301 SF
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

5A4D43B46E10429588C8, KNIGHT, 263

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/19/16 Time: 1300 (continued)

5500011 Purposeful Rounding (continued)
Comment:
<Esc>

Activity Date: 05/19/16 Time: 1344

Patient Notes: Nursing Notes
- Create 05/19/16 1344 ST 05/19/16 1345 ST
Abnormal? N Confidential? N
to rad and back to room via w/c on 100% NRM, back on high flow at 40% with sat 98% at this time. no s/s of any distress noted.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 1400

0840	Positioning			A Q2H	CP
- Document	05/19/16 1400 TK2	05/19/16 1442 TK2			
6409	FALLS SCREEN - FOLLOW-UP			A 02,14	CP
- Document	05/19/16 1400 TK2	05/19/16 1442 TK2			

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/19/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking:

Patient on Anticoagulants?

5A4D43B46E1042958BC8, KNIGHT, 264

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/19/16 Time: 1402

25 PT: Daily Documentation A PS
- Create 05/19/16 1402 JW 05/19/16 1402 JW

Activity Date: 05/19/16 Time: 1437

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/19/16 1437 SP 05/19/16 1438 SP
OXYHOOD/Hi Flow
Time: 1437
Interface: MED
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31.0
Temp in Hood:
Water Level: 800
Respirations: 18
Pulse: 96
O2 Sat: 95
--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/19/16 Time: 1447

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/19/16 1447 SP 05/19/16 1448 SP
RESPIRATORY THERAPY TREATMENT

%/L of O2: 30 LPM NC Y O2 Sat: 95 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/19/16 Time: 1447 (continued)

09 RESP THERAPY - TREATMENT (continued)
PRE ASSESSMENT: Pre-Assessment HR: 109 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 110 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH Y Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/19/16 Time: 1500

5500011 Purposeful Rounding A CP
- Document 05/19/16 1500 SF 05/19/16 1514 SF
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:

5A4D43B46E10429588C8, KNIGHT, 265

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/19/16 Time: 1500 (continued)

5500011 Purposeful Rounding (continued)
<Esc>

Activity Date: 05/19/16 Time: 1600

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/19/16 1600 TK2 05/19/16 1611 TK2
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 98
High Rate: 110
Change From Baseline: N
Notify MD: N Check Alarm:

Comment:

0840 Positioning A Q2H CP
- Document 05/19/16 1600 TK2 05/19/16 1608 TK2

120000 Critical Care Flowsheet A Q4H CP
- Document 05/19/16 1600 TK2 05/19/16 1610 TK2
Critical Care Flowsheet Time: 1600

Temperature: 98.6
Temperature Source+: Tympanic
Pulse: 87
Pulse Source+: MONITOR
Respirations: 18
SPON:
Vent Resp:
Blood Pressure: 100/64
BP Location+: L Arm
BP Position+: SITTING
O2 Sat: 95
%/L of O2: 30
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/19/16 1600 TK2 05/19/16 1609 TK2
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/19/16 Time: 1600

800001 Education/Teaching Assessment A 04,16 CP
- Document 05/19/16 1600 TK2 05/19/16 1611 TK2
Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
Comment: UNDERSTANDS

Material Codes: VERBAL
Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Patient Notes: Nursing Notes
- Create 05/19/16 1600 ST 05/19/16 1830 ST
Abnormal? N Confidential? N
remains in recliner, tolerating well, no s/s of any distress noted. vss. o2 sat drops with activity, recovers quickly. remains on high flow at 40% with sats 93-95%.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 266

Problem/Outcome/Intervention Description

	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/19/16 Time: 1628											
	014	RESP THERAPY - OXYHOOD							A	Q2H	
	- Document	05/19/16	1628	SP	05/19/16	1628	SP				

OXYHOOD/Hi Flow
Time: 1628
Interface: MED
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31.0
Temp in Hood:
Water Level: 700
Respirations: 20
Pulse: 89
O2 Sat: 96

--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/19/16 Time: 1700

	1200041	IV Pump Totals - Critical Care							A	05,17	
	- Document	05/19/16	1700	TK2	05/19/16	1807	TK2				

IV Pump Totals (Clearing Pump at end of Shift)

Medication (A):	IV FLUIDS / POTASSIU	IV Fluids (A):	800
Medication (B):		IV Fluids (B):	
Medication (C):		IV Fluids (C):	
Medication (D):		IV Fluids (D):	
Medication (E):		IV Fluids (E):	
Medication (F):		IV Fluids (F):	
Medication (G):		IV Fluids (G):	
Medication (H):		IV Fluids (H):	

PUMP TOTAL 800 cc

	125	CRITICAL CARE REPORT							A	05,17	
	- Document	05/19/16	1700	TK2	05/19/16	1805	TK2				

Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC

Problem/Outcome/Intervention Description

	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/19/16 Time: 1700 (continued)											
CP	125	CRITICAL CARE REPORT (continued)									

Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N

K/MG Protocol: NO
Last K: 3.3 Covered: YES Blood Pressure: 121/91
Last MG: Covered: Temperature: 98.6

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm

CP Mental Status: Alert & Oriented

Respirations: 18 VENTILATOR DOCUMENTATION:
O2 Sat: 96 Vent type:
%/L of O2: 80 Tidal Volume Vent Set Rate:
O2 Mode+: Hi-flow NASAL CANNULA Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:

COMMENT:

Tubes+: Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+: 16
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd:

Abd Appearance+: Last BM: 05/18/16

CP

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:

5A4D43B46E10429588C8, KNIGHT, 267

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 1700 (continued)

125 CRITICAL CARE REPORT (continued)

IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60 ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C 545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILUADID IV X1 DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES. PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT 20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED. O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:

Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment: NA

IV Site #1: DISCONTINUED
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: SL
Date Insert/DC #1: 05/19/16
IV #1 Comment: OUTDATED

IV Site #3: LEFT FOREARM
Site Appear #3: NORMAL
Type of Cath #3: Jelco
Cath Gauge #3: 22
Fluid/Rate #3: KVO
Date Insert/DC #3: 05/19/16
IV #3 Comment: GOOD RETURN / GOOD FLUSH

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 1700 (continued)

125 CRITICAL CARE REPORT (continued)

IV Site #2: DISCONTINUED
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/19/16
IV #2 Comment: OUTDATED

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/19/16 1700 TK2 05/19/16 1806 TK2
INTAKE

PO: 1755 IV FLUIDS: Y PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI): Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: 1050 Bowel Incont Episodes: T Tube: Ileostomy: 1575
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Dng (Output):

Comment:

5500011 Purposeful Rounding A CP
- Document 05/19/16 1700 SF 05/19/16 1710 SF
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E10429588C8, KNIGHT, 268

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 1751

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/19/16 1751 SP 05/19/16 1752 SP

OXYHOOD/Hi Flow
Time: 1751
Interface: MED
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31.0
Temp in Hood:
Water Level: 500
Respirations: 18
Pulse: 95
O2 Sat: 96
--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/19/16 Time: 1800

0840 Positioning A Q2H CP
- Document 05/19/16 1800 TK2 05/19/16 1807 TK2

1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/19/16 1800 TK2 05/19/16 1808 TK2
Diet Ordered: MECH SOFT
Meal: BREAKFAST, LUNCH, DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement: PROTSTAT
PO Supplement: 30 cc (Total Intake)

Comment:

120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/19/16 1800 TK2 05/19/16 1809 TK2
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >90% : MET MET

COMMENT: 30% VIA HIGH FLOW NC
UP IN CHAIR FOR 9 HOURS TODAY.

525003 IV Site Check A 06,18 CP
- Document 05/19/16 1800 TK2 05/19/16 1809 TK2
IV Site WNL: Y If No:

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 1800 (continued)

525003 IV Site Check (continued) CP
Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type:
Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact:
Dressing changed: Date: Change:
Tenderness of the Site:
BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5500010 Rounds Surveillance A 06,18 CP
- Document 05/19/16 1800 TK2 05/19/16 1809 TK2

Activity Date: 05/19/16 Time: 1809

Patient Notes: Nursing Notes
- Create 05/19/16 1809 TK2 05/19/16 1813 TK2
Abnormal? N Confidential? N
ALERT / ORIENTED. NO C/O PAIN AT THIS TIME. UP IN CHAIR FOR 9 HOURS TODAY RETURNED TO BED WITH STANDBY ASSIST THIS EVENING. NO C/O PAIN SINCE EARLY AFTERNOON. ILIOSTOMY AND FOLEY CATHETER TO GRAVITY DRAINAGE. DISCONTINUED OUTDATED IVs AND PLACED NEW SITE TO LFA. CURRENTLY AT 30% O2 VIA HIGH FLOW NC. IN BED WITH TV ON. CALL LIGHT IN REACH. REVIEWED CALL FOR ASSIST. APPETITE IMPROVING.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 1900

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/19/16 1900 RM 05/19/16 2326 RM
****Nursing Report (Hand Off)****

Report Received/Care Assumed Report Given Bedside:
To/From TO RAFIK
Comment

Activity Date: 05/19/16 Time: 1955

5500011 Purposeful Rounding A CP
- Document 05/19/16 1955 JW* 05/19/16 2003 JW*
Pain
Potty
Position

5A4D43B46E10429588C8, KNIGHT, 269

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 1955 (continued)

5500011 Purposeful Rounding (continued)
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/19/16 Time: 2000

1699 Prostat Supplement A 08,20 OE
- Document 05/19/16 2000 RM 05/20/16 0046 RM
Prostat given: Y

Comment:
120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/19/16 2000 RM 05/20/16 0059 RM
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 85
High Rate: 100
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/19/16 2000 RM 05/20/16 0046 RM
120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/19/16 2000 RM 05/20/16 0059 RM
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Size Left+: 3mm
Lt Reaction To Light+: Reactive

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: Weak
LLE+: Weak

Peripheral Sensory Deficit:
Site:

Vision Impairment:
Hearing Impairment:

Continued On Next Page

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: S1,S2 Transvenous Pacemaker: Secured at cm
Telemetry Pattern+: SINUS TACHYCARDIA Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses
Dorsalis Lt+: Normal Radial Rt+: Normal

5A4D43B46E10429588C8, KNIGHT, 270

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Dorsalis Rt+: Normal
Post Tib Lt+: Normal
Post Tib Rt+: Normal
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Lt+: Normal
Femoral Rt+:
Femoral Lt+:
Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 21 O2 Sat: 93 %/L of O2: 30 Cyanosis: N Pallor: N

O2 Mode+: Hi-flow NASAL CANNULA
RR Description+: WNL

Resp Pattern+: Shallow
Chest Expansions+: Symmetrical
Cough+: Non-effective
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

Breath Sounds
LUL+: Diminished
LLL+: Diminished
RUL+: Diminished
RML+: Diminished
RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull:

Comment

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no prostheses, no amputations.

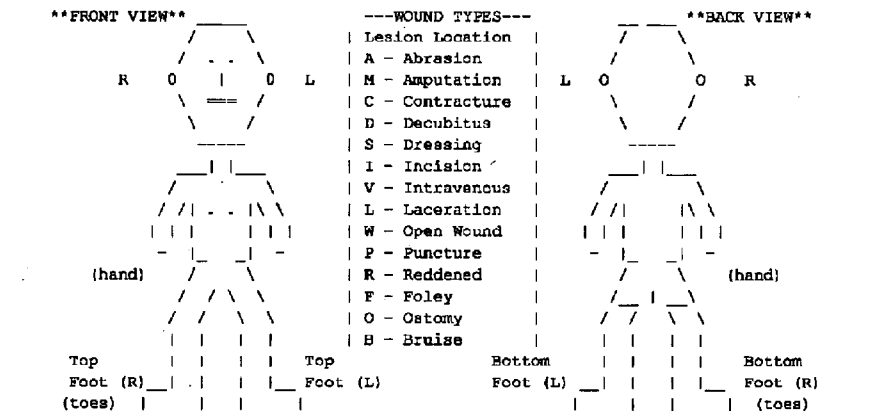
ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>: GENRALIZED WEAKNESS NOTED



COMMENT:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: GOOD

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

5A4D43B46E10429588C8, KNIGHT, 271

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

120001 SKIFT ASSESSMENT-Critical Care (continued)

Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #2:
Wound Appear #2:
Closure Type #2:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains:

Skin Comment <Esc>: PT HAS MID LINE ABD INCISION THAT IS DRY AND INTACT. PT HAS JP DRAIN ON THE LT SIDE AND ILIOSTOMY ON THE RT SIDE. NO SIGNS OF INFECTION NOTED AROUND THE STOMA

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited: 3
No Impairment:

Activity Score
Bedfast:
Chairfast: 2
Walks Occasionally:
Walks Frequently:

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate: 3
Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited: 3
No Limitations:

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Total Braden Score: 18

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N
Emesis: N Diarrhea: N
By C-Diff Protocol - Watery loose stool: N

Last BM: 05/19/16 Incontinent Stool:
Stool Amount+:
Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness MIDDLE
Abd Appearance+: SOFT
DISTENDED
RUQ+: HYPOACTIVE
LUQ+: HYPOACTIVE
RLQ+: HYPOACTIVE
LLQ+: HYPOACTIVE

Tubes+:
Tube Drainage: Tube To Suction:
OGT/NGT is secured at cm
Stoma Present: Y Location: RT ABD
Appearance: PINK
Ostomy Appliance: Y
Drainage Characteristics: CLOUDY GRAY

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

120001 SKIFT ASSESSMENT-Critical Care (continued)

GI Comment <Esc>: ILIOSTOMY NOTED TO RT ABD, WAFFER C/D/I. GRAY LIQUID STOOL DRAINING INTO COLLECTION BAG.
Rectal Tube: N

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y
Urine Color+: Amber
Urine Odor+: Normal
Character+: CLEAR
Incontinent Bladder:
Suprapubic Catheter:
Urostomy:
Stoma Appearance

Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD: Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: FOLEY CATHETER INTACT AND DRAINING TO GRAVITY.

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y
Pain Scale:
Pain Location+:
Quality Of Pain+:
Onset/Duration:
Pain Med Given<Esc>:

Acceptable Scale/Goal for EXCELLENT pain management this shift:

Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: SEE NURSES NOTES

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

5A4D43B46E1042958C8, KNIGHT, 272

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning

Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.

525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/19/16 2000 RM 05/20/16 0100 RM

IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1:	LEFT FOREARM	IV Site #3:
Site Appear #1:	NORMAL	Site Appear #3:
Type of Cath #1:	Jelco	Type of Cath #3:
Cath Gauge #1:	22	Cath Gauge #3:
Fluid/Rate #1:	SL	Fluid/Rate #3:
Date Insert/DC #1:	05/19/16	Date Insert/DC #3:
IV #1 Comment:	WNL	IV #3 Comment:
	<Esc>	<Esc>
IV Site #2:		IV Site #4:
Site Appear #2:		Site Appear #4:
Type of Cath #2:		Type of Cath #4:
Cath Gauge #2:		Cath Gauge #4:
Fluid/Rate #2:		Fluid/Rate #4:
Date Insert/DC #2:		Date Insert/DC #4:
IV #2 Comment:		IV #4 Comment:
	<Esc>	<Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/19/16 2000 RM 05/20/16 0046 RM
Type of Isolation: NONE Tissue Test:

7370 Discharge Planning Assessment A QS CP
- Document 05/19/16 2000 RM 05/20/16 0046 RM

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
NONE AT THIS TIME

NEEDS IDENTIFIED:

Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

7370 Discharge Planning Assessment (continued)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

Do you have questions about insurance or need to speak to a financial counselor? N

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/19/16 2000 RM 05/20/16 0047 RM

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs 1

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 11

*****Interventions*****

5A4D43B46E10429588C8, KNIGHT, 273

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/19/16 2000 RM 05/20/16 0040 RM
Temperature: 99.1
Temperature Source+: Tympanic
Pulse: 94
Respirations: 19
Blood Pressure: 104/64
MAP: 77
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater than 3hrs)

Physician Notified: N
If NO, Reason: Physician Already Aware

Patient Notes: Nursing Notes
- Create 05/19/16 2000 RM 05/20/16 0030 RM
Abnormal? N Confidential? N
REPORT GIVEN. ASSESSMENT COMPLETE. SEE SHIFT ASSESSMENT. PT IS AOX3. PT DENIES PAIN OR DSITRESS AT THIS TIME. NO SIGNS OF DISTRESS NOTED. WILL CONTIUE TO

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 2000 (continued)

Patient Notes: Nursing Notes (continued)
MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 2002

120000 Critical Care Flowsheet A Q4H CP
- Document 05/19/16 2002 RM 05/19/16 2323 RM
Critical Care Flowsheet Time:

Temperature: 99.1
Temperature Source+: Tympanic
Pulse: 95
Pulse Source+: MONITOR
Respirations:
SPON:
Vent Resp:
Blood Pressure: 104/64
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 92
%/L of O2:
ETCO2:
A-LINE BP:
MAP: 77
Intra-Abd Pressure:
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:
Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm
Weight (lbs): (Oz): kg:
Weight Source:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Comment:

Activity Date: 05/19/16 Time: 2035

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/19/16 2035 JW2 05/19/16 2036 JW2
OXYHOOD/Hi Flow
Time: 2035
Interface: MED
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 30.8
Temp in Hood:
Water Level: 300
Respirations: 18
Pulse: 90
O2 Sat: 93
--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

5A4D43B46E10429588C8, KNIGHT, 274

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 2036

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/19/16 2036 JW2 05/19/16 2037 JW2

RESPIRATORY THERAPY TREATMENT

%/L of O2: 30 LPM 40 NC Y O2 Sat: 93 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Inline Y A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 90 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 92 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/19/16 Time: 2036 (continued)

09 RESP THERAPY - TREATMENT (continued)
DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/19/16 Time: 2100

5500011 Purposeful Rounding A CP
- Document 05/19/16 2100 JW* 05/19/16 2106 JW*
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/19/16 Time: 2200

0840 Positioning A Q2H CP
- Document 05/19/16 2200 RM 05/20/16 0100 RM

Activity Date: 05/19/16 Time: 2218

Patient Notes: Nursing Notes
- Create 05/19/16 2218 RM 05/19/16 2218 RM
Abnormal? N Confidential? N
PT COMPLAINED OF ABDOMINAL PAIN 5/10. VICODAN PO GIVEN. SEE EMAR. WILL CONTIUE TO MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/19/16 Time: 2221

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/19/16 2221 JW2 05/19/16 2222 JW2
OXYHOOD/Hi Flow
Time: 2221
Interface: MED

5A4D43B46E10429588C8, KNIGHT, 275

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/19/16 Time: 2221 (continued)

014 RESP THERAPY - OXYHOOD (continued)

Set FiO2: 30
Analyzed FiO2:
Liter Flow: 40
Temp on Heater: 31
Temp in Hood:
Water Level: 100
Respirations: 19
Pulse: 94
O2 Sat: 92

--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/19/16 Time: 2300

5500011 Purposeful Rounding A CP
- Document 05/19/16 2300 JW* 05/20/16 0322 JW*
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 0000

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/20/16 0000 RM 05/20/16 0101 RM
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 85
High Rate: 100
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:

0840 Positioning A Q2H CP
- Document 05/20/16 0000 RM 05/20/16 0101 RM

120000 Critical Care Flowsheet A Q4H CP
- Document 05/20/16 0000 RM 05/20/16 0043 RM
Critical Care Flowsheet Time: 0000

Temperature: 98.8 Nursing Note:
Temperature Source+: Tympanic
Pulse: 85 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0000 (continued)

120000 Critical Care Flowsheet (continued)

Respirations: 21 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 112/77 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 95 Calibrate: Void (ml): ml
%/L of O2: 30
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 89
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
Patient Notes: Nursing Notes
- Create 05/20/16 0000 RM 05/20/16 0031 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME. WILL CONTIUE TO MONITOR THE PT.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 0048

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/20/16 0048 JW2 05/20/16 0049 JW2
OXYHOOD/Hi Flow
Time: 0048
Interface: MED
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 35
Temp on Heater: 31
Temp in Hood:
Water Level: 1000
Respirations: 21
Pulse: 95
O2 Sat: 87

--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day: Y

Comment:

Activity Date: 05/20/16 Time: 0100

5500011 Purposeful Rounding A CP
- Document 05/20/16 0100 JW* 05/20/16 0322 JW*
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)

5A4D43B46E10429588C8, KNIGHT, 276

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 0100 (continued)

5500011 Purposeful Rounding (continued)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 0102

014	RESP THERAPY - OXYHOOD							A	Q2H	CP
- Document	05/20/16	0102	JW2	05/20/16	0103	JW2				

OXYHOOD/Hi Flow
Time: 0102
Interface: MED
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 35
Temp on Heater: 31
Temp in Hood:
Water Level: 1000
Respirations: 22
Pulse: 86
O2 Sat: 94

--Charges--
Oxyhood/Hi Flow Install:
Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/20/16 Time: 0200

0840	Positioning							A	Q2H	CP
- Document	05/20/16	0200	RM	05/20/16	0227	RM				
6409	FALLS SCREEN - FOLLOW-UP							A	02,14	CP
- Document	05/20/16	0200	RM	05/20/16	0227	RM				

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

Total Score:

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation

5A4D43B46E10429588C8, KNIGHT, 277

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
In Rm when pt OOB to BSC, BR, Shower,etc. Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?
Patient Notes: Nursing Notes
- Create 05/20/16 0200 RM 05/20/16 0316 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHNAGE IN CONDITION NOTED AT THIS TIME.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 0300

5500011 Purposeful Rounding A CP
- Document 05/20/16 0300 JW* 05/20/16 0322 JW*
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 0400

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/20/16 0400 RM 05/20/16 0520 RM
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 85
High Rate: 100
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 0400

0840 Positioning A Q2H CP
- Document 05/20/16 0400 RM 05/20/16 0519 RM
120000 Critical Care Flowsheet A Q4H CP
- Document 05/20/16 0400 RM 05/20/16 0520 RM
Critical Care Flowsheet Time: 0400

Temperature: 98.9 Nursing Note:
Temperature Source+: Tympanic
Pulse: 80 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 105/73 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 95 Calibrate: Void (ml): ml
%/L of O2: 30
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 83
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/20/16 0400 RM 05/20/16 0520 RM
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/20/16 0400 RM 05/20/16 0520 RM
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing

5A4D43B46E1042958BC8, KNIGHT, 278

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0400 (continued)

800001 Education/Teaching Assessment (continued)
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Patient Notes: Nursing Notes
- Create 05/20/16 0400 RM 05/20/16 0528 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 0418

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/20/16 0418 JW2 05/20/16 0419 JW2
OXYHOOD/Hi Flow
Time: 0418
Interface: MED
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 30
Temp on Heater: 31
Temp in Hood:
Water Level: 800
Respirations: 20 --Charges--
Pulse: 85 Oxyhood/Hi Flow Install:
O2 Sat: 94 Oxyhood/Hi Flow Day:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0418 (continued)

014 RESP THERAPY - OXYHOOD (continued)
Comment:

Activity Date: 05/20/16 Time: 0500

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/20/16 0500 RM 05/20/16 0526 RM
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): ABX IV Fluids (A): 50
Medication (B): IV Fluids (B):
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 50 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/20/16 0500 RM 05/20/16 0521 RM
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:
STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N
K/MG Protocol: NO
Last K: Covered: YES Blood Pressure: 105/73
Last MG: Covered: Temperature: 98.9

5A4D43B46E1042958BC8, KNIGHT, 279

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm

Mental Status: Alert & Oriented

Respirations: 20 VENTILATOR DOCUMENTATION:
O2 Sat: 94 Vent type:
%/L of O2: 30 Tidal Volume Vent Set Rate:
O2 Mode+: Hi-flow NASAL CANNULA Pressure Support Mode
FiO2 Peep:

Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:

COMMENT:

Tubes+: Urinary Catheter Inserted: 05/15/16
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+: 16
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd:

Abd Appearance+: Last BM: 05/20/16

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60
ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C
545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILAUDID IV X1

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES. PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT 20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED. O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:

Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment: NA

IV Site #1: DISCONTINUED
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 18
Fluid/Rate #1: SL
Date Insert/DC #1: 05/19/16
IV #1 Comment: OUTDATED

IV Site #2: DISCONTINUED
Site Appear #2: NORMAL
Type of Cath #2: Jelco
Cath Gauge #2: 18
Fluid/Rate #2: SL
Date Insert/DC #2: 05/19/16
IV #2 Comment: OUTDATED

IV Site #3: LEFT FOREARM
Site Appear #3: NORMAL
Type of Cath #3: Jelco
Cath Gauge #3: 22
Fluid/Rate #3: KVO
Date Insert/DC #3: 05/19/16
IV #3 Comment: GOOD RETURN / GOOD FLUSH

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

5A4D43B46E10429588C8, KNIGHT, 280

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0500

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/20/16 0500 RM 05/20/16 0526 RM

INTAKE

PO: 500 IV FLUIDS: PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI):
Dialysis (Intake):

OUTPUT

Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: 1400 Bowel Incont Episodes: T Tube: Ileostomy: 1000
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: 20 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Dng (Output):

Comment:

5500011 Purposeful Rounding A CP
- Document 05/20/16 0500 JW* 05/20/16 0522 JW*
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 0526

150011 Weight, Monitor Daily A DAILY@0600 CP
- Document 05/20/16 0526 RM 05/20/16 0527 RM
Weight (lbs): 161
(Oz): 0
kg: 73.028
Weight Source: Bedscale

Activity Date: 05/20/16 Time: 0551

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/20/16 0551 JW2 05/20/16 0551 JW2
OXYHOOD/Hi Flow
Time: 0551
Interface: MED

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0551 (continued)

014 RESP THERAPY - OXYHOOD (continued)
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 30
Temp on Heater: 31
Temp in Hood:
Water Level: 700
Respirations: 19 --Charges--
Pulse: 90 Oxyhood/Hi Flow Install:
O2 Sat: 94 Oxyhood/Hi Flow Day:

Comment:
Patient Notes: Respiratory Therapy Notes
- Create 05/20/16 0551 JW2 05/20/16 0552 JW2
Abnormal? N Confidential? N
BIPAP ON STANDBY PT REMAINED ON HI FLOW NC THROUGH NIGHT.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 0600

0840 Positioning A Q2H CP
- Document 05/20/16 0600 RM 05/20/16 0606 RM
120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/20/16 0600 RM 05/20/16 0606 RM
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >90% : MET MET

COMMENT:
525003 IV Site Check A 06,18 CP
- Document 05/20/16 0600 RM 05/20/16 0606 RM
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:

5A4D43B46E10429588C8, KNIGHT, 281

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/20/16 Time: 0600 (continued)

525003 IV Site Check (continued)
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/20/16 0600 RM 05/20/16 0606 RM
Patient Notes: Nursing Notes
- Create 05/20/16 0600 RM 05/20/16 0606 RM
Abnormal? N Confidential? N
PT IS SLEEPING. NO SIGNS OF DISTRESS NOTED. NO CHANGE IN CONDITION NOTED AT THIS TIME.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 0711

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/20/16 0711 ST 05/20/16 0712 ST
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From SUSIE / RAFIK

Comment

Activity Date: 05/20/16 Time: 0714

012 RESP THERAPY - NON-INVASIVE VENTILATION A AD CP
- Document 05/20/16 0714 SP 05/20/16 0714 SP
NON-INVASIVE VENTILATION

Time: 0714 Number: 38 Ventilator: N
IPAP: EPAP:
PS: Mode: ALARMS Apnea:
Set Rate/Back up: Low VE:
FiO2/LPM: High RR:
Low Pressure:

PATIENT DATA
Blood Pressure: Pulse: Respirations: O2 Sat:
Sensitivity: VT: VE: I Time:

Breath Sounds:

Mask Size: Mask Type:

Skin Integrity (of mask area):

Action Taken: STANDBY HIGH FLOW ON

CHARGES
BiPAP with RR Install:
BiPAP with RR Day:
BiPAP with out Rate Install:
BiPAP with out Rate Day:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/20/16 Time: 0714

016 RESP THERAPY - EQUIPMENT CHANGE OUT A QD@1130 CP
- Document 05/20/16 0714 SP 05/20/16 0714 SP
EQUIPMENT CHANGE OUT

Closed Suction System (PRN) N
HME (24-48HRS) N
Nebs (Every Wed) N
O2 Humidifiers (Every Wed) N
NRB (Every Wed) N
Venturi (Every Wed) N

Comment:
09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/20/16 0714 SP 05/20/16 0715 SP
RESPIRATORY THERAPY TREATMENT

%/L of O2: 30 LPM NC O2 Sat: 96 FIO2 VM PRB NRB
O2 24 hrs Y CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Inline Y A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 93 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 96 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:

5A4D43B46E10429588C8, KNIGHT, 282

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 0714 (continued)

09 RESP THERAPY - TREATMENT (continued)

COUGH Y Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood

Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment HIGH FLOW AT 30%
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella Y IS Y O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/20/16 0714 SP 05/20/16 0714 SP
OXYHOOD/Hi Flow
Time: 0714
Interface: MKD
Set FiO2: 30
Analyzed FiO2:
Liter Flow: 30
Temp on Heater: 30.9
Temp in Hood:
Water Level: 600
Respirations: 18 --Charges--
Pulse: 93 Oxyhood/Hi Flow Install:
O2 Sat: 96 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/20/16 Time: 0715

08 RESP THERAPY - PATIENT EVALUATION A Q72H@0800 CP
- Document 05/20/16 0715 SP 05/20/16 0716 SP
RESPIRATORY CARE PATIENT EVALUATION

RT ASSESSMENT TYPE: F/U ADULT Date: 05/20/16 Time: 0716

PULMONARY HISTORY: SURGICAL PATIENT:
NONE No Surgeries

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 0715 (continued)

08 RESP THERAPY - PATIENT EVALUATION (continued)

Smoking Hx 1 Non-Thoracic 1
Pulmonary Disease Thoracic/Upper Abd
Home Oxygen, Home Tx, Severe/ Thoracic Surgery w/Pulm Dis
Chronic w/Exacerbation

ACTIVITY LEVEL:
Ambulatory
Amb w/Assistance 1
Non-Ambulatory
Parplegic/Quad

RESPIRATORY PATTERN:
Normal Breath Pattern (RR12-20)
Increased Resp Rate (RR20-25) 1
Dyspnea/Irreg Pattern/Use
of Accessory Muscles/Severe
Severe Dyspnea/Use of Accessory
muscles/Assist Ventilation (RR>30)

CHEST X-RAY:
Clear 0
Chronic Radiographic Changes
Infiltrates/Atelectasis/Pleural Effusion 2
Known Pulmonary Dis or CXR not available

AUSCULTATION:
Clear
Diminished 1
Rales
Wheezes/Rhonchi/Stridor

MENTAL STATUS:
Alert, Oriented, Cooperative 0
Disoriented, Follows Commands
Restrained/Obtunded/Uncooperative
Comatose.

INSPECTION:
No Signs of Discomfort 0
Dyspnea/SOB Noted
Dyspnea, Pursed Lip Breathing,
Accessory Muscle Use, Abd Breathing,
Cyanosis, Jugular Vein Distention,
Nasal Flaring, Retractions, or
Tactile Fremitus

COUGH:
Strong, Spontaneous, NPC
Strong Productive
Weak Prod/Non Prod 2
No Spont Cough/Sx may be needed

Total Points: 9

TOTAL POINTS EVALUATION RESULTS Improved Status/Mod Risk

Activity Date: 05/20/16 Time: 0755

1699 Prostat Supplement A 08,20 OE
- Document 05/20/16 0755 ST 05/20/16 0755 ST
Prostat given: Y

Comment:
120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/20/16 0755 ST 05/20/16 0759 ST
Telemetry Rhythm: SINUS RHYTHM

Low Rate: 90
High Rate: 98
Change From Baseline: N
Notify MD: N Check Alarm: Y

5A4D43B46E10429588C8, KNIGHT, 283

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

120009 Telemetry Monitoring - Critical Care (continued)
Comment:
0840 Positioning A Q2H CP
- Document 05/20/16 0755 ST 05/20/16 0755 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/20/16 0755 ST 05/20/16 0755 ST
Diet Ordered: MECH SOFT
Meal: BREAKFAST
% Diet Taken: >75% (GOOD)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:
1200008 Oral Care - Critical Care A DAILY CP
- Document 05/20/16 0755 ST 05/20/16 0800 ST
120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/20/16 0755 ST 05/20/16 0759 ST
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Size Left+: 3mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: Weak
LLE+: Weak

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Vision Impairment: GLASSES
Hearing Impairment:

Mental Status: Alert & Oriented
Continued On Next Page
Glasgow Coma Scale Y

Eye Opening
Spontaneously: 4
To Speech:
To Pain:
No Response:

Best Verbal Response
Converses/Oriented: 5
Converses/Disoriented:
Inappropriate Words:
Incomprehensible:
No Response:

Best Motor Responses
Obeys Command: 6
Localizes Pain:
Withdraws To Pain:
Abnormal Flexion:
Abnormal Extension:
No Response:

Total Glasgow Score: 15

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: N WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: 95 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: Normal Transvenous Pacemaker: N Secured at cm
Telemetry Pattern+: SINUS RHYTHM Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+:
Loc 1+:
Pitting:
Edema 2+:
Loc 2+:
Pitting:
TED Hose: N
IPC: Y
Venous Foot Pump: N
Edema 3+:
Loc 3+:
Pitting:
Edema 4+:
Loc 4+:
Pitting:

Peripheral Pulses
Dorsalis Lt+: Normal
Dorsalis Rt+: Normal
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal
Femoral Rt+:
Femoral Lt+:
Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

5A4D43B46E10429588C8, KNIGHT, 284

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Respirations: 16 O2 Sat: 96 %/L of O2: 30 Cyanosis: N Pallor: N

O2 Mode+: Hi-flow NASAL CANNULA
RR Description+: WNL

Resp Pattern+: Shallow
Chest Expansions+: Symmetrical
Cough+: Non-effective
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

Breath Sounds
LUL+: Diminished
LLL+: Diminished
RUL+: Diminished
RML+: Diminished
RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull:

Comment
MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Problem/Outcome/Intervention Description

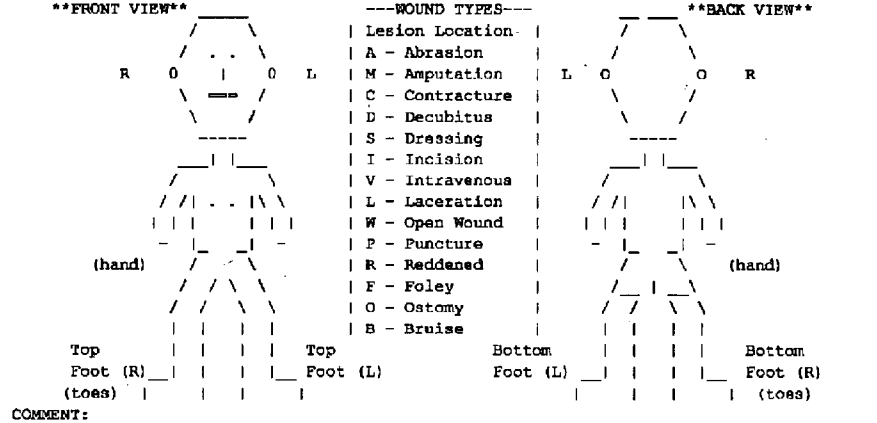
Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>:



COMMENT:
Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and turgor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: GOOD
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+:
Dressing Type #1:
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, FOLEY, OSTOMY

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

5A4D43B46E1042958BC8, KNIGHT, 285

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited:
No Impairment: 4

Activity Score
Bedfast:
Chairfast:
Walks Occasionally: 3
Walks Frequently:

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate:
Excellent: 4

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited: 3
No Limitations:

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Total Braden Score: 21

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/20/16 Incontinent Stool: Y
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:

Abd Girth: cm Tenderness
Abd Appearance+: SOFT
DISTENDED
RUQ+: HYPOACTIVE
LUQ+: HYPOACTIVE
RLQ+: HYPOACTIVE
LLQ+: HYPOACTIVE
GI Comment <Esc>:

Tubes+:
Tube Drainage: N Tube To Suction:
OGT/NGT is secured at cm
Stoma Present: Y Location: RT ABD
Appearance: PINK
Ostomy Appliance: Y
Drainage Characteristics: ORANGE
Rectal Tube: N

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? Y
Currently Menses:
LMP:
Urine Color+: Amber
Urine Odor+: Normal
Character+: CLEAR
Prostate Problems:
Incontinent Bladder:
Suprapubic Catheter:

Dialysis
CAPD: Peritoneal Dialysis:
Hemodialysis:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Urostomy: Hemo Site Description+:
Stoma Appearance Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/20/16 0755 ST 05/20/16 0800 ST
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT FOREARM IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Jelco Type of Cath #3:

5A4D43B46E10429588C8, KNIGHT, 286

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

525002 IV THERAPY ASSESSMENT (continued)

Cath Gauge #1: 22 Cath Gauge #3:
Fluid/Rate #1: SL Fluid/Rate #3:
Date Insert/DC #1: 05/19/16 Date Insert/DC #3:
IV #1 Comment: IV #3 Comment:
<Esc> <Esc>

IV Site #2: IV Site #4:
Site Appear #2: Site Appear #4:
Type of Cath #2: Type of Cath #4:
Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/20/16 0755 ST 05/20/16 0755 ST
Type of Isolation: NONE Tissue Test:

6907 PATIENT BATH - Critical Care A DAILY CP
- Document 05/20/16 0755 ST 05/20/16 0755 ST
Hygiene: Assisted Date: 05/20/16

CHG Bath given: Y If no, Reason:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)

Patient Refused (Bath): Nurse Notified (Bath):

Hygiene Comment:

7370 Discharge Planning Assessment A QS CP
- Document 05/20/16 0755 ST 05/20/16 0756 ST

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY NURSE ASSISTING WITH HOME SUPPLYS

NEEDS IDENTIFIED:

Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

7370 Discharge Planning Assessment (continued)

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/20/16 0755 ST 05/20/16 0757 ST

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking 1
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 10

*****Interventions*****
Bed Wheels Locked Y Fall assessment completed Y
Bed in Low Position Y Patient needs Assessed q2hr Y
Call Light within reach Y Environment Assessed Fall Risk Y
Personal Items within reach Y

5A4D43B46E10429588C8, KNIGHT, 287

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0755 (continued)

9610 Fall Risk Assessment/Interventions (continued)

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P Y
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: BED IN LOWEST POSITION AND LOCKED, CALL BELL W/I REACH, PT DOES NOT ATTEMPT TO GET OOB UNASSISTED

Fall Score Ranking: Moderate Level of Care: Assist

Activity Date: 05/20/16 Time: 0800

120000 Critical Care Flowsheet A Q4H CP
- Document 05/20/16 0800 ST 05/20/16 0813 ST
Critical Care Flowsheet Time: 0800

Temperature: 98.4
Temperature Source+: Tympanic
Pulse: 93
Pulse Source+: MONITOR
Respirations: 16
SPON:
Vent Resp:
Blood Pressure: 107/67
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 96
%/L of O2: 30
ETCO2:
A-LINE BP:
MAP:
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:

Glycemic Protocol:
Fingerstick BS:
Frequency:

Cooling Blanket:
Warming Blanket:

Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 0800 (continued)

120000 Critical Care Flowsheet (continued)
Comment:
99 SEPSIS Documentation A QS CP
- Document 05/20/16 0800 ST 05/20/16 0813 ST
Temperature: 98.4
Temperature Source+: Tympanic
Pulse: 93
Respirations: 16
Blood Pressure: 107/67
MAP: 79
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:
If NO, Reason:
Patient Notes: Nursing Notes
- Create 05/20/16 0800 ST 05/20/16 0857 ST
Abnormal? N Confidential? N
assessment completed, pt resting quietly in high fowlers eating breakfast. Dr Budhoo in to see pt, wife at bedside. ostomy nurse Kristie M. RN at bedside given instructions to wife and pt.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 0821

5500011 Purposeful Rounding A CP
- Document 05/20/16 0821 JS 05/20/16 0821 JS
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 0957

014 RESP THERAPY - OXYHOOD A Q2H CP
- Document 05/20/16 0957 SP 05/20/16 0958 SP
OXYHOOD/Hi Flow
Time: 0957
Interface: MED
Set FiO2: 30
Analyzed FiO2:

5A4D43B46E10429588C8, KNIGHT, 288

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 0957 (continued)

014 RESP THERAPY - OXYHOOD (continued)
Liter Flow: 30
Temp on Heater: 31.0
Temp in Hood:
Water Level: 500
Respirations: 20 --Charges--
Pulse: 92 Oxyhood/Hi Flow Install:
O2 Sat: 96 Oxyhood/Hi Flow Day:

Comment:

Activity Date: 05/20/16 Time: 1007

0840 Positioning A Q2H CP
- Document 05/20/16 1007 ST 05/20/16 1007 ST

Activity Date: 05/20/16 Time: 1017

014 RESP THERAPY - OXYHOOD I Q2H CP
- Ed Status 05/20/16 1017 SP 05/20/16 1017 SP A => I
- Document 05/20/16 1017 SP 05/20/16 1018 SP
OXYHOOD/Hi Flow
Time:
Interface:
Set FiO2:
Analyzed FiO2:
Liter Flow:
Temp on Heater:
Temp in Hood:
Water Level:
Respirations: 20 --Charges--
Pulse: 90 Oxyhood/Hi Flow Install:
O2 Sat: 96 Oxyhood/Hi Flow Day:

Comment: SB PT. ON 4LPM WITH N/C

Activity Date: 05/20/16 Time: 1020

Patient Notes: Nursing Notes
- Create 05/20/16 1020 ST 05/20/16 1035 ST
Abnormal? N Confidential? N
bath given and linens changed, up to recliner and tolerated well. off high flow and on N.C. @ 4/1 with sats 94-95%. pt teaching on foley removal w/ foley removed at this time. pt instructed on bladder scan. pt to call nurse when he has sputum specimen.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/20/16 Time: 1023

6901 PATIENT LINEN CHANGE A PRN CP
- Document 05/20/16 1023 JS 05/20/16 1023 JS
Linen Change 05/20/16

Patient Refused (Linen): Nurse Notified (Linen):
6907 PATIENT BATH - Critical Care A DAILY CP
- Document 05/20/16 1023 JS 05/20/16 1024 JS
Hygiene: Assisted Date: 05/20/16

CHG Bath given: Y If no, Reason:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)

Patient Refused (Bath): Nurse Notified (Bath):

Hygiene Comment:

Activity Date: 05/20/16 Time: 1056

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/20/16 1056 SP 05/20/16 1056 SP
RESPIRATORY THERAPY TREATMENT

%/L of O2: 4 LPM NC Y O2 Sat: 96 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 92 Pre-Assessment RR: 20

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:

5A4D43B46E10429588C8, KNIGHT, 289

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/20/16 Time: 1056 (continued)

09 RESP THERAPY - TREATMENT (continued)
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 93 Post-Assessment RR: 20

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH Y Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment HIGH FLOW ON STANDBY
<Esc> O2 AT 4LPM WITH N/C

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/20/16 Time: 1103

Patient Notes: Nursing Notes
- Create 05/20/16 1103 ST 05/20/16 1103 ST
Abnormal? N Confidential? N
pt teaching on prozac and he states that he takes this med at home, teaching on lovenox and he verbalizes understanding.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 1122

Patient Notes: Nursing Notes
- Create 05/20/16 1122 ST 05/20/16 1123 ST
Abnormal? N Confidential? N
up ambulating in halls with P.T., tolerating w/o problems. back to recliner with o2 n.c. w/ sats 95% on 4/1.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/20/16 Time: 1132

5500011 Purposeful Rounding A CP
- Document 05/20/16 1132 JS 05/20/16 1132 JS
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 1200

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/20/16 1200 ST 05/20/16 1318 ST
Telemetry Rhythm: SINUS RHYTHM
SINUS TACHYCARDIA
Low Rate: 95
High Rate: 105
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/20/16 1200 ST 05/20/16 1318 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/20/16 1200 ST 05/20/16 1318 ST
Diet Ordered: MECH SOFT
Meal: LUNCH
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:
120000 Critical Care Flowsheet A Q4H CP
- Document 05/20/16 1200 ST 05/20/16 1318 ST
Critical Care Flowsheet Time: 1200

Temperature: 98.7
Temperature Source+: Tympanic
Pulse: 103
Pulse Source+: MONITOR
Respirations: 20
SPON:
Vent Resp:
Blood Pressure: 109/74
BP Location+: L Arm
PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:

5A4D43B46E10429588C8, KNIGHT, 290

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 1200 (continued)

120000 Critical Care Flowsheet (continued)

BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 95 Calibrate: Void (ml): ml
%/L of O2: 4
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/20/16 Time: 1222

25 PT: Daily Documentation A PS
- Document 05/20/16 1222 CG 05/20/16 1224 CG

S: Patient with no complaints

Press ESC to get out of text boxes.

O: sit to stand with CGA
pt ambulated 200 ft RW with CGA, with 6L nasal O2
stand to sit with with CGA

A: patient tolerated increased ambulation well, O2 sats at 97% after GT.

P: Continue with POC

Activity Date: 05/20/16 Time: 1400

Patient Notes: Nursing Notes
- Create 05/20/16 1400 ST 05/20/16 1439 ST
Abnormal? N Confidential? N
bladder scan 160cc, will continue to monitor closely. pt ate banana and was unable to drain out of bag, bag changed per R. Gasque RN.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 1412

0840 Positioning A Q2H CP
- Document 05/20/16 1412 ST 05/20/16 1412 ST
6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/20/16 1412 ST 05/20/16 1413 ST

FALL SCREEN FOLLOW-UP

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 1412 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within the last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk

5A4D43B46E10429588C8, KNIGHT, 291

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 1412 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

or dosage within the last 24 hrs

MODERATE Risk (9-14) YELLOW sign on door
HIGH RISK (>14) RED Sign on door/chart

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking:
Patient on Anticoagulants?

Activity Date: 05/20/16 Time: 1428

5500011 Purposeful Rounding A CP
- Document 05/20/16 1428 JS 05/20/16 1428 JS
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 1438

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/20/16 1438 SP 05/20/16 1439 SP
RESPIRATORY THERAPY TREATMENT

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 1438 (continued)

09 RESP THERAPY - TREATMENT (continued)
%/L of O2: 4 LPM NC Y O2 Sat: 97 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 88 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 90 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH Y Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

5A4D43B46E1042958BC8, KNIGHT, 292

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 1438 (continued)

09 RESP THERAPY - TREATMENT (continued)
METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/20/16 Time: 1439

Patient Notes: Respiratory Therapy Notes
- Create 05/20/16 1439 SP 05/20/16 1440 SP
Abnormal? N Confidential? N
PATIENT TOLERATED HIGH FLOW EARLY AM UNTIL 10AM AT 30% 02.
-CHANGED TO 4LPM WITH N/C 02
SATS 95-97% HR 90 RR 20. TOLERATING WELL.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 1525

Patient Notes: Nursing Notes
- Create 05/20/16 1525 ST 05/20/16 1526 ST
Abnormal? N Confidential? N
ostomy nurse Kristie M. RN back to bedside, teaching to pt and wife, abd dsg chnaged per orders.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 1600

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/20/16 1600 ST 05/20/16 1627 ST
Telemetry Rhythm: SINUS RHYTHM

Low Rate: 90
High Rate: 98
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/20/16 1600 ST 05/20/16 1626 ST
120000 Critical Care Flowsheet A Q4H CP
- Document 05/20/16 1600 ST 05/20/16 1626 ST
Critical Care Flowsheet Time: 1600

Temperature: 98.5
Temperature Source+: Tympanic

Nursing Note:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 1600 (continued)

120000 Critical Care Flowsheet (continued)
Pulse: 91 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 20 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 116/75 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2: 4
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP:
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:
Comment:
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/20/16 1600 ST 05/20/16 1626 ST
TED Hose - removed for skin assessment and reapplied.

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied.

