The State of South Carolina
In The Court of Appeals

Appeal from Charleston County
Hon. Deadre Jefferson, Circuit Court Judge

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SC Court of Appeals

Case No. 2014-CP-10-4591
Appeal 2017-002392

Jane Doe 202, by John Doe MM and John Doe HS, each of whom holds power of attorney for Jane Doe,

Appellant

v.

City of North Charleston,
Leigh Anne McGowan, individually,
Charles Francis Wohlleb, individually,
Anthony M. Doxey, individually

Respondents

Record On Appeal
Volume Two

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STATE OF SOUTH CAROLINA	)	THE COURT OF COMMON PLEAS
	)	
COUNTY OF CHARLESTON	)	DOCKET NO. 2014-CP-10-4591
	)	
	)	
	)	
JANE DOE 202, through JOHN DOE MM and JOHN DOE HS, each of who holds Power of Attorney for JANE DOE	)	
	)	
Plaintiff	)	
	)	
vs.	)	
	)	
CITY OF NORTH CHARLESTON, LEIGH ANNE MCGOWAN, individually, CHARLES FRANCES WHOLLEB, individually, and ANTHONY M. DOXEY, individually	)	
	)	
Defendants	)	
	)	
	)	TRANSCRIPT OF RECORD

October 13, 2017
Charleston, South Carolina

VOLUME 10 (of 10)

B E F O R E:

THE HONORABLE DEADRA L. JEFFERSON, JUDGE

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

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Circuit Court Reporter

THE COURT: I'll think about it.

[Whereupon, the court reviews documents]

THE COURT: I'm going to instruct everything that starts with the elements of the 1983 cause of action and goes all the way through qualified immunity. That's basically the guts of the instruction because I don't think I need to reinstruct them on being fair and impartial and unanimity and all that stuff.

They've indicated what they want to hear are the elements of each cause of action and the definition. So I think that will cover what they have requested. Any exception from the plaintiff?

MR. MEYERS: No, Your Honor.

THE COURT: From the defense?

MS. SENN: None, to the extent of what you just said, Your Honor. I just would like them to be admonished or told that they were correct that they should not regard what they had in the jury room.

THE COURT: I told you I would consider that. They said they didn't read it. It seems to me superfluous to tell somebody to disregard something they told me they didn't read.

MS. SENN: I understand Your Honor, but out of an abundance of caution considering one side jury instruction went in there I would request such.

THE COURT: I'm going to tell them they have to only consider the law as I instructed and disregard and disabuse their mind of anything else. I'm going to play it by ear and see. I'll be right back. Give me a moment.

[Off the record momentarily]

THE COURT: Please get the jury.

[Whereupon, the jury enters at 10:27 a.m.]

THE COURT: Ladies and gentlemen I appreciate your patience. I'm the chief administration judge for the civil court for the 9th Circuit and I had to do what is called a docket meeting this morning for the cases that will be heard next week. So I appreciate you all accommodating me and being able to dispose of that responsibility before I was able to deal with each of the notes that you sent to the court.

I'm going to deal with your notes in reverse order. You've asked me to reinstruct you regarding the instructions and I am going to do that. And I got clarify from your Foreperson as to what it is you all were seeking. And as I advised him if there is something that I omit please make me aware of it. If it is something else that you desire to rehear and I will immediately accommodate your request. In addition I've had the other note which found a copy of jury

instructions in our jury room this morning. Are we allowed to review them. Your Foreperson indicated to me that no one had reviewed the instructions but out of an abundance of caution I'm going to instruct you as follows: I commend you for turning these over to us. These are not the court's jury instructions.

These are -- each side gets to request instructions and inadvertently the plaintiff's request it looks like probably there were multiple sets intended to disburse among other folk because of the volume of paper through human error it got attached to one of your exhibits.

So your Foreperson indicated that no one had reviewed them but again out of an abundance of caution if anyone did please disregard and disabuse your mind of it because you are required to follow the law precisely as I am now going to reinstruct you. And those are not the court's actual instructions.

JURY RECHARGE

THE COURT: In regard to your request I reinstruct you as follows: The plaintiff asserts claims pursuant to 42 United States Code Section 1983 against the defendants claiming that by entering her home without a warrant the defendants violated her 4th Amendment rights under the United States Constitution to be free from unreasonable seizures.

As I have instructed you this case is what is called a section 1983 action. Section 1983 of Title 42 of the United States Code provides that any citizen may file a civil action seeking damages against any person who under color of state law deprives that citizen of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

In order to prove her claims the plaintiff must establish by the greater weight or the preponderance of the evidence the following three elements: The defendants committed an act which operated to deprive the plaintiff of her rights secured by the United States Constitution. The defendants acted under color of state law and the defendants actions were the proximate cause of the plaintiff's damages.

Each of these elements must be established separately for the plaintiff to prevail on her claim. If

the plaintiff proves all of these elements by the preponderance of the evidence for her claim then you must return a verdict in favor of the plaintiff on that claim. If, however, she fails to prove any of these elements for her particular claim you must return a verdict for the defendants on that claim.

Because the individual defendants were officers of the City of North Charleston at the relevant time I instruct you that they were acting under color of state law. In other words the second element of the plaintiff's claim is not in dispute and you must find this element has been established.

I will now instruct you on the first element which is an act that deprives a person of his or her rights under the Constitution for the plaintiff's 4th Amendment warrantless entry claim I will then instruct you on the third element, proximate causation of damages.

The plaintiff, Rhonda Doe, alleges the defendants violated her rights under the 4th Amendment of the United States Constitution to be protected from unreasonable seizures by entering her home on March 27th of 2014 without a warrant. I instruct you that a warrantless entry is per se unreasonable and thus violates the 4th Amendment unless the search falls within one of the exceptions to the exclusionary rule. The burden rests on

the defendants to establish the existence of such an exception to the warrant requirement. The exigent circumstances doctrine allows warrantless entry by law enforcement officials when there is a compelling need for official action and no time to secure a warrant. Police may enter a home without a warrant when they have an objectively reasonable basis to believe an occupant is seriously injured or imminently threatened with serious injury.

This exception requires only an objectively reasonable basis for believing that a person within the house is in need of immediate aid. The existence of an exigency is determined based on the information available to the officer at the time of the warrantless entry. All the evidence within the officer's knowledge may be considered including the details they observed while responding to information provided to them.

Exceptions to the warrant requirement include the need to protect or preserve life or avoid serious injury. An action is reasonable under the 4th Amendment regardless of the individual officer's state of mind as long as the circumstances viewed objectively justify the action.

A fairly perceived need to act on the spot may justify entry under the exigent circumstances exception

to the warrant requirement. The likelihood of protecting the safety of officers has also been held to be an exigent circumstance. A warrantless entry is justified under the exigent circumstances doctrine where there is risk of danger to police or others inside or outside of a dwelling. In such circumstances a protective sweep of the premises may be permitted.

In reviewing the justification for a warrantless entry under the exigency exception it is appropriate to look to the totality of the circumstances to determine whether the officers actions were reasonable and justified. To determine whether officers had an objectively reasonable basis reasonableness must be judged from the perspective of a reasonable officer on the scene rather than with the 20/20 vision of hindsight and the calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split second judgments in circumstances that are tense, uncertain, and rapidly evolving.

I further instruct you that a police officer has the authority to arrest a person without a warrant for a misdemeanor committed in his presence. You must then decide whether the defendants have proven by the greater weight or the preponderance of the evidence that the defendants had an objectively reasonable basis under the

exigency exception to enter the residence without a warrant. To determine whether an exigency existed you should consider whether the facts and circumstances available to the defendants would cause a prudent officer to believe their entry under the exception of exigent circumstances was warranted. The defendant's actual motivation is irrelevant. Even if you determine his or her motive was improper.

An officer's improper motive is irrelevant to the question of whether the objective facts available to the officer at the time constituted an objectively reasonable basis to enter the residence. What matters is whether the defendant's acts were objectively reasonable in light of the facts and circumstances confronting the defendants. To establish the third element the plaintiff must prove by the greater weight or preponderance of the evidence that the constitutional violation was the proximate cause of her injuries.

To establish proximate cause the plaintiff must establish both causation in fact and legal cause. Causation in fact is proven by establishing that the plaintiff's injury would not have occurred but for the constitutional violation. Legal cause is proven by establishing that the injury was foreseeable, meaning that the injury was the natural and probable consequence

of the constitutional violation. To find that an act of the defendants caused an injury to the plaintiff you need not find that the defendants act was the nearest cause either in time or space of that injury. However, if the plaintiff's injury was caused by a later independent event that intervened between the defendant's act and the plaintiff's injury then defendants are not liable unless the injury was reasonably foreseeable by the defendants.

The plaintiff must prove that some injury from the defendant's act was foreseeable but does not have to prove that the particular injury that occurred was foreseeable. However, the defendants cannot be held responsible for things which could not be expected to happen.

The plaintiff has also alleged an action under 1983 for a failure to train. The inadequacy of police training may serve as the basis for a 1983 liability only where the failure to train amounts to deliberate indifference to the rights with whom the police come into contact.

The defendant, City of North Charleston may not be held liable for their alleged failure to train the defendant officers as no actionable claim against a supervisor can exist without a constitutional violation committed by an employee. A section 1983 failure to

train claim cannot be maintained against a governmental employer in a case where there is no underlying constitutional violation by the employee. To allege a claim of failure to train the plaintiff must prove deliberate indifference by the defendant, City of North Charleston. Deliberate indifference may be found where the need for more or different training is so obvious and the failure to train is likely to result in the violation of constitutional rights.

To impose liability under 1983 for failure to train its officers the plaintiff must plead and prove by a preponderance of the evidence the following elements: That the officers actually violated the plaintiff's constitutional or statutory rights, that the officers acted under the color of state law and as I have explained as officers of the City of North Charleston that element is established; that the City failed to train properly the officers thus illustrating a deliberate indifference to the rights of the persons with whom the officers come into contact.

And finally that the failure to train actually caused the officers to violate the plaintiff's rights and is so closely related to the deprivation of the plaintiff's rights as to be the moving force that caused the ultimate injury. A section 1983 failure to train

claim cannot be maintained against a governmental employer in a case where there is no underlying constitutional violation by the employee.

I instruct you that deliberate indifference is the conscious choice to disregard the consequences of one's acts or omissions. The plaintiff may prove deliberate indifference in this case by showing that the defendant, City of North Charleston knew its failure to train adequately made it highly predictable that it's police officers would engage in conduct that would deprive persons such as the plaintiff of her rights.

I further instruct you that deliberate indifference is a stringent standard of fault requiring proof that a municipal actor disregarded a known or obvious consequence of his actions.

Thus the plaintiff must prove the City had actual or constructive notice that a particular omission in their training program causes officers to violate citizen's constitutional rights. If proven by the plaintiff the City may be deemed deliberately indifferent if the policy makers chose to retain that program.

I further instruct you that municipal liability under a 1983 action attaches where and only where a deliberate choice to follow a course of action is made from among various alternatives by the relevant

officials. I further instruct you that when a plaintiff alleges a failure to train case it is ordinarily necessary that the plaintiff must prove a pattern of similar constitutional violations by untrained employees to demonstrate deliberate indifference for purposes of proving a failure to train case.

When municipal liability is premised on omissions in training law enforcement officers a plaintiff must show that the municipal officials were at least deliberately indifferent to the constitutional rights of the citizenry in their failure to train. Allegations of mere negligence are insufficient to state a claim.

The fact that more or better training could have been instituted is not enough by itself to establish a claim for deliberate indifference. It is recognized even adequately trained officers occasionally make mistakes and those mistakes say little about the training program. A sufficiently close causal link must be shown between the potentially inculpating training deficiency or deficiencies and the specific violation alleged.

This requires first that a specific deficiency rather than general laxness or ineffectiveness in training be shown. It then requires that the deficiency or deficiencies be such given the manifest exigencies of police work at to make occurrences of the specific

violation a reasonable probability than a mere possibility. The specific deficiency or deficiencies must be such as to make the specific violation almost bound to happen sooner or later rather than merely likely to happen in the long run.

I have explained to you the required elements of proof of the plaintiff's section 1983 claims. If you find for the plaintiff on one of her 1983 claims it will then be necessary for you to address the issue of damages. On the other hand if you decide for the defendants on all section 1983 claims then it will not be necessary for you to address the issue of damages.

The fact that I have instructed you on the proper measure of damages should not be considered as an indication of any view of this court as to which party is entitled to your verdict in this case. Instructions as to the measure of damages are given only for your guidance in the event that you should find in favor of the plaintiff on one of her claims.

The plaintiff has the burden of proving damages by the greater weight or the preponderance of the evidence. Damages must be proven with a reasonable degree of certainty. Recovery cannot be based on damages that are purely speculative. You may not base your determination of plaintiff's damages on speculation, conjecture or

guesswork. The plaintiff is not required to prove the amount of damages alleged to a mathematical certainty. The fact that the exact amount of damages may be difficult to ascertain or that damages cannot be measured by a pecuniary standard is no reason for denying an award of damages. Although damages need not be established to a mathematical certainty they must be established to a reasonable certainty and they should be a reasonably close estimate of the plaintiffs alleged losses.

For a plaintiff's claims you may consider an award of actual damages. Actual damages are properly called compensatory damages meaning to compensate to make an injured party whole, to put him in as close to the same position that he was in prior to the injury or loss insofar as a money judgment can do this.

In other words actual or compensatory damages include compensation for all injuries or losses that were the natural and proximate result of the alleged wrongful conduct of the defendants. Damages are never presumed and the burden is on the plaintiff to present evidence that supports the assessment of damages.

The assessment must be ascertainable from the evidence and sufficient to enable you, the jury, to make a fair and reasonable determination of damages, if any. Without adequate proof by a preponderance of the evidence

there can be no award of damages in any amount. You may consider the following types of damages if they are established by the greater weight or the preponderance of the evidence:

Bodily injury, physical and mental pain and suffering, mental anguish, expenses incurred for necessary medical treatment, loss of enjoyment of life suffered as a result of the injury and any other losses reflected by the character of the injury. Pain and suffering damages compensate the plaintiff for physical discomfort and emotional response to the sensation of pain caused by the injury itself.

In making an estimate of damages to be awarded for pain and suffering you may consider the nature and extent of the injuries and the suffering occasioned by them and their duration. The amount of damages, if any, to be awarded for pain and suffering must be left to your judgment.

There is no definite standard by which to compensate for pain and suffering. You and you alone have the authority to determine the amount, if any, to be allowed for pain and suffering and the law requires that you use calm and reasonable judgment to ensure that the damages, if any, are just and reasonable in light of the testimony and evidence presented in the case. If you award

compensatory damages for physical injuries to the plaintiff you may also consider damages for mental or emotional injury to the plaintiff. The term mental anguish includes both the results of mental sensation of pain and also the accompanying feelings of distress, fright, and anxiety. That is mental anguish covers not only the pain associated with the injury but also the mental reaction to that pain and to the possible consequences of that injury.

Mental anguish is more than mere disappointment, anger, worry, resentment or embarrassment though it may include all of these. And it includes mental sensation of pain resulting from such painful emotions as grief, severe disappointment, indignation, wounded pride, shame, despair and humiliation.

Mental anguish can be composed of fright, nervousness, grief, anxiety, worry, humiliation, embarrassment or ordeal where it is the natural and proximate consequence of the wrong in light of the testimony and evidence presented in the case.

The amount of damages, if any, for mental suffering cannot be exactly measured. To that end compensatory damages may include not only out of pocket loss and other monetary harms but also such injuries as impairment of reputation, personal humiliation and mental anguish and

suffering. The injured party may also recover for such future damages as it is reasonably certain will of necessity result from the injuries.

The principal underlying compensation for future damages is that only one action can be brought and therefore only one recovery had. It is proper to include in the estimate of future damages compensation for pain and suffering as will with reasonable certainty result.

I further instruct you that if you return a verdict for the plaintiff on a section 1983 claim but the plaintiff has failed to prove actual or compensatory damages for her claims then you must award nominal damages of one dollar for that claim.

A person whose federal rights were violated is entitled to a recognition of that violation even if he or she suffered no actual injury. Nominal damages such as one dollar are designed to acknowledge the depravation of a federal right even where you find no actual injury occurred.

However, if you find actual injury you must award compensatory damages within your fact finding province as I've previously instructed rather than nominal damages. I further instruct you ladies and gentlemen that if you find that the plaintiff was permanently injured as a result of the defendant's actions you must then decide

how, if at all, that injury will affect the rest of the plaintiff's life. A person's life expectancy is determined by a life expectancy table, which is part of the laws of the state of South Carolina. The life expectancy table is only an estimate of the probable average remaining length of life of all persons in our state of a given age.

The plaintiff is a 69 year old female with a life expectancy according to the South Carolina life expectancy table of 17.12 years. This fact is to be considered by you along with any other facts and circumstances in evidence bearing on the plaintiff's life expectancy including occupation, habits and health at the time of injury in deciding the amount of damages, if any, to be awarded to the plaintiff.

Ladies and gentlemen the plaintiff has the burden of proving her damages by the greater weight of the evidence. But this does not mean that she must prove them to a mathematical certainty or produce evidence of the precise amount of damages she alleges to have suffered rather the evidence put forth by the plaintiff should be such as to enable you, the jury, to determine what amount of damages, if any, is fair just and reasonable. The defendants claim that at the time of the incident the plaintiff was suffering from an existing

physical defect. Even if you should find this to be so the mere fact of an existing defect would not prevent the plaintiff from recovering damages from the defendant. The defendant takes the plaintiff as he or she is found and the plaintiff is entitled to recover damages resulting from the aggravation of a preexisting injury as well as for any new or additional injuries sustained in the subsequent incident provided of course such aggravation or new injuries are the natural and proximate result of the act or omissions of the defendant.

Under our laws a person who injures another is responsible for all the effects which are related to the incident and this is true no matter what the plaintiff's physical condition was when the incident occurred. It may seem that if the plaintiff had been in good health the injury would not have happened or that it would have been easier to cure. That would in no way affect the defendant's liability.

If the presence of a disease or an existing physical condition aggravates and prolongs the injury which in turn increases the amount of damages then the plaintiff is entitled to recover the increased amount. If you find that the plaintiff had an existing physical impairment before the incident the amount you award for damages, should not include damages for the existing impairment.

I further instruct you that when the plaintiff is injured or damaged by the wrongful acts of another person it is the duty of the plaintiff to reasonably try to avoid and lessen the damages.

Those damages which may be avoided by the use of reasonable efforts, care and prudence by the plaintiff cannot be the proximate result of the defendants acts. Therefore, the plaintiff cannot recover for damages which reasonably might have been avoided.

The efforts required by the plaintiff must be determined by the rules of common sense and fair dealing and what a person of ordinary reason and prudence would do under the same or similar circumstances. The plaintiff is not required to use unreasonable efforts or great expense to avoid and lessen the damages. The defendant has the burden of proving a failure to lessen damages on the part of the plaintiff by the preponderance or greater eight of the evidence.

The plaintiff is required to use reasonable care and diligence to reduce the seriousness of the injuries caused by the defendant. This duty includes making a reasonable attempt to see a doctor and take part in any other recommended therapy programs. If you find that the plaintiff has failed to do this the plaintiff may recover damages for the injuries themselves but not damages for

the aggravation of the injuries. In addition to actual damages the plaintiff has asked for an award of punitive damages, which are also called exemplary damages. If you find the plaintiff is entitled to actual or nominal damages under 42-USC-1983 then you may consider whether the plaintiff is entitled to punitive damages.

Punitive damages are imposed as punishment. They are not intended to compensate. Punitive damages are allowed in the interest of society in the nature of punishment and as a warning, an example to deter the wrongdoer and others from committing like offenses in the future. Moreover they serve to vindicate a private right by requiring the wrongdoer to pay money to the injured party. The plaintiff has the burden of proving that punitive damages should be awarded by clear and convincing evidence.

To support an award of punitive damages the plaintiff must prove by clear and convincing evidence that the conduct complained of included a consciousness of wrongdoing at the time of the conduct. Clear and convincing is a legal term meaning more than just the preponderance of the evidence. Clear and convincing proof leaves no substantial doubt in your mind. It is proof that establishes in your mind not only that the proposition at issue is probable but that it is highly

probable. Punitive damages may only be awarded against an individual defendant in an action pursuant to 42 U.S.C. 1983 where the individual's conduct is shown to be motivated by evil motive or intent or where it involves reckless or callous indifference to the federally protected rights of others.

Reckless and callous are terms used to describe a conscious failure to use reasonable care. A person whose behavior is reckless or callous is not only careless in their actions but also aware they are being careless. You can consider the following factors if you deem an award of punitive damages is proper:

The defendant's degree of culpability, the duration of the conduct, the defendant's awareness or concealment of the conduct, the existence of similar past conduct, the likelihood the award will deter the defendant or others from like conduct whether the award is reasonably related to the harm likely to result from such conduct, and the defendant's ability to pay.

The defendants have asserted the affirmative defense of qualified immunity. And in that regard I instruct you that governmental officials performing discretionary functions generally are shielded from liability for civil damages insofar as their conduct does not violate clearly established statutory on constitutional rights of which a

reasonable person would have know. I instruct you that government officials who are performing discretionary functions should be shielded from civil liability through qualified immunity since that defense protects all but the plainly incompetent or those who knowingly violate the law.

This accommodation exists because officials should not err always on the side of caution because they fear being sued. Where that rule is applicable officials can know that they will not be held personally liable as long as their actions are reasonable in light of the current American law.

One reason for the defense of qualified immunity is that if reasonable mistakes would always be resolved in favor of an action then effective law enforcement would be lost. The qualified immunity inquiry must be filtered through the lens of the officer's perceptions at the time of the incident in question.

Limit second guessing to reasonableness of actions with the benefit of 20/20 hindsight and limits the need for decision-makers to sort through conflicting versions of actual facts and allows them to focus instead on what the police officer reasonably perceived. I further instruct you that there are certain exemptions from liability for governmental entities such as the

defendants in this case. Once such exemption says that a governmental entity is not liable for a loss resulting from the exercise of discretion or judgment by the governmental entity or employee, or the performance or failure to perform any act or service which is in the discretion or judgment of the governmental entity or employee.

A governmental entity is entitled to immunity if it shows that when faced with alternatives it weighed competing considerations and made a conscious choice and then used accepted professional standards to make that choice.

Ladies and gentlemen that will conclude the reinstruction. If there is anything further you need the court to address please make me aware of it and I will accommodate your request immediately. If you would, go with the bailiffs and resume your deliberations.

[Whereupon, the jury exits at 10:59 a.m.]

THE COURT: Any exceptions from the plaintiff?

MR. MEYERS: No, Your Honor.

THE COURT: From the defense?

MR. DORSEL: None that we haven't previously argued.

THE COURT: We'll await further instructions from the jury.

[Whereupon, court is in recess awaiting further instruction from the jury]

THE COURT: The jury's note reads as follows: First question can you please define the word preponderance. And in that regard I'll reinstruct them on the greater weight or the preponderance of the evidence which is the burden of proof.

And their second question is do all the criteria under section 1983 claiming the 4th Amendment have to met. And I think the simple answer to that question is yes. Is there any exception from the plaintiff?

MR. MEYERS: No, I don't think so, Your Honor.

THE COURT: From the defense?

MS. SENN: No, ma'am.

THE COURT: What I'm going to do is bring them back in and reinstruct them and then I will just tell them the answer to their second question is yes. Any exception from the plaintiff?

[Whereupon, court's exhibit number 25 is marked by the court reporter]

THE COURT: I'm trying to figure out a simple way to answer this question because I think they may have two concepts confused but maybe not. The first question is an easy answer. May we please have a copy of the U.S.C. 42 section 1983 and the answer to that question, of course, is no; I would have to reinstruct them.

But the second question is for there to be a violation of a civil right, 4th Amendment, the plaintiff must demonstrate through the preponderance of the evidence to be bodily harm or injury or mental i.e. damages. And I'm trying really to figure out what they're asking. I'm not certain whether they have the concept of proximate cause or damages confused. I think the remedy is to just reinstruct them on the elements of 42 U.S.C. 1983 and what must be proven in order to establish.

So I think they're not stuck on the failure to train part of it. I think they're working through the warrantless entry part of it. First of all those three elements have to be met and then they move on to damages. That might be the simple way to answer it; I don't know what do y'all think? What does the plaintiff think?

MR. MEYERS: I think your projection is correct,

Your Honor. That's the way I read it too that that's what they are trying to focus on. But if the court goes back to the elements I think you need to include the nominal damages instruction too because they may be looking for a particular impact on the plaintiff versus the violation itself.

THE COURT: Well, I don't think they get to damages unless they determine the three elements of the 1983 action have been met, which is that there was a violation of her right, that they acted under color of state law and that -- it requires more than just the violation; there has to be proximate cause, which is what I think they are struggling with in this case.

And they don't even get to damages unless they determine in their fact finding province that proximate cause has been established by a preponderance of the evidence because you don't even to nominal damages unless there is -- well, you can get to nominal damages if you find there is a violation of rights and you find the person has no damages you can award ---

MR. MEYERS: --- that's what I'm saying ---

THE COURT: --- award the dollar. But I don't think -- I don't know, what does the defense think?

MS. SENN: Certainly if Your Honor is intending to or thinking of instructing them on the dollar we would

asking about police training. I think they are talking about the first part of the instruction. And I think the instruction in and of itself is clear that you don't get to damages unless you find there was a violation. And even if you find there was a violation you still have to prove damages.

But even if you find that no damages have been established you can award a dollar, which is nominal damages. So give me one second and let me look through this right quick and then I'll tell you exactly what I'm going to do.

[Whereupon, the court reviews documents]

THE COURT: I am debating because the more I read this note the more I think they have confused damages in the elements of section 1983. And I think it could be very confusing again to go through this whole explanation of damages because I think they are clear on what amounts to damages and how you calculate damages.

I'm just inclined to reinstruct the elements of 1983 and instruct that before you even get to damages -- that there are two different concepts -- and before you get to damages you have to determine whether the elements of the 1983 claim have been met; that being the 4th Amendment. And in that regard I'll reinstruct them on the elements of 1983. And then if they ask me to reinstruct on

damages I will do that again, but that is a lot. I can't just dissect that out; I'd have to reinstruct all of damages, which is aggravated preexisting condition, the affirmatives defenses; all of that again.

And I think all they're asking is in order for there to be a violation of a civil rights 4th Amendment the plaintiff must demonstrate through the preponderance of the evidence there to be bodily harm or injury and that's really not the inquiry. The inquiry is whether the plaintiff has proven by a preponderance of the evidence those three elements and whether the State -- the defense has proven that there existed an exigent circumstance by a preponderance of the evidence thereby eliminating the second element being the violation, the Constitutional violation.

And then the next hurdle is whether the plaintiff has established that there was proximate cause of an injury. And then if they ask me for more then I'll instruct more, otherwise I'm going to have to reinstruct all of damages and I'm just not convinced that they need that, that they are not clear about what damages are. I think they're asking -- I think they have confused two concepts, which is it is no different than in a negligence case when you have to establish the four elements of negligence and you don't get to damages

unless you've established those four elements of negligence. And that's my perception. Is there any exception from the plaintiff?

MR. MEYERS: Well, yes Your Honor, just because if they are not also given the information about the nominal damage then they could be confused ---

THE COURT: --- I don't even think they get to that unless they establish those elements of the 1983 action.

MR. MEYERS: As long as they understand that the elements in the 1983 action include nominal damages ---

THE COURT: --- that's damages. They don't even get to damages unless you've established these three elements.

MR. MEYERS: Yes, but element three is the proximate connection.

THE COURT: That's proximate cause and that's how you get to damages. Proximate cause is not damages. Proximate cause is these things triggered damages.

MR. MEYERS: So what the court has articulated if I'm hearing you right is that a direction of the jury ---

THE COURT: --- I don't think they are unclear as to what constitutes damages. I think they are unclear as to what is required to be proven in 1983 which is constitutional violation under color of state law, proximate cause.

MR. MEYERS: And then the burden shift to the defendants ---

THE COURT: --- to prove that there was a negligence based on a reasonably objective, blah, blah. Any exception from the defense?

MS. SENN: No, ma'am.

THE COURT: And then this jury has been very articulate. They've been very outspoken. If they need more I anticipate they will tell me that. I just don't see me going through 20 minutes of damages when I don't think they are unclear about that issue. I think they know what constitutes damages. Get the jury for me please.

[Whereupon, the jury enters at 12:26 p.m.]

THE COURT: Ladies and gentlemen I received your note. The first question is may we please have a copy of U.S.C. 42 Section 1983 and the short answer to that question is I cannot provide you with a copy.

First, the federal statute is probably 100 pages in and of itself and what I give you are instructions that redacted from that statute that have been approved and subject to case law telling us exactly what the elements of a 1983 action. And under our rules we do not allow for the jury to have a copy of the jury instructions. So I will not be able to accommodate that request. Your

THIRD JURY RECHARGE

THE COURT: The plaintiff asserts claims pursuant to 42 United States Code Section 1983 against the defendants claiming that by entering her home without a warrant the defendants violated her 4th Amendment rights under the United States Constitution to be free from unreasonable seizures.

As I have instructed this case is what is called a section 1983 case. Section 1983 of Title 42 of the United States Code provides that any citizen may file a civil action seeking damages against any person who under color of state law deprives that citizen of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

In order to prove her claims the plaintiff must establish by the greater weight or the preponderance of the evidence the following three elements: The defendants committed an act which operated to deprive the plaintiff of her rights secured by the United States Constitution. Second that the defendants acted under color of state law. And finally the defendants actions were the proximate cause of the plaintiff's damages.

Each of these elements must be established separately for the plaintiff to prevail on her claim. If the plaintiff proves all of these elements by the greater

weight or the preponderance of the evidence for her claim then you must return a verdict in favor of the plaintiff on that claim. If however she fails to prove any of these elements for her particular claim you must return a verdict for the defendants on that claim.

Because the individual defendants were officers of the City of North Charleston at the relevant time I instruct you that they were acting under color of state law. In other words the second element of the plaintiff's claim is not in dispute and you must find that this element has been established.

I will now instruct you on the first element that being an act that deprives a person of his or her rights under the Constitution for the plaintiff's 4th Amendment warrantless entry claim. I will then instruct you on the third element proximity causation of damages. The plaintiff, Rhonda Doe, alleges that the defendants violated her rights under the 4th Amendment of the United States Constitution to be protected from unreasonable seizures by entering her home on March 27th of 2014 without a warrant.

And in that regard I instruct you a warrantless entry is per se unreasonable and violates the 4th Amendment unless the search falls within one of the exceptions to the exclusionary rule. The burden rests on

the defendants to establish the existence of such an exception to the warrant requirement. The exigent circumstances doctrine allows warrantless entry by law enforcement officials where there is a compelling need for official action and no time to secure a warrant.

Police may enter a home without a warrant when they have an objectively reasonable basis to believe that an occupant is seriously injured or imminently threatened with serious injury. This exception requires only an objectively reasonable basis for believing that a person within the house is in need of immediate aid.

The existence of exigency is determined based on the information available to the officer at the time of the warrantless entry. All the evidence within the officer's knowledge may be considered including the details they observed while responding to information provided to them. Exceptions to the warrant requirement include the need to protect to preserve life or avoid serious injury.

An action is reasonable under the 4th Amendment regardless of the individual officer's state of mind as long as the circumstances viewed objectively justify the action. A fairly perceived need to act on the spot may justify entry under the exigent circumstances exception to the warrant requirement. Protecting the safety of police officers has also been held an exigent

circumstance. A warrantless entry is justified under the exigent circumstances doctrine where there is risk of danger to police or others inside or outside a dwelling. In such circumstances a protective sweep of the premises may be permitted.

In reviewing the justification for a warrantless entry under the exigency exception it is appropriate to look to the totality of the circumstances to determine whether the officer's actions were reasonable and justified.

To determine whether officers had an objectively reasonable basis reasonableness must be judged from the perspective of a reasonable officer on the scene rather than with 20/20 vision of hindsight and the calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split second judgments in circumstances that are tense, uncertain and rapidly evolving.

I further instruct you that a police officer has the authority to arrest a person without a warrant for a misdemeanor committed in his presence. Ladies and gentlemen you must decide whether the defendants have proven by the greater weight or the preponderance of the evidence that the defendants had an objectively reasonable basis under the exigency exception to enter

the residence without a warrant. To determine whether an exigency existed you should consider whether the facts and circumstances available to the defendants would cause a prudent officer to believe their entry under the exception of exigent circumstances was warranted.

The defendants actual motivation is irrelevant. Even if you determine his or her motive was improper and officer's improper motive is irrelevant to the question of whether the objective facts available to the officer at the time constituted an objectively reasonable basis to enter the residence.

What matters is whether the defendants acts were objectively reasonable in light of the facts and circumstances confronting the defendants. To establish the third element the plaintiff must prove by the greater weight or preponderance of the evidence that the constitutional violation was the proximate cause of her injuries.

To establish proximate cause the plaintiff must establish both causation in fact and legal cause. Causation in fact is proven by establishing that the plaintiff's injury would not have occurred but for the constitutional violation. Legal cause is proven by establishing that the injury was foreseeable meaning that the injury was the natural and probable consequence of

the constitutional violation. To find that an act of the defendants caused an injury to the plaintiff you need not find that the defendants act was the nearest cause either in time or space of that injury.

However, if the plaintiff's injury was caused by a later independent event that intervened between the defendant's act and the plaintiff's injury then defendants are not liable unless the injury was reasonably foreseeable by the defendants.

The plaintiff must prove that some injury from the defendant's act was foreseeable but does not have to prove that the particular injury that occurred was foreseeable. However, the defendants cannot be held responsible for things which could not be expected to happen.

THE COURT: That concludes the additional instruction. If you need anything further please advise us and I will accommodate your request immediately.

[Whereupon, the jury exits at 12:37 p.m.]

THE COURT: Any exceptions from the plaintiff?

MR. MEYERS: I do have a concern, Your Honor that you do have to get onto the subject of injury to give the instruction you've just given touches on that. They have to prove the causation of the injury and I think they could conceivable be hung up on whether the nominal damage fits as part of the injury.

THE COURT: They wouldn't get to that unless you prove there was an injury. There was a constitutional violation.

MR. MEYERS: Yes. But if they conclude there is a constitutional violation ---

THE COURT: --- I don't think they ---

MR. MEYERS: --- they also think they have to find that ---

THE COURT: --- I don't think they are unclear about damages.

MR. MEYERS: Okay.

THE COURT: I think they mixed the two concepts which is they had to prove that a damage constituted a violation and that's not correct. There are three

elements that have to be proven; that there was a violation, that they acted under color of state law and there is proximate cause. You don't even get to damages until those three elements are met. And I think it would run the risk of them being confused in that regard.

But if they need something else they'll tell us. I don't think they are unclear about what constitutes damages. I think they were unclear about what constitutes the elements of the 1983 cause of action. They don't even get to nominal damages unless you've proven that there was a constitutional violation.

MR. MEYERS: To that extent I see it differently.

THE COURT: Yes, I don't think they are confused about that. I'll note your exception for the record. Any exceptions from the defense?

MR. DORSEL: No, Your Honor.

THE COURT: Their lunch should get here by 1:00. If it gets here sooner than that I'll let you know. But I would ask that you all not leave the courtroom until I excuse you for lunch so that we can have consensus about what time you need to return and I will let you know that as soon as their lunch arrives. And I've had the note marked as a court's exhibit. We'll await further instructions from the jury.

[Whereupon, court is in recess]

VERDICT

THE COURT: All right. We have a verdict. Is there anything from the plaintiff or the defendant before I receive the jury?

MR. MEYERS: Only what I've already said, Your Honor about the ---

THE COURT: --- I think we've covered that. I'm talking about anything else before receiving their verdict?

MR. MEYERS: Nothing else.

THE COURT: Anything from the defense?

MR. DORSEL: No, Your Honor.

[Whereupon, the jury enters at 12:50 p.m.]

THE COURT: Mr. Foreman, is it correct that the jury has reached a verdict?

THE FOREPERSON: Yes ma'am, we have.

THE COURT: If you would give the verdict forms to the bailiff for me please?

[Whereupon, the verdict forms are provided to the bailiff and then to the court]

THE COURT: And the verdict forms read as follows: As to the plaintiffs claims against the City of North Charleston question one, do you find that the plaintiff has proven by a preponderance of the evidence that the City of North Charleston violated Rhonda Doe's

POST TRIAL MOTIONS

THE COURT: Are there any post trial motions from the plaintiff?

MR. MEYERS: None I can think of at the moment, Your Honor.

THE COURT: Well, I need to hear them now. I don't take ten days. Ten days from now I'll have to get a transcript and relearn it because I'll be doing something else the next week.

MR. MEYERS: Well, I would move for a new trial just based on the jury instruction that we had at the very end. I was pretty sure that's what they were concerned about and the failure to give that instruction I think precluded them from considering that possibility.

THE COURT: Does the defendant have any post trial motions and response to Mr. Meyer's motion?

MS. SENN: Not in response to his motion, no ma'am.

THE COURT: Do you have any motions?

MS. SENN: Yes, ma'am. We'd move under S.C. Annotated 15-36-10 for sanctions as well as Rule 11 because when this case was started it was frivolous litigation and the ---

THE COURT: --- don't you have to put him on notice? Did you plead that?

MS. SENN: I probably did, Your Honor, but I went

different -- had a very different factual recitation on both sides, which were diametrically different in their posture. The jury in its fact finding province determined who they believed in terms of -- because there are lots of nuances one of which being the exigency exception. I think that -- and I'm sort of crossing over both sides of what you all have argued to the court.

First dealing with Mr. Meyers motion for a new trial I'm denying that motion. I do not find that the verdict in this case was actuated by passion, prejudice, sympathy, or some other evidence found outside of the evidence. I think there was more that replete evidence to support the jury's finding that there was not a constitutional violation.

I do not believe that his argument is with merit dealing with the additional instruction. This has been an astute jury who asked a lot of questions and I do stand by my original observation that -- I think they were mixing apples and oranges in common parlance.

There are elements that had to be met before they ever got to damages and for the nominal damages to have ever been a question they would have had to have met the first hurdle; one being that there was a constitutional violation. And apparently they found that there was not when they answered the first question. And so I do not

find any merit to that argument nor do I find any -- the only time the court should grant a new trial or grant relief in that regard is when there is no evidence to support a jury's finding. And I find -- I've been observing these jurors for two weeks. They have been very attentive.

They have I think given absolutely due consideration to the arguments, the facts and the law. They deliberated from 3 o'clock to 6:02 on yesterday and from 9:30 to 12:46 today, which means they gave a great amount of attention to the facts and circumstances of this case as well as applying the law to this case. And I just don't see any basis to disturb that award.

And you all look at juries from an advocacy standpoint. I have the luxury of being a lot more objective and I know I've done this long enough to know from body language where people's positions are. And I pretty much know where -- I'm not clairvoyant but I can kind of tell from the dynamic of a jury who is leaning one way or the other, what they are sort of thinking.

And I can also tell from notes exactly what the trend of thought is in deliberations. And I don't think the jury was ever unclear as to what constituted damages. I think their real consternation was whether the police had the right to enter this house based on exigency. And

based on their findings they clearly found that the State, I mean the defense in this case met their burden by a preponderance of proof that an exigency based on an objectively reasonable basis existed to enter the house to prevent harm or imminent harm to someone was in the residence.

I always felt that the argument regarding training was tenuous. Officers are not clinicians. They are required to look at the totality of the circumstance when they go into a situation and make a determination based on that totality. And there was more than abundant evidence in the nature of the testimony of the gentleman Brian Bennett which was the defense expert regarding the training that officers received on dealing not just with vulnerable adults but children, the vulnerable population in general and that that training was more than adequate in terms of their training.

It was just such a -- either -- it was a creditability contest. Either the jury was going to believe Ms. Meyer, Parker Meyer's version of events or they were going to believe the officer's version. And based on their verdict they believed the officer's version which is totally within the ambit of their fact finding province. Now as it regards a frivolous civil proceeding claim, I'm looking at your answer...

IN THE COURT OF COMMON PLEAS
FOR THE STATE OF SOUTH CAROLINA
CHARLESTON COUNTY

DEPOSITION OF KATHY BOLUS, M.D.

JANE DOE 202, BY JOHN DOE MM AND JOHN DOE HS, EACH OF WHOM HOLDS POWER OF ATTORNEY FOR JANE DOE,

Plaintiff,

vs. CASE NO. 2014-CP-10-4591

CITY OF NORTH CHARLESTON; LEIGH ANNE MCGOWAN, INDIVIDUALLY, CHARLES FRANCIS WHOLLEB, INDIVIDUALLY, ANTHONY M. DOXEY, INDIVIDUALLY; HOWARD THOMAS, INDIVIDUALLY, AND MICHAEL KOURIS, INDIVIDUALLY,

Defendants.

DEPONENT: KATHY BOLUS, M.D.

DATE: July 14, 2016

TIME: 8:57 a.m. - 9:42 a.m.

LOCATION: SENN LEGAL
3 Wesley Drive
Charleston, SC 29407

REPORTED BY: SARAH GACIOCH

BY MR. DORSEL:

Q. And likewise, just hearing the word "dementia," and based on the interactions with Jane Doe, is there any indication, in your experience, that she couldn't be left alone?

A. No. No, sir.

Q. And what is your overall opinion on whether the officers knew or should have known that Jane Doe couldn't be left alone?

MR. MEYERS: Same objection. Outside the scope of expertise. Go ahead, Dr. Bolus.

BY THE WITNESS: What's my opinion whether they should have known? I think that Officer McGowan when she heard that the patient had dementia, as she said, it just didn't register in her mind. So, you know, had she -- had it registered at the time, then certainly the officers could have inquired. I think Parker, or the daughter, certainly could have or should have let one of the officers know that the mother couldn't be left alone, and I just don't think either thing happened.

BY MR. DORSEL:

Q. Okay. Now, the second opinion, March 27 did not lead to the hospitalization on March 29th, I

want to talk to you about that, and first I want to -- one of the things that's talked about is a UTI. What is a UTI?

A. UTI is an infection of the urinary tract, and most commonly it's a bladder infection or cystitis.

Q. Now, does a UTI effect or have different effects on people that suffer from dementia?

A. Yes. It's not as easy -- in a young woman who has a blader infection, they have the classic symptoms of burning when they urinate, of going frequently, of feeling like if they don't go right now they are going to wet themselves. As you get older, you lose those sensations in the bladder. So older adults don't have the symptoms that you do classically when you're younger. Then when you have dementia on top of that, you don't have the -- any queues, the typical queues.

Usually the things that might signify in an elderly sick patient that they have a bladder infection would be a change in their mental status, a change in their behavior, you know, something is different from that patient, and that's usually an indication that you need to look for an infection.

Q. When you say "a change in behavior," what kind of behaviors are you talking about?

A. Well, when you're dealing with dementia particularly, it is increase in agitation, increased wandering, more hallucinations, more combative, or more sedate, you know, more not -- not as conscious, not as interactive with the outside world.

Q. All right. And typically with urinary tract infections, how long do they take to develop?

A. Generally it takes one to two weeks for the bacteria to get into the bladder and cause enough problems that it can lead to systemic symptoms, which is what you would see in the elderly patients.

Q. Now, can a person develop a urinary tract infection by sitting in a dirty diaper for 12 to 15 hours?

A. That is certainly possible, yes.

Q. And if that were two happen, what would you expect?

A. Well, if somebody had been sitting in a dirty diaper for 12 to 15 hours, there would -- you would expect to see that their bottom that was exposed to the urine and the stool for 15 hours would be red, like diaper rash like you would see with a baby.

Q. And what would -- would you expect anything else in terms of behavior, if it were to start suddenly from sitting in a diaper all day?

A. Well, if you get a urinary tract infection that's severe enough to cause a hospitalization, if that's what the question is, generally for that to happen you need a couple of days, but for a severe urinary tract infection to cause a hospitalization, they usually get what they call delirium, which is in medical terms an altered sensorium. They are not able to interact with the world around them. They are not -- they are not as attentive. They can't concentrate. They can't answer questions. They just don't interact with the world around them, and that's what they call a delirium, and that's an acute change, and you would expect to see that if the UTI is what led to her hospitalization on the 29th.

Q. Well, and let's talk about our case and Jane Does' hospitalization. The hospital records say she had a UTI; do you know for sure whether she had a UTI or not?

MR. MEYERS: Object to the form of the question.

BY MR. DORSEL:

Q. Let me rephrase that.

A. Okay.

Q. In our case, based on the hospital records,

are you aware of whether any testing was done to confirm that she had a UTI?

A. No. She did not -- what she had was what they call a dirty urine. She had bacteria in her urine and white cells in her urine, which a lot of elderly patients do have from incontinence, from inability to empty their bladder all the way, from poor hygiene. So just the fact that she had white cells and bacteria in her urine does not mean she had a urinary tract infection; in fact, only 38 percent of dirty urines are positive for a urinary tract infection. The confirmatory test would have been a urine culture, which she did not have. So we don't have any true documentation that she had a urinary tract infection.

Q. Well, for the purposes of this testimony, if Jane Doe did, in fact, have a UTI, do you have an opinion on when that UTI would have started?

A. Well, it's certainly possible that it could have started weeks before when they first started noticing that her behavior -- that she was more agitated and more combative, and that had she been going to a doctor regularly certainly would have caused them to go ahead and check her urine to see if she had an infection. And there were also

periods of time where she was left at home while Parker was working where she certainly could have dirtied her diaper as soon as Parker left, and she could have got a urinary tract infection that way. So there's no way to say if she had a UTI when it started, but that would have been the first time to look for it.

Q. Okay. Well, do you have an opinion in this case whether Jane Doe sitting in her diaper for that time period, 12 to 15 hours, actually caused her UTI in this case, if she had one?

A. I don't believe that, that was the cause of her UTI if she had one, right, because, one, it was too early; two, she was definitely not delirious when she got admitted. When she got admitted to the hospital, she was awake; she was alert; she was answering questions; she could tell them the president; she told them their names; she told them she was a happy person. Certainly attentive, concentrating, participating in the interview, definitely not symptoms of delirium.

Q. Did you see anything in the records about redness or skin breakdown?

A. No. And it didn't appear that she had any redness of her bottom, and I'm sure they looked,

because there was the question of abuse, and so there was no mention ever that it looked like she had been sitting in a dirty diaper for a long period of time.

Q. Now, the hospitalization on March 29, do you have any opinion on whether it was caused by not eating or drinking fluids for that time frame?

A. It does not appear that, that was an issue at all when you look at her labs. She doesn't appear dehydrated. Her urine is not concentrated to suggest dehydration. Her protein scores were all good, so she appeared to be well fed and well hydrated. If you look at Parker's testimony, she always opened a bag of chips before she put the mom to bed, and the mom always had access to water, Gatorade, coke, and was able to twist off the top, so she had access to food and water; not the best food and water, but she had access, and she appeared to be well hydrated and well fed when she got admitted.

Q. And then is there anything in the testimony of Jane Does' brother that would indicate whether or not, not eating or drinking led to her hospitalization?

A. Certainly not that I read. He went to see

her the following day when he found out, so early afternoon, after, it sounds like, about 15 hours that she was left alone. He found her in the house, said that she was doing fine. Fed her some ice cream. The house wasn't a mess. She didn't appear to be agitated. He felt like she was okay for him to then leave her for two more hours to pick Parker up from the jail.

They came back from the jail. Again, she seemed to be fine at home. They felt comfortable leaving her again to go see the lawyer. Then when they got home from the lawyer, she was eating fine, went to bed fine, had a -- and when he got back to see her on Saturday morning, she was eating breakfast. So she definitely seemed to be eating, behaving, and sleeping well.

Q. All right. And along those same lines, maybe consistent with what you just talked about, do you have any opinion as to whether being left alone had any change in her dementia?

A. You mean, you're talking about on the 29th?

Q. I'm sorry, yeah, let me rephrase that. We know that she went to the hospital on Saturday, March 29. Why do you think she had to go to the hospital at that point?

MR. MEYERS: Objection to the form of the question. Outside the scope of expertise. Go ahead, Dr. Bolus.

BY THE WITNESS: So you're -- what I feel like the events that led to her hospitalization I think were a culmination of several things. One, she had progression of her disease. She was to a point where she was wandering more, had more agitation, and was more combative, and that is part of -- a very difficult part of dementia as it progresses.

She was left alone that afternoon after they went to the, as Parker said, the doc-in-the-box. They brought the mom home, and then her dad came and picked her up and took her to the doctor. So she was -- so the mother was left home alone. Her routine had changed completely from her normal routine when he was home by herself, and at some point, because nobody was at the house with her, she wandered outside, saw Parker's car, which is usually not there when Parker's not there, and obviously that frightened her. She thought somebody was in it, nobody responded, and she was able to track down these neighbors, and they called 911.

So I think she got agitate -- she got

paranoid because she saw the car there. She got agitated because now the police have come again to the house, and by the time Sam got there, it was dusk, and then she also had some sundowning, so she was agitated from that whole event. And then Sam was so confused as to what was going on, and the police were called a second time. He couldn't calm the mom down, and he did the appropriate thing, which was call the police.

BY MR. DORSEL:

Q. Now, so let me back up a little bit, one of the reasons you gave for why she would need to go to the hospital on the 29th or why she needed to was the progression of the disease; is that correct?

A. Correct.

Q. All right. And another reason is that she was left alone on March 29th?

A. I think that had she not been left alone on that day and somebody had been at the house with her and redirected her behavior or gave her things to do so she wasn't left by herself, she probably would not have wandered out the front door and seen Parker's car, or if she had, then somebody at the house could have said, oh, that's just Parker's car, everything is fine, and things would not have

escalated the way they were. I think it was just a combination: Her disease had progressed; she was left alone; no one was there to redirect her; and Sam was confused. Had someone been there, I don't think she would have ever been admitted.

Q. And just -- you said she was left alone but Parker's car was there and that was different than her normal routine; what do you mean by that?

A. At least from Parker's testimony, they had set up a system where Parker would feed her in the morning and then leave to go do whatever she had to do with her work for a couple hours and then come back home and then leave again, however that situation works. So whenever Parker left her, Parker was in her car, and whenever Parker was home, Parker was home, and so the fact that Parker was gone and the car was there was a change in the usual routine.

Q. And is it your understanding that the mother didn't know whose car that was at that time?

A. Clearly she did not recognize that it was Parker's car.

Q. Okay. And so what is your overall opinion on whether the events of March 27th with the police coming into the house, whether or not that led --

directly led to her hospitalization on March 29th?

A. I don't think that the police coming into the house had anything to do with her hospitalization. I think that her disease had progressed in such a way that she obviously had wandered or had attracted the attention of at least two different neighbors at two different times that were concerned enough about her to call the police and get her a check, but I don't think -- I think the events of 3/27 brought her to the attention of health professionals, which ultimately I think helped her situation, but I don't think they led to her hospitalization any way.

Q. Okay. And is that to a reasonable degree of medical certainty?

A. Yes, sir.

Q. Now, the third area of your opinions was that the events of March 27th had no long-term effects on her dementia. What is the basis for that opinion?

A. Well, when you review her follow-up, after she got out of the hospital she saw the psychiatrist in June and then saw them again in August. When she went back to see the psychiatrist in June, the daughter reported that her behavior was excellent, that she was doing well; she had gained weight; she was eating well; she was not depressed. You read

her mood was not anxious. She was functioning well. So eating, gaining weight, participating in life essentially. She had a behaviorist at home. She had the hygienist at home. She had the home health nurse, so I think the stress level at home had also improved.

Q. With regard to the hospital records from MUSC from March 29th until she was released, were there anything in those hospital records that indicated to you whether her condition improved or deteriorated?

A. From when she got out of the hospital?

Q. Yeah. From her admission in the hospital to her discharge.

A. If you look at her, when she first got admitted the psychiatrist always evaluate her level of functioning and certainly her weight, et cetera. Her global assessment of function was what they call at 20, which is pretty severe. The psychiatrist look at -- they make -- the global assessment of function is a subjective assessment of how she's functioning, and they look at how she communicates, how she participates in society, how she's carrying on her activities of daily living, what her insight is.

When she was seen in May in 2013 that global

assessment of function was at a 41 to a 50. It had dropped when she stopped all of her medicines in June to a 30, but then it went back up to the 41 to 50 in July 2013.

By the time she got admitted to the hospital, her global assessment of function was a 20, which is a big drop. After she got out of the hospital and she was seeing the psychiatrist, it had improved to a 30, which meant that her functional level had improved since her hospitalization, in addition to her weight had improved from 118 to 126, and her strength had improved.

Q. Okay. Now, the -- with regard to the global functioning assessment in July of 2013, so 8 months before this, where she was in a 41 to 50 rage, to March 29th of 2014, when she had dropped all the way to 20, do you have an opinion as to what could have caused that drop?

A. Well, more than likely it was just progression of her disease. I think that had she been seeing a doctor regularly or an internist regularly or psychiatry, I think that maybe they could have gotten home health in earlier, maybe they could have got her on medications earlier, could have improved her behavior before it escalated like

it did. So I think it was probably lower than it could have been, because she wasn't seeing any internal medicine doctor regularly.

Q. All right. You mentioned -- I'm sorry, with regard to the global assessment, when she entered the hospital in March 29th, it was at a 20, and when she left it was at a 30; is that correct?

A. When she followed up in June, so two months later, it had improved to a 30, and then when she followed up two months later it was still at a 30, so she was maintaining a better level of functioning than she was when she was admitted.

Q. What, if anything, does that tell you about whether the events of March 27th, 2014 had any long-term effects on her dementia?

A. Well, clearly since her function had improved, I think, if anything, what the 27th did is brought her to the attention of the doctors, and it actually helped her. It got her the help she needed at home, the medicines she needed, but as far as long-term effects, I don't see any.

Q. All right. Now, you mentioned "home health," what is home health?

A. Home health is -- how best to describe it? It is when you can get nurses that come into the

house and help take care of the patients at home, and what they -- they have all different phases, but they can come into the house and help with medications; they can monitor blood pressures. Within the home health agency, they have physical therapists; they have behavioral therapist; they have aides that can help with the cleaning, and -- not cleaning, I'm sorry, with the bathing and the showering, et cetera. So it is an avenue that we can use as a step between being in a hospital and functioning on your own where they might need a little extra help.

Q. Now, you, as an internist, have you prescribed that for patients, prescribed home health?

A. Yes, sir. Plenty of times.

Q. And my understanding in this case is that home health came in, I believe, in May of 2013 -- I'm sorry, May of 2014?

A. Correct.

Q. Do you have any opinion as to whether or not Jane Doe could have received home health care in 2013, the year before this?

A. She certainly could have. You have to qualify for home health, as long as there's a

reason. So a reason could be generalized weakness. It could be behavior that they needed somebody to come in and evaluate her behavior. A lot of times we'll get a home health agency to go in and assess to get a social worker in there, to see, you know, what's at the house, what can we do to make life easier? Is there other funding available that might help with taking care of whoever?

Q. All right. And Jane Does' primary care doctor was Dr. Karen Thomas, is that something Dr. Thomas could have prescribed?

A. She certain could have, yes.

Q. I know there were several visits at an adult daycare that the daughter mentioned for her mother; is an adult daycare the same as home health?

A. No. No. Definitely not.

Q. Is an adult daycare, would you consider it medical treatment?

A. No. I do not.

Q. Okay. All right. Doctor, have all your opinions been to a reasonable degree of medical certainly?

A. Yes, sir.

Q. Thank you.

MR. MEYERS: I take it you're concluded?

MR. DORSEL: I am.

MR. MEYERS: Couldn't tell for sure. I didn't want to overrun you.

E X A M I N A T I O N

BY MR. MEYERS:

Q. Dr. Bolus, good morning.

A. Good morning.

Q. Let me just ask you a few things. Is there any indication in the records that you reviewed that home health had been suggested to the family earlier and they had turned it down?

A. Not that I reviewed, no, sir.

Q. Okay. And if I've understood you, the way you see the impact of the police making a forced entry into this house about 10:30 at night on a Thursday night, that if it had some effect that you would have expected that to show up in the mother's condition in the days and weeks following the intrusion; is that fair?

A. I think that if it -- when you're saying if it had an effect, from a traumatic standpoint, yes, I think we would have seen that in the first four months that she got out of the hospital for sure.

Q. And in your review of the records, you didn't feel like that was present?

In The Matter Of:

Jane Doe 202 v.
City of North Charleston, et al.

Jessica Broadway, MD
Vol. II
July 18, 2016

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Original File 07-18-16 Jessica Broadway_MD.txt
Min-U-Script® with Word Index

STATE OF SOUTH CAROLINA	) COURT OF COMMON PLEAS
	:
COUNTY OF CHARLESTON	) CASE NO. 2014-CP-4691

JANE DOE 202, by her POAs JOHN DOE MM AND JOHN DOE HS,

Plaintiff,

vs.

CITY OF NORTH CHARLESTON; LEIGH ANNE McGOWAN, INDIVIDUALLY; CHARLES FRANCIS WHOLLEB; INDIVIDUALLY; ANTHONY M. DOXEY, INDIVIDUALLY; MICHAEL KOURIS, INDIVIDUALLY; and HOWARD THOMAS, INDIVIDUALLY,

Defendants.

VIDEO DEPOSITION OF JESSICA BROADWAY, MD, VOLUME II

DATE: Monday, July 18, 2016

TIME: 1:01 p.m.

LOCATION: MUSC Institute of Psychiatry
97 President Street
Charleston, SC

REPORTER: Margaret F. Barnett
Court Reporter
and Notary Public

APPEARANCES OF COUNSEL:

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E X H I B I T S

(No Exhibits Proffered)

THE VIDEOGRAPHER: The date today is July 18th, 2016, and the time is 1:01. This is the video deposition of Jessica Broadway, M.D., in the matter of Jane Doe 202 versus the City of North Charleston, et al. in the State of South Carolina, Court of Common Pleas, County of Charleston, case number 2014-CP-10-4591. This deposition is being held at the Medical University of South Carolina, located at 67 President Street in Charleston, South Carolina.

Will counsel please identify themselves for the record.

MR. MEYERS: My name is Gregg Meyers, representing the plaintiff.

MR. DORSEL: My name is Chris Dorsel, representing the defendants.

MS. FAIRBAIRN: And I'm Vivian Fairbairn, on behalf of MUSC and Dr. Broadway.

THE VIDEOGRAPHER: Please swear the witness.

THE COURT REPORTER: Do you solemnly swear the testimony you're about to give will be the truth, the whole truth and nothing but the truth so help you God?

THE WITNESS: I do.

EXAMINATION

BY MR. MEYERS:

Q. Dr. Broadway, good afternoon.

A. Good afternoon.

Q. We've met before. My name is Gregg Meyers. I appreciate your time this afternoon. Would you start by just stating your full name for the benefit of the court reporter, please.

A. Jessica Lynn Broadway.

Q. You do what for a living?

A. I am an assistant professor of psychiatry, generally treating inpatient, in the inpatient unit.

Q. And is it correct to understand you have a medical license?

A. That is correct. I have a medical license.

Q. You're a doctor licensed in what state or states?

A. The state of South Carolina.

Q. And where is it you work?

A. Here at Medical University of South Carolina.

Q. And in what part of the Medical University? I think you mentioned it, but if you wouldn't mind.

A. I work at the Institute of Psychiatry.

Q. This is a case where you heard the videographer recite the caption where the plaintiff is styled a woman by the reference of Jane Doe 202. Are you aware of the identity of that person?

A. I am aware of the identity of Jane Doe 202.

Q. And is it correct to understand you are the treating doctor for Jane Doe 202?

A. Yes.

Q. Is it agreeable to you to try to refer to her as much as you can as either Jane Doe or Mother Doe or the mother? Is that --

A. Yes.

Q. -- workable? Thank you.

Court rules allow a treating doctor like yourself to appear by video for purposes of a jury trial, and what we've tried to do today is take your video deposition for that purpose. Is it agreeable to you for us to use your video deposition for that purpose?

A. Yes.

Q. In the course of this, I'm going to ask you a number of opinions that you hold and also just get some factual information from you. Let me at this

point offer you as an expert on the medical conditions of Jane Doe 202 as understood at MUSC, the history given MUSC as to those medical conditions and the treatment of Jane Doe for those medical conditions.

Let me start by handing you and asking you a few questions about what is designated as page 237 of the 299 pages that we initially got relating to Jane Doe's admission.

A. Thank you.

Q. Does this appear to be a page from the MUSC medical record?

A. This does appear to be a page from the MUSC medical record.

Q. And let me note just for purposes of the record that I have redacted all of the identifying information of Jane Doe from this and each of the other pages that I will hand you today. But if you would, we can certainly confirm that this is her medical record, but let me ask and let me offer this page into evidence at this point for purposes of the video.

Dr. Broadway, let me ask you to direct your attention to the first paragraph.

A. Okay.

Q. Under the history of present illness --

A. Uh-huh.

Q. -- page. The third line from the bottom of that paragraph starts with: difficult time naming simple objects such as a pen and a chair. Do you see that line?

A. Yes. The -- so the, yeah, the third line from the bottom of the first paragraph.

Q. And this is a record that's dated May 9th, 2013. Can you describe for us the value of a conversation about simple, everyday objects like a pen and a chair and how that's helpful in gathering information about a person suspected of having dementia.

A. One of the symptoms of dementia is loss of language function, and so one of the ways that we can test that is by something called confrontational naming, which is showing a person with dementia an object and asking them to tell us what the name of that object is.

Q. And is that what is going on here as referred to in this record?

A. That would be my assumption, although this is -- this record indicates that somebody is presenting that history to the writer of this paragraph.

Q. Understood.

A. Not indicating that that was their exam. Somebody presented this information, that this person is known to have these difficulties already.

Q. Is it correct to understand that it is kind of a summary of some of the history for the patient?

A. That is my understanding.

Q. Paragraph 2 on this page refers to in the third line down, there's a -- the line begins: did not have dementia. Do you see that line?

A. Uh-huh.

Q. The next sentence is what I wanted to ask you about, which I believe states: Since then, she has had a gradual decline with several stepwise declines, mostly after stressors, including the death of her father and the death of her sister. Do you see that sentence?

A. I do.

Q. Can you describe for me what a stepwise decline refers to in this history?

A. I can only assume that that means that she had a notable decline that was a more abrupt decline after those particular events.

Q. And from a medical point of view, what's

the present understanding of any connection, if there is one, between stress events and stepwise declines?

A. I don't think that there is a clear connection that's known, necessarily.

Q. All right. And is -- is it correct to understand that sometimes you might see that and sometimes not?

A. That is correct.

Q. Okay, understood. And then the third paragraph, the next to the last paragraph on the page is what I'm trying to refer to, there's a line three lines from the bottom. The line begins worthlessness or guilt?

A. Uh-huh.

Q. And then the sentence that begins at the end of that line, that begins: Patient has good understanding that she has memory problems and understand the progression of her disease and is accepting of this but feels she wants to make the most of her life while she can.

A. Uh-huh.

Q. Do you see that entry?

A. Uh-huh.

Q. Can you describe the -- how typical it is for an Alzheimer's patient to face their decline with

the reaction of wanting to get as much out of their life as they can while they're still functioning enough to enjoy it.

A. That's not necessarily typical. It's more often seen in patients with Alzheimer's/dementia, that they lack insight into their deficits. Certainly, in the earlier stages, people can have some remaining insight into their deficits. A typical reaction is difficult to say. I mean, everybody reacts to the stress of hearing a difficult diagnosis differently, some people.

Q. Is it still correct from a medical point of view that once diagnosed with Alzheimer's, if indeed that condition is present, it is -- there's no way to cure it?

A. That is correct.

Q. So eventually a person will be killed by Alzheimer's?

MR. DORSEL: Objection, leading.

BY MR. MEYERS:

Q. I mean, is that fair?

A. It is fair to say that people will eventually die with Alzheimer's. That's not always the thing that kills them.

Q. Sure. Somebody might be killed by some

other means, but, typically, if Alzheimer's is the cause of death, what's the mechanism of death, typically?

A. The mechanism of death varies from person to person. Assuming there are no other health conditions that are leading to an earlier demise, usually as the brain function deteriorates, people begin having more difficulty with things such as swallowing, developing aphasia or difficulty swallowing. Sorry, not aphasia, dysphasia. Difficulty swallowing, sometimes get aspiration, pneumonia or other things like that.

In the advanced stages people become bedbound, may develop other bed sores, may develop what we refer to as terminal anorexia, loss of appetite and thirst drive, and so they, you know, can sometimes just sort of wither away from those type causes.

Q. Is there a particular timetable that patients are seen once they know they have Alzheimer's?

A. I think we still quote an average of about ten years.

Q. And what I'm trying to understand is, between doctor visits, is there any particular set

schedule for an Alzheimer's patient to see a doctor?

A. No. There's no particular set schedule that, you know, somebody has to be seen on a particular schedule.

Q. And what's the longest period of time for in terms of frequency between doctor visits that you've had experience with for an Alzheimer's patient?

A. Most frequently, one year.

Q. What's the --

A. Would be the max.

Q. And what's the purpose of the doctor visit for an Alzheimer's patient?

A. General health checkup, medication refills.

Q. And is there any more you can do other than manage the symptoms of Alzheimer's?

A. In term -- I don't understand the question, I'm sorry.

Q. Yeah, and I'm glad to try to make it more precise. I understood you to tell me that Alzheimer's can't be cured?

A. Correct.

Q. And what I wanted to understand was the -- the symptom management of Alzheimer's behaviors, if there's -- how doctor visits help in that.

A. So we prescribe medications that help to some degree with the cognitive symptoms of Alzheimer's, and for some patients we prescribe medications that may help with the behavioral aspects of the illness. Does that answer your question?

Q. It does. And if Jane Doe, who was seen here, that's the first entry I believe --

A. Uh-huh.

Q. -- in May of 2013, and in July, my next page, is when the diagnosis was confirmed.

A. Okay.

Q. All right. If she was doing pretty well, as a matter of symptoms was pretty stable between July 2013 and March of 2014, is there any management of symptoms that would have been needed, if those symptoms were largely consistent?

A. Not necessarily.

Q. All right, let me show you page 241 from the 299 pages of records that we got. This page should be dated July 11, 2013. Do you see that?

A. Uh-huh.

Q. I'm interested in three questions in the second paragraph.

A. Okay.

Q. Three lines down there's a report that

neuropsych testing confirmed a likely diagnosis of Alzheimer's dementia. Do you see that?

A. I see that.

Q. And do you agree that is the diagnosis for Jane Doe?

A. I agree that that is her diagnosis.

Q. And then further down in that paragraph, there's a line that begins, daughter at time needs to leave patient on her own, usually two to three hours, but has been away up to six hours. Do you see that entry?

A. Uh-huh.

Q. Can you describe how common it is for families to consult with doctors here at MUSC about trying to manage the need to sometimes leave and also supervise?

A. I would say that that's a very common occurrence, particularly when we have a new diagnosis of dementia. We -- you know, that's sort of standard of care, to discuss safety concerns at home and how to mitigate the risks.

Q. If you can, from your experience, give me a sense of how many times in terms of percentage Alzheimer's patients are actually living entirely alone.

A. Most of them live -- well, I can't say most of them. A large percentage, I would say probably ten to 25, maybe even higher, 30 percent of patients live entirely alone for the first maybe stage of their illness.

Q. And only after that can they get some other caregiver present?

A. Correct. A lot of times when people are living alone in that first stage or their early years of their illness, they may have a caregiver who checks on them couple times a week.

Q. If an Alzheimer's patient lives with family, can you describe how doctors help the family gauge how to increase their supervision over time as the needs increase, needs of the patient?

A. Can you say that one more time, please?

Q. I'm interested in, if an Alzheimer's patients lives with family.

A. Uh-huh.

Q. So there are other family members helping on care.

A. Uh-huh.

Q. To understand how doctors assist the family in gauging how the family can increase their supervision as the needs of the person increase.

A. How they can or when they should?

Q. Well, I mean, kind of how that's sorted out.

A. So we may ask some safety questions such as wandering, you know, is this patient wandering. Does this patient have problems with leaving the stove on. You know, have there been any safety concerns, safety briefs. And we talk about medication compliance and how necessary it is for direct supervision of somebody taking their medications. You know, in a very early stages, setting out a pill reminder might be fine, but then when the family, when we ask, you know, are the pills appropriately taken, find out if they've occasionally left pills behind, or if they've accidentally taken three days because they don't know what day of the week it is anymore, those sorts of questions.

Q. Is it fair to say that as the needs of the patient increase, then the assistance given needs to increase too?

A. That is correct.

Q. Understood. The last thing I wanted to ask you about is the last two lines of this, this starts three lines down, but the last sentence is: Patient's daughter reports buying a family puppy and

reports that this animal has brought her mother significant enjoyment. Do you see that entry?

A. I do.

Q. Is it at all uncommon for a pet to benefit an Alzheimer's patient?

A. Is that -- I would not say that's uncommon.

Q. In your experience, can you describe if social activities that are designed for newly-diagnosed Alzheimer's patients can be a good strategy to stimulate a newly-diagnosed Alzheimer's patient?

A. We -- I would say that we recommend them. Whether there's evidence to say that that actually increases cognitive stimulation, I'm not -- not aware of any solid evidence that that's helpful.

Q. And why is it a recommendation despite not knowing that for sure?

A. That's a good question. I think in part a lot of times the social activities such as an adult day program are recommended to provide some relief to the family, a break, if you will, as well as to give the older adult maybe a sense of independence and a sense of self still from the socializing.

Q. Have you ever had a situation where

someone brought either art lessons to an Alzheimer's patient or took an Alzheimer's patient to art lessons?

A. Uh-huh.

Q. And in your experience, has that ever been beneficial?

A. We use recreation therapy all the time in the hospital, and I think at least short-term benefits we see them.

Q. Let me ask you to take a look at another page from the medical records from MUSC. This is page 183. Does this appear to be a record from MUSC?

A. It does.

MR. MEYERS: And I think I neglected to move into evidence page 241, and I'll do that now, along with page 183.

MR. DORSEL: I would object as cumulative.

BY MR. MEYERS:

Q. With page 183 there is a reference on the third line of the handwritten entry that says ER since 3/29/14. Do you see that?

A. I do.

Q. Can you describe if it's unusual for a patient who comes in to the Institute of Psychiatry to be admitted through the emergency room?

A. That is not at all usual.

Q. And what I was trying to do is to see if the admission -- at the top right corner where the redactions are?

A. Uh-huh.

Q. It says ADM. Does that mean date of admission?

A. Correct.

Q. And that says April 2nd, 2014?

A. Correct.

Q. Can you explain the continuity between the ER -- coming to the emergency department and then getting into the hospital three days later?

A. Uh-huh. We frequently have patients that will present to the emergency room and are seen by Psychiatry usually within 12 to 24 hours, sometimes less, of the patient presenting to the emergency room and having this determined to be a psychiatric issue. And at some point when the decision is made for admission, they are then retained in the emergency room until such time as a bed is available in the hospital for them to be transferred to.

Q. Is it correct to understand that her hospital stay effectively started in the emergency room on the 29th of March?

A. That's correct.

Q. All right, understood. Let me show you page 179 from the medical record. This should be the discharge order. Does it appear to be that?

A. This does appear to be our discharge order.

MR. MEYERS: And let me move into evidence page 179 from the medical record.

BY MR. MEYERS:

Q. Can you tell down at the bottom there, it appears the date on the discharge order, when is that signed?

A. April 18th, 2014.

Q. And would you presume that's the date she was discharged?

A. I would presume that.

Q. In the middle of the page there is a location where she's discharged or transferred to. And what does that entry say?

A. Home or self-care.

Q. All right, so is it correct to understand that when she was discharged, A, it was on the 18th of April, and, B, it was to her home?

A. Correct.

Q. All right, understood.

MR. DORSEL: And I would object as

cumulative again.
BY MR. MEYERS:
Q. All right, let me show you page 1 from the medical record. There is on -- first of all, does this appear to be another page from the medical record?
A. It does appear to be a page from the medical record.
MR. MEYERS: All right, let me move this page also into evidence.
MR. DORSEL: Same objection as to cumulative.
BY MR. MEYERS:
Q. There is a presenting clinical section on this page, and let me ask you a few questions about that. In paragraph 1, five lines up from the bottom of that paragraph, in the middle of the line that starts: violent with digging her fingernails into her daughter's skin?
A. Uh-huh.
Q. Do you see that?
A. I do.
Q. The next sentence I think says: For the past couple of days, patient has called the police twice accusing her daughter of abusing her. Do you

see that entry?

A. I do.

Q. And can you tell me if that factored into the information MUSC was trying to assess as to Jane Doe?

A. That did factor into our assessment.

Q. And what was it that MUSC looked for to indicate if there was indeed any abuse of Jane Doe?

A. We had the nurses do what we could call a skin audit or a body audit, where, you know, when they are giving her or assisting her with a shower, they're going to look closely over her body for signs of bruising and, you know, any marks, that sort of thing, healing scars.

Q. And was there any indication that you are aware of that, in fact, Jane Doe was being abused by anybody?

A. I was informed from my staff that they saw no bruising, scarring, or evidence of physical assault or abuse.

Q. What would MUSC have done about investigating abuse if there had not been that allegation of abuse?

A. There probably still would have been a skin audit done, because we do that on everybody, to

make sure that they don't come into the hospital with unknown wounds or decubitus ulcers or that sort of thing. But in this particular case, I asked them to, because of the concern that there may have been abuse at home, to document that very clearly.

Q. And you didn't find any indication of abuse?

A. No.

Q. The second paragraph, if I could ask you to direct your attention to the opening of this paragraph. Let me read it, and tell me if I've read it correctly. I'm going to try to interpret the abbreviations. Tell me if you agree it says:

On interview, patient states that she is happy person. Happy is in quotation marks. Although reports that for the past couple of days, quote: Things have not been good, unquote. When asked what she was referring to, comma, states that, quote: Men came into the house, unquote, which caused her to be concerned.

Do you see that entry?

A. I do see that.

Q. And is it correct to understand this is information being attributed to Jane Doe?

A. Meaning when it says she says --

Q. Right.

A. -- that is attributed to Jane Doe, that Jane Does is the "she"?

Q. Yes.

A. Yes, that's correct.

Q. And can you tell me, for your purpose in treating her, how did you interpret that information from her as it relates to her distress?

A. Can you please clarify the question, I'm sorry?

Q. I want to understand, from a treating point of view, getting that information from her where she's relating that things have not been good and she explained why, how -- how you understood that as related to stress on her?

A. I think at first we were not sure how to interpret her claim that men came into the house, because she has dementia and we didn't know whether she was relaying an actual event or an imagined event, and her brother told us that he was unaware of anything. And then during the course of her hospital stay, when Daughter Doe explained what had happened, then it seemed to make more sense that that event caused her to have some stress and that that was what she was likely referring to.

Q. Do you have an opinion, to a reasonable degree of medical certainty, that the events with men entering her house a few days before she appeared at MUSC contributed to her agitation?

MR. DORSEL: Objection, speculation.

BY MR. MEYERS:

Q. Go ahead.

A. Okay. Contributed to, yes.

Q. And was that factored into treating her for her agitation and distress?

A. Not necessarily.

Q. All right, how does a -- if a patient identifies things that have caused him or her stress or anxiety, what's the -- how is that information useful to you in treating the patient?

A. It's certainly useful to know what a trigger for stress was. At the time that she was in the hospital, she -- any agitation or stress or anxiety seemed to diminish very quickly on the unit. We didn't see any evidence of ongoing anxiety, stress, nightmares, et cetera, that warranted further treatment.

To answer your question how that would have played into things, if she had continued to have anxiety, distress, talk about that on a frequent

basis, then we may have started her on some anxiety medications or that sort of thing.

Q. All right, so from your clinical perspective, it was sufficient to just stabilize her in a quiet place where there weren't people coming into the unit unexpectedly?

A. Correct.

MR. DORSEL: Objection, leading.

BY MR. MEYERS:

Q. Let me show you page 2 of the MUSC medical record. Or what I believe is page 2. Does this appear to be part of the medical record?

A. This does appear to be part of the medical record.

MR. MEYERS: Let me move page 2 into evidence.

BY MR. MEYERS:

Q. Let me start with items 11 and 12 on this list of 16 items.

MR. DORSEL: Same objection, cumulative.

BY MR. MEYERS:

Q. Do you see those two items?

A. I do.

Q. One says full feces incontinence, the other says -- well, why don't you tell me what that

abbreviation means.

A. I believe that means unspecified urinary incontinence.

Q. And describe what incontinence means.

A. Incontinence is a loss of control over bladder or bowel function.

Q. So if she is incontinent, she does not control when she goes to the bathroom?

A. Correct.

Q. All right, understood. Now, move up to item 3, if you would.

A. Okay.

Q. Which refers to a urinary tract infection NOS. Do you see that entry?

A. I do.

Q. Tell me what NOS means.

A. Not otherwise specified.

Q. Does not otherwise specified mean you don't know if she had a urinary tract infection?

A. No. Not otherwise specified often means -- it means that we didn't add any additional qualifiers to it, which could include something like the causative agent such as E. coli, if we knew that that was a causative agent, or a urinary tract infection acute or a urinary tract infection due to

urinary retention. There are lots of qualifiers that one can add to a general diagnosis like that. It's not necessary, but they can be added. In this case they were not added.

Q. All right, is there any uncertainty in this record or in your mind that she did not indeed have a urinary tract infection?

A. No. There's no uncertainty in my mind.

Q. Describe what a urinary tract infection can do to the confusion level of a vulnerable adult.

A. Urinary tract infections in older adults can cause increased confusion, can lead to delirium, which is usually a temporary sort of generalized global dysfunction of the brain with increasing confusion, agitation, sleep-wake cycle reversal.

Q. What I want to do is talk to you about the timing of a urinary tract infection, and I'm going to ask you to assume six pieces of information are true. All right?

A. Okay.

Q. Piece No. 1: that Jane Doe was in a clean, adult diaper the evening of March 27th, so two days before her appearance at the emergency room, okay?

Number 2 is that by 10:30 p.m. on March

27th, police made a warrantless entry into her house and removed her daughter from the house.

Item 3 is that Jane Doe was left alone after her daughter was removed.

Item 4 is that Jane Doe was unable to change her own adult diaper or use the bathroom or use the telephone.

Item 5 is Jane Doe was not able to control when she urinated or had a bowel movement.

And item 6 is that Jane Doe stayed in that adult diaper from 11 p.m. on March 27th to after 4 p.m. on March 28th, so a period of some 17 or more hours. Afterwards, the daughter was able to return home and change her.

MR. DORSEL: Objection. Counsel is testifying.

BY MR. MEYERS:

Q. Now, if you assume those facts are true hypothetically, do you have an opinion, to a reasonable degree of medical certainty, as to whether those conditions could have increased the risk to Jane Doe of developing a urinary tract infection?

A. They could increase the risk of developing a urinary tract infection if those facts are -- if those assumptions are fact.

Q. I want to talk with you, you were shown some records, and the first one was from May of 2013. This would be --

A. These are the records that --

Q. Right, that Mr. Meyers showed you.

A. Okay.

MS. FAIRBAIRN: Reference the page number just so she's at the right one.

MR. DORSEL: It's, uh, sorry --

THE WITNESS: 237?

BY MR. DORSEL:

Q. 237.

A. Okay.

Q. This record that Mr. Meyers showed to you, all of the information in this record was provided by either the brother or the daughter; correct? Or -- or Jane Doe?

A. Correct.

Q. All right. And so this is when they talk about, after stress, declining several steps, that's the daughter's or the brother's opinion; correct?

A. Correct.

Q. That's not a medical opinion?

A. No.

Q. Okay. Now, the next one you had, which is

page 241, is July 11th of 2013.

A. Uh-huh.

Q. And this was the last visit at MUSC in the year 2013; correct?

A. I would have to reference the medical record to confirm that.

Q. Okay. Well, let me see here. On July 11, 2013, did the medical staff recommend that she follow up in two to three months?

A. I don't have the second page of that note with the assessment and plan. So that would be probably page 242 or 243.

Q. Here it is. I only have one copy of it, page 243.

A. Okay. In the assessment and plan it does say follow up in two to three months.

Q. Okay. Now, when we talked to you in your deposition you had said that there was a follow-up visit in October of 2013 that they did not show up for. Is that correct?

A. I believe that that's true.

Q. All right. And -- and then there's another follow-up visit on -- in December of 2013 scheduled, and Jane Doe and her daughter did not show up for that visit either. Is that correct?

MR. MEYERS: Objection to the form of the question, go ahead.

THE WITNESS: I believe that's correct.

BY MR. DORSEL:

Q. All right. And the next time she was actually seen at MUSC was on March 29, 2014, and that's the time she was there for the incident we're here to talk about. Is that correct?

A. Uh-huh.

Q. I have not seen any records from July of 2013 through March of 2014 where she was seen by a doctor. So that would be eight months without seeing any doctor?