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/20/16 1600 ST 05/20/16 1627 ST
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

5A4D43B46E1042958BC8, KNIGHT, 293

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 1600 (continued)

800001 Education/Teaching Assessment (continued)

Care/Education Codes: POC
DIET
DIS
ACTIVITY
Comment: UNDERSTANDS

Material Codes: VERBAL
Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED, OSTOMY CARE. IMPORTANCE OF TCDB

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/20/16 Time: 1612

Patient Notes: Wound Care Note
- Create 05/20/16 1612 KM 05/20/16 1630 KM
Abnormal? N Confidential? N
MET PT AND SPOUSE AT 3P IN HIS ROOM. PT UP IN CHAIR, VERY ALERT. INTERESTED IN LEARNING MORE ABOUT SELF CARE. HAS BEEN EATING MORE SOLID FOODS SO WILL SWITCH BACK TO DRAINABLE BAG AND STOP USING UROSTOMY BAG AS IT HAS GOTTEN CLOGGED. SPOUSE AND PT VERY ATTENTIVE AND ASKING QUESTIONS. WE PREPARED NEW POUCHING SYSTEM. PT SUCCESSFULLY APPLIED NEW CLAMP TO BAG. MOLDED WAFER WITH MY ASSISTANCE. WE REMOVED OLD SYSTEM - AREA VERY TENDER TO PATIENT. CLEANSED WITH WATER AND PATTED DRY. NOTED THERE HAD BEEN LEAKING UNDER WAFER FROM 6-8 O'CLOCK WITH SOME STINGING TO AREA. NO VISIBLE OPEN OR IRRITATED AREA. DEMONSTRATED USING SLIGHT DUSTING OF STOMA POWDER OVER THIS AREA, DUSTING OFF EXTRA AND USING STOMA PASTE ON WAFER TO MEET UP WITH THIS AREA. CONNECTED BAG TO WAFER AND APPLIED TO PT'S ABDOMEN. PT HAS MULTIPLE SKIN TEARS FROM TAPE. WE PLACED A DRY 2X2 TO DENUDED AREA BELOW STOMA UNDER THE WAFER TAPE. I APPLIED DUODERM ON ABDOMEN WHERE TAPE HAD CAUSED SKIN TRAUMA AND ELIZABETH AND I CHANGED HIS MIDLINE ABD WOUND DRESSING. STAPLE LINE WITH SOME AREAS GAPPED OPEN AND OTHERS MORE APPROXIMATED. MINIMAL RED DRAINAGE. NO ERYTHEMA, INDURATION, OR ODOR. DRY GAUZE OVER STAPLE LINE COVERED WITH ABD AND SECURED WITH TAPE TO DUODERM, NOT SKIN. DRAIN SPONGE AROUND JP DRAIN. EDUCATED PT ON REASON FOR DUODERM, THAT IT SHOULD NOT BE REMOVED BUT LEFT IN PLACE UNTIL IT COMES OFF ON IT'S OWN - IT IS TO PROTECT SKIN FROM ADHESIVES AND TAPE SHOULD BE PUT ON TOP OF IT. STATES UNDERSTANDING. I REPORTED ALL OF THIS OFF TO S. TALBOT, LPN.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 1627

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/20/16 1627 ST 05/20/16 1629 ST
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): ABX IV Fluids (A): 100
Medication (B): IV Fluids (B):
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 100 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/20/16 1627 ST 05/20/16 1628 ST
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N

K/MG Protocol: NO
Last K: Covered: Blood Pressure: 116/75
Last MG: Covered: Temperature: 98.5

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm

Mental Status: Alert & Oriented

5A4D43B46E1042958C8, KNIGHT, 294

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 1627 (continued)

125 CRITICAL CARE REPORT (continued)

Respirations: 20 VENTILATOR DOCUMENTATION:
O2 Sat: 97 Vent type:
%/L of O2: 4 Tidal Volume Vent Set Rate:
O2 Mode+: NASAL CANNULA Pressure Support Mode
FiO2 Peep:
Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:

COMMENT:

Tubes+: Urinary Catheter Inserted:
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+:
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd: 05/20/16

Abd Appearance+: Last BM: 05/20/16

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist

Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60
ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C
545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILUADID IV X1
DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING
150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER
ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES.
PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 1627 (continued)

125 CRITICAL CARE REPORT (continued)
ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT
20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED.
O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:

Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment: NA

IV Site #1:
Site Appear #1:
Type of Cath #1:
Cath Gauge #1:
Fluid/Rate #1:
Date Insert/DC #1:
IV #1 Comment:

IV Site #3: LEFT FOREARM
Site Appear #3: NORMAL
Type of Cath #3: Jelco
Cath Gauge #3: 22
Fluid/Rate #3: KVO
Date Insert/DC #3: 05/19/16
IV #3 Comment: GOOD RETURN / GOOD FLUSH

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/20/16 1627 ST 05/20/16 1628 ST
INTAKE

PO: 960 IV FLUIDS: Y PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention Foley Irrigation (CBI):

5A4D43B46E10429588C8, KNIGHT, 295

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 1627 (continued)

150012 Intake/Output (No IVs) Critical Care (continued)
to document IV/Blood fluids. Dialysis (Intake):

OUTPUT
Void (ml): 150 Bladder Incont Episodes: Emesis: Colostomy:
Foley: 750 Bowel Incont Episodes: T Tube: Ileostomy: 1750
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: 0 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Dng (Output):

Comment:

Activity Date: 05/20/16 Time: 1728

Patient Notes: Nursing Notes
- Create 05/20/16 1728 ST 05/20/16 1729 ST
Abnormal? N Confidential? N
resting quietly in semi-fowlers talking with visitors at bedside, no s/s of any distress noted at this time. resp even nonlabored on 4/l nc with o2 sats 95-96%.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 1740

Patient Notes: Nursing Notes
- Create 05/20/16 1740 ST 05/20/16 1741 ST
Abnormal? N Confidential? N
Dr Ellis in to see pt and notified that jp drain is not draining anything and does he want it out and he states not at this time.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 1801

0840 Positioning A Q2H CP
- Document 05/20/16 1801 ST 05/20/16 1801 ST
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/20/16 1801 ST 05/20/16 1801 ST
Diet Ordered: MECH SOFT
Meal: DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 1801

120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/20/16 1801 ST 05/20/16 1806 ST
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >90% : MET MET

COMMENT:
525003 IV Site Check A 06,18 CP
- Document 05/20/16 1801 ST 05/20/16 1807 ST
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:

CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/20/16 1801 ST 05/20/16 1807 ST

Activity Date: 05/20/16 Time: 1900

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/20/16 1900 CB4 05/20/16 2236 CB4
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given N Bedside: Y

To/From CANDACE RN/SUSIE T. RN

Comment

5A4D43B46E10429588C8, KNIGHT, 296

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 1954

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/20/16 1954 CG* 05/20/16 2009 CG*

RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM 3 NC Y O2 Sat: 97 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 89 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 89 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 1954 (continued)

09 RESP THERAPY - TREATMENT (continued)
DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/20/16 Time: 2000

1699 Prostat Supplement A 08,20 OE
- Document 05/20/16 2000 CB4 05/21/16 0126 CB4
Prostat given: Y

Comment:
120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/20/16 2000 CB4 05/20/16 2351 CB4
Telemetry Rhythm: SINUS RHYTHM

Low Rate: 70
High Rate: 85
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/20/16 2000 CB4 05/20/16 2327 CB4
- Document 05/20/16 2000 CB4 05/20/16 2328 CB4
120000 Critical Care Flowsheet A Q4H CP
- Document 05/20/16 2000 CB4 05/20/16 2332 CB4
Critical Care Flowsheet Time: 2000

Temperature: 98.8 Nursing Note:
Temperature Source+: Tympanic
Pulse: 85 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 16 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 121/82 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 97 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm

5A4D43B46E1042958BC8, KNIGHT, 297

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

120000 Critical Care Flowsheet (continued)

MAP: 93

Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

120001 SHIFT ASSESSMENT-Critical Care A QS CP
- Document 05/20/16 2000 CB4 05/20/16 2350 CB4

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative
Site:

Speech/Cry+: Clear

Vision Impairment: GLASSES
Responsive To+: Spontaneous
Hearing Impairment:

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale N

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: 85 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: S1,S2 Transvenous Pacemaker: N Secured at cm
Telemetry Pattern+: SINUS RHYTHM Sensitivity: Rate:
Demand: N Asynchronous: N
Pulse Rhythm+: Regular Atrial: N Ventricular: N
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+:	Normal	Radial Rt+:	Normal
Dorsalis Rt+:	Normal	Radial Lt+:	Normal
Post Tib Lt+:		Femoral Rt+:	
Post Tib Rt+:		Femoral Lt+:	
Carotid Rt+:		Cap Refill RUE+:	Brisk
Carotid Lt+:		Cap Refill LUE+:	Brisk
Brachial Rt+:		Cap Refill RLE+:	Brisk
Brachial Lt+:		Cap Refill LLE+:	Brisk

Cardio Comment <Esc>: PT HAS NO COMPLAINTS OF CHEST PAIN/DISCOMFORT.

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 16 O2 Sat: 96 %/L of O2: 3 Cyanosis: N Pallor: N

O2 Mode+: NASAL CANNULA
RR Description+: WNL

Breath Sounds
LUL+: Coarse
LLL+: Diminished
RUL+: Coarse

Resp Pattern+: Regular
Chest Expansions+: Symmetrical
Cough+: Non-productive
Sputum Amount+:

5A4D43B46E10429588C8, KNIGHT, 298

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Sputum Consistency+: RML+: Coarse
Sputum Color+:
Airway Suctioned+: RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

Chest Tube: CT Size:
CT Type:
CT Location:
CT Drainage:

Incentive Spirometer Volume pull:

Comment
MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

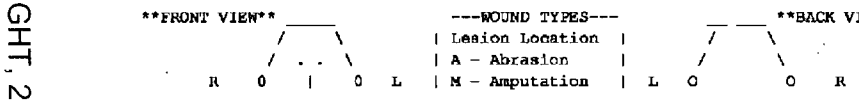
ROM Limitations+: Paralysis+:

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+:

Transfer, Lift, or Ambulation equipment DRAW SHEET
Musc-Skel Comment <Esc>:

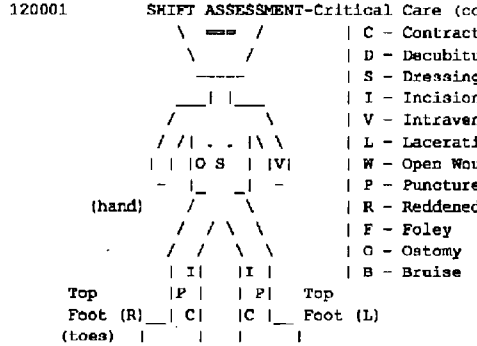


Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)



COMMENT:
Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and turgor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Staples
Dressing Type #1: ABD PAD
Dress Appear #1: CDI

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY.

Skin Comment <Esc>: MID LINE ABD INCISION CDI. JP DRAIN ON LT SIDE. OSTOMY ON RT SIDE. OSTOMY BEEFY RED.
Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally: 3	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3

5A4D43B46E10429588C8, KNIGHT, 299

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Rarely Moist: 4 No Limitations:

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/20/16 Incontinent Stool:
Emesis: N Diarrhea: N Stool Amount+: Moderate
By C-Diff Protocol - Watery loose stool: N Stool Color+: Greenish
Stool Consistency+: Liquid

Abd Girth: cm Tenderness Tubes+: Jackson Pratt
Abd Appearance+: ROUND Tube Drainage: Y Tube To Suction: Y
OGT/NGT is secured at cm
RUQ+: ACTIVE Stoma Present: Y Location: RLQ
LUQ+: ACTIVE Appearance: BEEFY RED
RLQ+: ACTIVE Ostomy Appliance: Y
LLQ+: ACTIVE Drainage Characteristics: GREEN
GI Comment <Esc>: Rectal Tube:

Genitourinary WNL: N WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N Currently Menses:
LMP:
Urine Color+: Prostate Problems:
Urine Odor+:
Character+: ***Dialysis***
Incontinent Bladder: CAPD: Peritoneal Dialysis:
Suprapubic Catheter: Hemodialysis:
Urostomy: Hemo Site Description+:
Stoma Appearance Last Dialysis Treatment:

GU Comment <Esc>: FOLEY REMOVED TODAY. BLADDER SCAN Q6H X24 HRS. DO NOT KNOW COLOR OR CHARACTER, PT HAS NOT VOIDED YET THIS SHIFT.

**********PAIN ASSESSMENT**********

Pt C/O Pain: N Acceptable Scale/Goal for EXCELLENT

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning

Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: PT VERBALIZES UNDERSTANDING OF POC. ALL CARE EXPLAINED WHEN GIVEN
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/20/16 2000 CB4 05/20/16 2353 CB4
IV Site Change: N # Of Attempts: IV Tube Change: N IV DISCONTINUED N

IV Site #1: LEFT FOREARM
Site Appear #1: NO REDNESS NOTED
Type of Cath #1: Jelco
Cath Gauge #1: 22
Fluid/Rate #1: SL
Date Insert/DC #1: 05/19/16
IV #1 Comment: WNL
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:

5A4D43B46E1042958BC8, KNIGHT, 300

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

525002 IV THERAPY ASSESSMENT (continued)
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>
6421 ISOLATION Patient Type A 08,20 CP
- Document 05/20/16 2000 CB4 05/20/16 2328 CB4
Type of Isolation: NONE Tissue Test: N
7370 Discharge Planning Assessment A QS CP
- Document 05/20/16 2000 CB4 05/20/16 2328 CB4
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY NURSE ASSISTING WITH HOME SUPPLIES

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/16/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/20/16 2000 CB4 05/20/16 2331 CB4
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0

*****Gait/Balance*****
Normal or N/A secondary neuro deficit

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (3pt)
RN Judgement (4pt) 4

Total Score: 9

*****Interventions*****
Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y
Assess q2hr 7A-7P
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

5A4D43B46E10429588C8, KNIGHT, 301

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Comment:

Fall Score Ranking: Moderate Level of Care: Assist
99 SEPSIS Documentation A QS CP
- Document 05/20/16 2000 CB4 05/20/16 2327 CB4
Temperature: 98.8
Temperature Source+: Tympanic (May use most recent
Pulse: 85 VITAL SIGNS taken
Respirations: 16 if they are WNL and
Blood Pressure: 121/82 no greater then 3hrs)
MAP: 93
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk

Physician Notified: N
If NO, Reason: Physician Already Aware
Patient Notes: Nursing Notes
- Create 05/20/16 2000 CB4 05/21/16 0149 CB4
Abnormal? N Confidential? N
RECEIVED REPORT. PM ASSESSMENT COMPLETED. PT ALERT AND ORIENTED. PT ON 3L NC WITH O2 SATS >95%. PT HAS MID ABD INCISION WITH ABD DRESSING IN PLACE, DRESSING CDI. JP DRAIN SECURED AND SUCTIONING SEROUS FLUID. ILEOSTOMY TO RUQ DRAINING GREEN LIQUID STOOL. EMPTIED 250ML. PT HAS NO COMPLAINTS OF PAIN OR DISCOMFORT AT THIS TIME. ENCOURAGED PT TO USE IS. VSS. NO SIGNS OF DISTRESS NOTED. CALL BELL WIR. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 05/20/16 Time: 2010

Patient Notes: Nursing Notes
- Create 05/20/16 2010 CB4 05/21/16 0156 CB4
Abnormal? N Confidential? N
BLADDER SCAN SHOWED 450. PT STATES THAT HE SHOULD BE ABLE TO VOID BY MIDNIGHT. PT REFUSES ANY TYPE OF CATHETERIZATION.

Addendum: 05/21/16 at 0202 by CB4 BARKER,CANDACE RN

EDUCATED PT ON EMPTYING ILEOSTOMY BAG. MINIMAL ASSISTANCE NEEDED WHILE EMPTYING THE BAG. 75ML OF GREEN LIQUID STOOL REMOVED.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/20/16 Time: 2141

5500011 Purposeful Rounding A CP
- Document 05/20/16 2141 VB 05/20/16 2141 VB
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/20/16 Time: 2200

0840 Positioning A Q2H CP
- Document 05/20/16 2200 CB4 05/20/16 2355 CB4
Patient Notes: Nursing Notes
- Create 05/20/16 2200 CB4 05/21/16 0151 CB4
Abnormal? N Confidential? N
PT LYING IN BED WATCHING TV. PT COMPLAINED OF PAIN, ADMINISTERED PRN PAIN MED. SCHEDULED MEDS ADMINISTERED, SEE EMAR FOR DETAILS. PT HAS NO OTHER COMPLAINTS AT THIS TIME. CALL BELL WIR.

Addendum: 05/21/16 at 0153 by CB4 BARKER,CANDACE RN

PT HAS BEEN PULLING 700-1000 ON IS. PT STATES HAS BEEN USING DURING COMMERCIAL BREAKS WHILE WATCHING TV.
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 0000

Patient Notes: Nursing Notes
- Create 05/21/16 0000 CB4 05/21/16 0159 CB4
Abnormal? N Confidential? N
PT SLEEPING IN BED, WOKE FOR HIM TO TRY TO VOID IN URINAL. PT VOIDED 425ML OF CLEAR/AMBER URINE. PT HAS NO COMPLAINTS OF PAIN OR DISCOMFORT AT THIS TIME. VSS. CALL BELL WIR.
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 0010

5500011 Purposeful Rounding A CP
- Document 05/21/16 0010 VB 05/21/16 0010 VB
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

5A4D43B46E10429588C8, KNIGHT, 302

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/21/16 Time: 0010 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/21/16 Time: 0022

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/21/16 0022 CB4 05/21/16 0127 CB4
Telemetry Rhythm: SINUS RHYTHM

Low Rate: 70
High Rate: 80
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:

0840 Positioning A Q2H CP
- Document 05/21/16 0022 CB4 05/21/16 0126 CB4

120000 Critical Care Flowsheet A Q4H CP
- Document 05/21/16 0022 CB4 05/21/16 0127 CB4
Critical Care Flowsheet Time: 0022

Temperature: 98.8 Nursing Note:
Temperature Source+: Tympanic
Pulse: 81 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 16 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 127/78 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 96 Calibrate: Void (ml): ml
%/L of O2: 3
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 90
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/21/16 Time: 0200

0840 Positioning A Q2H CP
- Document 05/21/16 0200 CB4 05/21/16 0247 CB4

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/21/16 Time: 0200

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/21/16 0200 CB4 05/21/16 0247 CB4

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

5A4D43B46E10429588C8, KNIGHT, 303

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?
Patient Notes: Nursing Notes
- Create 05/21/16 0200 CB4 05/21/16 0739 CB4
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES CLOSED. NO DISTRESS NOTED. CALL BELL WIR.
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 0302

5500011 Purposeful Rounding A CP
- Document 05/21/16 0302 VB 05/21/16 0303 VB
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0302 (continued)

5500011 Purposeful Rounding (continued)
Comment:
<Esc>

Activity Date: 05/21/16 Time: 0400

Patient Notes: Nursing Notes
- Create 05/21/16 0400 CB4 05/21/16 0740 CB4
Abnormal? N Confidential? N
PT COMPLAINED OF PAIN. ADMINISTERED PRN VICODIN. PT HAS NO OTHER COMPLAINTS AT THIS TIME. VSS. NO DISTRESS NOTED. CALL BELL WIR.
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 0445

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/21/16 0445 CB4 05/21/16 0530 CB4
Telemetry Rhythm: SINUS RHYTHM

Low Rate: 70
High Rate: 80
Change From Baseline: N
Notify MD: N Check Alarm: Y

Comment:
0840 Positioning A Q2H CP
- Document 05/21/16 0445 CB4 05/21/16 0528 CB4
120000 Critical Care Flowsheet A Q4H CP
- Document 05/21/16 0445 CB4 05/21/16 0530 CB4
Critical Care Flowsheet Time: 0445

Temperature: 97.2
Temperature Source+: Tympanic
Pulse: 74
Pulse Source+: MONITOR
Respirations: 18
SPON:
Vent Resp:
Blood Pressure: 126/79
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 96
%/L of O2: 2
ETCO2:
A-LINE BP:
MAP: 95
Intra-Abd Pressure:

PCWP:
CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Nursing Note:
Glycemic Protocol:
Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

5A4D43B46E10429588C8, KNIGHT, 304

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 0445

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/21/16 0445 CB4 05/21/16 0528 CB4
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/21/16 0445 CB4 05/21/16 0531 CB4
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
Comment: UNDERSTANDS

Material Codes: VERBAL

Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 0445 (continued)

800001 Education/Teaching Assessment (continued)
New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/21/16 Time: 0500

1200041 IV Pump Totals - Critical Care A 05,17 CP
- Document 05/21/16 0500 CB4 05/21/16 0649 CB4
IV Pump Totals (Clearing Pump at end of Shift)

Medication (A): NS/ABX IV Fluids (A): 109
Medication (B): IV Fluids (B):
Medication (C): IV Fluids (C):
Medication (D): IV Fluids (D):
Medication (E): IV Fluids (E):
Medication (F): IV Fluids (F):
Medication (G): IV Fluids (G):
Medication (H): IV Fluids (H):

PUMP TOTAL 109 cc

125 CRITICAL CARE REPORT A 05,17 CP
- Document 05/21/16 0500 CB4 05/21/16 0543 CB4
Primary Diagnosis: INTESTINAL PERFORATION,PERITONITIS
Sec Diag/Comorbidities:
Previous Medical Hx:
<Esc>

ANXIETY
Whiplash
Other - MVC
Hand Abrasion
Abrasion of Multiple Sites w/o Infection
Chest Contusion
Abdominal Wall Contusion

Code Status+: Full Code
OSA HIGH RISK: OSA Physician Appt: Restraints: N Date:

STATUS: ICU PCU Y TELE Activity: OOB to cha IPC: Y
Venous Foot Pump: N
K/MG Protocol: NO
Last K: Covered: Blood Pressure: 126/79
Last MG: Covered: Temperature: 97.2

5A4D43B46E10429588C8, KNIGHT, 305

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/21/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

Pacemaker: N Sensitivity: Rate: Cooling Blanket: N
Defibrillator: N Demand: N Asynchronous: N Warming Blanket: N
Transvenous Pacemaker: N Atrial: N Ventricular: N
Secured at cm

Mental Status: Alert & Oriented

Respirations: 18 VENTILATOR DOCUMENTATION:
O2 Sat: 98 Vent type:
%/L of O2: 2 Tidal Volume Vent Set Rate:
O2 Mode+: NASAL CANNULA Pressure Support Mode
FiO2 Peep:

Airway:
Secured at Modified Ramsey Score
cm @ TOF
Position:
Size Chest Tube: CT Type:
CT Size: CT Drainage:

COMMENT:

Tubes+: Urinary Catheter Inserted:
Tube Drainage: N Tube To Suction: N Urinary Catheter Size+:
Ostomy Appliance: Rectal Tube: Urinary Catheter Irrigation: N
Drainage Characteristics: Suprapubic Catheter: N Foley Dc'd: 05/20/16

Abd Appearance+: Last BM: 05/20/16

Tube Feeding Type: CC/HR: FREE H2O FLUSH Amount:

Dialysis
CAPD: Peritoneal Dialysis: Hemodialysis: Glycemic Protocol:
Hemo Site Description+: Fingerstick BS: Y
Last Dialysis Treatment: Frequency: ACHS
Level:

Central Line, PICC, Mediport Maintenance Checklist
Dressing changed: Date: Change:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size: Date:

Procedure: 5/17 7A-NONE

Comment: 5/15 MVA COUPLE WEEKS AGO, FREE AIR / FLUID IN ABD, ABD SURGERY TODAY
DR RIMKUS, JP DRAIN, STAPLES, ABD DSG
5/16 DILAUDID 1MG IV PRN
MORPHINE 2MG IV PRN
5/16 DILAUDID 2 MG Q4H TO CONTROL PAIN. SIPS AND CHIPS
5/16 P-A VSS,O2 NC TITRATED TO KEEP SAO2 91-92%,O2 4L NC 92%,JP DRAINED 60
ML YELLOW DRAINAGE,ILEOSTOMY EMPTIED WITH 150ML TAN LIQUID THIS SHIFT,F/C
545ML AMBER URINE,BS ACHS BS IN 80'S,MORPHINE IV X1, THEN DILAUDID IV X1

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/21/16 Time: 0500 (continued)

125 CRITICAL CARE REPORT (continued)

DILUADID MORE EFFECTIVE.PULLING UP ON IS TO 500ML.TORADOL IV X1.NS INFUSING 150ML/HR.TELE ST,ABD DRESSING D&I.
5/17 7A PT UP OOB TO CHAIR. PT GIVEN IV DILAUDID AND TORDOL IV PRN PER ORDERS. PT ALSO STARTED ON PO VICODIN FOR PAIN. RELIEF NOTED AT TIMES. PT DEMONSTRATED USE OF IS, 500-750. SEEN BY WOCN FOR ILIOSTOMY TEACHING ILIOSTOMY BAG CONNECTED TO FOLEY BAG. OUTPUT THIS SHIFT 1325ML. JP OUTPUT 20ML. FOLEY UOP 1250. PT GIVEN IV LAXIX X2 DOSES THIS SHIFT. O2 HUMIDIFIED. O2 WEANED TO 40% VENTI MASK TO MAINTAIN SATS >92%.
5/20/16 PM-PT WEANED2L NC WITH O2 SATS 98%. VSS. GREEN STOOL OP IN OSTOMY. SEROUS FLUID FROM JP. BLADDER SCANS COMPLETED Q6H. PT VOIDED IN URINAL. VSS

Pulm Art Cath: Zeroed:
Location:
Secured at cm
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

CVP Line: Zeroed:
Location:
Dressing:
Appearance:
Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

A-Line: IABP: Zeroed:
Location:
Dressing:
Appearance:

Phlebostatic Axis Marked:
Waveform:
Date Flush Change:
Date Tubing Change:

Comment: NA

IV Site #1:
Site Appear #1:
Type of Cath #1:
Cath Gauge #1:
Fluid/Rate #1:
Date Insert/DC #1:
IV #1 Comment:

IV Site #3: LEFT FOREARM
Site Appear #3: NORMAL
Type of Cath #3: Jelco
Cath Gauge #3: 22
Fluid/Rate #3: SL
Date Insert/DC #3: 05/19/16
IV #3 Comment: WNL

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:

5A4D43B46E1042958BC8, KNIGHT, 306

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/21/16 Time: 0500

150012 Intake/Output (No IVs) Critical Care A 05,17 CP
- Document 05/21/16 0500 CB4 05/21/16 0648 CB4
INTAKE

PO: 600 IV FLUIDS: PO Supplement:
TF Tube: Blood Products: NG Irrigation:
TF Flush: ***Use PUMP TOTALS intervention to document IV/Blood fluids. Foley Irrigation (CBI):
Dialysis (Intake):

OUTPUT
Void (ml): 450 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 475
SP Catheter: Void Episodes: NG/PEG TUBE: Urostomy:
Foley (Residual): Stool Episodes: 0 Duodenal Tube: Ileoconduit:
Diapers: Liquid Stool:

#1 JP: 5 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:
Pericardial Dng (Output):

Comment:

Activity Date: 05/21/16 Time: 0600

120003 Goals/Outcomes - Critical Care A 18,06 CP
- Document 05/21/16 0600 CB4 05/21/16 0649 CB4
CRITICAL CARE GOALS/OUTCOMES

Goal #1: HEMODYNAMICALLY STABLE : MET MET

Goal #2: SAFETY MAINTAINED : MET MET

Goal #3: TITRATE O2 TO KEEP SAO2 >90% : MET MET

COMMENT:
150011 Weight, Monitor Daily A DAILY@0600 CP
- Document 05/21/16 0600 CB4 05/21/16 0644 CB4
Weight (lbs): 149
(Oz): 01
kg: 67.614
Weight Source: Bedscale
525003 IV Site Check A 06,18 CP
- Document 05/21/16 0600 CB4 05/21/16 0649 CB4
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/21/16 Time: 0600 (continued)

525003 IV Site Check (continued)
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: N If no, Reason: BATH PRIOR SHIFT WITH CHG Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
- Document 05/21/16 0600 CB4 05/21/16 0650 CB4
IV Site WNL: Y If No:

Comment: #22 SALINE LOCK LFA FLUSHES WELL

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: N If no, Reason: BATH PRIOR SHIFT WITH CHG Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/21/16 0600 CB4 05/21/16 0644 CB4

Activity Date: 05/21/16 Time: 0601

Patient Notes: Respiratory Therapy Notes
- Create 05/21/16 0601 CG* 05/21/16 0602 CG*
Abnormal? N Confidential? N
PT REMAINED STABLE WITH O2 @ 3L/M NC. SPO2 97%. HI- FLOW AND CPAP ON SB.
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 0620

Patient Notes: Nursing Notes
- Create 05/21/16 0620 CB4 05/21/16 0744 CB4
Abnormal? N Confidential? N
ADMINISTERED SCHEDULED MED, SEE EMAR FOR DETAILS. Q6H BLADDER SCAN

5A4D43B46E10429588C8, KNIGHT, 307

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0620 (continued)

Patient Notes: Nursing Notes (continued)
PERFORMED WITH 357ML OF URINE READING. INFORMED PT THAT HE NEEDED TO TRY TO VOID WITH URINAL OR HE WOULD NEED CATHETERIZATION. PT VOIDED 400ML IN URINAL. REPOSITIONED PT IN BED. 100ML GREEN LIQUID OUT OF ILLEOSTOMY. 5ML SEROUS FLUID OF OF JP DRAIN. VSS. NO DISTRESS NOTED. PT HAS NO COMPLAINTS AT THIS TIME. CALL BELL WIR.

Note Type Description
No Type None

Activity Date: 05/21/16 Time: 0643

0840 Positioning A Q2H CP
- Document 05/21/16 0643 CB4 05/21/16 0643 CB4

Activity Date: 05/21/16 Time: 0700

5500011 Purposeful Rounding A CP
- Document 05/21/16 0700 JM 05/21/16 0816 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/21/16 Time: 0702

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/21/16 0702 TT2 05/21/16 0702 TT2
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From MARSHA/CANDACE

Comment

Activity Date: 05/21/16 Time: 0749

016 RESP THERAPY - EQUIPMENT CHANGE OUT A QD@1130 CP
- Document 05/21/16 0749 MES 05/21/16 0749 MES
EQUIPMENT CHANGE OUT

Closed Suction System (PRN)
HME (24-48HRS)
Nebs (Every Wed) N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0749 (continued)

016 RESP THERAPY - EQUIPMENT CHANGE OUT (continued)
O2 Humidifiers (Every Wed)
NRB (Every Wed)
Venturi (Every Wed)

Comment:

Activity Date: 05/21/16 Time: 0756

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/21/16 0756 MES 05/21/16 0756 MES
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM 3 NC Y O2 Sat: 99 FIO2 VM PRB NRB
O2 24 hrs Y CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Y Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 98 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 98 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood

5A4D43B46E10429588C8, KNIGHT, 308

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0756 (continued)

09 RESP THERAPY - TREATMENT (continued)
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/21/16 Time: 0757

Problem: RT - INADEQUATE OXYGEN								C		
- Ed Status	05/21/16	0757	MES	05/21/16	0757	MES				A => C
- Ed Status	05/21/16	0757	MES	05/21/16	0757	MES				C => C
Outcome: ADEQUATE OXYGENATION								C		
- Ed Status	05/21/16	0757	MES	05/21/16	0757	MES				A => C
- Ed Status	05/21/16	0757	MES	05/21/16	0757	MES				C => C
011 PULMONARY CONSULT DOC - RESP THERAPY								C	Q48H	CP
- Ed Status	05/21/16	0757	MES	05/21/16	0757	MES				A => C
014 RESP THERAPY - OXYHOOD								C	Q2H	CP
- Ed Status	05/21/16	0757	MES	05/21/16	0757	MES				I => C

Activity Date: 05/21/16 Time: 0800

1699 Prostat Supplement								A	08,20	OE
- Document	05/21/16	0800	MW	05/21/16	1036	MW				

Prostat given: Y

Comment:

120009 Telemetry Monitoring - Critical Care								A	Q4H	CP
- Document	05/21/16	0800	MW	05/21/16	1040	MW				

Telemetry Rhythm: SINUS RHYTHM

Low Rate: 85
High Rate: 87
Change From Baseline: N
Notify MD: N Check Alarm:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0800 (continued)

120009 Telemetry Monitoring - Critical Care (continued)
Comment:

0840 Positioning								A	Q2H	CP
- Document	05/21/16	0800	MW	05/21/16	1035	MW				
1160 Nutritional Monitoring								A	08,12,18	CP
- Document	05/21/16	0800	MW	05/21/16	1035	MW				

Diet Ordered: MECH SOFT
Meal: BREAKFAST
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement:
PO Supplement: co (Total Intake)

Comment:

120000 Critical Care Flowsheet								A	Q4H	CP
- Document	05/21/16	0800	MW	05/21/16	1037	MW				

Critical Care Flowsheet Time: 0800

Temperature: 98.1 Nursing Note:
Temperature Source+: Tympanic
Pulse: 89 PCWP: Glycemic Protocol:
Pulse Source+: MONITOR CVP: Fingerstick BS:
Respirations: 18 MPA: Frequency:
SPON: PAP:
Vent Resp: CO: Cooling Blanket:
Blood Pressure: 123/77 CI: Warming Blanket:
BP Location+: L Arm SVR:
BP Position+: SEMI-FOWLER'S PVR: Foley: ml
O2 Sat: 99 Calibrate: Void (ml): ml
%/L of O2:
ETCO2: Transvenous Pacer Setting: V Output mA Set Rate:
A-LINE BP: Secured at cm
MAP: 87
Intra-Abd Pressure: Weight (lbs): (Oz): kg:
Weight Source:

Comment:

1200008 Oral Care - Critical Care								A	DAILY	CP
- Document	05/21/16	0800	MW	05/21/16	1041	MW				
120001 SHIFT ASSESSMENT-Critical Care								A	QS	CP
- Document	05/21/16	0800	MW	05/21/16	1040	MW				

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

5A4D43B46E1042958C8, KNIGHT, 309

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Behavior+: Calm/Cooperative

Speech/Cry+: Clear

Responsive To+: Spontaneous

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

If Score < or = 5, call Lifepoint 1-800-269-9777

Neuro Comment <Esc>: ALERT/ORIENTED.

Peripheral Sensory Deficit:

Site:

Vision Impairment:

Hearing Impairment:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Chest Pain: N Heart Rate: 85 Comfort Measures Only NA
If Yes, Document in Pain Assessment Intervention.
Palpitations: N Pacemaker: N Defibrillator: N
Heart Sounds+: S1,S2 Transvenous Pacemaker: Secured at cm
Telemetry Pattern+: SINUS RHYTHM Sensitivity: Rate:
Demand: Asynchronous:
Pulse Rhythm+: Regular Atrial: Ventricular:
Dizziness/Syncope+:
JVD+: Comment:

Edema 1+: Edema 2+:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Loc 1+: Loc 2+: TED Hose: N
IPC: Y
Pitting: Pitting: Venous Foot Pump: N
Edema 3+: Edema 4+:
Loc 3+: Loc 4+:
Pitting: Pitting:

Peripheral Pulses

Dorsalis Lt+: Normal	Radial Rt+: Normal
Dorsalis Rt+: Normal	Radial Lt+: Normal
Post Tib Lt+:	Femoral Rt+:
Post Tib Rt+:	Femoral Lt+:
Carotid Rt+:	Cap Refill RUE+: Brisk
Carotid Lt+:	Cap Refill LUE+: Brisk
Brachial Rt+:	Cap Refill RLE+: Brisk
Brachial Lt+:	Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 99 %/L of O2: 3 Cyanosis: N Pallor: N

O2 Mode+: NASAL CANNULA
RR Description+: WNL

Resp Pattern+: Regular
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway Suctioned+:

Breath Sounds

LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

COPD Educational Video:
Airway: Secured at cm @ Position: Size F

VENTILATOR DOCUMENTATION:
Vent type:
Tidal Volume Vent Set Rate:
Pressure Support Mode
FiO2 Peep:

VAP BUNDLE:
HOB > 30 degrees
DVT Prophylaxis
PUD Prophylaxis
Sedation Vacation
Weaning Parameter Completed RT
Oral Care Completed
Subglottic Suction

Modified Ramsey Score
TOF

5A4D43B46E10429588C8, KNIGHT, 310

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/21/16 Time: 0800 (continued)

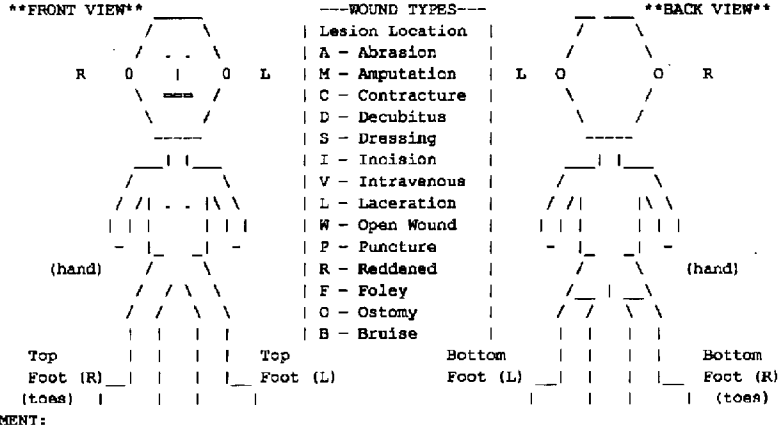
120001 SHIFT ASSESSMENT-Critical Care (continued)

Chest Tube: CT Size:
CT Type: Incentive Spirometer Volume pull:
CT Location:
CT Drainage:

Comment
MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Paralysis+:
Joint Swelling+: Amputations+:
Muscle Spasms+: Contractures+:
Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment DRAW SHEET
Musc-Skel Comment <Esc>: GENRALIZED WEAKNESS NOTED POST OP SORENESS



COMMENT:
Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Staples
Dressing Type #1: ABD PAD
Dress Appear #1: CDI
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains: JP DRAIN, OSTOMY. PIV X2

Skin Comment <Esc>: JP DRAIN WITH SCANT AMT OF YELLOW DRAINAGE, ILEOSTOMY WITH SMALL AMTS OF GREEN LOOSE STOOL
Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate:
No Impairment:	Walks Frequently:	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited:	No Apparent Problem:
Rarely Moist:	No Limitations:	

Total Braden Score:

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/20/16 Incontinent Stool: Y
Emesis: N Diarrhea: N Stool Amount+: Small
By C-Diff Protocol - Watery loose stool: N Stool Color+: Greenish
Stool Consistency+: Semi-Liquid

5A4D43B46E1042958C8, KNIGHT, 311

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/21/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Abd Girth: cm Tenderness
Abd Appearance+: ROUND
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
GI Comment <Esc>: ILIOSTOMY NOTED TO RT ABD, WAFFER C/D/I. GREEN SEMI LIQUID STOOL DRAINING INTO COLLECTION BAG.
Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Tubes+: Jackson Pratt
Tube Drainage: N Tube To Suction: N
OGT/NGT is secured at cm
Stoma Present: Y Location: RLQ
Appearance: BEEFY RED
Ostomy Appliance: Y
Drainage Characteristics: GREEN
Rectal Tube: N

Does Patient have a Foley Catheter? N
Urine Color+:
Urine Odor+:
Character+:
Incontinent Bladder:
Suprapubic Catheter:
Urostomy:
Stoma Appearance

Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD: Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: VOIDING IN URINAL

**********PAIN ASSESSMENT**********

Pt C/O Pain: N
Pain Scale:
Pain Location+:
Quality Of Pain+:
Onset/Duration:
Pain Med Given<Esc>:
Time Med Given:
Pain Comment<Esc>:

Acceptable Scale/Goal for EXCELLENT pain management this shift:
Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:
Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment:

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/21/16 Time: 0800 (continued)

120001 SHIFT ASSESSMENT-Critical Care (continued)

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y
Appropriate teaching for disease process utilized: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.

525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/21/16 0800 MW 05/21/16 1041 MW
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1:	LEFT FOREARM	
Site Appear #1:	NO REDNESS NOTED	
Type of Cath #1:	Jelco	
Cath Gauge #1:	22	
Fluid/Rate #1:	SL	
Date Insert/DC #1:	05/19/16	
IV #1 Comment:	WNL	
	<Esc>	
IV Site #2:		
Site Appear #2:		
Type of Cath #2:		
Cath Gauge #2:		
Fluid/Rate #2:		
Date Insert/DC #2:		
IV #2 Comment:		
	<Esc>	
IV Site #3:		
Site Appear #3:		
Type of Cath #3:		
Cath Gauge #3:		
Fluid/Rate #3:		
Date Insert/DC #3:		
IV #3 Comment:		
	<Esc>	
IV Site #4:		
Site Appear #4:		
Type of Cath #4:		
Cath Gauge #4:		
Fluid/Rate #4:		
Date Insert/DC #4:		
IV #4 Comment:		
	<Esc>	

6421 ISOLATION Patient Type A 08,20 CP
- Document 05/21/16 0800 MW 05/21/16 1036 MW
Type of Isolation: NONE Tissue Test:

6907 PATIENT BATH - Critical Care A DAILY CP
- Document 05/21/16 0800 MW 05/21/16 1036 MW
Hygiene: Date: 05/21/16

CHG Bath given: N If no, Reason: BATH PRIOR SHIFT WITH CHG
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)

Patient Refused (Bath): Y Nurse Notified (Bath): 0

Hygiene Comment:

5A4D43B46E1042958BC8, KNIGHT, 312

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0800

7370 Discharge Planning Assessment A QS
- Document 05/21/16 0800 MW 05/21/16 1036 MW

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY NURSE ASSISTING WITH HOME SUPPLIES

NEEDS IDENTIFIED:
Home Health: Y
Wound Care: N
Medical Equipment: N
Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested:

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/21/16 0800 MW 05/21/16 1037 MW

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics,

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 0800 (continued)

CP 9610 Fall Risk Assessment/Interventions (continued)

Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 4

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: BED IN LOWEST POSITION AND LOCKED, CALL BELL W/I REACH, PT DOES NOT ATTEMPT TO GET OOB UNASSISTED

Fall Score Ranking: Low
Level of Care: Assist

5A4D43B46E10429588C8, KNIGHT, 313

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/21/16 Time: 0800

99 SEPSIS Documentation — A QS — CP
- Document 05/21/16 0800 MW 05/21/16 1035 MW

Temperature: 98.1
Temperature Source+: Tympanic
Pulse: 89
Respirations: 18
Blood Pressure: 123/77
MAP: 87
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:
If NO, Reason:

Patient Notes: Nursing Notes
- Create 05/21/16 0800 MW 05/21/16 1136 MW
Abnormal? N Confidential? N
AM ASSESSMENT COMPLETED, PT IS AWAKE ALERT/ORIENTED. DENIES PAIN AT THIS TIME. MIDLINE ABD DRESSING INTACT, ILEOSTOMY PRESENT TO R UPPER ABD WITH SEMI FORMED GREEN STOOL PRESENT. JP TO L ABD WITH SCANT AMT OF YELLOW DRAINAGE PRESENT. VSS. AFEBRILE. NO DISTRESS, 3L/NC SPO2 98%. IPC BILAT. CALL LIGHT IN REACH
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 0900

5500011 Purposeful Rounding — A — CP
- Document 05/21/16 0900 JM 05/21/16 0923 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/21/16 Time: 1000

0840 Positioning — A Q2H — CP
- Document 05/21/16 1000 MW 05/21/16 1041 MW
Patient Notes: Nursing Notes
- Create 05/21/16 1000 MW 05/21/16 1139 MW
Abnormal? N Confidential? N
ABD DRESSING D/C, CLEANED IN BETWEEN STAPLES WITH QTIP AND NS. CLOUDY BROWNISH DRAINAGE FROM SOME AREAS BETWEEN STAPLES, NO FOUL ODOR NOTED. PT SENSITIVE TO TAPE, DUODERMS PLACED ON PT BY WOUND CARE TO AVOID CONTACT WITH TAPE, ABD

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/21/16 Time: 1000 (continued)

Patient Notes: Nursing Notes (continued)
PLACED OVER INCISION AND SECURED WITH PAPER TAPE, JP DRAIN SITE CLEAND AND DRAIN SPONGE PLACED AND SECURED WITH AS LITTLE TAPE AS POSSIBLE. PT AMBULATED IN HALLWAY WITH PT, TOLERATED WELL. UP IN CHAIR. DR BUDHOO TO CHANGE PAIN MEDS.
Note Type Description
Problem Critical Care Plan of Care

Activity Date: 05/21/16 Time: 1039

25 PT: Daily Documentation — A — PS
- Document 05/21/16 1039 JB 05/21/16 1041 JB

S: PATIENT AGREEABLE TO TREATMENT

Press ESC to get out of text boxes.

O: TRANSFER TRAINING WITH CONTACT GAURD ASSISTANCE FOR SUPINE TO SIT AND SIT TO STAND.
GAIT TRAINING FOR 320 FEET WITH ROLLING WALKER INCLUDING RIGHT AND LEFT TURNS SBA.

A: pt WITH OCCASIONAL ACCELERATION OR DECCELERATION THAT DID NOT RESULT IN LOB AND WAS CORRECTED BY THE PATIENT. pt CONTINUES TO SHOW NEED FOR PT DUE TO DIFFICULTY WITH TRANSFERS AND GAIT

P: CONT. POC

Activity Date: 05/21/16 Time: 1100

5500011 Purposeful Rounding — A — CP
- Document 05/21/16 1100 JM 05/21/16 1306 JM
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/21/16 Time: 1116

09 RESP THERAPY - TREATMENT — A RT-QID — CP
- Document 05/21/16 1116 MES 05/21/16 1122 MES
RESPIRATORY THERAPY TREATMENT

5A4D43B46E10429588C8, KNIGHT, 314

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1116 (continued)

09 RESP THERAPY - TREATMENT (continued)

%/L of O2: LPM 3 NC Y O2 Sat: 99 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 82 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 82 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency
Expected Actions/Side Effects Other

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1116 (continued)

09 RESP THERAPY - TREATMENT (continued)

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/21/16 Time: 1139

Patient Notes: Nursing Notes
- Create 05/21/16 1139 MW 05/21/16 1140 MW
Abnormal? N Confidential? N
PT REMAINS UP IN CHAIR. NO DISTRESS. DR BUDHOO AWARE PT REQUEST PAIN MEDS.
Note Type Description
Problem Critical Care Plan of Care

Activity Date: 05/21/16 Time: 1200

120009 Telemetry Monitoring - Critical Care A Q4H CP
- Document 05/21/16 1200 MW 05/21/16 1259 MW
Telemetry Rhythm: SINUS RHYTHM

Low Rate: 78
High Rate: 81
Change From Baseline: N
Notify MD: N Check Alarm:

Comment:
0840 Positioning A Q2H CP
- Document 05/21/16 1200 MW 05/21/16 1258 MW
1160 Nutritional Monitoring A 08,12,18 CP
- Document 05/21/16 1200 MW 05/21/16 1258 MW
Diet Ordered: MECH SOFT
Meal: LUNCH
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement:
PO Supplement: cc (Total Intake)

Comment:
120000 Critical Care Flowsheet A Q4H CP
- Document 05/21/16 1200 MW 05/21/16 1259 MW
Critical Care Flowsheet Time: 1200

Temperature: 98.7 Nursing Note:
Temperature Source+: Tympanic
Pulse: 80 PCWP: Glycemic Protocol:

5A4D43B46E1042958BC8, KNIGHT, 315

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 1200 (continued)

120000 Critical Care Flowsheet (continued)

Pulse Source+: MONITOR
Respirations: 20
SPON:
Vent Resp:
Blood Pressure: 132/83
BP Location+: L Arm
BP Position+: SEMI-FOWLER'S
O2 Sat: 97
%/L of O2: 2
ETCO2:
A-LINE BP:
MAP: 101
Intra-Abd Pressure:

CVP:
MPA:
PAP:
CO:
CI:
SVR:
PVR:
Calibrate:

Fingerstick BS:
Frequency:
Cooling Blanket:
Warming Blanket:
Foley: ml
Void (ml): ml

Transvenous Pacer Setting: V Output mA Set Rate:
Secured at cm

Weight (lbs): (Oz): kg:
Weight Source:

Comment:

Activity Date: 05/21/16 Time: 1300

5500011	Purposeful Rounding							A		CP
- Document	05/21/16	1300	JM	05/21/16	1307	JM				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
Patient Notes: Nursing Notes
- Create 05/21/16 1300 MW 05/21/16 1300 MW
Abnormal? N Confidential? N
MEDICATED WITH PERCOLONE 10MG FOR ABD PAIN, SEE EMAR. UP IN CHAIR. EATING LUNCH NO DISTRESS.
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 1400

0840	Positioning							A	Q2H	CP
- Document	05/21/16	1400	MW	05/21/16	1424	MW				
6409	FALLS SCREEN - FOLLOW-UP							A	02,14	CP
- Document	05/21/16	1400	MW	05/21/16	1424	MW				

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/21/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door

5A4D43B46E10429588C8, KNIGHT, 316

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/21/16 Time: 1441

09 RESP THERAPY - TREATMENT A RT-QID CP
- Document 05/21/16 1441 FS 05/21/16 1452 FS
RESPIRATORY THERAPY TREATMENT

%/L of O2: 2 LPM 2 NC Y O2 Sat: 100 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
RHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1441 (continued)

09 RESP THERAPY - TREATMENT (continued)

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 79 Pre-Assessment RR: 22

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 80 Post-Assessment RR: 22

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/21/16 Time: 1454

Patient Notes: Nursing Notes
- Create 05/21/16 1454 MW 05/21/16 1456 MW
Abnormal? N Confidential? N
DR ELLIS IN TO SEE PT, PLAN TO TX TO SX IF BED AVAIL. ILEOSTOMY EMPTIED OF 150CC LIQ GREEN DRAINAGE. REPLACED ABD TO ABD INCISION AND SECURED WITH PAPER TAPE.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 317

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1457

Patient Notes: Nursing Notes
- Create 05/21/16 1457 MW 05/21/16 1457 MW
Abnormal? N Confidential? N
DECREASED NC TO 1L, SP02 95%. NO DISTRESS
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 1602

Patient Notes: Nursing Notes
- Create 05/21/16 1602 MW 05/21/16 1603 MW
Abnormal? N Confidential? N
PT AMBULATED IN HALLWAY ON RA, SP02 RANGE 92-95%, PT TOLERATED WELL. ASSISTED TO WHEELCHAIR IN ROOM, REPORT CALLED TO PAM RN ON SX AND PT TX TO RM 232. SPOUSE AWARE. BELONGINGS AND MEDS TAKEN WITH PT
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 1603

6911 Transfer/Nursing Report Record A PRN CP
- Document 05/21/16 1603 MW 05/21/16 1605 MW
Patient Transfer/Nursing Report Record

I. Patient Transfer: Transfer to: 2S Other:
Date: 05/21/16 Time: 1603 From (Room#): CC26 To (Room#): 232
Ambulatory Stretcher Wheelchair Y Monitor Bed Restraints: N

Dentures: N Contacts: N Glasses: Y Hearing Aide(s): N Prostheses: N Clothing N
Sent W/Pt: Sent W/Pt: Valuables Sent W/Pt: Loc Sent W/Pt:Y Sent W/Pt: Other Sent W/Pt: Sent W/Pt:

Answer if Applicable, NA if not applicable
Old Chart Refrigerated Medications Y Current Medications Y
Present Chart Y Medications from Home Kardex
Med Admin Record & Up-to-date Med Rec List Reviewed with rec
Other,Specify

Blood Sugar Testing Frequency ACHS Blood Glucose Level: 183
Date Flu Vaccination Received: NFS
Allergies:
PPD Test: Date Result CXR: Date Result

II. Status at Time of Transfer: (within 24 hours)
Vital Signs:Temperature: 98.7 INTAKE PO: 600 IV:
Respirations: 20 OUTPUT Source: Amount: 1200
Pulse: 80
Blood Pressure: 132/83 IV Site Labeled: Y IV Tubing:
Pain Scale: 7 IV Site Status: WNL IV Type:
Rate:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1603 (continued)

6911 Transfer/Nursing Report Record (continued)
Urinary Catheter Inserted: Foley bag changed (Date): Last BM: 05/20/16

III. Assessment at Time of Transfer: Patient Primary Care Giver

Communication:
Understands Y
Can make self understood Y
Hearing Y
Vision Y

Diet/Nutrition:
Problem eating or drinking N
Problems swallowing N
Problem chewing N
Dietary consult done N
Current Diet: MECH SOFT

Fall Prevention:
On Fall Prevention in Hospital Y
Fall(s) in last 3 days N
Fall(s) in last month N
Activity limitations
Devices in use: WALKER

Skin: Turgor: WNL ABN Incision:
Decubiti: N Stage:
Location/Size:

Dressing Change: Y Date: 05/21/16Time: 1000
Wound Care: CLEAN BETWEEN STAPLES
<Esc>

HAND OFF to Receiving Personnel:
Situation: Y
Background: Y
Assessment: Y
Recommendations: Y

Positive for MRSA?