A. Uh-huh.

Q. And do you understand that she was not seen by her primary care physician for more than a year?

A. I am unaware of that information other than what you're telling me.

Q. Okay. Would you agree that a patient like Dane Joe in 2013 should be seen by a psychiatrist or a family doctor at least every two to three months or maybe once every six months?

A. I think, as I stated earlier, at a minimum they should be seen every year just, you know, that --

A. To some degree, but a lot -- reading this, a lot of the history, it says per brother, per brother, per brother, so --

Q. If you look on the -- in the second paragraph.

A. Yes.

Q. I should have referenced that, but it says: on interview, patient states. So she was able to talk with this provider; correct?

A. To some degree, yes.

Q. And she was -- she told him that -- or she knew who the president was? I think that's in the last sentence of that second paragraph.

A. Yes. It does say oriented to president.

Q. All right, so she knew what city she was in, what state she was in, and also knew that she was at a hospital; correct?

A. Yes.

Q. All right, and this was two days after the police incident?

A. Uh-huh.

Q. On March 27?

A. Correct.

Q. And in this hospital interview, this was an unfamiliar environment to her. Is that fair to

say?

A. Correct.

Q. And would you agree that dementia patients function better in a familiar environment?

A. Usually, yes.

Q. And the most familiar environment to them would be their own home; correct?

A. Correct.

Q. Now, if she could answer these questions and talk to a doctor in the unfamiliar environment on March 29, would you agree that when she was in her own home on March 27, that she most likely could answer the simple questions that the officers posed to her?

A. Based on what's written here, which nobody said, but it says here specifically she had difficulty verbalizing her answers but could give the answers if given three choices. So she was having difficulty talking to the person in the hospital. I would imagine that she had some difficulty at home as well.

Q. Well, and what the officers have said is that she appeared to recognize that they were police officers.

A. Uh-huh.

Q. That they announced themselves and they said why they were there and they asked her where her

daughter was. She knew where her daughter was. She was able to direct them upstairs. Based on all of that, would that be something that Jane Doe could have done in her own home, familiar environment on that night?

A. Probably, yes.

Q. And would any of that indicate to a officer or layperson that she had dementia?

MR. MEYERS: Objection to the form of the question as outside the witness's expertise.

THE WITNESS: If -- if she was able to recognize that they were police officers and direct them upstairs to her daughter, you're asking if somebody would interpret those abilities to be consistent with dementia?

BY MR. DORSEL:

Q. Correct.

A. Probably not.

Q. Is it fair to say that if that occurred, that she recognized them, directed them upstairs, that the officers very well may not have known she had dementia?

A. I -- I can't speculate that they -- whether they knew that or not. It was my understanding that they had been informed of that,

but, if not, then yes, it's possible they would not have known she had dementia.

Q. Okay. And this was -- I mean, at that point she didn't look sick; correct?

A. She did not appear sick.

Q. And at that time of night, 10:30 at night, she was in her pajamas, her hair was probably a little messed up. That wouldn't indicate that someone has dementia; correct?

A. No.

Q. And, let's see here. Are you aware of whether the daughter told the officers that her mother had dementia or Alzheimer's?

A. I was not personally present when this all went down. I was informed by either you or Mr. Meyers that the daughter alleged she did tell the police that, but that is the scope of my knowledge of that situation.

Q. Okay. And based on those things, being able to answer questions, recognizing them, not appearing to be dressed inappropriately, would any of that indicate that a person cannot be left alone?

A. I don't know that that's enough of a -- with dementia, that's not enough to know whether somebody could be left alone, just looking at somebody

and having them say hello.

Q. Okay. Well, and let me ask you this. Your --

A. I can't say that it would be obvious that she shouldn't be left alone. She didn't -- you know, she wasn't in a wheel -- she wasn't wheelchair bound or bedbound or, you know, had the IV running or something.

Q. Right. Your understanding of why the police were there is because you believe someone called to report elder abuse. Is that correct?

A. It was my understanding from this and at the time of the admission that the patient -- somebody had told the admitting physician that the patient had called the emergency room alleging elderly abuse.

Q. Okay. Now, and have you ever determined whether that was true or not?

A. We did not find any evidence of elder abuse.

Q. Okay. And did you ever find out what -- who actually called the police?

A. Not until this initial deposition from I believe Mr. Meyers or you.

Q. Okay. And you understand the neighbors called because the daughter was outside banging on the

MUSC

IC ' Referral Repc

04, -014 12:28:25

000091341

Referral Coordinator: Judy Roulette

Call Date: 03/30/2014

Call Time: 02:12:42

First Name: [redacted] Last Name: [redacted] DOB: 10/08/1947 MRN: [redacted] Race: CAUCASIAN

Address: [redacted] Sex: F City: NORTH CHARLESTOON State: SC Zip: 29405-4142

Phone (H): [redacted] SSN: [redacted] Age: 66 M/S: SINGLE

Diagnosis:

DEMENTIA WITH BEHAVIORAL DISTURBANCE

IOPREFERRAL

Special Care Instructions:

NO KNOWN ALLERGIES.
CURRENT MEDICATIONS: DONEPEZIL (ARICEPT) 10 MG TABLET, LEXAPRO 20 MG T[illegible]

Presenting Clinical:

PT IS A 66Y/O WOMAN WITH HX OF ALZHEIMER'S DEMENTIA WHO PRESENTS TO ED VIA EMS WITH WORSENING AGITATION AND BEHAVIORAL DISTURBANCE. MOST OF HX WAS GATHERED FROM BROTHER WHO WAS INTERVIEWED AT PT'S BEDSIDE. PT WAS INITIALLY SEEN BY DR SEERY IN MAY OF 2013 AT THAT TIME TO BE EVALUATED FOR WORSENING MEMORY AND LANGUAGE DIFFICULTIES. NEUROPSYCH TESTING WAS PERFORMED AT THAT TIME CONFIRMING A LIKELY DIAGNOSIS OF ALZHEIMER'S DEMENTIA. AT THAT TIME, PT WAS HAVING DIFFICULTY PERFORMING TASKS AT HOME HOWEVER WAS ABLE TO USE THE BATHROOM ON HER OWN AND SHOWER HERSELF. PER BROTHER DAUGHTER MOVED IN WITH PT TO ACT AS HER PRIMARY CAREGIVER WHICH SHE HAS FULFILLED THAT ROLE SINCE. OVER THE PAST YEAR, PT HAS BECOME MORE DEPENDENT ON HER DAUGHTER FOR ASSISTANCE AND IS NOW UNABLE TO TOILET HERSELF, FEED HERSELF, OR BATHE HERSELF. PER BROTHER, FOR THE PAST MONTH PT HAS BECOME MORE COMBATIVE PRIMARILY WITH HER DAUGHTER REPORTEDLY FIGHTING HER WHENEVER SHE IS TRYING TO ASSIST WITH HER ADLS ALSO BECOMING MORE VIOLENT WITH DIGGING HER FINGERNAILS IN HER DAUGHTER'S SKIN. FOR THE PAST COUPLE OF DAYS, PT HAS CALLED THE POLICE TWICE ACCUSING HER DAUGHTER OF ABUSING HER. SHE HAS ALSO BEGUN WANDERING AWAY FROM THE HOUSE AND TELLING RANDOM STRANGERS THAT SHE IS BEING ABUSED. PER BROTHER, TO HIS KNOWLEDGE THE ALLEGED ABUSE IS FALSE. PT WAS BROUGHT TO THE HOSPITAL FOR FURTHER EVALUATION AS PER BROTHER, FAMILY BELIEVES THAT PT IS NO LONGER ABLE TO BE TAKEN CARE OF BY HER DAUGHTER WITH HOPES THAT A LONGER CARE LIVING FACILITY WOULD BE APPROPRIATE.

ON INTERVIEW, PT STATES THAT SHE IS "HAPPY" PERSON ALTHOUGH REPORTS THAT FOR THE PAST COUPLE OF DAYS "THINGS HAVE NOT BEEN GOOD". WHEN ASKED WHAT SHE WAS REFERRING TO, STATES THAT "MEN CAME INTO THE HOUSE" WHICH CAUSED HER TO BE CONCERNED. PER BROTHER, HE IS UNAWARE OF THIS EVENT. PT HAD NO RECOLLECTION WHY SHE WAS IN THE HOSPITAL EXCEPT THAT SHE BELIEVED HER DAUGHTER HAD SOMETHING TO DO WITH IT. SHE DENIED ANY DEPRESSIVE SYMPTOMS, MANIA, ANXIETY OR PSYCHOSIS. SHE DENIES ANY SI/HI. PT WAS APPROPRIATE IN MOOD AND AFFECT DURING THE INTERVIEW BUT WAS NOT ORIENTED TO MONTH, DAY OF WEEK OR YEAR. PT HAD DIFFICULTY VERBALIZING HER ANSWERS HOWEVER IF YOU WERE TO GIVE HER 3 ANSWER CHOICES, SHE WAS ABLE TO GIVE THE RIGHT ANSWER MOST OF THE TIME. SHE WAS ALSO ORIENTED TO PRESIDENT, STATE, CITY AND HOSPITAL. POOR RECENT AND REMOTE MEMORY.

IOP Treatment Instructions:

. UPON ADMISSION TO SCU, INITIATE ALL APPROPRIATE PRECAUTIONS INCLUDING Q 15MIN CHECKS, UR, EP, VP.

Referral Information

Caller Name: RESIDENT Unit: SCU EXTENSION Rapid Access? : N

Caller Phone: 15876 Charleston Center? N

Referring Agency: 1 WED Type: 1 WEST ER

Referrer's First Name: CHALLYN Admit Status: ACCEPTED Planned Admit D/T: 04/02/2014 14:12:42

Referrer's Last Name: MALONE, MD Not Admit Reason: Admit Disposition: VOLUNTARY

Emergency Contact Information

Name: [redacted] Relationship: CCHILD Phone (W): Phone (H): [redacted]

Address: Guadrianship / Other:

Primary Insurance

Type: HUMANA GOLD CHOICE/MA FFS Name: Relationship: Policy #: [redacted]

Employer: SSN: - - Benefits/Phone: (800)457-4708

Group #: [redacted] Notes:

Secondary In[illegible]

Type: Name: Policy #:

Employer: SSN: - -

Group #: Notes:

P:105025522 DOB:10/08/1947 W F

[redacted]

M: [redacted]

Patient Name: [redacted], [redacted] MR #: [redacted] PAT #: [redacted]

Sex:	F	Admitted:	4/02/14
Birthdate:	10/08/1947	Discharged:	4/18/14
Age at Admit:	066	LOS:	16 FC: MF
Attending Phys:	054153 CRAIG, MARY	UB82 Disp:	01

Current DRG: 057 - DEGEN NERV SYS DISORD W/O MCC CODER ID: onkotzj
APR-DRG 042 APR-SOI 2 APR-ROM 2

Diagnoses	M1	M2	Description
1. 331.0	Y		ALZHEIMER'S DISEASE
2. 294.11	Y		DEMENT,CCE, W/BEHAV DIST
3. 599.0	Y		URIN TRACT INFECTION NOS
4. 780.09	Y		OTH ALTERAT CONSCIOUSNESS
5. 272.4	Y		HYPERLIPIDEMIA NEC/NOS
6. 311	Y		DEPRESSIVE DISORDER NEC
7. 780.79	Y		OTHER MALAISE FATIGUE
8. 781.0	Y		ABN INVOLUN MOVEMENT NEC
9. 333.2	Y		MYOCLONUS
10. 300.9	Y		UNSP NONPSYCHOTIC MENTAL
11. 787.60	Y		FULL FECES INCONTINENCE
12. 788.30	Y		UNSP URINARY INCONTINENCE
13. 787.03	Y		VOMITING ALONE
14. V17.0	E		FAM HX-PSYCHIATRIC COND
15. V16.8	E		FAMILY HX-MALIGNANCY NEC
16. V16.3	E		FAMILY HX-BREAST MALIG

Electronically Authenticated by:
MARY HART CRAIG, MD
On 05/08/2014 04:04 PM EDT

PHYSICIAN SIGNATURE AND DATE

CANCER STAGING: _____T _____N _____M _____STAGING

Patient [redacted]

MR [redacted]

Encounter [redacted]

Page 1 of 1

[redacted] ID [redacted] 04-APR-2014 06:44:05 Adult ECG-4NORTH ROUTINE RECORD

08-OCT-1947 (66 yr)
Female Unknown

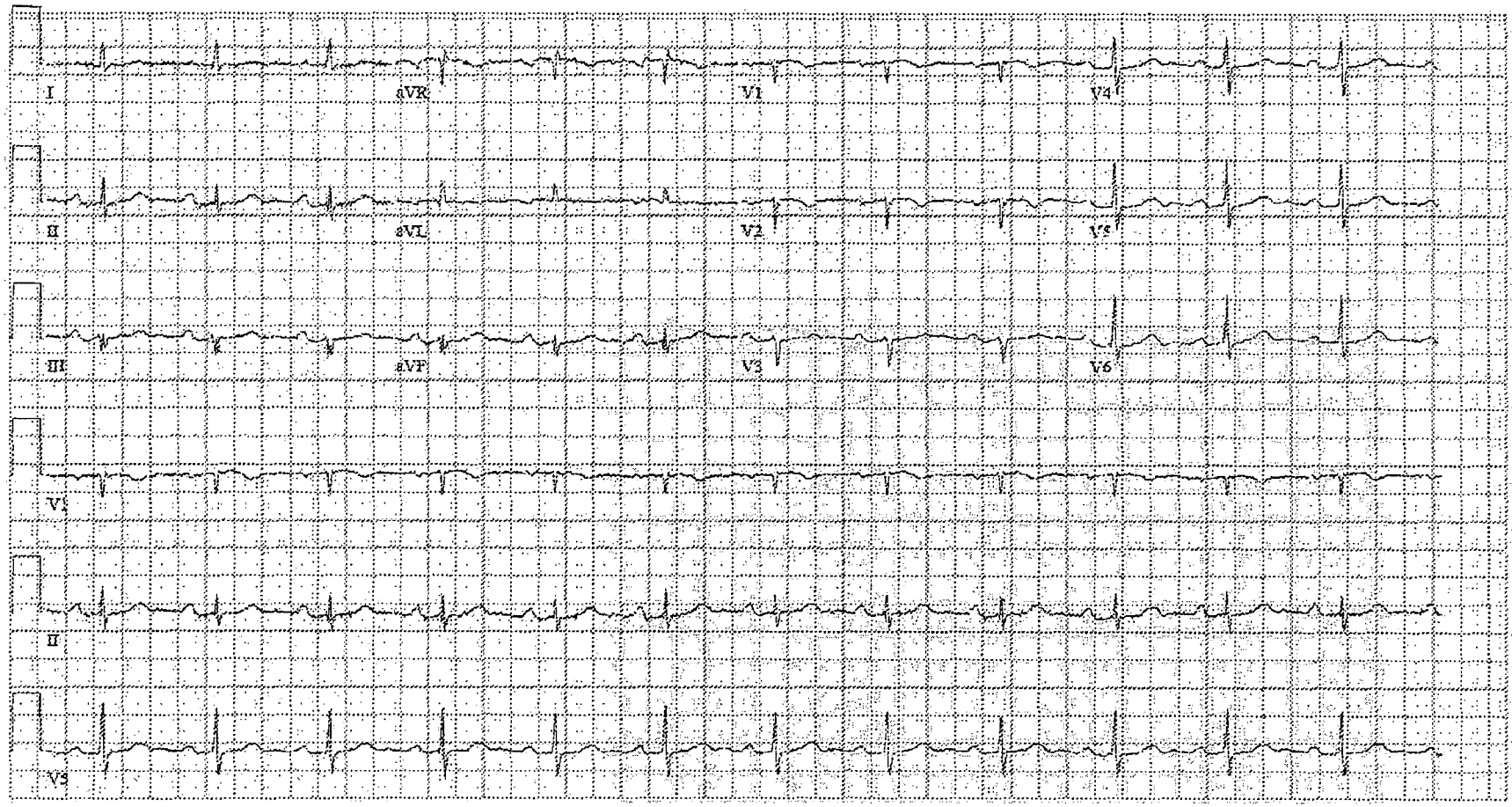
Room:P411
Loc:35

Vent. rate	74	BPM
PR interval	200	ms
QRS duration	74	ms
QT/QTc	390/432	ms
P-R-T axes	76 -14	61

*** Poor data quality, interpretation may be adversely affected
Normal sinus rhythm
Cannot rule out Anterior infarct (cited on or before Abnormal ECG
No previous ECGs available
Confirmed by HENDRIX MD, GRADY (1006) on 4/4/2014 4:42:36 PM

Technician: NRS
Test ind:Dysrhythmias

Referred by: JESSICA BROADWAY Confirmed By: GRADY HENDRIX MD



25mm/s 10mm/mV 150Hz 7.1.1 12SL 237 CID: 3

SID: 1083675 EID 1006 EDT: 16:42 04-APR-2014 ORDER: 409454916 ACCOUNT: 105025522

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[redacted] Opt Out:
MUSC - Live
AdmHx mod/inact Hx
From: 04/02/2014 16:38 To: 04/18/2014 20:08
Rm-Bed: P411 - L Admit Dt: 04/02/2014 16:38
Age: 66 yr Gender: F MD: Broadway, Jessica L., MD
DOB: 10/08/1947 Acct [redacted]
MRN: [redacted]
Requested: 04/19/2014 05:40 Page 1 of 4

Allergy History

Seq	Allergen	Confirmed Date/Time		Type	Onset Date	Primary Reaction	Other Reaction	Severity	Comment	Reporting Relation	Reported By	Source	Charted Date/Time	Sensitivity Class	Verified By	Verified Date	Confirmed By
1	NKA		[O]	Drug	--	--	--	--	--	--	--	MEDS	03/30/2014 17:48	AL	Staffid, Sag52	30-MAR-14	

Inactive Allergy History

No Data Found

Problem History

No Data Found

Medication History

No Data Found

Clinical History

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
AdvancedDirectiv	Does the patient have a written	[ ]	NO DATA FOUND			
	Would the pt like to talk to someone re:	[ ]	NO DATA FOUND			
	Notify Hospital Chaplain?	[ ]	NO DATA FOUND			
	Notified Date/Time	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
Chart Allergy	Allergen:	[ ]	NO DATA FOUND			
	Primary Reaction:	[ ]	NO DATA FOUND			
	Severity:	[ ]	NO DATA FOUND			
	Other Reaction:	[ ]	NO DATA FOUND			
	Allergy Comment:	[ ]	NO DATA FOUND			
	Verifying RPh:	[ ]	NO DATA FOUND			
CONTACT INFO	Primary Contact	[O]	[redacted]	04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
	Phone - Cell	[O]		04/02/2014 18:10	04/02/2014 18:26	Talley, Yalena , RN
		[O]		04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
	Relationship	[O]		04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
	Patient lives with	[O]		04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
	Additional Contact	[O]		04/02/2014 18:10	04/02/2014 18:15	Talley, Yalena , RN
		[O]	Stanley Huggins	04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
	Phone - Home	[O]	843-514-5905	04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
CONTACT INFO	Phone - Home	[ ]	NO DATA FOUND			
	Phone - Work	[ ]	NO DATA FOUND			
	Additional Contact	[ ]	NO DATA FOUND			

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
CONTACT INFO	Phone - Home	[]	NO DATA FOUND			
	Phone - Work	[]	NO DATA FOUND			
	Phone - Cell	[]	NO DATA FOUND			
	Relationship	[]	NO DATA FOUND			
	Phone - Work	[]	NO DATA FOUND			
	Phone - Cell	[]	NO DATA FOUND			
	Primary Care MD	[]	NO DATA FOUND			
	Comment	[]	NO DATA FOUND			
Immunizations	Influenza	[]	NO DATA FOUND			
	If yes, date	[]	NO DATA FOUND			
	Pneumovax	[]	NO DATA FOUND			
	If yes, date	[]	NO DATA FOUND			
	Tetanus	[]	NO DATA FOUND			
	If yes, date	[]	NO DATA FOUND			
	Varicella	[]	NO DATA FOUND			
	If yes, date	[]	NO DATA FOUND			
OB patients only	Gravida	[]	NO DATA FOUND			
	Term	[]	NO DATA FOUND			
	Pre- term	[]	NO DATA FOUND			
	Abort	[]	NO DATA FOUND			
	Living	[]	NO DATA FOUND			
	EDC	[]	NO DATA FOUND			
	Anesth preferred	[]	NO DATA FOUND			
	Last meal	[]	NO DATA FOUND			
	Baby up for adoption (BUFA)	[]	NO DATA FOUND			
	No prenatal care	[]	NO DATA FOUND			
	Feeding plan	[]	NO DATA FOUND			
	Water source	[]	NO DATA FOUND			
	Comment	[]	NO DATA FOUND			
Patient History	Reason for hosp (pt own words)	[O]	unable to verbalize	04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
	Reason	[O]	Dementia with Behavioral Disturbances	04/02/2014 18:10	04/02/2014 18:15	Talley, Yalena , RN
		[O]	Dem	04/02/2014 18:10	04/02/2014 18:13	Talley, Yalena , RN
	High blood pressure	[O]	No	04/02/2014 18:10	04/02/2014 18:15	Talley, Yalena , RN
	Neuro	[O]	No	04/02/2014 18:10	04/02/2014 18:15	Talley, Yalena , RN
	Fainting	[O]	No	04/02/2014 18:10	04/02/2014 18:15	Talley, Yalena , RN
	Speech	[O]	Yes	04/02/2014 18:10	04/02/2014 18:15	Talley, Yalena , RN
	GI	[O]	No	04/02/2014 18:10	04/02/2014 18:15	Talley, Yalena , RN
	Heart	[O]	No	04/02/2014 18:10	04/02/2014 18:17	Talley, Yalena , RN
	Resp/Lung	[O]	No	04/02/2014 18:10	04/02/2014 18:17	Talley, Yalena , RN
	Kidney/Bladder	[O]	No	04/02/2014 18:10	04/02/2014 18:17	Talley, Yalena , RN
	Endocrine	[O]	No	04/02/2014 18:10	04/02/2014 18:17	Talley, Yalena , RN
	Liver	[O]	No	04/02/2014 18:10	04/02/2014 18:17	Talley, Yalena , RN
	Bleed disorders	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN

Patient: [redacted] MRN: [redacted] Encounter: [redacted] Page 2 of 4
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Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
Patient History	Sickle cell	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Rheumatology	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Dermatology	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Cancer	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Transplant	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Psychiatric	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Violence	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	HIV	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Bld transf/react	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	OB/Gyn	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
	Dev disability	[O]	No	04/02/2014 18:10	04/02/2014 18:19	Talley, Yalena , RN
Patient History	Comment	[ ]	NO DATA FOUND			
	Neuro select	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Falls	[ ]	NO DATA FOUND			
	Faint/Falls comment	[ ]	NO DATA FOUND			
	Swallow difficulty	[ ]	NO DATA FOUND			
	Spch/Swallow cmt	[ ]	NO DATA FOUND			
	GI select	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Heart select	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Resp/Lung select	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	GU select	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Endo select	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Liver select	[ ]	NO DATA FOUND			
	Hepatitis type	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Anticoagulants	[ ]	NO DATA FOUND			
	Bld dis/anticoag cmt	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Rheum select	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Psych other	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			

Clinical History (continued)

Subject	Question		Response	Confirmed Date/Time	Charted Date/Time	Confirmed By
Patient History	Violence other	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	OB/Gyn other	[ ]	NO DATA FOUND			
	LNMP, if applicable	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Failure to thrive	[ ]	NO DATA FOUND			
	Dev dis/FTT cmt	[ ]	NO DATA FOUND			
	Other	[ ]	NO DATA FOUND			
Substance Use	Use of Tobacco	[ ]	NO DATA FOUND			
	Daily amount	[ ]	NO DATA FOUND			
	# of years	[ ]	NO DATA FOUND			
	Last use	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Use of Alcohol	[ ]	NO DATA FOUND			
	Daily amount	[ ]	NO DATA FOUND			
	# of years	[ ]	NO DATA FOUND			
	Last use	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Use of Rec Drugs	[ ]	NO DATA FOUND			
	Daily amount	[ ]	NO DATA FOUND			
	# of years	[ ]	NO DATA FOUND			
	Last use	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
Surgical Hx	Surgical Hx	[ ]	NO DATA FOUND			
	Surg Hx- Neurological	[ ]	NO DATA FOUND			
	Surg Hx- Respiratory	[ ]	NO DATA FOUND			
	Surg Hx- Cardiovascular	[ ]	NO DATA FOUND			
	Surg Hx- GI	[ ]	NO DATA FOUND			
	Surg Hx- UroRenal	[ ]	NO DATA FOUND			
	Surg Hx- Reproductive	[ ]	NO DATA FOUND			
	Surg Hx- Orthopedic	[ ]	NO DATA FOUND			
	Surg Hx- Other	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			
	Comment	[ ]	NO DATA FOUND			

Admission Assessment Discharge Rpt
From 04/02/2014 16:38 To 04/18/2014 20:08

Admission History Change Report

Observables

Template: Adult AA and ALL IOP Patients

Observable Name	Observation	Action Taken	Chart Time	Perform Time	Confirm Time
Category: Contact Information					
Does the pt have an Advance Directive?	No	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Primary Contact	[redacted]	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Phone - Cell	[redacted]	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
	[redacted]	Modify	04/02/2014 18:26 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Relationship	child	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Patient lives with	[redacted]	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Additional Contact	Stanley Huggins	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
	Sam Huggins	Modify	04/02/2014 18:15 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Phone - Home	[redacted]	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Category: IOP Patient History					
Observable Name	Observation	Action Taken	Chart Time	Perform Time	Confirm Time
Is this an IOP Patient?	yes	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Psychiatric Family History	mother-dementia/depression	Original	04/02/2014 18:24 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
	mother had dementia/depression	Modify	04/02/2014 18:25 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
	mother had dementia and depression	Modify	04/02/2014 18:25 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Medical Family History	Sister-breast cancer/brain cancer	Original	04/02/2014 18:24 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
	Sister had breast cancer/brain cancer	Modify	04/02/2014 18:25 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN

Admission Assessment Discharge Rpt
From 04/02/2014 16:38 To 04/18/2014 20:08

Admission History Change Report (continued)

Observables

Template: Adult AA and ALL IOP Patients

Category: IOP Patient History

Observable Name	Observation	Action Taken	Chart Time	Perform Time	Confirm Time
Medical Family History	Sister had breast cancer and brain cancer	Modify	04/02/2014 18:25 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Key relationships/living situatior	lives with daughter	Original	04/02/2014 18:24 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN

Category: Patient History

Observable Name	Observation	Action Taken	Chart Time	Perform Time	Confirm Time
Reason for hosp (pt own words)	unable to verbalize	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Reason	Dem	Original	04/02/2014 18:13 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
	Dementia with Behavioral Disturbances	Modify	04/02/2014 18:15 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
High blood pressure	No	Original	04/02/2014 18:15 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Neuro	No	Original	04/02/2014 18:15 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Fainting	No	Original	04/02/2014 18:15 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Speech	Yes	Original	04/02/2014 18:15 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
GI	No	Original	04/02/2014 18:16 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Heart	No	Original	04/02/2014 18:17 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Respiratory/Lung	No	Original	04/02/2014 18:17 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Kidney/Bladder	No	Original	04/02/2014 18:17 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Endocrine	No	Original	04/02/2014 18:17 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Liver	No	Original	04/02/2014 18:17 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN

Admission Assessment Discharge Rpt
From 04/02/2014 16:38 To 04/18/2014 20:08

Admission History Change Report **(continued)**

Observables

Template: Adult AA and ALL IOP Patients

Category: Patient History

Observable Name	Observation	Action Taken	Chart Time	Perform Time	Confirm Time
Bleeding disorders	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Sickle cell	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Rheumatology	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Dermatology	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Cancer	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Transplant	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Psychiatric	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Violence	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
HIV	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Blood transfusion reaction	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
OB/Gyn	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Developmental disability	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN

Category: Substance Use

Observable Name	Observation	Action Taken	Chart Time	Perform Time	Confirm Time
Smoking Status	never a smoker	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Use of smokeless tobacco?	no	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN
Use of alcohol	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN

Admission Assessment Discharge Rpt
From 04/02/2014 16:38 To 04/18/2014 20:08

Admission History Change Report **(continued)**

Observables

Template: Adult AA and ALL IOP Patients

Category: Substance Use

Observable Name	Observation	Action Taken	Chart Time	Perform Time	Confirm Time
Use of recreational drugs	No	Original	04/02/2014 18:19 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN	04/02/2014 18:10 TALLEY, YALENA, RN

Allergy History

Allergen	Type	Onset Date	Primary Reaction	Other Reaction	Severity	Comment	Confirmed By and Date/Time
NKA	Drug						

Clinical History

Subject	Question	Response	Last Charted By and Date/Time	Confirmed By and Date/Time
CONTACT INFO	Primary Contact	[redacted]	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Phone - Cell	[redacted]	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Relationship	child	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Patient lives with	[redacted]	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Additional Contact	Sam Huggins	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Phone - Home	[redacted]	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
Patient History	Reason for hosp (pt own words)	unable to verbalize	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Reason	Dementia with Behavioral Disturbances	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	High blood pressure	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Neuro	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Fainting	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Speech	Yes	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	GI	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Heart	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Resp/Lung	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Kidney/Bladder	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Endocrine	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Liver	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Bleed disorders	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Sickle cell	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Rheumatology	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Dermatology	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Cancer	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Transplant	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Psychiatric	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10

Clinical History (continued)

Subject	Question	Response	Last Charted By and Date/Time	Confirmed By and Date/Time
Patient History	Violence	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	HIV	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Blc transf/react	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	OB/Gyn	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10
	Dev disability	No	Talley, Yalena , RN 04/02/2014 18:10	Talley, Yalena , RN 04/02/2014 18:10

Medication History

NO DATA FOUND

narrative

04/02/2014 00:00 TO 04/02/2014 23:59

Legend Charting

04/02/2014 17:27

IOP AdmNutrition

WithinNormLimits - Absence of cond = malnutrition, new diabetes, new transplant	Jefferson, Georgia , RN 04/04/2014 13:35
Other findings - Appetite = no change	Jefferson, Georgia , RN 04/04/2014 13:35
Other findings - Weight = no change	Jefferson, Georgia , RN 04/04/2014 13:35
Other findings - Food allergies = no	Jefferson, Georgia , RN 04/04/2014 13:35

Adm Nutrition (81147)

Nutrition Risks = no risk	Jefferson, Georgia , RN 04/04/2014 13:35

04/02/2014 18:27

IOP ADT Detail

Arrival to unit = 04/02/2014 16:34	Talley, Yalena , RN 04/02/2014 19:08
Admission = voluntary	Talley, Yalena , RN 04/02/2014 19:08
Reason admitted = Dementia/depression	Talley, Yalena , RN 04/02/2014 19:08
Prior admission = no	Talley, Yalena , RN 04/02/2014 19:08
PriorAdm, describ = none	Talley, Yalena , RN 04/02/2014 19:08
Prior Psych Care = no	Talley, Yalena , RN 04/02/2014 19:08

Pt Belongings (81187)

Jewelry = safe	Talley, Yalena , RN 04/02/2014 19:08
Jewelry desc = see inventory sheet	Talley, Yalena , RN 04/02/2014 19:08

narrative

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Legend Charting

04/02/2014 18:27

Pt Belongings (81187)

Money = safe	Talley, Yalena , RN 04/02/2014 19:08
Glasses = not applicable	Talley, Yalena , RN 04/02/2014 19:08
Contacts = not applicable	Talley, Yalena , RN 04/02/2014 19:08
Hearing aid = not applicable	Talley, Yalena , RN 04/02/2014 19:08
Dentures = not applicable	Talley, Yalena , RN 04/02/2014 19:08
Suitcase/clothes = not applicable	Talley, Yalena , RN 04/02/2014 19:08
Notes: unit storage	
Case/clothg desc = see inventory sheet	Talley, Yalena , RN 04/02/2014 19:08
Medical equip = not applicable	Talley, Yalena , RN 04/02/2014 19:08
Belongings other = not applicable	Talley, Yalena , RN 04/02/2014 19:08
Notes: see inventory note	
BelongOth desc = see inventory	Talley, Yalena , RN 04/02/2014 19:08
ValuablesDisp - Valuables to = unit lock box	Talley, Yalena , RN 04/02/2014 19:08

Adm Ass Epi Present on Admit

Bed Sore/Ulcer - PtwBedSoreUlcer?* = no	Talley, Yalena , RN 04/02/2014 19:08
Bed Sore/Ulcer - BedSorePast6mth?* = no	Talley, Yalena , RN 04/02/2014 19:08

Exposures (81190)

If yes notify IC - Isolat prev stay = no	Talley, Yalena , RN 04/02/2014 19:08

Influenza vacc

Oct1-Mar31, but varies year to year - UnknownVaccRecvd* = cont screen	Talley, Yalena , RN 04/02/2014 19:08
RecentTransplant - Bone marrow = no	Talley, Yalena , RN 04/02/2014 19:08
RecentTransplant - Solid organ = no	Talley, Yalena , RN 04/02/2014 19:08
No to ALL above - Egg Allergy = No - cont screen	Talley, Yalena , RN 04/02/2014 19:08
No to ALL above - Check for order* = done	Talley, Yalena , RN 04/02/2014 19:08
No to ALL above - RequestVacRxCom* = done	Talley, Yalena , RN 04/02/2014 19:08

Pneumonia vacc

UnknownVaccRecvd* = cont screen	Talley, Yalena , RN 04/02/2014 19:08
Contraindications - Pt/fam refuses = no	Talley, Yalena , RN 04/02/2014 19:08
Contraindications - Pt <65 recvd x2* = no	Talley, Yalena , RN 04/02/2014 19:08

narrative

04/02/2014 00:00 TO 04/02/2014 23:59

Legend Charting

04/02/2014 18:27

Pneumonia vacc

Contraindications - Bone marrow = no	Talley, Yalena , RN 04/02/2014 19:08
Contraindications - Solic organ = no	Talley, Yalena , RN 04/02/2014 19:08
Contraindications - Shingles vaccine = no	Talley, Yalena , RN 04/02/2014 19:08
Contraindications - Vaccine allergy = no	Talley, Yalena , RN 04/02/2014 19:08
Contraindications - Patient pregnant = no	Talley, Yalena , RN 04/02/2014 19:08
Continue screen - Patient 65+ yo = yes	Talley, Yalena , RN 04/02/2014 19:08
Continue screen - EverRecvdVaccine = no, give vaccine	Talley, Yalena , RN 04/02/2014 19:08
Continue screen - Check for order* = done	Talley, Yalena , RN 04/02/2014 19:08
Continue screen - RequestVacRxCom* = done	Talley, Yalena , RN 04/02/2014 19:08

Adm Diabetes (18112)

Pt w/hx diabetes = no	Talley, Yalena , RN 04/02/2014 19:08

Adm Functional (81154)

AbnFnd:Comm/Cog - Comm/Cognition = diff responding, memory impair, unclear speech	Talley, Yalena , RN 04/02/2014 19:08
SpeechPathConsult - Notify MD = done	Jefferson, Georgia , RN 04/04/2014 09:24
SpeechPathConsult - Notify Date/Time = 04/02/2014 18:27	Jefferson, Georgia , RN 04/04/2014 09:24
ADLs - Diff performing = bathing, self-feeding, toileting	Talley, Yalena , RN 04/02/2014 19:08
OT Consult - Notify MD = done	Jefferson, Georgia , RN 04/04/2014 09:24
OT Consult - Notify Date/Time = 04/02/2014 18:27	Jefferson, Georgia , RN 04/04/2014 09:24
Mobility - Mobility = diff ambulation	Jefferson, Georgia , RN 04/04/2014 09:24
Mobility - Impaired use LE = right, left	Jefferson, Georgia , RN 04/04/2014 09:24
Mobility - Use aides = walker, wheelchair	Jefferson, Georgia , RN 04/04/2014 09:24
PT consult - Notify Date/Time = 04/02/2014 18:27	Jefferson, Georgia , RN 04/04/2014 09:24
POC - Implement POC = done	Jefferson, Georgia , RN 04/04/2014 09:24

IOP AdmNutrition

WithinNormLimits - Consume/digest = food	Talley, Yalena , RN 04/02/2014 19:08
WithinNormLimits - Absence of cond = gestational diab, long bone fx>65y, malnutrition, new diabetes, new transplant	Talley, Yalena , RN 04/02/2014 19:08
Other findings - Appetite = no change	Talley, Yalena , RN 04/02/2014 19:08
Other findings - Weight = no change	Talley, Yalena , RN 04/02/2014 19:08

narrative

04/02/2014 00:00 TO 04/02/2014 23:59

Legend Charting

04/02/2014 18:27

IOP AdmNutrition

Other findings - Food allergies = no	Talley, Yalena , RN 04/02/2014 19:08

IOP AA PsychRiskAssess

Trauma - PhysDomesticAbuse = no	Talley, Yalena , RN 04/02/2014 19:08
Trauma - Sexual abuse = no	Talley, Yalena , RN 04/02/2014 19:08
Trauma - Neglect = no	Talley, Yalena , RN 04/02/2014 19:08
Trauma - Violent crime = no	Talley, Yalena , RN 04/02/2014 19:08
Trauma - Emotional abuse = no	Talley, Yalena , RN 04/02/2014 19:08
Trauma - Trauma in hosp = no	Talley, Yalena , RN 04/02/2014 19:08
Trauma - AuthoritiesNotif = no	Talley, Yalena , RN 04/02/2014 19:08
Elopement - Intent/wish = yes	Talley, Yalena , RN 04/02/2014 19:08
Elopement - History = yes	Talley, Yalena , RN 04/02/2014 19:08
Violence - Hx of violence = yes	Talley, Yalena , RN 04/02/2014 19:08
Violence - CurrentAgitation = no	Talley, Yalena , RN 04/02/2014 19:08
Violence - HxOfImpulsivity = yes	Talley, Yalena , RN 04/02/2014 19:08
Violence - HxViolenceInHosp* = unknown	Talley, Yalena , RN 04/02/2014 19:08
Age/Gender - Youth 12-18 yrs = no	Talley, Yalena , RN 04/02/2014 19:08
Age/Gender - College student = no	Talley, Yalena , RN 04/02/2014 19:08
Age/Gender - Elderly, over 65 = yes	Talley, Yalena , RN 04/02/2014 19:08
Age/Gender - Male = no	Talley, Yalena , RN 04/02/2014 19:08
Ethnic/Cultural - Native American = no	Talley, Yalena , RN 04/02/2014 19:08
Ethnic/Cultural - Alaskan Native = no	Talley, Yalena , RN 04/02/2014 19:08
Ethnic/Cultural - Veteran = no	Talley, Yalena , RN 04/02/2014 19:08
Ethnic/Cultural - Incarc/homeless* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Depression = yes	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Schizophrenia = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - CommHallucination* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Biopolar disorder = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Substance abuse = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - GamblingAddicton = no	Talley, Yalena , RN 04/02/2014 19:08

narrative

04/02/2014 00:00 TO 04/02/2014 23:59

Legend Charting

04/02/2014 18:27

IOP AA PsychRiskAssess

Current Hx Of - Sexual abuse = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Incest = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - DomViolnceVictim = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Other assault = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Other trauma* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Chronic illness = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Insomnia = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - PrevSuicideAttpt = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - SuicAttHospJail* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - FamilyHxSuicide = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - SuicCloseFriend* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Witness Suicide* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - Bullying* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - RecentSignifLoss* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - FinancialWorries = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - PerceivesBurden* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of Has a weapon* = no	Talley, Yalena , RN 04/02/2014 19:08
Current Hx Of - SexOrientIssues* = no	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - AnxiousAgitated* = yes	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - Angry = no	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - Suspicious = no	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - Stoic* = no	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - Impulsive = yes	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - RecentPersChg* = no	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - HopelessHelpless* = no	Talley, Yalena , RN 04/02/2014 19:08
Seen Or Desc As - WithdrawnIsolatd* = no	Talley, Yalena , RN 04/02/2014 19:08

IOP Mental Status

Appearance = disheveled	Talley, Yalena , RN 04/02/2014 19:08
Gait = unusual	Talley, Yalena , RN 04/02/2014 19:08

narrative

04/02/2014 00:00 TO 04/02/2014 23:59

Legend Charting

04/02/2014 18:27

IOP Mental Status

Hygiene = good	Talley, Yalena , RN 04/02/2014 19:08
Eye contact = good	Talley, Yalena , RN 04/02/2014 19:08
Posture = slouched	Talley, Yalena , RN 04/02/2014 19:08
Motor behavior = hyperactive	Talley, Yalena , RN 04/02/2014 19:08
Speech quantity = min responsive	Talley, Yalena , RN 04/02/2014 19:08
Speech quality = soft, incomprehensible	Talley, Yalena , RN 04/02/2014 19:08
Affect = constricted	Talley, Yalena , RN 04/02/2014 19:08
Mood = appropriate	Talley, Yalena , RN 04/02/2014 19:08
Thought process = disorganized, incoherent	Talley, Yalena , RN 04/02/2014 19:08

IOP Alcohol Use Hx

DrinkWithAlcohol* = a=never	Talley, Yalena , RN 04/02/2014 19:08
HxDTsWithdrawal* = no	Talley, Yalena , RN 04/02/2014 19:08
HxSeizrWithdraw* = no	Talley, Yalena , RN 04/02/2014 19:08

narrative

04/02/2014 00:00 TO 04/02/2014 23:59

Legend Charting

04/02/2014 18:27

Ped IOP AA Epi PsychRiskAssess

Elopement - Intent/wish = yes — Talley, Yalena , RN 04/02/2014 19:08

Elopement - History = yes — Talley, Yalena , RN 04/02/2014 19:08

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPASSESSMT

Inventory of Patient's Medications Not Sent Home on Admission

Page 1 of 1

Form Origination Date: 8/09
Version: 1

Version Date: 8/09

[redacted] DOB:10/08/1947 W F
[redacted]
[redacted]
EAdm:04/02/14 M[redacted]

Each medication, dose, and number of doses will be listed. Two RNs must sign verification of the count of controlled substances. The patient / guardian will be asked to sign verifying the inventory. When the medication is returned, the patient / guardian and RN will sign verifying the return of the medications.

Medication	Dose	Number of Doses	Not Returned
Namenda	10mg	0	
Donepezil HCL	10mg	0	
Aricept Donepezil	10mg	14	

Bag number 87960010

Yalena G. Talley, RN — 4/2/14 — 1740 AM / PM

RN Signature — Date — Time

_____ — _____ — _____ AM / PM

RN Signature (for controlled substances) — Date — Time

Medications will be disposed of if not retrieved after thirty days following discharge.

_____ — _____ — _____ AM / PM

Patient Signature verifying above inventory — Date — Time

Check box above to indicate medication not returned to patient for clinical reasons as determined by Attending Psychiatrist / Licensed Independent Practitioner

_____ — _____ — _____ AM / PM

Patient / Guardian Signature verifying receipt of medications — Date — Time

_____ — _____ — _____ AM / PM

RN Signature verifying return of medications to Patient / Guardian — Date — Time

iop_all_docu_inventorynotsenthome

OTE 900931 8/09

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPASSESSMT"

Institute of Psychiatry
Patient Inventory

Form Origination Date: 5/06
Version: 2 Version Date: 8/09

[redacted] DOB:10/02/1947 W F
[redacted]
EAdm:04/02/14 [redacted]

Belongings List (describe items including brand)	Disposition of Belongings (check applicable column)								
	N/A	With Patient	Patient Closet	Sent Home	Med Room	Lock Box	Unit Storage	IOP Safe	Hospital Security
☐ Glasses ☐ Contact lenses									
Dentures ☐ Upper ☐ Lower ☐ Full ☐ Partial									
Hearing aid ☐ Left ☐ Right									
Prosthesis (specify)									
✓ Blue oxford button-up		✓					✓		
✓ Plaid skirt		✓					✓		
✓ Plaid blazer		✓					✓		
✓ Black leather flat shoes		✓					✓		
Silver colored bracelet c white colored stones							✓		
silver colored bracelet c clasp							✓		
silver colored open bracelet							✓		
silver colored watch							✓		
silver colored ring c blue colored stone							✓		
black velvet necklace c silver colored cross c red colored stones							✓		
black leather like purse							✓		

1. Money to safe: _____ (Valuable envelope number). $ 1.76 (Amount) *1- quarters *0.41- pennies *0.30- dimes *0.05 nickles _____ Staff Initials

2. Valuables to safe: _____ (Valuable envelope number) _____ Staff Initials

Comments: _____

I understand the hospital cannot be responsible for any personal property that I do not request to be secured at time of admission, or left 30 days from discharge date.

_____ _____ _____ AM/PM
Patient / Caregiver Signature Date Time

Yalena A. Talley, RN 4/2/14 1736 AM/PM
Staff Signature Date Time

Remove this Receipt Before Attempting to Seal Bag. Retain for Records.

Patient's Name: [redacted] ID#: [redacted]
Unit / Clinic: SCA ED Date: 4/2/14
Prepared by: YAT 8796010

iop_all_docu... Rev. 8/09

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPASSESSMT

Institute of Psychiatry
Patient Inventory

Form Origination Date: 5/08
Version: 2 Version Date: 8/09

[redacted] 008:10/08/1947 W F
[redacted]
[redacted]
EAdm:04/02/14[redacted]

Belongings List (Describe items including brand)	Disposition of Belongings (check applicable column)									
	N/A	With Patient	Patient Closet	Sent Home	Med Room	Lock Box	Unit Storage	IOP Safe	Hospital Security	
4/10/14 White Sweater / PJ Bottom (Light Pink, Brown, Gray) Gray Shoes High heel						✓				✓ LQ
Mary Kay Make-up case							✓			✓ LQ
Neutrogena Lip Moisturizer							✓			✓ LQ
In Purse Maybelline Ultra Liner (No brush)							✓			✓ LQ
Covergirl wet sticks (No brush)							✓			✓ LQ
Panavue Slide "King of Kings"							✓			✓ LQ
Black Pen							✓			✓ LQ
SC ID							✓			✓ LQ
Humana Insurance Card							✓			✓ LQ
Medicare Insurance Card							✓			✓ LQ
WD 4-3-14 ✓ marled beige sweater		✓								✓ LQ
✓ white button up shirt		✓								✓ LQ
✓ pink/grey PJ bottoms		✓								✓ LQ
✓ pink moccassin slippers		✓								✓ LQ
✓ pink brush		✓								✓ LQ
perfume					✓	in drawer				✓ LQ
4/10 Pink, Gray PJ Bottoms / Pink White Jacket ✓ LQ LQ										

Comments: _____

I understand the hospital cannot be responsible for any personal property that I do not request to be secured at time of admission, or left 30 days from discharge date.

Patient / Caregiver Signature — Date — Time AM/PM

Yalina G. Dalley, RN — Staff Signature

4/2/14 — Date

1736 AM/PM — Time

Original to Medical Record

Copy to Patient / Caregiver

iop_all_docu_ptInventory

OTE 700192 Rev. 8/09

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPASSESSMT"

MEDICATION RECONCILIATION
(IOP NP, PA and Physician Assessment)
Page 1 of 1

Form Origination Date: 12/11
Version: 1 Version Date: 12/11

[redacted] F

Patient Name
MRN
PATIENT IDENTIFICATION LABEL

Drug Sensitivities / Allergies (list food / drug / latex / other allergies)
☒ No known drug allergies ☐ Unable to assess, reason

Drug / Substance	Reaction, if known

Current Medications

Medications (including herbal supplements and over-the-counter)	Dose / Frequency / Route	Last Dose / Comments	Continue in Hospital Y	N	Δ
Aricept	10mg PO QHS		☑	☐	☐
Lexapro	20mg PO daily		☑	☐	☐
Namenda	10mg PO BID		☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Medication Reconciliation Updates (by Pharmacy Team) Initials JB Date 4/03/14
☐ No updates to medication list

Medications (including herbal supplements and over-the-counter)	Dose / Frequency / Route	Last Dose / Comments	Reviewer (Initials)

Automatic Therapeutic Substitutions

Outpatient Medication	Dose / Frequency	Changed to	Dose / Frequency

Appropriate physician notified of discrepancies between medication list and the current medication orders.
Source of medication list ☐ Patient
☑ Family / caregiver (name) Sammy Huggins [redacted] Phone number
☐ Pharmacy Phone number
☐ Other Phone number
☐ Home meds stored on unit
Please see Medication Reconciliation (page 1) performed by Pharmacy Team.

Initials [redacted] Signature & Title [redacted] Pager ID 15876 Date 3/30/14 Time 1:39 AM/PM
Initials [redacted] Signature & Title [redacted] Pager ID 14582 Date 4/03/14 Time 910 AM/PM
iop_admission_med_rec_phys OTE 700774 12/11

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPASSESSMT

Central Inpatient Program Services (CIPS) Assessment

Page 1 of 2

Form Origination Date: 02/11
Version: 2 Version Date: 3/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14
MRN [redacted]

PATIENT IDENTIFICATION LABEL

Date: 2 Apr '14 Time: 1700 AM/PM Methods: ☒ Chart review ☒ Observation ☒ Interview

Reason for Admission: Pt is 2066 yo woman w/hx of alzheimers dementia who presents to ED via EMS w/ wandering, aggression & behavioral disturbances. Pt has had progressive decline in ADLs, calling family & wandering.

☐ Refused to participate in interview ☐ Unable to assess _____

Response to Initial Interview
- ☐ Compliant
- ☒ Receptive
- ☐ Resistant
- ☐ Drowsy
- ☒ Guarded
- ☐ Other _____

Grooming / Hygiene / Self-Care
- ☐ Carefully groomed
- ☒ Disheveled
- ☐ Clean
- ☐ Poor activities of daily living

Affect / Mood
- ☐ Bright / happy
- ☐ Labile
- ☒ Suspicious / paranoid
- ☐ Appropriate to situation
- ☐ Inappropriate
- ☒ Sad / flat / blunted
- ☐ Euphoric
- ☒ Anxious
- ☐ Irritable / angry
- ☒ Other "just want to go home."

Cognition
- ☐ Remains on task
- ☐ Preoccupied with personal issues
- ☐ Loses interest quickly
- ☐ Easily distracted
- ☐ Psychotic
- ☒ Circumstantial
- ☒ Poor insight and judgment
- ☒ Other disorganized, poor historian

Stressors
- ☐ Death (who and when) _____
- ☐ Financial _____
- ☐ Housing _____
- ☐ Relationship problems _____
- ☐ School _____
- ☐ Legal _____
- ☐ Work _____
- ☐ Health issues _____
- ☒ Psychotic symptoms Dementia
- ☒ Other ↓ behavioral disturbances

Leisure Skills and Interests

Exercise / athletics
- ☐ Cardio
- ☐ Athletics
- ☐ Swimming
- ☐ Bicycling
- ☐ Running / jogging
- ☒ Dancing / shag
- ☒ Walking
- ☐ Hiking
- ☐ Weight lifting
- ☐ Yoga
- ☒ Other demonstrated floor exercises

Outdoors / adventure
- ☐ Travel
- ☐ Backpacking
- ☐ Horseback riding
- ☐ Water sports
- ☐ Boating
- ☐ Fishing
- ☐ Hunting
- ☒ Gardening w/ assistance
- ☒ Time outside
- ☒ Beach
- ☐ Other _____

Relaxation / entertainment
- ☐ Bath / shower
- ☐ Relaxation techniques
- ☐ Music
- ☐ Meditation
- ☐ Driving
- ☐ Alone time
- ☐ Reading
- ☐ Music
- ☐ Television
- ☐ Movies
- ☐ Video games
- ☐ Internet
- ☐ Other _____

INITIALS
OTE 700671 3/12

iop_cips_assess

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPASSESSMT

Central Inpatient Program Services (CIPS) Assessment

Form Origination Date: 02/11
Version: 2 Version Date: 3/12

[redacted] DOB: 10/08/1947 W F

Patient Name [redacted] Adm: 04/02/14
MRN [redacted]
PATIENT IDENTIFICATION LABEL

Social
- ☐ AA / NA
- ☒ Visiting
- ☒ Going out to eat
- ☐ Hanging out with friends
- ☐ Phone calls
- ☐ Dating
- ☐ Cards
- ☐ Table games
- ☐ Community organizations
- ☐ School clubs
- ☐ Church
- ☐ Other _____

Family
- ☐ Picnics / outings
- ☐ Meals
- ☒ Play with children / grandchildren
- ☐ Family activities
- ☐ Pets
- ☐ Vacations / travel
- ☒ Other "daughter & son"

Spiritual
- ☐ Church / Sunday school
- ☐ Spiritual readings
- ☐ Choir
- ☐ Prayer / meditation
- ☐ Other _____

Volunteer

Creative / mental
- ☐ Writing _____
- ☐ Reading / library
- ☐ Games
- ☐ Photography
- ☐ Drawing / painting
- ☐ Craft
- ☐ Puzzles
- ☐ Home improvement
- ☐ Singing
- ☐ Needlework
- ☐ Building / fixing something
- ☐ Pottery
- ☐ Playing musical instrument
- ☐ Computers / internet
- ☒ Other "support to wife/daughter"

Work Status
- ☐ Full-time
- ☐ Part-time
- ☐ Position _____
- ☐ Student _____
- ☐ Unemployed
- ☐ Disability
- ☐ Retired
- ☐ Other _____

Limitations / Barriers to Learning
- ☒ Physical unsteady gait, bell coord
- ☒ Sensory WNL
- ☒ Cognitive confused, disoriented
- ☐ Motivation _____
- ☐ Other _____

Problem Areas to Be Addressed by CIPS
- ☐ Substance abuse / dependence Specify _____
- ☒ Depression
- ☐ Anxiety
- ☐ Problem-solving skills
- ☐ Limited / poor coping skills
- ☐ Anger management
- ☐ Limited / poor social skills
- ☒ Poor leisure functioning
- ☐ Psychosis
- ☐ Mania / hypomania
- ☐ Behavioral problems / combative
- ☒ Other violent Alzheimer's Dementia

Recommendations
- ☐ Participate in therapy track
  - ☐ COD
  - ☐ MAP
  - ☐ Living skills
  - ☐ Adolescent
- ☒ Not appropriate for group involvement at this time Inability to engage
- ☒ 1:1 as appropriate

Initials [redacted] Signature & Title [redacted] Pager ID _____ Date 2-APR-14 Time 1700 AM/PM

Initials [redacted] Signature & Title [redacted] Pager ID _____ Date 3-APR-14 Time 1840 AM/PM

Initials _____ Signature & Title _____ Pager ID _____ Date _____ Time _____ AM/PM

INITIALS [redacted]

iop_cips_assess

OTE 700671 3/12

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPASSESSMT

Admission Suicide Severity Rating Scale

Form Origination Date: 02/11
Version: 2 Version Date: 10/13

Pat[redacted] DOB:10/08/1947 W F
MRN [redacted] EAdm:04/02/14 [redacted] EL

SUICIDAL BEHAVIOR Check all that apply as long as they are separate events; must assess all types	Past Week	Lifetime
Actual Suicide Attempt: A potentially self-injurious act committed with at least some wish to die as a result of the act. Behavior was in part thought of as a method to kill oneself. If there is any intent / desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be any injury or harm, just the potential for injury or harm. Even if an individual denies intent / wish to die, it may be inferred clinically from the behavior or circumstances. Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. Have you made a suicide attempt? What did you do? Have you ever done anything to harm yourself? What did you do? Have you ever done anything dangerous where you could have died? What did you do? Were you trying to end your life when you ?	☐ Yes ☑ No	☐ Yes ☑ No Total # of Attempts
Non-Suicidal Self-Injurious Behavior: Have you ever done anything to harm yourself without ANY intention of killing yourself (to relieve stress, feel better, get sympathy, or get something else to happen)? If yes, describe:	☐ Yes ☑ No	☐ Yes ☐ No
Interrupted Attempt: Has there been a time when you started to do something to try to end your life but someone or something stopped you before you actually did anything? If yes, describe:	☐ Yes ☑ No	☐ Yes ☑ No Total # of Attempts
Aborted Attempt: Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything? If yes, describe:	☐ Yes ☑ No	☐ Yes ☑ No Total # of Attempts
Preparatory Acts or Behaviors: Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away, or writing a suicide note)? If yes, describe:	☐ Yes ☑ No	☐ Yes ☐ No

Lethality Ratings (Suicide Attempts Only—Actual, Interrupted, Aborted)	Initial Attempt	Most Recent Attempt	Most Lethal Attempt
Actual Lethality / Physical Injury 0 = None or very minor (such as superficial scratches) 1 = Minor (such as mild bleeding, 1st-degree burns) 2 = Moderate—medical attention needed (such as somewhat responsive, 2nd-degree burns, bleeding of a major vessel) 3 = Moderately severe—medical hospitalization required (such as comatose with intact reflexes, 3rd-degree burns over less than 20% of the body, extensive blood loss with stable vital signs, major fractures) 4 = Severe—medical intensive care required (such as comatose without reflexes, 3rd-degree burns over ≥ 20% of body, extensive blood loss with unstable vital signs, major damage to internal organs) 5 = Death likely, despite available medical care	—	—	—
Potential Lethality: Only answer if Actual Lethality = 0. 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not cause death 2 = Behavior likely to result in death despite available medical care	—	—	—

Signature / Title: Yalena G. Talley, RN Pager: _____ Date: 4/2/14 Time: 2102 AM / PM

Adapted with permission from the Columbia Suicide Severity Rating Scale (C-SSRS)

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPASSESSMT

Admission Suicide Severity Rating Scale

Page 1 of 2

Form Origination Date: 02/11
Version: 2 Version Date: 10/13

[redacted] DOB:10/08/1947 W F
Pat[redacted]
MRI[redacted]
EAdm:04/02/14 [redacted] ABEL

SUICIDAL IDEATION Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes," ask questions 3, 4, and 5. If the answer to question 1 and / or question 2 is "yes," complete "Intensity of Ideation" section below.	Past Week	Lifetime
1) **Wish to be Dead: Have you wished you were dead or wished you could go to sleep and not wake up?** Comments: _____	☐ Yes ☑ No	☐ Yes ☑ No
2) **Suicidal Thoughts: Have you actually had any thoughts of killing yourself?** Comments: _____	☐ Yes ☑ No	☐ Yes ☑ No
3) **Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Have you been thinking about how you might kill yourself?** Comments: _____	☐ Yes ☐ No	☐ Yes ☐ No
4) **Suicidal Intent without Specific Plan: Have you had these thoughts and had some intention of acting on them?** Comments: _____	☐ Yes ☐ No	☐ Yes ☐ No
5) **Suicidal Intent with Specific Plan: Have you started to work out or worked out the details of how to kill yourself?** Comments: _____ **Do you intend to carry out this plan?** Comments: _____	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
INTENSITY OF IDEATION: If any suicidal ideation is endorsed in questions 1 or 2 above, complete intensity ratings below for the most severe level of ideation assessed in questions 1-5—the time the patient was feeling the most suicidal during the past week and lifetime.	Past Week	Lifetime
Frequency: How many times have you had these thoughts? 1 = Less than once a week 4 = Daily / almost daily 2 = Once a week 5 = Many times each day 3 = 2–5 times in a week		
Duration: When you have these thoughts, how long do they last? 1 = Fleeting—few seconds or minutes 4 = 4–8 hours / most of day 2 = Less than 1 hour / some of the time 5 = More than 8 hours / persistent 3 = 1–4 hours / a lot of the time		
Controllability: Could / can you stop thinking about killing yourself or wanting to die if you want to? 1 = Easily able to control thoughts 4 = Can control thoughts with a lot of difficulty 2 = Can control thoughts with little difficulty 5 = Unable to control thoughts 3 = Can control thoughts with some difficulty 0 = Does not attempt to control thoughts		
Deterrents: Are there things—anyone or anything (e.g., family, religion, pain of death)—that stopped you from wanting to die or acting on thoughts of committing suicide? 1 = Deterrents definitely stopped you from attempting suicide 4 = Deterrents most likely did not stop you 2 = Deterrents probably stopped you 5 = Deterrents definitely did not stop you 3 = Uncertain that deterrents stopped you 0 = Does not apply		
Reasons for Ideation: What sort of reasons did you have for thinking about wanting to die or killing yourself? 1 = Completely to get attention, revenge, or a reaction from others 2 = Mostly to get attention, revenge, or a reaction from others 3 = Equally to get attention, revenge, or a reaction from others and to end / stop pain 4 = Mostly to end or stop the pain (you couldn't go on living with the pain or how you are feeling) 5 = Completely to end or stop the pain (you couldn't go on living with the pain or how you are feeling) 0 = Does not apply		

Initials: YHO

Adapted with permission from the Columbia Suicide Severity Rating Scale (C-SSRS)

iop_admission_suicide_severity_rating_scale

OTE 700776 Rev.10/13

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPREASSESS

Suicide Risk Monitor
24 Hour Monitor and Discharge Assessment

Form Origination Date: 3/05
Version: 6 Version Date: 3/12

P: [redacted] DOB:10/08/1947 W F
[redacted]
[redacted]
Adm:04/02/14 M: [redacted]

PATIENT IDENTIFICATION LABEL

SUICIDAL IDEATION: Ask questions 1 and 2. If the answer to question 2 is "yes," complete remainder of form, including Page 2. If the answers to questions 1 and 2 are "no," proceed to "Suicidal Behavior" section on Page 2.

1) Wish to be Dead: Since the last assessment, have you wished you were dead or wished you could go to sleep and not wake up?

Night Shift:	☐ No	☐ Yes, describe:
Day Shift:	☑ No	☐ Yes, describe:
Evening Shift:	☐ No	☐ Yes, describe:

2) Suicidal Thoughts: Since the last assessment, have you had any thoughts of killing yourself?

Night Shift:	☐ No	☐ Yes, describe:
Day Shift:	☑ No	☐ Yes, describe:
Evening Shift:	☐ No	☐ Yes, describe:

3) Suicidal Thoughts with Method: Since the last assessment, have you been thinking about how you might kill yourself?

Night Shift:	☐ No	☐ Yes, describe:
Day Shift:	☐ No	☐ Yes, describe:
Evening Shift:	☐ No	☐ Yes, describe:

4) Suicidal Intent without Specific Plan: Since the last assessment, have you had these thoughts and had some intention of acting on them?

Night Shift:	☐ No	☐ Yes, describe:
Day Shift:	☐ No	☐ Yes, describe:
Evening Shift:	☐ No	☐ Yes, describe:

5) Suicidal Intent with Specific Plan: Since the last assessment, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

Night Shift:	☐ No	☐ Yes, describe:
Day Shift:	☐ No	☐ Yes, describe:
Evening Shift:	☐ No	☐ Yes, describe:

INTENSITY OF IDEATION: If any suicidal ideation is endorsed, complete intensity ratings below.	Night	Day	Evening
Frequency: Since the last assessment, how often have you had thoughts about killing yourself? 1 = Almost never 2 = Rarely 3 = Sometimes 4 = Often 5 = Constantly	___	N/A	___
Duration: When you had these thoughts, how long did they last? 1 = A few seconds to a few minutes 2 = Less than 1 hour 3 = 1–4 hours 4 = 4–8 hours 5 = More than 8 hours	___	N/A	___
Controllability: Can you stop thinking about killing yourself or wanting to die, if you want to? 1 = Can easily control these thoughts 2 = Can control them with a little difficulty 3 = Can control them with some difficulty 4 = Can control these thoughts with a lot of difficulty 5 = Unable to control these thoughts 0 = Does not try to control these thoughts	___	N/A	___
Reasons for Ideation: Since the last assessment, what reasons have you had for thinking about wanting to die or kill yourself? 1 = Completely to get attention, revenge, or a reaction from others 2 = Mostly to get attention, revenge, or a reaction from others 3 = Equally to get attention, revenge, or a reaction from others AND to stop the pain 4 = Mostly to end or stop the pain 5 = Completely to end or stop the pain	___	N/A	___

Night Shift RN Initials: _____ Day Shift RN Initials: LG Evening Shift RN Initials: _____

Adapted with permission from the Columbia Suicide Severity Rating Scale(C-SSRS)

iop_all_docu_suicideriskmonitor

OTE 901049 Rev. 3/12

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPREASSESS

Suicide Risk Monitor
24 Hour Monitor and Discharge Assessment

Form Origination Date: 3/05
Version: 6 Version Date: 3/12

[redacted] DOB:10/08/1947 W F
[redacted]
[redacted]
Adm:04/02/14 [redacted]

PATIENT IDENTIFICATION LABEL

Suicidal Behavior: Since the last assessment, have you done anything to harm yourself or done anything dangerous where you could have died (accidentally or on purpose)?

Night Shift:	☐ No	☐ Yes, describe: _____
Day Shift:	☑ No	☐ Yes, describe: _____
Evening Shift:	☐ No	☐ Yes, describe: _____

If positive for suicidal behavior, assess for lethality of suicide attempts (actual, interrupted, aborted). For actual suicide attempts, assess "Actual Lethality." For interrupted and / or aborted suicide attempts, assess "Potential Lethality." Lethality Ratings	Night	Day	Evening
Actual Lethality / Physical Injury 0 = None or very minor (such as superficial scratches) 1 = Minor (such as mild bleeding, 1st-degree burns) 2 = Moderate—medical attention needed (such as somewhat responsive, 2nd-degree burns, bleeding of a major vessel) 3 = Moderately severe—medical hospitalization required (such as comatose with intact reflexes, 3rd-degree burns over less than 20% of the body, extensive blood loss with stable vital signs, major fractures) 4 = Severe—medical intensive care required (such as comatose without reflexes, 3rd-degree burns over ?20% of body, extensive blood loss with unstable vital signs, major damage to internal organs) 5 = Death likely, despite available medical care	—	N/A	—
Potential Lethality: Only answer if Actual Lethality = 0. 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not cause death 2 = Behavior likely to result in death despite available medical care	—	N/A	—

☐ Unable to assess due to _____

☐ Treatment plan discussed / reviewed / revised with patient

Night Shift Comments: _____

Signature of Night Shift RN: _____ Date: _____ Time: _____ AM / PM

☐ Unable to assess due to _____

☑ Treatment plan discussed / reviewed / revised with patient

Day Shift Comments: Pt denies SI thoughts of harm to self and others.

Signature of Day Shift RN: L. J Lucas, RN Date: 4/8/14 Time: 0934 (AM) PM

☐ Unable to assess due to _____

☐ Treatment plan discussed / reviewed / revised with patient

Evening Shift Comments: _____

Signature of Evening Shift RN: _____ Date: _____ Time: _____ AM / PM

Adapted with permission from the Columbia Suicide Severity Rating Scale(C-SSRS)

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPREASSESS

Suicide Risk Monitor
24 Hour Monitor and Discharge Assessment

Form Origination Date: 3/05
Version: 6 Version Date: 3/12

P[redacted] DOB:10/08/1947 W F
[redacted]
[redacted]
Adm:04/02/14 [redacted]

PATIENT IDENTIFICATION LABEL

SUICIDAL IDEATION: Ask questions 1 and 2. If the answer to question 2 is "yes," complete remainder of form, including Page 2. If the answers to questions 1 and 2 are "no," proceed to "Suicidal Behavior" section on Page 2.

1) **Wish to be Dead: Since the last assessment, have you wished you were dead or wished you could go to sleep and not wake up?**
   - Night Shift: ☐ No ☐ Yes, describe: _____
   - Day Shift: ☑ No ☐ Yes, describe: _____
   - Evening Shift: ☐ No ☐ Yes, describe: _____

2) **Suicidal Thoughts: Since the last assessment, have you had any thoughts of killing yourself?**
   - Night Shift: ☐ No ☐ Yes, describe: _____
   - Day Shift: ☑ No ☐ Yes, describe: _____
   - Evening Shift: ☐ No ☐ Yes, describe: _____

3) **Suicidal Thoughts with Method: Since the last assessment, have you been thinking about how you might kill yourself?**
   - Night Shift: ☐ No ☐ Yes, describe: _____
   - Day Shift: ☐ No ☐ Yes, describe: _____
   - Evening Shift: ☐ No ☐ Yes, describe: _____

4) **Suicidal Intent without Specific Plan: Since the last assessment, have you had these thoughts and had some intention of acting on them?**
   - Night Shift: ☐ No ☐ Yes, describe: _____
   - Day Shift: ☐ No ☐ Yes, describe: _____
   - Evening Shift: ☐ No ☐ Yes, describe: _____

5) **Suicidal Intent with Specific Plan: Since the last assessment, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?**
   - Night Shift: ☐ No ☐ Yes, describe: _____
   - Day Shift: ☐ No ☐ Yes, describe: _____
   - Evening Shift: ☐ No ☐ Yes, describe: _____

INTENSITY OF IDEATION: If any suicidal ideation is endorsed, complete intensity ratings below:	Night	Day	Evening
Frequency: Since the last assessment, how often have you had thoughts about killing yourself? 1 = Almost never 2 = Rarely 3 = Sometimes 4 = Often 5 = Constantly	___	N/A	___
Duration: When you had these thoughts, how long did they last? 1 = A few seconds to a few minutes 2 = Less than 1 hour 3 = 1–4 hours 4 = 4–8 hours 5 = More than 8 hours	___	N/A	___
Controllability: Can you stop thinking about killing yourself or wanting to die, if you want to? 1 = Can easily control these thoughts 2 = Can control them with a little difficulty 3 = Can control them with some difficulty 4 = Can control these thoughts with a lot of difficulty 5 = Unable to control these thoughts 0 = Does not try to control these thoughts	___	N/A	___
Reasons for Ideation: Since the last assessment, what reasons have you had for thinking about wanting to die or kill yourself? 1 = Completely to get attention, revenge, or a reaction from others 2 = Mostly to get attention, revenge, or a reaction from others 3 = Equally to get attention, revenge, or a reaction from others AND to stop the pain 4 = Mostly to end or stop the pain 5 = Completely to end or stop the pain	___	N/A	___

Night Shift RN Initials: _____ Day Shift RN Initials: LQ Evening Shift RN Initials: _____

Adapted with permission from the Columbia Suicide Severity Rating Scale(C-SSRS)

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPREASSESS

Suicide Risk Monitor
24 Hour Monitor and Discharge Assessment

Form Origination Date: 3/05
Version: 5 Version Date: 3/12

[redacted] DOB:10/08/1947 W F
[redacted]
[redacted]
Adm:04/02/14 [redacted]

PATIENT IDENTIFICATION LABEL

Suicidal Behavior: Since the last assessment, have you done anything to harm yourself or done anything dangerous where you could have died (accidentally or on purpose)?

Night Shift: ☐ No ☐ Yes, describe: _____
Day Shift: ☑ No ☐ Yes, describe: _____
Evening Shift: ☐ No ☐ Yes, describe: _____

If positive for suicidal behavior, assess for lethality of suicide attempts (actual, interrupted, aborted). For actual suicide attempts, assess "Actual Lethality." For interrupted and / or aborted suicide attempts, assess "Potential Lethality." Lethality Ratings:	Night	Day	Evening
Actual Lethality / Physical Injury 0 = None or very minor (such as superficial scratches) 1 = Minor (such as mild bleeding, 1st-degree burns) 2 = Moderate—medical attention needed (such as somewhat responsive, 2nd-degree burns, bleeding of a major vessel) 3 = Moderately severe—medical hospitalization required (such as comatose with intact reflexes, 3rd-degree burns over less than 20% of the body, extensive blood loss with stable vital signs, major fractures) 4 = Severe—medical intensive care required (such as comatose without reflexes, 3rd-degree burns over ?20% of body, extensive blood loss with unstable vital signs, major damage to internal organs) 5 = Death likely, despite available medical care	___	N/A	___
Potential Lethality: Only answer if Actual Lethality = 0. 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not cause death 2 = Behavior likely to result in death despite available medical care	___	N/A	___

☐ Unable to assess due to _____

☐ Treatment plan discussed / reviewed / revised with patient

Night Shift Comments: _____

Signature of Night Shift RN: _____ Date: _____ Time: _____ AM / PM

☐ Unable to assess due to _____

☑ Treatment plan discussed / reviewed / revised with patient

Day Shift Comments: Pt denies SI thoughts of harm to self and others.

Signature of Day Shift RN: L. J. Lawson, RN Date: 4/8/14 Time: 0932 (AM) PM

☐ Unable to assess due to _____

☐ Treatment plan discussed / reviewed / revised with patient

Evening Shift Comments: _____

Signature of Evening Shift RN: _____ Date: _____ Time: _____ AM / PM

Adapted with permission from the Columbia Suicide Severity Rating Scale(C-SSRS)

[redacted]
MUSC
IV Administration Report
FROM: 04/02/14 16:38 TO: 04/18/14 20:09
ROOM: *P411-L* ADM: 04/02/14 16:38
AGE: 66Y SEX: F MD: BROADWAY, JESSICA L
DOB: 10/08/1947 ID: [redacted] MR: [redacted]
REQUESTED:04/19/14 05:40
OPT OUT:
Page: 1

Order#	IV Type	Sched Type	Start Dt/Tm	Sched Dt/Tm	End Dt/Tm
1	IV	Routine	04/12/14 12:05	04/12/14 13:00	04/12/14 19:59

Detail - Bottle Type: O Begin Vol: 1000 ML I/O Label: NaCl 0.9%
SODIUM CHLORIDE 0.9% 1000 ML
IV access = Peripheral; ** 1000 mL** x 7 Hours

Admin Dt/Tm	Bot#	Act	Site	Rate/Units	Dose/Units	Charted By/At
04/12 13:36	1-0	Start	antR	150 ML/HR		LB33 04/12 13:37
04/13 01:25	1-0	End	antR	150 ML/HR		TAB6 04/13 01:25

Care Providers:
LB33 BLIZZARD, LAUREN, RN
TAB6 BLACK, TAMMY, RN

YTzz TALLEY, YALENA, RN
KM11 MADDEN, KATHERINE, RN
NN37 NZIOKA, NANCY, RN
NRSMSMITH, NICHOLE R, RN

[redacted]
MUSC
Medication Administration Report
FROM: 04/02/14 16:38 TO: 04/18/14 23:59
ROOM: *P411-L* ADM: 04/02/14 16:38
AGE: 66Y SEX: F MD: BROADWAY, JESSICA L
DOB: 10/08/1947 ID: [redacted]
REQUESTED:04/19/14 05:40
OPT OUT:

* see end of page for Administration Note
■ see end of page for Not-Given reason
HOLD: DISCONTINUED:

	start/stop	ord	04/02/14 Day:1 11 15 19 23 03	04/03/14 Day:2 11 15 19 23 03	04/04/14 Day:3 11 15 19 23 03
SCHEDULED MEDICATIONS					
DIVALPROEX EC (DIVALPROEX)					
125 MG=1 DR TAB PO EVERY 12 HOURS	04/02 21:00 04/18 16:40	11	20:34 YT22	07:47 KM11 / 20:19 NN37	07:48 KM11 / 20:46 NRSM
	M:DO NOT CRUSH OR CHEW				
DONEPEZIL ORALLY Disintegrating (DONEPEZIL)					
10 MG=1 TAB PO DAILY	04/03 08:30 04/08 09:36	13		07:47 KM11	07:48 KM11
	M:DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.				
Escitalopram					
10 MG=1 TAB PO DAILY	04/03 08:30 04/18 16:40	14		07:47 KM11	07:48 KM11
MEMANTINE (NAMENDA)					
10 MG=1 TAB PO TWICE DAILY	04/02 21:00 04/18 16:40	10	20:34 YT22	07:47 KM11 / 20:19 NN37	07:48 KM11 / 20:46 NRSM
Sulfamethox-Trimeth 800-160MG (Sulfamethoxazole-Trimethoprim)					
1 TAB PO EVERY 12 HOURS	04/02 21:00 04/09 20:59	12	20:34 YT22	07:47 KM11 / 20:19 NN37	07:48 KM11 / 20:46 NRSM

ACTIVE ALLERGIES: NKA

ANB9 BEERS, ANGELA, RN
BLA0 KOHLER, CATHERINE, RN
PB33 BLEVINS, PHIL, RN
LQ11 QUINN, LESLIE, RN
VF55 FORD, VINETTA RN

[redacted]
MUSC
Medication Administration Report
FROM: 04/02/14 16:38 TO: 04/13/14 23:09
ROOM: *P411-L* ADM: 04/02/14 16:38
AGE: 66Y SEX: F MD: BROADWAY, JESSICA L
DOB: 10/08/1947 ID: [redacted] MR: [redacted]
REQUESTED:04/13/14 05:40
OPT OUT:

* see end of page for Administration Note
■ see end of page for Not-Given reason
HOLD: DISCONTINUED:

	start/stop	ord	04/05/14 Day:4					04/06/14 Day:5					04/07/14 Day:6				
			11	15	19	23	03	11	15	19	23	03	11	15	19	23	03
SCHEDULED MEDICATIONS																	
DIVALPROEX EC (DIVALPROEX)																	
125 MG=1 DR TAB PO EVERY 12 HOURS	04/02 21:00 04/18 16:40	11	08:27 ANB9			20:42 BLA0		08:08 PB33			20:26 BLA0		08:26 LQ11			20:38 VF55	
	M:DO NOT CRUSH OR CHEW																
DONEPEZIL ORALLY Disintegrating (DONEPEZIL)																	
10 MG=1 TAB PO DAILY	04/03 08:30 04/08 09:36	13	08:27 ANB9					08:08 PB33					07:43 LQ11				
	M:DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.																
5 MG=1 TAB PO AT BEDTIME	04/07 21:00 04/08 09:36	15														20:38 VF55	
	M:DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.																
Escitalopram																	
10 MG=1 TAB PO DAILY	04/03 08:30 04/18 16:40	14	08:27 ANB9					08:08 PB33					07:43 LQ11				
MEMANTINE (NAMENDA)																	
10 MG=1 TAB PO TWICE DAILY	04/02 21:00 04/18 16:40	10	08:27 ANB9			20:42 BLA0		08:08 PB33			20:26 BLA0		07:43 LQ11			20:38 VF55	
Sulfamethox-Trimeth 800-160MG (Sulfamethoxazole-Trimethoprim)																	
1 TAB PO EVERY 12 HOURS	04/02 21:00 04/09 20:59	12	08:27 ANB9			20:42 BLA0		08:08 PB33			20:26 BLA0		08:26 LQ11			20:38 VF55	

ACTIVE ALLERGIES: NKA

CONTINUED

DR30 REYNOLDS, DAWN, RN
YS60 YATES, SARAH, RN
ANMO MALONE, ANGELINA, RN
RV56 VINSON, ROSELYN, RN
PB33 BLEVINS, PHIL, RN
NN37 NZIOKA, NANCY, RN
VICS VICK, STANISHA, RN

[redacted]

REQUESTED:04/18/14 05:40
OPT OUT:

* see end of page for Administration Note
■ see end of page for Not-Given reason
:HOLD: :DISCONTINUED:

	start/stop	ord	04/08/14 Day:7					04/09/14 Day:8					04/10/14 Day:9				
			11	15	19	23	03	11	15	19	23	03	11	15	19	23	03
SCHEDULED MEDICATIONS																	
DIVALPROEX EC (DIVALPROEX)																	
125 MG=1 DR TAB PO EVERY 12 HOURS	04/02 21:00 04/18 16:40	11	08:07 DR30			20:17 YS60		08:28 ANMO			20:12 RV56		07:42 PB33			20:29 NN37	
	M:DO NOT CRUSH OR CHEW																
DONEPEZIL ORALLY Disintegrating (DONEPEZIL)																	
10 MG=1 TAB PO DAILY	04/03 08:30 04/08 09:36	13	08:07 DR30														
	M:DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.																
Escitalopram																	
10 MG=1 TAB PO DAILY	04/03 08:30 04/18 16:40	14	08:07 DR30					08:28 ANMO					07:42 PB33				
MEMANTINE (NAMENDA)																	
10 MG=1 TAB PO TWICE DAILY	04/02 21:00 04/18 16:40	10	08:07 DR30			20:17 YS60		08:28 ANMO			20:12 RV56		07:42 PB33			20:29 NN37	
Rivastigmine 9.5 MG/24 HR (EXELON)																	
1 PATCH PTCH TOPL DAILY	04/09 08:30 04/13 07:09	17						08:28 ANMO					07:42 PB33				
	M:INDICATION: dementia; exelon Adverse rxn to formulary med vomiting, nausea, significant weight loss ; THIS MEDICATION IS NONFORMULARY.																
Sulfamethox-Trimeth 800-160MG (Sulfamethoxazole-Trimethoprim)																	
1 TAB PO EVERY 12 HOURS	04/02 21:00 04/09 20:59	12	08:07 DR30			20:17 YS60		08:28 ANMO									
TUBERCULIN PPD (APLISOL,TUBERSOL)																	
5 UNIT=0.1 ML I DERMAL_I ONCE	x1 Dose	18	14:27 VICS *														
	M:-REFRIGERATE EXPIRES==> **DISCARD IF NOT USED WITHIN 8 HRS** LO~ #: EXPIRATI; ON: MANUFACTURER: NURSES:PLEASE DOCUMENT IN PATIENT RECORD: DATE, VACCINE NA; ME, DOSE SITE, ROUTE, MANUFA																
PRN MEDICATIONS																	
Ondansetron ORAL Disintegrating (Ondansetron)																	
8 MG=(2 x 4 MG TAB) PO EVERY 8 HOURS AS NEEDED	04/08 09:34 04/18 16:40	16	09:54 VICS													20:29 NN37	
	M:INDICATION: *For:Nausea and Vomiting; *ORALLY DISINTEGRATING TABLET* PLACE DIRECTLY ON THE TONGUE																

TUBERCULIN PPD (APLISOL,TUBERSOL)
04/08 14:27 VICS * Lot#C4513Bb; Exp 05/27/2016

ACTIVE ALLERGIES: NKA

CONTINUED

[redacted] DOB: 10/08/1947 - Medication Administration Report

ROOM: *P411-L*

PERM

[redacted]

PB33 BLEVINS, PHIL, RN
YS60 YATES, SARAH, RN
LQ11 QUINN, LESLIE, RN
VF55 FORD, VINETTA RN
LB33 BLIZZARD, LAUREN, RN
RV56 VINSON, ROSELYN, RN

[redacted]

REQUESTED:04/13/14 05:40
OPT OUT:

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■ see end of page for Not-Given reason
HOLD: DISCONTINUED

start/stop	ord	04/11/14 Day:10 11 15 19 23 03	04/12/14 Day:11 11 15 19 23 03	04/13/14 Day:12 11 15 19 23 03

SCHEDULED MEDICATIONS

DIVALPROEX EC (DIVALPROEX)

125 MG=1 DR TAB PO EVERY 12 HOURS

start/stop	ord	04/11/14 Day:10 11 15 19 23 03	04/12/14 Day:11 11 15 19 23 03	04/13/14 Day:12 11 15 19 23 03
04/02 21:00 04/18 16:40	11	07:55 PB33 20:09 YS60	09:28 LQ11 20:40 VF55	08:43 LB33 * ■

M:DO NOT CRUSH OR CHEW

Escitalopram

10 MG=1 TAB PO DAILY

start/stop	ord	04/11/14 Day:10 11 15 19 23 03	04/12/14 Day:11 11 15 19 23 03	04/13/14 Day:12 11 15 19 23 03
04/03 08:30 04/18 16:40	14	07:55 PB33	09:28 LQ11	08:43 LB33

MEMANTINE (NAMENDA)

10 MG=1 TAB PO TWICE DAILY

start/stop	ord	04/11/14 Day:10 11 15 19 23 03	04/12/14 Day:11 11 15 19 23 03	04/13/14 Day:12 11 15 19 23 03
04/02 21:00 04/18 16:40	10	07:55 PB33 20:09 YS60	09:28 LQ11 20:40 VF55	08:43 LB33 ■

Rivastigmine 9.5 MG/24 HR (EXELON)

1 PATCH PTCH TOPL DAILY

start/stop	ord	04/11/14 Day:10 11 15 19 23 03	04/12/14 Day:11 11 15 19 23 03	04/13/14 Day:12 11 15 19 23 03
04/09 08:30 04/13 07:09	17	07:55 PB33	09:28 LQ11	

M:INDICATION: dementia; exelon Adverse rxn to formulary med vomiting, nausea, significant weight loss ; THIS MEDICATION IS NONFORMULARY.