CODE STATUS (Resuscitation)
CPR Y
Intubation Y
Do Not Resuscitate N
Living Will N
If yes, copy on chart?
Healthcare POA N
If yes, copy on chart?
Name of Surrogate:

IV. Family Notified of Transfer Y
Date: 05/21/16 Time: 1605
Whom contacted WIFE

Admit Assess Complete and signed: Y
Patient Care Plan initiated: Y
Report called to: PAM, RN
Additional Comments: SURGICAL

Activity Date: 05/21/16 Time: 1608

Patient Notes: Nursing Notes
- Create 05/21/16 1608 PS 05/21/16 1616 PS
Abnormal? N Confidential? N
D. PT RECEIVED TO ROOM 232 FROM ICU VIA W/C. ORIENTATED +3. MINIMAL ASSIST FROM CHAIR TO BED. SCD'S OFF AT THIS TIME. S/L TO LEFT F/A. ABD SOFT, CHEST SOUNDS CLEAR, FOX ON R/A 95%, ENCOURAGED TO USE I/S. ILEOSTOMY TO RIGHT LOWER ABD WITH LIQUID GREEN, JP TO LEFT LOWER ABD WITH SMALL AMT YELLOW DRAINAGE. STAPLE LINE TO MID ABD WITH ABD PAD AND PAPER TAPE. TEMP-98.7, P-84, RESP-16, BP-115/71. PT INSTRUCTED TO CALL FOR ASSIST AS NEEDED. WILL CONTINUE TO MONITOR.
Note Type Description
Intervention Rounds Surveillance

5A4D43B46E10429588C8, KNIGHT, 318

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Documented Units	From Change
Activity Date: 05/21/16		**Time: 1619**								
Problem: *Bowel Resection							A			
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
- Resequence	05/21/16	1619	PS	05/21/16	1619	PS				6 => 1
Outcome: Respiratory Status: Ventilation							A			
Definition: Movement of air in and out of the lungs										
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
3140 Airway Management							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
Outcome: Fluid Balance							A			
Definition: Water balance in the intracellular and extracellular compartments of the body										
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
2080 Fluid/Electrolyte Management							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
Outcome: Wound Healing: Primary Intention							A			
Definition: Extent of regeneration of cells and tissues following intentional closure										
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
3440 Incision Site Care							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6540 Infection Control							A			CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
Outcome: Bowel Elimination							A			
Definition: Formation and evacuation of stool										
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
0430 Bowel Management STOOL ASSESSMENT							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
3668 PEG/PEJ Tube Care							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
Outcome: Post Operative Care							A			
Definition: Patient free of post operative complications										
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1629 OSA ASSESSMENT							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6955 Anticoagulant Educ Materials Provided							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6990 Post Operative Care - GOALS							A	08,20		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6991 Post Operative Care - OUTCOMES							A	18,06		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
Problem: *Standard Of Care							A			
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
- Resequence	05/21/16	1619	PS	05/21/16	1619	PS				7 => 2

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Documented Units	From Change
Activity Date: 05/21/16		**Time: 1619**								
Outcome: Standard Of Care							A			
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
0840 Positioning							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
10026 DISCHARGE PATIENT-Escorted							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1160 Nutritional Monitoring							A	18		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
150005 Intake/Output							A	06,18		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1663 IPC, TED, VFP Documentation							A	04,16		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1750022 Neurological Surveillance							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1750023 Cardiovascular Surveillance							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1750024 Respiratory Surveillance							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1750026 Musculoskeletal Surveillance							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1750027 Gastrointestinal Surveillance							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1750028 Genitourinary Surveillance							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
1750029 Integumentary Surveillance							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
275051 VTE Prophylaxis Orders Complete?							A	08,20		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
3592 TED/HEEL PROTECTORS/IPC Skin Assessment							A	04,16		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
525001 Medications, PRN							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
525002 IV THERAPY ASSESSMENT							A	Q8		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
525003 IV Site Check							A	06,18		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
5500 Off-Unit for Test/Procedure							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
5500010 Rounds Surveillance							A	06,18		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
5500011 Purposeful Rounding							A	Q2HODD		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6409 FALLS SCREEN - FOLLOW-UP							A	02,14		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6650 SHIFT ASSESSMENT (Surveillance)							A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6901 PATIENT LINEN CHANGE							A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				

5A4D43B46E10429588C8, KNIGHT, 319

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change
Activity Date: 05/21/16		**Time: 1619**								
6902	PATIENT TURNED						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6903	PATIENT FED						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6904	PATIENT BED/CHAIR ALARM SET						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6905	PATIENT BATH						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6910	Last BM						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6911	Transfer/Nursing Report Record						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6922	Nursing Report (Hand Off)						A	07,19		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6923	Message (Hand Off)						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6944	Supplements/Tube Feedings						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6945	TIME OUT-Universal Protocol Beside Proc						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6952	RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)						A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
6980	Vital Signs Manual Recheck						A	AD		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
7310	Admission Care						A	ONCE		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
7370	Discharge Planning Assessment						A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
7371	Discharge Information for PATIENT						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
750006	PAIN ASSESSMENT						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
750011	Pain Assessment (Telemetry Unit)						A			CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
75015	Discharge Med Rec via RXM						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
7900	Flu Vaccination Received						A	PRN		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
800001	Education/Teaching Assessment						A	04,16		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
9610	Fall Risk Assessment/Interventions						A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
99	SEPSIS Documentation						A	QS		CP
- Create	05/21/16	1619	PS	05/21/16	1619	PS				
Problem: Critical Care Plan of Care							C			
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
- Resequence	05/21/16	1619	PS	05/21/16	1619	PS				1 => 3
Outcome: RESPIRATORY STATUS-Critical Care							C			
Definition: Maintenance of adequate ventilation thru a patent airway to maintain arterial blood gas										
Outcome: RESPIRATORY STATUS-Critical Care (continued) concentration, oximetry reading, and/or capnography reading WNL										
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				C => C
120004	Ventilator Documentation-Critical Care						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
120039	Sedation/Paralysis Scale-Critical Care						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
Outcome: CARDIOVASCULAR STATUS-Critical Care							C			
Definition: Cardiac Pump effectiveness to provide adequate systemic and coronary perfusion pressure										
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				C => C
120009	Telemetry Monitoring - Critical Care						C	Q4H		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
150035	Hemodynamic Monitoring (Crit Care)						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
Outcome: NEUROLOGICAL STATUS-Critical Care							C			
Definition: Ability of the peripheral and central nervous system to receive, process, and respond to internal & external stimuli as demonstrated by appropriate arousal, orientation, and attention to the environment										
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				C => C
6954	STROKE EDUCATION						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
Outcome: GI/GU STATUS-Critical Care							C			
Definition: Adequate urine output, bowel elimination, and nutritional status										
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				C => C
Outcome: Critical Care Interventions							C			
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				C => C
0840	Positioning						C	Q2H		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
10026	DISCHARGE PATIENT-Escorted						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
108	CHF/AMI/STROKE/DVT HQI Screen						C			CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
1160	Nutritional Monitoring						C	08,12,18		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
120000	Critical Care Flowsheet						C	Q4H		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
1200008	Oral Care - Critical Care						C	DAILY		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
120001	SHIFT ASSESSMENT-Critical Care						C	QS		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
120003	Goals/Outcomes - Critical Care						C	18,06		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
1200041	IV Pump Totals - Critical Care						C	05,17		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C

5A4D43B46E1042958C8, KNIGHT, 320

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/21/16		**Time: 1619**								
120040	Bedside Procedure Doc - Critical Care						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
125	CRITICAL CARE REPORT						C	05,17		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
150011	Weight, Monitor Daily						C	DAILY@0600		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
150012	Intake/Output (No IVs) Critical Care						C	05,17		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
1661	Foot Drop Boots - ON						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
1662	Foot Drop Boots - OFF						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
1663	IPC, TED, VFP Documentation						C			CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
2380	Medication Management						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
275051	VTE Prophylaxis Orders Complete?						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
3592	TED/HEEL PROTECTORS/IPC Skin Assessment						C	04,16		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
400002	Wound Care/Dressing Change						C	AD		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
525002	IV THERAPY ASSESSMENT						C	QS		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
525003	IV Site Check						C	06,18		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
5500	Off-Unit for Test/Procedure						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
5500010	Rounds Surveillance						C	06,18		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
5500011	Purposeful Rounding						C			CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6409	FALLS SCREEN - FOLLOW-UP						C	02,14		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6421	ISOLATION Patient Type						C	08,20		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6680	Vital Signs						C	AD		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6901	PATIENT LINEN CHANGE						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6902	PATIENT TURNED						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6903	PATIENT FED						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6907	PATIENT BATH - Critical Care						C	DAILY		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6910	Last BM						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/21/16		**Time: 1619**								
6911	Transfer/Nursing Report Record						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6922	Nursing Report (Hand Off)						C	07,19		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6952	RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
6955	Anticoagulant Educ Materials Provided						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
7370	Discharge Planning Assessment						C	QS		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
7371	Discharge Information for PATIENT						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
750006	PAIN ASSESSMENT						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
75015	Discharge Med Rec via RXM						C			CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
7900	Flu Vaccination Received						C	PRN		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
800001	Education/Teaching Assessment						C	04,16		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
9610	Fall Risk Assessment/Interventions						C	QS		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
99	SEPSIS Documentation						C	QS		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
Problem: RT - RESPIRATORY FAILURE							C			
- Resequence	05/21/16	1619	PS	05/21/16	1619	PS				2 => 4
Problem: RT - BRONCHOSPASM/INADEQUATE VENTILATION							A			
- Resequence	05/21/16	1619	PS	05/21/16	1619	PS				3 => 5
Problem: RT - INADEQUATE VENTILATION/OXYGENATION							C			
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
- Resequence	05/21/16	1619	PS	05/21/16	1619	PS				4 => 6
Outcome: ADEQUATE VENTILATION							C			
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				None => C
012	RESP THERAPY - NON-INVASIVE VENTILATION						C	AD		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
016	RESP THERAPY - EQUIPMENT CHANGE OUT						C	QD@1130		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
08	RESP THERAPY - PATIENT EVALUATION						C	Q72H@0800		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
09	RESP THERAPY - TREATMENT						C	RT-QID		CP
- Ed Status	05/21/16	1619	PS	05/21/16	1619	PS				A => C
Problem: RT - INADEQUATE OXYGEN							C			
- Resequence	05/21/16	1619	PS	05/21/16	1619	PS				5 => 7

Activity Date: 05/21/16 **Time: 1643**

Patient Notes: Nursing Notes
- Create 05/21/16 1643 PS 05/21/16 1644 PS
Abnormal? N Confidential? N
D. IV ABX AS ORDERED.

5A4D43B46E10429588C8, KNIGHT, 321

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1643 (continued)

Patient Notes: Nursing Notes (continued)
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/21/16 Time: 1700 (continued)

5500011 Purposeful Rounding (continued)
- Document 05/21/16 1700 MG 05/21/16 1823 MG
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/21/16 Time: 1800

6980 Vital Signs Manual Recheck A AD CP
- Document 05/21/16 1800 MG 05/21/16 1824 MG
Vital Signs Manual Recheck

Temperature: 98.6
Temperature Source+: Oral
Pulse: 76
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 107/69
BP Location+:
BP Position+: SEMI-FOWLER'S
O2 Sat: 95

Notified:
Comment:

Activity Date: 05/21/16 Time: 1801

Patient Notes: Nursing Notes
- Create 05/21/16 1801 PS 05/21/16 1801 PS
Abnormal? N Confidential? N
D. NUMEROUS FAMILY WITH PT. MEDICATED WITH PERCOLONE 10 MG PO FOR ABD INCISIONAL PAIN. JP WITH SCANT AMT YELLOW DRAINAGE. ILEOSTOMY WITH MOD AMT GREEN LIQUID. IV TO S/L POST ABX.
Note Type Description
Intervention Rounds Surveillance

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 1802

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/21/16 1802 PS 05/21/16 1803 PS
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: SOFT
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
1160 Nutritional Monitoring A 18 CP
- Document 05/21/16 1802 PS 05/21/16 1802 PS
Diet Ordered: SOFT
Meal: DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement:
PO Supplement: cc (Total Intake)

5A4D43B46E10429588C8, KNIGHT, 322

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/21/16 Time: 1802 (continued)

1160 Nutritional Monitoring (continued)
Comment:
150005 Intake/Output A 06,18 CP
- Document 05/21/16 1802 PS 05/21/16 1803 PS
INTAKE
PO: 350 IV: 100 Blood: TPN: NG Irrigation:
TF Tube: IVPB: 200 Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 300 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 200
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/21/16 1802 PS 05/21/16 1804 PS
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Semi-permeable Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Y Dressing changed: Date: Change:
Tenderness of the Site: N BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/21/16 1802 PS 05/21/16 1804 PS

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/21/16 Time: 1900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/21/16 1900 JL 05/21/16 2047 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/21/16 Time: 1912

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/21/16 1912 MG* 05/21/16 1929 MG*
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From MELISSA,RN/PAM,RN

Comment
Patient Notes: Nursing Notes
- Create 05/21/16 1912 MG* 05/22/16 0032 MG*
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT, VISITING WITH FAMILY MEMBERS. NO C/O PAIN AT PRESENT. SALINE LOCK TO LEFT FOREARM INTACT AND PATENT, NO S/S REDNESS OR INFILTRATION NOTED. DRESSING TO ABD C/D/I. JP TO LEFT SIDE INTACT AND COMPRESSED. ILEOSTOMY TO RIGHT SIDE W/APPLIANCE INTACT, DRAINING GREENISH DRAINAGE. I/S AT BEDSIDE. REFUSES SCDS. NO ACUTE DISTRESS. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 05/21/16 Time: 2000

Outcome: ADEQUATE VENTILATION A
- Ed Status 05/21/16 2000 JF7 05/21/16 2000 JF7 C => A
09 RESP THERAPY - TREATMENT A AD CP
- Ed Status 05/21/16 2000 JF7 05/21/16 2000 JF7 C => A
- Document 05/21/16 2000 JF7 05/21/16 2001 JF7
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 98 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub

5A4D43B46E10429588C8, KNIGHT, 323

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/21/16 Time: 2000 (continued)

09 RESP THERAPY - TREATMENT (continued)

HHN Sub Y
Demo and Eval
Continous Neb 1st Hour
Continous Neb Sub

MDI Install
MDI Subsequent
MDI Additional Tx:
Pulse Ox Single Y
Pulse Ox over-noc
Pulse Ox Continuous

Incentive Install
Pt Instructed
Pt Achieves ml
Pt Understands/will use on own
Pt unable to comprehend or perform TX
Nurse Notified Nurse will follow-up
MODE: M/P Y Mask Inline A/C M/AC
CPT Initial
CPT Subsequent
CPT w/Bed:
Oscillating PEP
NT Suction

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 80 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 78 Post-Assessment RR: 16

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Adverse Reactions:
Comment:
COUGH Y Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/21/16 Time: 2000 (continued)

09 RESP THERAPY - TREATMENT (continued)
RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/21/16 Time: 2056

6680 Vital Signs A 06,10,14,18,22,02 OE
- Create 05/21/16 2056 JL 05/21/16 2056 JL

Activity Date: 05/21/16 Time: 2057

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/21/16 2057 JL 05/21/16 2057 JL
Temperature: 98.6
Temperature Source+: Oral
Pulse: 82
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 116/72
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 96 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/21/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/21/16 2100 JL 05/21/16 2102 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E10429588C8, KNIGHT, 324

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/21/16		**Time: 2130**								
1699 Prostat Supplement							A	08,20		OE
- Document	05/21/16	2130	MG*	05/21/16	2342	MG*				
Prostat given: N										
Comment:										
3140 Airway Management							A	QS		CP
- Document	05/21/16	2130	MG*	05/21/16	2342	MG*				
3440 Incision Site Care							A	QS		CP
- Document	05/21/16	2130	MG*	05/21/16	2342	MG*				
0430 Bowel Management STOOL ASSESSMENT							A	QS		CP
- Document	05/21/16	2130	MG*	05/21/16	2340	MG*				
BM Consistency: Liquid										
BM Color: Green										
BM Amount: SMALL										
Comment: 200 ML GREENISH LIQUID FROM OSTOMY										
1629 OSA ASSESSMENT							A	QS		CP
- Document	05/21/16	2130	MG*	05/21/16	2341	MG*				
OSA Assessment										
CAPNOGRAPHY Monitor in place: N										
If NO, Reason: NI										
Education reviewed with patient? N										
If NO, Reason: NI										
Hi risk or known controlled, signage placed on patient door: N										
OSA HIGH RISK: N										
Follow-up Physician Appt: NONE										
6955 Anticoagulant Educ Materials Provided							A	QS		CP
- Document	05/21/16	2130	MG*	05/21/16	2349	MG*				
Anticoagulant Educ Material provided to Patient &/or Family? Y										
Comment:										
CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)										
>>>>>>COMPLETE Intervention after Filing<<<<<<										
6990 Post Operative Care - GOALS							A	08,20		CP
- Document	05/21/16	2130	MG*	05/21/16	2351	MG*				
Post-Operative Care - GOALS										
Patient demonstrates use of Incentive Spirometer: Y										
Goal: 8-10 TIMES EVERY HOUR										
Patient demonstates technique for splinting incision: Y										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/21/16		**Time: 2130 (continued)**								
6990 Post Operative Care - GOALS (continued)										
Patient verbalizes understanding of pain scale: Y										
Goal: 5/10										
Pain Scale: NUMERIC										
Patient verbalizes understanding of activity level: Y										
Prescribed activity level: ASSIST										
Patient verbalizes understanding DVT prevention including:										
TEDS N IPC Y Pedal Exercises Y										
Goal: PREVENT DVT'S										
Provide patient with form #2292										
Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y										
Diet: SOFT										
Patient verbalizes signs/symptoms of infection including:										
Redness Y Swelling Y Discharge Y Temperature Y										
BS Frequency: N/A										
Smoking Status: Never smoker Nursing Note: N										
0840 Positioning							A	QS		CP
- Document	05/21/16	2130	MG*	05/21/16	2340	MG*				
150005 Intake/Output							A	06,18		CP
- Document	05/21/16	2130	MG*	05/21/16	2202	MG*				
INTAKE										
PO: IV: Blood: TPN: NG Irrigation:										
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):										
TF Flush: PO Supplement: FFP: Dialysis (Intake):										
OUTPUT										
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:										
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 200										
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:										
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:										
Diapers: G Tube (Residual): Liquid Stool:										
#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):										
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:										
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:										

5A4D43B46E10429588C8, KNIGHT, 325

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 2130 (continued)

150005 Intake/Output (continued)
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/21/16 2130 MG* 05/21/16 2356 MG*
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/21/16 2130 MG* 05/21/16 2357 MG*
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: LEFT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 22
Fluid/Rate #1: SL
Date Insert/DC #1: 05/19/16
IV #1 Comment:
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/21/16 2130 MG* 05/21/16 2349 MG*
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented
Vision Impairment: GLASSES
Hearing Impairment:

Continued On Next Page
Glasgow Coma Scale N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 2130 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Eye Opening
Spontaneously: 4
To Speech:
To Pain:
No Response:

Best Verbal Response
Converses/Oriented: 5
Converses/Disoriented:
Inappropriate Words:
Incomprehensible:
No Response:

Best Motor Responses
Obeys Command: 6
Localizes Pain:
Withdraws To Pain:
Abnormal Flexion:
Abnormal Extension:
No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet: N Sticker: N
Comfort Measures Only NA
Chest Pain: N If Yes, Document in Pain Assessment Intervention.
Heart Sounds+: S1,S2
Telemetry Pattern+:
Pulse Rhythm+: Regular
Heart Rate:
Pacemaker: N Defibrillator: N
Dizziness/Syncope+:
Palpitations: N
JVD+:

Edema 1+:
Loc 1+:
Pitting:
Edema 2+:
Loc 2+:
Pitting:
TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses
Dorsalis Lt+: Normal
Dorsalis Rt+: Normal
Post Tib Lt+:
Post Tib Rt+:
Femoral Rt+:
Femoral Lt+:
Cap Refill RUE+: Brisk

5A4D43B46E10429588C8, KNIGHT, 326

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	Occurred by	Recorded Date	Recorded Time	Recorded by	Sts	Frequency Documented Comment	Documented Units	From Change

Activity Date: 05/21/16 Time: 2130 (continued)

6650 SKIFT ASSESSMENT (Surveillance) (continued)

Carotid Rt+:
Carotid Lt+:
Brachial Rt+: Normal
Brachial Lt+: Normal
Radial Rt+: Normal
Radial Lt+: Normal

Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>: PT HAS NO COMPLAINTS OF CHEST PAIN/DISCOMFORT.

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 96 %/L of O2:
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Regular
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

Lung Sounds: Profile

COPD Educational Video:

Resp Comment <Esc>:

Cyanosis: N
Pallor: N

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI
Musc-Skel Comment <Esc>: GENRALIZED WEAKNESS NOTED POST OP SORENESS

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: Y
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Staples
Dressing Type #1: ABD PAD
Dress Appear #1: CDI

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally: 3	Adequate:
No Impairment:	Walks Frequently:	Excellent: 4
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N
Emesis: N Diarrhea: N
By C-Diff Protocol - Watery loose stool: N

Last BM: 05/21/16
Stool Amount+: Small
Stool Color+: Greenish
Stool Consistency+: Liquid
Incontinent Stool: Y

5A4D43B46E10429588C8, KNIGHT, 327

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 2130 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: ROUND

GI Comment <Esc>: ILEOSTOMY NOTED TO RT ABD, WAFER C/D/I. GREEN LIQUID STOOL DRAINING INTO OSTOMY APPLIANCE.

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Currently Menses:
LMP:
Urine Color+: Amber
Character+: CLEAR
Urine Odor+: Normal
Prostate Problems:
Incontinent Bladder: N
Suprapubic Catheter: N

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: VOIDING IN URINAL

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y
Pain Scale: 3
Acceptable Scale/Goal for EXCELLENT pain management this shift: 0
Pain Location+: ABDOMINAL
Quality Of Pain+:
Onset/Duration:
Pain Med Given<Esc>:
Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

Pain Comment<Esc>: DECLINES OFFER FOR PRN AT THIS TIME. WILL CONTINUE TO MONITOR.

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE
Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 2130 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: POC, MEDICATIONS, DVT PREVENTION, WOUND CARE

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/21/16 2130 MG* 05/21/16 2349 MG*
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370 Discharge Planning Assessment A QS CP
- Document 05/21/16 2130 MG* 05/21/16 2351 MG*
----------DISCHARGE PLANNING ASSESSMENT----------

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY NURSE ASSISTING WITH HOME SUPPLIES

NEEDS IDENTIFIED:
Home Health: Y
Medical Equipment: N
Wound Care: N
Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested:

5A4D43B46E1042958BC8, KNIGHT, 328

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 2130 (continued)

7370 Discharge Planning Assessment (continued)
Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/21/16 2130 MG* 05/21/16 2356 MG*

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking 1
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs 0
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 6

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door HIGH RISK (>14) RED Sign on door/chart

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/21/16 Time: 2130 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Rainforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist
99 SEPSIS Documentation A QS CP
- Document 05/21/16 2130 MG* 05/21/16 2340 MG*
Temperature: 98.6
Temperature Source+: Oral
Pulse: 82
Respirations: 18
Blood Pressure: 116/72
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk
(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: N
If NO, Reason: Physician Already Aware

Activity Date: 05/21/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/21/16 2300 JL 05/22/16 0202 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E1042958BC8, KNIGHT, 329

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/21/16		Time: 2358								
3668	PEG/PEJ Tube Care							C	QS	CP
- Ed Status	05/21/16	2358	MG*	05/21/16	2358	MG*				A => C
Activity Date: 05/22/16		Time: 0100								
5500011	Purposeful Rounding							A	Q2HODD	CP
- Document	05/22/16	0100	JL	05/22/16	0203	JL				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/22/16 Time: 0142

09 RESP THERAPY - TREATMENT C AD CP
- Document 05/22/16 0142 JF7 05/22/16 0143 JF7

RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 93 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 78 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change
Activity Date: 05/22/16		Time: 0142 (continued)								
09	RESP THERAPY - TREATMENT (continued)									

Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 72 Post-Assessment RR: 16

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/22/16 Time: 0200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/22/16 0200 JL 05/22/16 0203 JL

Temperature: 97.9
Temperature Source+: Oral
Pulse: 78
Pulse Source+: BRACHIAL
Respirations: 17
Blood Pressure: 117/71
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

5A4D43B46E10429588C8, KNIGHT, 330

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/22/16 Time: 0200 (continued)

6680 Vital Signs (continued)
O2 Sat: 94 Nursing Note:

TPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/22/16 Time: 0225

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/22/16 0225 MG* 05/22/16 0405 MG*

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within the last 24 hrs
Additional point for change in medications

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/22/16 Time: 0225 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)
Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/22/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 0300 JL 05/22/16 0616 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

5A4D43B46E10429588C8, KNIGHT, 331

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/22/16 Time: 0300 (continued)

5500011 Purposeful Rounding (continued)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/22/16 Time: 0405

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/22/16 0405 MG* 05/22/16 0405 MG*
IPC: Y
TED Hose: N
Venous Foot Pump: N

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/22/16 0405 MG* 05/22/16 0405 MG*
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/22/16 0405 MG* 05/22/16 0405 MG*
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
diet, physician follow-up, medications, what to do if Comment
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/22/16 Time: 0405 (continued)

800001 Education/Teaching Assessment (continued)
DIS
ACTIVITY
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/22/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 0500 JL 05/22/16 0616 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/22/16 Time: 0600

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/22/16 0600 JL 05/22/16 0617 JL
Temperature: 98.1
Temperature Source+: Oral
Pulse: 74
Pulse Source+: BRACHIAL
Respirations: 17
Blood Pressure: 114/71
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 94 Nursing Note:

5A4D43B46E10429588C8, KNIGHT, 332

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/22/16 Time: 0600 (continued)

6680 Vital Signs (continued)

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/22/16 Time: 0633

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/22/16 0633 MG* 05/22/16 0633 MG*
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: SOFT
Outcome:

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

Problem/Outcome/Intervention Description

Activity Date: 05/22/16 Time: 0633

150005 Intake/Output A 06,18 CP
- Document 05/22/16 0633 MG* 05/22/16 0634 MG*
INTAKE
PO: 960 IV: 170 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 750 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy:
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

525003 IV Site Check A 06,18 CP
- Document 05/22/16 0633 MG* 05/22/16 0634 MG*
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Semi-permeable Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Y Dressing changed: Date: Change:
Tenderness of the Site: N BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change:N Date: Change:
Huber Needle Size:
CHG Bath given: N If no, Reason: BATH PRIOR SHIFT WITH CHG Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5500010 Rounds Surveillance A 06,18 CP
- Document 05/22/16 0633 MG* 05/22/16 0634 MG*

Activity Date: 05/22/16 Time: 0649

Patient Notes: Nursing Notes
- Create 05/22/16 0649 MG* 05/22/16 0651 MG*
Abnormal? N Confidential? N
AT BEDREST, AWAKE AND ALERT. NO C/O PAIN AT PRESENT. NO DISTRESS NOTED. JP

5A4D43B46E1042958C8, KNIGHT, 333

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/22/16 Time: 0649 (continued)

Patient Notes: Nursing Notes (continued)
INTACT AND COMPRESSED. SCDS ON AND PUMPING. MIDLINE DRESSING DRY AND INTACT. ILEOSTOMY APPLIANCE INTACT, DRAINAGE IS GREENISH SEMI LIQUID THIS AM. URINE IS DARK AMBER. CALL BELL IN REACH.

Note Type Description
No Type None

Activity Date: 05/22/16 Time: 0700

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 0700 MG 05/22/16 0835 MG

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/22/16 Time: 0706

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/22/16 0706 FS 05/22/16 0708 FS
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 95 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/F Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/22/16 Time: 0706 (continued)

09 RESP THERAPY - TREATMENT (continued)
Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 71 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 71 Post-Assessment RR: 16

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/22/16 Time: 0730

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/22/16 0730 MM 05/22/16 0800 MM
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From FROM: MELISSA, RN

Comment

5A4D43B46E1042958C8, KNIGHT, 334

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment / Documented Units	From Change

Activity Date: 05/22/16 Time: 0730

Patient Notes: Nursing Notes
- Create 05/22/16 0730 MM 05/22/16 0817 MM
Abnormal? N Confidential? N
REPORT RECEIVED. PT AWAKE AND ALERT. LAYING IN BED. RESPIRATIONS EVEN AND UNLABORED. IV SL, SITE WNL. MIDLINE ABD DRESSING INTACT, NO VISIBLE DRAINAGE PRESENT. OSTOMY INTACT TO RLQ ABD, STOMA MOIST AND PINK, SMALL AMOUNT OF BROWN STOOL PRESENT, NO LEAK PRESENT IN APPLIANCE. NO S/S OF DISTRESS PRESENT. INSTRUCTED TO CALL FOR ASSISTANCE AS NEEDED. CALL BELL IN REACH. SIDEAILS UP X 2. BED ALARM ON.
Note Type Description
No Type None

Activity Date: 05/22/16 Time: 0800

1699 Prostat Supplement A 08,20 OE
- Document 05/22/16 0800 MM 05/22/16 1409 MM
Prostat given: Y

Comment:
3140 Airway Management A QS CP
- Document 05/22/16 0800 MM 05/22/16 1409 MM
3440 Incision Site Care A QS CP
- Document 05/22/16 0800 MM 05/22/16 1409 MM
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/22/16 0800 MM 05/22/16 1409 MM
BM Consistency: Soft
BM Color: Green
BM Amount: SMALL

Comment: SOFT GREENISH/BROWN STOOL PRESENT IN OSTOMY APPLIANCE.
1629 OSA ASSESSMENT A QS CP
- Document 05/22/16 0800 MM 05/22/16 1409 MM
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE
6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/22/16 0800 MM 05/22/16 1409 MM
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment / Documented Units	From Change

Activity Date: 05/22/16 Time: 0800 (continued)

6955 Anticoagulant Educ Materials Provided (continued)
CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<
6990 Post Operative Care - GOALS A 08,20 CP
- Document 05/22/16 0800 MM 05/22/16 1410 MM
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: SOFT

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note:
0840 Positioning A QS CP
- Document 05/22/16 0800 MM 05/22/16 1409 MM
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/22/16 0800 MM 05/22/16 1410 MM
VTE Prophylaxix Orders Complete? Y

5A4D43B46E1042958BC8, KNIGHT, 335

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 0800

525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/22/16 0800 MM 05/22/16 1411 MM
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED N

IV Site #1: LEFT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 22
Fluid/Rate #1: SL
Date Insert/DC #1: 05/19/16
IV #1 Comment:
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/22/16 0800 MM 05/22/16 1415 MM
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+:
Rt Reaction To Light+:
Size Left+:
Lt Reaction To Light+:

Strength Of Extremities
RUE+:
LUE+:
RLE+:
LLE+:

Peripheral Sensory Deficit:
Site:
Vision Impairment:
Hearing Impairment:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously:	Converses/Oriented: 5	Obeys Command: 6
To Speech: 3	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
No Response:

Total Glasgow Score: 14

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet: Sticker:
Comfort Measures Only NA
Chest Pain: N If Yes, Document in Pain Assessment Intervention.
Heart Sounds+: S1,S2
Telemetry Pattern+:
Pulse Rhythm+: Regular
Heart Rate: 83
Pacemaker: N Defibrillator: N
Dizziness/Syncope+:
Palpitations: N
JVD+:

Edema 1+:
Loc 1+:
Pitting:
Edema 2+:
Loc 2+:
Pitting:
TED Hose: N
IPC: Y
Venous Foot Pump: N

Peripheral Pulses
Dorsalis Lt+: Normal
Dorsalis Rt+: Normal
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal
Femoral Rt+:
Femoral Lt+:
Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

5A4D43B46E1042958BC8, KNIGHT, 336

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/22/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Cardio Comment <Esc>: NO C/O CHEST PAIN OR DISCOMFORT.

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 02 Sat: 94 %/L of O2: 0

O2 Mode+: ROOM AIR

RR Description+:

Resp Pattern+: Regular

Chest Expansions+: Symmetrical

Cough+: Absent

Sputum Amount+: Moderate

Sputum Consistency+:

Sputum Color+:

Airway+: Patent

Airway Suctioned+:

Breath Sounds

LUL+: Clear

LLL+: Diminished

RUL+: Clear

RML+: Clear

RLL+: Diminished

Lung Sounds: CLEAR, BASES DIMINISHED

COPD Educational Video: Profile

Resp Comment <Esc>: ENCOURAGED TO COUGH, DEEP BREATHE, AND USE I.S. 10 X Q1H.

Cyanosis: N

Pallor: N

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:

Paralysis+:

Joint Swelling+:

Amputations+:

Muscle Spasms+:

Contractures+:

Deformities+:

Weakness+:

Transfer, Lift, or Ambulation equipment NI

Musc-Skel Comment <Esc>: GENRALIZED WEAKNESS PRESENT POST OP SORENESS

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal

Skin Temp+: Warm

Skin To Touch+: Dry

Skin Condition+: Warm & Dry

Wound Site #1: MIDLINE ABD

Wound Appear #1+:

Closure Type #1+:

Dressing Type #1: ABD PAD

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/22/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Dress Appear #1: INTACT, NO VISIBLE DRNG

Turgor+: ELASTIC

Mucous Membranes+: Moist & Intact

Specialty Bed: Y

Decubiti: N

Location/Size<Esc>:

Stage+:

Wound Site #2:

Wound Appear #2+:

Closure Type #2+:

Dressing Type #2:

Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally: 3	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N

Emesis: N Diarrhea: N

By C-Diff Protocol - Watery loose stool: N

Last BM: 05/22/16

Stool Amount+: Small

Stool Color+: Greenish

Stool Consistency+: Liquid

Incontinent Stool: N

Rectal Tube: N

Tubes+: Jackson Pratt

Tube Drainage: Y

Tube To Suction: Y

Stoma Present: Y

Ostomy Appliance: Y

Bowel Sounds

RUQ+: ACTIVE

LUQ+: ACTIVE

RLQ+: ACTIVE

LLQ+: ACTIVE

Abd Appearance+: ROUND

5A4D43B46E1042958BC8, KNIGHT, 337

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

GI Comment <Esc>: ILEOSTOMY PRESENT TO RT ABD, WAFER C/D/I. GREEN LIQUID STOOL DRAINING INTO OSTOMY APPLIANCE.

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems:
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N ***Dialysis***
Suprapubic Catheter: N CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: N Acceptable Scale/Goal for EXCELLENT pain management this shift: 4
Pain Scale:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>: SEE EMAR

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: WILL MEDICATE FOR PAIN PRN.

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test:

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Specific Barriers To Learning

Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION:

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/22/16 0800 MM 05/22/16 1409 MM
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370 Discharge Planning Assessment A QS CP
- Document 05/22/16 0800 MM 05/22/16 1410 MM

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY NURSE ASSISTING WITH HOME SUPPLIES

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested:

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY

5A4D43B46E10429588C8, KNIGHT, 338

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 0800

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/22/16 0800 MM 05/22/16 1410 MM

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 8

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/22/16 0800 MM 05/22/16 0818 MM

Temperature: 98.1
Temperature Source+: Oral
Pulse: 74
Respirations: 17
Blood Pressure: 114/71
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physicion Notified:
If NO, Reason:

Activity Date: 05/22/16 Time: 0842

Patient Notes: Nursing Notes
- Create 05/22/16 0842 MM 05/22/16 0842 MM
Abnormal? N Confidential? N
AWAKE AND ALERT. SITTING UP IN BED. EATING BREAKFAST. AM MEDS GIVEN.
Note Type Description
No Type None

Activity Date: 05/22/16 Time: 0900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 0900 MG 05/22/16 1033 MG
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E1042958C8, KNIGHT, 339

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/22/16		**Time: 1000**								
6680 Vital Signs							A	06,10,14,18,22,02		OE
- Document	05/22/16	1000	MG	05/22/16	1034	MG				
Temperature: 98.8										
Temperature Source+: Oral										
Pulse: 79										
Pulse Source+: BRACHIAL										
Respirations: 16										
Blood Pressure: 116/72										
BP Location+:										
BP Position+: SEMI-FOWLER'S										
Weight (lbs):										
(Oz):										
kg:										
Weight Source:										
O2 Sat: 95					Nursing Note:					
IPI: (Surgical Patients ONLY)										
Pt Out of Room:		Patient Refused:			Nurse Notified:					
Activity Date: 05/22/16		**Time: 1100**								
5500011 Purposeful Rounding							A	Q2HODD		CP
- Document	05/22/16	1100	MG	05/22/16	1136	MG				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 05/22/16		**Time: 1300**								
5500011 Purposeful Rounding							A	Q2HODD		CP
- Document	05/22/16	1300	MG	05/22/16	1519	MG				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment:										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/22/16		**Time: 1300 (continued)**								
5500011 Purposeful Rounding (continued)										
<Esc>										
Activity Date: 05/22/16		**Time: 1400**								
6680 Vital Signs							A	06,10,14,18,22,02		OE
- Document	05/22/16	1400	MG	05/22/16	1519	MG				
Temperature: 98.8										
Temperature Source+: Oral										
Pulse: 74										
Pulse Source+: BRACHIAL										
Respirations: 16										
Blood Pressure: 118/73										
BP Location+:										
BP Position+: SEMI-FOWLER'S										
Weight (lbs):										
(Oz):										
kg:										
Weight Source:										
O2 Sat: 94					Nursing Note:					
IPI: (Surgical Patients ONLY)										
Pt Out of Room:		Patient Refused:			Nurse Notified:					
6409 FALLS SCREEN - FOLLOW-UP							A	02,14		CP
- Document	05/22/16	1400	MM	05/22/16	1516	MM				

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose

*****Gait/Balance*****
Normal or N/A secondary neuro deficit

5A4D43B46E10429588C8, KNIGHT, 340

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/22/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach

Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/22/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/22/16 Time: 1454

Patient Notes: Nursing Notes
- Create 05/22/16 1454 MM 05/22/16 1938 MM
Abnormal? N Confidential? N
PT PREMEDICATED WITH DILAUDID PRIOR TO DRESSING CHANGE PER PT REQUEST. PT AWAKE AND ALERT. LAYING IN BED.
Note Type Description
No Type None

Activity Date: 05/22/16 Time: 1500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 1500 MG 05/22/16 1519 MG
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/22/16 Time: 1530

Patient Notes: Nursing Notes
- Create 05/22/16 1530 MM 05/22/16 1947 MM
Abnormal? N Confidential? N
MIDLINE ABD DRESSING REMOVED. SMALL AMOUNT OF BROWNISH/RED DRAINAGE PRESENT, STAPLES REMOVED, WOUND OPEN APPROXIMATELY 1 INCH DEEP. WOUND BED PINK WITH TANNISH COLOR PRESENT. WOUND PACKED WITH KERLIX DAMPENED WITH DAKINS AS ORDERED, COVERED WITH DRY GAUZE, ABD PAD, SECURED WITH MONTGOMERY STRAPS. PRIOR TO PLACING MONTGOMERY STRAPS TO PT'S SKIN AREA WAS COVERED WITH TEGADERM DRESSINGS. REPORT RECEIVED FROM PT'S WIFE THAT PT HAS DUODERMS IN PLACE THAT WERE PLACED ON PRIOR SHIFT/DAY DUE TO SKIN AREAS BLISTERED FROM PAPER TAPE. JP DRAIN TUBING STRIPPED. SCANT AMOUNT OF SEROUS DRAINAGE PRESENT IN JP DRAIN, SUTURE INTACT, NEW DRESSING APPLIED.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 341

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/22/16		**Time: 1600**								
1663	IPC, TED, VFP Documentation						A	04,16		CP
- Document	05/22/16	1600	MM	05/22/16	1804	MM				
IPC: Y										
TED Hose: N										
Venous Foot Pump: N										
3592	TED/HEEL PROTECTORS/IPC Skin Assessment						A	04,16		CP
- Document	05/22/16	1600	MM	05/22/16	1804	MM				
TED Hose - removed for skin assessment and reapplied.										
IPC - removed for skin assessment and reapplied. Y										
Heel Protectors - removed for skin assessment and reapplied.										
Comment:										
800001	Education/Teaching Assessment						A	04,16		CP
- Document	05/22/16	1600	MM	05/22/16	1805	MM				
Written Education Materials Provided.										
CHF EDUCATION: N										
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions.								Instructional video shown? Comment		
STROKE/TIA EDUCATION N								Education Material Provided:		Educ Material Date:
Activation of Emerg Med System:								Need for F/U after discharge:		
Medication prescribed at discharge:								Risk factors for stroke:		
Warning signs & symptoms for stroke:										
Venous Thromboembolism (VTE) Warfarin EDUCATION N								DVT PE		
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised										
Avoid major diet chges or notify Health Prof before changing										
Compliance Education: Importance of taking warfarin as instructed										
Important to monitor warfarin w/scheduled PT/INR blood draws										
Potential for Adverse Drug Reactions & Interactions:										
Don't take/DC any meds or OTC meds except thru Phys or Pharm										
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level										
Education Session Date:								Follow-up Education:		
Care/Education Codes: POC								Material Codes: VERBAL		
DIET										
DIS										
ACTIVITY										
MEDS										
TX										
Comment: UNDERSTANDS								Comment: UNDERSTANDS		
EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/22/16		**Time: 1600 (continued)**								
800001	Education/Teaching Assessment (continued)									
Outcome: VERBAL										
Non-Surgical Open Wound: N Date Began:										
New Surgical Flap or Graft: N Date of Surgery: 05/15/16										
Activity Date: 05/22/16		**Time: 1700**								
5500011	Purposeful Rounding						A	Q2HODD		CP
- Document	05/22/16	1700	MG	05/22/16	1840	MG				
Pain										
Potty										
Position										
Proximity (phone,bedside table,ice pitcher,call light reach)										
Personal Needs (anything else you need?)										
Pick up (tidy room)										
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 05/22/16		**Time: 1800**								
6680	Vital Signs						A	06,10,14,18,22,02		OE
- Document	05/22/16	1800	MG	05/22/16	1841	MG				
Temperature: 99.0										
Temperature Source+: Oral										
Pulse: 75										
Pulse Source+: BRACHIAL										
Respirations: 16										
Blood Pressure: 116/69										
BP Location+:										
BP Position+: SEMI-FOWLER'S										
Weight (lbs):										
(Oz):										
kg:										
Weight Source:										
O2 Sat: 94 Nursing Note:										
IPI: (Surgical Patients ONLY)										
Pt Out of Room: Patient Refused: Nurse Notified:										

5A4D43B46E10429588C8, KNIGHT, 342

Problem/Outcome/Intervention Description

	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change
	Activity Date: 05/22/16		Time: 1800								
	6991	Post Operative Care - OUTCOMES						A	18,06		
CP	- Document	05/22/16	1800	MM	05/22/16	1805	MM				
	Post Operative Care - OUTCOMES										
	Patient demonstrates use of Incentive Spirometer: Y										
	Goal: 8-10 TIMES EVERY HOUR										
	Outcome: DEMON										
	Patient demonstates technique for splinting incision: Y										
	Outcome: DEMON										
	Patient verbalizes understanding of pain scale: Y										
	Goal: 5/10										
	Outcome: VERBAL										
	Pain Scale: NUMERIC										
	Patient verbalizes understanding of activity level: Y										
	Prescribed activity level: ASSIST										
	Outcome: VERBAL										
	Patient verbalizes understanding DVT prevention including:										
	TEDS N IPC Y Pedal Exercises Y										
	Goal: PREVENT DVT'S										
	Outcome: DEMON										
	Provide patient with form #2292										
	Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y										
	Diet: REGULAR										
	Outcome:										
	Patient verbalizes signs/symptoms of infection including:										
	Redness Y Swelling Y Discharge Y Temperature Y										
	Outcome:										
	BS Frequency: N/A										
	Smoking Status: Never smoker								Nursing Note:		
	1160	Nutritional Monitoring						A	18		
	- Document	05/22/16	1800	MM	05/22/16	1805	MM				
	Diet Ordered: REGULAR										
	Meal: BREAKFAST, LUNCH, DINNER										
	% Diet Taken: 25% - 50% (FAIR)										
	Oral Supplement:										
	PO Supplement: cc (Total Intake)										

Problem/Outcome/Intervention Description

	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change
	Activity Date: 05/22/16		Time: 1800 (continued)								
CP	1160	Nutritional Monitoring (continued)									
	Comment:										
	150005	Intake/Output						A	06,18		CP
	- Document	05/22/16	1800	MM	05/22/16	1901	MM				
	INTAKE										
	PO: 750 IV: 350 Blood: TPN: NG Irrigation:										
	TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):										
	TF Flush: PO Supplement: FFP: Dialysis (Intake):										
	OUTPUT										
	Void (ml): 700 Bladder Incont Episodes: Emesis: Colostomy:										
	Foley: Bowel Incont Episodes: T Tube: Ileostomy: 275										
	Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:										
	SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:										
	Diapers: G Tube (Residual): Liquid Stool:										
	#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):										
	#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:										
	#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:										
	OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:										
	Comment:										
	525003	IV Site Check						A	06,18		CP
	- Document	05/22/16	1800	MM	05/22/16	1806	MM				
	IV Site WNL: Y If No:										
	Comment:										
	Central Line, PICC, Mediport Maintenance Checklist										
	Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N										
	Dressing Type: Unused lumens capped, locked, & covered:										
	Dressing clean, dry, & intact: Dressing changed: Date: Change:										
	Tenderness of the Site: BioPatch applied:										
	CAP Changed: Date: Change:										
	IV Tube Change: Date: Change:										
	Huber Needle Size:										
	CHG Bath given: If no, Reason: Date:										
	(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)										
	Change transparent dressing every 7 days or if dressing damp, loosened or soiled.										
CP	Was Central Line removal discussed with physician daily?										
	If NO, explain:										
	5500010	Rounds Surveillance						A	06,18		CP
	- Document	05/22/16	1800	MM	05/22/16	1806	MM				
	Patient Notes: Nursing Notes										
	- Create	05/22/16	1800	MM	05/22/16	1948	MM				
	Abnormal? N Confidential? N										
	AWAKE AND ALERT. RESTING IN BED. RESPIRATIONS EVEN AND UNLABORED. IV ABX INFUSING, SITE WNL. ABD DRESSING INTACT, NO VISIBLE DRAINAGE PRESENT. OSTOMY										

5A4D43B46E1042958C8, KNIGHT, 343

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/22/16 Time: 1800 (continued)

Patient Notes: Nursing Notes (continued)
APPLIANCE INTACT, 50 CC OF GREENISH STOOL EMPTIED AT THIS TIME, NO LEAK PRESENT IN APPLIANCE. PT TOLERATING DIET, NO C/O N/V. PT DOING EXERCISES IN BED AND AT SIDE OF BED TODAY. CALL BELL IN REACH. SIDERAILS UPX 2. INSTRUCTED TO CALL FOR ASSISTANCE AS NEEDED.

Note Type Description
No Type None

Activity Date: 05/22/16 Time: 1900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 1900 JL 05/22/16 2121 JL

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/22/16 Time: 1910

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/22/16 1910 CG* 05/22/16 1920 CG*

RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 93 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
NPPV
R/A Y
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/22/16 Time: 1910 (continued)

09 RESP THERAPY - TREATMENT (continued)

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 85 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 85 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/22/16 Time: 1922

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/22/16 1922 MG* 05/22/16 1929 MG*

****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From MELISSA,RN/MICHELLE,RN

Comment

5A4D43B46E1042958C8, KNIGHT, 344

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/22/16 Time: 1922

Patient Notes: Nursing Notes
- Create 05/22/16 1922 MG* 05/23/16 0348 MG*
Abnormal? N Confidential? N
RECEIVED REPORT FROM MICHELLE, RN. RESTING IN BED, AWAKE AND ALERT. DRESSING TO ABD C/D/I. ILEOSTOMY APPLIANCE INTACT. NOT WEARING SCDS, REPORTS HE HAS PERFORMED EXERCISES INSTEAD. SALINE LOCK TO LEFT FOREARM INTACT AND PATENT, NO REDNESS OR SWELLING NOTED. DENIES ANY NEEDS AT PRESENT. WILL CONTINUE TO MONITOR.

Note Type	Description
No Type	None

Activity Date: 05/22/16 Time: 1955

1699 Prostat Supplement A 08,20 OE
- Document 05/22/16 1955 MG* 05/22/16 2305 MG*
Prostat given: Y

Comment:
3140 Airway Management A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2305 MG*
3440 Incision Site Care A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2305 MG*
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/22/16 1955 MG* 05/22/16 2305 MG*
BM Consistency: Soft
BM Color: Green
BM Amount: SMALL

Comment:
1629 OSA ASSESSMENT A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2305 MG*
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE
6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2310 MG*
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/22/16 Time: 1955 (continued)

6955 Anticoagulant Educ Materials Provided (continued)

>>>>>>COMPLETE Intervention after Filing<<<<<<
6990 Post Operative Care - GOALS A 08,20 CP
- Document 05/22/16 1955 MG* 05/22/16 2310 MG*
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
0840 Positioning A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2305 MG*
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/22/16 1955 MG* 05/22/16 2312 MG*
VTE Prophylaxix Orders Complete? Y

5A4D43B46E10429588C8, KNIGHT, 345

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 1955

525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2312 MG*
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: LEFT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Jelco
Cath Gauge #1: 22
Fluid/Rate #1: SL
Date Insert/DC #1: 05/19/16
IV #1 Comment:
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2310 MG*
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented

Vision Impairment: GLASSES
Hearing Impairment:

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/padal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: S1,S2

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate:

Pacemaker: N Defibrillator: N

Dizziness/Syncope+:

Palpitations:

JVD+:

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: Y
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal	Femoral Rt+:
Dorsalis Rt+: Normal	Femoral Lt+:
Post Tib Lt+:	
Post Tib Rt+:	Cap Refill RUE+: Brisk
Carotid Rt+:	Cap Refill LUE+: Brisk
Carotid Lt+:	Cap Refill RLE+: Brisk
Brachial Rt+:	Cap Refill LLE+: Brisk
Brachial Lt+:	
Radial Rt+: Normal	
Radial Lt+: Normal	

5A4D43B46E10429588C8, KNIGHT, 346

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/22/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Cardio Comment <Esc>: NO C/O CHEST PAIN OR DISCOMFORT.

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 16 O2 Sat: 94 %/L of O2: 0

O2 Mode+: ROOM AIR

RR Description+: WNL

Resp Pattern+: Regular

Chest Expansions+: Symmetrical

Cough+: Absent

Sputum Amount+: Moderate

Sputum Consistency+: Thick

Sputum Color+: Beige

Airway+: Patent

Airway Suctioned+:

Breath Sounds

LUL+: Clear

LLL+: Diminished

RUL+: Clear

RML+: Clear

RLL+: Diminished

Lung Sounds: CLEAR, BASES DIMINISHED

COPD Educational Video: Profile

Resp Comment <Esc>: ENCOURAGED TO COUGH, DEEP BREATHE, AND USE I.S. 10 X Q1H.