Simvastatin

10 MG=1 TAB PO AT BEDTIME

start/stop	ord	04/11/14 Day:10 11 15 19 23 03	04/12/14 Day:11 11 15 19 23 03	04/13/14 Day:12 11 15 19 23 03
04/11 21:00 04/18 16:40	19	20:09 YS60	20:40 VF55	■

M:*FOOD-DRUG INTERACTION* EDUCATE PATIENT & DOCUMENT TEACHING. AVOID GRAPEFRU; IT JUICE WITH THIS MEDICATION UNLESS INSTRUCTED OTHERWISE BY YOUR PHYSICIAN.

PRN MEDICATIONS

LORAZEPAM

2 MG=1 TAB PO EVERY 4 HOURS AS NEEDED

start/stop	ord	04/11/14 Day:10 11 15 19 23 03	04/12/14 Day:11 11 15 19 23 03	04/13/14 Day:12 11 15 19 23 03
04/02 16:47 04/14 09:23	8			15:40 RV56 *

M:INDICATION: *For:Acute anxiety

DIVALPROEX EC (DIVALPROEX)
04/13 23:15 RV56 ■ Sedated * pt anxious earlier wanting to go home Ativan 2mg PO given @ 1540 Pt continues to be sedated Night meds held
MEMANTINE (NAMENDA)
04/13 23:15 RV56 ■ Sedated
Simvastatin
04/13 23:15 RV56 ■ Sedated
LORAZEPAM
04/13 15:40 RV56 * pt anxious Verbalizing need to go home

ACTIVE ALLERGIES: NKA

CONTINUED
[redacted]

PERM

PB33 BLEVINS, PHIL, RN
YS60 YATES, SARAH, RN
RGER GAINES, RANDI, RN
CHOR HORLEACK, CHRISTOPHER, RN
ANM0 MALONE, ANGELINA, RN
NN37 NZIOKA, NANCY, RN

[redacted]

REQUESTED:04/19/14 05:40
OPT OUT

* see end of page for Administration Note
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SCHEDULED MEDICATIONS

	start/stop	ord	04/14/14 Day:13 11 15 19 23 03	04/15/14 Day:14 11 15 19 23 03	04/16/14 Day:15 11 15 19 23 03
DIVALPROEX EC (DIVALPROEX)					
125 MG=1 DR TAB PO EVERY 12 HOURS	04/02 21:00 04/18 16:40	11	08:31 PB33 20:46 YS60	07:54 RGER 20:18 CHOR	08:49 ANM0 20:31 NN37
	M:DO NOT CRUSH OR CHEW				
Escitalopram					
10 MG=1 TAB PO DAILY	04/03 08:30 04/18 16:40	14	08:31 PB33	07:49 RGER	08:49 ANM0
MEMANTINE (NAMENDA)					
10 MG=1 TAB PO TWICE DAILY	04/02 21:00 04/18 16:40	10	08:31 PB33 20:46 YS60	07:49 RGER 20:18 CHOR	08:49 ANM0 20:31 NN37
Simvastatin					
10 MG=1 TAB PO AT BEDTIME	04/11 21:00 04/18 16:40	19	20:46 YS60	20:18 CHOR	20:31 NN37
	M:*FOOD-DRUG INTERACTION* EDUCATE PATIENT & DOCUMENT TEACHING. AVOID GRAPEFRU; IT JUICE WITH THIS MEDICATION UNLESS INSTRUCTED OTHERWISE BY YOUR PHYSICIAN.				

ACTIVE ALLERGIES: NKA

[redacted]

DR30 REYNOLDS, DAWN, RN
YS60 YATES, SARAH, RN
LQ11 QUINN, LESLIE, RN

[redacted]

REQUESTED:04/18/14 05:40
DPT:OU

* see end of page for Administration Note
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start/stop	ord	04/17/14 Day:16 11	15	19	23	03	04/18/14 Day:17 11	15	19	23	03

SCHEDULED MEDICATIONS

DIVALPROEX EC (DIVALPROEX)

125 MG=1 DR TAB PO EVERY 12 HOURS

start/stop	ord	11	15	19	23	03	11	15	19	23	03
04/02 21:00 04/18 16:40	11	08:22 DR30			20:20 YS60		08:06 LQ11				
M:DO NOT CRUSH OR CHEW											

Escitalopram

10 MG=1 TAB PO DAILY

start/stop	ord	11	15	19	23	03	11	15	19	23	03
04/03 08:30 04/18 16:40	14	08:22 DR30					08:06 LQ11				

MEMANTINE (NAMENDA)

10 MG=1 TAB PO TWICE DAILY

start/stop	ord	11	15	19	23	03	11	15	19	23	03
04/02 21:00 04/18 16:40	10	08:22 DR30			20:20 YS60		08:06 LQ11				

Simvastatin

10 MG=1 TAB PO AT BEDTIME

start/stop	ord	11	15	19	23	03	11	15	19	23	03
04/11 21:00 04/18 16:40	19				20:20 YS60						
M:*FOOD-DRUG INTERACTION* EDUCATE PATIENT & DOCUMENT TEACHING. AVOID GRAPEFRU; IT JUICE WITH THIS MEDICATION UNLESS INSTRUCTED OTHERWISE BY YOUR PHYSICIAN.											

ACTIVE ALLERGIES: NKA

MUSC Health

Physician Name: Erin Seery
171 Ashley Avenue
Charleston, SC 29425
(843) 792-2123
SCLN: 31870
DEA: FS1607843
DHEC:
NPI:

Patient Name: [redacted] DOB: 10/08/1947 W F
Date of Birth: Adm: 04/02/14 M: [redacted]
MRN:
Patient Identification Label

GIVE THIS PRESCRIPTION TO YOUR PHARMACIST

Date: 4/18/14

Allergies: NKA

Medication	Dosage	Route	How often	Dispense amount	Refills	Indication
simvastatin	10mg	PO	qHS	One Month Supply	None	cholestero
lexapro	10mg	PO	qam	One Month Supply	None	mood
namenda	10mg	PO	BID	One Month Supply	None	memory
divalproex sodium	125mg	PO	BID	One Month Supply	None	mood
		PO		One Month Supply	None	
		PO		One Month Supply	None	

Physician Signature
DISPENSE AS WRITTEN

Physician Signature
SUBSTITUTION PERMITTED

PRESCRIPTION

[redacted] 10/08/1947 W F

Page 1 of 1

MUSC Health
INSTITUTE OF PSYCHIATRY

2.00

IOPNURSING

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1

Page 1 of 1

Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted]
MRN Adm:04/02/14 M1083675
PATIENT IDENTIFICATION LABEL

Date: 4/5/14
Room Number: 412
Document patient location code every 15 minutes and initial.

Activity Level ☒ UR ☐ IOP

Observation Level
☒ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☒ Fall precautions ☒ Violence precautions
☐ Substance abuse withdrawal ☒ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening:
Night: 8.00

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	JH	0:15	18	JH	0:30	18	JH	0:45	18	JH
1:00	18	JH	1:15	18	JH	1:30	18	JH	1:45	18	JH
2:00	18	JH	2:15	18	JH	2:30	18	JH	2:45	18	JH
3:00	18	JH	3:15	18	JH	3:30	18	JH	3:45	18	JH
4:00	18	JH	4:15	18	JH	4:30	18	JH	4:45	18	JH
5:00	18	JH	5:15	18	JH	5:30	18	JH	5:45	18	JH
6:00	18	JH	6:15	18	JH	6:30	18	JH	6:45	18	JH
7:00	1	JH	7:15	1	JH	7:30	1	JH	7:45	1	NS
8:00	1	NS	8:15	1	NS	8:30	1	NS	8:45	1	NS
9:00	1	NS	9:15	1	NS	9:30	1	NS	9:45	1	NS
10:00	1	NS	10:15	1	NS	10:30	1	NS	10:45	1	NS
11:00	1	NS	11:15	1	NS	11:30	1	NS	11:45	1	NS
12:00	1	NS	12:15	1	NS	12:30	1	NS	12:45	1	NS
13:00	1	NS	13:15	1	NS	13:30	1	NS	13:45	1	NS
14:00	1	NS	14:15			14:30	18	NS	14:45	18	NS
15:00	18	NS	15:15	18	NS	15:30	18	CO	15:45	1	CO
16:00	1	CO	16:15	1	CO	16:30	1	CO	16:45		
17:00			17:15			17:30			17:45		
18:00			18:15			18:30			18:45		
19:00			19:15			19:30	D/C		19:45		
20:00			20:15			20:30			20:45		
21:00			21:15			21:30			21:45		
22:00			22:15			22:30			22:45		
23:00			23:15			23:30			23:45		

Initials	Signature
JH	Jesse Wm Hudson, TA
NS	Nyasha Sithole, TA
CO	Carissa Young, TA

iop_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPNURSING

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1
Page 1 of 1
Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14
MRN

PATIENT IDENTIFICATION LABEL

Date: 4/11/14
Room Number: 4126
Document patient location code every 15 minutes and initial

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening: 12
Night: 8

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00			0:15			0:30			0:45		
1:00			1:15			1:30			1:45		
2:00			2:15			2:30			2:45		
3:00			3:15			3:30			3:45		
4:00			4:15			4:30			4:45		
5:00			5:15			5:30			5:45		
6:00			6:15			6:30			6:45		
7:00			7:15			7:30			7:45		
8:00			8:15			8:30			8:45		
9:00			9:15			9:30			9:45		
10:00			10:15			10:30			10:45		
11:00			11:15			11:30			11:45		
12:00			12:15			12:30			12:45		
13:00			13:15			13:30			13:45		
14:00			14:15			14:30			14:45		
15:00			15:15			15:30			15:45		
16:00			16:15			16:30			16:45		
17:00			17:15			17:30			17:45		
18:00			18:15			18:30			18:45		
19:00			19:15			19:30			19:45		
20:00			20:15			20:30			20:45		
21:00			21:15			21:30			21:45		
22:00			22:15			22:30			22:45		
23:00			23:15			23:30			23:45		

Initials	Signature
JH	Jesse W^m Hudson, TA

Initials	Signature
	D. Shawcraft TA
AW	AW, WLPA
VE	Vedia Cooke, TA

Initials	Signature
nd	Nyoka L.H., TA

iop_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

2.00

IOPNURSING

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14
MRN [redacted]
PATIENT IDENTIFICATION LABEL

Date: 4/10/14
Room Number: 412B
Document patient location code every 15 minutes and initial.

Activity Level ☒ UR ☐ IOP

Observation Level
☒ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☒ Fall precautions ☒ Violence precautions
☐ Substance abuse withdrawal ☒ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening: 1.25
Night: 8.00

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other:

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	1B	JH	0:15	1B	JH	0:30	1B	JH	0:45	1B	JH
1:00	1B	JH	1:15	1B	JH	1:30	1B	JH	1:45	1B	JH
2:00	1B	JH	2:15	1B	JH	2:30	1B	JH	2:45	1B	JH
3:00	1B	JH	3:15	1B	JH	3:30	1B	JH	3:45	1B	JH
4:00	1B	JH	4:15	1B	JH	4:30	1B	JH	4:45	1B	JH
5:00	1B	JH	5:15	1B	JH	5:30	1B	JH	5:45	1B	JH
6:00	1B	JH	6:15	1B	JH	6:30	1B	JH	6:45	1B	JH
7:00	1	JH	7:15	1	JH	7:30	1	JH	7:45	1	JH
8:00	1	MD	8:15	1	MD	8:30	1	MD	8:45	1	MD
9:00	1	MD	9:15	1	MD	9:30	1	MD	9:45	1	MD
10:00	1	MD	10:15	1	MD	10:30	1	MD	10:45	1	MD
11:00	1	MD	11:15	1	MD	11:30	1	MD	11:45	1	MD
12:00	1	MD	12:15	1	MD	12:30	1	MD	12:45	1	MD
13:00	1	MD	13:15	1	MD	13:30	1	MD	13:45	1	MD
14:00	1	MD	14:15	1	MD	14:30	1	MD	14:45	1	MD
15:00	1	MD	15:15	1	MD	15:30	1	MD	15:45	1	MD
16:00	1	MD	16:15	1	MD	16:30	1	MD	16:45	1	MD
17:00	1	MD	17:15	1	MD	17:30	1	MD	17:45	1	MD
18:00	1	MD	18:15	1	MD	18:30	1	MD	18:45	1	MD
19:00	1	MD	19:15	1	MD	19:30	1	MD	19:45	1	MD
20:00	1	MD	20:15	20	MD	20:30	1	MD	20:45	1	MD
21:00	1	MD	21:15	1	MD	21:30	1	MD	21:45	1	MD
22:00	1	MD	22:15	1	MD	22:30	1	MD	22:45	1	MD
23:00	1	MD	23:15	1	MD	23:30	1	MD	23:45	1	MD

Initials	Signature
JH	Jesse W. Hudson, TA
MD	Morgan Dorsey
	[illegible]

iop_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

2.00

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

Patient Name [redacted]
MRN
DOB:10/08/1947 W F
PATIENT IDENTIFICATION LABEL

Date: 4/15/14
Room Number: 412K
Document patient location code every 15 minutes and initial.

Activity Level ☒ UR ☐ IOP

Observation Level
☒ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☒ Fall precautions ☒ Violence precautions
☐ Substance abuse withdrawal ☒ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening:
Night: 8.00

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	JH	0:15	18	JH	0:30	18	JH	0:45	18	JH
1:00	18	JH	1:15	18	JH	1:30	18	JH	1:45	18	JH
2:00	18	JH	2:15	18	JH	2:30	18	JH	2:45	18	JH
3:00	18	JH	3:15	18	JH	3:30	18	JH	3:45	18	JH
4:00	18	JH	4:15	18	JH	4:30	18	JH	4:45	18	JH
5:00	18	JH	5:15	18	JH	5:30	18	JH	5:45	18	JH
6:00	18	JH	6:15	18	JH	6:30	18	JH	6:45	18	JH
7:00	18	JH	7:15	18	JH	7:30	18	JH	7:45	1	
8:00	1		8:15	1		8:30	1		8:45	1	
9:00	1		9:15	1		9:30	1		9:45	1	
10:00	1		10:15	1		10:30	1		10:45	17	
11:00	17		11:15	17		11:30	17		11:45	18	
12:00	18		12:15	17		12:30	17		12:45	18	
13:00	18		13:15	1		13:30	1		13:45	18	
14:00	17		14:15	17		14:30	18		14:45	17	
15:00	17		15:15	17		15:30	1	AR	15:45	1	
16:00	17	AR	16:15	1	AR	16:30	1	AR	16:45	1	AR
17:00	1	AR	17:15	1	AR	17:30	1	AR	17:45	1	AR
18:00	1	AR	18:15	1	AR	18:30	17	AR	18:45	17	AR
19:00	17	AR	19:15	17	AR	19:30	17	AR	19:45	18	
20:00	18		20:15	18		20:30	1		20:45	18	
21:00	18		21:15	18		21:30	18		21:45	18	
22:00	18		22:15	18		22:30	18		22:45	18	JH
23:00	18		23:15	18		23:30	18		23:45	18	JH

Initials	Signature
JH	Jesse W. Henderson, TA
JH	

Initials	Signature
BB	Bradley Bobo TA
JH	

Initials	Signature
AR	TA
JH	TA

iop_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

2.00

IOPNURSING

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1

Page 1 of 1

Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted]
MRN [redacted] Adm:04/02/14

PATIENT IDENTIFICATION LABEL

412 R

Date: 4/4/14
Room Number: 412

Document patient location code every 15 minutes and initial.

Activity Level ☒ UR ☐ IOP

Observation Level
☒ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☒ Fall precautions ☒ Violence precautions
☐ Substance abuse withdrawal ☒ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: 4.5
Evening: 4.5
Night: 8.00

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other:
24. Other:
25. Other:

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	JH	0:15	18	JH	0:30	18	JH	0:45	18	JH
1:00	18	JH	1:15	18	JH	1:30	18	JH	1:45	18	JH
2:00	18	JH	2:15	18	JH	2:30	18	JH	2:45	18	JH
3:00	18	JH	3:15	18	JH	3:30	18	JH	3:45	18	JH
4:00	18	JH	4:15	18	JH	4:30	18	JH	4:45	18	JH
5:00	18	JH	5:15	18	JH	5:30	18	JH	5:45	18	JH
6:00	18	JH	6:15	18	JH	6:30	18	JH	6:45	18	JH
7:00	18	JH	7:15	18	JH	7:30	18	JH	7:45	18	JH
8:00	18	JH	8:15	18	JH	8:30	1	JH	8:45	1	JH
9:00	1	JH	9:15	1	JH	9:30	17	JH	9:45	17	JH
10:00	1	JH	10:15	18	JH	10:30	18	JH	10:45	18	JH
11:00	17	JH	11:15	17	JH	11:30	1	JH	11:45	17	JH
12:00	1	JH	12:15	1	JH	12:30	1	JH	12:45	1	JH
13:00	1	JH	13:15	1	JH	13:30	1	JH	13:45	1	JH
14:00	1	JH	14:15	1	JH	14:30	1	JH	14:45	1	JH
15:00	1	JH	15:15	1	JH	15:30	17	SN	15:45	17	SN
16:00	18	SN	16:15	18	SN	16:30	18	SN	16:45	18	SN
17:00	1	SN	17:15	1	SN	17:30	1	SN	17:45	1	SN
18:00	20	SN	18:15	20	SN	18:30	20	SN	18:45	18	SN
19:00	18	SN	19:15	18	SN	19:30	18	SN	19:45	18	SN
20:00	18	SN	20:15	18	SN	20:30	18	SN	20:45	18	SN
21:00	18	SN	21:15	18	SN	21:30	18	SN	21:45	18	SN
22:00	18	SN	22:15	18	SN	22:30	18	SN	22:45	18	SN
23:00	18	SN	23:15	18	SN	23:30	18	JH	23:45	18	JH

Initials	Signature
JH	Jesse W. Hudson, TA

Initials	Signature
NS	Nyasha Smith, TA
R.N.	Latoya Nicole

Initials	Signature
CMB	Chris Blume MD

iop_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

0.50

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1
Page 1 of 1
Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14
MRN

PATIENT IDENTIFICATION LABEL

Date: 4.13.14
Room Number: 4HR
Document patient location code every 15 minutes and initial.

Activity Level ☒ UR ☐ IOP

Observation Level
☒ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☒ Fall precautions ☒ Violence precautions
☐ Substance abuse withdrawal ☒ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening:
Night: 6-30

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	20	JH	0:15	20	JH	0:30	20	JH	0:45	20	JH
1:00	20	JH	1:15	18	JH	1:30	18	JH	1:45	18	JH
2:00	18	JH	2:15	18	JH	2:30	18	JH	2:45	18	JH
3:00	18	JH	3:15	18	JH	3:30	18	JH	3:45	18	JH
4:00	18	JH	4:15	18	JH	4:30	18	JH	4:45	18	JH
5:00	18	JH	5:15	18	JH	5:30	18	JH	5:45	18	JH
6:00	18	JH	6:15	18	JH	6:30	18	JH	6:45	18	JH
7:00	18	JH	7:15	18	JH	7:30	18	JH	7:45	15	JH
8:00	15	RR	8:15	15	RR	8:30	15	RR	8:45	1	RR
9:00	1	RR	9:15	1	RR	9:30	17	RR	9:45	1	RR
10:00	1	RR	10:15	1	RR	10:30	1	RR	10:45	1	RR
11:00	1	RR	11:15	20	DW	11:30	20	DW	11:45	20	DW
12:00	20	DW	12:15	1	RR	12:30	1	RR	12:45	1	RR
13:00	1	RR	13:15	1	RR	13:30	1	RR	13:45	1	RR
14:00	1	RR	14:15	1	RR	14:30	1	RR	14:45	1	RR
15:00	1	RR	15:15	1	RR	15:30	1	TR	15:45	1	TR
16:00	1	TR	16:15	1	TR	16:30	1	TR	16:45	1	TR
17:00	1	TR	17:15	1	TR	17:30	1	TR	17:45	1	TR
18:00	20	TR	18:15	20	TR	18:30	20	TR	18:45	20	TR
19:00	1	TR	19:15	1	TR	19:30	1	TR	19:45	20	TR
20:00	20	TR	20:15	20	TR	20:30	20	TR	20:45	20	TR
21:00	20	TR	21:15	20	TR	21:30	20	TR	21:45	20	TR
22:00	20	TR	22:15	20	TR	22:30	20	TR	22:45	15	TR
23:00	18	TR	23:15	18	TR	23:30	18	JH	23:45	18	JH

Initials	Signature
JH	Jesse W. Hudson, TA
RR	Raquel R. Robinson, TA
DW	Jordan Weaver
TR	Tonya Ramey, TA

lcp_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1

Page 1 of 1

Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14

MRN

PATIENT IDENTIFICATION LABEL

Date: 4-15-14
Room Number: 411C
Document patient location code every 15 minutes and initial.

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: ____
Evening: 8
Night: 8

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: ____
24. Other: ____
25. Other: ____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	JW	0:15	18	JW	0:30	18	JW	0:45	18	JW
1:00	18	JW	1:15	18	MD	1:30	18	JW	1:45	18	MD
2:00	18	MD	2:15	18	MD	2:30	18	MD	2:45	18	MD
3:00	18	MD	3:15	18	JW	3:30	18	JW	3:45	18	JW
4:00	18	JW	4:15	18	JW	4:30	18	JW	4:45	18	JW
5:00	18	JW	5:15	18	JW	5:30	18	JW	5:45	18	JW
6:00	18	JW	6:15	18	JW	6:30	18	JW	6:45	18	JW
7:00	18	JW	7:15	18	MD	7:30	18	MD	7:45	18	MD
8:00	18	MD	8:15	18	MD	8:30	18	MD	8:45	18	MD
9:00	18	MD	9:15	18	MD	9:30	18	MD	9:45	18	MD
10:00	18	MD	10:15	18	MD	10:30	18	MD	10:45	18	MD
11:00	18	MD	11:15	18	MD	11:30	18	MD	11:45	18	MD
12:00	18	MD	12:15	18	MD	12:30	18	MD	12:45	1	MD
13:00	1	MD	13:15	1	MD	13:30	1	MD	13:45	1	MD
14:00	1	MD	14:15	1	MD	14:30	1	MD	14:45	1	MD
15:00	1	MD	15:15	1	MD	15:30	1	MD	15:45	1	TR
16:00	1	TR	16:15	1	TR	16:30	1	TR	16:45	1	TR
17:00	1	TR	17:15	1	TR	17:30	1	TR	17:45	1	TR
18:00	1	TR	18:15	1	TR	18:30	1	TR	18:45	1	TR
19:00	17	TR	19:15	17	TR	19:30	1	TR	19:45	1	TR
20:00	1	TR	20:15	1	TR	20:30	1	TR	20:45	1	TR
21:00	1	TR	21:15	1	TR	21:30	1	TR	21:45	1	VC
22:00	1	VC	22:15	1	VC	22:30	1	VC	22:45	1	VC
23:00	1	VC	23:15	1	JW	23:30	20	JW	23:45	20	JW

Initials	Signature
JW	Jesse W Hudson, TA

Initials	Signature
MD	Morgan Davis
VC	Dylan Cobb, TA
TR	[illegible] TA

Initials	Signature
JW	[illegible]
	[illegible]
	[illegible]
TR	[illegible] TA

icp_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

2.00

IOPNURSING

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 412R Version Date: 7/12

Patient Name: [redacted]
MRN: [redacted] 10/08/1947 W F
PATIENT IDENTIFICATION LABEL

Date: 4/10/14
Room Number: 412E
Document patient location code every 15 minutes and initial.

Activity Level ☒UR ☐IOP

Observation Level
☒Q15min ☐Visual
☐Visual while awake ☐Visual while asleep
☐1:1

Precautions and Protocols
☐Suicide precaution ☒Fall precautions ☒Violence precautions
☐Substance abuse withdrawal ☒Elopement precautions
☐Minimum seizure ☐Maximum seizure
☐CIWA ☐Eating disorder ☐Opiate ☐Toileting

Sleep Hours
Day:
Evening: 2.5
Night: 8.00

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	JH	0:15	18	JH	0:30	18	JH	0:45	18	JH
1:00	18	JH	1:15	18	JH	1:30	18	JH	1:45	18	JH
2:00	18	JH	2:15	18	JH	2:30	18	JH	2:45	18	JH
3:00	18	JH	3:15	18	JH	3:30	18	JH	3:45	18	JH
4:00	18	JH	4:15	18	JH	4:30	18	JH	4:45	18	JH
5:00	18	JH	5:15	18	JH	5:30	18	JH	5:45	18	JH
6:00	18	JH	6:15	18	JH	6:30	18	JH	6:45	18	JH
7:00	18	JH	7:15	18	JH	7:30	18	JH	7:45	18	CD
8:00	18	CD	8:15	18	CD	8:30	18	CD	8:45	18	CD
9:00	18	CD	9:15	1	CD	9:30	17	CD	9:45	17	CD
10:00	17	CD	10:15	12	CD	10:30	12	CD	10:45	12	CD
11:00	17	CD	11:15	12	CD	11:30	12	CD	11:45	12	CD
12:00	17	CD	12:15	12	CD	12:30	20	CD	12:45	20	CD
13:00	20	CD	13:15	20	CD	13:30	20	CD	13:45	20	CD
14:00	20	CD	14:15	20	CD	14:30	20	CD	14:45	17	CD
15:00	17	CD	15:15	17	CD	15:30	17	CD	15:45	17	CD
16:00	17	CD	16:15	17	CD	16:30	17	CD	16:45	17	CD
17:00	17	CD	17:15	17	CD	17:30	17	CD	17:45	17	CD
18:00	17	CD	18:15	17	CD	18:30	17	CD	18:45	17	CD
19:00	17	CD	19:15	17	CD	19:30	17	CD	19:45	17	CD
20:00	17	CD	20:15	17	CD	20:30	17	CD	20:45	17	CD
21:00	17	CD	21:15	17	CD	21:30	17	CD	21:45	18	CD
22:00	18	CD	22:15	18	CD	22:30	18	CD	22:45	18	CD
23:00	18	CD	23:15	18	CD	23:30	18	CD	23:45	18	CD

Initials	Signature
JH	Jesse Wm Hudson, TA
CD	Cassie Dowdy, TA
SN	Sofia Nieto
W	[illegible]

iop_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1

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Version Date: 7/12

2

Patient Name [redacted] DOB:10/09/1947 W F
MRN [redacted] 02/14
PATIENT ID [redacted]

Date: 4/10/19
Room Number: 4WL
Document patient location code every 15 minutes and initial.

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocol
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: ____
Evening: 5.50
Night: 7.25

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: ____
24. Other: ____
25. Other: ____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	AR	0:15	18	AR	0:30	18	AR	0:45	18	AR
1:00	18	AR	1:15	18	AR	1:30	18	AR	1:45	17	AR
2:00	18	AR	2:15	18	AR	2:30	18	AR	2:45	18	AR
3:00	18	AR	3:15	18	AR	3:30	18	AR	3:45	18	AR
4:00	18	AR	4:15	18	AR	4:30	18	AR	4:45	18	AR
5:00	18	AR	5:15	18	AR	5:30	17	AR	5:45	1	AR
6:00	1	AR	6:15	1	AR	6:30	1	AR	6:45	1	AR
7:00	1	AR	7:15	1	AR	7:30	1	AR	7:45	1	AR
8:00	1	AR	8:15	1	AR	8:30	1	AR	8:45	1	AR
9:00	1	AR	9:15	1	AR	9:30	1	AR	9:45	1	AR
10:00	17	AR	10:15	17	AR	10:30	17	AR	10:45	17	AR
11:00	1	AR	11:15	1	AR	11:30	1	AR	11:45	22	AR
12:00	22	AR	12:15	22	AR	12:30	1	AR	12:45	1	AR
13:00	1	AR	13:15	1	AR	13:30	1	AR	13:45	1	AR
14:00	1	AR	14:15	1	AR	14:30	1	AR	14:45	1	AR
15:00	17	AR	15:15	17	AR	15:30	17	AR	15:45	17	AR
16:00	17	AR	16:15	17	AR	16:30	17	AR	16:45	17	AR
17:00	18	AR	17:15	18	AR	17:30	18	AR	17:45	18	AR
18:00	18	AR	18:15	18	AR	18:30	18	AR	18:45	18	AR
19:00	18	AR	19:15	18	AR	19:30	18	AR	19:45	18	AR
20:00	18	AR	20:15	18	AR	20:30	17	AR	20:45	17	AR
21:00	18	AR	21:15	17	AR	21:30	17	AR	21:45	17	AR
22:00	18	AR	22:15	18	AR	22:30	18	AR	22:45	18	AR
23:00	18	AR	23:15	18	AR	23:30	18	AR	23:45	18	AR

Initials	Signature
AR	[signature] TA
JH	Jesse W. Johnson, TA
WS	Wilhelmina Stanley
SN	Sophia Nicks
RS	Rhonda Smith TA

iop_nsg_pt_location

CTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

1.25

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted]
MRN Adm:04/02/14

PATIENT IDENTIFICATION LABEL

Date: 4/9/14
Room Number: 7116
Document patient location code every 15 minutes and initial.

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening: 1.25
Night: 6.75

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18		0:15	18		0:30	18		0:45	18	
1:00	18		1:15	18		1:30	18		1:45	18	
2:00	18		2:15	18		2:30	18		2:45	18	
3:00	18		3:15	18		3:30	18		3:45	18	
4:00	18		4:15	18		4:30	18		4:45	18	
5:00	18		5:15	18		5:30	17		5:45	17	
6:00	17		6:15	17		6:30	17		6:45	17	
7:00	17		7:15	1		7:30	1		7:45	1	
8:00	1		8:15	1		8:30	1		8:45	1	
9:00	1		9:15	1		9:30	1		9:45	1	
10:00	1		10:15	1		10:30	1		10:45	1	
11:00	1		11:15	1		11:30	1		11:45	1	
12:00	1		12:15	1		12:30	1		12:45	1	
13:00	1		13:15	1		13:30	1		13:45	1	
14:00	1		14:15	1		14:30	1		14:45	17	
15:00	17		15:15	1		15:30	1		15:45	1	
16:00	17		16:15	17		16:30	17		16:45	17	
17:00	1		17:15	17		17:30	17		17:45	17	
18:00	17		18:15	17		18:30	17		18:45	17	
19:00	17		19:15	17		19:30	17		19:45	17	
20:00	16		20:15	16		20:30	17		20:45	18	
21:00	17		21:15	18		21:30	18		21:45	18	
22:00	18		22:15	18		22:30	18	AR	22:45	18	AR
23:00	18		23:15	18		23:30	18	AR	23:45	18	AR

Initials	Signature
AR	[signature] TA

Initials	Signature
[illegible]	[illegible]
MS	Melissa Stanley
[illegible]	[signature]

Initials	Signature
JW	Jessaya Nicks

iop_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

1.0

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1

Page 1 of 1

Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name _____ Adm:04/02/14 [redacted]
MRN _____

PATIENT IDENTIFICATION LABEL

Date: 4/8/14
Room Number: A116
Document patient location code every 15 minutes and initial

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: _____
Evening: 6
Night: 10:45

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	MD	0:15	18	MD	0:30	18	MD	0:45	18	MD
1:00	18	MD	1:15	18	MD	1:30	18	MD	1:45	18	MD
2:00	18	MD	2:15	18	MD	2:30	18	MD	2:45	18	MD
3:00	18	MD	3:15	18	MD	3:30	18	MD	3:45	18	MD
4:00	18	MD	4:15	18	MD	4:30	18	MD	4:45	18	MD
5:00	18	JH	5:15	18	JH	5:30	18	JH	5:45	17	MD
6:00	18	MD	6:15	1	MD	6:30	1	MD	6:45	1	MD
7:00	1	MD	7:15	1	MD	7:30	1	MD	7:45	1	MD
8:00	1	MD	8:15	1	MD	8:30	1	MD	8:45	1	MD
9:00	1	MD	9:15	1	MD	9:30	1	MD	9:45	1	MD
10:00	17	MD	10:15	17	MD	10:30	17	MD	10:45	17	MD
11:00	17	MD	11:15	17	MD	11:30	17	MD	11:45	17	MD
12:00	17	MD	12:15	17	MD	12:30	17	MD	12:45	1	MD
13:00	1	MD	13:15	1	MD	13:30	1	MD	13:45	1	MD
14:00	1	MD	14:15	1	MD	14:30	1	MD	14:45	1	MD
15:00	1	MD	15:15	1	MD	15:30	1	MD	15:45	1	MD
16:00	1	MD	16:15	1	MD	16:30	1	MD	16:45	1	MD
17:00	1	MD	17:15	1	MD	17:30	1	MD	17:45	1	MD
18:00	1	MD	18:15	1	MD	18:30	1	MD	18:45	17	MD
19:00	17	MD	19:15	17	MD	19:30	17	MD	19:45	17	MD
20:00	17	MD	20:15	1	MD	20:30	1	MD	20:45	1	MD
21:00	1	MD	21:15	1	MD	21:30	1	MD	21:45	1	MD
22:00	1	MD	22:15	17	MD	22:30	17	MD	22:45	18	MD
23:00	18	MD	23:15	18	MD	23:30	18	MD	23:45	18	MD

Initials	Signature

Initials	Signature
AM	Ann M. McCray TA
MD	Morgan Dorsey

Initials	Signature
JH	Jesse Wm Hudson, TA

icp_nsg_pt_location

OTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

2.00

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14
MRN

PATIENT IDENTIFICATION LABEL

Date: 4/7/14
Room Number: 4HC
Document patient location code every 15 minutes and initial.

Activity Level ☒ UR ☐ IOP

Observation Level
☒ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☒ Fall precautions ☒ Violence precautions
☐ Substance abuse withdrawal ☒ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: 7
Evening: 8
Night: 8:00

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	JH	0:15	18	JH	0:30	18	JH	0:45	18	JH
1:00	18	JH	1:15	18	JH	1:30	18	JH	1:45	18	JH
2:00	18	JH	2:15	18	JH	2:30	18	JH	2:45	18	JH
3:00	18	JH	3:15	18	JH	3:30	18	JH	3:45	18	JH
4:00	18	JH	4:15	18	JH	4:30	18	JH	4:45	18	JH
5:00	18	JH	5:15	18	JH	5:30	18	JH	5:45	18	JH
6:00	18	JH	6:15	18	JH	6:30	17	JH	6:45	1	JH
7:00	1	JH	7:15	1	JH	7:30	1	JH	7:45	1	MD
8:00	1	MD	8:15	1	MD	8:30	1	MD	8:45	1	MD
9:00	1	MD	9:15	1	MD	9:30	1	MD	9:45	1	MD
10:00	1	MD	10:15	1	MD	10:30	1	MD	10:45	1	MD
11:00	1	MD	11:15	1	MD	11:30	1	MD	11:45	17	MD
12:00	17	MD	12:15	17	MD	12:30	17	MD	12:45	1	MD
13:00	1	MD	13:15	1	MD	13:30	1	MD	13:45	1	MD
14:00	17	DD	14:15	1	DD	14:30	1	DD	14:45	17	DD
15:00	17	MD	15:15	17	MD	15:30	17	MD	15:45	17	MD
16:00	17	MD	16:15	17	MD	16:30	17	MD	16:45	1	MD
17:00	1	MD	17:15	1	MD	17:30	1	MD	17:45	1	MD
18:00	1	MD	18:15	1	MD	18:30	1	MD	18:45	1	MD
19:00	1	MD	19:15	1	MD	19:30	1		19:45	17	
20:00	17		20:15	1		20:30	1		20:45	1	
21:00	1		21:15	1		21:30	1		21:45	17	
22:00	17		22:15	17		22:30	17		22:45	17	
23:00	1		23:15	1		23:30	1		23:45	17	

Initials	Signature
JH	Jesse WH Hudson, TA

Initials	Signature
RH	Rhonda Johnson TA
MD	Morgan Dailey

Initials	Signature
DD	Dennis DD JH
	Ivan J. McCain TA

iop_nsg_pt_location

OTE 901640-7/12

MUSC Health
INSTITUTES OF PSYCHIATRY

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

2 [redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14
MRN

PATIENT IDENTIFICATION LABEL

Date: 4-6-14
Room Number: 4111
Document patient location code every 15 minutes and initial.

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening:
Night 8

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other:
24. Other:
25. Other:

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18	AR	0:15	18	AR	0:30	18	AR	0:45	18	AR
1:00	18	AR	1:15	18	AR	1:30	18	AR	1:45	18	AR
2:00	18	AR	2:15	18	AR	2:30	18	AR	2:45	18	AR
3:00	18	AR	3:15	18	AR	3:30	18	AR	3:45	18	AR
4:00	18	AR	4:15	18	AR	4:30	18	AR	4:45	18	AR
5:00	18	AR	5:15	18	AR	5:30	18	AR	5:45	18	AR
6:00	16	AR	6:15	17	AR	6:30	18	AR	6:45	18	AR
7:00	16	AR	7:15	18	AR	7:30	17	CH	7:45	17	CH
8:00	1	CH	8:15	1	CH	8:30	1	CH	8:45	17	CH
9:00	17	CH	9:15	18	CH	9:30	18	CH	9:45	18	CH
10:00	18	JV	10:15	18	JV	10:30	18	JV	10:45	18	JV
11:00	18	JV	11:15	18	CH	11:30	17	CH	11:45	1	CH
12:00	17	CH	12:15	1	CH	12:30	17	CH	12:45	17	CH
13:00	17	CH	13:15	17	CH	13:30	17	CH	13:45	17	CH
14:00	17	CH	14:15	17	CH	14:30	18	CH	14:45	18	CH
15:00	18	CH	15:15	1	CH	15:30	1	CH	15:45	1	TR
16:00	1	TR	16:15	1	TR	16:30	1	TR	16:45	1	TR
17:00	17	TR	17:15	17	TR	17:30	1	TR	17:45	1	TR
18:00	1	TR	18:15	21	TR	18:30	21	TR	18:45	21	TR
19:00	1	TR	19:15	1	TR	19:30	1	TR	19:45	1	TR
20:00	1	TR	20:15	17	TR	20:30	17	TR	20:45	17	TR
21:00	17	TR	21:15	17	TR	21:30	15	TR	21:45	15	TR
22:00	15	TR	22:15	15	TR	22:30	15	TR	22:45	15	TR
23:00	15	TR	23:15	15	TR	23:30	15	TR	23:45	15	TR

Initials	Signature
AR	Alex Ring TA

Initials	Signature
MA	Wanda Ingram TA
CH	Chenel Hair, TA

Initials	Signature
JH	Jesse W. Hudson, TA
TR	TA

iop_nsg_pi_location

OTE 901640 7/12

MUSC Health
INSTITUTES OF PSYCHIATRY

2.0

IOPNURSING

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted] Adm:04/02/14
MRN

PATIENT IDENTIFICATION LABEL

Date: 4-5-2014
Room Number: 4116
Document patient location code every 15 minutes and initial.

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☑ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: ___
Evening: .5
Night: 7.0

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: ___
24. Other: ___
25. Other: ___

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00	18		0:15	18		0:30	18		0:45	18	
1:00	18		1:15	18		1:30	18		1:45	18	
2:00	18		2:15	18		2:30	18		2:45	18	
3:00	18		3:15	18		3:30	18		3:45	18	
4:00	18		4:15	18		4:30	18		4:45	18	
5:00	17		5:15	17		5:30	17		5:45	17	
6:00	17		6:15	17		6:30	17		6:45	17	
7:00	17		7:15	17		7:30	17		7:45	17	
8:00	1		8:15	1		8:30	1		8:45	1	
9:00	1		9:15	1		9:30	1		9:45	1	
10:00	1		10:15	1		10:30	1		10:45	1	
11:00	1		11:15	17		11:30	1		11:45	17	
12:00	17		12:15	1		12:30	1		12:45	17	
13:00	17		13:15	1		13:30	1		13:45	1	
14:00	1		14:15	1		14:30	1		14:45	17	
15:00	17		15:15	1		15:30	1		15:45	17	
16:00	1		16:15	1		16:30	1		16:45	17	
17:00	1		17:15	1		17:30	1		17:45	1	
18:00	1		18:15	1		18:30	1		18:45	1	
19:00	1		19:15	1		19:30	17	TR	19:45	1	TR
20:00	1	AR	20:15	17	AR	20:30	17	AR	20:45	17	AR
21:00	17	AR	21:15	17	AR	21:30	18	AR	21:45	18	AR
22:00	18	AR	22:15	18	AR	22:30	18	AR	22:45	18	AR
23:00	18	AR	23:15	18	AR	23:30	18	AR	23:45	18	AR

Initials	Signature

Initials	Signature
	McCray TA
AR	TA

Initials	Signature
DN	
TR	

icp_nsg_pt_location

OTE 901640 7/12

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MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

[redacted] DOB:10/08/1947 W F

Patient Name [redacted]/14
MRN

PATIENT IDENTIFICATION LABEL

Date: 4/4/14
Room Number: 401L
Document patient location code every 15 minutes and initial.

Activity Level ☑ OR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day:
Evening: 1
Night: 8

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00			0:15			0:30			0:45		
1:00			1:15			1:30			1:45		
2:00			2:15			2:30			2:45		
3:00			3:15			3:30			3:45		
4:00			4:15			4:30			4:45		
5:00			5:15			5:30			5:45		
6:00			6:15			6:30			6:45		
7:00			7:15			7:30			7:45		
8:00			8:15			8:30			8:45		
9:00			9:15			9:30			9:45		
10:00			10:15			10:30			10:45		
11:00			11:15			11:30			11:45		
12:00			12:15			12:30			12:45		
13:00			13:15			13:30			13:45		
14:00			14:15			14:30			14:45		
15:00			15:15			15:30			15:45		
16:00			16:15			16:30			16:45		
17:00			17:15			17:30			17:45		
18:00			18:15			18:30			18:45		
19:00			19:15			19:30			19:45		
20:00			20:15			20:30			20:45		
21:00			21:15			21:30			21:45		
22:00			22:15			22:30			22:45		
23:00			23:15			23:30			23:45		

Initials	Signature

Initials	Signature
DJ	Dawn Crawford TA
MO	Morgan Davey
SN	Sequoya Nicks

Initials	Signature
AW	Amanda Smith TA
DW	Jordan Weaver

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.5

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPNURSING

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12
Version:1

Page 1 of 1

[redacted]

Patient Name [redacted]
MRN [redacted] DOB:10/08/1947 W F
[redacted] BEL

Date: 4-3-14
Room Number: 411C
Document patient location code every 15 minutes and initial.

Activity Level ☐ DR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: ____
Evening: 1.5
Night: 6.5

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: ____
24. Other: ____
25. Other: ____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00			0:15			0:30			0:45		
1:00			1:15			1:30			1:45		
2:00			2:15			2:30			2:45		
3:00			3:15			3:30			3:45		
4:00			4:15			4:30			4:45		
5:00			5:15			5:30			5:45		
6:00			6:15			6:30			6:45		
7:00			7:15			7:30			7:45		
8:00			8:15			8:30			8:45		
9:00			9:15			9:30			9:45		
10:00			10:15			10:30			10:45		
11:00			11:15			11:30			11:45		
12:00			12:15			12:30			12:45		
13:00			13:15			13:30			13:45		
14:00			14:15			14:30			14:45		
15:00			15:15			15:30			15:45		
16:00			16:15			16:30			16:45		
17:00			17:15			17:30			17:45		
18:00			18:15			18:30			18:45		
19:00			19:15			19:30			19:45		
20:00			20:15			20:30			20:45		
21:00			21:15			21:30			21:45		
22:00			22:15			22:30			22:45		
23:00			23:15			23:30			23:45		

Initials	Signature

Initials	Signature
MD	[signature]

Initials	Signature
[illegible]	[signature]

iop_nsg_pt_location

CTE 901640 7/12

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPNURSING"

Institute of Psychiatry
PATIENT LOCATION

Form Origination Date: 7/12 Page 1 of 1
Version:1 Version Date: 7/12

Patient Name [redacted] DOB:10/08/1947 W F
MRN [redacted] EAdm:04/02/14 LABEL

Date: 04/02/14
Room Number: 411
Document patient location code every 15 minutes and initial.

Activity Level ☑ UR ☐ IOP

Observation Level
☑ Q15min ☐ Visual
☐ Visual while awake ☐ Visual while asleep
☐ 1:1

Precautions and Protocols
☐ Suicide precaution ☑ Fall precautions ☑ Violence precautions
☐ Substance abuse withdrawal ☑ Elopement precautions
☐ Minimum seizure ☐ Maximum seizure
☐ CIWA ☐ Eating disorder ☐ Opiate ☐ Toileting

Sleep Hours
Day: _____
Evening: _____
Night: _____

Patient Location Key
1. Day room
2. Activity room
3. Admission
4. Treatment room
5. With doctor or SW
6. Play room
7. Atrium
8. Park
9. Fitness room
10. Cafeteria
11. School class room
12. Dx test off unit
13. IOP auditorium
14. ECT
15. Court
16. Bathroom
17. Patient room awake
18. Patient room asleep
19. Seclusion
20. Asleep in day area
21. Group on unit
22. Group off unit
23. Other: _____
24. Other: _____
25. Other: _____

Hour	Patient Location Code	Staff Initials	15 Minute	Patient Location Code	Staff Initials	30 Minute	Patient Location Code	Staff Initials	45 Minute	Patient Location Code	Staff Initials
0:00			0:15			0:30			0:45		
1:00			1:15			1:30			1:45		
2:00			2:15			2:30			2:45		
3:00			3:15			3:30			3:45		
4:00			4:15			4:30			4:45		
5:00			5:15			5:30			5:45		
6:00			6:15			6:30			6:45		
7:00			7:15			7:30			7:45		
8:00			8:15			8:30			8:45		
9:00			9:15			9:30			9:45		
10:00			10:15			10:30			10:45		
11:00			11:15			11:30			11:45		
12:00			12:15			12:30			12:45		
13:00			13:15			13:30			13:45		
14:00			14:15			14:30			14:45		
15:00			15:15			15:30			15:45		
16:00			16:15			16:30	13	SN	16:45	1	SN
17:00	1	SN	17:15	1	SN	17:30	1	SN	17:45	1	SN
18:00	1	SN	18:15	1	SN	18:30	1	SN	18:45	1	SN
19:00	1	SN	19:15	1	SN	19:30	1	SN	19:45	1	SN
20:00	1	SN	20:15	1	SN	20:30	1	SN	20:45	1	SN
21:00	1	SN	21:15	1	SN	21:30	1	SN	21:45	1	SN
22:00	1	SN	22:15	17	SN	22:30	18	SN	22:45	17	SN
23:00	17	SN	23:15	17	SN	23:30	18	SN	23:45	18	SN

Initials	Signature
S.N.	Shaniqua Nicks

Initials	Signature

Initials	Signature

iop_nsg_pt_location

OTE 901640 7/12

IOP Nursing Form	04/02		04/03		
Chart Review	19:08	20:24	04:29	05:44	08:30
Chart check			done		
Admission Note	19:08	20:24	04:29	05:44	08:30
Patient on unit	04/02/2014 16:38				
Accompanied by	Meducare				
Transport mode	stretcher				
CommitmentStatus	voluntary				
RiskPotentialScr	elopement falls violence				
AbleToParticipat WillngToParticip Describe Observ lvl noOrd PtEdAdmitProcess Body Search Done	no yes & Q15mins check no & &				
BodySearchDoneBy	&				
Dispo Belongings Significant Obsv Consent signed CommitmntPwkDone AdvncDirecDeterm Initiated forms	searched stored none yes & no yes Pt/Fam Education Treatment plan				
ConfidCodeGiven	yes &				

04/02/14 19:08 Describe(YT22): pt speech is very incoherent and soft.
04/02/14 19:08 PtEdAdmitProcess(YT22): family member educated about admission process over the phone
04/02/14 19:08 Body Searoh Done(YT22): yes
04/02/14 19:08 BodySearchDoneBy(YT22): Yalena Talley, RN
04/02/14 19:08 Consent signed(YT22): Verbal consent received over the phone from POA Sam Huggins
04/02/14 19:08 ConfidCodeGiven(YT22) Given to daughter Parker Meyer

ADL	19:08	20:24	04:29	05:44	08:30
Bath/shower	prompt				
Mouth care	prompt				
Room neatness	dependent				
Ambulate	independent				
Turn, position	independent		independent		
Toileting	independent		assist independent		
CARE PROVIDERS	YT22		TAB6		

BLACK, TAMMY(TAB6)RN TALLEY, YALENA(YT22)RN

IOP Nursing Form	04/02		04/03		
Sleep	19:00	20:24	04:29	05:44	08:30
No. hrs of sleep				6.5	
Diet	19:08	20:24	04:29	05:44	08:30
Meal type	regular				
Breakfast amt					75%
Lunch amt					
Dinner amt		100%			
Neuro/EENT	19:08	20:24	04:29	05:44	08:30
Follows commands NoSensoryDeficit	WNL WNL				
NormHear&/orAid Abs of drainage	WNL WNL		WNL		
Norm closure Abs of swelling Patent nares No bleed/disch	WNL WNL WNL WNL		WNL WNL WNL		
Lvl of conscious Behavior/neuro	disoriented agitated restless				
Disoriented	situation to place to time		unable to assess		
Respiratory	19:08	20:24	04:29	05:44	08:30
Respiratory	no distress		no distress		
No cough,dyspnea Natural airway No O2 requiremnt	WNL WNL WNL				
Cardiovascular	19:08	20:24	04:29	05:44	08:30
ChestPain rating	0 Wong-Baker(fac e)				
Gastrointestinal	19:08	20:24	04:29	05:44	08:30
Continent No c/o N/V	WNL WNL		WNL WNL		
Genitourinary	19:08	20:24	04:29	05:44	08:30
Continent	WNL		WNL		
Func/Musculoskel	19:08	20:24	04:29	05:44	08:30
No act restrict	WNL for age				
No use of device	no devices		no devices		
Skin	19:08	20:24	04:29	05:44	08:30
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score	3=slight limited 4=rarely moist 4=walks frequent 4=no limitation 3=adequate 3=no app:prob 21				
CARE PROVIDERS	YT22	SEN9	TAB6	LSD4	MMM

BLACK, TAMMY(TAB6)RN
MADDOX, MORGAN M(MMM)TA
NICKS, SEQUOYA(SEN9)TA
SANSCRAITE, LAUREN(LSD4)TA
TALLEY, YALENA(YT22)RN

CONTINUED

IOP Nursing Form	04/02		04/03		
Skin-Cont.	19:08	20:24	04:29	05:44	08:30
Skin	WNL				
Comfort	19:08	20:24	04:29	05:44	08:30
Pain score	0 Wong-Baker(fac e)		0 sleeping		
EdmonsonFallRisk	19:08	20:24	04:29	05:44	08:30
Age	50 to 79 (10)				
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted	no (0) yes (13) no (0) yes (13)				
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory	yes (8) no (0) no (0) no (0) no (0)				
No medications Cardiac meds Psych meds Inc in meds/prns	no (0) no (0) yes (8) no (0)				
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium	no (0) no (0) no (0) no (0)				
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets	Yes (7) no (0) no (0) N/A (0) N/A (0)				
Dec po 24 hours	appetite norm(0)				
SleepDisturbance	NoDisturbance(8)				
History of falls	No history (8)				
Total score	75				
RiskPrecautions	19:08	20:24	04:29	05:44	08:30
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet	no no no no fall assess				
Any of above	no		no		
Precautions	violence falls elopement		violence falls elopement		
Date/time Init	04/02/2014 16:38				
CARE PROVIDERS	YT22		TAB6		

BLACK, TAMMY(TAB6)RN TALLEY, YALENA(YT22)RN

IOP Nursing Form	04/02		04/03		
Act/Observ Level	19:08	20:24	04:29	05:44	08:30
Activity Level	unit restriction		unit restriction		
ObservationLevel	Q15mins check		Q15mins check		
Obs pt behavior	19:08	20:24	04:29	05:44	08:30
Appearance	dressed approp		dressed approp		
Behavior	cooperative good eye contact				
Speech	soft rapid				
Mood	euthymic		unable to assess		
Interact w/staff Invested in tx	positive no				
Interact w/peers	appropBoundaries				
Motor	hyperactive				
Affect	blunted				
Hallucinations	none				
Thought process	disorganized		unable to assess		
Delusions	none				
LevelOfConscious	alert				
Orientation	to person				
Impairment	to time to place to situation				
Impairment, desc Concentration	& attend to task				
Pay attention	able				

04/02/14 19:08 Impairment, desc(YT22): pt is aware that she is downtown but did not know where she was downtown. When asked if she knew who the president is, she said, "I know, but I just can't say it".

Problem list	19:08	20:24	04:29	05:44	08:30
Depressed mood Agitation Impulsivity Hyperactivity Dementia Disorientation Confusion	present present present present present present present		present present present		
Anxiety	present				
Interventions	19:08	20:24	04:29	05:44	08:30
Support via 1:1	done		done		
MaintainRiskPreq	falls violence elopement		falls violence elopement		
Provided	reality orient				
CARE PROVIDERS	YT22		TAB6		

BLACK, TAMMY(TAB6)RN TALLEY, YALENA(YT22)RN

[redacted]

REQUESTED:04/19/14 05:40
OPT OUT:

IOP Nursing Form	04/02		04/03		
PatientResponses	19:08	20:24	04:29	05:44	08:30
Class/activities	not applicable				
Followed direct	done				
Interaction	minimal				
Social support	pos fam interact				
Responded to	redirection				
Agitation	decreased				
Illness/disease	unableToVerbaliz				
Structure/milieu	no response				
No self-harm	none		none		
Shift Sign	19:08	20:24	04:29	05:44	08:30
For shift, RN	managed care		reviewed doc managed care		
Suicide Assess	19:08	20:24	04:29	05:44	08:30
Suicide Ideation	no thoughts=0				
Suicide plan	no plan=0				
Plan lethality	no plan=0				
Elopement risk	low risk=1				
Impulsivity Guilt/shame HelplessHopeless Anhedonia Anxiety Imp prob solving Anger/hostile	no no no no yes yes no				
Symptom Score	2 0-2 symptoms=0				
Morbid thoughts	none/rarely=0				
Safety agreement	reliablyAgrees=0				
AdmitD/Tsuicide	0=No				
Attempt history	noPrevAttempt=0				
Appraisal ofRisk	trustworthy=0				
Total Score	0 0-6 lowPotenti al				
CARE PROVIDERS	YT22		TAB6		

BLACK, TAMMY(TAB6)RN TALLEY, YALENA(YT22)RN

IOP Nursing Form	04/03				
Chart Review	13:19	14:43	14:49	18:09	21:59
Chart check					
ADL	13:19	14:43	14:49	18:09	21:59
Bath/shower		prompt			
Mouth care		prompt			
Room neatness		prompt			
Ambulate		independent			
Turn, position		independent			
Toileting		independent			
Sleep	13:19	14:43	14:49	18:09	21:59
No. hrs of sleep					1
Diet	13:19	14:43	14:49	18:09	21:59
Lunch amt	75%				
Dinner amt				50%	
Neuro/EENT	13:19	14:43	14:49	18:09	21:59
Follows commands NoSensoryDeficit		WNL WNL			
NormHear&/orAid Abs of drainage		WNL WNL			
Norm closure Abs of swelling No visual impair		WNL WNL			
Patent nares No bleed/disch		WNL WNL			
Lvl of conscious Behavior/neuro		disoriented calm			
Disoriented		situation to place to time			
Respiratory	13:19	14:43	14:49	18:09	21:59
Respiratory		no distress			
Spont respers NonLaboredEffort RegClrBreathSnds No cough,dyspnea Natural airway No O2 requiremnt		 WNL WNL WNL			
Cough					
Cardiovascular	13:19	14:43	14:49	18:09	21:59
Angina/chestPain PalpPeriphPulses Cap refill<3 sec Thigh/CalfTender Absence of edema					
ChestPain rating					
CARE PROVIDERS	MMM	KM11		MMM	LSD4

MADDEN, KATHERINE(KM11)RN MADDOX, MORGAN M(MMM)TA SANSCRAITE, LAUREN(LSD4)TA

IOP Nursing Form	04/03				
Gastrointestinal	13:19	14:43	14:49	18:09	21:59
Norm bowelSounds AbdSoftNontender Continent No c/o N/V Normal dentition MucousMembIntact		 WNL WNL			
Genitourinary	13:19	14:43	14:49	18:09	21:59
Continent Adequate UOP		WNL			
NoAbnVagBld/Dsch					
Func/Musculoskel	13:19	14:43	14:49	18:09	21:59
No act restrict		WNL for age			
No use of device		no devices			
Skin	13:19	14:43	14:49	18:09	21:59
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score		4=no impairmnt 4=rarely moist 4=walks frequent 4=no limitation 3=adequate 3=no app.probl 22			
Skin		WNL denies impairmnt			
Comfort	13:19	14:43	14:49	18:09	21:59
Pain score		0 Numeric Value			
EdmonsonFallRisk	13:19	14:43	14:49	18:09	21:59
Age		50 to 79 (10)			
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted		no (0) yes (13) yes (14) no (0)			
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory		no (0) no (0) yes (10) no (0) no (0)			
No medications Cardiac meds Psych meds Inc in meds/prns		no (0) yes (10) yes (8) no (0)			
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium		no (0) no (0) no (0) yes (12)			
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware		Yes (7) no (0) no (0) N/A (0)			
CARE PROVIDERS		KM11			

MADDEN, KATHERINE(KM11)RN

[redacted]

OPT OUT:

IOP Nursing Form	04/03				
EdmonsonFallRisk Cont:	13:19	14:43	14:49	18:09	21:59
Unsteady/Forgets		N/A (0)			
Dec po 24 hours		appetite norm(0)			
SleepDisturbance		NoDisturbance(8)			
History of falls		No history (8)			
Total score		100			
RiskPrecautions	13:19	14:43	14:49	18:09	21:59
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet		no no no no fall assess			
Any of above		no			
Precautions		falls elopement			
Act/Observ Level	13:19	14:43	14:49	18:09	21:59
Activity Level		unit restriction			
ObservationLevel		Q15mins check			
Misc Events	13:19	14:43	14:49	18:09	21:59
Misc events		&	&		
04/03/14 14:43 Misc events(KM11):		pt cooperative with staff. required prompting for all adls and activities. pt showered this shift - required prompting but was able to complete commands.			
04/03/14 14:49 Misc events(KM11):		body check completed on pt, no bruising or lesions noted to body. some liver spots on skin of chest and arms appropriate for age			
Obs pt behavior	13:19	14:43	14:49	18:09	21:59
Appearance		dressed approp malodorous			
Behavior		cooperative poor eye contact guarded			
Speech		normal rate soft			
Mood		fearful			
Interact w/staff Invested in tx		positive no			
Interact w/peers		inappropBoundr			
Motor		normal			
Affect		blunted			
Hallucinations					
Thought process		disorganized			
Delusions		none			
LevelOfConscious		awake			
Orientation		to person			
CARE PROVIDERS		KM11	KM11		

MADDEN, KATHERINE(KM11)RN

IOP Nursing Form	04/03				
Obs pt behavior-Cont.	13:19	14:43	14:49	18:09	21:59
Impairment		to time to place to situation			
Concentration		attend to task			
Pay attention		able			
Problem list	13:19	14:43	14:49	18:09	21:59
Depressed mood Impulsivity Dementia Disorientation Confusion		present present present present present			
Anxiety		present			
Interventions	13:19	14:43	14:49	18:09	21:59
Support via 1:1		done			
MaintainRiskPrec		falls violence elopement			
Safety plan Provided					
Environ interv					
PatientResponsee	13:19	14:43	14:49	18:09	21:59
Class/activities		attended active particip			
Followed direct		done			
Interaction		minimal			
Responded to		redirection distraction			
Agitation		decreased			
Illness/disease		unableToVerbaliz			
Structure/milieu		positiv response			
AdhereSafetyPlan					
No self-harm		none			
Shift Sign	13:19	14:43	14:49	18:09	21:59
For shift, RN		reviewed doc managed care			
CARE PROVIDERS		KM11			

MADDEN, KATHERINE(KM11)RN

IOP Nursing Form	04/03	04/04			
Chart Review	22:23	05:42	12:52	14:28	17:46
Chart check	done			done	
ADL	22:23	05:42	12:52	14:28	17:46
Bath/shower	prompt			prompt	
Mouth care	prompt			prompt	
Room neatness	prompt			prompt	
Ambulate	independent			independent	
Turn, position	prompt			independent	
Toileting	assist			assist	
Sleep	22:23	05:42	12:52	14:28	17:46
No. hrs of sleep		8			
Diet	22:23	05:42	12:52	14:28	17:46
Breakfast amt			50%		
Lunch amt			50%		
Dinner amt					30%
Neuro/EENT	22:23	05:42	12:52	14:28	17:46
Follows commands NoSensoryDeficit	WNL WNL			WNL WNL	
NormHear&/orAid Abs of drainage	WNL WNL			WNL WNL	
Norm closure Abs of swelling No visual impair	WNL WNL WNL			WNL WNL WNL	
Patent nares No bleed/disch	WNL WNL			WNL WNL	
Lvl of conscious	disoriented			disoriented	
Disoriented	situation to place to time			situation to place to time	
Respiratory	22:23	05:42	12:52	14:28	17:46
Respiratory	no distress			no distress	
Spont respers NonLaboredEffort RegClrBreathSnds No cough,dyspnea Natural airway No O2 requiremnt	WNL WNL all lobes WNL WNL WNL			WNL WNL WNL WNL WNL	
Cough	none				
Cardiovascular	22:23	05:42	12:52	14:28	17:46
Angina/chestPain PalpPeriphPulses Cap refill<3 sec Thigh/CalfTender Absence of edema	none WNL WNL none WNL			none WNL	
ChestPain rating	sleeping				
CARE PROVIDERS	NRSM	LSD4	MMM	KM11	SEN9

MADDEN, KATHERINE(KM11)RN
SANSCRAITE, LAUREN(LSD4)TA
MADDOX, MORGAN M(MMM)TA
SMITH, NICHOLE R(NRSM)RN
NICKS, SEQUOYA(SEN9)TA

IOP Nursing Form	04/03	04/04			
Gastrointestinal	22:23	05:42	12:52	14:28	17:46
Norm bowelSounds	WNL				
AbdSoftNontender	WNL			WNL	
Continent	&			WNL	
No c/o N/V	WNL			WNL	
Normal dentition	WNL				
MucousMembIntact	WNL				
04/03/14 22:23 Continent(NRSM): No BM reported this shift					
Genitourinary	22:23	05:42	12:52	14:28	17:46
Continent	WNL			WNL	
Adequate UOP	WNL				
NoAbnVagBld/Dsch	WNL				
Func/Musculoskel	22:23	05:42	12:52	14:28	17:46
No act restrict	WNL for age			WNL for age	
No use of device	no devices			no devices	
Skin	22:23	05:42	12:52	14:28	17:46
Sens perception	3=slight limited			3=slight limited	
Moisture	4=rarely moist			4=rarely moist	
Activity	4=walks frequent			4=walks frequent	
Mobility	4=no limitation			3=slight limited	
Nutrition	3=adequate			3=adequate	
Friction & shear	3=no app.probl			3=no app.probl	
Total score	21			20	
Skin	WNL denies impairmnt			WNL denies impairmnt	
Comfort	22:23	05:42	12:52	14:28	17:46
Pain score	0 sleeping			0 Numeric Value	
EdmonsonFallRisk	22:23	05:42	12:52	14:28	17:46
Age				50 to 79 (0)	
AlertOriented				no (0)	
AgitationAnxiety				yes (13)	
IntrmitlyConfusd				yes (14)	
ConfusdDisornted				no (0)	
Independent				no (0)	
Catheter/ostomy				no (0)	
ElimWassistance				yes (10)	
Altered Elim				no (0)	
IncontAmbulatory				no (0)	
No medications				no (0)	
Cardiac meds				yes (10)	
Psych meds				yes (8)	
Inc in meds/prns				no (0)	
BipolarSchizoaff				no (0)	
Subst/alc abuse				no (0)	
MajorDepress d/o				no (0)	
DementiaDelirium				yes (12)	
IndSteadyImmobil				Yes (7)	
ProperDevice use				no (0)	
VertigoHypoWeak				no (0)	
CARE PROVIDERS	NRSM			KM11	

MADDEN, KATHERINE(KM11)RN SMITH, NICHOLE R(NRSM)RN

IOP Nursing Form	04/03	04/04			
EdmonsonFallRisk-Cont	22:23	05:42	12:52	14:28	17:46
Unsteady/Aware Unsteady/Forgets				N/A (0) N/A (0)	
Dec po 24 hours				appetite norm(0)	
SleepDisturbance				ReprtdDistrb(12)	
History of falls				No history (8)	
Total score				104	
RiskPrecautions	22:23	05:42	12:52	14:28	17:46
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet	no no yes no fall assess			no no yes no fall assess	
Any of above	no			no	
Precautions	violence falls elopement			violence falls elopement	
Act/Observ Level	22:23	05:42	12:52	14:28	17:46
Activity Level	unit restriction			unit restriction	
ObservationLevel	Q15mins check			Q15mins check	
Misc Events	22:23	05:42	12:52	14:28	17:46
Misc events				&	
04/04/14 14:28 Misc events(KM11): Pt cooperative with staff, able to follow simple commands, required prompting for all adls and self care					
Obs pt behavior	22:23	05:42	12:52	14:28	17:46
Appearance	dressed approp			dressed approp	
Behavior	cooperative poor eye contact			cooperative good eye contact	
Speech	normal rate soft			normal rate soft	
Mood	fearful			sad fearful	
Interact w/staff Invested in tx	positive no			positive no	
Interact w/peers	appropBoundaries			appropBoundaries	
Motor	normal hyperactive			normal	
Affect	blunted			blunted	
Hallucinations	none			none	
Thought process	disorganized			disorganized	
Delusions	none			none	
LevelOfConscious	somnolent			awake	
Orientation	to person			to person	
Impairment	to time to place to situation			to time to place to situation	
	NRSM			KM1 CARE PRCVIDERS	

MADDEN, KATHERINE(KM11)RN SMITH, NICHOLE R(NRSM)RN

IOP Nursing Form	04/03	04/04			
Obs pt behavior-Cont	22:23	05:42	12:52	14:28	17:46
Concentration	attend to task			attend to task	
Pay attention	able			able	
Problem list	22:23	05:42	12:52	14:28	17:46
Depressed mood Dementia Disorientation Confusion	present present present present			present present present present	
Anxiety	present			present	
Interventions	22:23	05:42	12:52	14:28	17:46
Support via 1:1	done			done	
MaintainRiskPrec	falls violence elopement			falls violence elopement	
Safety plan Provided	done positiveReinforc reassurance clear direction			done reality orient positiveReinforc distraction redirection reassurance clear direction	
Environ interv	decrease stimuli			decrease stimuli	
PatientResponses	22:23	05:42	12:52	14:28	17:46
Class/activities	attended active particip			attended active particip	
Followed direct	done			done	
Interaction	minimal			minimal	
Responded to	redirection distraction			redirection distraction	
Agitation	decreased			decreased	
Illness/disease	unableToVerbaliz			unableToVerbaliz	
Structure/milieu				positiv response	
AdhereSafetyPlan	done			done	
No self-harm	none			none	
Shift Sign	22:23	05:42	12:52	14:28	17:46
For shift, RN	reviewed doc managed care			reviewed doc managed care	
CARE PROVIDERS	NRSM			KM11	

MADDEN, KATHERINE(KM11)RN SMITH, NICHOLE R(NRSM)RN

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REQUESTED:04/15/14 05:40
OPT OUT:
Page: 14

IOP Nursing Form	04/04	04/05			
Chart Review	23:10	06:10	12:38	13:09	17:30
Chart check			done		
ADL	23:10	06:10	12:38	13:09	17:30
Bath/shower			prompt		
Mouth care			prompt		
Room neatness			prompt		
Ambulate			independent		
Turn, position			independent		
Toileting			assist		
Sleep	23:10	06:10	12:38	13:09	17:30
No. hrs of sleep	1	7.0			
Diet	23:10	06:10	12:38	13:09	17:30
Breakfast amt				100%	
Lunch amt				50%	
Dinner amt					75%
Neuro/EENT	23:10	06:10	12:38	13:09	17:30
Follows commands NoSensoryDeficit			WNL WNL		
NormHear&/orAid Abs of drainage			WNL WNL		
Norm closure Abs of swelling No visual impair.			WNL WNL WNL		
Patent nares No bleed/disch			WNL WNL		
Lvl of conscious Behavior/neuro			disoriented restless		
Disoriented			situation to place to time		
Respiratory	23:10	06:10	12:38	13:09	17:30
Respiratory			no distress		
Cardiovascular	23:10	06:10	12:38	13:09	17:30
Angina/chestPain Thigh/CalfTender Absence of edema			none none WNL		
ChestPain rating			0 Numeric Value		
Gastrointestinal	23:10	06:10	12:38	13:09	17:30
AbdSoftNontender Continent No c/o N/V			WNL WNL WNL		
CARE PROVIDERS	SEN9	AM69	ANB9	BBT6	BLA0

BEERS, ANGELA(ANB9)RN
MCCRAY, AMY(AM69)TA
BERRY, BRIAN(BBT6)TA
NICKS, SEQUOYA(SEN9)TA
KOHLER, CATHERINE(BLA0)RN

IOP Nursing Form	04/04	04/05			
Genitourinary	23:10	00:10	12:38	13:09	17:30
Continent			WNL		
Func/Musculoskel	23:10	06:10	12:38	13:09	17:30
No act restrict			WNL for age		
No use of device			no devices		
Skin	23:10	06:10	12:38	13:09	17:30
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score			3=slight limited 4=rarely moist 4=walks frequent 3=slight limited 3=adequate 3=no app.probl 20		
Skin			WNL denies impairmnt		
Comfort	23:10	06:10	12:38	13:09	17:30
Pain score			0 Numeric Value		
EdmoneonFallRisk	23:10	06:10	12:38	13:09	17:30
Age			50 to 79 (10)		
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted			no (0) yes (13) yes (14) no (0)		
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory			no (0) no (0) yes (10) no (0) no (0)		
No medications Cardiac meds Psych meds Inc in meds/prns			no (0) yes (10) yes (8) no (0)		
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium			no (0) no (0) no (0) yes (12)		
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets			Yes (7) no (0) no (0) N/A (0) N/A (0)		
Dec po 24 hours			appetite norm(0)		
SleepDisturbance			NoDisturbance(8)		
History of falls			No history (8)		
Total score			100		
CARE PROVIDERS			ANB9		

BEERS, ANGELA(ANB9)RN

IOP Nursing Form	04/04	04/05			
RiskPrecautions	23:10	00:10	12:38	13:09	17:30
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet			no no yes no fall assess		
Any of above			no		
Precautions			violence falls elopement		
Act/Observ Level	23:10	06:10	12:38	13:09	17:30
Activity Level			unit restriction		
ObservationLevel			Q15mins check		
Misc Events	23:10	06:10	12:38	13:09	17:30
Misc events			&		
04/05/14 12:38 Misc events(ANB9): Pt is calm and cooperative with staff. No irritability noted. Remains confused and disorganized.					
Obs pt behavior	23:10	06:10	12:38	13:09	17:30
Appearance			dressed approp		
Behavior			cooperative		
Speech			normal rate soft		
Mood			anxious		
Interact w/staff Invested in tx			positive no		
Interact w/peers			appropBoundaries		
Motor			normal		
Affect			blunted		
Hallucinations			none		
Thought process			disorganized		
Delusions			none		
LevelOfConscious			awake		
Orientation			to person		
Impairment			to time to place to situation		
Concentration			attend to task		
Pay attention			able		
Problem list	23:10	06:10	12:38	13:09	17:30
Dementia Disorientation Confusion			present present present		
Anxiety			present		
CARE PROVIDERS			ANB9		

BEERS, ANGELA(ANB9)RN

IOP Nursing Form	04/04	04/05			
Interventions	23:10	00:10	12:38	13:09	17:30
Support via 1:1			done		
MaintainRiskPrec			falls violence elopement		
Safety plan Provided			done reality orient positiveReinforc reassurance clear direction		
Environ interv			decrease stimuli		
PatientResponses	23:10	06:10	12:38	13:09	17:30
Class/activities			attended active particip		
Followed direct			done		
Interaction			minimal		
Agitation			decreased		
Illness/disease			unableToVerbaliz		
Structure/milieu			positiv response		
AdhereSafetyPlan			done		
No self-harm			none		
Shift Sign	23:10	06:10	12:38	13:09	17:30
For shift, RN			reviewed doc managed care		
CARE PROVIDERS			ANB9		

BEERS, ANGELA(AN89)RN

[redacted]

OPT OUT:

IOP Nursing Form	04/05		04/08		
Chart Review	22:08	22:38	02:59	06:16	09:54
Chart check		done	done		
ADL	22:08	22:38	02:59	06:16	09:54
Bath/shower		prompt			
Mouth care		prompt			
Room neatness		prompt			
Ambulate		independent			
Turn, position		independent			
Toileting		assist			
Sleep	22:08	22:38	02:59	06:16	09:54
No. hrs of sleep	.5			8	
Diet	22:08	22:38	02:59	06:16	09:54
Breakfast amt					100%
Neuro/EENT	22:08	22:38	02:59	06:16	09:54
Follows commands NoSensoryDeficit		WNL WNL			
NormHear&/orAid Abs of drainage		WNL WNL			
Norm closure Abs of swelling No visual impair		WNL WNL WNL			
Patent nares No bleed/disch		WNL WNL			
Lvl of conscious Behavior/neuro		disoriented restless			
Disoriented		situation to place to time			
Respiratory	22:08	22:38	02:59	06:16	09:54
Respiratory		no distress	no distress		
Spont respers NonLaboredEffort RegClrBreathSnds No cough,dyspnea Natural airway No O2 requiremnt		WNL WNL all lobes WNL WNL WNL			
Cough		none			
Cardiovascular	22:08	22:38	02:59	06:16	09:54
Angina/chestPain Absence of edema		none WNL	none		
ChestPain rating		sleeping			
CARE PROVIDERS	APR	NN37	BLA0	APR	CH99

HARRIS, CHEVALIER(CH99)TA
RIESMEYER, ALEXANDER P(APR)TA
KOHLER, CATHERINE(BLA0)RN
NZIOKA, NANCY(NN37)RN

IOP Nursing Form	04/05		04/06		
Gastrointestinal	22:08	22:38	02:59	06:16	09:54
AbdSoftNontender Continent No c/o N/V		WNL WNL WNL	WNL		
Genitourinary	22:08	22:38	02:59	06:16	09:54
Continent Adequate UOP		WNL WNL	WNL		
NoAbnVagBld/Dsch		WNL			
Func/Musculoskel	22:08	22:38	02:59	06:16	09:54
No act restrict		WNL for age	WNL for age		
No use of device		no devices	no devices		
Skin	22:08	22:38	02:59	06:16	09:54
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score		3=slight limited 4=rarely moist 4=walks frequent 3=slight limited 3=adequate 3=no app.probl 20			
Skin		WNL denies impairmnt	WNL		
Comfort	22:08	22:38	02:59	06:16	09:54
Pain score		0 sleeping	0 sleeping		
EdmonsonFallRisk	22:08	22:38	02:59	06:16	09:54
Age		50 to 79 (10)			
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted		no (0) yes (13) yes (14) no (0)			
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory		no (0) no (0) no (0) no (0) no (0)			
No medications Cardiac meds Psych meds Inc in meds/prns		no (0) yes (10) yes (8) no (0)			
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium		no (0) no (0) no (0) yes (12)			
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets		Yes (7) no (0) yes (10) N/A (0) N/A (0)			
Dec po 24 hours		appetite norm(0)			
CARE PROVIDERS		NN37	BLA0		

KOHLER, CATHERINE(BLA0)RN NZIOKA, NANCY(NN37)RN

IOP Nursing Form	04/05		04/06		
EdmonsonFallRisk-Cont	22:08	22:38	02:59	06:16	09:54
SleepDisturbance		NoDisturbance(8)			
History of falls		No history (8)			
Total score		100			
RiskPrecautions	22:08	22:38	02:59	06:16	09:54
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet		no no yes no fall assess	no no no no fall assess		
Any of above		no	no		
Precautions		violence falls elopement	violence falls elopement		
Act/Observ Level	22:08	22:38	02:59	06:16	09:54
Activity Level		IOP w/staff	unit restriction		
ObservationLevel		Q15mins check	Q15mins check		
Misc Events	22:08	22:38	02:59	06:16	09:54
Misc events		&	&		
04/06/14 22:38 Misc events(NN37): Calm and cooperative during shift. Attended group this evening.					
04/06/14 02:59 Misc events(BLA0): Pt sleeping without disturbance.					
Obs pt behavior	22:08	22:38	02:59	06:16	09:54
Appearance		dressed approp			
Behavior		cooperative			
Speech		normal rate normal volume			
Mood		anxious			
Interact w/staff Invested in tx		positive no			
Interact w/peers		appropBoundaries			
Motor		normal			
Affect		blunted			
Hallucinations		none			
Thought process		disorganized			
Thought content					
Delusions		none			
LevelOfConscious		somnolent	somnolent		
Orientation		to person			
Impairment		to time to place to situation			
Concentration		attend to task			
Pay attention		able			
CARE PROVIDERS		NN37	BLA0		

KOHLER, CATHERINE(BLA0)RN NZIOKA, NANCY(NN37)RN

IOP Nursing Form	04/05		04/06		
Problem list	22:08	22:38	02:59	06:16	09:54
Dementia Disorientation Confusion		present present present			
Anxiety		present			
Interventions	22:08	22:38	02:59	06:16	09:54
Support via 1:1		done			
MaintainRiskPreo		falls	falls violence elopement		
Safety plan Provided		done positiveReinforc redirection reassurance	done		
Environ interv		decrease stimuli			
PatientResponses	22:08	22:38	02:59	06:16	09:54
Class/activities		attended			
Followed direct		done			
Interaction		minimal			
Responded to		redirection			
Agitation		decreased			
Illness/disease		unableToVerbaliz			
Structure/milieu		positiv response			
AdhereSafetyPlan		done	done		
No self-harm		none	none		
Shift Sign	22:08	22:38	02:59	06:16	09:54
For shift, RN		reviewed doc managed care	reviewed doc managed care		
CARE PROVIDERS		NN37	BLA0		

KOHLER, CATHERINE(BLA0)RN NZIOKA, NANCY(NN37)RN

IOP Nursing Form	04/06				04/07
Chart Review	10:41	11:48	22:05	22:36	03:32
Chart check		done		done	done
ADL	10:41	11:48	22:05	22:36	03:32
Bath/shower			prompt		
Mouth care			independent prompt		
Room neatness			assist prompt		
Ambulate			independent		
Turn, position			independent		
Toileting			assist		
Sleep	10:41	11:48	22:05	22:36	03:32
No. hrs of sleep					
Diet	10:41	11:48	22:05	22:36	03:32
Dinner amt			0%		
Respiratory	10:41	11:48	22:05	22:36	03:32
Respiratory					no distress
Cardiovascular	10:41	11:48	22:05	22:36	03:32
Angina/chestPain					none
Gastrointestinal	10:41	11:48	22:05	22:36	03:32
Continent					WNL
Genitourinary	10:41	11:48	22:05	22:36	03:32
Continent					WNL
Func/Musculoskel	10:41	11:48	22:05	22:36	03:32
No act restrict					WNL for age
No use of device					no devices
Skin	10:41	11:48	22:05	22:36	03:32
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score					4=no impairmnt 4=rarely moist 4=walks frequent 4=no limitation 3=adequate 3=no app.probl 22
Skin					WNL
Comfort	10:41	11:48	22:05	22:36	03:32
Pain score	0 sleeping				0 sleeping
EdmonsonFallRisk	10:41	11:48	22:05	22:36	03:32
Age	50 to 79 (10)				
AlertOriented AgitationAnxiety IntrmittyConfusd ConfusdDisornted	no (0) yes (13) yes (14) no (0)				
Independent Catheter/ostomy	no (0) no (0)				
CARE PROVIDERS	LQ11	LQ11	RCTA	BLA0	BLA0

KOHLER, CATHERINE(BLA0)RN QUINN, LESLIE(LQ11)RN ROBINSON, TANOVA C(RCTA)TA

IOP Nursing Form	04/06				04/07
EdmonsonFallRisk-Cont	10:41	11:48	22:05	22:36	03:32
ElimWassistance Altered Elim IncontAmbulatory	yes (10) no (0) no (0)				
No medications Cardiac meds Psych meds Inc in meds/prns	no (0) yes (10) yes (8) no (0)				
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium	no (0) no (0) no (0) yes (12)				
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets	Yes (7) no (0) yes (10) N/A (0) N/A (0)				
Deo po 24 hours	appetite norm(0)				
SleepDisturbance	NoDisturbance(8)				
History of falls	No history (8)				
Total score	110				
RiskPrecautions	10:41	11:48	22:05	22:36	03:32
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet	no no yes no fall assess			no no no no fall assess	no no no no fall assess
Any of above	no			no	no
Precautions	violence falls elopement			violence falls elopement	violence falls elopement
Act/Observ Level	10:41	11:48	22:05	22:36	03:32
Activity Level	IOP w/staff		IOP w/staff		IOP w/staff
ObservationLevel	Q15mins check		Q15mins check		Q15mins check
Misc Events	10:41	11:48	22:05	22:36	03:32
Misc events	&				&
04/06/14 10:41 Misc events(LQ11): Calm and cooperative. Spending most of time in her room.					
04/07/14 03:32 Misc events(BLA0): Pt sleeping without disturbance.					
Obs pt behavior	10:41	11:48	22:05	22:36	03:32
Appearance	dressed approp		dressed approp		
Behavior	cooperative		cooperative &		
Speech	normal rate normal volume		normal rate normal volume		
Mood	anxious		anxious		
Interact w/staff Invested In tx	positive no		positive no		
CARE PROVIDERS	LQ11		RCTA	BLA0	BLA0

KOHLER, CATHERINE(BLA0)RN QUINN, LESLIE(LQ11)RN ROBINSON, TANOVA C(RCTA)TA

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REQUESTED:04/19/14 05:40
OPT OUT:
Page: 24

IOP Nursing Form	04/06				04/07
Obs pt behavior-Cont.	10:41	11:48	22:05	22:36	09:32
Interact w/peers	appropBoundaries		positive		
Motor	normal unsteady gait		normal		
Affect	fat		flat		
Hallucinations	none		none		
Thought process	coherent &				
Thought content	appropriate				
Delusions	none				
LevelOfConscious	alert awake somnolent				somnolent
Orientation	to person				
Impairment	to time to place to situation				
Concentration	attend to task				
Pay attention	able				

04/06/14 10:41 Thought process(LQ11): minimal interaction

04/06/14 22:05 Behavior(RCTA): Pt was in the mileau throughout the shift. Pt had postive interaction with staff and peers. Pt had no questions or concerns.