Cyanosis: N

Pallor: N

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized

Paralysis+:

Joint Swelling+:

Amputations+:

Muscle Spasms+:

Contractures+:

Deformities+:

Weakness+: Generalized

Transfer, Lift, or Ambulation equipment NI

Musc-Skel Comment <Esc>: GENRALIZED WEAKNESS PRESENT POST OP SORENESS

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal

Skin Temp+: Warm

Skin To Touch+: Dry

Wound Site #1: MIDLINE ABD

Wound Appear #1+: CLEAN/DRY

Closure Type #1+: Open

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/22/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Skin Condition+: Warm & Dry

Turgor+: ELASTIC

Mucous Membranes+: Moist & Intact

Specialty Bed: Y

Decubiti: N

Location/Size<Esc>:

Stage+:

Dressing Type #1: WET TO DRY DAKIN'S

Dress Appear #1: INTACT, NO VISIBLE DRNG

Wound Site #2:

Wound Appear #2+:

Closure Type #2+:

Dressing Type #2:

Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>: JP DRAIN WITH SCANT AMT OF YELLOW DRAINAGE, ILEOSTOMY WITH SMALL AMTS OF GREEN LOOSE STOOL

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally: 3	Adequate:
No Impairment:	Walks Frequently:	Excellent: 4
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N

Emesis: N

Constipation: N

Diarrhea: N

By C-Diff Protocol - Watery loose stool: N

Last BM: 05/22/16

Stool Amount+: Small

Stool Color+: Greenish

Stool Consistency+: Liquid

Incontinent Stool: N

Rectal Tube: N

Tubes+: Jackson Pratt

Tube Drainage: Y

Tube To Suction: Y

Stoma Present: Y

Ostomy Appliance: Y

Bowel Sounds

RUQ+: ACTIVE

LUQ+: ACTIVE

RLQ+: ACTIVE

LLQ+: ACTIVE

Abd Appearance+: ROUND

5A4D43B46E1042958BC8, KNIGHT, 347

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

GI Comment <Esc>: ILEOSTOMY PRESENT TO RT ABD, WAFER C/D/I. GREEN LIQUID STOOL DRAINING INTO OSTOMY APPLIANCE.
Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Currently Menses:
LMP:
Urine Color+: Amber
Prostate Problems:
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N
Dialysis
Suprapubic Catheter: N
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: VOIDING IN URINAL

**********PAIN ASSESSMENT**********

Pt C/O Pain: N
Acceptable Scale/Goal for EXCELLENT pain management this shift:
Pain Scale:
Pain Location+:
Patient Sleeping:
Quality Of Pain+:
Sleeping Resp:
Respiratory Quality:
Onset/Duration:
Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given:
Date:
Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment:

Type of Isolation: NONE
Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/22/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2310 MG*
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2311 MG*
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY NURSE ASSISTING WITH HOME SUPPLIES

NEEDS IDENTIFIED:
Home Health: Y
Wound Care: N
Medical Equipment: N
Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY

5A4D43B46E10429588C8, KNIGHT, 348

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/22/16 Time: 1955

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2312 MG*

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 5

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/22/16 Time: 1955 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/22/16 1955 MG* 05/22/16 2305 MG*

Temperature: 99.0
Temperature Source+: Oral
Pulse: 75
Respirations: 16
Blood Pressure: 116/69
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:
If NO, Reason:

Activity Date: 05/22/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 2100 JL 05/22/16 2121 JL

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/22/16 Time: 2131

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/22/16 2131 JL 05/22/16 2131 JL

Temperature: 99.1
Temperature Source+: Oral
Pulse: 85
Pulse Source+: BRACHIAL

5A4D43B46E1042958BC8, KNIGHT, 349

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/22/16 Time: 2131 (continued)

6680 Vital Signs (continued)
Respirations: 18
Blood Pressure: 109/71
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 94 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/22/16 Time: 2140

Patient Notes: Nursing Notes
- Create 05/22/16 2140 MG* 05/23/16 0351 MG*
Abnormal? N Confidential? N
DRESSING CHANGE PERFORMED. REMOVED OLD ABD AND GAUZE. CLEANED WITH NSS. WOUND BED PINK AND CLEAN. APPLIED 2 DAKIN'S SOLUTION DAMPENED GAUZE, THEN DRY GAUZE AND ABD. SECURED WITH MONTGOMERY STRAPS. TOLERATED WITH MINIMAL DIFFICULTY. RECEIVED PAIN MEDICATION 30 MINUTES PRIOR TO BEGINNING OF DRESSING CHANGE.
Note Type Description
No Type None

Activity Date: 05/22/16 Time: 2216

150005 Intake/Output A 06,18 CP
- Document 05/22/16 2216 MG* 05/22/16 2217 MG*
INTAKE
PO: IV: Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 75
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/22/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/22/16 2300 JL 05/22/16 2327 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 0100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 0100 JL 05/23/16 0148 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 0153

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/23/16 0153 JL 05/23/16 0153 JL
Temperature: 98.9
Temperature Source+: Oral
Pulse: 80
Pulse Source+: BRACHIAL
Respirations: 17
Blood Pressure: 106/70
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 98 Nursing Note:

IPI: (Surgical Patients ONLY)

5A4D43B46E10429588C8, KNIGHT, 350

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 0153 (continued)

6680 Vital Signs (continued)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/23/16 Time: 0157

09 RESP THERAPY - TREATMENT C RT-QID CP
- Document 05/23/16 0157 CG* 05/23/16 0302 CG*
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 96 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install Pulse Ox Single
MDI Subsequent Pulse Ox over-noc
MDI Additional Tx: Pulse Ox Continuous
Incentive Install CPT Initial
Pt Instructed CPT Subsequent
Pt Achieves ml CPT w/Bed:
Pt Understands/will use on own Oscillating PEP
Pt unable to comprehend or perform TX NT Suction
Nurse Notified Nurse will follow-up
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 86 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 86 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 0157 (continued)

09 RESP THERAPY - TREATMENT (continued)

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/23/16 Time: 0210

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/23/16 0210 MG* 05/23/16 0309 MG*

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

5A4D43B46E10429588C8, KNIGHT, 351

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 0210 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking:

Patient on Anticoagulants?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 0300 JL 05/23/16 0609 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 0301

Outcome: ADEQUATE VENTILATION A
- Ed Status 05/23/16 0301 CG* 05/23/16 0301 CG* C -> A
012 RESP THERAPY - NON-INVASIVE VENTILATION A AD CP
- Ed Status 05/23/16 0301 CG* 05/23/16 0301 CG* C => A
016 RESP THERAPY - EQUIPMENT CHANGE OUT A QD@1130 CP
- Ed Status 05/23/16 0301 CG* 05/23/16 0301 CG* C => A
08 RESP THERAPY - PATIENT EVALUATION A Q72H@0800 CP
- Ed Status 05/23/16 0301 CG* 05/23/16 0301 CG* C => A
09 RESP THERAPY - TREATMENT A RT-QID CP
- Ed Status 05/23/16 0301 CG* 05/23/16 0301 CG* C => A

Activity Date: 05/23/16 Time: 0417

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/23/16 0417 MG* 05/23/16 0417 MG*
IPC: R
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/23/16 0417 MG* 05/23/16 0417 MG*
TED Hose - removed for skin assessment and reapplied. NA
IPC - removed for skin assessment and reapplied. REF
Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/23/16 0417 MG* 05/23/16 0417 MG*
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
Instructional video shown?

5A4D43B46E10429588C8, KNIGHT, 352

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 0417 (continued)

800001 Education/Teaching Assessment (continued)
diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC, DIET, DIS, ACTIVITY, MEDS, TX Material Codes: VERBAL
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/23/16 Time: 0500

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change
5500011 Purposeful Rounding								A	Q2HODD		CP
- Document	05/23/16	0500	JL	05/23/16	0609	JL					

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 0500 (continued)

5500011 Purposeful Rounding (continued)

Comment:
<Esc>

Activity Date: 05/23/16 Time: 0600

6680 Vital Signs								A	06,10,14,18,22,02		OE
- Document	05/23/16	0600	JL	05/23/16	0610	JL					

Temperature: 99.5
Temperature Source+: Oral
Pulse: 91
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 102/65
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 91 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Patient Notes: Nursing Notes

- Create	05/23/16	0600	MG*	05/23/16	0624	MG*	

Abnormal? N Confidential? N
AT 0550, PT C/O SHARP STABBING PAIN UNDER LEFT AXILLA, STATING HE COULD NOT TAKE A DEEP BREATH. ON ASSESSMENT, PT TAKING SHORT, SHALLOW RESPIRATIONS, 28/MINUTE. O2 SAT 94% ON RA, HR 95. BREATH SOUNDS WITH CRACKLES AUSCULTATED IN LUL AND RLL, VERY DIMINISHED BREATH SOUNDS IN LLL. PT APPREHENSIVE. DR. WALKER PAGED.

Note Type	Description
No Type	None

Activity Date: 05/23/16 Time: 0610

Patient Notes: Nursing Notes

- Create	05/23/16	0610	MG*	05/23/16	0624	MG*	

Abnormal? N Confidential? N
DR. WALKER RETURNED CALL, NOTIFIED OF PT STATUS. NEW ORDERS GIVEN.

Note Type	Description
No Type	None

5A4D43B46E10429588C8, KNIGHT, 353

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented / Comment	Units	From Change

Activity Date: 05/23/16 Time: 0646

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/23/16 0646 MG* 05/23/16 0646 MG*
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR
Outcome:

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome:

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
150005 Intake/Output A 06,18 CP
- Document 05/23/16 0646 MG* 05/23/16 0650 MG*
INTAKE
PO: 1560 IV: 175 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 900 Bladder Incont Episodes: Emesis: Colostomy:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented / Comment	Units	From Change

Activity Date: 05/23/16 Time: 0646 (continued)

150005 Intake/Output (continued)
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 100
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 15 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/23/16 0646 MG* 05/23/16 0651 MG*
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/23/16 0646 MG* 05/23/16 0651 MG*

Activity Date: 05/23/16 Time: 0651

Patient Notes: Nursing Notes
- Create 05/23/16 0651 MG* 05/23/16 0653 MG*
Abnormal? N Confidential? N
RESTING IN HIGH FOWLER'S POSITION. O2 SAT 93% ON RA, HR 97, STATES PAIN IS NOW ABOUT A 6. RR 20, RESPIRATIONS UNLABORED AND ABLE TO SPEAK IN COMPLETE SENTENCES WITHOUT SOB. ABD AND PCXR COMPLETED. WILL REPORT TO ONCOMING STAFF NURSE.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 354

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 0700

5500011 Purposeful Rounding — A — Q2HODD — CP
- Document 05/23/16 0700 MG 05/23/16 0950 MG

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

6922 Nursing Report (Hand Off) — A — 07,19 — CP
- Document 05/23/16 0700 PS 05/23/16 0725 PS

****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From melissa, godwin rn

Comment

Activity Date: 05/23/16 Time: 0730

1699 Prostat Supplement — A — 08,20 — OE
- Document 05/23/16 0730 PS 05/23/16 1127 PS

Prostat given: Y

Comment:

3140 Airway Management — A — QS — CP
- Document 05/23/16 0730 PS 05/23/16 1127 PS

3440 Incision Site Care — A — QS — CP
- Document 05/23/16 0730 PS 05/23/16 1127 PS

0430 Bowel Management — A — QS — CP
STOOL ASSESSMENT
- Document 05/23/16 0730 PS 05/23/16 1127 PS

BM Consistency: Liquid
BM Color: Brown
BM Amount: MEDIUM

Comment: SOFT GREENISH/BROWN STOOL PRESENT IN OSTOMY APPLIANCE.

1629 OSA ASSESSMENT — A — QS — CP
- Document 05/23/16 0730 PS 05/23/16 1127 PS

OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

1629 OSA ASSESSMENT (continued) — CP

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided — A — QS — CP
- Document 05/23/16 0730 PS 05/23/16 1133 PS

Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS — A — 08,20 — CP
- Document 05/23/16 0730 PS 05/23/16 1133 PS

Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:

5A4D43B46E10429588C8, KNIGHT, 355

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

6990 Post Operative Care - GOALS (continued)
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

0840	Positioning							A	QS	CP
- Document	05/23/16	0730	PS	05/23/16	1127	PS				
275051	VTE Prophylaxis Orders Complete?							A	08,20	CP
- Document	05/23/16	0730	PS	05/23/16	1134	PS				
VTE Prophylaxix Orders Complete? Y										
525002	IV THERAPY ASSESSMENT							A	QS	CP
- Document	05/23/16	0730	PS	05/23/16	1134	PS				

IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: LEFT FOREARM
Site Appear #1: NORMAL
Type of Cath #1: Protectiv
Cath Gauge #1: 22
Fluid/Rate #1: SL
Date Insert/DC #1: 05/19/16
IV #1 Comment: DRSG INTACT.
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6650	SHIFT ASSESSMENT (Surveillance)							A	QS	CP
- Document	05/23/16	0730	PS	05/23/16	1133	PS				

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+:
Rt Reaction To Light+:
Size Left+:
Lt Reaction To Light+:

Behavior+: Depressed

Speech/Cry+: Clear

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Site:

Vision Impairment: GLASSES

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Responsive To+: Spontaneous Hearing Impairment: NONE

Mental Status: Alert & Oriented ***Continued On Next Page***

Glasgow Coma Scale

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: Sticker:
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate:

Pacemaker: N Defibrillator: N

Dizziness/Syncope+:

Palpitations: N

JVD+: Flat

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses

5A4D43B46E1042958C8, KNIGHT, 356

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency	Documented Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Dorsalis Lt+:
Dorsalis Rt+:
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal
Femoral Rt+:
Femoral Lt+:
Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: O2 Sat: 94 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+:
Resp Pattern+: Shallow
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+:
Airway Suctioned+:
COPD Educational Video:

Breath Sounds
LUL+: Fine Crackles
LLL+: Diminished
RUL+: Fine Crackles
RML+: Fine Crackles
RLL+: Diminished
Lung Sounds: UPPER CRACKLES, DECREASED
Profile TO BASES

Resp Comment <Esc>:

Cyanosis: N
Pallor: N

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+:
Paralysis+:
Joint Swelling+:
Amputations+:
Muscle Spasms+:
Contractures+:
Deformities+:
Weakness+: Generalized

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency	Documented Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>: PT TIRES EASILY.

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1: CLEAN/DRY
Closure Type #1: Open
Dressing Type #1: WET TO DRY DAKIN'S
Dress Appear #1: INTACT, NO VISIBLE DRNG
Wound Site #2:
Wound Appear #2:
Closure Type #2:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally: 3	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/23/16

5A4D43B46E1042958BC8, KNIGHT, 357

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Emesis: N Diarrhea: N Stool Amount+: Small
By C-Diff Protocol - Watery loose stool: N Stool Color+: Greenish
Stool Consistency+: Liquid
Incontinent Stool: N

Rectal Tube: ***Bowel Sounds***
Tubes+: RUQ+: ACTIVE
Tube Drainage: N LUQ+: ACTIVE
Tube To Suction: N RLQ+: ACTIVE
Stoma Present: Y LLQ+: ACTIVE
Ostomy Appliance: Y Abd Appearance+: ROUND
SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems: N
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N ***Dialysis***
Suprapubic Catheter: N CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: 3 pain management this shift: 4
Pain Location+: ABDOMINAL
Patient Sleeping:
Quality Of Pain+: SORE Sleeping Resp:
Respiratory Quality:
Onset/Duration: POST-OP/INTERMITTENT Respiratory Depth:
Pain Med Given<Esc>: SEE MAR

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: WILL CONTINUE TO MONITOR.

******RESPONSE TO PLAN OF CARE/TREATMENT******

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: PAIN MEDICATION, DIET, ACTIVITY
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/23/16 0730 PS 05/23/16 1133 PS
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/23/16 0730 PS 05/23/16 1133 PS
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
OSTOMY NURSE ASSISTING WITH HOME SUPPLIES

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

Do you have questions about insurance or need to speak to a financial counselor? N

Would you like a dietitian to talk with you about your diet? N

5A4D43B46E10429588C8, KNIGHT, 358

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

7370 Discharge Planning Assessment (continued)

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/23/16 0730 PS 05/23/16 1134 PS

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present 2
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 8

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/23/16 Time: 0730 (continued)

9610 Fall Risk Assessment/Interventions (continued)

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/23/16 0730 PS 05/23/16 1126 PS

Temperature: 98.9
Temperature Source+: Oral
Pulse: 93
Respirations: 16
Blood Pressure: 103/68
MAP:
Mental Status: Alert & Oriented

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

Physician Notified: N
If NO, Reason: Physician Already Aware

Patient Notes: Nursing Notes
- Create 05/23/16 0730 PS 05/23/16 0803 PS
Abnormal? N Confidential? N
d. pt awake, resting in bed. orientated +3. skin warm, dry, pale. abd soft. jp to left abd with small amt serous drainage, ost to right lower abd with green/brown with some consistency. denies any discomfort. resp-18-22. fox on r/a 94%. mid abd drsg with abd pads and gauze intact and dry. s/l to left f/a hob elevated. encouraged to use i/s which does with good effort. denies any productive cough. urinal at bed-side. pt instructed to call for assist as needed.
Note Type Description
Intervention Rounds Surveillance

5A4D43B46E10429588C8, KNIGHT, 359

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/23/16 Time: 0804

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/23/16 0804 BE 05/23/16 0806 BE
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 94 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single Y
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 94 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 94 Post-Assessment RR: 18

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/23/16 Time: 0804 (continued)

09 RESP THERAPY - TREATMENT (continued)
DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/23/16 Time: 0821

016 RESP THERAPY - EQUIPMENT CHANGE OUT A QD@1130 CP
- Document 05/23/16 0821 SE 05/23/16 0821 SE
EQUIPMENT CHANGE OUT

Closed Suction System (PRN)
HME (24-48HRS)
Nebs (Every Wed)
O2 Humidifiers (Every Wed)
NRB (Every Wed)
Venturi (Every Wed)

Comment:

Activity Date: 05/23/16 Time: 0849

Patient Notes: CASE MGT/SOCIAL WORK SVS NOTES
- Create 05/23/16 0849 JB* 05/23/16 0850 JB*
Abnormal? N Confidential? N
DISCHARGE PLANNING DISCUSSED WITH PATIENT. OSTOMY NURSE IS FOLLOWING. PATIENT IS UNSURE IF HE WANTS HOME HEALTH TO FOLLOW HIM AT DISCHARGE.
Note Type Description
No Type None

Activity Date: 05/23/16 Time: 0857

09 RESP THERAPY - TREATMENT A RT-Q6H CP
- Ed Directs 05/23/16 0857 SE 05/23/16 0857 SE
05/17 2157 AD ==> 05/17 2157 AD
05/19 0630 RT-QID ==> 05/19 0630 RT-QID
--> 05/23 0800 RT-Q6H

Activity Date: 05/23/16 Time: 0900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 0900 MG 05/23/16 0950 MG
Pain

5A4D43B46E10429588C8, KNIGHT, 360

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/23/16 Time: 0900 (continued)

5500011 Purposeful Rounding (continued)
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 0902

Patient Notes: Nursing Notes
- Create 05/23/16 0902 PS 05/23/16 0902 PS
Abnormal? N Confidential? N
D. PT MEDICATED WITH PERCOLONE 10 MG PO FOR PREVENTIVE PAIN FOR DRSG CHANGE.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/23/16 Time: 0910

Patient Notes: Nursing Notes
- Create 05/23/16 0910 PS 05/23/16 1235 PS
Abnormal? N Confidential? N
D. PT AMBULATING IN HALLWAY WITH PHY THER. TOELRATING WELL, TIRES EASILY. NO SOB NOTED.
Note Type Description
Intervention Positioning

Activity Date: 05/23/16 Time: 0915

25 PT: Daily Documentation A PS
- Document 05/23/16 0915 JW 05/23/16 1139 JW

S: Pt in bed, reports have some pain in L lung last but feeling a little better at this time.

Press ESC to get out of text boxes.

O: Performed supine to sit to stand with CGAx1
Gt amb ~ 150' with RW and CGAx1
Stand to sit to supine with CGAx1

A: Pt amb and transferring well with less assistance today.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/23/16 Time: 0915 (continued)

25 PT: Daily Documentation (continued)
P: Cont POC

Activity Date: 05/23/16 Time: 0945

Patient Notes: Nursing Notes
- Create 05/23/16 0945 PS 05/23/16 1116 PS
Abnormal? N Confidential? N
D. PT DRSG REMOVED FROM MID ABD. MOD AMT SEROUS DRAINAGE TO OLD DRSG. WOUND ABOUT 6" LONG, ABOUT 3/4" WIDE, NARROWER AT ENDS. ABOUT 1/4" DEEP. BEEFY RED 1/4 DAKINS WET TO DRY WITH KERLIX, DRY 4/4, ABD PADS. MONTGOMERY STRAPS IN PLACE. PT WITH SOME DISCOMFORT DURING PACKING. NEW DRAIN SPONGE APPLIED TO JP SITE.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/23/16 Time: 1000

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/23/16 1000 MG 05/23/16 1031 MG
Temperature: 98.9
Temperature Source+: Oral
Pulse: 93
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 103/68
BP Location+:
BP Position+: SEMI-FOWLER'S
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 93 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/23/16 Time: 1100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 1100 MG 05/23/16 1122 MG
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

5A4D43B46E10429588C8, KNIGHT, 361

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 1100 (continued)

5500011 Purposeful Rounding (continued)

Comment:
<Esc>

Activity Date: 05/23/16 Time: 1113

Patient Notes: Nursing Notes
- Create 05/23/16 1113 PS 05/23/16 1114 PS
Abnormal? N Confidential? N
D. PT GIVEN LASIX 40 MG IV AS ORDERED. IV ABX INFUSING. PT UNDERSTANDS FLUID RESTRICION.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/23/16 Time: 1147

Patient Notes: Medical Nutrition Therapy
- Create 05/23/16 1147 LH 05/23/16 1155 LH
Abnormal? N Confidential? N
MNT FU

ASSESSMENT
-GLU 130, BUN 24, NA 135, CA 7.7, ALB 2.0, MAG 2.5
-MED: PROTONIX, LASIX
-PT APPETITE IS POOR, WILLING TO TRY ENSURE, NO CRAZY ABOUT BREEZE. PT IS ON A 1500 CC FLUID RESTRICTION

DIAGNOSIS
-NO NEW DX

INTERVENTION
-DIET RX: REGULAR
GOAL: ADEQUATE PO INTAKE
-SUPPLEMENT: PROSTAT ONCE DAILY, ENSURE BID PO
GOAL: WT MAINTANENCE

COORDINATION OF CARE: NO DC NEEDS

FU LEVEL 1 26-28
LINDSEY HARRIS, RD LD
Note Type Description
No Type None

Activity Date: 05/23/16 Time: 1234

Patient Notes: Nursing Notes
- Create 05/23/16 1234 PS 05/23/16 1234 PS
Abnormal? N Confidential? N
D. OOB TO CHAIR. VOIDING LARGE AMTS CLEAR YELLOW URINE IN URINAL. CALL BELL IN REACH.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 1234 (continued)

Patient Notes: Nursing Notes (continued)
Note Type Description
Intervention Positioning

Activity Date: 05/23/16 Time: 1300 (continued)

5500011 Purposeful Rounding (continued)
- Document 05/23/16 1300 MG 05/23/16 1400 MG
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 1334

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/23/16 1334 PS 05/23/16 1334 PS

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern

5A4D43B46E10429588C8, KNIGHT, 362

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 1334 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach

Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 1334 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Fall Score Ranking:

Patient on Anticoagulants?

Activity Date: 05/23/16 Time: 1354

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/23/16 1354 BE 05/23/16 1400 BE
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 96 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 93 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 94 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment

5A4D43B46E10429588C8, KNIGHT, 363

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1354 (continued)

09 RESP THERAPY - TREATMENT (continued)
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/23/16 Time: 1400

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/23/16 1400 MG 05/23/16 1425 MG
Temperature: 98.6
Temperature Source+: Oral
Pulse: 100
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 98/60
BP Location+:
BP Position+: SITTING
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/23/16 Time: 1401

Problem: RT - INADEQUATE VENTILATION/OXYGENATION C
- Ed Status 05/23/16 1401 BE 05/23/16 1401 BE A => C
Outcome: ADEQUATE VENTILATION C
- Ed Status 05/23/16 1401 BE 05/23/16 1401 BE A => C

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1401

012 RESP THERAPY - NON-INVASIVE VENTILATION C AD CP
- Ed Status 05/23/16 1401 BE 05/23/16 1401 BE A => C
016 RESP THERAPY - EQUIPMENT CHANGE OUT C QD@1130 CP
- Ed Status 05/23/16 1401 BE 05/23/16 1401 BE A => C
08 RESP THERAPY - PATIENT EVALUATION C Q72H@0800 CP
- Ed Status 05/23/16 1401 BE 05/23/16 1401 BE A => C
09 RESP THERAPY - TREATMENT C RT-Q6H CP
- Ed Status 05/23/16 1401 BE 05/23/16 1401 BE A => C

Activity Date: 05/23/16 Time: 1411

Patient Notes: Nursing Notes
- Create 05/23/16 1411 PS 05/23/16 1411 PS
Abnormal? N Confidential? N
D. REMAINS UP IN CHAIR. MEDICATED WITH PERCOLONE 10 MG PO FOR ABD INCISIONOAL PAIN. CALL BELL IN REACH.
Note Type Description
Intervention Positioning

Activity Date: 05/23/16 Time: 1450

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/23/16 1450 PS 05/23/16 1450 PS
Temperature:
Temperature Source+:
Pulse: 96
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 108/61
BP Location+: R Arm
BP Position+: SEMI-FOWLER'S
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/23/16 Time: 1458

Patient Notes: Nursing Notes
- Create 05/23/16 1458 PS 05/23/16 1459 PS
Abnormal? N Confidential? N
D. S/L TO LEFT F/A REMOVED FOR OUTDATE, #20 PLACED TO RIGHT A/C. GOOD BLD RETURN AND FLUSHES EASILY. PT RETURNED TO BED WITH MINIMAL ASSIST.
Note Type Description
Intervention IV THERAPY ASSESSMENT

5A4D43B46E10429588C8, KNIGHT, 364

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 1500

5500011 Purposeful Rounding — A — Q2HODD — CP
- Document 05/23/16 1500 MG 05/23/16 1804 MG
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 1502

525002 IV THERAPY ASSESSMENT — A — QS — CP
- Document 05/23/16 1502 PS 05/23/16 1503 PS
IV Site Change: Y # Of Attempts: 1 IV Tube Change: IV DISCONTINUED

IV Site #1:	LEFT FOREARM	IV Site #3:
Site Appear #1:	NORMAL	Site Appear #3:
Type of Cath #1:	Protectiv	Type of Cath #3:
Cath Gauge #1:	22	Cath Gauge #3:
Fluid/Rate #1:	SL	Fluid/Rate #3:
Date Insert/DC #1:	05/19/16	Date Insert/DC #3:
IV #1 Comment:	D/C FOR OUTDATE	IV #3 Comment:
	<Esc>	<Esc>
IV Site #2:	RIGHT ANTECUBITAL SPACE	IV Site #4:
Site Appear #2:	NORMAL	Site Appear #4:
Type of Cath #2:	Protectiv	Type of Cath #4:
Cath Gauge #2:	20	Cath Gauge #4:
Fluid/Rate #2:	S/L	Fluid/Rate #4:
Date Insert/DC #2:	05/23/16	Date Insert/DC #4:
IV #2 Comment:	DRSG INTACT.	IV #4 Comment:
	<Esc>	<Esc>

Activity Date: 05/23/16 Time: 1542

Patient Notes: Nursing Notes
- Create 05/23/16 1542 PS 05/23/16 1542 PS
Abnormal? N Confidential? N
* UNDONE *
D. CLEAR LIQUIDS IN PROGRESS.

Undone: 05/23/16 at 1543 by SKINNER,PAMELA RN
Reason: DOC ON WRONG PT

Note Type Description
Intervention Rounds Surveillance

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/23/16 Time: 1631

1663 IPC, TED, VFP Documentation — A — 04,16 — CP
- Document 05/23/16 1631 PS 05/23/16 1631 PS
IPC: R
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment — A — 04,16 — CP
- Document 05/23/16 1631 PS 05/23/16 1632 PS
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment — A — 04,16 — CP
- Document 05/23/16 1631 PS 05/23/16 1632 PS
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

5A4D43B46E10429588C8, KNIGHT, 365

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 1631 (continued)

800001 Education/Teaching Assessment (continued)

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/23/16 Time: 1659

Patient Notes: Wound Care Note
- Create 05/23/16 1659 KM 05/23/16 1705 KM
Abnormal? N Confidential? N
PT'S SPOUSE REMOVED OLD OSTOMY POUCHING SYSTEM. SKIN A BIT RED AND TENDER - APPEARS TO BE RELATED TO ADHESIVES. MINIMAL LEAKING NOTED ON SKIN BARRIER AT AREA FROM 7-8 O'CLOCK. CLEANSED WITH WATER. CAVILON SKIN BARRIER APPLIED TO HELP WITH IRRITATION FROM ADHESIVE. NOTED AREA WHERE LEAKING OCCURED TO HAVE SMALL AMT MUCOCUTANEOUS SEPARATION WITH MUCOUS COMING OUT OF IT. DR. RIMKUS AWARE AND STATES THIS IS OK DUE TO THE DISTAL END OF THE LOOP ILEOSTOMY BEING PRESENT THERE. REASSURED PT AND SPOUSE THIS WAS OK. WE USED STOMAHESIVE PASTE OVER THIS AREA FOR ADDED PROTECTION AND ABSORPTION. SPOUSE SUCCESSFULLY MOLDED AND PLACED NEW POUCHING SYSTEM TO SKIN. THEY HAVE BEEN EMPTYING THE POUCHING SYSTEM THEMSELVES INDEPENDENTLY. WILL CHECK ON PT TOMORROW.
Note Type Description
No Type None

Activity Date: 05/23/16 Time: 1700

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 1700 MG 05/23/16 1804 MG
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
Patient Notes: Nursing Notes
- Create 05/23/16 1700 PS 05/23/16 1700 PS
Abnormal? N Confidential? N
D. OSTOMY NURSE IN AND CHANGED OSTOMY WITH FAMILY AND PT. PT TOLERATED WELL. IV ABX AS ORDERED.
Note Type Description
Intervention Rounds Surveillance

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 1738

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/23/16 1738 PS 05/23/16 1738 PS
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
1160 Nutritional Monitoring A 18 CP
- Document 05/23/16 1738 PS 05/23/16 1738 PS
Diet Ordered: REGULAR
Meal: BREAKFAST, LUNCH, DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement:
PO Supplement: cc (Total Intake)

5A4D43B46E10429588C8, KNIGHT, 366

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/23/16 Time: 1738 (continued)

1160 Nutritional Monitoring (continued)
Comment:
150005 Intake/Output A 06,18 CP
- Document 05/23/16 1738 PS 05/23/16 1739 PS
INTAKE
PO: 950 IV: 50 Blood: TPN: NG Irrigation:
TF Tube: IVPB: 400 Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 1100 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 200
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 15 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/23/16 1738 PS 05/23/16 1739 PS
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Semi-permeable Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Y Dressing changed: Date: Change:
Tenderness of the Site: N BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/23/16 1738 PS 05/23/16 1739 PS

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/23/16 Time: 1800

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/23/16 1800 MG 05/23/16 1825 MG
Temperature: 98.5
Temperature Source+: Oral
Pulse: 90
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 105/70
BP Location+:
BP Position+: SEMI-FOWLER'S
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/23/16 Time: 1855

Patient Notes: Nursing Notes
- Create 05/23/16 1855 PS 05/23/16 1904 PS
Abnormal? N Confidential? N
D. LITTLE APPETITE FOR PM MEAL. DENIES ANY NAUSEA. JP TO LEFT ABD WITH SMALL AMT SEROUS DRAINAGE. OSTOMY TO RIGHT ABD WITH SMALL AMT GREEN/BROWN STOOL. REFUSED OFFER FOR PAIN MEDICATION. S/L TO RIGHT A/C INTACT. URINAL AT BED-SIDE. R/A FOX 95%. WILL CONTINUE TO MONITOR.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/23/16 Time: 1900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 1900 DP 05/24/16 0054 DP
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

5A4D43B46E10429588C8, KNIGHT, 367

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented / Comment	Units	From Change
Activity Date: 05/23/16		**Time: 1920**								
6922	Nursing Report (Hand Off)						A	07,19		CP
- Document	05/23/16	1920	MG*	05/23/16	2359	MG*				
****Nursing Report (Hand Off)****										
Report Received/Care Assumed Y Report Given Bedside: Y										
To/From MELISSA,RN/PAM,RN										
Comment										
Activity Date: 05/23/16		**Time: 1955**								
1699	Prostat Supplement						A	08,20		OE
- Document	05/23/16	1955	MG*	05/24/16	0144	MG*				
Prostat given: Y										
Comment:										
3140	Airway Management						A	QS		CP
- Document	05/23/16	1955	MG*	05/24/16	0144	MG*				
3440	Incision Site Care						A	QS		CP
- Document	05/23/16	1955	MG*	05/24/16	0144	MG*				
0430	Bowel Management						A	QS		CP
STOOL ASSESSMENT										
- Document	05/23/16	1955	MG*	05/24/16	0144	MG*				
BM Consistency: Liquid										
BM Color: Brown										
BM Amount: MEDIUM										
Comment:										
1629	OSA ASSESSMENT						A	QS		CP
- Document	05/23/16	1955	MG*	05/24/16	0144	MG*				
OSA Assessment										
CAPNOGRAPHY Monitor in place: N										
If NO, Reason: NI										
Education reviewed with patient? N										
If NO, Reason: NI										
Hi risk or known controlled, signage placed on patient door: N										
OSA HIGH RISK: N										
Follow-up Physician Appt: NONE										
6955	Anticoagulant Educ Materials Provided						A	QS		CP
- Document	05/23/16	1955	MG*	05/24/16	0151	MG*				
Anticoagulant Educ Material provided to Patient &/or Family? Y										
Comment:										
CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented / Comment	Units	From Change
Activity Date: 05/23/16		**Time: 1955 (continued)**								
6955	Anticoagulant Educ Materials Provided (continued)									
>>>>>>COMPLETE Intervention after Filing<<<<<<										
6990	Post Operative Care - GOALS						A	08,20		CP
- Document	05/23/16	1955	MG*	05/24/16	0151	MG*				
Post-Operative Care - GOALS										
Patient demonstrates use of Incentive Spirometer: Y										
Goal: 8-10 TIMES EVERY HOUR										
Patient demonstates technique for splinting incision: Y										
Patient verbalizes understanding of pain scale: Y										
Goal: 5/10										
Pain Scale: NUMERIC										
Patient verbalizes understanding of activity level: Y										
Prescribed activity level: ASSIST										
Patient verbalizes understanding DVT prevention including:										
TEDS N IPC Y Pedal Exercises Y										
Goal: PREVENT DVT'S										
Provide patient with form #2292										
Patient verbalizes understanding of adequate										
nutrition to promote tissue healing. Y										
Diet: REGULAR										
Patient verbalizes signs/symptoms of infection including:										
Redness Y Swelling Y Discharge Y Temperature Y										
BS Frequency: N/A										
Smoking Status: Never smoker Nursing Note: N										
0840	Positioning						A	QS		CP
- Document	05/23/16	1955	MG*	05/24/16	0144	MG*				
275051	VTE Prophylaxis Orders Complete?						A	08,20		CP
- Document	05/23/16	1955	MG*	05/24/16	0153	MG*				
VTE Prophylaxix Orders Complete? Y										

5A4D43B46E1042958C8, KNIGHT, 368

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 1955

525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/23/16 1955 MG* 05/24/16 0154 MG*
IV Site Change: Y # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT ANTECUBITAL SPACE
Site Appear #1: NORMAL
Type of Cath #1: Protectiv
Cath Gauge #1: 20
Fluid/Rate #1: SL
Date Insert/DC #1: 05/23/16
IV #1 Comment:
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/23/16 1955 MG* 05/24/16 0151 MG*
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 2mm
Rt Reaction To Light+: Reactive
Size Left+: 2mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Depressed
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented

Vision Impairment: GLASSES
Hearing Impairment: NONE

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/23/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
No Response:
Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet: N Sticker: N
Comfort Measures Only NA
Chest Pain: N If Yes, Document in Pain Assessment Intervention.
Heart Sounds+: Normal
Telemetry Pattern+:
Pulse Rhythm+: Regular
Heart Rate:
Pacemaker: N Defibrillator: N
Dizziness/Syncope+:
Palpitations: N
JVD+: Flat

Edema 1+:
Loc 1+:
Pitting:
Edema 2+:
Loc 2+:
Pitting:
TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal	Femoral Rt+:
Dorsalis Rt+: Normal	Femoral Lt+:
Post Tib Lt+:	
Post Tib Rt+:	Cap Refill RUE+: Brisk
Carotid Rt+:	Cap Refill LUE+: Brisk
Carotid Lt+:	Cap Refill RLE+: Brisk
Brachial Rt+:	Cap Refill LLE+: Brisk
Brachial Lt+:	
Radial Rt+: Normal	
Radial Lt+: Normal	

5A4D43B46E10429588C8, KNIGHT, 369

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Cardio Comment <Esc>: NO C/O CHEST PAIN OR DISCOMFORT.

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.
Respirations: 16 O2 Sat: 94 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Shallow
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+: Moderate
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

COPD Educational Video:

Breath Sounds
LUL+: Diminished
LLL+: Diminished
RUL+: Diminished
RML+: Diminished
RLL+: Diminished
Lung Sounds: DIMINISHED
Profile

Resp Comment <Esc>: NOT TAKING DEEP BREATHS, DIMINISHED BREATH SOUNDS, NOT MUCH AIR EXCHANGE. ENCOURAGED TO T,C,&DB, USE I/S AND AMBULATE
STATES NO PAIN AS LONG AS NOT TAKING DEEP BREATHS
Cyanosis: N
Pallor: N

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Wound Site #1: MIDLINE ABD
Wound Appear #1+: CLEAN/DRY

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Closure Type #1+: Open
Dressing Type #1: WET TO DRY DAKIN'S
Dress Appear #1: INTACT, NO VISIBLE DRNG

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>: JP DRAIN WITH SCANT AMT OF YELLOW DRAINAGE, ILEOSTOMY WITH MOD AMT OF BROWN LIQUID STOOL
Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally: 3	Adequate: 3
No Impairment:	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N
Emesis: N Diarrhea: N
By C-Diff Protocol - Watery loose stool: N

Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y

Last BM: 05/23/16
Stool Amount+: Moderate
Stool Color+: Brown
Stool Consistency+: Liquid
Incontinent Stool: N

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE

5A4D43B46E1042958BC8, KNIGHT, 370

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Ostomy Appliance: Y Abd Appearance+: ROUND
SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N Currently Menses:
LMP:
Urine Color+: Amber Prostate Problems: N
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N ***Dialysis***
Suprapubic Catheter: N CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: N Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: REPORTS NO PAIN AS LONG AS HE DOES NOT TAKE DEEP BREATHS, THEREFORE BREATHING PATTERN IS SHALLOW

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1955 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: TURN,COUGH,DEEP BREATHE. USE OF I/S. AMBULATION. PAIN MEDICATION. POC.

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/23/16 1955 MG* 05/24/16 0151 MG*
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370 Discharge Planning Assessment A QS CP
- Document 05/23/16 1955 MG* 05/24/16 0152 MG*
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

5A4D43B46E1042958BC8, KNIGHT, 371

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1955 (continued)

7370 Discharge Planning Assessment (continued)

Comment: WILL REASSESS DAILY

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/23/16 1955 MG* 05/24/16 0152 MG*

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 4

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/23/16 Time: 1955 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/23/16 1955 MG* 05/24/16 0144 MG*
Temperature: 99.0
Temperature Source+: Oral
Pulse: 92
Respirations: 16
Blood Pressure: 105/70
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: N
If NO, Reason: Physician Already Aware
Patient Notes: Nursing Notes
- Create 05/23/16 1955 MG* 05/24/16 0254 MG*
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT, WATCHING TV. RESPIRATIONS SHALLOW. STATES HE DOESN'T WANT TO TAKE DEEP BREATHS BECAUSE IT HURTS. INSTRUCTED ON T,C,DB, AND USING I/S AND AMBULATING. BREATH SOUNDS VERY DIMINISHED BILATERALLY. O2 SAT 94%. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 05/23/16 Time: 1958

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/23/16 1958 KO2 05/23/16 1959 KO2
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 97 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y

5A4D43B46E10429588C8, KNIGHT, 372

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/23/16 Time: 1958 (continued)

09 RESP THERAPY - TREATMENT (continued)

Demo and Eval
MDI Install
MDI Subsequent
MDI Additional Tx:
Incentive Install
Pt Instructed
Pt Achieves ml
Pt Understands/will use on own
Pt unable to comprehend or perform TX
Nurse Notified Nurse will follow-up
MODE: M/P Y Mask Inline A/C M/AC

Continous Neb 1st Hour
Continous Neb Sub
Pulse Ox Single
Pulse Ox over-noc
Pulse Ox Continuous
CPT Initial
CPT Subsequent
CPT w/Bed:
Oscillating PEP
NT Suction

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 94 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 96 Post-Assessment RR: 16

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted N
Rhonchi Rales Diminished Adverse Reactions: N
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/23/16 Time: 1958 (continued)

09 RESP THERAPY - TREATMENT (continued)

Unable to Comprehend
Reinforcement Needed

Activity Date: 05/23/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 2100 DP 05/24/16 0054 DP
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 2200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/23/16 2200 DP 05/24/16 0055 DP
Temperature: 99.0
Temperature Source+: Oral
Pulse: 92
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 105/70
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 94 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/23/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/23/16 2300 DP 05/24/16 0054 DP
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

5A4D43B46E10429588C8, KNIGHT, 373

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/23/16 Time: 2300 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/23/16 Time: 2320

150005 Intake/Output A 06,18 CP
- Document 05/23/16 2320 MG* 05/23/16 2346 MG*

INTAKE

PO:	IV:	Blood:	TPN:	NG Irrigation:
TF Tube:	IVPB:	Platelet:	Lipid:	Foley Irrigation (CBI):
TF Flush:		PO Supplement:	FFP:	Dialysis (Intake):

OUTPUT

Void (ml): 1250	Bladder Incont Episodes:	Emesis:	Colostomy:
Foley:	Bowel Incont Episodes:	T Tube:	Ileostomy:
Foley (Residual):	Void Episodes:	NG/PEG TUBE:	Urostomy:
SP Catheter:	Stool Episodes:	Duodenal Tube:	Ileoconduit:
	Diapers:	G Tube (Residual):	Liquid Stool:

#1 JP:	#1 Chest Tube:	Left Ureteral:	Dialysis (Output):
#2 JP:	#2 Chest Tube:	Right Ureteral:	Thoracentesis:
#3 JP:	#1 Hemovac:	Left Nephrostomy:	Paracentesis:
OTHER:	#2 Hemovac:	Right Nephrostomy:	Wound Vac:

Comment:

Activity Date: 05/24/16 Time: 0100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 0100 DP 05/24/16 0252 DP
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/24/16 Time: 0154

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/24/16 0154 MG* 05/24/16 0154 MG*

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

5A4D43B46E10429588C8, KNIGHT, 374

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/24/16 Time: 0154 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/24/16 Time: 0200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/24/16 0200 DP 05/24/16 0322 DP

Temperature: 98.9
Temperature Source+: Oral
Pulse: 90
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 100/68
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 94 Nursing Note:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/24/16 Time: 0200 (continued)

6680 Vital Signs (continued)
IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/24/16 Time: 0204

150005 Intake/Output A 06,18 CP
- Document 05/24/16 0204 MG* 05/24/16 0204 MG*

INTAKE

PO:	IV:	Blood:	TPN:	NG Irrigation:
TF Tube:	IVPB:	Platelet:	Lipid:	Foley Irrigation (CBI):
TF Flush:		PO Supplement:	FFP:	Dialysis (Intake):

OUTPUT

Void (ml):	Bladder Incont Episodes:	Emesis:	Colostomy:	
Foley:	Bowel Incont Episodes:	T Tube:	Ileostomy:	350
Foley (Residual):	Void Episodes:	NG/PEG TUBE:	Urostomy:	
SP Catheter:	Stool Episodes:	Duodenal Tube:	Ileoconduit:	
	Diapers:	G Tube (Residual):	Liquid Stool:	

#1 JP:	#1 Chest Tube:	Left Ureteral:	Dialysis (Output):
#2 JP:	#2 Chest Tube:	Right Ureteral:	Thoracentesis:
#3 JP:	#1 Hemovac:	Left Nephrostomy:	Paracentesis:
OTHER:	#2 Hemovac:	Right Nephrostomy:	Wound Vac:

Comment:

Activity Date: 05/24/16 Time: 0222

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/24/16 0222 KO2 05/24/16 0223 KO2

RESPIRATORY THERAPY TREATMENT

%/L of O2:	LPM NC	O2 Sat: 98	FIO2	VM	PRB	NRB	
O2 24 hrs	CPO in use	BIPAP	I:	E:	RATE:		
R/A Y		NPPV					
Hand Held Nebulizer Install			Metaneb/IPPB Install				
Neb Induced Sputum			Metaneb/IPPB Sub				
HHN Sub Y							
Demo and Eval			Continous Neb 1st Hour				
			Continous Neb Sub				
MDI Install							
MDI Subsequent			Pulse Ox Single				
MDI Additional Tx:			Pulse Ox over-noc				
			Pulse Ox Continuous				
Incentive Install							
Pt Instructed			CPT Initial				
Pt Achieves	ml		CPT Subsequent				
Pt Understands/will use on own			CPT w/Bed:				

5A4D43B46E10429588C8, KNIGHT, 375

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 0222 (continued)

09 RESP THERAPY - TREATMENT (continued)
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 83 Pre-Assessment RR: 14

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 85 Post-Assessment RR: 14

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted N
Rhonchi Rales Diminished Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment PT SLEPT THROUGH TX
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend Y
Reinforcement Needed

Activity Date: 05/24/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 0300 DP 05/24/16 0323 DP
Pain
Potty
Position

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 0300 (continued)

5500011 Purposeful Rounding (continued)
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/24/16 Time: 0357

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/24/16 0357 MG* 05/24/16 0357 MG*
IPC: R
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/24/16 0357 MG* 05/24/16 0357 MG*
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/24/16 0357 MG* 05/24/16 0358 MG*
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

5A4D43B46E10429588C8, KNIGHT, 376

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 0357 (continued)

800001 Education/Teaching Assessment (continued)

Care/Education Codes: POC
DIET
DIS
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS

Material Codes: VERBAL
Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/24/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 0500 DP 05/24/16 0616 DP
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/24/16 Time: 0600

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/24/16 0600 DP 05/24/16 0645 DP
Temperature: 98.5
Temperature Source+: Oral
Pulse: 103
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 109/73
BP Location+:
BP Position+: SUPINE
Weight (lbs):

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 0600 (continued)

6680 Vital Signs (continued)
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/24/16 0600 MG* 05/24/16 0601 MG*
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 8-10 TIMES EVERY HOUR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome:

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A

5A4D43B46E10429588C8, KNIGHT, 377

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 0600 (continued)

6991 Post Operative Care - OUTCOMES (continued)
Smoking Status: Never smoker Nursing Note: N
150005 Intake/Output A 06,18 CP
- Document 05/24/16 0600 MG* 05/24/16 0603 MG*
INTAKE
PO: 800 IV: 160 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 175
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 12 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/24/16 0600 MG* 05/24/16 0603 MG*
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/24/16 0600 MG* 05/24/16 0603 MG*

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 0611

Patient Notes: Nursing Notes
- Create 05/24/16 0611 MG* 05/24/16 0613 MG*
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT. REPORTS FEELING STIFF THIS AM. O2 SAT 91% ON RA. DRESSING TO ABD DRY AND INTACT. JP INTACT AND COMPRESSED. DECLINES SCDS. ENCOURAGED TO USE I/S. ILEOSTOMY APPLIANCE INTACT. CALL BELL IN REACH.
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 0730

Patient Notes: Nursing Notes
- Create 05/24/16 0730 BL5 05/24/16 1318 BL5
Abnormal? N Confidential? N
SEE PI, POC AND GOALS
AWAKE
ENCOURAGED 1/S, ACCUPELLA, SCD AND WALK, WALK AND IN CHAIR
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 0735

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 0735 EW 05/24/16 0735 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/24/16 Time: 0800

1699 Prostat Supplement A 08,20 OE
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
Prostat given:

Comment:
3140 Airway Management A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
3440 Incision Site Care A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/24/16 0800 BL5 05/24/16 1229 BL5
BM Consistency: Liquid

5A4D43B46E10429588C8, KNIGHT, 378

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 0800 (continued)

0430 Bowel Management (continued)
BM Color: Brown
BM Amount: MEDIUM

Comment: SOFT GREENISH/BROWN STOOL PRESENT IN OSTOMY APPLIANCE.

1629 OSA ASSESSMENT A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1229 BL5
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS A 08,20 CP
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 30-40 TIMES EVERY HOUR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 0800 (continued)

6990 Post Operative Care - GOALS (continued)
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

0840 Positioning A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1229 BL5

275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/24/16 0800 BL5 05/24/16 1231 BL5
VTE Prophylaxix Orders Complete? Y

525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1232 BL5
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT ANTECUBITAL SPACE IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Protectiv Type of Cath #3:
Cath Gauge #1: 20 Cath Gauge #3:
Fluid/Rate #1: SL Fluid/Rate #3:
Date Insert/DC #1: 05/23/16 Date Insert/DC #3:
IV #1 Comment: CDI IV #3 Comment:
<Esc> <Esc>

IV Site #2: IV Site #4:
Site Appear #2: Site Appear #4:
Type of Cath #2: Type of Cath #4:
Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1303 BL5
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

5A4D43B46E10429588C8, KNIGHT, 379

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Size Left+: 3mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented

Vision Impairment: GLASSES
Hearing Impairment: NONE

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>: COOPERATIVE

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+:

Pulse Rhythm+: Regular

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Heart Rate: 88
Pacemaker: N Defibrillator: N

Dizziness/Syncope+:
Palpitations: N

JVD+: Flat

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: Y
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+:	Normal	Femoral Rt+:	
Dorsalis Rt+:	Normal	Femoral Lt+:	
Post Tib Lt+:	Normal		
Post Tib Rt+:	Normal	Cap Refill RUE+:	Brisk
Carotid Rt+:		Cap Refill LUE+:	Brisk
Carotid Lt+:		Cap Refill RLE+:	Brisk
Brachial Rt+:	Normal	Cap Refill LLE+:	Brisk
Brachial Lt+:	Normal		
Radial Rt+:	Normal		
Radial Lt+:			

Cardio Comment <Esc>: NO C/O CHEST PAIN OR DISCOMFORT.

Respiratory WNL: Y WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 16 O2 Sat: 93 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Shallow
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+: Moderate
Sputum Consistency+:
Sputum Color+:
Airway+:
Airway Suctioned+:

Breath Sounds
LUL+: Diminished
LLL+: Diminished
RUL+: Diminished
RML+: Diminished
RLL+: Diminished

Lung Sounds: DIMINISHED
COPD Educational Video: Profile

Resp Comment <Esc>: NOT TAKING DEEP BREATHS, DIMINISHED BREATH SOUNDS, NOT MUCH AIR EXCHANGE. ENCOURAGED TO T,C,&DB, USE I/S , ACCUPELA AND AMBULATE
STATES NO PAIN AS LONG AS NOT TAKING DEEP BREATHS
Cyanosis: N
Pallor: N

MUSC-SKEL WNL: Y WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement

5A4D43B46E10429588C8, KNIGHT, 380

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/24/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>: PT TIRES EASILY. OOB WALKING WITH STRONG ASST.. ENCOURAGED OFTEN AND IN CHAIR

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WET TO DRY DAKIN'S
Dress Appear #1: INTACT, NO VISIBLE DRNG

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY, PIV

Skin Comment <Esc>: WILL APPLY WOUND VAC SOON

Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited:
No Impairment:

Activity Score
Bedfast:
Chairfast:
Walks Occasionally:
Walks Frequently:

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate:
Excellent:

Moisture Score
Constantly Moist:

Mobility Score
Completely Immobile:

Friction & Shear Score
Problem:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/24/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Very Moist:
Occasionally Moist:
Rarely Moist:

Very Limited:
Slightly Limited:
No Limitations:

Potential Problem:
No Apparent Problem:

Total Braden Score:

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
By C-Diff Protocol - Watery loose stool: N

Constipation: N
Diarrhea: N

Last BM: 05/24/16
Stool Amount+: Moderate
Stool Color+: Brown
Stool Consistency+: Liquid
Incontinent Stool: N

Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: ROUND SOFT

GI Comment <Esc>: OSOTMY

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N

Urine Color+: Amber
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N
Suprapubic Catheter: N

Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: VOIDING IN URINAL

**********PAIN ASSESSMENT**********

5A4D43B46E10429588C8, KNIGHT, 381

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: SEE EMAR

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: N Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG. IVF AND IV ABX, ACITIVITY, I/S , ACCUPELLA, SCD, WOUND VAC

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From BETHANY/MELISSA

Comment
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 0800

7370 Discharge Planning Assessment A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1230 BL5
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1231 BL5
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics,

5A4D43B46E10429588C8, KNIGHT, 382

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 0000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazapines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs 1

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 10

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y
Assess q2hr 7A-7P Y
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: BED IN LOWEST POSITION AND LOCKED, CALL BELL W/I REACH, PT DOES NOT ATTEMPT TO GET OOB UNASSISTED; ENCOURAGED TO BE OOB WITH ASST OFTER

Fall Score Ranking: Moderate
Level of Care: Assist

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 0800

99 SEPSIS Documentation A QS CP
- Document 05/24/16 0800 BL5 05/24/16 1229 BL5
Temperature: 98.5
Temperature Source+: Oral
Pulse: 106
Respirations: 16
Blood Pressure: 106/68
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk
(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: N
If NO, Reason: Physician Already Aware

Activity Date: 05/24/16 Time: 0812

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/24/16 0812 BE 05/24/16 0813 BE
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPN NC O2 Sat: 93 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install
Neb Induced Sputum
HHN Sub Y
Demo and Eval
MDI Install
MDI Subsequent
MDI Additional Tx:
Incentive Install
Pt Instructed
Pt Achieves ml
Pt Understands/will use on own
Pt unable to comprehend or perform TX
Nurse Notified Nurse will follow-up
MODE: M/P Y Mask Inline A/C M/AC
Metaneb/IPPB Install
Metaneb/IPPB Sub
Continous Neb 1st Hour
Continous Neb Sub
Pulse Ox Single
Pulse Ox over-noc
Pulse Ox Continuous
CPT Initial
CPT Subsequent
CPT w/Bed:
Oscillating PEP
NT Suction

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 93 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

5A4D43B46E10429588C8, KNIGHT, 383

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/24/16 Time: 0812 (continued)

09 RESP THERAPY - TREATMENT (continued)

POST ASSESSMENT: Post-Assessment HR: 93 Post-Assessment RR: 16

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted N
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB MDI Y CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/24/16 Time: 0815

Patient Notes: Nursing Notes
- Create 05/24/16 0815 BL5 05/24/16 0918 BL5
Abnormal? N Confidential? N
DR RIMKUS ROUNDS...WOUND VAC ORDERED
PT TOLD HE MUST GET OOB AND WALL, AND USE THE I/S 30-40 X HOUR, TO HELP LUNG FUNCTION
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 0900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 0900 EW 05/24/16 1029 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/24/16 Time: 0900 (continued)

5500011 Purposeful Rounding (continued)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/24/16 Time: 1006

Patient Notes: Nursing Notes
- Create 05/24/16 1006 BL5 05/24/16 1006 BL5
Abnormal? N Confidential? N
OOB WALKING WITH 1 ASST
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 1008

Patient Notes: Nursing Notes
- Create 05/24/16 1008 BL5 05/24/16 1009 BL5
Abnormal? N Confidential? N
SCD IN PLACE; I/S DEMONSTRATED...WEAK PULL AT 500, ENCOURAGED TO 1000- 1500.
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 1030

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/24/16 1030 EW 05/24/16 1033 EW
Temperature: 98.5
Temperature Source+: Oral
Pulse: 106
Pulse Source+: BRACHIAL
Respirations: 16
Blood Pressure: 106/68
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

5A4D43B46E10429588C8, KNIGHT, 384

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 1120

Patient Notes: Nursing Notes
- Create 05/24/16 1120 BL5 05/24/16 1120 BL5
Abnormal? N Confidential? N
WOUND VAC APPLIED 125 MMHG SUCTION, CONTINUOUS
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 1127

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 1127 EW 05/24/16 1128 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/24/16 Time: 1300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 1300 EW 05/24/16 1428 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/24/16 Time: 1310

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/24/16 1310 AP 05/24/16 1310 AP
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 97 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 1310 (continued)

09 RESP THERAPY - TREATMENT (continued)
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 104 Pre-Assessment RR: 20

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 104 Post-Assessment RR: 18

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y

5A4D43B46E10429588C8, KNIGHT, 385

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/24/16 Time: 1310 (continued)

09 RESP THERAPY - TREATMENT (continued)
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/24/16 Time: 1315

Patient Notes: Nursing Notes
- Create 05/24/16 1315 BL5 05/24/16 1358 BL5
Abnormal? N Confidential? N
OOB WALKING TO SOLARUIM
UASING I/ AND ACCUPELLA
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 1355

25 PT: Daily Documentation A PS
- Document 05/24/16 1355 JW 05/24/16 1554 JW

S: Pt sitting up in bedside chair, reports just finished walking to sitting area at end of hallway and sitting for ~ 30 mins. Pt now in room and sittng in chair and states will get up again later and walk again after resting.

Press ESC to get out of text boxes.

O:

A:

P: Cont as needed.

Activity Date: 05/24/16 Time: 1400

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/24/16 1400 BL5 05/24/16 1548 BL5

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/24/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 0

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

5A4D43B46E10429588C8, KNIGHT, 386

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/24/16 Time: 1428

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/24/16 1428 EW 05/24/16 1430 EW
Temperature: 98.4
Temperature Source+: Oral
Pulse: 106
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 91/46
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/24/16 Time: 1529

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 1529 EW 05/24/16 1530 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 1529 (continued)

5500011 Purposeful Rounding (continued)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
6901 PATIENT LINEN CHANGE A PRN CP
- Document 05/24/16 1529 EW 05/24/16 1529 EW
Linen Change 05/24/16

Patient Refused (Linen): Nurse Notified (Linen):

Activity Date: 05/24/16 Time: 1530

Patient Notes: Wound Care Note
- Create 05/24/16 1530 KM 05/24/16 1531 KM
Abnormal? N Confidential? N
CHECKED ON PT AND SPOUSE. THE POUCHING SYSTEM SHE APPLIED YESTERDAY IS ON, NO LEAKS. PT AND SPOUSE TO CHANGE THE SYSTEM WITH MY GUIDANCE ON FRIDAY. WILL DROP IN TO CHECK ON THEM TOMORROW.
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 1600

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/24/16 1600 BL5 05/24/16 1938 BL5
IPC: Y
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/24/16 1600 BL5 05/24/16 1938 BL5
TED Hose - removed for skin assessment and reapplied.

IPC - removed for skin assessment and reapplied.

Heel Protectors - removed for skin assessment and reapplied.

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/24/16 1600 BL5 05/24/16 1938 BL5
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

5A4D43B46E10429588C8, KNIGHT, 387

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	From Units	Change

Activity Date: 05/24/16 Time: 1600 (continued)

800001 Education/Teaching Assessment (continued)

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/24/16 Time: 1627

Patient Notes: Nursing Notes
- Create 05/24/16 1627 BL5 05/24/16 1628 BL5
Abnormal? N Confidential? N
OOB WALKING TO NURSES STATION TO SEE WIFE, ELIZABETH IN HER OFFICE
BACK TO SOLARIUM TO SIT.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	From Units	Change

Activity Date: 05/24/16 Time: 1650

Patient Notes: Nursing Notes
- Create 05/24/16 1650 BL5 05/24/16 1650 BL5
Abnormal? N Confidential? N
BATH
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 1700

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 1700 EW 05/24/16 1840 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/24/16 Time: 1730

Patient Notes: Nursing Notes
- Create 05/24/16 1730 BL5 05/24/16 1951 BL5
Abnormal? N Confidential? N
BACK TO BED
WOUND VAC ACTIVATED 125 MMHG CONTINUOUS WITH MINIAML S/S RETURN
SL PATENT, CDI
OSOTOMY...WIFE ASST KRISTY, WOUND NURSE, TO CHANGE EARLIER.
JP...DC TOMORROW??
SEE EMAR FOR PAIN MEDS
Note Type Description
No Type None

Activity Date: 05/24/16 Time: 1830

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/24/16 1830 BL5 05/24/16 1938 BL5
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 30-40 TIMES EVERY HOUR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

5A4D43B46E10429588C8, KNIGHT, 388

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 1830 (continued)

6991 Post Operative Care - OUTCOMES (continued)

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

1160 Nutritional Monitoring A 18 CP
- Document 05/24/16 1830 BL5 05/24/16 1938 BL5
Diet Ordered: REGULAR
Meal: BREAKFAST, LUNCH, DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement: PROTSTAT
PO Supplement: 30 cc (Total Intake)

Comment:
150005 Intake/Output A 06,18 CP
- Document 05/24/16 1830 BL5 05/24/16 1939 BL5
INTAKE
PO: 1200 IV: Blood: TPN: NG Irrigation:
TF Tube: IVPB: 400 Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 1000 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 750

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 1830 (continued)

150005 Intake/Output (continued)
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 25 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/24/16 1830 BL5 05/24/16 1939 BL5
IV Site WNL: Y If No:

Comment: cdi

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/24/16 1830 BL5 05/24/16 1939 BL5

Activity Date: 05/24/16 Time: 1840

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/24/16 1840 EW 05/24/16 1840 EW
Temperature: 99.0
Temperature Source+: Oral
Pulse: 99
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 111/72
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:

5A4D43B46E10429588C8, KNIGHT, 389

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 1840 (continued)

6680 Vital Signs (continued)
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/24/16 Time: 1900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 1900 SW6 05/24/16 2213 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>
6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/24/16 1900 SS4 05/24/16 2257 SS4
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From BETHANY LEWIS RN

Comment

Activity Date: 05/24/16 Time: 1930

Patient Notes: Nursing Notes
- Create 05/24/16 1930 SS4 05/24/16 2311 SS4
Abnormal? N Confidential? N
BEDSIDE REPORT RECEIVED FROM BETHANY. CARE ASSUMED. ASSESSMENT COMPLETE (SEE INTERVENTIONS). PT RESTING IN BED WITH EYES OPEN. RA, ALERT AND ORIENTED X3. IV SITE #20 RAC SL. OSTOMY TO RUQ WITH JP DRAIN TO LUQ. BILATERAL SCDS ON. CONTINOUS PULSE OX (CAPNO) IN PLACE. POST OP GOALS IN PLACE. HOB UP. SR UP. CALL LIGHT, TELEPHONE, WATER PITCHER AND BEDSIDE TABLE WITHIN REACH. WILL CONTINUE TO MONITOR.

Addendum: 05/25/16 at 0041 by SS4 SARVIS,SABRINA RN

WOUND VAC TO MIDLINE ABD, 125MMHG. NO COMPLICATIONS NOTED.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 2000

1699 Prostat Supplement A 08,20 OE
- Document 05/24/16 2000 SS4 05/24/16 2258 SS4
Prostat given: Y

Comment:
3140 Airway Management A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2258 SS4
3440 Incision Site Care A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2258 SS4
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/24/16 2000 SS4 05/24/16 2258 SS4
BM Consistency:
BM Color:
BM Amount:

Comment: SOFT GREENISH/BROWN STOOL PRESENT IN OSTOMY APPLIANCE.
1629 OSA ASSESSMENT A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2258 SS4
OSA Assessment

CAPNOGRAPHY Monitor in place: Y
If NO, Reason: NI

Education reviewed with patient? Y
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE
6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2305 SS4
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<
6990 Post Operative Care - GOALS A 08,20 CP
- Document 05/24/16 2000 SS4 05/24/16 2306 SS4
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 30-40 TIMES EVERY HOUR

Patient demonstates technique for splinting incision: Y

5A4D43B46E10429588C8, KNIGHT, 390

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/24/16 Time: 2000 (continued)

6990 Post Operative Care - GOALS (continued)

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

0840	Positioning			A	QS	CP
- Document	05/24/16 2000 SS4	05/24/16 2258 SS4				
275051	VTE Prophylaxis Orders Complete?			A	08,20	CP
- Document	05/24/16 2000 SS4	05/24/16 2307 SS4				
VTE Prophylaxix Orders Complete? Y						
525002	IV THERAPY ASSESSMENT			A	QS	CP
- Document	05/24/16 2000 SS4	05/24/16 2307 SS4				

IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT ANTECUBITAL SPACE IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Protectiv Type of Cath #3:
Cath Gauge #1: 20 Cath Gauge #3:
Fluid/Rate #1: SL Fluid/Rate #3:
Date Insert/DC #1: 05/23/16 Date Insert/DC #3:
IV #1 Comment: IV #3 Comment:
<Esc> <Esc>

IV Site #2: IV Site #4:
Site Appear #2: Site Appear #4:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/24/16 Time: 2000 (continued)

525002 IV THERAPY ASSESSMENT (continued)
Type of Cath #2: Type of Cath #4:
Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2305 SS4

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Size Left+: 3mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Vision Impairment: GLASSES
Hearing Impairment: NONE

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness.

5A4D43B46E10429588C8, KNIGHT, 391

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Peripheral/pedal pulses present. Skin warm and dry.
Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+: SINUS RHYTHM

Pulse Rhythm+: Regular

Heart Rate: 93

Pacemaker: N Defibrillator: N

Dizziness/Syncope+:

Palpitations: N

JVD+:

Edema 1+:
Loc 1+:

Edema 2+:
Loc 2+:

TED Hose: N
IPC: Y

Pitting:

Pitting:

Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal
Dorsalis Rt+: Normal
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal

Femoral Rt+:
Femoral Lt+:

Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 20 O2 Sat: 94 %/L of O2: 0

O2 Mode+: ROOM AIR

RR Description+: WNL

Resp Pattern+: Unlabored

Chest Expansions+: Symmetrical

Cough+: Productive

Sputum Amount+: Moderate

Sputum Consistency+: Thick

Breath Sounds

LUL+: Clear

LLL+: Diminished

RUL+: Clear

RML+: Diminished

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Sputum Color+: Beige

Airway+: Patent

RLL+: Diminished

Airway Suctioned+:

Lung Sounds:

COPD Educational Video:

Profile

Resp Comment <Esc>:

Cyanosis:
Pallor:

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized

Paralysis+:

Joint Swelling+:

Amputations+:

Muscle Spasms+:

Contractures+:

Deformities+:

Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER

Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WET TO DRY DAKIN'S
Dress Appear #1: INTACT, NO VISIBLE DRNG

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown: N

5A4D43B46E10429588C8, KNIGHT, 392

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally: 3	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem: 2
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem:
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N
Emesis: N Diarrhea: N
By C-Diff Protocol - Watery loose stool: N

Last BM: 05/24/16
Stool Amount+: Large
Stool Color+: Brown
Stool Consistency+: Liquid
Incontinent Stool: N

Rectal Tube: N
Tubes+:
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: ROUND
SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N

Currently Menses:
LMP:
Prostate Problems:

Urine Color+: Amber
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N

Dialysis

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/24/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Suprapubic Catheter: N
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: 4 pain management this shift: 5
Pain Location+:
Quality Of Pain+:
Onset/Duration:
Pain Med Given<Esc>:

Patient Sleeping: N
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

Pain Comment<Esc>: WILL CONTINUE TO MONITOR

******RESPONSE TO PLAN OF CARE/TREATMENT******

Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: Y	Language: N	Visual: Y	Motivation: N	Cultural: N	Cognitive: N
Reading: N	Age Related: N	Auditory: N	Emotional: Y	Religious: N	Finances: N

EDUCATION/INTERVENTION: REVIEWED: SAFETY, PLAN OF CARE, DIET, ACTIVITY, MEDS, PAIN, TX, DISCHARGE PLANNING

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2305 SS4
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

5A4D43B46E1042958C8, KNIGHT, 393

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/24/16 Time: 2000

7370 Discharge Planning Assessment A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2306 SS4

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC

NEEDS IDENTIFIED:
Home Health: Y
Wound Care: N
Medical Equipment: N
Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2307 SS4

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking 1
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

*****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 10

*****Interventions*****

Bed Wheels Locked Y	Fall assessment completed Y
Bed in Low Position Y	Patient needs Assessed q2hr Y
Call Light within reach Y	Environment Assessed Fall Risk Y
	Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P	
Assess q1hr 7P-7A Y	
Frequent Re-orientation Y	
Reinforce Call Light use Y	
Bed/Chair Alarm in use Y	
Friction Footwear when OOB Y	
In Rm when pt OOB to BSC, BR, Shower,etc. Y	

HIGH RISK (>14) RED Sign on door/chart

	Remain W/patient whenever OOB
	If OOB to chair, q30min monitoring
	Assess q1hr 7A-7P
	Assess q1hr 7P-7A
	Reinforce Call Light Use
	Frequent Re-orientation
	Bed/Chair Alarm in Use
	Friction Footwear when OOB
	In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate
Level of Care: Assist

5A4D43B46E1042958BC8, KNIGHT, 394

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 2000

99 SEPSIS Documentation A QS CP
- Document 05/24/16 2000 SS4 05/24/16 2257 SS4
Temperature: 99.5
Temperature Source+: Oral (May use most recent
Pulse: 89 VITAL SIGNS taken
Respirations: 20 if they are WNL and
Blood Pressure: 101/66 no greater then 3hrs)
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

Physician Notified: N
If NO, Reason: Physician Already Aware

Activity Date: 05/24/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 2100 SW6 05/24/16 2213 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/24/16 Time: 2200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/24/16 2200 SW6 05/24/16 2203 SW6
Temperature: 98.2
Temperature Source+: Oral
Pulse: 58
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 173/84
BP Location+: R Arm
BP Position+: SITTING
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/24/16 Time: 2200 (continued)

6680 Vital Signs (continued)
IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:
- Edit Results 05/24/16 2200 SW6 05/24/16 2207 SW6
Temperature: 99.5 [98.2]
Pulse: 89 [58]
Blood Pressure: 101/66 [173/84]
BP Position+: SUPINE [SITTING]
O2 Sat: 92 []

Activity Date: 05/24/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/24/16 2300 SW6 05/25/16 0251 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/24/16 Time: 2313

Patient Notes: Nursing Notes
- Create 05/24/16 2313 SS4 05/24/16 2314 SS4
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES CLOSE. RESP WNL. NO DISTRESS NOTED. CONTINOUS PULSE OX IN PLACE. HOB UP. SR UP. CALL LIGHT WITHIN REACH. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 0035

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/25/16 0035 KO2 05/25/16 0527 KO2
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 94 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour

5A4D43B46E10429588C8, KNIGHT, 395

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/25/16 Time: 0035 (continued)

09 RESP THERAPY - TREATMENT (continued)

Continous Neb Sub

MDI Install
MDI Subsequent
MDI Additional Tx:

Pulse Ox Single
Pulse Ox over-noc
Pulse Ox Continuous

Incentive Install
Pt Instructed
Pt Achieves ml
Pt Understands/will use on own
Pt unable to comprehend or perform TX
Nurse Notified Nurse will follow-up

CPT Initial
CPT Subsequent
CPT w/Bed:
Oscillating PEP
NT Suction

MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 95 Pre-Assessment RR: 17

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 96 Post-Assessment RR: 17

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted N
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment PT SLEPT THROUGH TX
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/25/16 Time: 0035 (continued)

09 RESP THERAPY - TREATMENT (continued)

Reinforcement Needed

Activity Date: 05/25/16 Time: 0100

5500011 Purposeful Rounding A Q2RODD CP
- Document 05/25/16 0100 SW6 05/25/16 0251 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/25/16 Time: 0200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/25/16 0200 SW6 05/25/16 0245 SW6
Temperature: 98.5
Temperature Source+: Oral
Pulse: 101
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 101/65
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/25/16 0200 SS4 05/25/16 0236 SS4

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

5A4D43B46E1042958C8, KNIGHT, 396

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/25/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 0300 SW6 05/25/16 0654 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/25/16 Time: 0400

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/25/16 0400 SS4 05/25/16 0421 SS4
IPC: Y
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/25/16 0400 SS4 05/25/16 0421 SS4
TED Hose - removed for skin assessment and reapplied.

IPC - removed for skin assessment and reapplied. Y

5A4D43B46E10429588C8, KNIGHT, 397

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0400 (continued)

3592 TED/HEEL PROTECTORS/IPC Skin Assessment (continued)

Heel Protectors - removed for skin assessment and reapplied.

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/25/16 0400 SS4 05/25/16 0421 SS4
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
diet, physician follow-up, medications, what to do if Comment
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 0500 SW6 05/25/16 0655 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/25/16 Time: 0551

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/25/16 0551 SS4 05/25/16 0551 SS4
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 30-40 TIMES EVERY HOUR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

5A4D43B46E10429588C8, KNIGHT, 398

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/25/16 Time: 0551 (continued)

6991 Post Operative Care - OUTCOMES (continued)

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

150005 Intake/Output A 06,18 CP
- Document 05/25/16 0551 SS4 05/25/16 0600 SS4

INTAKE

PO: 1000	IV:	Blood:	TPN:	NG Irrigation:
TF Tube:	IVPB: 200	Platelet:	Lipid:	Foley Irrigation (CBI):
TF Flush:		PO Supplement:	FFP:	Dialysis (Intake):

OUTPUT

Void (ml): 500	Bladder Incont Episodes:	Emesis:	Colostomy:
Foley:	Bowel Incont Episodes:	T Tube:	Ileostomy: 650
Foley (Residual):	Void Episodes:	NG/PEG TUBE:	Urostomy:
SP Catheter:	Stool Episodes:	Duodenal Tube:	Ileoconduit:
	Diapers:	G Tube (Residual):	Liquid Stool:

#1 JP: 10	#1 Chest Tube:	Left Ureteral:	Dialysis (Output):
#2 JP:	#2 Chest Tube:	Right Ureteral:	Thoracentesis:
#3 JP:	#1 Hemovac:	Left Nephrostomy:	Paracentesis:
OTHER:	#2 Hemovac:	Right Nephrostomy:	Wound Vac:

Comment:

525003 IV Site Check A 06,18 CP
- Document 05/25/16 0551 SS4 05/25/16 0603 SS4
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:

CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/25/16 Time: 0551

5500010 Rounds Surveillance A 06,18 CP
- Document 05/25/16 0551 SS4 05/25/16 0603 SS4

Activity Date: 05/25/16 Time: 0600

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/25/16 0600 SW6 05/25/16 0652 SW6
Temperature: 98.1
Temperature Source+: Oral
Pulse: 81
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 95/63
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/25/16 Time: 0610

Patient Notes: Nursing Notes
- Create 05/25/16 0610 SS4 05/25/16 0611 SS4
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES OPEN. NO DISTRESS NOTED. RESP WNL. WOUND VAC TO MIDLINE ABD INTACT WITH 125MMHG SUCTION. JP DRAIN INTACT WITH OSTOMY IN PLACE. HOB UP. SR UP. CALL LIGHT WITHIN REACH. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 0720

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 0720 EW 05/25/16 0720 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:

5A4D43B46E1042958BC8, KNIGHT, 399

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/25/16 Time: 0720 (continued)

5500011 Purposeful Rounding (continued)
<Esc>

Activity Date: 05/25/16 Time: 0721

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/25/16 0721 BE 05/25/16 0723 BE
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 93 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single Y
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 93 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 93 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/25/16 Time: 0721 (continued)

09 RESP THERAPY - TREATMENT (continued)

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/25/16 Time: 0730

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/25/16 0730 NR2 05/25/16 0731 NR2
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From NATALIE / SABRINA

Comment

Activity Date: 05/25/16 Time: 0747

Patient Notes: Nursing Notes
- Create 05/25/16 0747 NR2 05/25/16 0753 NR2
Abnormal? N Confidential? N
REPORT RECEIVED AND CARE ASSUMED BY THIS RN, PT RESTING BED EYES OPEN, BREATHS EVEN AND UNLABORED, NO S/S OF IMMEDIATE DISTRESS NOTED, PT DENIES NEEDS AT THIS TIME, JP DRAINING STRAW COLORED DRAINAGE, OSTOMY INTACT, DRAINING GREENISH BROWN SEMI LIQUID STOOL, WOUND VAC ATTACHED, DRESSING C/D/I PRESSURE AT 125, DRAINAGE SEROSANGUIENOUS, IPC AT BEDSIDE, WILL CONTINUE TO MONITOR, BED POSITIONED FOR SAFETY AND CALL BELL/PHONE IN REACH
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 0800

1699 Prostat Supplement A 08,20 OE
- Document 05/25/16 0800 NR2 05/25/16 1542 NR2
Prostat given: Y

Comment:

5A4D43B46E10429588C8, KNIGHT, 400

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/25/16 Time: 0800

0430 Bowel Management — A QS — CP
STOOL ASSESSMENT
- Document 05/25/16 0800 NR2 05/25/16 1516 NR2
BM Consistency: Liquid
BM Color: Brown
BM Amount: MEDIUM

Comment:

1629 OSA ASSESSMENT — A QS — CP
- Document 05/25/16 0800 NR2 05/25/16 1516 NR2
OSA Assessment

CAPNOGRAPHY Monitor in place: Y
If NO, Reason: NI

Education reviewed with patient? Y
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided — A QS — CP
- Document 05/25/16 0800 NR2 05/25/16 1527 NR2
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS — A 08,20 — CP
- Document 05/25/16 0800 NR2 05/25/16 1527 NR2
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 30-40 TIMES EVERY HOUR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

6990 Post Operative Care - GOALS (continued) — CP
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

275051 VTE Prophylaxis Orders Complete? — A 08,20 — CP
- Document 05/25/16 0800 NR2 05/25/16 1530 NR2
VTE Prophylaxix Orders Complete? Y

525002 IV THERAPY ASSESSMENT — A QS — CP
- Document 05/25/16 0800 NR2 05/25/16 1530 NR2
IV Site Change: Y # Of Attempts: 1 IV Tube Change: N IV DISCONTINUED N

IV Site #1: RIGHT ANTECUBITAL SPACE IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Protectiv Type of Cath #3:
Cath Gauge #1: 20 Cath Gauge #3:
Fluid/Rate #1: SL Fluid/Rate #3:
Date Insert/DC #1: 05/23/16 Date Insert/DC #3:
IV #1 Comment: CDI IV #3 Comment:
<Esc> <Esc>

IV Site #2: RIGHT ANTECUBITAL SPACE IV Site #4:
Site Appear #2: NORMAL Site Appear #4:
Type of Cath #2: Protectiv Type of Cath #4:
Cath Gauge #2: 20 Cath Gauge #4:
Fluid/Rate #2: S/L Fluid/Rate #4:
Date Insert/DC #2: 05/23/16 Date Insert/DC #4:
IV #2 Comment: DRSG INTACT. IV #4 Comment:
<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) — A QS — CP
- Document 05/25/16 0800 NR2 05/25/16 1526 NR2
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time
Speech clear, responses appropriate. No facial droop. Pupils
equal, round, and reactive to light. Hand grips strong/equal

5A4D43B46E10429588C8, KNIGHT, 401

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Equal
Size Left+: 3mm
Lt Reaction To Light+: Reactive
Equal

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative

Site:

Speech/Cry+: Clear

Vision Impairment: GLASSES
Hearing Impairment: NONE

Responsive To+: Spontaneous

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+:

Pulse Rhythm+: Regular

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Heart Rate: 93 Pacemaker: N Defibrillator: N

Dizziness/Syncope+: Palpitations: N

JVD+: Flat

Edema 1+: Edema 2+:
Loc 1+: Loc 2+:
Pitting: Pitting:
TED Hose: N
IPC: Y
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+:	Normal	Femoral Rt+:	
Dorsalis Rt+:	Normal	Femoral Lt+:	
Post Tib Lt+:	Normal		
Post Tib Rt+:	Normal	Cap Refill RUE+:	Brisk
Carotid Rt+:		Cap Refill LUE+:	Brisk
Carotid Lt+:		Cap Refill RLE+:	Brisk
Brachial Rt+:	Normal	Cap Refill LLE+:	Brisk
Brachial Lt+:	Normal		
Radial Rt+:	Normal		
Radial Lt+:	Normal		

Cardio Comment <Esc>: NO C/O CHEST PAIN OR DISCOMFORT.

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 94 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+: Productive
Sputum Amount+: Moderate
Sputum Consistency+: Thick
Sputum Color+: Beige
Airway+: Patent
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Diminished
RLL+: Diminished

Lung Sounds: DIMINISHED

COPD Educational Video: Profile

Resp Comment <Esc>: PT DEMONSTRATED USE OF IS, ENCOURAGED TO KEEP USING, DEEP BREATHING ENCOURAGED, LUNGS SOUNDS DIMINISHED BUT AIR EXCHANGE IS DEMONSTRATED

Cyanosis: N
Pallor: N

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement

5A4D43B46E10429588C8, KNIGHT, 402

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized Paralysis+:

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER

Musc-Skel Comment <Esc>: AMBULATION ENCOURAGED WITH ASSISTANCE, TIRES EASILY, USES WALKER WITH ASSIST

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE
Dress Appear #1: C/D/I
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>: WOUND VAC APPLIED, SUCTION AT 125, DRAINING SEROSANGUIENOUS DRAINAGE

Is Pt At Risk For Immobility Or Skin Breakdown: Y

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally: 3	Adequate: 3
No Impairment:	Walks Frequently:	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/25/16
Emesis: N Diarrhea: N Stool Amount+: Moderate
By C-Diff Protocol - Watery loose stool: N Stool Color+: Greenish Brown
Stool Consistency+: Liquid
Incontinent Stool: N
Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: ROUND SOFT

GI Comment <Esc>: OSOTMY C/D/I, GOOD SEAL, STOMA RED AND BEEFY, APPEARS HEALTHY, WILL CONTINUE TO MONITOR

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N Currently Menses:
LMP:
Urine Color+: Yellow Prostate Problems: N
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N
Suprapubic Catheter: N

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: PT USES URINAL

**********PAIN ASSESSMENT**********

5A4D43B46E1042958BC8, KNIGHT, 403

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>: SEE EMAR

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: Y Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION:
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/25/16 0800 NR2 05/25/16 1527 NR2
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/25/16 0800 NR2 05/25/16 1527 NR2
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

NEEDS IDENTIFIED:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

7370 Discharge Planning Assessment (continued)
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/25/16 0800 NR2 05/25/16 1528 NR2
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis,

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking 1
Deconditioning 1
Change in gait pattern 1
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated

5A4D43B46E10429588C8, KNIGHT, 404

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Fractures, Seizures, Arthritis, Dementia Consistantly demonstrated
None present 0 RN Judgement (9pt)
1-2 present RN Judgement (4pt)
3 or more present
Total Score: 8

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: AMULATES WELL WITH ASSIST, USES WALKER

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/25/16 0800 NR2 05/25/16 1515 NR2
Temperature: 98.8
Temperature Source+: Oral
Pulse: 105
Respirations: 18
Blood Pressure: 112/57
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 0800 (continued)

99 SEPSIS Documentation (continued)
If NO, Reason:

Activity Date: 05/25/16 Time: 0945

3140 Airway Management A QS CP
- Document 05/25/16 0945 NR2 05/25/16 0945 NR2
3440 Incision Site Care A QS CP
- Document 05/25/16 0945 NR2 05/25/16 0945 NR2
0840 Positioning A QS CP
- Document 05/25/16 0945 NR2 05/25/16 0945 NR2

Activity Date: 05/25/16 Time: 0959

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 0959 EW 05/25/16 0959 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/25/16 Time: 1000

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/25/16 1000 EW 05/25/16 1003 EW
Temperature: 98.5
Temperature Source+: Oral
Pulse: 93
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 106/72
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

5A4D43B46E1042958BC8, KNIGHT, 405

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/25/16 Time: 1030

25 PT: Daily Documentation — A — PS
- Document 05/25/16 1030 JW 05/25/16 1251 JW

S: Pt sitting in chair in solarium, reports feeling a little better today.

Press ESC to get out of text boxes.

O: Performed sit to stand with SBAX1
GT amb ~ 250' with RW and CGAX1
Stand to sit in bedside chair with CGAX1

A: Pt amb and transferring with little assistance at this time.

P: Cont POC

Activity Date: 05/25/16 Time: 1100

5500011 Purposeful Rounding — A — Q2HODD — CP
- Document 05/25/16 1100 EW 05/25/16 1101 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/25/16 Time: 1109

Patient Notes: Medical Nutrition Therapy
- Create 05/25/16 1109 LH 05/25/16 1112 LH
Abnormal? N Confidential? N
MNT FU

ASSESSMENT
-LABS: GLU 124, NA 135, CA 8, ALB 2, PHOS 2.1
-PT DOING FAIR. APPETITE REMAINS POOR. PT IS ON A FLUID RESTRICTION AND STAYS VERY THIRSTY INSTEAD OF HUNGRY. IS TOLERATING THE PROSTAT AND ENSURE DESPITE NOT LIKING THEM VERY MUCH.
-PT ASKING FOR A HAMBURGER BUT WAS SCARED ABOUT THE FAT CONTENT. ENCOURAGED PT TO MAY BE EAT ONLY HALF AND SEE HOW HE FEELS.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/25/16 Time: 1109 (continued)

Patient Notes: Medical Nutrition Therapy (continued) — PS
DIAGNOSIS
-NO NEW

INTERVENTION
-DIET RX: REGULAR, 1500 ML FLUID RESTRICTION
GOAL: ADEUQATE PO INTAKE
-SUPPLEMENT: PROSTAT BID PO, ENSURE BID PO
GOAL: IMPROVED LAB VALUES, WOUND HEALING

COORDINATION OF CARE: nO DC NEEDS

FU LEVEL 2 29-31
LINDSEY HARRIS, RD LD
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 1130

Patient Notes: Nursing Notes
- Create 05/25/16 1130 NR2 05/25/16 1723 NR2
Abnormal? N Confidential? N
PT RESTING IN CHAIR, HAS AMBULATED TODAY WITH ASSIST AND WALKER, DENIES NEEDS AT THIS TIME. OSTOMY BAG EMPTIED WITH 200 ML GREENISH BROWN LIQUID STOOL. PT DEMONSTRATED USE OF IS, ENCOURAGED TO CONTINUE. CHAIR LOCKED FOR SAFETY, CALL BELL AND PHONE IN REACH. NO S/S OF IMMEDIATE DISTRESS NOTED, WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 1200

Patient Notes: CASE MGT/SOCIAL WORK SVS NOTES
- Create 05/25/16 1200 JB* 05/25/16 1200 JB*
Abnormal? N Confidential? N
WOUND VACC ORDER HAS BEEN PLACED. AWAITING MD SIGNATURE. REFERRAL TO AMEDISYS HOME HEALTH PER PATIENT'S CHOICE.
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 1300

5500011 Purposeful Rounding — A — Q2HODD — CP
- Document 05/25/16 1300 EW 05/25/16 1409 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

5A4D43B46E10429588C8, KNIGHT, 406

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/25/16 Time: 1300 (continued)

5500011 Purposeful Rounding (continued)
Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/25/16 Time: 1306

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/25/16 1306 BE 05/25/16 1312 BE
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 93 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: N/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 90 Pre-Assessment RR: 18

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 90 Post-Assessment RR: 18

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted Y
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/25/16 Time: 1306 (continued)

09 RESP THERAPY - TREATMENT (continued)

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/25/16 Time: 1400

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/25/16 1400 NR2 05/25/16 1531 NR2

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning

5A4D43B46E10429588C8, KNIGHT, 407

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach

Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 1400 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/25/16 Time: 1410

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/25/16 1410 EW 05/25/16 1411 EW
Temperature: 98.8
Temperature Source+: Oral
Pulse: 105
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 112/57
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 94 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/25/16 Time: 1517

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 1517 EW 05/25/16 1517 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/25/16 Time: 1546

Patient Notes: CASE MGT/SOCIAL WORK SVS NOTES
- Create 05/25/16 1546 JB* 05/25/16 1546 JB*
Abnormal? N Confidential? N
SIGNED WOUND VACC ORDER FAXED TO KCI

5A4D43B46E10429588C8, KNIGHT, 408

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/25/16 Time: 1546 (continued)

Patient Notes: CASE MGT/SOCIAL WORK SVS NOTES (continued)
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 1554 (continued)

1663 IPC, TED, VFP Documentation (continued)
- Document 05/25/16 1554 NR2 05/25/16 1555 NR2
IPC: Y
TED Hose: N
Venous Foot Pump: N

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/25/16 1554 NR2 05/25/16 1555 NR2
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. Y

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

800001 Education/Teaching Assessment A 04,16 CP
- Document 05/25/16 1554 NR2 05/25/16 1555 NR2
Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
MEDS

Material Codes: VERBAL

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/25/16 Time: 1554 (continued)

800001 Education/Teaching Assessment (continued)
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/25/16 Time: 1723

Patient Notes: Nursing Notes
- Create 05/25/16 1723 NR2 05/25/16 1725 NR2
Abnormal? N Confidential? N
PT RESTING IN CHAIR EYES OPEN, DENIES NEEDS AT THIS TIME, SAYS PAIN IS BETTER TODAY, RESPIRATIONS EVEN AND UNLABORED, NO S/S OF IMMEDIATE DISTRESS, CALL BELL AND PHONE IN REACH, CHAIR LOCKED FOR SAFETY, WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 1744

Patient Notes: Nursing Notes
- Create 05/25/16 1744 NR2 05/25/16 1746 NR2
Abnormal? N Confidential? N
PT RESTING IN BED EYES OPEN. C/O BEING GASSY IN REGARDS TO OSTOMY. COMFORTABLE IN BED, PAIN MANAGED, REQUESTED MORE PAIN MEDS WHEN TIME. CALL BELL AND PHONE IN REACH, NO S/S OF IMMEDIATE DISTRESS NOTED, IV ANCEF INFUSING, WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 1751

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 1751 EW 05/25/16 1751 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

5A4D43B46E1042958C8, KNIGHT, 409

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/25/16 Time: 1751 (continued)

5500011 Purposeful Rounding (continued)

Comment:
<Esc>

Activity Date: 05/25/16 Time: 1752

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/25/16 1752 EW 05/25/16 1755 EW
Temperature: 100.0
Temperature Source+: Oral
Pulse: 89
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 104/68
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/25/16 Time: 1800

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/25/16 1800 NR2 05/25/16 1920 NR2
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 30-40 TIMES EVERY HOUR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/25/16 Time: 1800 (continued)

6991 Post Operative Care - OUTCOMES (continued)
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
1160 Nutritional Monitoring A 18 CP
- Document 05/25/16 1800 NR2 05/25/16 1920 NR2
Diet Ordered: REGULAR
Meal: BREAKFAST, LUNCH, DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement: PROTSTAT
PO Supplement: 30 cc (Total Intake)

Comment:
150005 Intake/Output A 06,18 CP
- Document 05/25/16 1800 NR2 05/25/16 1922 NR2
INTAKE
PO: 1396 IV: 25 Blood: TPN: NG Irrigation:
TF Tube: IVPB: 150 Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 600 Bladder Incont Episodes: Emesis: Colostomy: 700
Foley: Bowel Incont Episodes: T Tube: Ileostomy:
Foley (Residual): Void Episodes: 3 NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 5 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

5A4D43B46E10429588C8, KNIGHT, 410

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/25/16 Time: 1800 (continued)

150005 Intake/Output (continued)

Comment:

525003 IV Site Check — A 06,18 — CP
- Document 05/25/16 1800 NR2 05/25/16 1922 NR2
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5500010 Rounds Surveillance — A 06,18 — CP
- Document 05/25/16 1800 NR2 05/25/16 1922 NR2

6901 PATIENT LINEN CHANGE — A PRN — CP
- Document 05/25/16 1800 EW 05/25/16 1800 EW
Linen Change 05/25/16

Patient Refused (Linen): Nurse Notified (Linen):

6905 PATIENT BATH — A PRN — CP
- Document 05/25/16 1800 EW 05/25/16 1801 EW
Hygiene: Assisted Date: 05/25/16
Patient Refused (Bath): Nurse Notified (Bath):

Hygiene Comment: PT SAID WIFE WILL ASSIST WITH BATH.

Activity Date: 05/25/16 Time: 1900

5500011 Purposeful Rounding — A Q2HODD — CP
- Document 05/25/16 1900 SW6 05/25/16 2145 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/25/16 Time: 1900 (continued)

5500011 Purposeful Rounding (continued)
Comment:
<Esc>

Activity Date: 05/25/16 Time: 1922

Patient Notes: Nursing Notes
- Create 05/25/16 1922 NR2 05/25/16 1925 NR2
Abnormal? N Confidential? N
PT RESTING IN BED, EYES OPEN, CALM, HAS BEEN C/O GAS PAIN, SEE EMAR. PT DENIUES NEEDS AT THIS TIME, IV ANTIBIOTIC INFUSING, OSTOMY C/D/I, STOMA RED AND BEEFY, APPEARS HEALTHY. WIFE AT BEDSIDE OFF AND ON THROUGHOUT DAY. JP DRAIN DRAINING STRAW COLORED DRAINAGE. BED LOCKED FOR SAFETY, CALL BELL IN REACH, WOUND VAC APPLIED, PRESSURE AT 125, WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 1929

6922 Nursing Report (Hand Off) — A 07,19 — CP
- Document 05/25/16 1929 MG* 05/25/16 2021 MG*
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From MELISSA,RN/NORA,RN

Comment
Patient Notes: Nursing Notes
- Create 05/25/16 1929 MG* 05/25/16 2022 MG*
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT. WOUND VAC TO MIDLINE INCISION ON AND PUMPING. DRESSING INTACT. ILEOSTOMY APPLIANCE INTACT, STOMA PINK AND MOIST. NO C/O PAIN AT PRESENT. CALL BELL IN REACH. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 05/25/16 Time: 2030

1699 Prostat Supplement — A 08,20 — OE
- Document 05/25/16 2030 MG* 05/26/16 0044 MG*
Prostat given:

Comment: GETS WITH MEALS
3140 Airway Management — A QS — CP
- Document 05/25/16 2030 MG* 05/26/16 0044 MG*
3440 Incision Site Care — A QS — CP
- Document 05/25/16 2030 MG* 05/26/16 0044 MG*

5A4D43B46E10429588C8, KNIGHT, 411

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/25/16		Time: 2030								
0430	Bowel Management STOOL ASSESSMENT						A	QS		CP
- Document	05/25/16	2030	MG*	05/26/16	0043	MG*				
BM Consistency: Liquid										
BM Color: Green										
BM Amount: MEDIUM										
Comment:										
1629	OSA ASSESSMENT						A	QS		CP
- Document	05/25/16	2030	MG*	05/26/16	0044	MG*				
OSA Assessment										
CAPNOGRAPHY Monitor in place: N										
If NO, Reason: NI										
Education reviewed with patient? N										
If NO, Reason: NI										
Hi risk or known controlled, signage placed on patient door: N										
OSA HIGH RISK: N										
Follow-up Physician Appt: NONE										
6955	Anticoagulant Educ Materials Provided						A	QS		CP
- Document	05/25/16	2030	MG*	05/26/16	0050	MG*				
Anticoagulant Educ Material provided to Patient &/or Family? Y										
Comment:										
CareNotes	(Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)									
>>>>>>COMPLETE Intervention after Filing<<<<<<										
6990	Post Operative Care - GOALS						A	08,20		CP
- Document	05/25/16	2030	MG*	05/26/16	0050	MG*				
Post-Operative Care - GOALS										
Patient demonstrates use of Incentive Spirometer: Y										
Goal: 10 X HR										
Patient demonstates technique for splinting incision: Y										
Patient verbalizes understanding of pain scale: Y										
Goal: 5/10										
Pain Scale: NUMERIC										
Patient verbalizes understanding of activity level: Y										

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/25/16		Time: 2030 (continued)								
6990	Post Operative Care - GOALS (continued)									CP
Prescribed activity level: ASSIST										
Patient verbalizes understanding DVT prevention including:										
TEDS N IPC Y Pedal Exercises Y										
Goal: PREVENT DVT'S										
Provide patient with form #2292										
Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y										
Diet: REGULAR										
Patient verbalizes signs/symptoms of infection including:										
Redness Y Swelling Y Discharge Y Temperature Y										
BS Frequency: N/A										
Smoking Status: Never smoker								Nursing Note: N		
0840	Positioning						A	QS		CP
- Document	05/25/16	2030	MG*	05/26/16	0043	MG*				
275051	VTE Prophylaxis Orders Complete?						A	08,20		CP
- Document	05/25/16	2030	MG*	05/26/16	0052	MG*				
VTE Prophylaxix Orders Complete? Y										
525002	IV THERAPY ASSESSMENT						A	QS		CP
- Document	05/25/16	2030	MG*	05/26/16	0052	MG*				
IV Site Change:	# Of Attempts:			IV Tube Change:				IV DISCONTINUED		
IV Site #1: RIGHT ANTECUBITAL SPACE								IV Site #3:		
Site Appear #1: NORMAL								Site Appear #3:		
Type of Cath #1: Protectiv								Type of Cath #3:		
Cath Gauge #1: 20								Cath Gauge #3:		
Fluid/Rate #1: SL								Fluid/Rate #3:		
Date Insert/DC #1: 05/23/16								Date Insert/DC #3:		
IV #1 Comment: CDI								IV #3 Comment:		
<Esc>								<Esc>		
IV Site #2:								IV Site #4:		
Site Appear #2:								Site Appear #4:		
Type of Cath #2:								Type of Cath #4:		
Cath Gauge #2:								Cath Gauge #4:		
Fluid/Rate #2:								Fluid/Rate #4:		
Date Insert/DC #2:								Date Insert/DC #4:		
IV #2 Comment:								IV #4 Comment:		
<Esc>								<Esc>		

5A4D43B46E1042958BC8, KNIGHT, 412

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/25/16 Time: 2030

6650 SKIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/25/16 2030 MG* 05/26/16 0049 MG*

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Equal
Size Left+: 3mm
Lt Reaction To Light+: Reactive
Equal

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative
Site:

Speech/Cry+: Clear

Vision Impairment: GLASSES
Responsive To+: Spontaneous
Hearing Impairment: NONE

Mental Status: Alert & Oriented
Continued On Next Page

Glasgow Coma Scale

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA
Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/25/16 Time: 2030 (continued)

6650 SKIFT ASSESSMENT (Surveillance) (continued)

Heart Sounds+: Normal

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate:

Pacemaker: N Defibrillator: N

Dizziness/Syncope+:

Palpitations: N

JVD+: Flat

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: Y
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal
Dorsalis Rt+: Normal
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal

Femoral Rt+:
Femoral Lt+:

Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:
NO C/O CHEST PAIN OR DISCOMFORT.