Problem list	10:41	11:48	22:05	22:36	03:32
Dementia Disorientation Confusion	present present present		present present present		
Anxiety	present		present		
Interventions	10:41	11:48	22:05	22:36	03:32
Support via 1:1	done		done		
MaintainRiskPrec	falls violence elopement		falls violence elopement		falls violence elopement
Safety plan Provided	done positiveReinforc redirection reassurance clear direction		done positiveReinforc clear direction		done
Environ interv	decrease stimuli				
PatientResponses	10:41	11:48	22:05	22:36	03:32
Followed direct	done				
Interaction	minimal		spontaneous		
Responded to	redirection		distraction		
Agitation	decreased		continued		
Illness/disease	unableToVerbaliz				
Structure/milieu	positiv response				
CARE PROVIDERS	LQ11		RCTA		BLA0

KOHLER, CATHERINE(BLA0)RN QUINN, LESLIE(LQ11)RN ROBINSON, TANOVA C(RCTA)TA

IOP Nursing Form	04/06				04/07
PatientResponses-Opnt.	10:41	11:46	22:05	22:36	03:32
AdhereSafetyPlan	done		done		done
No self-harm	none		none		none
Shift Sign	10:41	11:46	22:05	22:36	03:32
For shift, RN	reviewed doc			reviewed doc	reviewed doc managed care
CARE PROVIDERS	LQ11		RCTA	BLA0	BLA0

KOHLER, CATHERINE(BLA0)RN QUINN, LESLIE(LQ11)RN ROBINSON, TANOVA C(RCTA)TA

IOP Nursing Form	04/07				
Chart Review	06:06	08:39	08:59	13:08	13:16
Chart check				done	
ADL	06:06	08:39	08:59	13:08	13:16
Bath/shower			prompt		
Mouth care			independent prompt		
Room neatness			assist prompt		
Ambulate			independent		
Turn, position			independent		
Toileting			independent		
Sleep	06:06	08:39	08:59	13:08	13:16
No. hrs of sleep	8.00				
Diet	06:06	08:39	08:59	13:08	13:16
Breakfast amt		25%			
Lunch amt					50%
Dinner amt					
Comfort	06:06	08:39	08:59	13:08	13:16
Pain score			0 Numeric Value		
EdmonsonFallRisk	06:06	08:39	08:59	13:08	13:16
Age			50 to 79 (10)		
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted			no (0) yes (13) yes (14) no (0)		
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory			no (0) no (0) yes (10) no (0) no (0)		
No medications Cardiac meds Psych meds Inc in meds/prns			no (0) yes (10) yes (8) no (0)		
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium			no (0) no (0) no (0) yes (12)		
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets			Yes (7) no (0) yes (10) N/A (0) N/A (0)		
Dec po 24 hours			appetite norm(0)		
SleepDisturbance			NoDisturbance(8)		
History of falls			No history (8)		
CARE PROVIDERS	H	MMM	LQ11	LQ11	MMM

HUDSON, JESSE(H)TA MADDOX, MORGAN M(MMM)TA QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/07				
EdmonsonFallRisk-Cont	00:00	08:39	08:59	13:08	13:16
Total score			110		
RiskPrecautions	06:06	08:39	08:59	13:08	13:16
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet			no no no no fall assess		
Any of above			no		
Precautions			violence falls elopement		
Act/Observ Level	06:06	08:39	08:59	13:08	13:16
Activity Level			IOP w/staff		
ObservationLevel			Q15mins check		
Misc Events	06:06	08:39	08:59	13:08	13:16
Misc events			&		
04/07/14 08:59 Misc events(LQ11): Disoriented. Calm and cooperative.					
Obs pt behavior	06:06	08:39	08:59	13:08	13:16
Appearance			dressed approp		
Behavior			cooperative good eye contact		
Speech			normal rate normal volume		
Mood			euthymic		
Interact w/staff Invested in tx			positive no		
Interact w/peers			positive appropBoundaries		
Motor			normal		
Affect			flat		
Hallucinations			none		
Thought process			coherent		
Thought content			appropriate		
Delusions			none		
LevelOfConscious			alert awake		
Orientation			to person		
Impairment			to time to place to situation		
Concentration			attend to task		
Pay attention			able		
CARE PROVIDERS			LQ11		

QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/07				
Problem list	00:00	08:39	08:59	13:08	13:16
Dementia Disorientation Confusion			present present present		
Anxiety			present		
Interventions	06:06	08:39	08:59	13:08	13:16
Support via 1:1			done		
MaintainRiskPreo			falls violence elopement		
Safety plan Provided			done positiveReinforc clear direction		
PatientResponses	06:06	08:39	08:59	13:08	13:16
Followed direct			done		
Interaction			spontaneous minimal		
Responded to			distraction		
Agitation			decreased		
Illness/disease			unableToVerbaliz		
Structure/milieu			positiv response		
AdhereSafetyPlan			done		
No self-harm			none		
Shift Sign	06:06	08:39	08:59	13:08	13:16
For shift, RN			reviewed doc		
CARE PROVIDERS			LQ11		

QUINN, LESLIE(LQ11)RN

[redacted]

REQUESTED:04/18/14 05:40
OPT OUT:
Page: 20

IOP Nursing Form	04/07			04/08	
Chart Review	17:51	20:25	22:39	06:41	08:17
Chart check		done			
Sleep	17:51	20:25	22:39	06:41	08:17
No. hrs of sleep			0	6.75	
Diet	17:51	20:25	22:39	06:41	08:17
Breakfast amt					25%
Dinner amt	50%				
Neuro/EENT	17:51	20:25	22:39	06:41	08:17
Follows commands NoSensoryDeficit		WNL WNL			
NormHear&/orAid Abs of drainage		WNL WNL			
Norm closure Abs of swelling Patent nares No bleed/disch		WNL WNL WNL WNL			
Lvl of conscious Behavior/neuro		disoriented calm			
Disoriented		situation to place to time			
Respiratory	17:51	20:25	22:39	06:41	08:17
Respiratory		no distress			
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt		WNL WNL WNL WNL WNL			
Cough		none			
Cardiovascular	17:51	20:25	22:39	06:41	08:17
Angina/chestPain Absence of edema		none WNL			
GastroIntestinal	17:51	20:25	22:39	06:41	08:17
Continent No c/o N/V		WNL WNL			
Genitourinary	17:51	20:25	22:39	06:41	08:17
Continent Adequate UOP		WNL WNL			
NoAbnVagBld/Dsch		WNL			
Func/Musculoskel	17:51	20:25	22:39	06:41	08:17
No act restrict		WNL for age			
No use of device		no devices			
CARE PROVIDERS	MMM	VF55	AM69	AM69	MMM

FORD, VINETTA(VF55)RN MADDOX, MORGAN M(MMM)TA MCCRAY, AMY(AM69)TA

IOP Nursing Form	04/07			04/08	
Skin	17:51	20:25	22:39	06:41	08:17
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score		4=no impairmnt 4=rarely moist 4=walks frequent 4=no limitation 3=adequate 3=no app.probl 22			
Skin		WNL denies impairmnt			
Comfort	17:51	20:25	22:39	06:41	08:17
Abn findings					
Pain score		0 Numeric Value			
Pain onset					
Interventions					
EdmonsonFallRisk	17:51	20:25	22:39	06:41	08:17
Age		50 to 79 (10)			
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted		yes (-4) no (0) yes (14) yes (13)			
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory		yes (8) no (0) no (0) no (0) no (0)			
No medications Cardiac meds Psych meds Inc in meds/prns		no (0) yes (10) yes (8) no (0)			
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium		no (0) no (0) no (0) yes (12)			
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets		Yes (7) no (0) no (0) N/A (0) N/A (0)			
Dec po 24 hours		appetite norm(0)			
SleepDisturbance		NoDisturbance(8)			
History of falls		No history (8)			
Total score		94			
RiskPrecautions	17:51	20:25	22:39	06:41	08:17
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg CARE PROVIDERS		no no no no VF55			

FORD, VINETTA(VF55)RN

IOP Nursing Form	04/07			04/08	
RiskPrecautions-Cont:	17:51	20:25	22:39	06:41	08:17
Any yes, complet		fall assess			
Any of above		no			
Precautions		violence falls elopement			
Act/Observ Level	17:51	20:25	22:39	06:41	08:17
Activity Level		unit restriction			
ObservationLevel		Q15mins check			
Misc Events	17:51	20:25	22:39	06:41	08:17
Misc events		&			
04/07/14 20:25 Misc events(VF55): pt calm and cooperative with staff. Intermentent restless periocs. Denies pain. NAD noted. Obeying command and redirection wthout hesitantcy.					
Obs pt behavior	17:51	20:25	22:39	06:41	08:17
Appearance		dressed approp			
Behavior		cooperative			
Speech		normal rate normal volume			
Mood		euthymic			
Interact w/staff Invested in tx		positive no			
Interact w/peers		positive			
Motor		normal unusual gait			
Affect		labile			
Hallucinations		none			
Thought process		unable to assess			
Thought content		appropriate			
Delusions		none			
LevelOfConscious		alert awake			
Orientation		to person			
Impairment		to time to place to situation			
Concentration		attend to task			
Pay attention		unable			
Problem list	17:51	20:25	22:39	06:41	08:17
Dementia Disorientation Confusion		present present present			
CARE PROVIDERS		VF55			

FORD, VINETTA(VF55)RN

IOP Nursing Form	04/07			04/08	
Interventions	17:51	20:25	22:39	06:41	08:17
Support via 1:1		done			
MaintainRiskPrec		falls violence elopement			
Safety plan Admin prn meds Provided		done positiveReinforc redirection reassurance clear direction			
Environ interv		decrease stimuli			
PatientResponses	17:51	20:25	22:39	06:41	08:17
Followed direct		done			
Struoture/millieu		positiv response			
AdhereSafetyPlan		done			
No self-harm		none			
Shift Sign	17:51	20:25	22:39	06:41	08:17
For shift, RN		reviewed doc managed care			
CARE PROVIDERS		VF55			

FORD, VINETTA(VF55)RN

IOP Nursing Form	04/08				
Diet	09:59	10:02	10:30	12:40	13:29
Lunch amt					25%
Dinner amt					
Neuro/EENT	09:59	10:02	10:30	12:40	13:29
Follows commands NoSensoryDeficit				WNL WNL	
NormHear&/orAid Abs of drainage				WNL WNL	
Norm closure Abs of swelling Patent nares No bleed/disch				WNL WNL WNL WNL	
Lvl of conscious Behavior/neuro				disoriented calm	
Disoriented				situation to time	
Respiratory	09:59	10:02	10:30	12:40	13:29
Respiratory				no distress	
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt				WNL WNL WNL WNL WNL	
Cardiovascular	09:59	10:02	10:30	12:40	13:29
Angina/chestPain Absence of edema				none WNL	
Gastrointestinal	09:59	10:02	10:30	12:40	13:29
Continent Last BM		&		WNL	
Stool amount Stool color Stool consistncy		moderate brown semi-formed			
Abdomen		nausea vomiting			
04/08/14 10:02 Last BM(VICS): 04/08/2014					
Genitourinary	09:59	10:02	10:30	12:40	13:29
Continent Adequate UOP				WNL WNL	
Func/Musculoskel	09:59	10:02	10:30	12:40	13:29
No act restrict				WNL for age	
No use of device				no devices	
Skin	09:59	10:02	10:30	12:40	13:29
Sens perception Moisture Activity Mobility Nutrition				4=no impairmnt 4=rarely moist 4=walks frequent 4=no limitation 3=adequate	
CARE PROVIDERS		VICS		VICS	MMM

MADDOX, MORGAN M(MMM)TA VICK, STANISHA(VICS)RN

IOP Nursing Form	04/08				
Skin-Cont.	09:59	10:02	10:30	12:40	13:29
Friction & shear Total score				3=no app.probl 22	
Skin				WNL	
Comfort	09:59	10:02	10:30	12:40	13:29
Abn findings	nausea vomiting				
Pain onset	new onset				
Interventions	meds (see MAR)				
EdmonsonFallRisk	09:59	10:02	10:30	12:40	13:29
Age				50 to 79 (0)	
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted				yes (-4) no (0) yes (14) yes (13)	
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory				yes (8) no (0) no (0) no (0) no (0)	
No medications Cardiac meds Psych meds Inc in meds/prns				no (0) yes (10) yes (8) no (0)	
BipolarSchizoAff Subst/alc abuse MajorDepress d/o DementiaDelirium				no (0) no (0) no (0) yes (12)	
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets				Yes (7) no (0) no (0) N/A (0) N/A (0)	
Dec po 24 hours				appetite norm(0)	
SleepDisturbance				NoDisturbance(8)	
History of falls				No history (8)	
Total score				94	
RiskPrecautions	09:59	10:02	10:30	12:40	13:29
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet				no no no no fall assess	
Any of above				no	
Precautions				violence falls elopement	
CARE PROVIDERS	VICS			VICS	

VICK, STANISHA(VICS)RN

IOP Nursing Form	04/08				
Act/Observ Level	09:59	10:02	10:30	12:40	13:29
Activity Level				unit restriction	
ObservationLevel				Q15mins check	
Misc Events	09:59	10:02	10:30	12:40	13:29
Misc events				&	
04/08/14 12:40 Misc events(VICS): Pt has not complained of N/V since adm of PRN zofran					
Obs pt behavior	09:59	10:02	10:30	12:40	13:29
Appearance				dressed approp	
Behavior				cooperative	
Speech				normal rate	
Mood				euthymic	
Interact w/staff Invested in tx				positive no	
Interact w/peers				positive	
Motor				normal unsteady gait	
Affect				flat	
Hallucinations				none	
Thought process				unable to assess	
Thought content				appropriate	
Delusions				none	
LevelOfConscious				alert awake	
Orientation				to person	
Impairment				to time to place to situation	
Concentration				attend to task	
Pay attention				unable	
Problem list	09:59	10:02	10:30	12:40	13:29
Dementia Disorientation Confusion				present present present	
Interventions	09:59	10:02	10:30	12:40	13:29
Support via 1:1				done	
MaintainRiskPrec				falls violence elopement	
Admin prn meds Monitor response	PO &		done &		
Environ interv				decrease stimuli	
04/08/14 09:59 Admin prn meds(VICS): 8mg of zofrzn for n/v.					
04/08/14 10:30 Monitor response(VICS): Pt resting comfortably. will continue to monitor					
CARE PROVIDERS	VICS		VICS	VICS	

VICK, STANISHA(VICS) RN

IOP Nursing Form	04/08				
PatientResponses	09:59	10:02	10:30	12:40	13:29
Followed direct				done	
Interaction				minimal	
AdhereSafetyPlan				done	
No self-harm				none	
Shift Sign	09:59	10:02	10:30	12:40	13:29
For shift, RN				reviewed doc managed care	
CARE PROVIDERS				VICS	

VICK, STANISHA(VICS)RN

[redacted]

OPT OUT:

IOP Nursing Form	04/08			04/09	
Chart Review	18:12	21:42	22:41	01:02	06:00
Chart check		done			done
ADL	18:12	21:42	22:41	01:02	06:00
Ambulate		independent		independent	
Turn, position		independent		independent	
Toileting		independent		independent	
Sleep	18:12	21:42	22:41	01:02	06:00
No. hrs of sleep			0		
Diet	18:12	21:42	22:41	01:02	06:00
Dinner amt	<0%				
Neuro/EENT	18:12	21:42	22:41	01:02	06:00
Follows commands NoSensoryDeficit		WNL WNL			
NormHear&/orAid Abs of drainage		WNL WNL			
Norm closure Abs of swelling Patent nares No bleed/disch		WNL WNL WNL WNL			
Lvl of conscious Behavior/neuro		disoriented calm			
Disoriented		situation to time			
Respiratory	18:12	21:42	22:41	01:02	06:00
Respiratory		no distress			
Cardiovascular	18:12	21:42	22:41	01:02	06:00
Angina/chestPain Absence of edema		none WNL			
ChestPain rating		0 Numeric Value			
Gastrointestinal	18:12	21:42	22:41	01:02	06:00
Continent No c/o N/V		WNL WNL			
Genitourinary	18:12	21:42	22:41	01:02	06:00
Continent Adequate UOP		WNL WNL			
Func/Musculoskel	18:12	21:42	22:41	01:02	06:00
No act restrict		WNL for age			
No use of device		no devices			
Skin	18:12	21:42	22:41	01:02	06:00
Sens perception Moisture Activity Mobility Nutrition Friction & shear		4=no impairmnt 4=rarely moist 4=walks frequent 4=no limitation 3=adequate 3=no app.probl			
CARE PROVIDERS	MMM	YS60	AM69	AM69	CEL

LAWTON, CLAUDIA(CEL)RN
YATES, SARAH(YS60)RN
MADDOX, MORGAN M(MMM)TA
MCCRAY, AMY(AM69)TA

IOP Nursing Form	04/08			04/09	
Skin Cont.	18:12	21:42	22:41	01:02	06:00
Total score		22			
Skin		WNL denies impairmnt			
Comfort	18:12	21:42	22:41	01:02	06:00
Pain score		0 Numeric Value		0 sleeping	
RiskPrecautions	18:12	21:42	22:41	01:02	06:00
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet		no no no no fall assess		no no no no fall assess	
Any of above		no		no	
Precautions		violence falls elopement		violence falls elopement	
Act/Observ Level	18:12	21:42	22:41	01:02	06:00
Activity Level		unit restriction		unit restriction	
ObservationLevel		Q15mins check		Q15mins check	
Obs pt behavior	18:12	21:42	22:41	01:02	06:00
Appearance		dressed approp		dressed approp	
Behavior		cooperative			
Speech		normal rate normal volume			
Mood		euthymic fearful &		unable to assess	
Interact w/staff Invested in tx		positive no			
Interact w/peers		positive			
Motor		normal unsteady gait			
Affect		flat			
Hallucinations		none			
Thought process		unable to assess		unable to assess	
Thought content		appropriate			
Delusions		none			
LevelOfConscious		alert awake			
Orientation		to person			
Impairment		to time to place to situation			
Concentration		attend to task			
Pay attention		unable			
CARE PROVIDERS		YS60		AM69 CEL	

LAWTON, CLAUDIA(CEL)RN MCCRAY, AMY(AM69)TA YATES, SARAH(YS60)RN

IOP Nursing Form	04/08			04/09	
Obs pt behavior-Cont.	18:12	21:42	22:41	01:02	06:00
04/08/14 21:42 Mood(YS60): is fearful of rommate					
Problem list	18:12	21:42	22:41	01:02	06:00
Dementia Disorientation Confusion		present present present			
Interventions	18:12	21:42	22:41	01:02	06:00
Support via 1:1		done			
MaintainRiskPrec		falls violence elopement			
Provided		reality orient positiveReinforc distraction reassurance clear direction			
Environ interv		decrease stimuli		decrease stimuli	
PatientResponses	18:12	21:42	22:41	01:02	06:00
Followed direct		done			
Interaction		spontaneous			
AdhereSafetyPlan		done		done	
No self-harm		none		none	
Shift Sign	18:12	21:42	22:41	01:02	06:00
For shift, RN		reviewed doc managed care		reviewed doc managed care	
CARE PROVIDERS		YS60		CEL AM69	

LAWTON, CLAUDIA(CEL)RN MCCRAY, AMY(AM69)TA YATES, SARAH(YS60)RN

IOP Nursing Form	04/09				
Chart Review	06:15	11:14	13:01	14:53	18:07
Chart check			done		
ADL	06:15	11:14	13:01	14:53	18:07
Bath/shower					
Ambulate			independent		
Turn, position			independent		
Toileting			independent		
Sleep	06:15	11:14	13:01	14:53	18:07
No. hrs of sleep	6.75				
Diet	06:15	11:14	13:01	14:53	18:07
Breakfast amt		40%			
Lunch amt				90%	
Dinner amt					85%
Neuro/EENT	06:15	11:14	13:01	14:53	18:07
Follows commands NoSensoryDeficit			WNL WNL		
NormHear&/orAid Abs of drainage			WNL WNL		
Norm closure Abs of swelling Patent nares No bleed/disch			WNL WNL WNL WNL		
Lvl of conscious Behavior/neuro			disoriented calm		
Disoriented			situation to time		
Respiratory	06:15	11:14	13:01	14:53	18:07
Respiratory			no distress		
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt			WNL WNL WNL WNL WNL		
Cardiovascular	06:15	11:14	13:01	14:53	18:07
Angina/chestPain			none		
Gastrointestinal	06:15	11:14	13:01	14:53	18:07
Continent No c/o N/V			WNL WNL		
Genitourinary	06:15	11:14	13:01	14:53	18:07
Continent Adequate UOP			WNL WNL		
CARE PROVIDERS	AM69	NSAA	LB33	NSAA	SEN9

BLIZZARD, LAUREN(LB33)RN MCCRAY, AMY(AM69)TA NICKS, SEQUOYA(SEN9)TA
STANLEY, NADINE(NSAA)TA

IOP Nursing Form	04/09				
Func/Musculoskel	06:15	11:14	13:01	14:53	18:07
No act restrict			WNL for age		
No use of device			no devices		
Skin	06:15	11:14	13:01	14:53	18:07
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score			4=no impairmnt 4=rarely moist 3=walks occasion 4=no limitation 3=adequate 3=no app.probl 21		
Skin			WNL denies impairmnt		
Comfort	06:15	11:14	13:01	14:53	18:07
Pain score			0 sleeping		
EdmonsonFallRisk	06:15	11:14	13:01	14:53	18:07
Age			50 to 79 (10)		
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted			yes (-4) no (0) yes (14) yes (13)		
Independent Catheter/ostomy ElimAssistance Altered Elim IncontAmbulatory			yes (8) no (0) no (0) no (0) no (0)		
No medications Cardiac meds Psych meds Inc in meds/prns			no (0) yes (10) yes (8) no (0)		
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium			no (0) no (0) no (0) yes (12)		
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets			Yes (7) no (0) no (0) N/A (0) N/A (0)		
Dec po 24 hours			appetite norm(0)		
SleepDisturbance			NoDisturbance(8)		
History of falls			No history (8)		
Total score			94		
RiskPrecautions	06:15	11:14	13:01	14:53	18:07
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg CARE PROVIDERS			no no yes no LB33		

BLIZZARD, LAUREN(LB33)RN

IOP Nursing Form	04/09				
RiskPrecautions-Cont.	00:15	11:14	13:01	14:53	18:07
Any yes, complet			fall assess		
Any of above			no		
Precautions			violence falls elopement		
Act/Observ Level	06:15	11:14	13:01	14:53	18:07
Activity Level			unit restriction		
ObservationLevel			Q15mins check		
Obs pt behavior	06:15	11:14	13:01	14:53	18:07
Appearance			dressed approp		
Behavior			cooperative		
Speech			normal rate normal volume		
Mood			unable to assess		
Interact w/staff Invested in tx			positive no		
Interact w/peers			positive		
Motor			unsteady gait		
Affect			congruent w/mood		
Hallucinations			none		
Thought process			unable to assess		
Thought content			appropriate		
Delusions			none		
LevelOfConscious			alert awake		
Orientation			to person to place		
Impairment			to time to situation		
Concentration			attend to task		
Pay attention			unable		
Problem list	06:15	11:14	13:01	14:53	18:07
Dementia Disorientation Confusion			present present present		
Interventions	06:15	11:14	13:01	14:53	18:07
Support via 1:1			done		
MaintainRiskPrec			falls violence elopement		
Safety plan Provided			done reassurance clear direction		
Environ interv			decrease stimuli		
CARE PROVIDERS			LB33		

BLIZZARD, LAUREN(LB33)RN

IOP Nursing Form	04/09				
PatientResponses	08:15	11:14	13:01	14:53	18:07
Followed direct			done		
Interaction			minimal		
Illness/disease			unableToVerbaliz		
AdhereSafetyPlan			done		
No self-harm			none		
Shift Sign	08:15	11:14	13:01	14:53	18:07
For shift, RN			reviewed doc managed care		
CARE PROVIDERS			LB33		

BLIZZARD, LAUREN(LB33)RN

IOP Nursing Form	04/09		04/10		
Chart Review	21:05	23:20	04:31	04:41	06:23
Chart check				done	
ADL	21:05	23:20	04:31	04:41	06:23
Bath/shower	&				
04/09/14 21:05 Bath/shower(SEN9): Pt had a shower on 04/09/2012					
Sleep	21:05	23:20	04:31	04:41	06:23
No. hrs of sleep		25			7.25
Diet	21:05	23:20	04:31	04:41	06:23
Breakfast amt					
Respiratory	21:05	23:20	04:31	04:41	06:23
Respiratory			no distress		
Cardiovascular	21:05	23:20	04:31	04:41	06:23
Angina/chestPain			none		
Gastrointestinal	21:05	23:20	04:31	04:41	06:23
Continent No c/o N/V			WNL WNL		
Genitourinary	21:05	23:20	04:31	04:41	06:23
Continent Adequate UOP			WNL WNL		
Func/Musculoskel	21:05	23:20	04:31	04:41	06:23
No act restrict			WNL for age		
No use of device			no devices		
Skin	21:05	23:20	04:31	04:41	06:23
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score			4=no impairmnt 4=rarely moist 4=walks frequent 4=no limitation 3=adequate 3=no app.probl 22		
Skin			denies impairmnt		
Comfort	21:05	23:20	04:31	04:41	06:23
Pain score			0 sleeping		
RiskPrecautions	21:05	23:20	04:31	04:41	06:23
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet			no no yes no fall assess		
Any of above			no		
Precautions			violence falls elopement		
CARE PROVIDERS	SEN9	SEN9	KDJ	KDJ	APR

JENKINS, KIMBERLY D(KDJ)RN NICKS, SEQUOYA(SEN9)TA RIESMEYER, ALEXANDER P(APR)TA

IOP Nursing Form	04/09		04/10		
Act/Observ Level	21:05	23:20	04:31	04:41	06:23
Activity Level			unit restriction		
ObservationLevel			Q15mins check		
Misc Events	21:05	23:20	04:31	04:41	06:23
Misc events			&		
04/10/14 04:31 Misc events(KDJ): pt has been asleep throughout the night.no omplaints or concerns. safety maintained.					
Obs pt behavior	21:05	23:20	04:31	04:41	06:23
Appearance			dressed approp		
Mood			unable to assess		
Motor			unsteady gait		
Thought process			unable to assess		
LevelOfConscious			somnolent		
Interventions	21:05	23:20	04:31	04:41	06:23
Support via 1:1			done		
MaintainRiskPreo			falls violence elopement		
Safety plan Monitor response			done done		
Environ interv			decrease stimuli		
PatientResponses	21:05	23:20	04:31	04:41	06:23
AdhereSafetyPlan			done		
No self-harm			none		
Shift Sign	21:05	23:20	04:31	04:41	06:23
For shift, RN			reviewed doc managed care		
CARE PROVIDERS			KDJ		

JENKINS, KIMBERLY D(KDJ)RN

IOP Nursing Form	04/10				
Chart Review	09:32	13:57	14:15	18:05	18:07
Chart check			done	done	
ADL	09:32	13:57	14:15	18:05	18:07
Bath/shower			assist		
Ambulate			independent	independent	
Turn, position			independent	independent	
Toileting			independent	independent	
Sleep	09:32	13:57	14:15	18:05	18:07
No. hrs of sleep					
Diet	09:32	13:57	14:15	18:05	18:07
Breakfast amt	90%				
Lunch amt		100%			
Dinner amt					0% &
04/10/14 18:07 Dinner amt(SEN9): Pt states she didnot want to eat because her stomach still hurts.					
Neuro/EENT	09:32	13:57	14:15	18:05	18:07
Follows commands NoSensoryDeficit				WNL WNL	
NormHear&/orAid Abs of drainage				WNL WNL	
Norm closure Abs of swelling Patent nares No bleed/disch				WNL WNL WNL WNL	
Lvl of conscious Behavior/neuro				disoriented calm	
Disoriented				situation to time	
Respiratory	09:32	13:57	14:15	18:05	18:07
Respiratory				no distress	
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt				WNL WNL WNL WNL WNL	
Cough				none	
Cardiovascular	09:32	13:57	14:15	18:05	18:07
Angina/chestPain				none	
Gastrointestinal	09:32	13:57	14:15	18:05	18:07
Continent No c/o N/V				WNL &	
04/10/14 18:05 No c/o N/V(NN37): Patient had a small amout of emesis at beginning of shift.					
CARE PROVIDERS	NSAA	NSAA	NSAA ANB9	NN37	SEN9

BEERS, ANGELA(ANB9)RN
STANLEY, NADINE(NSAA)TA
NICKS, SEQUOYA(SEN9)TA
NZIOKA, NANCY(NN37)RN

IOP Nursing Form	04/10				
Genitourinary	09:32	13:57	14:15	18:05	18:07
Continent				WNL	
Adequate UOP				WNL	
Func/Musculoskel	09:32	13:57	14:15	18:05	18:07
No act restrict				WNL for age	
No use of device				no devices	
Skin	09:32	13:57	14:15	18:05	18:07
Sens perception				4=no impairmnt	
Moisture				4=rarely moist	
Activity				4=walks frequent	
Mobility				4=no limitation	
Nutrition				3=adequate	
Friction & shear				3=no app.probl	
Total score				22	
Skin				WNL	
Comfort	09:32	13:57	14:15	18:05	18:07
Pain score				0 Numeric Value	
EdmonsonFallRisk	09:32	13:57	14:15	18:05	18:07
Age				50 to 79 (-0)	
AlertOriented				no (0)	
AgitationAnxiety				no (0)	
IntrmittlyConfusd				yes (14)	
ConfusdDisornted				yes (13)	
Independent				yes (8)	
Catheter/ostomy				no (0)	
ElimAssistance				no (0)	
Altered Elim				no (0)	
IncontAmbulatory				no (0)	
No medications				no (0)	
Cardiac meds				yes (10)	
Psych meds				yes (8)	
Inc in meds/prns				no (0)	
BipolarSchizoaff				no (0)	
Subst/alc abuse				no (0)	
MajorDepress d/o				no (0)	
DementiaDelirium				yes (12)	
IndSteadyImmobil				Yes (7)	
ProperDevice use				no (0)	
VertigoHypoWeak				no (0)	
Unsteady/Aware				N/A (0)	
Unsteady/Forgets				N/A (0)	
Dec po 24 hours				appetite norm(0)	
SleepDisturbance				NoDisturbance(8)	
History of falls				No history (8)	
Total score				98	
CARE PROVIDERS				NN37	

NZIOKA, NANCY(NN37)RN

IOP Nursing Form	04/10				
RiskPrecautions	09:32	13:57	14:15	18:05	18:07
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet			no no yes	no no yes no fall assess	
Any of above				no	
Precautions			violence falls elopement	violence falls elopement	
Act/Observ Level	09:32	13:57	14:15	18:05	18:07
Activity Level			unit restriction	unit restriction	
ObservationLevel			Q15mins check	Q15mins check	
Misc Events	09:32	13:57	14:15	18:05	18:07
Misc events			&	&	
04/10/14 14:15 Misc events(NSAA): patient on unit was visited by daughter					
04/10/14 18:05 Misc events(NN37): Patient resting in bed at this moment. Had an episode of small emesis at begining of shift. Denies abdominal pain or discomfort at this moment. Will coninues to monitor.					
Obs pt behavior	09:32	13:57	14:15	18:05	18:07
Appearance			dressed approp	dressed approp	
Behavior			cooperative	cooperative	
Speech			normal rate normal volume	normal rate normal volume	
Mood			euthymic	euthymic	
Interact w/staff Invested in tx			positive	positive no	
Interact w/peers			appropBoundaries	positive	
Motor			normal	unsteady gait	
Affect			blunted	congruent w/mood	
Hallucinations			none	none	
Thought process			disorganized	disorganized	
Thought content				appropriate	
Delusions			none	none	
LevelOfConscious			awake	alert awake	
Orientation			to person	to person	
Impairment			to situation	to time to place to situation	
Concentration				attend to task	
Pay attention			unable	unable	
CARE PROVIDERS			NSAA	NN37	

NZIOKA, NANCY(NN37)RN STANLEY, NADINE(NSAA)TA

IOP Nursing Form	04/10				
Problem list	09:32	13:57	14:15	18:05	18:07
Dementia Disorientation Confusion			present present present	present present	
Interventions	09:32	13:57	14:15	18:05	18:07
Support via 1:1				done	
MaintainRiskPreo			falls violence elopement	falls violence elopement	
Safety plan Monitor response			done	done done	
Provided				redirection reassurance clear direction	
Environ interv				decrease stimuli	
PatientResponses	09:32	13:57	14:15	18:05	18:07
Followed direct				done	
Interaction			spontaneous	spontaneous	
Illness/disease			verbal understan	unableToVerbaliz	
Structure/milieu				no response	
AdhereSafetyPlan				done	
No self-harm				none	
Shift Sign	09:32	13:57	14:15	18:05	18:07
For shift, RN			reviewed doc	reviewed doc managed care	
CARE PROVIDERS			ANB9 NSAA	NN37	

BEERS, ANGELA(AN89)RN NZIOKA, NANCY(NN37)RN STANLEY, NADINE(NSAA)TA

IOP Nursing Form	04/10	04/11			
Chart Review	23:05	04:35	04:51	04:55	09:14
Chart check				done	
ADL	23:05	04:35	04:51	04:55	09:14
Ambulate		independent			
Turn, position		independent			
Toileting		independent			
Sleep	23:05	04:35	04:51	04:55	09:14
No. hrs of sleep	3.50		8.00		
Respiratory	23:05	04:35	04:51	04:55	09:14
Respiratory		no distress			
Cardiovascular	23:05	04:35	04:51	04:55	09:14
Angina/chestPain				none	
Gastrointestinal	23:05	04:35	04:51	04:55	09:14
Continent				WNL	
Genitourinary	23:05	04:35	04:51	04:55	09:14
Continent				WNL	
Func/Musculoskel	23:05	04:35	04:51	04:55	09:14
No act restrict				WNL for age	
No use of device				no devices	
Skin	23:05	04:35	04:51	04:55	09:14
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score				4=no impairmnt 4=rarely moist 4=walks frequent 4=no limitation 2=prob adequate 3=no app.probl 21	
Skin				WNL	
Comfort	23:05	04:35	04:51	04:55	09:14
Pain score				0 sleeping	
RiskPrecautions	23:05	04:35	04:51	04:55	09:14
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet				no no no no fall assess	
Any of above				no	
Precautions		violence falls elopement			
Act/Observ Level	23:05	04:35	04:51	04:55	09:14
Activity Level		unit restriction			
ObservationLevel		Q15mins check			
CARE PROVIDERS	SEN9	H	H	BLA0	

HUDSON, JESSE(H)TA KOHLER, CATHERINE(BLA0)RN NICKS, SEQUOYA(SEN9)TA

IOP Nursing Form	04/10	04/11			
Misc Events	23:05	04:35	04:51	04:55	09:14
Misc events					&
04/11/14 09:14 Misc events(PB33): Pt began shaking while walking with staff and sat down trembling and with eyes fluttering. MD witnessed this and requested a FSBS and set of vital signs. Pt did not lose conciousness but may have soiled herself.					
Obs pt behavior	23:05	04:35	04:51	04:55	09:14
Interact w/staff LevelOfConscious		positive		somnolent	
Interventions	23:05	04:35	04:51	04:55	09:14
Support via 1:1		done			
MaintainRiskPrec		falls violence elopement			
Safety plan				done	
PatientResponses	23:05	04:35	04:51	04:55	09:14
AdhereSafetyPlan				done	
No self-harm		none			
Shift Sign	23:05	04:35	04:51	04:55	09:14
For shift, RN				reviewed doc managed care	
CARE PROVIDERS		H		BLA0	PB33