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 99 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+:
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Diminished
RLL+: Diminished

Lung Sounds: DIMINISHED

COPD Educational Video: Profile

Resp Comment <Esc>: PT DEMONSTRATED USE OF IS, ENCOURAGED TO KEEP

Cyanosis: N

5A4D43B46E10429588C8, KNIGHT, 413

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 2030 (continued)

6650 SKIFT ASSESSMENT (Surveillance) (continued)

USING, DEEP BREATHING ENCOURAGED, LUNGS SOUNDS DIMINISHED BUT AIR EXCHANGE IS DEMONSTRATED

Pallor: N

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+:
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>: WOUND VAC ON AND SUCTIONING AT 125, DRAINING SEROSANGUINOUS DRAINAGE
Is Pt At Risk For Immobility Or Skin Breakdown: Y

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally: 3	Adequate: 3

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 2030 (continued)

6650 SKIFT ASSESSMENT (Surveillance) (continued)

No Impairment:	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
By C-Diff Protocol - Watery loose stool: N
Constipation: N
Diarrhea: N
Last BM: 05/25/16
Stool Amount+:
Stool Color+:
Stool Consistency+:
Incontinent Stool:

Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: ROUND SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N

Urine Color+: Yellow
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N
Suprapubic Catheter: N

Currently Menses:
LMP:
Prostate Problems: N

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

5A4D43B46E10429588C8, KNIGHT, 414

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/25/16 Time: 2030 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
GU Comment <Esc>: PT USES URINAL

**********PAIN ASSESSMENT**********

Pt C/O Pain: N Acceptable Scale/Goal for EXCELLENT
Pain Scale: pain management this shift:
Pain Location+:
Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment:

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: Y	Language: N	Visual: Y	Motivation: N	Cultural: N	Cognitive: N
Reading: N	Age Related: N	Auditory: N	Emotional: Y	Religious: N	Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED.
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/25/16 2030 MG* 05/26/16 0049 MG*
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/25/16 2030 MG* 05/26/16 0050 MG*
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/25/16 Time: 2030 (continued)

7370 Discharge Planning Assessment (continued)

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/25/16 2030 MG* 05/26/16 0052 MG*
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications

5A4D43B46E10429588C8, KNIGHT, 415

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 2030 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Drop >20mmHG lying->standing
*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

or dosage within the last 24 hrs
****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 4

*****Interventions*****
Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low
Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/25/16 2030 MG* 05/26/16 0043 MG*
Temperature: 98.7
Temperature Source+: Oral
Pulse: 67
Respirations: 18
Blood Pressure: 112/70
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 2030 (continued)

99 SEPSIS Documentation (continued)
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

Physician Notified: N
If NO, Reason: Physician Already Aware

Activity Date: 05/25/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 2100 SW6 05/25/16 2145 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/25/16 Time: 2120

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/25/16 2120 SW6 05/25/16 2130 SW6
Temperature: 98.7
Temperature Source+: Oral
Pulse: 67
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 112/70
BP Location+: L Arm
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 93 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/25/16 Time: 2126

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/25/16 2126 KO2 05/25/16 2126 KO2
RESPIRATORY THERAPY TREATMENT

5A4D43B46E10429588C8, KNIGHT, 416

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 2126 (continued)

09 RESP THERAPY - TREATMENT (continued)

%/L of O2: LPM NC O2 Sat: 99 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 87 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 90 Post-Assessment RR: 16

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted N
Rhonchi Rales Diminished Adverse Reactions: N
Comment:
COUGH Y Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/25/16 Time: 2126 (continued)

09 RESP THERAPY - TREATMENT (continued)

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/25/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/25/16 2300 SW6 05/26/16 0243 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/26/16 Time: 0032

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/26/16 0032 KO2 05/26/16 0448 KO2
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 99 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction

5A4D43B46E10429588C8, KNIGHT, 417

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 0032 (continued)

09 RESP THERAPY - TREATMENT (continued)
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 81 Pre-Assessment RR: 14

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 82 Post-Assessment RR: 14

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted N
Rhonchi Rales Diminished Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment PT SLEPT THROUGH TX
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend Y
Reinforcement Needed

Activity Date: 05/26/16 Time: 0100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/26/16 0100 SW6 05/26/16 0244 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 0100 (continued)

5500011 Purposeful Rounding (continued)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/26/16 Time: 0200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/26/16 0200 SW6 05/26/16 0243 SW6
Temperature: 98.8
Temperature Source+: Oral
Pulse: 79
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 98/60
BP Location+: L Arm
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/26/16 Time: 0228

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/26/16 0228 MG* 05/26/16 0228 MG*

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

5A4D43B46E10429588C8, KNIGHT, 418

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/26/16 Time: 0228 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 0

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/26/16 Time: 0228 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/26/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/26/16 0300 SW6 05/26/16 0702 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/26/16 Time: 0430

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/26/16 0430 MG* 05/26/16 0448 MG*
IPC: R
TED Hose: N
Venous Foot Pump: N

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/26/16 0430 MG* 05/26/16 0448 MG*
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. REF

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

5A4D43B46E1042958C8, KNIGHT, 419

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 0430

800001 Education/Teaching Assessment A 04,16 CP
- Document 05/26/16 0430 MG* 05/26/16 0448 MG*
Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions.
Instructional video shown?
Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
MEDS
TX
Material Codes: VERBAL
Comment: UNDERSTANDS
Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/26/16 Time: 0449

150005 Intake/Output A 06,18 CP
- Document 05/26/16 0449 MG* 05/26/16 0450 MG*
INTAKE
PO: IV: Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 0449 (continued)

150005 Intake/Output (continued)
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 125
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

Activity Date: 05/26/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/26/16 0500 SW6 05/26/16 0702 SW6
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/26/16 Time: 0600

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/26/16 0600 SW6 05/26/16 0659 SW6
Temperature: 98.3
Temperature Source+: Oral
Pulse: 70
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 109/60
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

5A4D43B46E10429588C8, KNIGHT, 420

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 0600 (continued)

6680 Vital Signs (continued)
O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/26/16 Time: 0625

6991 Post Operative Care - OUTCOMES A 16,06 CP
- Document 05/26/16 0625 MG* 05/26/16 0651 MG*
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome:

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 0625

525003 IV Site Check A 06,18 CP
- Document 05/26/16 0625 MG* 05/26/16 0652 MG*
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/26/16 0625 MG* 05/26/16 0652 MG*

Activity Date: 05/26/16 Time: 0633

150005 Intake/Output A 06,18 CP
- Document 05/26/16 0633 MG* 05/26/16 0634 MG*
INTAKE
PO: 1200 IV: 170 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 200 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 650
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 10 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

5A4D43B46E10429588C8, KNIGHT, 421

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/26/16 Time: 0700

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/26/16 0700 NR2 05/26/16 0752 NR2
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From NATALIE / MELISSA

Comment

Activity Date: 05/26/16 Time: 0730

Patient Notes: Nursing Notes
- Create 05/26/16 0730 NR2 05/26/16 1141 NR2
Abnormal? N Confidential? N
REPORT RECEIVED AND CARE ASSUMED BY THIS RN, PT RESTING IN BED WITH EYES OPEN. DENIES NEEDS AT THIS TIME, PAIN CONTROLLED. NO S/S OF IMMEDIATE DISTRESS NOTED, RESPIRATIONS EVEN AND UNLABORED AT 18. MIDLINE INCISION SITE C/D/I WITH WOUND VAC APPLIED, SUCTIONING AT 125 WITH SEROSANGUINEOUS DRAINAGE NOTED. IV TO RIGHT A/C 20 GAUGE JELCO, SL. IPCs APPLIED, CALL BELL AND PHONE IN REACH, BED LOCKED FOR SAFETY, WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 05/26/16 Time: 0749

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/26/16 0749 FS 05/26/16 0751 FS
RESPIRATORY THERAPY TREATMENT

%/L of O2: 0 LPM NC O2 Sat: 99 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/26/16 Time: 0749 (continued)

09 RESP THERAPY - TREATMENT (continued)

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 78 Pre-Assessment RR: 14

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 78 Post-Assessment RR: 14

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/26/16 Time: 0800

1699 Prostat Supplement A 08,20 OE
- Document 05/26/16 0800 NR2 05/26/16 1033 NR2
Prostat given: Y

Comment:
3140 Airway Management A QS CP
- Document 05/26/16 0800 NR2 05/26/16 1033 NR2

5A4D43B46E1042958C8, KNIGHT, 422

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/26/16	Time: 0800									
3440	Incision Site Care						A	QS		CP
- Document	05/26/16	0800	NR2	05/26/16	1033	NR2				
0430	Bowel Management STOOL ASSESSMENT						A	QS		CP
- Document	05/26/16	0800	NR2	05/26/16	1032	NR2				

BM Consistency: Liquid
BM Color: Green
BM Amount: MEDIUM

Comment: SOFT GREENISH/BROWN STOOL PRESENT IN OSTOMY APPLIANCE.

1629	OSA ASSESSMENT						A	QS		CP
- Document	05/26/16	0800	NR2	05/26/16	1033	NR2				

OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955	Anticoagulant Educ Materials Provided						A	QS		CP
- Document	05/26/16	0800	NR2	05/26/16	1040	NR2				

Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990	Post Operative Care - GOALS						A	08,20		CP
- Document	05/26/16	0800	NR2	05/26/16	1040	NR2				

Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/26/16	Time: 0800 (continued)									
6990	Post Operative Care - GOALS (continued)									

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

0840	Positioning						A	QS		CP
- Document	05/26/16	0800	NR2	05/26/16	1032	NR2				
275051	VTE Prophylaxis Orders Complete?						A	08,20		CP
- Document	05/26/16	0800	NR2	05/26/16	1042	NR2				

VTE Prophylaxix Orders Complete? Y

525002	IV THERAPY ASSESSMENT						A	QS		CP
- Document	05/26/16	0800	NR2	05/26/16	1044	NR2				

IV Site Change: Y # Of Attempts: 1 IV Tube Change: Y IV DISCONTINUED

IV Site #1:	RIGHT ANTECUBITAL SPACE	IV Site #3:
Site Appear #1:	NORMAL	Site Appear #3:
Type of Cath #1:	Jelco	Type of Cath #3:
Cath Gauge #1:	20	Cath Gauge #3:
Fluid/Rate #1:	SL	Fluid/Rate #3:
Date Insert/DC #1:	05/26/16	Date Insert/DC #3:
IV #1 Comment:	C/D/I, IV ANTIBIOTICS INFUSING AT SCHEDULED TIMES, OTHERWISE SL, FLUSHES WELL	IV #3 Comment: <Esc>
IV Site #2:		IV Site #4:
Site Appear #2:		Site Appear #4:
Type of Cath #2:		Type of Cath #4:
Cath Gauge #2:		Cath Gauge #4:
Fluid/Rate #2:		Fluid/Rate #4:
Date Insert/DC #2:		Date Insert/DC #4:
IV #2 Comment:		IV #4 Comment:

5A4D43B46E1042958BC8, KNIGHT, 423

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Comment	Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

525002 IV THERAPY ASSESSMENT (continued)

<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP

- Document 05/26/16 0800 NR2 05/26/16 1040 NR2

Neurological WNL: Y WNLto include: Alert and orientad to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Equal
Size Left+: 3mm
Lt Reaction To Light+: Reactive
Equal

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Site:

Behavior+: Calm/Cooperative

Speech/Cry+: Clear

Vision Impairment: GLASSES
Hearing Impairment: NONE

Responsive To+: Spontaneous

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code

Bracelet: N Sticker: N
Comfort Measures Only NA

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency	Comment	Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate: 93

Pacemaker: N Defibrillator: N

Dizziness/Syncope+:

Palpitations: N

JVD+: Flat

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+:	Normal	Femoral Rt+:	
Dorsalis Rt+:	Normal	Femoral Lt+:	
Post Tib Lt+:	Normal		
Post Tib Rt+:	Normal	Cap Refill RUE+:	Brisk
Carotid Rt+:		Cap Refill LUE+:	Brisk
Carotid Lt+:		Cap Refill RLE+:	Brisk
Brachial Rt+:	Normal	Cap Refill LLE+:	Brisk
Brachial Lt+:	Normal		
Radial Rt+:	Normal		
Radial Lt+:	Normal		

Cardio Comment <Esc>: PT DENIES C/O CHEST PAIN OR DISCOMFORT

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 99 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+: Productive
Sputum Amount+: Moderate
Sputum Consistency+: Thick
Sputum Color+: Beige
Airway+: Patent
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

Lung Sounds: PT CLEAR THROUGHOUT
Profile ANTERIOR AND POSTERIOR

COPD Educational Video:

5A4D43B46E1042958BC8, KNIGHT, 424

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

WITH DIMINISHED BASES

Resp Comment <Esc>: PT RESPIRATORY EFFORT BETTER TODAY, DENIES SOB, BASES DIMINISHED BUT OTHERWISE CLEAR THROUGHOUT
Cyanosis: N
Pallor: N

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>: AMBULATION ENCOURAGED WITH ASSISTANCE, TIRES EASILY, USES WALKER WITH ASSIST

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>: WOUND VAC ON AND SUCTIONING AT 125, DRAINING SEROSANGUINOUS DRAINAGE
Is Pt At Risk For Immobility Or Skin Breakdown: Y

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score
Completely Limited:

Activity Score
Bedfast:

Nutrition Score
Very Poor:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Very Limited:
Slightly Limited:
No Impairment: 4

Chairfast:
Walks Occasionally: 3
Walks Frequently:

Probably Inadequate:
Adequate: 3
Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited: 3
No Limitations:

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
Constipation: N
Diarrhea: N
By C-Diff Protocol - Watery loose stool: N

Last BM: 05/26/16
Stool Amount+: Moderate
Stool Color+: Greenish Brown
Stool Consistency+: Liquid
Incontinent Stool: N

Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: ROUND SOFT

GI Comment <Esc>: OSOTMY C/D/I, GOOD SEAL, STOMA RED AND BEEFY, APPEARS HEALTHY, WILL CONTINUE TO MONITOR

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N

Currently Menses:
LMP:
Prostate Problems: N

Urine Color+: Yellow
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N
Suprapubic Catheter: N

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:

5A4D43B46E10429588C8, KNIGHT, 425

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Last Dialysis Treatment:

GU Comment <Esc>: PT USES URINAL, DENIES GU COMPLAINTS

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: 6 pain management this shift: 5
Pain Location+: ABDOMINAL
Patient Sleeping:
Quality Of Pain+: SORE Sleeping Resp:
Respiratory Quality:
Onset/Duration: POST-OP/INTERMITTENT Respiratory Depth:
Pain Med Given<Esc>: SEE MAR

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: PT STATES PAIN IS BETTER CONTROLLED TODAY, WILL CONTINUE TO MONITOR

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: Y Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION:
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/26/16 0800 NR2 05/26/16 1040 NR2
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/26/16 0800 NR2 05/26/16 1040 NR2
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

7370 Discharge Planning Assessment (continued)
Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/26/16 0800 NR2 05/26/16 1042 NR2
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking 1
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs

5A4D43B46E10429588C8, KNIGHT, 426

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

9610 Fall Risk Assessment/Interventions (continued)

No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 13

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P Y
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment: AMULATES WELL WITH ASSIST, USES WALKER

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A Q8 CP
- Document 05/26/16 0800 NR2 05/26/16 1032 NR2
Temperature: 98.3
Temperature Source+: Oral
Pulse: 70
Respirations: 18
Blood Pressure: 109/60
MAP: 101

(May use most recent VITAL SIGNS taken if they are WNL and no greater than 3hrs)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 0800 (continued)

99 SEPSIS Documentation (continued)
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

Physician Notified:
If NO, Reason:

Activity Date: 05/26/16 Time: 0915

Patient Notes: Nursing Notes
- Create 05/26/16 0915 NR2 05/26/16 1144 NR2
Abnormal? N Confidential? N
PT RESTING IN BED EYES OPEN, ASSESSMENTS COMPLETED, AM MEDS GIVEN. IV SITE TO RIGHT A/C CHANGED BY THIS RN TO RIGHT CEPHALIC VEIN, 20 GAUGE JELCO, IV ANTIBIOTIC INFUSING, SITE C/D/I. PT RECEIVED PAIN MEDS WITH AM MEDS, WILL CONTINUE TO MONITOR. CALL BELL AND PHONE IN REACH, BED LOCKED FOR SAFETY, WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 05/26/16 Time: 1000

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/26/16 1000 GM 05/26/16 1119 GM
Temperature: 99.2
Temperature Source+: Oral
Pulse: 90
Pulse Source+: MONITOR
Respirations: 20
Blood Pressure: 103/86
BP Location+: L Arm
BP Position+: SITTING
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/26/16 Time: 1030

Patient Notes: Nursing Notes
- Create 05/26/16 1030 NR2 05/26/16 1144 NR2
Abnormal? N Confidential? N
PT UP WITH PT, AMBULATING WELL IN HALLS WITH ASSISTANCE FROM WALKER

5A4D43B46E10429588C8, KNIGHT, 427

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 1030 (continued)

Patient Notes: Nursing Notes (continued)
Note Type Description
No Type None

Activity Date: 05/26/16 Time: 1120 (continued)

25 PT: Daily Documentation (continued)
- Document 05/26/16 1120 JW 05/26/16 1253 JW

S: Pt in bed, reports no new c/o

Press ESC to get out of text boxes.

O: Performed supine to sit to stand with CGAX1
GT amb ~ 250' with RW and CGAX1
Stand to sit to supine with CGAx1

A: Pt amb and transferring well with little assistance today.

P: Cont POC

Activity Date: 05/26/16 Time: 1144

Patient Notes: Nursing Notes
- Create 05/26/16 1144 NR2 05/26/16 1147 NR2
Abnormal? N Confidential? N
PT RESTING IN BED WITH EYES CLOSED, AROUSES EASILY. DENIES NEEDS AT THIS TIME, BED LOCKED FOR SAFETY, CALL BELL AND PHONE IN REACH, WILL CONTINUE TO MONITOR
Note Type Description
No Type None

Activity Date: 05/26/16 Time: 1244

Patient Notes: Nursing Notes
- Create 05/26/16 1244 PS 05/26/16 1244 PS
Abnormal? N Confidential? N
D. PT C/O ACID REFLUX, MEDICATED WITH 30CC MAALOX.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/26/16 Time: 1334

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/26/16 1334 FS 05/26/16 1335 FS
RESPIRATORY THERAPY TREATMENT

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 1334 (continued)

09 RESP THERAPY - TREATMENT (continued)
%/L of O2: 0 LPM NC O2 Sat: 96 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 78 Pre-Assessment RR: 14

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 78 Post-Assessment RR: 14

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: N Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2 Y

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

5A4D43B46E10429588C8, KNIGHT, 428

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 1334 (continued)

09 RESP THERAPY - TREATMENT (continued)
METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/26/16 Time: 1358

Patient Notes: CASE MGT/SOCIAL WORK SVS NOTES
- Create 05/26/16 1358 JB* 05/26/16 1358 JB*
Abnormal? N Confidential? N
RCI HAS APPROVED HOME WOUND VACC. WILL BE PLACED DAY OF DISCHARGE.
Note Type Description
No Type None

Activity Date: 05/26/16 Time: 1400

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/26/16 1400 GM 05/26/16 1432 GM
Temperature: 99.3
Temperature Source+: Oral
Pulse: 95
Pulse Source+: MONITOR
Respirations: 20
Blood Pressure: 100/65
BP Location+: L Arm
BP Position+: SITTING
Weight (lbs):
(Oz):
kg:
Weight Source:

02 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/26/16 Time: 1406

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/26/16 1406 PS 05/26/16 1406 PS

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 1406 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door

5A4D43B46E1042958C8, KNIGHT, 429

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 1406 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/26/16 Time: 1600

1663	IPC, TED, VFP Documentation	A	04,16	CP
- Document	05/26/16 1600 NR2 05/26/16 1641 NR2			
IPC: R				
TED Hose: N				
Venous Foot Pump: N				
3592	TED/HEEL PROTECTORS/IPC Skin Assessment	A	04,16	CP
- Document	05/26/16 1600 NR2 05/26/16 1642 NR2			

TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. REF

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

800001	Education/Teaching Assessment	A	04,16	CP
- Document	05/26/16 1600 NR2 05/26/16 1642 NR2			

Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if Comment

Instructional video shown?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 1600 (continued)

800001 Education/Teaching Assessment (continued)
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
ACTIVITY
MEDS
TX

Material Codes: VERBAL

Comment: UNDERSTANDS

Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/26/16 Time: 1619

Patient Notes: Wound Care Note
- Create 05/26/16 1619 KM 05/26/16 1620 KM
Abnormal? N Confidential? N
VISITED PT AND CHECKED POUCHING SYSTEM FOR LEAKS. NO LEAKS. TO BE CHANGED TOMORROW AFTERNOON BY PT AND SPOUSE. THEY ARE AWARE AND I WILL BE THERE IN THE AFTERNOON. PT'S NURSE NOTIFIED AS WELL.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 430

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/26/16 Time: 1823

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/26/16 1823 GM 05/26/16 1824 GM
Temperature: 99.8
Temperature Source+: Oral
Pulse: 90
Pulse Source+: MONITOR
Respirations: 20
Blood Pressure: 112/67
BP Location+: L Arm
BP Position+: SITTING
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 94 Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/26/16 Time: 1827

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/26/16 1827 NR2 05/26/16 1827 NR2
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/26/16 Time: 1827 (continued)

6991 Post Operative Care - OUTCOMES (continued)

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
1160 Nutritional Monitoring A 18 CP
- Document 05/26/16 1827 NR2 05/26/16 1827 NR2
Diet Ordered: REGULAR
Meal: BREAKFAST, LUNCH, DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement: PROTSTAT
PO Supplement: 30 cc (Total Intake)

Comment:
150005 Intake/Output A 06,18 CP
- Document 05/26/16 1827 NR2 05/26/16 1830 NR2
INTAKE
PO: 1882 IV: 20 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 700 Bladder Incont Episodes: Emesis: Colostomy: 600
Foley: Bowel Incont Episodes: T Tube: Ileostomy:
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 5 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/26/16 1827 NR2 05/26/16 1830 NR2
IV Site WNL: Y If No:

Comment:

5A4D43B46E1042958BC8, KNIGHT, 431

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 1027 (continued)

525003 IV Site Check (continued)

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5500010 Rounds Surveillance A 06,18 CP
- Document 05/26/16 1827 NR2 05/26/16 1830 NR2

Activity Date: 05/26/16 Time: 1900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/26/16 1900 JL 05/26/16 2124 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/26/16 Time: 1912

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/26/16 1912 MG* 05/26/16 1929 MG*
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From MELISSA,RN/NATALIE,RN

Comment

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/26/16 Time: 1912

Patient Notes: Nursing Notes
- Create 05/26/16 1912 MG* 05/26/16 1951 MG*
Abnormal? N Confidential? N
RESTING IN BED, AWAKE AND ALERT. NO C/O PAIN AT PRESENT. WOUND VAC TO ABD WOUND, ON, SUCTIONING AT 125 MMHG. JP INTACT AND COMPRESSED, SMALL AMOUNT SEROUS DRAINAGE NOTED. ILEOSTOMY APPLIANCE INTACT, GREENISH DRAINAGE NOTED. IV ABX INFUSING VIA 20G TO RIGHT AC. NAD NOTED. CALL BELL IN REACH.
Note Type Description
No Type None

Activity Date: 05/26/16 Time: 1915

Patient Notes: Nursing Notes
- Create 05/26/16 1915 NR2 05/26/16 1916 NR2
Abnormal? N Confidential? N
PT RESTING IN BED, REPORT GIVEN TO MELISSA, RN. PT FOOD CAME UP LATE, BUT DID ARRIVE, MAALOX DID HELP SO THE PT ATE WELL FOR DINNER. IV FLAGYL INFUSING AT 100 ML/HR, WILL BE COMPLETED SHORTLY. BED LOCKED CALL BELL AND PHONE IN REACH
Note Type Description
No Type None

Activity Date: 05/26/16 Time: 2000

1699 Prostat Supplement A 08,20 OE
- Document 05/26/16 2000 MG* 05/26/16 2341 MG*
Prostat given: Y

Comment:
3140 Airway Management A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2341 MG*
3440 Incision Site Care A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2341 MG*
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/26/16 2000 MG* 05/26/16 2341 MG*
BM Consistency: Liquid
BM Color: Green
BM Amount: MEDIUM

Comment: SOFT GREENISH STOOL PRESENT IN OSTOMY APPLIANCE.
1629 OSA ASSESSMENT A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2341 MG*
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

5A4D43B46E10429588C8, KNIGHT, 432

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

1629 OSA ASSESSMENT (continued)

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2348 MG*
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS A 08,20 CP
- Document 05/26/16 2000 MG* 05/26/16 2348 MG*
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

6990 Post Operative Care - GOALS (continued)

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note:
0840 Positioning A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2341 MG*
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/26/16 2000 MG* 05/26/16 2350 MG*
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2350 MG*
IV Site Change: Y # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT ANTECUBITAL SPACE IV Site #3:
Site Appear #1: NORMAL Site Appear #3:
Type of Cath #1: Jelco Type of Cath #3:
Cath Gauge #1: 20 Cath Gauge #3:
Fluid/Rate #1: SL Fluid/Rate #3:
Date Insert/DC #1: 05/26/16 Date Insert/DC #3:
IV #1 Comment: IV #3 Comment:
<Esc> <Esc>

IV Site #2: IV Site #4:
Site Appear #2: Site Appear #4:
Type of Cath #2: Type of Cath #4:
Cath Gauge #2: Cath Gauge #4:
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2348 MG*
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Reactive
Equal
Size Left+: 3mm
Lt Reaction To Light+: Reactive
Equal

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative

Site:

Speech/Cry+: Clear

Vision Impairment: GLASSES
Responsive To+: Spontaneous
Hearing Impairment: NONE

5A4D43B46E10429588C8, KNIGHT, 433

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate: Pacemaker: N Defibrillator: N

Dizziness/Syncope+: Palpitations: N

JVD+: Flat

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
IPC: R
Pitting: Pitting: Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal Femoral Rt+:
Dorsalis Rt+: Normal Femoral Lt+:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal

Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 92 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+:
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

COPD Educational Video:

Breath Sounds

LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

Lung Sounds: PT CLEAR THROUGHOUT
Profile ANTERIOR AND POSTERIOR WITH DIMINISHED BASES

Resp Comment <Esc>:

Cyanosis: N
Pallor: N

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized Paralysis+:

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER

5A4D43B46E1042958BC8, KNIGHT, 434

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+:
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE
Dress Appear #1: C/D/I
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>: WOUND VAC ON AND SUCTIONING AT 125 MMHG CONTINUOUSLY

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited: 3	Walks Occasionally: 3	Adequate: 3
No Impairment:	Walks Frequently:	Excellent:

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist: 4	No Limitations:	

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/26/16
Emesis: N Diarrhea: N Stool Amount+: Moderate

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

By C-Diff Protocol - Watery loose stool: N

Stool Color+: Greenish
Stool Consistency+: Liquid
Incontinent Stool: N

Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N

Currently Menses:
LMP:
Urine Color+: Amber
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N
Suprapubic Catheter: N
Prostate Problems: N

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT pain management this shift: 5
Pain Scale: 6
Pain Location+: ABDOMINAL
Quality Of Pain+: SORE
Onset/Duration: POST-OP/INTERMITTENT
Pain Med Given<Esc>:

SEE MAR

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

Pain Comment<Esc>:

Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

CONTINUE TO MONITOR

5A4D43B46E10429588C8, KNIGHT, 435

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: Y	Language: N	Visual: Y	Motivation: N	Cultural: N	Cognitive: N
Reading: N	Age Related: N	Auditory: N	Emotional: Y	Religious: N	Finances: N

EDUCATION/INTERVENTION: POC, PAIN CONTROL, TREATMENTS

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2348 MG*
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370 Discharge Planning Assessment A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2348 MG*

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N - Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

7370 Discharge Planning Assessment (continued)
Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2350 MG*

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 3

*****Interventions*****
Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y

5A4D43B46E10429588C8, KNIGHT, 436

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/26/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/26/16 2000 MG* 05/26/16 2341 MG*
Temperature: 100.2
Temperature Source+: Oral
Pulse: 86
Respirations: 18
Blood Pressure: 92/52
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk
Physician Notified: N
If NO, Reason: Physician Already Aware

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Activity Date: 05/26/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/26/16 2100 JL 05/26/16 2124 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/26/16 Time: 2100 (continued)

5500011 Purposeful Rounding (continued)
Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/26/16 Time: 2142

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/26/16 2142 JL 05/26/16 2142 JL
Temperature: 100.2
Temperature Source+: Oral
Pulse: 86
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 92/52
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 92
Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/26/16 Time: 2300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/26/16 2300 JL 05/26/16 2334 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/27/16 Time: 0100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 0100 JL 05/27/16 0114 JL
Pain
Potty

5A4D43B46E1042958C8, KNIGHT, 437

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0100 (continued)

5500011 Purposeful Rounding (continued)
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/27/16 Time: 0155

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/27/16 0155 MG* 05/27/16 0259 MG*

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0155 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing
*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 0

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/27/16 Time: 0200

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/27/16 0200 JL 05/27/16 0217 JL
Temperature: 99.1
Temperature Source+: Oral

5A4D43B46E10429588C8, KNIGHT, 438

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0200 (continued)

6680 Vital Signs (continued)
Pulse: 78
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 101/60
BP Location+: L Arm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 94 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/27/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 0300 LW8 05/27/16 0559 LW8
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/27/16 Time: 0427

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/27/16 0427 MG* 05/27/16 0427 MG*
IPC: R
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/27/16 0427 MG* 05/27/16 0427 MG*
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0427 (continued)

3592 TED/HEEL PROTECTORS/IPC Skin Assessment (continued)
Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/27/16 0427 MG* 05/27/16 0427 MG*
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ Instructional video shown?
pamphlet: HEART FAILURE CONTROL PLAN; includes activity,
diet, physician follow-up, medications, what to do if Comment
symptoms worsen and weight monitoring instructions.

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY CP
BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/27/16 Time: 0434

150005 Intake/Output A 06,18 CP
- Document 05/27/16 0434 MG* 05/27/16 0434 MG*
INTAKE

5A4D43B46E10429588C8, KNIGHT, 439

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0434 (continued)

150005 Intake/Output (continued)

PO: IV: Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT

Void (ml): 400 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 350
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

Activity Date: 05/27/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 0500 LW8 05/27/16 0559 LW8
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/27/16 Time: 0550

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/27/16 0550 MG* 05/27/16 0623 MG*
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0550 (continued)

6991 Post Operative Care - OUTCOMES (continued)
Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
525003 IV Site Check A 06,18 CP
- Document 05/27/16 0550 MG* 05/27/16 0623 MG*
IV Site WNL: Y If No:

Comment: cdi

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Semi-permeable Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Y Dressing changed: Date: Change:
Tenderness of the Site: N BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5A4D43B46E10429588C8, KNIGHT, 440

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/27/16 Time: 0550										
5500010 Rounds Surveillance							A	06,18		CP
- Document	05/27/16	0550	MG*	05/27/16	0623	MG*				
6980 Vital Signs Manual Recheck							A	AD		CP
- Document	05/27/16	0550	MG*	05/27/16	0626	MG*				

Vital Signs Manual Recheck

Temperature:
Temperature Source+:
Pulse:
Pulse Source+:
Respirations:
Blood Pressure: 106/60
BP Location+: L Forearm
BP Position+: SUPINE
O2 Sat:

Notified:
Comment:
Patient Notes: Nursing Notes
- Create 05/27/16 0550 MG* 05/27/16 0630 MG*
Abnormal? N Confidential? N
BP REPORTED AS 85/60, 89/60 BY CNA. MANUALLY RECHECKED, READING IS 106/60. PT REPORTS HE WAS SLEEPING VERY WELL. DENIES ANY DIZZINESS, DIAPHORESIS, SOB, WEAKNESS OR ANY OTHER PROBLEMS THIS AM. RESTING QUIETLY IN BED, WOUND VAC INTACT AND SUCTIONING AT 125 MMHG. JP INTACT AND COMPRESSED, ILEOSTOMY APPLIANCE INTACT, DRAINING GREENISH LIQUID BM. SALINE LOCK INTACT. CALL BELL IN REACH.

Note Type	Description
No Type	None

Activity Date: 05/27/16 Time: 0600

6680 Vital Signs							A	06,10,14,18,22,02		OE
- Document	05/27/16	0600	LW8	05/27/16	0643	LW8				

Temperature: 98.0
Temperature Source+: Oral
Pulse: 81
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 89/60
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change
Activity Date: 05/27/16 Time: 0600 (continued)										
6680 Vital Signs (continued)										

Pt Out of Room: Patient Refused: Nurse Notified: MGODWIN

Activity Date: 05/27/16 Time: 0655

Outcome: ADEQUATE VENTILATION							A			
- Ed Status	05/27/16	0655	JE	05/27/16	0655	JE				C => A
09 RESP THERAPY - TREATMENT							A	RT-Q6H		CP
- Ed Status	05/27/16	0655	JE	05/27/16	0655	JE				C => A
- Document	05/27/16	0655	JE	05/27/16	0656	JE				

RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 95 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 78 Pre-Assessment RR: 14

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 78 Post-Assessment RR: 14

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

5A4D43B46E10429588C8, KNIGHT, 441

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/27/16 Time: 0655 (continued)

09 RESP THERAPY - TREATMENT (continued)

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/27/16 Time: 0700

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 0700 LW8 05/27/16 1004 LW8
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/27/16 0700 PS 05/27/16 0727 PS
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From melissa, godwin rn

Comment

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/27/16 Time: 0720

Patient Notes: Nursing Notes
- Create 05/27/16 0720 PS 05/27/16 0737 PS
Abnormal? N Confidential? N
d. pt resting in bed. orientated +3. wound vac patent at 125cm suction to mid abd. small amt bld drainage to cannister, jp drain to left abd with scant amt serous drainage. ostomy to right abd with green liquid. abd soft, denies any nausea. i/v s/l to right a/c. comfortable at this time. fox on r/a 94%, chest sounds clear, decreased to bases. using i/s with good effort. urinal at bed-side. pt instructed to call for assist as needed. dr. epstein in to see pt. will continue to monitor.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/27/16 Time: 0725

1699 Prostat Supplement A 08,20 OE
- Document 05/27/16 0725 PS 05/27/16 1127 PS
Prostat given: Y

Comment: OFFERED TO PT WHO REFUSED AT AM
MEAL BUT WOULD TAKE LATER
3140 Airway Management A QS CP
- Document 05/27/16 0725 PS 05/27/16 1127 PS
3440 Incision Site Care A QS CP
- Document 05/27/16 0725 PS 05/27/16 1127 PS
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/27/16 0725 PS 05/27/16 1127 PS
BM Consistency:
BM Color:
BM Amount:

Comment: SOFT GREENISH STOOL PRESENT IN OSTOMY APPLIANCE.
1629 OSA ASSESSMENT A QS CP
- Document 05/27/16 0725 PS 05/27/16 1127 PS
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

5A4D43B46E10429588C8, KNIGHT, 442

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/27/16		Time: 0725								
6955 Anticoagulant Educ Materials Provided								A	QS	CP
- Document	05/27/16	0725	PS	05/27/16	1130	PS				
Anticoagulant Educ Material provided to Patient &/or Family? Y										
Comment:										
CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)										
>>>>>>COMPLETE Intervention after Filing<<<<<<										
6990 Post Operative Care - GOALS								A	08,20	CP
- Document	05/27/16	0725	PS	05/27/16	1130	PS				
Post-Operative Care - GOALS										
Patient demonstrates use of Incentive Spirometer: Y										
Goal: 10 X HR										
Patient demonstates technique for splinting incision: Y										
Patient verbalizes understanding of pain scale: Y										
Goal: 5/10										
Pain Scale: NUMERIC										
Patient verbalizes understanding of activity level: Y										
Prescribed activity level: ASSIST										
Patient verbalizes understanding DVT prevention including:										
TEDS N IPC Y Pedal Exercises Y										
Goal: PREVENT DVT'S										
Provide patient with form #2292										
Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y										
Diet: REGULAR										
Patient verbalizes signs/symptoms of infection including:										
Redness Y Swelling Y Discharge Y Temperature Y										
BS Frequency: N/A										
Smoking Status: Never smoker							Nursing Note: N			

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/27/16		Time: 0725								
0840 Positioning								A	QS	CP
- Document	05/27/16	0725	PS	05/27/16	1127	PS				
275051 VTE Prophylaxis Orders Complete?								A	08,20	CP
- Document	05/27/16	0725	PS	05/27/16	1132	PS				
VTE Prophylaxix Orders Complete? Y										
525002 IV THERAPY ASSESSMENT								A	QS	CP
- Document	05/27/16	0725	PS	05/27/16	1132	PS				

IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1:	RIGHT ANTECUBITAL SPACE	IV Site #3:	
Site Appear #1:	NORMAL	Site Appear #3:	
Type of Cath #1:	Protectiv	Type of Cath #3:	
Cath Gauge #1:	20	Cath Gauge #3:	
Fluid/Rate #1:	SL	Fluid/Rate #3:	
Date Insert/DC #1:	05/27/16	Date Insert/DC #3:	
IV #1 Comment:	DRSG INTACT.	IV #3 Comment:	
<Esc>		<Esc>	
IV Site #2:		IV Site #4:	
Site Appear #2:		Site Appear #4:	
Type of Cath #2:		Type of Cath #4:	
Cath Gauge #2:		Cath Gauge #4:	
Fluid/Rate #2:		Fluid/Rate #4:	
Date Insert/DC #2:		Date Insert/DC #4:	
IV #2 Comment:		IV #4 Comment:	
<Esc>		<Esc>	

6650 SHIFT ASSESSMENT (Surveillance)								A	QS	CP
- Document	05/27/16	0725	PS	05/27/16	1130	PS				

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils		***Strength Of Extremities***	
Size Right+:		RUE+:	WNL
Rt Reaction To Light+:		LUE+:	WNL
		RLE+:	WNL
Size Left+:		LLE+:	WNL
Lt Reaction To Light+:			
		Peripheral Sensory Deficit:	
Behavior+:	Calm/Cooperative	Site:	
Speech/Cry+:	Clear		
		Vision Impairment:	GLASSES
Responsive To+:	Spontaneous	Hearing Impairment:	NONE

Mental Status: Alert & Oriented ***Continued On Next Page***

Glasgow Coma Scale

Eye Opening ***Best Verbal Response*** ***Best Motor Responses***

5A4D43B46E10429588C8, KNIGHT, 443

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 0725 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Spontaneously: 4
To Speech:
To Pain:
No Response:

Converses/Oriented: 5
Converses/Disoriented:
Inappropriate Words:
Incomprehensible:
No Response:

Obeys Command: 6
Localizes Pain:
Withdraws To Pain:
Abnormal Flexion:
Abnormal Extension:
No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>:

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code
Bracelet:
Sticker:
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate:

Pacemaker: N Defibrillator: N

Dizziness/Syncope+:

Palpitations: N

JVD+: Flat

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+:
Dorsalis Rt+:
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:

Femoral Rt+:
Femoral Lt+:

Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 0725 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Brachial Rt+:
Brachial Lt+:
Radial Rt+: Normal
Radial Lt+: Normal

Cap Refill LLE+: Brisk

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: O2 Sat: 97 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+:

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+:
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

Lung Sounds: CLEAR
COPD Educational Video:
Profile WITH DIMINISHED BASES

Resp Comment <Esc>:

Cyanosis: N
Pallor: N

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER

Musc-Skel Comment <Esc>: TIRES EASILY.

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

5A4D43B46E10429588C8, KNIGHT, 444

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 0725 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:
Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE 125 CM
Dress Appear #1: C/D/I
Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:
Tubes/Drains: JP DRAIN, OSTOMY. PIV

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited:
No Impairment: 4

Activity Score
Bedfast:
Chairfast:
Walks Occasionally: 3
Walks Frequently:

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate: 3
Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited: 3
No Limitations:

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N Constipation: N Last BM: 05/26/16
Emesis: N Diarrhea: N Stool Amount+:
By C-Diff Protocol - Watery loose stool: N Stool Color+:
Stool Consistency+:
Incontinent Stool: N
Rectal Tube:
Tubes+:
Bowel Sounds
RUQ+: ACTIVE

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 0725 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Tube Drainage:
Tube To Suction:
Stoma Present:
Ostomy Appliance:
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Urine Color+: Amber
Character+: CLEAR
Urine Odor+: Normal
Incontinent Bladder: N
Suprapubic Catheter: N
Currently Menses:
LMP:
Prostate Problems: N
Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>:

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT pain management this shift: 5
Pain Scale: 3
Pain Location+: ABDOMINAL
Quality Of Pain+: SORE
Onset/Duration: POST-OP/INTERMITTENT
Pain Med Given<Esc>: SEE MAR
Patient Sleeping:
Sleeping Resp:
Respiratory Quality:
Respiratory Depth:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>: WILL CONTINUE TO MONITOR.

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College

5A4D43B46E1042958C8, KNIGHT, 445

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0725 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: Y	Language: N	Visual: Y	Motivation: N	Cultural: N	Cognitive: N
Reading: N	Age Related: N	Auditory: N	Emotional: Y	Religious: N	Finances: N

EDUCATION/INTERVENTION: PAIN MEDICATION, DIET, ACTIVITY
7370 Discharge Planning Assessment A QS CP
- Document 05/27/16 0725 PS 05/27/16 1130 PS
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0725

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/27/16 0725 PS 05/27/16 1132 PS
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 8

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use

5A4D43B46E10429588C8, KNIGHT, 446

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0725 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care:

99 SEPSIS Documentation A QS CP
- Document 05/27/16 0725 PS 05/27/16 1126 PS
Temperature: 98.4
Temperature Source+: Oral
Pulse: 94
Respirations: 18
Blood Pressure: 113/72
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: N
If NO, Reason: Protocol in Place

Activity Date: 05/27/16 Time: 0800

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/27/16 0800 PS 05/27/16 1132 PS
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

Activity Date: 05/27/16 Time: 0900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 0900 LW8 05/27/16 1004 LW8
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 0947

Patient Notes: Nursing Notes
- Create 05/27/16 0947 PS 05/27/16 0947 PS
Abnormal? N Confidential? N
D. PT MEDICATED WITH DILAUDID 1MG IV FOR PREVENTIVE PAIN DURING WOUND VAC CHANGE.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/27/16 Time: 1000

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/27/16 1000 LW8 05/27/16 1009 LW8
Temperature: 98.4
Temperature Source+: Oral
Pulse: 94
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 113/72
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 95 Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/27/16 Time: 1015

Patient Notes: Nursing Notes
- Create 05/27/16 1015 PS 05/27/16 1134 PS
Abnormal? N Confidential? N
D. DRSG CHANGED TO MID ABD. WOUND VAC SPONGE REMOVED. WOUND ABOUT 6" LONG, NARROWER AT ENDS, ABOUT 1'2" WIDE, ABOUT 1'2 " DEEP. BEEFY RED. NEW SPONGE APPLIED, SUCTION RESUMED AT 125CM WITH GOOD SUCTION, PT TOLERATED WELL.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/27/16 Time: 1100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 1100 LW8 05/27/16 1109 LW8
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)

5A4D43B46E10429588C8, KNIGHT, 447

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 1100 (continued)

5500011 Purposeful Rounding (continued)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/27/16 Time: 1155

Patient Notes: Nursing Notes
- Create 05/27/16 1155 PS 05/27/16 1237 PS
Abnormal? N Confidential? N
D. PT OOB TO BED-SIDE CHAIR, OSTOMY WITH MOD AMT GREEN LIQUID. JP DRAIN WITH SCANT AMT SEROUS DRAINAGE. WOUND VAC REMAINS PATENT 125CM SUCTION. COMFORTABLE AT THIS TIME. CALL BELL IN REACH.
Note Type Description
Intervention Positioning

Activity Date: 05/27/16 Time: 1251

Patient Notes: CASE MGT/SOCIAL WORK SVS NOTES
- Create 05/27/16 1251 JB* 05/27/16 1254 JB*
Abnormal? N Confidential? N
HOME WOUND VACC PLACED IN PATIENT'S ROOM FOR APPLICATION AT DISCHARGE.
Note Type Description
No Type None

Activity Date: 05/27/16 Time: 1300

5500011	Purposeful Rounding		A	Q2HODD	CP
- Document	05/27/16 1300 LW8	05/27/16 1348 LW8			

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/27/16 Time: 1320

25	PT: Daily Documentation		A		PS
- Document	05/27/16 1320 JW	05/27/16 1500 JW			

S: Pt in bedside chair, reports no new c/o

Press ESC to get out of text boxes.

Problem/Outcome/Intervention Description

Activity Date: 05/27/16 Time: 1320 (continued)

25 PT: Daily Documentation (continued)

O: Performed sit to stand with CGAX1
GT amb ~ 250' with RW and CGAX1
Stand to sit in bedside chair with CGAX1

A: Pt amb and transferring well

P: Pt to go home soon.

Activity Date: 05/27/16 Time: 1327

Patient Notes: Nursing Notes
- Create 05/27/16 1327 PS 05/27/16 1328 PS
Abnormal? N Confidential? N
D. AMBULATED IN HALLWAY WITH WALKER AND MINIMAL ASSIST. PT IN GOOD SPIRITS, TOLERATING WELL. REMAINS IN CHAIR. CALL BELL IN REACH.
Note Type Description
Intervention Positioning

Activity Date: 05/27/16 Time: 1342

6409	FALLS SCREEN - FOLLOW-UP		A	02,14	CP
- Document	05/27/16 1342 PS	05/27/16 1342 PS			

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

5A4D43B46E10429588C8, KNIGHT, 448

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/27/16 Time: 1342 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower, etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/27/16 Time: 1342 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/27/16 Time: 1400

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/27/16 1400 LW8 05/27/16 1428 LW8
Temperature: 98.0
Temperature Source+: Oral
Pulse: 90
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 108/74
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 95 Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/27/16 Time: 1402

09 RESP THERAPY - TREATMENT A RT-Q6H CP
- Document 05/27/16 1402 JE 05/27/16 1404 JE
RESPIRATORY THERAPY TREATMENT

%/L of O2: 0	LPM	NC	O2 Sat: 95	FIO2	VM	PRB	NRB	
O2 24 hrs	CPO in use		BIPAP	I:	E:	RATE:		
R/A Y			NPPV					
Hand Held Nebulizer Install					Metaneb/IPPB Install			
Neb Induced Sputum					Metaneb/IPPB Sub			
HHN Sub Y								
Demo and Eval					Continous Neb 1st Hour			
					Continous Neb Sub			
MDI Install								
MDI Subsequent					Pulse Ox Single			
MDI Additional Tx:					Pulse Ox over-noc			
					Pulse Ox Continuous			

5A4D43B46E1042958C8, KNIGHT, 449

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/27/16 Time: 1402 (continued)

09 RESP THERAPY - TREATMENT (continued)
Incentive Install
Pt Instructed — CPT Initial
Pt Achieves ml — CPT Subsequent
Pt Understands/will use on own — CPT w/Bad:
Pt unable to comprehend or perform TX — Oscillating PEP
Nurse Notified Nurse will follow-up — NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 80 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 78 Post-Assessment RR: 14

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions: N
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/27/16 Time: 1402

Patient Notes: Nursing Notes
- Create 05/27/16 1402 PS 05/27/16 1402 PS
Abnormal? N Confidential? N
D. OSTOMY NURSE AND CHANGED WAFER AND BAG WITH PT AND SPOUSE. PT REMAINS UP IN CHAIR. MEDICATED WITH PERCOLONE 10 MG PO FOR ABD INCISIONAL PAIN.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/27/16 Time: 1414

Patient Notes: Wound Care Note
- Create 05/27/16 1414 KM 05/27/16 1421 KM
Abnormal? N Confidential? N
PT'S SPOUSE PERFORMED POUCHING SYSTEM CHANGE TODAY, WAS ABLE TO TALK THROUGH STEPS. PT VERY ATTENTIVE DURING THIS AND WILL BE ABLE TO DO THIS INDEPENDENTLY - HAS IV IN R ARM IMPINGING HIS ABILITY TO ASSIST MUCH. SKIN INTACT, WNL AROUND STOMA. STOMA PINK, MOIST. PROTRUDES ABOUT 1/2". AREA BETWEEN 6-7 SEPARATED FROM SKIN AND WE EXPRESSED MUCOUS (THIS IS WHERE DR. RIMKUS SAID THE DISTAL END OF THE ILEUM IS AND SHOULD EXPECT THIS). INSTRUCTED PT AND SPOUSE TO BE SURE TO GENTLY RUB THIS AREA TO EXPEL MUCOUS DURING EACH BAG CHANGE. SHE APPLIED A SMALL AMT OF POWDER THERE AND USED CAVILON SPRAY. SMALL AMT OF STOMAHESIVE PAST TO WAFER THAT WILL LAY OVER THAT. PLACED NEW POUCHING SYSTEM ON INDEPENDENTLY. THEY HAVE MY CONTACT INFORMATION IF THEY HAVE ANY CONCERNS OR QUESTIONS.
Note Type Description
No Type None

Activity Date: 05/27/16 Time: 1600

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/27/16 1600 PS 05/27/16 1629 PS
IPC: R
TED Hose: N
Venous Foot Pump: N
3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/27/16 1600 PS 05/27/16 1629 PS
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/27/16 1600 PS 05/27/16 1629 PS
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, Instructional video shown?

5A4D43B46E1042958C8, KNIGHT, 450

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 1600 (continued)

800001 Education/Teaching Assessment (continued)
diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC, DIET, DIS, ACTIVITY, MEDS, TX
Material Codes: VERBAL
Comment: UNDERSTANDS
Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/27/16 Time: 1700

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 1700 JL 05/27/16 1711 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 1700 (continued)

5500011 Purposeful Rounding (continued)

Comment:
<Esc>

Activity Date: 05/27/16 Time: 1800

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/27/16 1800 JL 05/27/16 1801 JL
Temperature: 99.2
Temperature Source+: Oral
Pulse: 87
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 100/62
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 98 Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/27/16 Time: 1814

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/27/16 1814 PS 05/27/16 1815 PS
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

5A4D43B46E10429588C8, KNIGHT, 451

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change	

Activity Date: 05/27/16 Time: 1814 (continued)

6991 Post Operative Care - OUTCOMES (continued)
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: DEMON
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N
1160 Nutritional Monitoring A 18 CP
- Document 05/27/16 1814 PS 05/27/16 1814 PS
Diet Ordered: REGULAR
Meal: BREAKFAST, LUNCH, DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement: PROTSTAT
PO Supplement: 30 cc (Total Intake)

Comment:
150005 Intake/Output A 06,18 CP
- Document 05/27/16 1814 PS 05/27/16 1816 PS
INTAKE
PO: 1200 IV: 200 Blood: TPN: NG Irrigation:
TF Tube: IVPB: 600 Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 800 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 500
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 5 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac: 10

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change	

Activity Date: 05/27/16 Time: 1814 (continued)

150005 Intake/Output (continued)

Comment:
525003 IV Site Check A 06,18 CP
- Document 05/27/16 1814 PS 05/27/16 1816 PS
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Semi-permeable Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Y Dressing changed: Date: Change:
Tenderness of the Site: N BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/27/16 1814 PS 05/27/16 1816 PS

Activity Date: 05/27/16 Time: 1832

Patient Notes: Nursing Notes
- Create 05/27/16 1832 PS 05/27/16 1834 PS
Abnormal? N Confidential? N
D. PT REMAINS UP IN CHAIR. REFUSED OFFER FOR PAIN MEDICATION AT THIS TIME. CALL BELL IN REACH. OSTOMY TO RIGHT ABD INTACT WITH SMALL AMT GREEN LIQUID, JP TO LEFT ABD WITH SCANT AMT SEROUS DRAINAGE. WOUND VAC PATENT TO MID ABD WITH 125CM SUCTION. WILL CONTINUE TO MONITOR.
Note Type Description
Intervention Rounds Surveillance

Activity Date: 05/27/16 Time: 1900

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/27/16 1900 JL 05/27/16 1901 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

5A4D43B46E10429588C8, KNIGHT, 452

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 1900 (continued)

5500011 Purposeful Rounding (continued)

Comment:
<Esc>

Activity Date: 05/27/16 Time: 1922

Patient Notes: Nursing Notes
- Create 05/27/16 1922 PS 05/27/16 1922 PS
Abnormal? N Confidential? N
D. PT ASSISTED BACK TO BED. WOUND VAC PATIENT 125CM SUCTION. PT COMFORTABLE AT THIS TIME. URINAL AT BED-SIDE.
Note Type Description
Intervention Positioning

Activity Date: 05/27/16 Time: 1929

6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/27/16 1929 BG 05/27/16 1929 BG
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Bedside: Y

To/From PAM

Comment

Activity Date: 05/27/16 Time: 1958

Patient Notes: Nursing Notes
- Create 05/27/16 1958 BG 05/27/16 2002 BG
Abnormal? N Confidential? N
CARE ASSUMED FROM DAY NURSE. PT LAYING IN BED. A/O X3. PT RECENTLY MEDICATED FOR PAIN AT RIGHT AKA SITE. RESP EVEN AND UNLABORED. NO OTHER COMPLAINTS VOICED AT THIS TIME. IVF INFUSING AS ORDERED. OPTIFOAM DRESSING TO SACRAL WOUND. BED IN LOWEST POSITION. CALL LIGHT WITHIN REACH. WILL CONTINUE TO MONITOR PT.
Note Type Description
No Type None

Activity Date: 05/27/16 Time: 2000

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/27/16 2000 BG 05/27/16 2221 BG
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+:

Strength Of Extremities
RUE+: WNL

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Rt Reaction To Light+: Normal
Size Left+:
Lt Reaction To Light+: Normal

LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative Site:

Speech/Cry+: Clear

Vision Impairment: GLASSES
Responsive To+: Spontaneous Hearing Impairment: NONE

Mental Status: Alert & Oriented ***Continued On Next Page***

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>: A/O X4

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: Normal

Telemetry Pattern+: SINUS RHYTHM

Pulse Rhythm+: Regular

Heart Rate: Pacemaker: N Defibrillator: N

Dizziness/Syncope+: Palpitations: N

5A4D43B46E1042958C8, KNIGHT, 453

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/27/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

JVD+:

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal
Dorsalis Rt+: Normal
Post Tib Lt+:
Post Tib Rt+:
Carotid Rt+:
Carotid Lt+:
Brachial Rt+:
Brachial Lt+:
Radial Rt+:
Radial Lt+:

Femoral Rt+:
Femoral Lt+:

Cap Refill RUE+: Brisk
Cap Refill LUE+: Brisk
Cap Refill RLE+: Brisk
Cap Refill LLE+: Brisk

Cardio Comment <Esc>: N OCCMPLAINTS OF CP

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 19 O2 Sat: 92 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

COPD Educational Video:

Breath Sounds

LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

Lung Sounds: CLEAR
Profile WITH DIMINISHED BASES

Resp Comment <Esc>: NO SOB NOTED

Cyanosis: N
Pallor: N

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized

Paralysis+:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/27/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Joint Swelling+:

Amputations+:

Muscle Spasms+:

Contractures+:

Deformities+:

Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER

Musc-Skel Comment <Esc>:

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: MIDLINE ABD
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE 125 CM
Dress Appear #1: C/D/I

Wound Site #2:
Wound Appear #2+:
Closure Type #2+:
Dressing Type #2:
Dress Appear #2:

Tubes/Drains: JP DRAIN, OSTOMY. WOUND VAC

Skin Comment <Esc>:

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally:	Adequate:
No Impairment:	Walks Frequently:	Excellent:
Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist:	Slightly Limited:	No Apparent Problem:
Rarely Moist:	No Limitations:	

Total Braden Score:

5A4D43B46E10429588C8, KNIGHT, 454

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/27/16 Time: 2000 (continued)

6650 SKIFT ASSESSMENT (Surveillance) (continued)

If total score is < or = 16, initiate pressure ulcer prevention.

Gastrointestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
Constipation: N
Diarrhea: N
By C-Diff Protocol - Watery loose stool: N
Last BM: 05/27/16
Stool Amount+: Moderate
Stool Color+: Greenish
Stool Consistency+: Liquid
Incontinent Stool: N
Rectal Tube: N
Tubes+: Jackson Pratt
Tube Drainage: N
Tube To Suction: N
Stoma Present: Y
Ostomy Appliance: Y
Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Urine Color+:
Character+:
Urine Odor+:
Incontinent Bladder:
Suprapubic Catheter:
Currently Menses:
LMP:
Prostate Problems:
Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: VOIDING WITHOUT ISSUE

**********PAIN ASSESSMENT**********

Pt C/O Pain:
Pain Scale:
Pain Location+:
Quality Of Pain+:
Acceptable Scale/Goal for EXCELLENT pain management this shift:
Patient Sleeping:
Sleeping Resp: 16

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Comment	Documented Units	From Change

Activity Date: 05/27/16 Time: 2000 (continued)

6650 SKIFT ASSESSMENT (Surveillance) (continued)

Respiratory Quality: WNL
Respiratory Depth: WNL
Onset/Duration:
Pain Med Given<Esc>:

Time Med Given:
Date:
Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed

Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******

Response to Treatment:

Type of Isolation: NONE
Tissue Test: N

PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning

Physical: Y Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: POC, ACTIVITY, SAFETY, PAIN MANAGEMENT

Activity Date: 05/27/16 Time: 2017

1699 Prostat Supplement A 08,20 OE
- Document 05/27/16 2017 BG 05/27/16 2018 BG
Prostat given: N

Comment:
3140 Airway Management A QS CP
- Document 05/27/16 2017 BG 05/27/16 2018 BG
3440 Incision Site Care A QS CP
- Document 05/27/16 2017 BG 05/27/16 2018 BG
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/27/16 2017 BG 05/27/16 2017 BG
BM Consistency: Liquid
BM Color: Green
BM Amount: MEDIUM

Comment: SOFT GREENISH STOOL PRESENT IN OSTOMY.

5A4D43B46E10429588C8, KNIGHT, 455

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 2017

1629 OSA ASSESSMENT — A QS — CP
- Document 05/27/16 2017 BG 05/27/16 2017 BG
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided — A QS — CP
- Document 05/27/16 2017 BG 05/27/16 2018 BG
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS — A 08,20 — CP
- Document 05/27/16 2017 BG 05/27/16 2018 BG
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: 5/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC Y Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/27/16 Time: 2017 (continued)

6990 Post Operative Care - GOALS (continued)

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker

Nursing Note:
0840 Positioning — A QS — CP
- Document 05/27/16 2017 BG 05/27/16 2017 BG
275051 VTE Prophylaxis Orders Complete? — A 08,20 — CP
- Document 05/27/16 2017 BG 05/27/16 2019 BG
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT — A QS — CP
- Document 05/27/16 2017 BG 05/27/16 2020 BG
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1: RIGHT ANTECUBITAL SPACE
Site Appear #1: NORMAL
Type of Cath #1: Protectiv
Cath Gauge #1: 20
Fluid/Rate #1: SL
Date Insert/DC #1: 05/27/16
IV #1 Comment: C/D/I
<Esc>

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:
Fluid/Rate #2:
Date Insert/DC #2:
IV #2 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:
Fluid/Rate #4:
Date Insert/DC #4:
IV #4 Comment:
<Esc>

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) — A QS — CP
- Document 05/27/16 2017 BG 05/27/16 2018 BG
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370 Discharge Planning Assessment — A QS — CP
- Document 05/27/16 2017 BG 05/27/16 2018 BG
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

5A4D43B46E1042958BC8, KNIGHT, 456

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 2017 (continued)

7370 Discharge Planning Assessment (continued)
Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

NEEDS IDENTIFIED:
Home Health: Y
Wound Care: N
Medical Equipment: N
Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/27/16 2017 BG 05/27/16 2019 BG
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking 1
Deconditioning 1
Change in gait pattern 1
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs 0
1-2 within the last 24 hrs 2

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/27/16 Time: 2017 (continued)

9610 Fall Risk Assessment/Interventions (continued)
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing
*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present 2
3 or more present

3-4 within last 24 hrs 4
Additional point for change in medications or dosage within the last 24 hrs 1
****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated 2
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 13

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y
Assess q2hr 7A-7P Y
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate
Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/27/16 2017 BG 05/27/16 2017 BG
Temperature: 99.2
Temperature Source+: Oral
Pulse: 87
Respirations: 18
Blood Pressure: 100/62
MAP: 101
(May use most recent VITAL SIGNS taken if they are WNL and no greater than 3hrs)

5A4D43B46E10429588C8, KNIGHT, 457

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/27/16 Time: 2017 (continued)

99 SEPSIS Documentation (continued)
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 1
Sepsis Result: Low Sepsis Risk

Physician Notified: N
If NO, Reason: Protocol in Place

Activity Date: 05/27/16 Time: 2027

09 RESP THERAPY - TREATMENT A RT-Q6H CP
- Document 05/27/16 2027 AEH 05/27/16 2029 AEH
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 97 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 76 Pre-Assessment RR: 14

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 78 Post-Assessment RR: 16

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/27/16 Time: 2027 (continued)

09 RESP THERAPY - TREATMENT (continued)

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/27/16 Time: 2047

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/27/16 2047 JL 05/27/16 2048 JL
Temperature: 98.8
Temperature Source+: Oral
Pulse: 89
Pulse Source+: BRACHIAL
Respirations: 19
Blood Pressure: 105/75
BP Location+: L Forearm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 92 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

5A4D43B46E10429588C8, KNIGHT, 458

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/27/16		Time: 2100								
5500011 - Document	Purposeful Rounding 05/27/16	2100	JL	05/27/16	2145	JL		A	Q2HODD	
	Pain									
	Potty									
	Position									
	Proximity (phone,bedside table,ice pitcher,call light reach)									
	Personal Needs (anything else you need?)									
	Pick up (tidy room)									
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 05/27/16		Time: 2300								
5500011 - Document	Purposeful Rounding 05/27/16	2300	JL	05/28/16	0026	JL		A	Q2HODD	
	Pain									
	Potty									
	Position									
	Proximity (phone,bedside table,ice pitcher,call light reach)									
	Personal Needs (anything else you need?)									
	Pick up (tidy room)									
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 05/28/16		Time: 0100								
5500011 - Document	Purposeful Rounding 05/28/16	0100	JL	05/28/16	0138	JL		A	Q2HODD	
	Pain									
	Potty									
	Position									
	Proximity (phone,bedside table,ice pitcher,call light reach)									
	Personal Needs (anything else you need?)									
	Pick up (tidy room)									
Purposeful Rounding complete: Y										
Comment: <Esc>										
Activity Date: 05/28/16		Time: 0130								
09 - Document	RESP THERAPY - TREATMENT 05/28/16	0130	AC2	05/28/16	0831	AC2		A	RT-Q6H	
	RESPIRATORY THERAPY TREATMENT									

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/28/16		Time: 0130 (continued)								
CP 09	RESP THERAPY - TREATMENT (continued)									
	%/L of O2: LPM NC						O2 Sat:		FIO2	VM PRB NRB
	O2 24 hrs CPO in use						BIPAP		I:	E: RATE:
	R/A						NPPV			
	Hand Held Nebulizer Install								Metaneb/IPPB Install	
	Neb Induced Sputum								Metaneb/IPPB Sub	
	HHN Sub									
	Demo and Eval								Continous Neb 1st Hour	
									Continous Neb Sub	
	MDI Install									
	MDI Subsequent								Pulse Ox Single	
	MDI Additional Tx:								Pulse Ox over-noc	
									Pulse Ox Continuous	
	Incentive Install									
	Pt Instructed								CPT Initial	
CP	Pt Achieves						ml		CPT Subsequent	
	Pt Understands/will use on own								CPT w/Bed:	
	Pt unable to comprehend or perform TX								Oscillating PEP	
	Nurse Notified Nurse will follow-up								NT Suction	
	MODE: M/P Mask Inline A/C M/AC									
	MEDICATIONS: NEB Medication List								MDI Medication List	
	Medication stable, not discolored, not expired									
	PRE ASSESSMENT: Pre-Assessment HR:								Pre-Assessment RR:	
	PRE BREATH SOUNDS: Clear Wheezing								Stridor Tactile Fremitus	
	Rhonchi Rales								Diminished Audible	
	Comment:									
	Bilateral Right Left Upper Middle Lower									
CP	POST ASSESSMENT: Post-Assessment HR:								Post-Assessment RR:	
	POST BREATH SOUND: Clear Wheezing								Stridor Improvement Noted	
	Rhonchi Rales								Diminished Adverse Reactions:	
	Comment:									
	COUGH Productive: Sputum: Scant Thick Thin Blood Tinged									
	COLOR: White Clear Yellow Brown Green Blood									
	Patient C/O pain? RN Aware RN Notified Adverse Reaction noted									
	Comment <Esc>									
	PATIENT EDUCATION TOPIC:									
	THERAPY: NEB/IPPB MDI CPT/Accapella IS O2									
CP	DISEASE: COPD Asthma Smoking Cessation Meds & Frequency									
	Expected Actions/Side Effects Other									

5A4D43B46E10429588C8, KNIGHT, 459

Problem/Outcome/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/28/16 Time: 0130 (continued)											
09 RESP THERAPY - TREATMENT (continued)											
METHOD OF EDUCATION: Discussion Demonstration Literature											
WHO WAS INSTRUCTED: Patient Family Parent Spouse Name if other than patient											
RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Unable to Comprehend Reinforcement Needed											
Activity Date: 05/28/16 Time: 0143											
6680 Vital Signs - Document	A	05/28/16	0143	JL	05/28/16	0143	JL		A	06,10,14,18,22,02	OE
Temperature: 98.6											
Temperature Source+: Oral											
Pulse: 90											
Pulse Source+: BRACHIAL											
Respirations: 18											
Blood Pressure: 116/69											
BP Location+: L Forearm											
BP Position+:											
Weight (lbs):											
(Oz):											
kg:											
Weight Source:											
O2 Sat: 95 Nursing Note:											
IPI: (Surgical Patients ONLY)											
Pt Out of Room: Patient Refused: Nurse Notified:											
Activity Date: 05/28/16 Time: 0201											
6409 FALLS SCREEN - FOLLOW-UP - Document	A	05/28/16	0201	BG	05/28/16	0201	BG		A	02,14	CP

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

Problem/Outcome/Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency / Documented Units	From Change
Activity Date: 05/28/16 Time: 0201 (continued)											
6409 FALLS SCREEN - FOLLOW-UP (continued)											

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****
Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB

5A4D43B46E10429588C8, KNIGHT, 460

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/28/16 Time: 0201 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Assess q1hr 7P-7A	If OOB to chair, q30min monitoring
Frequent Re-orientation	Assess q1hr 7A-7P
Reinforce Call Light use	Assess q1hr 7P-7A
Bed/Chair Alarm in use	Reinforce Call Light Use
Friction Footwear when OOB	Frequent Re-orientation
In Rm when pt OOB to BSC, BR, Shower,etc.	Bed/Chair Alarm in Use
	Friction Footwear when OOB
	In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/28/16 Time: 0300

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 0300 JL 05/28/16 0630 JL
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/28/16 Time: 0419

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/28/16 0419 BG 05/28/16 0419 BG
IPC: R
TED Hose: N
Venous Foot Pump: N

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/28/16 0419 BG 05/28/16 0419 BG
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/28/16 Time: 0419 (continued)

3592 TED/HEEL PROTECTORS/IPC Skin Assessment (continued)
Comment:

800001 Education/Teaching Assessment A 04,16 CP
- Document 05/28/16 0419 BG 05/28/16 0419 BG
Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/28/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 0500 JL 05/28/16 0630 JL
Pain

5A4D43B46E1042958C8, KNIGHT, 461

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/28/16 Time: 0500 (continued)

5500011 Purposeful Rounding (continued)
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/28/16 Time: 0600

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/28/16 0600 JL 05/28/16 0631 JL
Temperature: 98.7
Temperature Source+: Oral
Pulse: 84
Pulse Source+: BRACHIAL
Respirations: 19
Blood Pressure: 116/64
BP Location+: L Forearm
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 94 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/28/16 Time: 0605

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/28/16 0605 BG 05/28/16 0606 BG
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10 X HR
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/28/16 Time: 0605 (continued)

6991 Post Operative Care - OUTCOMES (continued)
Goal: 5/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC N Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: REFUSING IPC
Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note:
525003 IV Site Check A 06,18 CP
- Document 05/28/16 0605 BG 05/28/16 0606 BG
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:

5A4D43B46E10429588C8, KNIGHT, 462

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/28/16		**Time: 0605**								
5500010 Rounds Surveillance							A	06,18		CP
- Document	05/28/16	0605	BG	05/28/16	0606	BG				
Activity Date: 05/28/16		**Time: 0622**								
150005 Intake/Output							A	06,18		CP
- Document	05/28/16	0622	BG	05/28/16	0624	BG				

INTAKE
PO: 1600 IV: Blood: TPN: NG Irrigation:
TF Tube: IVPB: 150 Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 1700 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 600
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

#1 JP: 50 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

Activity Date: 05/28/16		**Time: 0715**								
5500011 Purposeful Rounding							A	Q2HODD		CP
- Document	05/28/16	0715	DA	05/28/16	0715	DA				

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/28/16		**Time: 0725**								
1699 Prostat Supplement							A	08,20		OE
- Document	05/28/16	0725	PL2	05/28/16	1216	PL2				

Prostat given: Y

Comment: PROVIDED BY DIETARY

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment	Documented Units	From Change
Activity Date: 05/28/16		**Time: 0725**								
3140 Airway Management							A	QS		CP
- Document	05/28/16	0725	PL2	05/28/16	1216	PL2				
3440 Incision Site Care							A	QS		CP
- Document	05/28/16	0725	PL2	05/28/16	1216	PL2				
0430 Bowel Management							A	QS		CP
STOOL ASSESSMENT										
- Document	05/28/16	0725	PL2	05/28/16	1216	PL2				

BM Consistency: Liquid
BM Color: Brown
BM Amount: MEDIUM

Comment: ILEOSTOMY

1629 OSA ASSESSMENT							A	QS		CP
- Document	05/28/16	0725	PL2	05/28/16	1216	PL2				

OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE

6955 Anticoagulant Educ Materials Provided							A	QS		CP
- Document	05/28/16	0725	PL2	05/28/16	1216	PL2				

Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<

6990 Post Operative Care - GOALS							A	08,20		CP
- Document	05/28/16	0725	PL2	05/28/16	1217	PL2				

Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X/HR WHILE AWAKE

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Pain Scale: NUMERIC

5A4D43B46E10429588C8, KNIGHT, 463

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/28/16 Time: 0725 (continued)

6990 Post Operative Care - GOALS (continued)

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC N Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: N/A
Smoking Status: Never smoker Nursing Note: N

0840	Positioning		A	QS	CP
- Document	05/28/16 0725 PL2	05/28/16 1216 PL2			
275051	VTE Prophylaxis Orders Complete?		A	08,20	CP
- Document	05/28/16 0725 PL2	05/28/16 1218 PL2			

VTE Prophylaxix Orders Complete? Y

525002	IV THERAPY ASSESSMENT		A	QS	CP
- Document	05/28/16 0725 PL2	05/28/16 1219 PL2			

IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED N

IV Site #1:	RIGHT ANTECUBITAL SPACE	IV Site #3:
Site Appear #1:	NORMAL	Site Appear #3:
Type of Cath #1:	Protectiv	Type of Cath #3:
Cath Gauge #1:	20	Cath Gauge #3:
Fluid/Rate #1:	SL	Fluid/Rate #3:
Date Insert/DC #1:	05/27/16	Date Insert/DC #3:
IV #1 Comment:	INTACT/FLUSHES WELL	IV #3 Comment:
	<Esc>	<Esc>
IV Site #2:		IV Site #4:
Site Appear #2:		Site Appear #4:
Type of Cath #2:		Type of Cath #4:
Cath Gauge #2:		Cath Gauge #4:
Fluid/Rate #2:		Fluid/Rate #4:
Date Insert/DC #2:		Date Insert/DC #4:
IV #2 Comment:		IV #4 Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/28/16 Time: 0725 (continued)

525002 IV THERAPY ASSESSMENT (continued)
<Esc> <Esc>

6922	Nursing Report (Hand Off)		A	07,19	CP
- Document	05/28/16 0725 PL2	05/28/16 1216 PL2			

****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From P LESLIE RN/ B GORDON RN

Comment

6952	RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)		A	QS	CP
- Document	05/28/16 0725 PL2	05/28/16 1216 PL2			

Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:

7370	Discharge Planning Assessment		A	QS	CP
- Document	05/28/16 0725 PL2	05/28/16 1217 PL2			

==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

5A4D43B46E10429588C8, KNIGHT, 464

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/28/16 Time: 0725 (continued)

7370 Discharge Planning Assessment (continued)

Comment: WILL REASSESS DAILY

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/28/16 0725 PL2 05/28/16 1218 PL2

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist 2
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score: 6

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P Y
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/28/16 Time: 0725 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/28/16 0725 PL2 05/28/16 1215 PL2
Temperature: 98.7
Temperature Source+: Oral
Pulse: 84
Respirations: 19
Blood Pressure: 116/64
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: NA
If NO, Reason:

Patient Notes: Nursing Notes
- Create 05/28/16 0725 PL2 05/28/16 0842 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. PATIENT AAO. REPORT RECEIVED. SATS 94% RA, HR 88. WOUND VAC L OF MIDLINE ABDOMEN INTACT/SUCTION INTACT, JP LLQ INTACT; SCANT CLEAR YELLOW DRAINAGE PRESENT, SCANT REDNESS AT INSERTION SITE. OSTOMY RLQ, DRAINAGE AT WAFER/REINFORCED WITH GAUZE. IV RAV INTACT/SL AT THIS TIME. PATIENT DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.
Note Type Description
Intervention Nursing Report (Hand Off)

Activity Date: 05/28/16 Time: 0728

Patient Notes: Nursing Notes
- Create 05/28/16 0728 BG 05/28/16 0737 BG
Abnormal? N Confidential? N
PT MEDICATED FOR PAIN. LAYING IN BED RESTING. DENIES OTHER NEED AT THIS TIME. OSTOMY, JP, AND WOUND VAC OUTPUT DOCUMENTED. REPORT TO BE GIVEN TO ONCOMING NURSE.
Note Type Description
No Type None

5A4D43B46E10429588C8, KNIGHT, 465

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/28/16 Time: 0810

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/28/16 0810 PL2 05/28/16 1224 PL2

Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils
Size Right+: 3mm
Rt Reaction To Light+: Normal
Size Left+: 3mm
Lt Reaction To Light+: Normal

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:

Behavior+: Calm/Cooperative

Site:

Speech/Cry+: Clear

Vision Impairment: GLASSES
Hearing Impairment: NONE

Responsive To+: Spontaneous

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>: AAOX4

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/28/16 Time: 0810 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Heart Sounds+: S1,S2

Telemetry Pattern+: SINUS RHYTHM

Pulse Rhythm+: Regular

Heart Rate: 87

Pacemaker: N Defibrillator: N

Dizziness/Syncope+:

Palpitations: N

JVD+:

Edema 1+:
Loc 1+:
Pitting:

Edema 2+:
Loc 2+:
Pitting:

TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal	Femoral Rt+:
Dorsalis Rt+: Normal	Femoral Lt+:
Post Tib Lt+:	
Post Tib Rt+:	Cap Refill RUE+: Brisk
Carotid Rt+: Normal	Cap Refill LUE+: Brisk
Carotid Lt+: Normal	Cap Refill RLE+: Brisk
Brachial Rt+:	Cap Refill LLE+: Brisk
Brachial Lt+:	
Radial Rt+: Normal	
Radial Lt+: Normal	

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 94 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

Lung Sounds:
Profile

COPD Educational Video:

Resp Comment <Esc>: PERFORMS I/S WELL. ACAPELLA VALVE BEDSIDE. REPORTS Cyanosis:

5A4D43B46E10429588C8, KNIGHT, 466

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change

Activity Date: 05/28/16 Time: 0810 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

PERFORMS FREQUENTLY. Pallor:

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>: AMBULATING WITH WALKER/ASSIST

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: LEFT OF MIDLINE ABDOMEN
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE 125 CM
Dress Appear #1: C/D/I

Wound Site #2: LLQ JP
Wound Appear #2+:
Closure Type #2+: Suture
Dressing Type #2:
Dress Appear #2: SCANT REDNESS

Tubes/Drains:

Skin Comment <Esc>: ILEOSTOME RLQ, INTACT. SCANT REDNESS AT SACRUM, INTACT
Is Pt At Risk For Immobility Or Skin Breakdown: Y

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score	***Activity Score***	***Nutrition Score***
Completely Limited:	Bedfast:	Very Poor:
Very Limited:	Chairfast:	Probably Inadequate:
Slightly Limited:	Walks Occasionally: 3	Adequate: 3
No Impairment: 4	Walks Frequently:	Excellent:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change

Activity Date: 05/28/16 Time: 0810 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Moisture Score	***Mobility Score***	***Friction & Shear Score***
Constantly Moist:	Completely Immobile:	Problem:
Very Moist:	Very Limited:	Potential Problem:
Occasionally Moist: 3	Slightly Limited: 3	No Apparent Problem: 3
Rarely Moist:	No Limitations:	

Total Braden Score: 19

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
By C-Diff Protocol - Watery loose stool: N
Constipation: N
Diarrhea: N
Last BM: 05/28/16
Stool Amount+:
Stool Color+:
Stool Consistency+:
Incontinent Stool: N

Rectal Tube: N
Tubes+:
Tube Drainage:
Tube To Suction:
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: HYPOACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N

Urine Color+: Amber
Character+: CLEAR
Urine Odor+:
Incontinent Bladder: N
Suprapubic Catheter: N

Currently Menses:
LMP:
Prostate Problems: N

Dialysis
CAPD: N
Peritoneal Dialysis: N
Hemodialysis: N
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: DENIES DYSURIA, VOIDS IN URINAL

5A4D43B46E10429588C8, KNIGHT, 467

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/28/16 Time: 0810 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y Acceptable Scale/Goal for EXCELLENT
Pain Scale: 6 pain management this shift: 4
Pain Location+: ABDOMINAL
Patient Sleeping:
Quality Of Pain+: SHARP Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: Y Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: POC/MEDICATION/SAFETY/DIET/PAIN/ACTIVITY

Activity Date: 05/28/16 Time: 0831

Problem: RT - BRONCHOSPASM/INADEQUATE VENTILATION C
- Ed Status 05/28/16 0831 AC2 05/28/16 0831 AC2 A => C
Outcome: ADEQUATE VENTILATION C
- Ed Status 05/28/16 0831 AC2 05/28/16 0831 AC2 A => C
09 RESP THERAPY - TREATMENT C AD CP
- Ed Status 05/28/16 0831 AC2 05/28/16 0831 AC2 A => C
09 RESP THERAPY - TREATMENT A AD CP
- Ed Directs 05/28/16 0831 AC2 05/28/16 0831 AC2
05/17 2157 AD ==> 05/17 2157 AD
05/19 0630 RT-QID ==> 05/19 0630 RT-QID
05/23 0800 RT-Q6H ==> 05/23 0800 RT-Q6H

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/28/16 Time: 0831 (continued)

09 RESP THERAPY - TREATMENT (continued)
==> 05/28 0831 AD
- Document 05/28/16 0831 AC2 05/28/16 0831 AC2
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List MDI Medication List

Medication stable, not discolored, not expired
PRE ASSESSMENT: Pre-Assessment HR: Pre-Assessment RR:

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: Post-Assessment RR:

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Adverse Reactions:
Comment:
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? RN Aware RN Notified Adverse Reaction noted

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB MDI CPT/Accapella IS O2

5A4D43B46E10429588C8, KNIGHT, 468

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/28/16 Time: 0831 (continued)

09 RESP THERAPY - TREATMENT (continued)

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Demonstration Literature

WHO WAS INSTRUCTED: Patient Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend
Reinforcement Needed

- Document 05/28/16 0831 AC2 05/28/16 0831 AC2
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List MDI Medication List

Medication stable, not discolored, not expired
PRE ASSESSMENT: Pre-Assessment HR: Pre-Assessment RR:

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: Post-Assessment RR:

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Adverse Reactions:
Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From / Change

Activity Date: 05/28/16 Time: 0831 (continued)

09 RESP THERAPY - TREATMENT (continued)
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? RN Aware RN Notified Adverse Reaction noted

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB MDI CPT/Acoapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Demonstration Literature

WHO WAS INSTRUCTED: Patient Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/28/16 Time: 0842

Patient Notes: Nursing Notes
- Create 05/28/16 0842 PL2 05/28/16 0846 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. MEDICATED AS ORDERED. IV RAC FLUSHES WELL, INTACT/DRY; IV ABX INFUSING. ASSESSMENT PERFORMED. SATS 94% RA, HR 87, RR 18. OSTOMY WAFER/BAG REPLACED AT THIS TIME, TOLERATED WELL. PATIENT REPORTS VOIDING WITHOUT COMPLAINTS, URINAL. REPORTS BLOATED SENSATION, MAALOX HELPS. JP INTACT. WOUND VAC ABDOMEN, INTACT. REFUSING SCDS; VERBALIZES UNDERSTANDING. LOVENOX IN USE. REPORTS PT ASST AND PERFORMS MANY LEG EXERCISES HOURLY WHILE IN BED. PERFORMS I/S WELL; USES FREQUENTLY. PATIENT REPORTS UP TO BATHROOM YESTERDAY, TIRES EASILY. PATIENT DENIES ANY NEEDS. ASSISTED WITH TRAY. CALL BELL WITHIN REACH.
Note Type Description
Intervention SHIFT ASSESSMENT (Surveillance)

Activity Date: 05/28/16 Time: 0904

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 0904 DA 05/28/16 0904 DA
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)

5A4D43B46E10429588C8, KNIGHT, 469

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment / Documented Units	From / Change

Activity Date: 05/28/16 Time: 0904 (continued)

5500011 Purposeful Rounding (continued)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/28/16 Time: 0913

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/28/16 0913 DA 05/28/16 0917 DA
Temperature: 98.1
Temperature Source+: Oral
Pulse: 91
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 101/68
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/28/16 Time: 1027

Patient Notes: Nursing Notes
- Create 05/28/16 1027 PL2 05/28/16 1028 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. SPOUSE AND DAUGHTER IN ROOM. MEDICATED AS ORDERED. OSTOMY INTACT, NO LEAKAGE, 150mL EMPTIED. PATIENT ASSISTED TO CHAIR. REPORTS USING WALKER AS NEEDS. DENIES ANY OTHER NEEDS AT THIS TIME. CALL BELL WITHIN REACH.
Note Type Description
No Type None

Activity Date: 05/28/16 Time: 1041

6905 PATIENT BATH A PRN CP
- Document 05/28/16 1041 DA 05/28/16 1042 DA
Hygiene: Assisted Date: 05/28/16
Patient Refused (Bath): Nurse Notified (Bath):

Hygiene Comment:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Frequency / Comment / Documented Units	From / Change

Activity Date: 05/28/16 Time: 1042

6901 PATIENT LINEN CHANGE A PRN CP
- Document 05/28/16 1042 DA 05/28/16 1043 DA
Linen Change 05/28/16

Patient Refused (Linen): Nurse Notified (Linen):

Activity Date: 05/28/16 Time: 1052

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 1052 DA 05/28/16 1052 DA
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/28/16 Time: 1146

Patient Notes: Nursing Notes
- Create 05/28/16 1146 PL2 05/28/16 1147 PL2
Abnormal? N Confidential? N
PATIENT SITTING UP IN CHAIR. MEDICATED FOR PAIN. WOUND VAC INTACT, PLACED TOCHARGE. DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.
Note Type Description
No Type None

Activity Date: 05/28/16 Time: 1301

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 1301 DA 05/28/16 1302 DA
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

5A4D43B46E10429588C8, KNIGHT, 470

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 1348

09 - Document RESP THERAPY - TREATMENT A AD CP
05/28/16 1348 MES 05/28/16 1350 MES

RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 98 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 76 Pre-Assessment RR: 14

PRE BREATH SOUNDS: Clear Y Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 76 Post-Assessment RR: 16

POST BREATH SOUND: Clear Y Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Adverse Reactions:
Comment:
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 1348 (continued)

09 - Document RESP THERAPY - TREATMENT (continued)
DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/28/16 Time: 1405

6409 - Document FALLS SCREEN - FOLLOW-UP A 02,14 CP
05/28/16 1405 PL2 05/28/16 1405 PL2

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics,

5A4D43B46E10429588C8, KNIGHT, 471

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change

Activity Date: 05/28/16 Time: 1405 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach

Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door

Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking:

Patient on Anticoagulants?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change

Activity Date: 05/28/16 Time: 1407

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/28/16 1407 DA 05/28/16 1409 DA
Temperature: 98.1
Temperature Source+: Oral
Pulse: 79
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 88/50
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:
O2 Sat: 98 Nursing Note:
IPI: (Surgical Patients ONLY)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/28/16 Time: 1413

6980 Vital Signs Manual Recheck A AD CP
- Document 05/28/16 1413 DA 05/28/16 1413 DA
Vital Signs Manual Recheck
Temperature:
Temperature Source+:
Pulse:
Pulse Source+:
Respirations:
Blood Pressure: 113/75
BP Location+:
BP Position+:
O2 Sat:
Notified:
Comment:

Activity Date: 05/28/16 Time: 1507

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 1507 JA5 05/28/16 1507 JA5
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

5A4D43B46E10429588C8, KNIGHT, 472

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/28/16 Time: 1507 (continued)

5500011 Purposeful Rounding (continued)
Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/28/16 Time: 1603

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/28/16 1603 PL2 05/28/16 1603 PL2
IPC: R
TED Hose: N
Venous Foot Pump: N

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/28/16 1603 PL2 05/28/16 1603 PL2
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. NA

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:
800001 Education/Teaching Assessment A 04,16 CP
- Document 05/28/16 1603 PL2 05/28/16 1603 PL2
Written Education Materials Provided.
CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:
Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC
DIET
DIS
Material Codes: VERBAL

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/28/16 Time: 1603 (continued)

800001 Education/Teaching Assessment (continued)
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Activity Date: 05/28/16 Time: 1605

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/28/16 1605 PL2 05/28/16 1605 PL2
Temperature: 99.2
Temperature Source+: Oral
Pulse: 102
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 111/62
BP Location+: L Forearm
BP Position+: SITTING
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 98 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/28/16 Time: 1606

Patient Notes: Nursing Notes
- Create 05/28/16 1606 PL2 05/28/16 1607 PL2
Abnormal? N Confidential? N
PATIENT SITTING UP IN CHAIR. AMBULATED HALLS WITH SPOUSE, WALKER IN USE. VITALS OBTAINED. SATS TO 98% RA, STABLE. MEDICATED FOR PAIN AS ORDERED. OSTOMY INTACT. PATIENT PROVIDED WITH WATER AND JUICE. DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.

5A4D43B46E10429588C8, KNIGHT, 473

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 1606 (continued)

Patient Notes: Nursing Notes (continued)
Note Type Description
No Type None

Activity Date: 05/28/16 Time: 1644 (continued)

5500011 Purposeful Rounding (continued)
- Document 05/28/16 1644 DA 05/28/16 1644 DA
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete:

Comment:
<Esc>

Activity Date: 05/28/16 Time: 1653

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/28/16 1653 DA 05/28/16 1658 DA
Temperature:
Temperature Source+:
Pulse:
Pulse Source+:
Respirations:
Blood Pressure:
BP Location+:
BP Position+:
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/28/16 Time: 1700

Patient Notes: Nursing Notes
- Create 05/28/16 1700 PL2 05/28/16 1701 PL2
Abnormal? N Confidential? N
PATIENT UP AMBULATING IN HALL. WALKER/SPOUSE ASSISTING. SPOUSE ASSISTING IN BATH AT THIS TIME. CALL BELL WITHIN REACH.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 1700 (continued)

Patient Notes: Nursing Notes (continued)
Note Type Description
No Type None

Activity Date: 05/28/16 Time: 1855 (continued)

6991 Post Operative Care - OUTCOMES (continued)
- Document 05/28/16 1855 PL2 05/28/16 2043 PL2
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X/HR WHILE AWAKE
Outcome: DEMON

Patient demonstates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC N Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: REFUSE IPC, PEDAL EXERCISES FREQUEN
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: NONE
Smoking Status: Never smoker Nursing Note: N

5A4D43B46E1042958C8, KNIGHT, 474

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/28/16 Time: 1855

1160 Nutritional Monitoring — A 18 — CP
- Document 05/28/16 1855 PL2 05/28/16 2042 PL2
Diet Ordered: REGULAR
Meal: BREAKFAST, LUNCH, DINNER
% Diet Taken: 25% - 50% (FAIR)

Oral Supplement: PROTSTAT
PO Supplement: cc (Total Intake)

Comment:

150005 Intake/Output — A 06,18 — CP
- Document 05/28/16 1855 PL2 05/28/16 2044 PL2

INTAKE

PO: 1920	IV: 400	Blood:	TPN:	NG Irrigation:
TF Tube:	IVPB:	Platelet:	Lipid:	Foley Irrigation (CBI):
TF Flush:		PO Supplement:	FFP:	Dialysis (Intake):

OUTPUT

Void (ml): 1550	Bladder Incont Episodes:	Emesis:	Colostomy:
Foley:	Bowel Incont Episodes:	T Tube:	Ileostomy: 900
Foley (Residual):	Void Episodes:	NG/PEG TUBE:	Urostomy:
SP Catheter:	Stool Episodes:	Duodenal Tube:	Ileoconduit:
	Diapers:	G Tube (Residual):	Liquid Stool:

#1 JP: 10	#1 Chest Tube:	Left Ureteral:	Dialysis (Output):
#2 JP:	#2 Chest Tube:	Right Ureteral:	Thoracentesis:
#3 JP:	#1 Hemovac:	Left Nephrostomy:	Paracentesis:
OTHER:	#2 Hemovac:	Right Nephrostomy:	Wound Vac:

Comment:

525003 IV Site Check — A 06,18 — CP
- Document 05/28/16 1855 PL2 05/28/16 2045 PL2
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N

Dressing Type:	Unused lumens capped, locked, & covered:	
Dressing clean, dry, & intact:	Dressing changed: Date:	Change:
Tenderness of the Site:	BioPatch applied:	
	CAP Changed: Date:	Change:
	IV Tube Change: Date:	Change:
	Huber Needle Size:	

CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/28/16 Time: 1855 (continued)

525003 IV Site Check (continued)
If NO, explain:
5500010 Rounds Surveillance — A 06,18 — CP
- Document 05/28/16 1855 PL2 05/28/16 2045 PL2

Activity Date: 05/28/16 Time: 1900

6922 Nursing Report (Hand Off) — A 07,19 — CP
- Document 05/28/16 1900 TB 05/28/16 1947 TB
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From TRICIA/PRISCILLA

Comment
Patient Notes: Nursing Notes
- Create 05/28/16 1900 TB 05/28/16 2142 TB
Abnormal? N Confidential? N
RECEIVED REPORT FROM PRISCILLA,RN. ASSUMED CARE. PT RESTING IN BED. PT ON R/A. NO S/S DISTRESS. IV TO RIGHT AC C/D/I, ABX INFUSING. JP DRAIN IN PLACE TO LLQ, C/D/I, MILD REDNESS NOTED AROUND INSERTION SITE. WOUND VAC TO MIDLINE ABDOMEN INTACT. ILEOSTOMY IN PLACE TO RLQ, DRAINING GREEN LIQUID STOOL. PT DENIES ANY IMMEDIATE NEEDS. CALLBELL AND PERSONAL BELONGINGS WITHIN REACH. BED LOW AND LOCKED.

Note Type	Description
No Type	None

Activity Date: 05/28/16 Time: 1925

Patient Notes: Nursing Notes
- Create 05/28/16 1925 PL2 05/28/16 2048 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. OSTOMY RLQ INTACT, 900 OUTPUT TODAY. VOIDING WITHOUT COMPLAINTS. PAIN CONTROLLED AT THIS TIME. WOUND VAC DRESSING CHANGE IN PROGRESS BY C WHITE, RN. IV FLAGYL INFUSING TO RAC, INTACT/DRY. JP DRAIN INTACT TO LLQ. PATIENT AMBULATED HALLS TODAY, WALKER/ASSIST. SATS MAINTAINED MID TO UPPER 90S. PATIENT DENIES ANY OTHER NEEDS AT THIS TIME. PERFORMING I/S FREQUENTLY. CALL BELL WITHIN REACH.

Note Type	Description
No Type	None

Activity Date: 05/28/16 Time: 1928

5500011 Purposeful Rounding — A Q2HODD — CP
- Document 05/28/16 1928 VP2 05/28/16 1928 VP2
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)

5A4D43B46E10429588C8, KNIGHT, 475

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/28/16 Time: 1928 (continued)

5500011 Purposeful Rounding (continued)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/28/16 Time: 1931

Patient Notes: Nursing Notes
- Create 05/28/16 1931 TB 05/29/16 0220 TB
Abnormal? N Confidential? N
PT GIVEN DILAUDID PRIOR TO WOUND VAC DRESSING CHANGE, ADMINISTERED BY CASEY,RN.
Note Type Description
No Type None

Activity Date: 05/28/16 Time: 1943

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/28/16 1943 AEH 05/28/16 1943 AEH
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 98 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction
MODE: N/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 70 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency / Documented Units	From Change

Activity Date: 05/28/16 Time: 1943 (continued)

09 RESP THERAPY - TREATMENT (continued)
Comment:
Bilateral Y Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 72 Post-Assessment RR: 16

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH N Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency
Expected Actions/Side Effects Other

METHOD OF EDUCATION: Discussion Demonstration Literature

WHO WAS INSTRUCTED: Patient Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/28/16 Time: 2000

1699 Prostat Supplement A 08,20 OE
- Document 05/28/16 2000 TB 05/29/16 0201 TB
Prostat given: N

Comment:
3140 Airway Management A QS CP
- Document 05/28/16 2000 TB 05/29/16 0201 TB
3440 Incision Site Care A QS CP
- Document 05/28/16 2000 TB 05/29/16 0201 TB
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/28/16 2000 TB 05/29/16 0201 TB
BM Consistency: Liquid
BM Color: Green
BM Amount: MEDIUM

5A4D43B46E10429588C8, KNIGHT, 476

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

0430 Bowel Management (continued)
Comment: ILEOSTOMY
1629 OSA ASSESSMENT A QS CP
- Document 05/28/16 2000 TB 05/29/16 0201 TB
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE
6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/28/16 2000 TB 05/29/16 0204 TB
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<
6990 Post Operative Care - GOALS A 08,20 CP
- Document 05/28/16 2000 TB 05/29/16 0204 TB
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X/HR WHILE AWAKE

Patient demonstates technique for splinting incision: Y

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC N Pedal Exercises Y
Goal: PREVENT DVT'S

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

6990 Post Operative Care - GOALS (continued)
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: NONE
Smoking Status: Never smoker Nursing Note: N
0840 Positioning A QS CP
- Document 05/28/16 2000 TB 05/29/16 0201 TB
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/28/16 2000 TB 05/29/16 0205 TB
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/28/16 2000 TB 05/29/16 0205 TB
IV Site Change: # Of Attempts: IV Tube Change: IV DISCONTINUED

IV Site #1:	RIGHT ANTECUBITAL SPACE	IV Site #3:
Site Appear #1:	NORMAL	Site Appear #3:
Type of Cath #1:	Protectiv	Type of Cath #3:
Cath Gauge #1:	20	Cath Gauge #3:
Fluid/Rate #1:	SL	Fluid/Rate #3:
Date Insert/DC #1:	05/27/16	Date Insert/DC #3:
IV #1 Comment:		IV #3 Comment:
	<Esc>	<Esc>
IV Site #2:		IV Site #4:
Site Appear #2:		Site Appear #4:
Type of Cath #2:		Type of Cath #4:
Cath Gauge #2:		Cath Gauge #4:
Fluid/Rate #2:		Fluid/Rate #4:
Date Insert/DC #2:		Date Insert/DC #4:
IV #2 Comment:		IV #4 Comment:
	<Esc>	<Esc>

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/28/16 2000 TB 05/29/16 0204 TB
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

Pupils ***Strength Of Extremities***
Size Right+: 3mm RUE+: WNL

5A4D43B46E10429588C8, KNIGHT, 477

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Rt Reaction To Light+: Normal
Size Left+: 3mm
Lt Reaction To Light+: Normal

LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative

Speech/Cry+: Clear

Vision Impairment: GLASSES
Responsive To+: Spontaneous Hearing Impairment: NONE

Mental Status: Alert & Oriented

Continued On Next Page

Glasgow Coma Scale

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>: AAOX4, NO NEURO DEFICITS NOTED

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA

Chest Pain: N If Yes, Document in Pain Assessment Intervention.

Heart Sounds+: S1,S2

Telemetry Pattern+:

Pulse Rhythm+: Regular

Heart Rate: 87 Pacemaker: N Defibrillator: N

Dizziness/Syncope+: Palpitations:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

JVD+:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+:
Pitting: Pitting:

TED Hose: N
IPC: R
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+:	Normal	Femoral Rt+:	
Dorsalis Rt+:	Normal	Femoral Lt+:	
Post Tib Lt+:	Normal		
Post Tib Rt+:	Normal	Cap Refill RUE+:	Brisk
Carotid Rt+:		Cap Refill LUE+:	Brisk
Carotid Lt+:		Cap Refill RLE+:	Brisk
Brachial Rt+:	Normal	Cap Refill LLE+:	Brisk
Brachial Lt+:	Normal		
Radial Rt+:	Normal		
Radial Lt+:	Normal		

Cardio Comment <Esc>: PT DENIES CP/PRESSURE

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.

Respirations: 18 O2 Sat: 97 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL

Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+: Absent
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Diminished
RUL+: Clear
RML+: Clear
RLL+: Diminished

Lung Sounds:
COPD Educational Video: Profile

Resp Comment <Esc>: PERFORMS I/S WELL. ACAPELLA VALVE BEDSIDE. REPORTS PERFORMS FREQUENTLY.

Cyanosis:
Pallor:

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

ROM Limitations+: Generalized Paralysis+:

5A4D43B46E10429588C8, KNIGHT, 478

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Joint Swelling+: Amputations+:

Muscle Spasms+: Contractures+:

Deformities+: Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>: AMBULATING WITH WALKER/ASSIST

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry
Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed:
Decubiti:
Location/Size<Esc>:
Stage+:

Wound Site #1: LEFT OF MIDLINE ABDOMEN
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE 125 CM
Dress Appear #1: C/D/I
Wound Site #2: LLQ JP
Wound Appear #2+:
Closure Type #2+: Suture
Dressing Type #2:
Dress Appear #2: SCANT REDNESS
Tubes/Drains: JP DRAIN, OSTOMY. WOUND VAC

Skin Comment <Esc>: SCANT REDNESS AT SACRUM

Is Pt At Risk For Immobility Or Skin Breakdown:

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited:
No Impairment: 4

Activity Score
Bedfast:
Chairfast:
Walks Occasionally: 3
Walks Frequently:

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate: 3
Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited:
No Limitations: 4

Friction & Shear Score
Problem:
Potential Problem: 2
No Apparent Problem:

Total Braden Score: 20

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
By C-Diff Protocol - Watery loose stool: N
Constipation: N
Diarrhea: N
Last BM: 05/28/16
Stool Amount+:
Stool Color+:
Stool Consistency+:
Incontinent Stool:
Rectal Tube:
Tubes+:
Tube Drainage:
Tube To Suction:
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: HYPOACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>: OSOTMY C/D/I, GOOD SEAL, STOMA RED AND BEEFY, APPEARS HEALTHY, WILL CONTINUE TO MONITOR

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N
Urine Color+: Yellow
Character+:
Urine Odor+:
Incontinent Bladder:
Suprapubic Catheter:
Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD:
Peritoneal Dialysis:
Hemodialysis:
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: DENIES DYSURIA, VOIDS IN URINAL

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y
Pain Scale: 6
Pain Location+: ABDOMINAL
Acceptable Scale/Goal for EXCELLENT pain management this shift: 4
Quality Of Pain+: SHARP
Patient Sleeping: Y
Sleeping Resp: 16

5A4D43B46E1042958BC8, KNIGHT, 479

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)
Respiratory Quality: WNL
Onset/Duration: POST-OP/INTERMITTENT Respiratory Depth: WNL
Pain Med Given<Esc>: SEE EMAR

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: Y Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/28/16 2000 TB 05/29/16 0204 TB
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/28/16 2000 TB 05/29/16 0204 TB
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
HOME HEALTH...WOUND VAC, WALKER

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

7370 Discharge Planning Assessment (continued)
FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....
[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

Comment: WILL REASSESS DAILY
9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/28/16 2000 TB 05/29/16 0205 TB
FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning 1
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt) 9
RN Judgement (4pt)

5A4D43B46E10429588C8, KNIGHT, 480

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented / Comment	Units	From Change

Activity Date: 05/28/16 Time: 2000 (continued)

9610 Fall Risk Assessment/Interventions (continued)

Total Score: 13

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door Y

Assess q2hr 7A-7P Y
Assess q1hr 7P-7A Y
Frequent Re-orientation Y
Reinforce Call Light use Y
Bed/Chair Alarm in use Y
Friction Footwear when OOB Y
In Rm when pt OOB to BSC, BR, Shower,etc. Y

HIGH RISK (>14) RED Sign on door/chart

Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Moderate Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/28/16 2000 TB 05/29/16 0200 TB

Temperature: 98.6
Temperature Source+: Oral
Pulse: 84
Respirations: 18
Blood Pressure: 106/70
MAP: 101
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk

Physician Notified:
If NO, Reason:

(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented / Comment	Units	From Change

Activity Date: 05/28/16 Time: 2100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 2100 VP2 05/28/16 2208 VP2

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/28/16 Time: 2207

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/28/16 2207 VP2 05/28/16 2207 VP2

Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/28/16 Time: 2222

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/28/16 2222 VP2 05/28/16 2223 VP2

Temperature: 98.6
Temperature Source+: Oral
Pulse: 84
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 106/70
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 97 Nursing Note:

IPI: (Surgical Patients ONLY)

5A4D43B46E1042958BC8, KNIGHT, 481

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/28/16 Time: 2222 (continued)

6680 Vital Signs (continued)
Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/29/16 Time: 0033

Patient Notes: Nursing Notes
- Create 05/29/16 0033 TB 05/29/16 0220 TB
Abnormal? N Confidential? N
PT C/O ABDOMINAL PAIN, ADMINISTERED PERCOLONE.
Note Type Description
No Type None

Activity Date: 05/29/16 Time: 0100

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/29/16 0100 VP2 05/29/16 0225 VP2
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/29/16 Time: 0200

6409 FALLS SCREEN - FOLLOW-UP A 02,14 CP
- Document 05/29/16 0200 TB 05/29/16 0205 TB

FALL SCREEN FOLLOW-UP

Recent Fall: N (Falls since last FALL ASSESSMENT)

Condition Changed: N

Change in Meds: N

FALL SCREEN N NOTE: F12 if no Fall Screen necessary!!!

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/29/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs
3-4 within the last 24 hrs
Additional point for change in medications

****Demonstrates Unsafe Behavior*****
None demonstrated
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt)

Total Score:

*****Interventions*****

Bed Wheels Locked
Bed in Low Position
Call Light within reach
Fall assessment completed
Patient needs Assessed q2hr
Environment Assessed Fall Risk
Personal Items within reach

LOW RISK (0-8) GREEN sign on door
Assess q2hr 7A-7P as needed
Assess q1hr 7P-7A as needed
Assist/stand by Ambulation

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.

or dosage within the last 24 hrs
HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use

5A4D43B46E1042958BC8, KNIGHT, 482

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment / Documented Units	From Change

Activity Date: 05/29/16 Time: 0200 (continued)

6409 FALLS SCREEN - FOLLOW-UP (continued)
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Patient on Anticoagulants?

Activity Date: 05/29/16 Time: 0224

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/29/16 0224 VP2 05/29/16 0224 VP2
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/29/16 Time: 0246

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/29/16 0246 VP2 05/29/16 0246 VP2
Temperature: 98.6
Temperature Source+: Oral
Pulse: 83
Pulse Source+: BRACHIAL
Respirations: 17
Blood Pressure: 101/59
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 95 Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment / Documented Units	From Change

Activity Date: 05/29/16 Time: 0400

1663 IPC, TED, VFP Documentation A 04,16 CP
- Document 05/29/16 0400 TB 05/29/16 0422 TB
IPC: R
TED Hose: N
Venous Foot Pump: N

3592 TED/HEEL PROTECTORS/IPC Skin Assessment A 04,16 CP
- Document 05/29/16 0400 TB 05/29/16 0422 TB
TED Hose - removed for skin assessment and reapplied. NA

IPC - removed for skin assessment and reapplied. REF

Heel Protectors - removed for skin assessment and reapplied. NA

Comment:

800001 Education/Teaching Assessment A 04,16 CP
- Document 05/29/16 0400 TB 05/29/16 0422 TB
Written Education Materials Provided.

CHF EDUCATION: N
Patient provided with written discharge instruction booklet/ pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N DVT PE
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

Care/Education Codes: POC Material Codes: VERBAL
DIET
DIS
ACTIVITY
MEDS
TX
Comment: UNDERSTANDS Comment: UNDERSTANDS

EDUCATION/INTERVENTION: ALL CARE EXPLAINED AS PROVIDED. EDUCATED PT ON EMPTYING OSTOMY BAG.

5A4D43B46E10429588C8, KNIGHT, 483

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/29/16 Time: 0400 (continued)

800001 Education/Teaching Assessment (continued)

Outcome: VERBAL

Non-Surgical Open Wound: N Date Began:

New Surgical Flap or Graft: N Date of Surgery: 05/15/16

Patient Notes: Nursing Notes
- Create 05/29/16 0400 TB 05/29/16 0606 TB
Abnormal? N Confidential? N
EMPTIED ILEOSTOMY, 200ML GREENISH STOOL. NO OUTPUT FROM JP DRAIN. WILL CONTINUE TO MONITOR.
Note Type Description
No Type None

Activity Date: 05/29/16 Time: 0500

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/29/16 0500 VP2 05/29/16 0652 VP2
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/29/16 Time: 0550

Patient Notes: Nursing Notes
- Create 05/29/16 0550 TB 05/29/16 0550 TB
Abnormal? N Confidential? N
PT C/O PAIN, ADMINSITERED PERCOLONE
Note Type Description
No Type None

Activity Date: 05/29/16 Time: 0600

6991 Post Operative Care - OUTCOMES A 18,06 CP
- Document 05/29/16 0600 TB 05/29/16 0613 TB
Post Operative Care - OUTCOMES

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X/HR WHILE AWAKE
Outcome: DEMON

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/29/16 Time: 0600 (continued)

6991 Post Operative Care - OUTCOMES (continued)

Patient demonstrates technique for splinting incision: Y
Outcome: DEMON

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Outcome: VERBAL
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST
Outcome: VERBAL

Patient verbalizes understanding DVT prevention including:
TEDS N IPC N Pedal Exercises Y
Goal: PREVENT DVT'S
Outcome: REFUSE IPC, PEDAL EXERCISES FREQUEN
Provide patient with form #2292

Patient verbalizes understanding of adequate nutrition to promote tissue healing. Y
Diet: REGULAR
Outcome: VERBAL

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y
Outcome: VERBAL

BS Frequency: NONE
Smoking Status: Never smoker Nursing Note: N
150005 Intake/Output A 06,18 CP
- Document 05/29/16 0600 TB 05/29/16 0614 TB
INTAKE
PO: 360 IV: 200 Blood: TPN: NG Irrigation:
TF Tube: IVPB: Platelet: Lipid: Foley Irrigation (CBI):
TF Flush: PO Supplement: FFP: Dialysis (Intake):

OUTPUT
Void (ml): 700 Bladder Incont Episodes: Emesis: Colostomy:
Foley: Bowel Incont Episodes: T Tube: Ileostomy: 400
Foley (Residual): Void Episodes: NG/PEG TUBE: Urostomy:
SP Catheter: Stool Episodes: Duodenal Tube: Ileoconduit:
Diapers: G Tube (Residual): Liquid Stool:

5A4D43B46E10429588C8, KNIGHT, 484

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/29/16 Time: 0600 (continued)

150005 Intake/Output (continued)
#1 JP: 0 #1 Chest Tube: Left Ureteral: Dialysis (Output):
#2 JP: #2 Chest Tube: Right Ureteral: Thoracentesis:
#3 JP: #1 Hemovac: Left Nephrostomy: Paracentesis:
OTHER: #2 Hemovac: Right Nephrostomy: Wound Vac:

Comment:

525003 IV Site Check A 06,18 CP
- Document 05/29/16 0600 TB 05/29/16 0614 TB
IV Site WNL: Y If No:

Comment:

Central Line, PICC, Mediport Maintenance Checklist
Does Pt have Central Line, Picc, Dialysis Cath or Mediport? N
Dressing Type: Unused lumens capped, locked, & covered:
Dressing clean, dry, & intact: Dressing changed: Date: Change:
Tenderness of the Site: BioPatch applied:
CAP Changed: Date: Change:
IV Tube Change: Date: Change:
Huber Needle Size:
CHG Bath given: If no, Reason: Date:
(CHG Bath required for All PICC, Mediport, Central Line, Dialysis Catheter Patients.)
Change transparent dressing every 7 days or if dressing damp, loosened or soiled.

Was Central Line removal discussed with physician daily?
If NO, explain:
5500010 Rounds Surveillance A 06,18 CP
- Document 05/29/16 0600 TB 05/29/16 0614 TB

Activity Date: 05/29/16 Time: 0605

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/29/16 0605 VP2 05/29/16 0705 VP2
Temperature: 98.7
Temperature Source+: Oral
Pulse: 86
Pulse Source+: BRACHIAL
Respirations: 18
Blood Pressure: 96/63
BP Location+:
BP Position+: SUPINE
Weight (lbs):
(Oz):
kg:
Weight Source:

O2 Sat: 96 Nursing Note:

IPI: (Surgical Patients ONLY)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From Change

Activity Date: 05/29/16 Time: 0605 (continued)

6680 Vital Signs (continued)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/29/16 Time: 0700

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/29/16 0700 EW 05/29/16 0759 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
Patient Notes: Nursing Notes
- Create 05/29/16 0700 TB 05/29/16 0805 TB
Abnormal? N Confidential? N
PT RESTING COMFORTABLY. NO S/S DISTRESS. NO CHANGES NOTED DURING SHIFT.
CALLBELL WITHIN REACH. BED LOW AND LOCKED.
Note Type Description
No Type None

Activity Date: 05/29/16 Time: 0713

09 RESP THERAPY - TREATMENT A AD CP
- Document 05/29/16 0713 MES 05/29/16 0714 MES
RESPIRATORY THERAPY TREATMENT

%/L of O2: LPM NC O2 Sat: 98 FIO2 VM PRB NRB
O2 24 hrs CPO in use BIPAP I: E: RATE:
R/A Y NPPV
Hand Held Nebulizer Install Metaneb/IPPB Install
Neb Induced Sputum Metaneb/IPPB Sub
HHN Sub Y
Demo and Eval Continous Neb 1st Hour
Continous Neb Sub
MDI Install
MDI Subsequent Pulse Ox Single
MDI Additional Tx: Pulse Ox over-noc
Pulse Ox Continuous
Incentive Install
Pt Instructed CPT Initial
Pt Achieves ml CPT Subsequent
Pt Understands/will use on own CPT w/Bed:
Pt unable to comprehend or perform TX Oscillating PEP
Nurse Notified Nurse will follow-up NT Suction

5A4D43B46E10429588C8, KNIGHT, 485

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0713 (continued)

09 RESP THERAPY - TREATMENT (continued)
MODE: M/P Y Mask Inline A/C M/AC

MEDICATIONS: NEB Medication List A/A MDI Medication List

Medication stable, not discolored, not expired Y
PRE ASSESSMENT: Pre-Assessment HR: 76 Pre-Assessment RR: 16

PRE BREATH SOUNDS: Clear Wheezing Stridor Tactile Fremitus
Rhonchi Rales Diminished Y Audible
Comment:
Bilateral Right Left Upper Middle Lower

POST ASSESSMENT: Post-Assessment HR: 76 Post-Assessment RR: 16

POST BREATH SOUND: Clear Wheezing Stridor Improvement Noted
Rhonchi Rales Diminished Y Adverse Reactions:
Comment:
COUGH Productive: Sputum: Scant Thick Thin Blood Tinged

COLOR: White Clear Yellow Brown Green Blood
Patient C/O pain? N RN Aware RN Notified Adverse Reaction noted N

Comment
<Esc>

PATIENT EDUCATION TOPIC:

THERAPY: NEB/IPPB Y MDI CPT/Accapella IS O2

DISEASE: COPD Asthma Smoking Cessation Meds & Frequency Y
Expected Actions/Side Effects Y Other

METHOD OF EDUCATION: Discussion Y Demonstration Literature

WHO WAS INSTRUCTED: Patient Y Family Parent Spouse
Name if other than patient

RESPONSE TO EDUCATION: Patient Knowledgeable of Topic Y
Unable to Comprehend
Reinforcement Needed

Activity Date: 05/29/16 Time: 0725

1699 Prostat Supplement A 08,20 OE
- Document 05/29/16 0725 PL2 05/29/16 1233 PL2
Prostat given: Y

Comment: DIETARY

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0725

3140 Airway Management A QS CP
- Document 05/29/16 0725 PL2 05/29/16 1233 PL2
3440 Incision Site Care A QS CP
- Document 05/29/16 0725 PL2 05/29/16 1233 PL2
0430 Bowel Management A QS CP
STOOL ASSESSMENT
- Document 05/29/16 0725 PL2 05/29/16 1232 PL2
BM Consistency: Liquid
BM Color: Brown
BM Amount: MEDIUM

Comment: ILEOSTOMY
1629 OSA ASSESSMENT A QS CP
- Document 05/29/16 0725 PL2 05/29/16 1232 PL2
OSA Assessment

CAPNOGRAPHY Monitor in place: N
If NO, Reason: NI

Education reviewed with patient? N
If NO, Reason: NI

Hi risk or known controlled, signage placed on patient door: N

OSA HIGH RISK: N

Follow-up Physician Appt: NONE
0840 Positioning A QS CP
- Document 05/29/16 0725 PL2 05/29/16 1232 PL2

Activity Date: 05/29/16 Time: 0745

6955 Anticoagulant Educ Materials Provided A QS CP
- Document 05/29/16 0745 PL2 05/29/16 1234 PL2
Anticoagulant Educ Material provided to Patient &/or Family? Y
Comment:

CareNotes (Answer Y-yes for CareNotes Website---THEN REMOVE Y to file)

>>>>>>COMPLETE Intervention after Filing<<<<<<
6990 Post Operative Care - GOALS A 08,20 CP
- Document 05/29/16 0745 PL2 05/29/16 1234 PL2
Post-Operative Care - GOALS

Patient demonstrates use of Incentive Spirometer: Y
Goal: 10X/HR WHILE AWAKE

Patient demonstates technique for splinting incision: Y

5A4D43B46E10429588C8, KNIGHT, 486

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Comment	Documented Units	From Change

Activity Date: 05/29/16 Time: 0745 (continued)

6990 Post Operative Care - GOALS (continued)

Patient verbalizes understanding of pain scale: Y
Goal: <4/10
Pain Scale: NUMERIC

Patient verbalizes understanding of activity level: Y
Prescribed activity level: ASSIST

Patient verbalizes understanding DVT prevention including:
TEDS N IPC N Pedal Exercises Y
Goal: PREVENT DVT'S

Provide patient with form #2292

Patient verbalizes understanding of adequate
nutrition to promote tissue healing. Y
Diet: REGULAR

Patient verbalizes signs/symptoms of infection including:
Redness Y Swelling Y Discharge Y Temperature Y

BS Frequency: NONE
Smoking Status: Never smoker Nursing Note: N
275051 VTE Prophylaxis Orders Complete? A 08,20 CP
- Document 05/29/16 0745 PL2 05/29/16 1235 PL2
VTE Prophylaxix Orders Complete? Y
525002 IV THERAPY ASSESSMENT A QS CP
- Document 05/29/16 0745 PL2 05/29/16 1235 PL2
IV Site Change: N # Of Attempts: IV Tube Change: IV DISCONTINUED N

IV Site #1: RIGHT ANTECUBITAL SPACE
Site Appear #1: NORMAL
Type of Cath #1: Protectiv
Cath Gauge #1: 20
Fluid/Rate #1: SL
Date Insert/DC #1: 05/27/16
IV #1 Comment:
<Esc>

IV Site #2:
Site Appear #2:
Type of Cath #2:
Cath Gauge #2:

IV Site #3:
Site Appear #3:
Type of Cath #3:
Cath Gauge #3:
Fluid/Rate #3:
Date Insert/DC #3:
IV #3 Comment:
<Esc>

IV Site #4:
Site Appear #4:
Type of Cath #4:
Cath Gauge #4:

Problem/Outcome/Intervention Description

Activity Date: 05/29/16 Time: 0745 (continued)

525002 IV THERAPY ASSESSMENT (continued)
Fluid/Rate #2: Fluid/Rate #4:
Date Insert/DC #2: Date Insert/DC #4:
IV #2 Comment: IV #4 Comment:
<Esc> <Esc>
6922 Nursing Report (Hand Off) A 07,19 CP
- Document 05/29/16 0745 PL2 05/29/16 1234 PL2
****Nursing Report (Hand Off)****

Report Received/Care Assumed Y Report Given Y Bedside: Y

To/From P LESLIE RN/ T BOSSE RN

Comment
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam) A QS CP
- Document 05/29/16 0745 PL2 05/29/16 1234 PL2
Patient/Family RAPID RESPONSE Activation Education provided: Y

Comment:
7370 Discharge Planning Assessment A QS CP
- Document 05/29/16 0745 PL2 05/29/16 1234 PL2
==========DISCHARGE PLANNING ASSESSMENT==========

...WE WANT TO HELP YOU FEEL READY FOR DISCHARGE...

Can you think of any needs you may have when that happens?
DC HOM TODAY WITH HOME HEALTH AND WOUND VAC

NEEDS IDENTIFIED:
Home Health: Y Wound Care: N
Medical Equipment: N Nursing Home/Rehab Placement: N

FLU VACCINE (within last year)

Who will be taking you home from the hospital? WIFE ELIZABETH
Name and Phone number....

[redacted]

Would you like a dietitian to talk with you about your diet? N

Social Services Consult Requested: N Date Requested: 05/22/16

Physical Therapy Consult Needed-Make note on PURPLE SHEET

5A4D43B46E1042958BC8, KNIGHT, 487

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0745 (continued)

7370 Discharge Planning Assessment (continued)

Comment: WILL REASSESS DAILY

9610 Fall Risk Assessment/Interventions A QS CP
- Document 05/29/16 0745 PL2 05/29/16 1235 PL2

FALL RISK ASSESSMENT AND INTERVENTIONS

*****Patient LOC/Mental Status*****
A&O x3 or comatose 0
Disoriented x3 at all times
Interm confusion or change in LOC

*****History of Falls*****
No falls in past 12 months 0
1-2 falls in past 12 months

*****Ambulation/Elimination*****
Ambulatory & Continent 0
Chair/Bed bound-requires assist
Ambulatory and/or incontinent

****Systolic B/P (If indicated)****
No noted drop lying->standing 0
Drop <20mmHG lying->standing
Drop >20mmHG lying->standing

*****Predisposing Diseased/History*****
HISTORY OF: Hypotension, Vertigo, CVA, Parkinson's, Amputation, Osteoporosis, Fractures, Seizures, Arthritis, Dementia
None present 0
1-2 present
3 or more present

*****Gait/Balance*****
Normal or N/A secondary neuro deficit 0
Balance problem standing &/or walking
Deconditioning
Change in gait pattern
Jerking or unstable while turning
Requires assistive device 1

*****Medications*****
Patient profile reflects use of: Sedatives/Hypnotics, Antihistimines, Antihypertensives, Anesthetics, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Benzodiazepines.
None of the above within last 24 hrs
1-2 within the last 24 hrs 2
3-4 within last 24 hrs
Additional point for change in medications or dosage within the last 24 hrs

****Demonstrates Unsafe Behavior*****
None demonstrated 0
Occasionally demonstrated
Consistantly demonstrated
RN Judgement (9pt)
RN Judgement (4pt) 4

Total Score: 7

*****Interventions*****

Bed Wheels Locked Y
Bed in Low Position Y
Call Light within reach Y
Fall assessment completed Y
Patient needs Assessed q2hr Y
Environment Assessed Fall Risk Y
Personal Items within reach Y

LOW RISK (0-8) GREEN sign on door Y
Assess q2hr 7A-7P as needed Y
Assess q1hr 7P-7A as needed Y
Assist/stand by Ambulation Y

MODERATE Risk (9-14) YELLOW sign on door
Assess q2hr 7A-7P

HIGH RISK (>14) RED Sign on door/chart
Remain W/patient whenever OOB

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0745 (continued)

9610 Fall Risk Assessment/Interventions (continued)
Assess q1hr 7P-7A
Frequent Re-orientation
Reinforce Call Light use
Bed/Chair Alarm in use
Friction Footwear when OOB
In Rm when pt OOB to BSC, BR, Shower,etc.
If OOB to chair, q30min monitoring
Assess q1hr 7A-7P
Assess q1hr 7P-7A
Reinforce Call Light Use
Frequent Re-orientation
Bed/Chair Alarm in Use
Friction Footwear when OOB
In Room when Pt OOB to BSC, BR, Shower, etc.

PATIENT HAS FALLEN: Assess q15min until neuro checks are stable & pt not at immediate risk
Patient remains at HIGH RISK STATUS

Comment:

Fall Score Ranking: Low Level of Care: Assist

99 SEPSIS Documentation A QS CP
- Document 05/29/16 0745 PL2 05/29/16 1236 PL2
Temperature: 98.7
Temperature Source+: Oral
Pulse: 86
Respirations: 18
Blood Pressure: 96/63
MAP:
Mental Status: Alert & Oriented
Clinical Suspicion of Infection? N
Sepsis Criteria Count: 0
Sepsis Result: Low Sepsis Risk
(May use most recent VITAL SIGNS taken if they are WNL and no greater then 3hrs)

Physician Notified: NA
If NO, Reason:
Patient Notes: Nursing Notes
- Create 05/29/16 0745 PL2 05/29/16 1338 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. NAD PRESENT. WOUND VAC TO ABDOMEN INTACT/SUCTION PRESENT. JP TO LLQ INTACT. ILEOSTOMY TO RLQ INTACT/LOOSE BROWN STOOL PRESENT, 300mL EMPTIED. SATS 94% RA, HR 93. IV RAC SL AT THIS TIME. REPORT RECEIVED. PATIENT AAOX4. PATIENT DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.
Note Type Description
Intervention Nursing Report (Hand Off)

Activity Date: 05/29/16 Time: 0910

6650 SHIFT ASSESSMENT (Surveillance) A QS CP
- Document 05/29/16 0910 PL2 05/29/16 1240 PL2
Neurological WNL: Y WNLto include: Alert and oriented to person, place, and time Speech clear, responses appropriate. No facial droop. Pupils equal, round, and reactive to light. Hand grips strong/equal bilaterally. Moves all extremities with equal strength.

5A4D43B46E1042958BC8, KNIGHT, 488

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/29/16 Time: 0910 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Pupils
Size Right+: 4mm
Rt Reaction To Light+: Reactive
Size Left+: 4mm
Lt Reaction To Light+: Reactive

Strength Of Extremities
RUE+: WNL
LUE+: WNL
RLE+: WNL
LLE+: WNL

Peripheral Sensory Deficit:
Site:

Behavior+: Calm/Cooperative
Speech/Cry+: Clear
Responsive To+: Spontaneous
Mental Status: Alert & Oriented

Vision Impairment: GLASSES
Hearing Impairment: NONE

Continued On Next Page

Glasgow Coma Scale Y

Eye Opening	***Best Verbal Response***	***Best Motor Responses***
Spontaneously: 4	Converses/Oriented: 5	Obeys Command: 6
To Speech:	Converses/Disoriented:	Localizes Pain:
To Pain:	Inappropriate Words:	Withdraws To Pain:
No Response:	Incomprehensible:	Abnormal Flexion:
	No Response:	Abnormal Extension:
		No Response:

Total Glasgow Score: 15

Neuro Comment <Esc>: AAOX4

Cardiovascular WNL: Y WNL to include: Normal heart sounds, HR 60-100/min, no dizziness, syncope, palpitations, edema, or calf tenderness. Peripheral/pedal pulses present. Skin warm and dry. Patient BP WNL for them. No JVD. Capillary refill <3 sec.

Code Status+: Full Code Bracelet: N Sticker: N
Comfort Measures Only NA
Chest Pain: N If Yes, Document in Pain Assessment Intervention.
Heart Sounds+: S1,S2
Telemetry Pattern+: SINUS RHYTHM
Pulse Rhythm+: Regular
Heart Rate: 92 Pacemaker: N Defibrillator: N

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency Documented Comment	Units	From Change

Activity Date: 05/29/16 Time: 0910 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Dizziness/Syncope+: Palpitations: N
JVD+:

Edema 1+: Edema 2+:
Loc 1+: Loc 2+: TED Hose: N
Pitting: Pitting: IPC: R
Venous Foot Pump: N

Peripheral Pulses

Dorsalis Lt+: Normal		Femoral Rt+:	
Dorsalis Rt+: Normal		Femoral Lt+:	
Post Tib Lt+: Normal			
Post Tib Rt+: Normal		Cap Refill RUE+: Brisk	
Carotid Rt+: Normal		Cap Refill LUE+: Brisk	
Carotid Lt+: Normal		Cap Refill RLE+: Brisk	
Brachial Rt+: Normal		Cap Refill LLE+: Brisk	
Brachial Lt+: Normal			
Radial Rt+: Normal			
Radial Lt+: Normal			

Cardio Comment <Esc>:

Respiratory WNL: N WNL to include: Normal rate 12-24/mm, normal effort and non-labored, lungs clear bilaterally. No cough. No pain and no supplemental oxygen in use. No cyanosis or clubbing.
Respirations: 18 O2 Sat: 94 %/L of O2: 0
O2 Mode+: ROOM AIR
RR Description+: WNL
Resp Pattern+: Unlabored
Chest Expansions+: Symmetrical
Cough+:
Sputum Amount+:
Sputum Consistency+:
Sputum Color+:
Airway+: Patent
Airway Suctioned+:

Breath Sounds
LUL+: Clear
LLL+: Fine Crackles
RUL+: Clear
RML+: Clear
RLL+: Fine Crackles
Lung Sounds:
Profile

COPD Educational Video:
Resp Comment <Esc>:
Cyanosis: N
Pallor: N

MUSC-SKEL WNL: N WNL to include, ROM with no functional limitations for age, no joint swelling, no atrophy, normal symmetrical movement and strength, no muscle spasms, no deformities, no assistive devices, no protheses, no amputations.

5A4D43B46E1042958BC8, KNIGHT, 489

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0910 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

ROM Limitations+: Generalized
Paralysis+:

Joint Swelling+:
Amputations+:

Muscle Spasms+:
Contractures+:

Deformities+:
Weakness+: Generalized

Transfer, Lift, or Ambulation equipment WALKER
Musc-Skel Comment <Esc>: AMBULATES WITH WALKER

Skin WNL: N WNL to include: Skin warm, dry, intact with normal color and tugor, mucous membranes moist and pink, capilliary refill < 3 seconds. No cuts, abrasions, bruising or wounds.

Skin Color+: Normal
Skin Temp+: Warm
Skin To Touch+: Dry
Skin Condition+: Warm & Dry

Turgor+: ELASTIC
Mucous Membranes+: Moist & Intact
Specialty Bed: N
Decubiti: N
Location/Size<Esc>:

Stage+:

Wound Site #1: LEFT OF MIDLINE ABDOMEN
Wound Appear #1+: CLEAN/DRY
Closure Type #1+: Open
Dressing Type #1: WOUND VAC IN PLACE 125 CM
Dress Appear #1: C/D/I

Wound Site #2: LLQ JP
Wound Appear #2+:
Closure Type #2+: Suture
Dressing Type #2:
Dress Appear #2: SCANT REDNESS

Tubes/Drains: JP DRAIN, OSTOMY. WOUND VAC

Skin Comment <Esc>: SACRUM PRESENT WITH REDNESS, INTACT 1LEOSTOME INTACT RLQ
Is Pt At Risk For Immobility Or Skin Breakdown: N

**********BRADEN PRESSURE ULCER RISK ASSESSMENT**********

Sensory Perception Score
Completely Limited:
Very Limited:
Slightly Limited:
No Impairment: 4

Activity Score
Bedfast:
Chairfast:
Walks Occasionally: 3
Walks Frequently:

Nutrition Score
Very Poor:
Probably Inadequate:
Adequate: 3
Excellent:

Moisture Score
Constantly Moist:
Very Moist:
Occasionally Moist:
Rarely Moist: 4

Mobility Score
Completely Immobile:
Very Limited:
Slightly Limited: 3
No Limitations:

Friction & Shear Score
Problem:
Potential Problem:
No Apparent Problem: 3

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0910 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Total Braden Score: 20

If total score is < or = 16, initiate pressure ulcer prevention.

GastroIntestinal WNL: N WNL to include: Abdomen soft, active bowel sounds times 4 quadrants, no nausea, vomiting or bleeding. Stools within patient's own normal pattern and consistency. No pain/tenderness. No enteral tube or ostomy. Appetite within patient's own normal pattern.

Nausea: N
Emesis: N
By C-Diff Protocol - Watery loose stool: N
Constipation: N
Diarrhea: N
Last BM: 05/29/16
Stool Amount+: Moderate
Stool Color+: Brown
Stool Consistency+: Liquid
Incontinent Stool:

Rectal Tube: N
Tubes+:
Tube Drainage:
Tube To Suction:
Stoma Present: Y
Ostomy Appliance: Y

Bowel Sounds
RUQ+: ACTIVE
LUQ+: ACTIVE
RLQ+: ACTIVE
LLQ+: ACTIVE
Abd Appearance+: SOFT

GI Comment <Esc>:

Genitourinary WNL: Y WNL to include: void sufficient amount clear, yellow, odorless urine. Denies genital/pelvic drainage, itching or swelling. No urinary frequency, urgency, discomfort or incontinence. No known prostate problems for males. Normal menses for females if appropriate.

Does Patient have a Foley Catheter? N

Urine Color+:
Character+:
Urine Odor+:
Incontinent Bladder: N
Suprapubic Catheter: N

Currently Menses:
LMP:
Prostate Problems:

Dialysis
CAPD: N
Peritoneal Dialysis: N
Hemodialysis: N
Hemo Site Description+:
Last Dialysis Treatment:

GU Comment <Esc>: DENIES DYSURIA

**********PAIN ASSESSMENT**********

Pt C/O Pain: Y
Pain Scale: 6
Pain Location+:

Acceptable Scale/Goal for EXCELLENT pain management this shift: 4

5A4D43B46E10429588C8, KNIGHT, 490

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0910 (continued)

6650 SHIFT ASSESSMENT (Surveillance) (continued)

Patient Sleeping:
Quality Of Pain+: Sleeping Resp:
Respiratory Quality:
Onset/Duration: Respiratory Depth:
Pain Med Given<Esc>:

Time Med Given: Date: Reassess: (See below)
Enter time as appropriate or DONE if reassessment completed
Pain Comment<Esc>:

******RESPONSE TO PLAN OF CARE/TREATMENT******
Response to Treatment: STABLE

Type of Isolation: NONE Tissue Test: N
PATIENT/FAMILY SCREENING AND EDUCATION DOCUMENTATION

Patient's Level Of Education+: College
Readiness to Learn: GOOD
Ability To Understand Verbal Instructions: Y
Ability To Understand Written Instruction: Y
Learning Preference+: Verbal
Knowledge of Educational Needs/Treatment Plan: Y

Specific Barriers To Learning
Physical: Y Language: N Visual: Y Motivation: N Cultural: N Cognitive: N
Reading: N Age Related: N Auditory: N Emotional: Y Religious: N Finances: N

EDUCATION/INTERVENTION: POC/MEDICATION/SAFETY/DIET/PAIN/ACTIVITY

Activity Date: 05/29/16 Time: 0914

Patient Notes: Nursing Notes
- Create 05/29/16 0914 PL2 05/29/16 0918 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. DC PLANNED TO HOME TODAY PER DR. EPSTEIN. JP DRAIN REMOVED, TOLERATED WELL. GAUZE/TEGADERM PLACED. ASSESSMENT PERFORMED. PATIENT AAOX4. OSTOMY INTACT/300mL EMPTIED. WOUND VAC INTACT TO SUCTION. SATS 94% RA, HR 92, RR 18. FINCE CRACKLES BASES, DEEP COUGH/BREATHING WHILE SPLINTING PERFORMED WITH PATIENT. PAIN CONTROLLED AT THIS TIME. IV CEFAZOLIN INFUSING TO RAC, DRESSING INTACT/DRY. PATIENT REPORTS VOIDING WOITHOUT COMPLAINTS. PATIENT REPORTS PERFORMING I/S FREQUENTLY. PATIENT DENIES ANY NEEDS AT THIS TIME. CALL BELL WITHIN REACH.
Note Type Description
Intervention SHIFT ASSESSMENT (Surveillance)

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts Comment	Frequency Documented Units	From Change

Activity Date: 05/29/16 Time: 0953

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/29/16 0953 EW 05/29/16 0953 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>
7371 Discharge Information for PATIENT A PRN CP
- Document 05/29/16 0953 CW7 05/29/16 0959 CW7
Discharge Diagnosis: OSTOMY
Discharge Diagnosis Care Notes given to Patient: Y

***COMMUNITY REFERRALS - Service Needed

Home Health? Y Home Health Company: AMEDISYS
Hospice? NONE Hospice Agency:
Facility? NONE Facility Name:
Equipment? NONE Equipment Needed:
Other:

Diet: REGULAR Dietary Supplements NONE
Comment:

***ACTIVITIES

No Restrictions: Up with walker Cane Crutches
Resume activities as tolerated: Up with assistance X Fall Precautions
No driving for days. Other
No heavy lifting (No more than lbs for days.)
May return to work/school on Restrictions CONTINUE AMBULATING AS TOLERATED.
Activities as per Dr instructions.
Follow-up Appointments

Date:	Time:	With Whom:	Reason:	Patient/SO to Arrange:
1:	:	DR,RIMKUS	F/U TUE OR WED CALL FOR APPT:	
2:	:		347-7291	
3:	:			

Follow up with as scheduled as needed

***WOUND CARE INTRUCTIONS X

Leave incision open to air Keep same dressing on until clinic appointment
Keep wound/incision clean and dry Cover incision with gauze or transparent dressing X
If Steri-strips loose, remove them Other WOUND VAC TO BE MANAGED BY HOME HEALTH.
OSTOMY TO BE ASSISTED BY HOME HEALTH.

5A4D43B46E1042958C8, KNIGHT, 491

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/29/16 Time: 0953 (continued)

7371 Discharge Information for PATIENT (continued)

***MEDICATION INFORMATION

Universal Medication Form Given: Y New Prescriptions Given: Y

Patient verbalized understanding of Medications: Y

Patient/Family has been instructed to bring updated current medication list when returning to Conway Medical Center: Y

Educ material given patient/significant other-all new meds Y

Date Flu Vaccination Received: NFS

Patient states counseling was given and understood on the risks associated with smoking and second hand smoke: Y Why Not? <Esc>

***EDUCATION Written Education Materials Provided.

Patient provided with written discharge instruction booklet/pamphlet: HEART FAILURE CONTROL PLAN; includes activity, diet, physician follow-up, medications, what to do if symptoms worsen and weight monitoring instructions. CHF Indicators: Instructional video shown? Comment

STROKE/TIA EDUCATION N Education Material Provided: Educ Material Date:
Activation of Emerg Med System: Need for F/U after discharge:
Medication prescribed at discharge: Risk factors for stroke:
Warning signs & symptoms for stroke:

Venous Thromboembolism (VTE) Warfarin EDUCATION N
Diet Education: Consistent amt foods w/Vit K rather than avoidance advised
Avoid major diet chges or notify Health Prof before changing
Compliance Education: Importance of taking warfarin as instructed
Important to monitor warfarin w/scheduled PT/INR blood draws
Potential for Adverse Drug Reactions & Interactions:
Don't take/DC any meds or OTC meds except thru Phys or Pharm
Warfarin increases risk of bleeding Diet & Meds can affect the PT/INR level
Education Session Date: Follow-up Education:

***PAIN MANAGEMENT X

You may have some pain and discomfort from your procedure. A prescription for pain may be given to you before you leave the hospital. If the doctor did not prescribe medication for pain, you may take your non-prescription pain reliever.

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/29/16 Time: 0953 (continued)

7371 Discharge Information for PATIENT (continued)

Notify Physician for: If you feel that your pain is increasing, or is unrelieved,
Temperature over 101 for 24hrs Y Incision red, swollen, or warm Y
Foul odor from Wound or Drainage Y Wound red, swollen, or warm Y

Valuables taken from safe (if stored): Contacts: N Sent W/Pt:
Personal belongings taken: Y Glasses: Y Sent W/Pt: Y
Medications taken: (if stored) Hearing Aide(s): N Sent W/Pt:
Dependency/Mental Health Diagnosis: N Dentures: N Sent W/Pt:
Prostheses: N Sent W/Pt:

Patient Owned Med Equipment Details: Taken home:

ADDITIONAL GENERAL INSTRUCTIONS: CONTACT DR. RIMKUS ON MON/TUES FOR FOLLOW UP APPOINTMENT IN OFFICE.
<Esc> RETURN TO EMERGENCY ROOM FOR PROBLEMS.

Instructions Given To: Patient: Y Significant Other: Relationship:

If limited English or hearing impaired, interpreter offered?
Interpreter:

Requested electronic discharge instructions. N
Electronic copy of discharge instructions given: N

Escorted By: HOSP STAFF
Via: WHEELCHAIR

I have received and understand the above instructions and was given the opportunity to ask questions. Yes No

Discharge nurse: PRISCILLA RN

Patient/Responsible Person Signature & Relationship:

Activity Date: 05/29/16 Time: 0955

6680 Vital Signs A 06,10,14,18,22,02 OE
- Document 05/29/16 0955 EW 05/29/16 0957 EW
Temperature: 98.2
Temperature Source+: Oral
Pulse: 97
Pulse Source+: BRACHIAL
Respirations: 20
Blood Pressure: 100/66
BP Location+:
BP Position+:
Weight (lbs):
(Oz):

5A4D43B46E10429588C8, KNIGHT, 492

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/29/16 Time: 0955 (continued)

6680 Vital Signs (continued)
kg:
Weight Source:

O2 Sat: Nursing Note:

IPI: (Surgical Patients ONLY)

Pt Out of Room: Patient Refused: Nurse Notified:

Activity Date: 05/29/16 Time: 1142

5500011 Purposeful Rounding A Q2HODD CP
- Document 05/29/16 1142 EW 05/29/16 1142 EW
Pain
Potty
Position
Proximity (phone,bedside table,ice pitcher,call light reach)
Personal Needs (anything else you need?)
Pick up (tidy room)

Purposeful Rounding complete: Y

Comment:
<Esc>

Activity Date: 05/29/16 Time: 1151

Patient Notes: Nursing Notes
- Create 05/29/16 1151 PL2 05/29/16 1156 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. SPOUSE PRESENT IN ROOM. MEDICATED AS ORDERED. DC INFORMATION REVIEWED WITH PATIENT AND SPOUSE. WRITTEN PRESCRIPTIONS TO SPOUSE. WOUND VAC CHANGED TO HOME VAC, SUCTION RESUMED; DRESSING INTACT. GAUZE TEGADERM TO LLQ, OLD JP SITE INTACT/DRY. OSTOMY RLQ INTACT, 200mL EMPTIED. CALL PLACED TO AMEDISYS BY C WHITE, RN. PATIENT AND SPOUSE VERBALIZE UNDERSTANDING OF DC INFORMATION, NO QUESTIONS AT THIS TIME. PROVIDED WITH WRITTEN COPY. IV ABX INFUSING AT THIS TIME. PATIENT DENIES ANY NEEDS. PROVIDED WITH OSTOMY SUPPLIES AND DRESSING FOR JP SITE. CALL BELL WITHIN REACH.

Addendum: 05/29/16 at 1236 by PL2 LESLIE,PRISCILLA RN

HOME WOUND VAC EDUCATION TO PATIENT AND SPOUSE.
Note Type Description
No Type None

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency	Documented Units	From Change

Activity Date: 05/29/16 Time: 1240

Patient Notes: Nursing Notes
- Create 05/29/16 1240 PL2 05/29/16 1241 PL2
Abnormal? N Confidential? N
PATIENT RESTING IN BED. IV SITE DC AT THIS TIME, TOLERATED WELL. PATIENT PROVIDED WITH TOWELS, WANTS TO FRESHEN UP PRIOR TO LEAVING. ADVISED TO CALL WHEN READY TO LEAVE. SPOUSE PRESENT IN ROOM.
Note Type Description
No Type None

Activity Date: 05/29/16 Time: 1255

Patient Notes: Nursing Notes
- Create 05/29/16 1255 PL2 05/29/16 1325 PL2
Abnormal? N Confidential? N
PATIENT TRANSPORTED TO PRIVATE VEHICLE BY HOSPITAL STAFF.
Note Type Description
No Type None

Activity Date: 05/29/16 Time: 1318

000000	MEDHOST (ER) Info	D			CP
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
10	PT: Intial Evaluation	D			AS
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
1699	Prostat Supplement	D	08,20		OE
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
25	PT: Daily Documentation	D			PS
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
6680	Vital Signs	D	06,10,14,18,22,02		OE
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
7322	CASE MANAGEMENT EVALUATION/DC	D	PRN		AS
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
Problem: *Bowel Resection		D			
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
Outcome: Respiratory Status: Ventilation		D			
Definition: Movement of air in and out of the lungs					
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
3140	Airway Management	D	QS		CP
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
Outcome: Fluid Balance		D			
Definition: Water balance in the intracellular and extracellular compartments of the body					
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
2080	Fluid/Electrolyte Management	D	PRN		CP
- Ed Status	05/29/16 1318 his 05/29/16 1318 his				A => D
Outcome: Wound Healing: Primary Intention		D			
Definition: Extent of regeneration of cells and tissues following intentional closure					

5A4D43B46E1042958BC8, KNIGHT, 493

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change
Outcome: Wound Healing: Primary Intention (continued)										
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
3440 Incision Site Care							D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6540 Infection Control							D			CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
Outcome: Bowel Elimination							D			
Definition: Formation and evacuation of stool										
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
0430 Bowel Management							D	QS		CP
STOOL ASSESSMENT										
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
Outcome: Post Operative Care							D			
Definition: Patient free of post operative complications										
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1629 OSA ASSESSMENT							D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6955 Anticoagulant Educ Materials Provided							D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6990 Post Operative Care - GOALS							D	08,20		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6991 Post Operative Care - OUTCOMES							D	18,06		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
Problem: *Standard Of Care							D			
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
Outcome: Standard Of Care							D			
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
0840 Positioning							D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
10026 DISCHARGE PATIENT-Escorted							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1160 Nutritional Monitoring							D	18		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
150005 Intake/Output							D	06,18		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1663 IPC, TED, VFP Documentation							D	04,16		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1750022 Neurological Surveillance							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1750023 Cardiovascular Surveillance							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1750024 Respiratory Surveillance							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1750026 Musculoskeletal Surveillance							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1750027 Gastrointestinal Surveillance							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
1750028 Genitourinary Surveillance							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Comment	Frequency Documented Units	From Change
Activity Date: 05/29/16				Time: 1318						
1750029 Integumentary Surveillance							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
275051 VTE Prophylaxis Orders Complete?							D	08,20		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
3592 TED/HEEL PROTECTORS/IPC Skin Assessment							D	04,16		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
525001 Medications, PRN							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
525002 IV THERAPY ASSESSMENT							D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
525003 IV Site Check							D	06,18		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
5500 Off-Unit for Test/Procedure							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
5500010 Rounds Surveillance							D	06,18		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
5500011 Purposeful Rounding							D	Q2HODD		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6409 FALLS SCREEN - FOLLOW-UP							D	02,14		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6650 SHIFT ASSESSMENT (Surveillance)							D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6901 PATIENT LINEN CHANGE							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6902 PATIENT TURNED							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6903 PATIENT FED							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6904 PATIENT BED/CHAIR ALARM SET							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6905 PATIENT BATH							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6910 Last BM							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6911 Transfer/Nursing Report Record							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6922 Nursing Report (Hand Off)							D	07,19		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6923 Message (Hand Off)							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6944 Supplements/Tube Feedings							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6945 TIME OUT-Universal Protocol Beside Proc							D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6952 RAPID RESPONSE ACTIVATION EDUC (Pt/Fam)							D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
6980 Vital Signs Manual Recheck							D	AD		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D

5A4D43B46E1042958BC8, KNIGHT, 494

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From / Change
Activity Date: 05/29/16		**Time: 1318**								
7310	Admission Care						D	ONCE		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
7370	Discharge Planning Assessment						D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
7371	Discharge Information for PATIENT						D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
750006	PAIN ASSESSMENT						D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
750011	Pain Assessment (Telemetry Unit)						D			CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
75015	Discharge Med Rec via RXM						D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
7900	Flu Vaccination Received						D	PRN		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
800001	Education/Teaching Assessment						D	04,16		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
9610	Fall Risk Assessment/Interventions						D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
99	SEPSIS Documentation						D	QS		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
Problem: RT - INADEQUATE VENTILATION/OXYGENATION							D			
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
Outcome: ADEQUATE VENTILATION							D			
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
09	RESP THERAPY - TREATMENT						D	AD		CP
- Ed Status	05/29/16	1318	his	05/29/16	1318	his				A => D
Activity Date: 05/30/16		**Time: 0720**								
7323	CASE MANAGEMENT - Discharge Plan						A	PRN		AS
- Create	05/30/16	0720	JB*	05/30/16	0721	JB*				
- Document	05/30/16	0720	JB*	05/30/16	0721	JB*				

CASE MANAGEMENT - Discharge Plan

D/C Date 05/29/16 DISCHARGE DISPOSITION: H DC Dispostion Status: N
PCP

SPECIFIC DISCHARGE DISPOSITION LOCATION:
SUB ACUTE REHAB ALF HOSPICE

HHS ACUTE REHAB
AMEDISYS
PSYCHIATRIC: DSS DME

LTAC NH - LONG TERM CARE DME - Ordered Equipment:

CLTC

HANDOUTS GIVEN:
Community Clinics Long Term Care Home Care Transportation
Resource Directory Social Security Rx Assist
Substance Abuse Homelessness RCF Advance Directives

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Sts	Frequency / Documented Comment	Units	From / Change
Activity Date: 05/30/16		**Time: 0720 (continued)**								
7323	CASE MANAGEMENT - Discharge Plan (continued)									
Other:										
~~REFERRALS WERE MADE FOR THE FOLLOWING AGENCIES:~~~~~~										
ALF (Assisted Living Facility)										
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
SNF (Skilled Nursing Facility)										
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
HOSPICE										
TO FACILITY:										Referral status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
ACUTE REHAB REFERRAL:										
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
HHS (Home Health Services) Y										
TO AGENCY: AMEDISYS										Referral Status: N
TO AGENCY:										Referral Status:
TO AGENCY:										Referral Status:
TO AGENCY:										Referral Status:
NH-LTC REFERRAL:										
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:
TO FACILITY:										Referral Status:

CLTC (Community Long Term Care) Referral Status:
DSS REFERRAL:
TO WHICH SERVICE: Referral Status:

DME REFERRAL:

TO PROVIDER: Referral Status: Equipment ordered:

5A4D43B46E10429588C8, KNIGHT, 495

Problem/Outcome/Intervention Description

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Frequency Documented Units	From Change

Activity Date: 05/30/16 Time: 0720 (continued)

7323 CASE MANAGEMENT - Discharge Plan (continued)
TO PROVIDER: Referral Status: Equipment ordered:

:

TO PROVIDER: Referral Status: Equipment ordered:

:

TO PROVIDER: Referral Status: Equipment ordered:

PSYCHIATRIC REFERRAL:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:
TO FACILITY: Referral Status:

TRANSITIONAL CARE: Follow up Appointment:
Contact Date: Physician: Date: Time:
Contact Time: Physician: Date: Time:
Physician: Date: Time:

Follow up appointment scheduled prior to D/C.
Follow up appointment scheduled post D/C.

New Primary Care Provider Established. New Primary Care Provider:
Comments: PATIENT WAS DISCHARGED HOME WITH HIS WIFE. HE WAS DISCHARGED WITH WOUND VACC AND WILL BE FOLLOWED BY AMEDISYS HOME HEALTH.

Activity Date: 05/30/16 Time: 0756

7323 CASE MANAGEMENT - Discharge Plan						D	PRN		AS
- Ed Status	05/30/16	0756	his	05/30/16	0756	his			A -> D

Monogram	Initials	Name	Nurse Type
	MEDITECH	MEDITECH	RN
AC2	ACAMPBELL2	CAMPBELL, AMY	RRT
AEH	AHENDERSON	EDGE-HENDERSON, ABRAN	RRT
AP	APRUITT	PRUITT, APRIL	RRT
AW3	AWRIGHT3	WRIGHT, ANTHONY	RN
BD	BDALUZ	DA LUZ, BIANCA	MST
BE	BEPLER	EPLER, BRANDY	RTLPN
BG	BGORDON	GORDON, BRITTANY	RN
BL5	BLEWIS5	LEWIS, BETHANY	RN
BW	BPAUL	PAUL, BETSY	RN
CB4	CBARKER4	BARKER, CANDACE	RN
CG	CGARAVITO	GARAVITO, CHRISTOPHER	PT
CG*	CGRAVES	GRAVES, CHARLENE	CRT
CP	CPETTY	PETTY, CHERYL	RN

Monogram	Initials	Name	Nurse Type
CW7	CWHITE7	WHITE, CORAZON	RN
DA	DAMARAL	AMARAL, DEBORAH	NA
DP	DPENNINGTO	PENNINGTON, DIANE	MST
EW	EWHEELER	WHEELER, EVA	NA
FS	FSLOAN	SLOAN, FRED	CRT
GM	GMILLER	MILLER, GINA	RN
JA5	JANDERSON5	ANDERSON, JOANN	NA
JB	JBALDWIN	BALDWIN, JONATHAN	PTA
JB*	JBURLESON	BURLESON, GLORIA JEAN	RN
JE	JELLIOTT	ELLIOTT, JOETTA	RCP
JF7	JWHITE7	WHITE, JENNIFER	CRT
JL	JLEWIS10	LEWIS, JORDON	US
JM	JMARQUARDT	MARQUARDT, JACKIE	MST
JS	JSMITH1	SMITH, JACQUELINE	MST
JW	JWILLIAMSO	WILLIAMSON, JASON	PTA
JW*	JWATERS	WATERS, JOHN	MST
JW2	JWILSON2	WILSON, JESSIE	RRT
KK	KBELLAM	BELLAM, KATIE	RN
KK*	KKAWAKAMI	KAWAKAMI, KENICHI	RRT
KM	KMANJARREZ	MANJARREZ, KRISTIE	RN
KO2	KODOM2	ODOM, KIM	RRT
LF	LFADRI	FADRI, LOURDES	RN
LF*	LFARNAM1	FARNAM, LARISSA	RD
LH	LHARRIS2	HARRIS, LINDSEY	RD
LW8	LWILLIAMS8	WILLIAMS, LASHIKA	NA
M	MEDHOST	MEDHOST	None
MB4	ABROWN4	BROWN, AMBER	MST
MES	MSANDERS	SANDERS, MICHELE E	CRT
MG	MGALLOWAY	GALLOWAY, MELISSA	MST
MG*	MGODWIN	GODWIN, MELISSA	RN
MM	MMAPLES	MAPLES, MICHELE	RN
MW	MWILLIAMS	WILLIAMS, MARSHA	RN
NR2	NROBERTS2	ROBERTS, NATALIE	RN
NW	NWHEELER	WHEELER, NIKKI	MST
PL2	PLESLIE2	LESLIE, PRISCILLA	RN
PS	PSKINNER2	SKINNER, PAMELA	RN
RM	RMESHREKI	MESHREKI, RAFIK	RN
SE	SESTES	ESTES, SUSAN	CRT
SF	SFRY	FRY, STEPHANIE	MST
SG	SGUTKNECHT	GUTKNECHT, SHARON	RD
SH2	SHERRINGT2	HERRINGTON, SHERRY	RN
SO	SOKLOTA	OKLOTA, SARAH LYNN	NM
SP	SPAITSEL	PAITSEL, SUSANNA	RRT
SS4	SSARVIS4	SARVIS, SABRINA	RN
ST	STALBOT	TALBOT, SUSIE	LPN
SW6	SWILLIAMS6	WILLIAMS, SHARON	NA
TB	TBOSSE2	BOSSE, TRICIA	RN
TK2	TKOCH2	KOCH, THOMAS	RN
TT2	TRUPE2	RUPE, TAMMIE	RN
VB	VBLACK	BLACK, VICTOR	MST
VP2	VPARKER2	PARKER, VIVIAN	NA
WC	WCHICKERIN	CHICKERING, WESLYN	LMSW
his		automatic by program	

5A4D43B46E10429588C8, KNIGHT, 496