BLEVINS, PHIL(PB33)RN HUDSON, JESSE(H)TA KOHLER, CATHERINE(BLA0)RN

IOP Nursing Form	04/11				
Chart Review	10:07	11:35	16:06	21:02	21:29
Chart check			done	done	
ADL	10:07	11:35	16:06	21:02	21:29
Ambulate				independent	
Turn, position				independent	
Toileting				independent	
Sleep	10:07	11:35	16:06	21:02	21:29
No. hrs of sleep					
Diet	10:07	11:35	16:06	21:02	21:29
Breakfast amt		0%			
Dinner amt					0%

04/11/14 21:29 Dinner amt(SEN9): pt didinot want to eat

Neuro/EENT	10:07	11:35	16:06	21:02	21:29
Follows commands NoSensoryDeficit			WNL WNL	WNL WNL	
NormHear&/orAid Abs of drainage			WNL WNL	WNL WNL	
Norm closure Abs of swelling Patent nares No bleed/disch			WNL WNL WNL WNL	WNL WNL WNL WNL	
Lvl of conscious Behavior/neuro			disoriented lethargic calm	disoriented calm	
Disoriented			situation to place to time	situation to place to time	
Respiratory	10:07	11:35	16:06	21:02	21:29
Respiratory			no distress	no distress	
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt				WNL WNL WNL WNL WNL	
Cough				none	
Cardiovascular	10:07	11:35	16:06	21:02	21:29
Angina/chestPain				none	
Gastrointestinal	10:07	11:35	16:06	21:02	21:29
Continent No c/o N/V			WNL WNL	WNL WNL	
Genitourinary	10:07	11:35	16:06	21:02	21:29
Continent Adequate UOP			WNL WNL	WNL WNL	
CARE PROVIDERS		LWD3	PB33	YS60	SEN9

BLEVINS, PHIL(PB33)RN NICKS, SEQUOYA(SEN9)TA WELLS, LASONYA(LWD3)TA
YATES, SARAH(YS60)RN

IOP Nursing Form	04/11				
Func/Musculoskel	10:07	11:35	16:06	21:02	21:29
No act restriot			WNL for age	WNL for age	
No use of device				no devices	
Skin	10:07	11:35	16:06	21:02	21:29
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score			4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 2=prob adequate 3=no app.probl 19	4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 2=prob adequate 3=no app.probl 19	
Skin			WNL	WNL	
Comfort	10:07	11:35	16:06	21:02	21:29
Pain score			5 Wong-Baker(face) &	0 sleeping	
04/11/14 16:06 Pain score(PB33): says her legs don't feel good					
EdmonsonFallRisk	10:07	11:35	16:06	21:02	21:29
Age			50 to 79 (10)		
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted			no (0) no (0) yes (14) yes (13)		
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory			no (0) no (0) yes (10) no (0) yes (12)		
No medications Cardiac meds Psych meds Inc in meds/prns			no (0) yes (10) no (0) no (0)		
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium			no (0) no (0) no (0) yes (12)		
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets			Yes (7) no (0) no (0) N/A (0) N/A (0)		
Dec po 24 hours			appetite norm(0)		
SleepDisturbance			NoDisturbance(8)		
History of falls			No history (8)		
Total score			104		
CARE PROVIDERS			PB33	YS60	

BLEVINS, PHIL(PB33)RN YATES, SARAH(YS60)RN

[redacted]

OPT OUT:

IOP Nursing Form	04/11				
RiskPrecautions	10:07	11:35	16:06	21:02	21:29
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet				no no no no fall assess	
Any of above				no	
Precautions				violence falls elopement	
Act/Observ Level	10:07	11:35	16:06	21:02	21:29
Activity Level				unit restriction	
ObservationLevel				Q15mins check	
Misc Events	10:07	11:35	16:06	21:02	21:29
Misc events	(modified) &				
04/11/14 10:07 Misc events(PB33): Pt incontinent of stool. Pt was cleaned and brief changed and Pt was then transported to 1W main Hospital for Stat EEG.					
Obs pt behavior	10:07	11:35	16:06	21:02	21:29
Appearance			dressed approp	dressed approp	
Behavior			cooperative	cooperative	
Speech			normal rate normal volume	normal rate normal volume	
Mood			euthymic	euthymic	
Interact w/staff Invested in tx			positive no	positive no	
Interact w/peers			positive	positive	
Motor			unsteady gait	unsteady gait	
Affect			congruent w/mood	congruent w/mood	
Hallucinations			none	none	
Thought process			disorganized	disorganized	
Thought content			appropriate	appropriate	
Delusions			none	none	
LevelOfConscious			somnolent	somnolent	
Orientation			to person	to person	
Impairment			to time to place to situation	to time to place to situation	
Concentration			attend to task	attend to task	
Pay attention			unable	unable	
Problem list	10:07	11:35	16:06	21:02	21:29
Dementia Disorientation Confusion			present present present	present present present	
CARE PROVIDERS	PB33		PB33	YS60	

BLEVINS, PHIL(PB33)RN YATES, SARAH(YS60)RN

IOP Nursing Form	04/11				
Interventions	10:07	11:35	16:00	21:02	21:29
Support via 1:1			done	done	
MaintainRiskPrec			falls min seizure elopement	falls min seizure elopement	
Safety plan Monitor response			done done	done done	
Provided			distraction redirection	distraction redirection	
Environ interv				decrease stimuli	
PatientResponses	10:07	11:35	16:06	21:02	21:29
Followed direct			done	done	
Interaction			minimal	minimal	
Illness/disease			unableToVerbaliz	unableToVerbaliz	
Structure/milieu			no response	no response	
AdhereSafetyPlan			done	done	
No self-harm			none	none	
Shift Sign	10:07	11:36	16:06	21:02	21:29
For shift, RN			reviewed doc	reviewed doc managed care	
CARE PROVIDERS			PB33	YS60	

BLEVINS, PHIL(PB33)RN YATES, SARAH(YS60)RN

[redacted]

REQUESTED:04/18/14 05:40
OPT OUT:

IOP Nursing Form	04/11	04/12			
Chart Review	21:40	05:30	06:21	10:24	12:31
Chart check		done			
Sleep	21:46	05:30	06:21	10:24	12:31
No. hrs of sleep	.5		8		
Diet	21:46	05:30	06:21	10:24	12:31
Breakfast amt					0%
Lunch amt					
Neuro/EENT	21:46	05:30	06:21	10:24	12:31
Follows commands NoSensoryDeficit		WNL WNL		WNL WNL	
NormHear&/orAid Abs of drainage				WNL WNL	
Norm closure Abs of swelling No visual impair				WNL WNL WNL	
Patent nares No bleed/disch		WNL		WNL WNL	
Lvl of conscious Behavior/neuro				disoriented calm	
Disoriented				situation to person to place to time	
Respiratory	21:46	05:30	06:21	10:24	12:31
Respiratory		no distress		no distress	
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt		WNL WNL WNL WNL WNL		WNL WNL WNL WNL WNL	
Cough				none	
Cardiovascular	21:46	05:30	06:21	10:24	12:31
Angina/chestPain		none		none	
GastroIntestinal	21:46	05:30	06:21	10:24	12:31
Continent No c/o N/V		WNL WNL		WNL WNL	
Genitourinary	21:46	05:30	06:21	10:24	12:31
Continent		WNL		WNL	
Funo/Musculoskel	21:46	05:30	06:21	10:24	12:31
No act restrict		WNL for age		WNL for age	
No use of device		no devices		no devices	
CARE PROVIDERS	SEN9	CHOR	TW2	LQ11	MMM

HORLBACK, CHRISTOPHER(CHOR)RN
QUINN, LESLIE(LQ11)RN
MADDOX, MORGAN M(MMM)TA
WILSON, TIFFNEY(TW2)TA
NICKS, SEQUOYA(SEN9)TA

[redacted]

REQUESTED:04/18/14 05:40
OPT OUT:

IOP Nursing Form	04/11	04/12			
Skin	21:46	05:30	06:21	10:24	12:31
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score				4=no impairmnt 4=rarely moist 3=walks occasion 3=slight limited 2=prob adequate 3=no app.probl 19	
Skin				WNL	
Comfort	21:46	05:30	06:21	10:24	12:31
Pain score		0 Numeric Value		0 sleeping	
EdmonsonFallRisk	21:46	05:30	06:21	10:24	12:31
Age				50 to 79 (10)	
AlertOriented AgitationAnxiety IntrmittyConfusd ConfusdDisornted				no (0) no (0) yes (14) yes (13)	
Independent Catheter/ostomy ElimWaasistance Altered Elim IncontAmbulatory				no (0) no (0) yes (10) no (0) no (0)	
No medications Cardiac meds Psych meds Inc in meds/prns				no (0) yes (10) no (0) no (0)	
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium				no (0) no (0) no (0) yes (12)	
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets				Yes (7) no (0) no (0) N/A (0) N/A (0)	
Dec po 24 hours				appetite norm(0)	
SleepDisturbance				NoDisturbance(8)	
History of falls				No history (8)	
Total score				92	
RiskPrecautions	21:46	05:30	06:21	10:24	12:31
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet		no no no no fall assess		no no no no fall assess	
Any of above		no		no	
Precautions		violence falls elopement		violence falls elopement	
CARE PROVIDERS		CHOR		LQ11	

HORLBACK, CHRISTOPHER(CHOR)RN QUINN, LESLIE(LQ11)RN

CONTINUED

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REQUEST ID:04/13/14 05:40
OPT OUT:
Page: 59

IOP Nursing Form	04/11	04/12			
Act/Observ Level	21:40	05:30	06:21	10:24	12:31
Activity Level		unit restriction		unit restriction	
ObservationLevel		Q15mins check		Q15mins check	
Misc Events	21:46	05:30	06:21	10:24	12:31
Misc events				&	
04/12/14 10:24 Misc events(LQ11): Pt calm and cooperative. Slept late.					
Obs pt behavior	21:46	05:30	06:21	10:24	12:31
Appearance				dressed approp	
Behavior				cooperative	
Speech				normal rate soft	
Mood				euthymic	
Interact w/staff Invested in tx				positive no	
Interact w/peers				appropBoundaries	
Motor				unsteady gait	
Affect				congruent w/mood	
Hallucinations		none		none	
Thought process				disorganized	
Thought content				appropriate	
Delusions				none	
LevelOfConscious		somnolent		somnolent	
Orientation				to person	
Impairment				to time to place to situation	
Concentration				attend to task	
Pay attention				unable	
Problem list	21:46	05:30	06:21	10:24	12:31
Dementia Disorientation Confusion				present present present	
Interventions	21:46	05:30	06:21	10:24	12:31
Support via 1:1				done	
MaintainRiskPrec				falls min seizure elopement	
Safety plan Monitor response		done done		done done	
Provided				positiveReinforc	
PatientResponses	21:46	05:30	06:21	10:24	12:31
Followed direct				done	
Interaction				minimal	
Med adherence				voluntary	
CARE PROVIDERS		CHOR		LQ11	

HORLBACK, CHRISTOPHER(CHOR)RN QUINN, LESLIE(LQ11)RN

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CONTINUED
DOB: 10/08/1947 - muha_iop24hr

PERM

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IOP Nursing Form	04/11	04/12			
PatientResponses-Cont.	21:40	05:30	06:21	10:24	12:31
Oth responses		sleeping		sleeping	
Illness/disease				unableToVerbaliz	
Structure/milieu				no response	
AdhereSafetyPlan		done		done	
No self-harm				none	
Shift Sign	21:40	05:30	06:21	10:24	12:31
For shift, RN		reviewed doc managed care		reviewed doc managed care	
CARE PROVIDERS		CHOR		LQ11	

HORLBACK, CHRISTOPHER(CHOR)RN QUINN, LESLIE(LQ11)RN

[redacted]

OPT OUT:

IOP Nursing Form	04/12				
Chart Review	13:27	13:37	14:18	15:52	15:53
Chart check			done		
Diet	13:27	13:37	14:18	15:52	15:53
Lunch amt	0%				
Vascular Access	13:27	13:37	14:18	15:52	15:53
Location		antecubital R			antecubital R
Insertion date		04/12/2014			
Gauge		#22			
Site appear		secure			infiltrated
Site dressing		dry and intact			warm pack
Interventions		IV fluid started			dc'ed/RN
Misc Events	13:27	13:37	14:18	15:52	15:53
Misc events				&	
04/12/14 15:52 Misc events(RGER): Pt IV infiltrated and has been removed.					
CARE PROVIDERS	MMM	LB33	LQ11	RGER	RGER

BLIZZARD, LAUREN(LB33)RN
GAINES, RANDI(RGER)RN
MADDOX, MORGAN M(MMM)TA
QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/12			04/13	
Chart Review	20:50	21:55	22:54	01:29	03:38
Chart check			done		done
ADL	20:50	21:55	22:54	01:29	03:38
Ambulate			independent	independent	
Turn, position			independent	independent	
Toileting			independent	independent	
Sleep	20:50	21:55	22:54	01:29	03:38
No. hrs of sleep					
Diet	20:50	21:55	22:54	01:29	03:38
Dinner amt		50%			
Neuro/EENT	20:50	21:55	22:54	01:29	03:38
Follows commands NoSensoryDeficit			WNL WNL		
NormHear&/orAid Abs of drainage			WNL WNL		
Norm closure Abs of swelling No visual impair			WNL WNL WNL		WNL WNL
Patent nares No bleed/disch			WNL WNL		WNL WNL
Lvl of conscious Behavior/neuro			disoriented calm		disoriented calm
Disoriented			situation to place		situation to place to time
Respiratory	20:50	21:55	22:54	01:29	03:38
Respiratory			no distress	no distress	no distress
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt					WNL WNL WNL WNL WNL
Cardiovascular	20:50	21:55	22:54	01:29	03:38
Angina/chestPain			none		none
Gastrointestinal	20:50	21:55	22:54	01:29	03:38
Continent No c/o N/V			WNL WNL		WNL WNL
Genitourinary	20:50	21:55	22:54	01:29	03:38
Continent			WNL		WNL
Func/Musculoskel	20:50	21:55	22:54	01:29	03:38
No act restrict					WNL for age
No use of device					no devices
CARE PROVIDERS		RCTA	RGER	H	TAB6

BLACK, TAMMY(TAB6)RN
ROBINSON, TANOVA C(RCTA)TA
GAINES, RANDI(RGER)RN
HUDSON, JESSE(H)TA

IOP Nursing Form	04/12			04/13	
Skin	20:50	21:55	22:54	01:29	03:38
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score			4=no impairmnt 4=rarely moist 3=walks occasion 4=no limitation 2=prob adequate 3=no app.probl 20		
Skin			denies impairmnt		
Comfort	20:50	21:55	22:54	01:29	03:38
Pain score			0 Numeric Value		0 sleeping
EdmonsonFallRisk	20:50	21:55	22:54	01:29	03:38
Age			50 to 79 (10)		
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted			no (0) no (0) yes (14) yes (13)		
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory			no (0) no (0) yes (10) no (0) no (0)		
No medications Cardiac meds Psych meds Inc in meds/prns			no (0) yes (10) no (0) no (0)		
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium			no (0) no (0) no (0) yes (12)		
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets			Yes (7) no (0) no (0) N/A (0) N/A (0)		
Deo po 24 hours			appetite norm(0)		
SleepDisturbance			NoDisturbance(8)		
History of falls			No history (8)		
Total score			92		
RiskPrecautions	20:50	21:55	22:54	01:29	03:38
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet			no no no no fall assess		
Any of above			no		no
Precautions			violence falls elopement	violence falls elopement	violence falls elopement
CARE PROVIDERS			RGER	H	TAB6

BLACK, TAMMY(TAB6)RN GAINES, RANDI(RGER)RN HUDSON, JESSE(H)TA

IOP Nursing Form	04/12			04/13	
Act/Observ Level	20:50	21:55	22:54	01:29	03:30
Activity Level				unit restriction	
ObservationLevel				Q15mins check	
Vascular Access	20:50	21:55	22:54	01:29	03:38
Location	wrist L				wrist L
Insertion date	04/12/2014				
Gauge	#22				
Site appear	secure				secure
Site dressing	dry and intact				dry and intact
Interventions	IV inserted IV fluid started				saline lock
Misc Events	20:50	21:55	22:54	01:29	03:38
Misc events					&
04/13/14 03:38 Misc events(TAB6): pt. slept well. No behavioral issues.					
Obs pt behavior	20:50	21:55	22:54	01:29	03:38
Appearance			dressed approp		dressed approp
Behavior			cooperative		cooperative
Speech			normal rate normal volume		normal rate normal volume
Mood			euthymic		unable to assess
Interact w/staff Invested in tx			positive no	positive	 no
Interact w/peers			appropBoundaries		
Motor			unsteady gait		unsteady gait
Affect			congruent w/mood		
Hallucinations			none		none
Thought process			disorganized		
Thought content			appropriate		
Delusions			none		
LevelOfConscious			somnolent		
Orientation			to person		
Impairment			to time to place		
Concentration			attend to task		
Pay attention			unable		
Problem list	20:50	21:55	22:54	01:29	03:38
Dementia Disorientation Confusion			present present present		present present present
Intetventions	20:50	21:55	22:54	01:29	03:38
Support via 1:1			done	done	done
MaintainRiskPrec				falls violence elopement	
CARE PROVIDERS	RGER		RGER	H	TAB6

BLACK, TAMMY(TAB6)RN GAINES, RANDI(RGER)RN HUDSON, JESSE(H)TA

IOP Nursing Form	04/12			04/13	
Interventions-Cont.	20:50	21:55	22:54	01:29	03:38
Safety plan Monitor response			done done		
Environ interv					decrease stimuli
PatientResponses	20:50	21:55	22:54	01:29	03:38
Followed direct			done		
Interaction			minimal		
Med adherence			voluntary		
Oth responses			able2concentrate		sleeping
Illness/disease			unableToVerbaliz		
Structure/milieu			no response		
AdhereSafetyPlan			done		
No self-harm			none	none	
Shift Sign	20:50	21:55	22:54	01:29	03:38
For shift, RN			reviewed doo managed care		reviewed doo managed care
CARE PROVIDERS			RGER	H	TAB6

BLACK, TAMMY(TAB6)RN GAINES, RANDI(RGER)RN HUDSON, JESSE(H)TA

IOP Nursing Form	04/13				
Chart Review	05:50	09:44	10:49	13:10	19:35
Chart check			done		done
ADL	05:56	09:44	10:49	13:10	19:35
Ambulate			independent		
Turn, position			independent		independent
Toileting			independent		independent
Sleep	05:56	09:44	10:49	13:10	19:35
No. hrs of sleep	6.50				
Diet	05:56	09:44	10:49	13:10	19:35
Breakfast amt		0% &			
Lunch amt				30%	

04/13/14 09:44 Breakfast amt(LB33): pt. stated she was hungry then did not want to eat even after staff offered her food and attempted to feed pt.

Neuro/EENT	05:56	09:44	10:49	13:10	19:35
Follows commands NoSensoryDeficit					WNL WNL
NormHear&/orAid Abs of drainage			WNL WNL		WNL WNL
Norm closure Abs of swelling No visual impair			WNL WNL		WNL WNL WNL
Patent nares No bleed/disch			WNL WNL		WNL WNL
Lvl of conscious Behavior/neuro			disoriented calm		disoriented calm
Disoriented			situation to place to time		situation to place to time
Respiratory	05:56	09:44	10:49	13:10	19:35
Respiratory			no distress		no distress
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt			WNL WNL WNL WNL WNL		
Cardiovascular	05:56	09:44	10:49	13:10	19:35
Angina/chestPain			none		none
Gastrointestinal	05:56	09:44	10:49	13:10	19:35
Continent No c/o N/V			WNL WNL		WNL WNL
Genitourinary	05:56	09:44	10:49	13:10	19:35
Continent			WNL		WNL
CARE PROVIDERS	H	LB33	LB33	RROB	RGER

BLIZZARD, LAUREN(LB33)RN GAINES, RANDI(RGER)RN HUDSON, JESSE(H)TA
ROBINSON, RAGINE(RROB)TA

IOP Nursing Form	04/13				
Func/Musculoskel	05:56	09:44	10:49	13:10	19:35
No act restrict			WNL for age		
No use of device			no devices		
Skin	05:56	09:44	10:49	13:10	19:35
Sens perception			4=no impairmnt		4=no impairmnt
Moisture			4=rarely moist		4=rarely moist
Activity			3=walks occasion		3=walks occasion
Mobility			4=no limitation		4=no limitation
Nutrition			1=very poor		2=prob adequate
Friction & shear			3=no app.probl		2=poten.problm
Total score			19		19
Comfort	05:56	09:44	10:49	13:10	19:35
Pain score			0 sleeping		0 Numeric Value
EdmonsonFallRisk	05:56	09:44	10:49	13:10	19:35
Age			50 to 79 (10)		
AlertOriented			no (0)		
AgitationAnxiety			no (0)		
IntrmittyConfusd			no (0)		
ConfusdDisornted			yes (13)		
Independent			no (0)		
Catheter/ostomy			no (0)		
ElimWassistance			yes (10)		
Altered Elim			yes (12) &		
IncontAmbulatory			yes (12)		
No medications			no (0)		
Cardiac meds			yes (10)		
Psych meds			yes (8)		
Inc in meds/prns			no (0)		
BipolarSchizoaff			no (0)		
Subst/alc abuse			no (0)		
MajorDepress d/o			no (0)		
DementiaDelirium			yes (12)		
IndSteadyImmobil			Yes (7)		
ProperDevice use			no (0)		
VertigoHypoWeak			no (0)		
Unsteady/Aware			yes (8)		
Unsteady/Forgets			N/A (0)		
Dec po 24 hours			appetite norm(0)		
SleepDisturbance			NoDisturbance(8)		
History of falls			No history (8)		
Total score			118		
04/13/14 10:49 Altered Elim(LB33): Incontinence					
RiskPrecautions	05:56	09:44	10:49	13:10	19:35
Fall past 24 hr			no		
C/o dizziness			no		
Unsteady gait			yes		
New med/dose chg			no		
CARE PROVIDERS			LB33		RGER

BLIZZARD, LAUREN(LB33)RN GAINES, RANDI(RGER)RN

[redacted]
REQUESTED:04/13/14 05:40
OPT OUT:

IOP Nursing Form	04/13				
RiskPrecautions-Cont	05:56	09:44	10:49	13:10	19:35
Any yes, complet			fall assess		
Any of above			no		
Precautions			violence falls elopement		
Act/Observ Level	05:56	09:44	10:49	13:10	19:35
Activity Level			unit restriction		
ObservationLevel			Q15mins check		
Misc Events	05:56	09:44	10:49	13:10	19:35
Misc events			&		&
04/13/14 10:49 Misc events(LB33): Pt. calm, cooperative, more alert this am though disoriented, will continue to monitor.					
04/13/14 19:35 Misc events(RGER): Pt has been sitting quietly in day area sleeping or watching TV					
Obs pt behavior	05:56	09:44	10:49	13:10	19:35
Appearance			dressed approp		
Behavior			cooperative		
Speech			normal rate normal volume		
Mood			unable to assess		
Interact w/staff Invested in tx			positive no		
Interact w/peers			appropBoundaries		
Motor			unsteady gait		
Affect			congruent w/mood		
Hallucinations			none		
Thought process			disorganized		
Thought content			appropriate		
Delusions			none		
LevelOfConscious			somnolent		
Orientation			to person		
Impairment			to time to place to situation		
Concentration			attend to task		
Pay attention			unable		
Problem list	05:56	09:44	10:49	13:10	19:35
Dementia Disorientation Confusion			present present present		
Interventions	05:56	09:44	10:49	13:10	19:35
Support via 1:1			done		
MaintainRiskPrec			falls violence elopement		
CARE PROVIDERS			LB33		RGER

BLIZZARD, LAUREN(LB33)RN GAINES, RANDI(RGER)RN

IOP Nursing Form	04/13				
Interventions-Cont.	05:56	09:44	10:49	13:10	19:35
Safety plan Monitor response			done done		
Environ interv			decrease stimuli		
PatientResponses	05:56	09:44	10:49	13:10	19:35
Followed direct			done		
Interaction			minimal		
Med adherence			voluntary		
Oth responses			sleeping		
Illness/disease			unableToVerbaliz		
AdhereSafetyPlan			done		
No self-harm			none		
Shift Sign	05:56	09:44	10:49	13:10	19:35
For shift, RN			reviewed doc managed care		reviewed doc managed care
CARE PROVIDERS			LB33		RGER

BLIZZARD, LAUREN(LB33)RN GAINES, RANDI(RGER)RN

IOP Nursing Form	04/14				
Chart Review	02:12	04:56	06:11	12:50	13:13
Chart check			done		
ADL	02:12	04:56	06:11	12:50	13:13
Bath/shower				assist	
Mouth care				assist	
Room neatness				dependent	
Ambulate	independent			assist	
Turn, position	independent			independent	
Toileting	independent			independent	
Sleep	02:12	04:56	06:11	12:50	13:13
No. hrs of sleep		8.00			
Diet	02:12	04:56	06:11	12:50	13:13
Breakfast amt				0%	
Neuro/EENT	02:12	04:56	06:11	12:50	13:13
Alert,orientedx3 Follows commands NoSensoryDeficit				& WNL WNL	
NormHear&/orAid Abs of drainage				WNL WNL	
Norm closure Abs of swelling No visual impair				WNL WNL WNL	
Patent nares No bleed/disch				WNL WNL	
Lvl of conscious Behavior/neuro				disoriented calm	
Disoriented				to person	
04/14/14 12:50 Alert,orientedx3(CB22): pt verbalized her name and states she in the hospital					
Respiratory	02:12	04:56	06:11	12:50	13:13
Respiratory	no distress			no distress	
Cardiovascular	02:12	04:56	06:11	12:50	13:13
Angina/chestPain				none	
GastroIntestinal	02:12	04:56	06:11	12:50	13:13
Continent No c/o N/V				& WNL	
04/14/14 12:50 Continent(CB22): incontinent					
Genitourinary	02:12	04:56	06:11	12:50	13:13
Continent Adequate UOP				WNL WNL	
Func/Musculoskel	02:12	04:56	06:11	12:50	13:13
No act restrict				WNL for age	
No use of device				no devices	
CARE PROVIDERS	H	H	CEL	CB22	

BALTIMORE, CARMEN(CB22)RN HUDSON, JESSE(H)TA LAWTON, CLAUDIA(CEL)RN

IOP Nursing Form	04/14				
Skin	02:12	04:50	06:11	12:50	13:13
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score				3=slight limited 3=occasnly moist 3=walks occasion 4=no limitation 2=prob adequate 3=no app.probl 18	
Skin				WNL denies impairmnt	
Comfort	02:12	04:56	06:11	12:50	13:13
Pain score				0 Numeric Value	
EdmonsonFallRisk	02:12	04:56	06:11	12:50	13:13
Age				50 to 79 (*0)	
AlertOriented AgitationAnxiety IntrmittyConfusd ConfusdDisornted				no (0) no (0) no (0) yes (13)	
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory				no (0) no (0) yes (10) no (0) no (0)	
No medications Cardiac meds Psych meds Inc in meds/prns				yes (10) no (0) yes (8) no (0)	
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium				no (0) no (0) yes (10) yes (12)	
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets				Yes (7) no (0) no (0) yes (8) Yes (15)	
Dec po 24 hours				appetite norm(0)	
SleepDisturbance				NoDisturbance(8)	
History of falls				No history (8)	
Total score				119	
RiskPrecautions	02:12	04:56	06:11	12:50	13:13
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet	no no yes no fall assess			no no yes no fall assess	
Any of above				yes	
CARE PROVIDERS	CEL			CB22	

BALTIMORE, CARMEN(CB22)RN LAWTON, CLAUDIA(CEL)RN

IOP Nursing Form	04/14				
RiskPrecautions-Cont.	02:12	04:56	06:11	12:50	13:13
Precautions	violence falls elopement			violence falls elopement	
Act/Observ Level	02:12	04:56	06:11	12:50	13:13
Activity Level	unit restriction			unit restriction	
ObservationLevel	Q15mins check			Q15mins check	
Vascular Access	02:12	04:56	06:11	12:50	13:13
Interventions					
Obs pt behavior	02:12	04:56	06:11	12:50	13:13
Appearance				dressed approp	
Behavior				cooperative	&
Speech				slow soft (modified) &	
Mood				anhedonic dysphoric	
Interact w/staff Invested in tx	positive			positive yes	
Interact w/peers				positive appropBoundaries	
Motor				unusual gait unsteady gait	
Affect				flat	
Hallucinations				none	
Thought process				blocking	
Thought content				appropriate	
Delusions					none
LevelOfConscious					somnolent
Orientation					to person to place
Concentration					attend to task
Pay attention					able

04/14/14 12:50 Speech(CB22): answered to simple questions today

04/14/14 13:13 Behavior(CB22): pt smiled, cooperative and answered simple question after taking a shower.pt was in the bed all morning and refused BK until dierect pt oob. denies SI and hallucination.

Problem list	02:12	04:56	06:11	12:50	13:13
Dementia Disorientation Confusion					present present present
CARE PROVIDERS	H			CB22	CB22

BALTIMORE, CARMEN(CB22)RN HUDSON, JESSE(H)TA

IOP Nursing Form	04/14				
Interventions	02:12	04:50	06:11	12:50	13:13
Support via 1:1	done				done
MaintainRiskPrec	falls violence elopement				suicide falls elopement
Safety plan OthInterventions					done provide limits provideStructure
Provided					positiveReinforc reassurance
Environ interv					decrease stimuli
Provided ed					coping skills
PatientResponses	02:12	04:50	06:11	12:50	13:13
Class/activities					no: applicable
Recovery/goal wk					no: applicable
Followed direct					done
Interaction					withdrawn
Med adherence					voluntary
Oth responses					sleeping ab e2oonoentrate
Structure/milieu					positiv response
Self-monitorTech					in use
AdhereSafetyPlan					done
No self-harm	none				none
MorningCommMtg					dic not attend
Shift Sign	02:12	04:56	06:11	12:50	13:13
For shift, RN	reviewed doc managed care				reviewed doc managed care
CARE PROVIDERS	CEL H				CB22

BALTIMORE, CARMEN(CB22)RN HUDSON, JESSE(H)TA LAWTON, CLAUDIA(CEL)RN

IOP Nursing Form	04/14				
Chart Review	13:27	13:42	22:12	22:35	22:48
Chart check			done		
ADL	13:27	13:42	22:12	22:35	22:48
Ambulate			independent		
Turn, position			independent		
Toileting			independent		
Sleep	13:27	13:42	22:12	22:35	22:48
No. hrs of sleep					4.5
Diet	13:27	13:42	22:12	22:35	22:48
Breakfast amt		15%			
Lunch amt		15%			
Dinner amt				10%	
Neuro/EENT	13:27	13:42	22:12	22:35	22:48
Follows commands NoSensoryDeficit			WNL WNL		
NormHear&/orAid Abs of drainage			WNL WNL		
Norm closure Abs of swelling No visual impair			WNL WNL WNL		
Patent nares No bleed/disch			WNL WNL		
Lvl of conscious Behavior/neuro			disoriented calm		
Disoriented			situation to place to time		
Respiratory	13:27	13:42	22:12	22:35	22:48
Respiratory			no distress		
Cardiovascular	13:27	13:42	22:12	22:35	22:48
Angina/chestPain			none		
Gastrointestinal	13:27	13:42	22:12	22:35	22:48
Continent No c/o N/V			WNL & WNL		
04/14/14 22:12 Continent(YS60): episodes of incontenince sporadically					
Genitourinary	13:27	13:42	22:12	22:35	22:48
Continent Adequate UOP			WNL WNL		
Func/Musculoskel	13:27	13:42	22:12	22:35	22:48
No act restrict			WNL for age		
No use of device			no devices		
CARE PROVIDERS		NS77	YS60	SEN9	SEN9

NICKS, SEQUOYA(SEN9)TA SMITH, NYASHIA(NS77)TA YATES, SARAH(YS60)RN

IOP Nursing Form	04/14				
Skin	13:27	13:42	22:12	22:35	22:48
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score			3=slight limited 3=occasnly moist 3=walks occasion 4=no limitation 2=prob adequate 3=no app.probl 18		
Skin			WNL denies impairmnt		
Comfort	13:27	13:42	22:12	22:35	22:48
Pain score			0 Numeric Value		
RiskPrecautions	13:27	13:42	22:12	22:35	22:48
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet			no no yes no fall assess		
Any of above			yes		
Precautions			violence falls elopement		
Act/Observ Level	13:27	13:42	22:12	22:35	22:48
Activity Level			unit restriction		
ObservationLevel			Q15mins check		
Vascular Access	13:27	13:42	22:12	22:35	22:48
Interventions	dc'ed/RN &				
04/14/14 13:27 Interventions(PB33): INT was uncovered and contaminated.					
Obs pt behavior	13:27	13:42	22:12	22:35	22:48
Appearance			dressed approp		
Behavior			cooperative		
Speech			normal rate soft		
Mood			unable to assess		
Interact w/staff Invested in tx			positive no		
Interact w/peers			appropBoundaries		
Motor			unsteady gait		
Affect			congruent w/mood		
Hallucinations			none		
Thought process			disorganized		
Thought content			appropriate		
Delusions			none		
LevelOfConscious			somnolent		
Orientation			to person		
CARE PROVIDERS	PB33		YS60		

BLEVINS, PHIL(PB33)RN YATES, SARAH(YS60)RN

IOP Nursing Form	04/14				
Obs pt behavior-Cont.	13:27	13:42	22:12	22:35	22:48
Impairment			to time to place to situation		
Concentration			attend to task		
Pay attention			able		
Problem list	13:27	13:42	22:12	22:35	22:48
Dementia Disorientation Confusion			present present present		
Interventions	13:27	13:42	22:12	22:35	22:48
Support via 1:1			done		
MaintainRiskPreo			falls violence elopement		
Safety plan Monitor response			done done		
Provided			clear direction		
Environ interv			decrease stimuli		
PatientResponses	13:27	13:42	22:12	22:35	22:48
Followed direct			done		
Interaction			minimal		
Med adherence			voluntary		
Oth responses			sleeping		
Illness/disease			unableToVerbaliz		
AdhereSafetyPlan			done		
No self-harm			none		
Shift Sign	13:27	13:42	22:12	22:35	22:48
For shift, RN			reviewed doc managed care		
CARE PROVIDERS			YS60		

YATES, SARAH(YS60)RN

IOP Nursing Form	04/15				
Chart Review	00:05	04:40	09:58	10:18	10:48
Chart check					done
ADL	00:05	04:40	09:58	10:18	10:48
Ambulate	independent				
Turn, position	independent				
Toileting	independent				
Sleep	00:05	04:40	09:58	10:18	10:48
No. hrs of sleep		8.00			
Diet	00:05	04:40	09:58	10:18	10:48
Breakfast amt			15%		
Lunch amt					
Neuro/EENT	00:05	04:40	09:58	10:18	10:48
Follows commands NoSensoryDeficit				WNL WNL	
NormHear&/orAid Abs of drainage				WNL WNL	
Norm closure Abs of swelling No visual impair				WNL WNL WNL	
Patent nares Lvl of conscious Behavior/neuro				WNL disoriented lethargic calm	
Disoriented				situation to person to place to time	
Respiratory	00:05	04:40	09:58	10:18	10:48
Respiratory	no distress			no distress	
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt				WNL WNL WNL WNL WNL	
Cough				none	
Cardiovascular	00:05	04:40	09:58	10:18	10:48
Angina/chestPain				none	
Gastrointestinal	00:05	04:40	09:58	10:18	10:48
Continent No c/o N/V				WNL WNL	
Genitourinary	00:05	04:40	09:58	10:18	10:48
Continent				WNL	
CARE PROVIDERS	H	H	LF44	LQ11	LQ11

FIELDS; LIZZIE(LF44)TA HUDSON, JESSE(H)TA QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/15				
Func/Musculoskel	00:05	04:40	09:58	10:18	10:48
No use of device				no devices	
Weakness				generalized	
Skin	00:05	04:40	09:58	10:18	10:48
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score				3=slight limited 3=occasnly moist 3=walks occasion 3=slight limited 2=prob adequate & 3=no app.probl 17	
04/15/14 10:18 Nutrition(LQ11): needs to be prompted and/or fed					
Comfort	00:05	04:40	09:58	10:18	10:48
Pain score				0 sleeping	
EdmonsonFallRisk	00:05	04:40	09:58	10:18	10:48
Age				50 to 79 (-0)	
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted				no (0) no (0) no (0) yes (13)	
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory				no (0) no (0) yes (10) no (0) no (0)	
No medications Cardiac meds Psych meds Inc in meds/prns				yes (10) yes (10) & yes (8) no (0)	
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium				no (0) no (0) no (0) yes (12)	
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets				Yes (7) no (0) no (0) N/A (0) Yes (15)	
Dec po 24 hours				appetite norm(0)	
SleepDisturbance				NoDisturbance(8)	
History of falls				No history (8)	
Total score				111	
04/15/14 10:18 Cardiac meds(LQ11): Simvastatin					
CARE PROVIDERS				LQ11	

QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/15				
RiskPrecautions	00:05	04:40	09:58	10:18	10:48
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet				no no yes no fall assess	
Any of above				no	
Precautions	violence falls elopement			violence falls elopement	
Act/Observ Level	00:05	04:40	09:58	10:18	10:48
Activity Level	unit restriction			unit restriction	
ObservationLevel	Q15mins check			Q15mins check	
Misc Events	00:05	04:40	09:58	10:18	10:48
Misc events				&	
04/15/14 10:18 Misc events(LQ11): Pt disoriented and lethargic.					
Obs pt behavior	00:05	04:40	09:58	10:18	10:48
Appearance				unkempt dressed approp	
Behavior				cooperative	
Speech				normal rate soft	
Mood				unable to assess	
Interact w/staff Invested in tx	positive			positive no	
Interact w/peers				appropBoundaries	
Motor				unsteady gait	
Affect				congruent w/mood	
Hallucinations				none	
Thought process				disorganized	
Thought content				appropriate	
Delusions				none	
LevelOfConscious				somnolent	
Orientation				to person	
Impairment				to time to place to situation	
Concentration				attend to task	
Pay attention				able	
Problem list	00:05	04:40	09:58	10:18	10:48
Dementia Disorientation Confusion				present present present	
CARE PROVIDERS	H			LQ11	

HUDSON, JESSE(H)TA QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/15				
Interventions	00:05	04:40	09:58	10:18	10:48
Support via 1:1	done			done	
MaintainRiskPrec	falls violence elopement			falls violence elopement	
Safety plan OthInterventions				done provide limits provideStruoture	
Provided				reality orient positiveReinforc redirection clear direction	
Environ interv				decrease stimuli	
PatientResponses	00:05	04:40	09:58	10:18	10:48
Followed direct				done	
Interaction				minimal	
Med adherence				voluntary	
Oth responses				sleeping	
Interacted w/				peer group	
Illness/disease				unableToVerbaliz	
Structure/milieu				no response	
AdhereSafetyPlan				done	
No self-harm	none			none	
Shift Sign	00:05	04:40	09:58	10:18	10:48
For shift, RN				reviewed doc managed care	
CARE PROVIDERS	H			LQ11	

HUDSON, JESSE(H)TA QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/15				04/16
ADL	14:33	19:04	21:02	21:58	00:34
Ambulate			independent		
Turn, position			independent		
Toileting			independent		
Sleep	14:33	19:04	21:02	21:58	00:34
No. hrs of sleep				1	
Diet	14:33	19:04	21:02	21:58	00:34
Lunch amt	15%				
Dinner amt		10%			
Neuro/EENT	14:33	19:04	21:02	21:58	00:34
Alert,orientedx3 Follows commands NoSensoryDeficit					WNL WNL WNL
NormHear&/orAid Abs of drainage					WNL WNL
Norm closure Abs of swelling No visual impair					WNL WNL WNL
Patent nares No bleed/disch					WNL WNL
Behavior/neuro					calm
Disoriented					situation to place to time
Respiratory	14:33	19:04	21:02	21:58	00:34
Respiratory					no distress
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt					WNL WNL WNL WNL WNL
Cough					none
Cardiovascular	14:33	19:04	21:02	21:58	00:34
Angina/chestPain					none
Gastrointestinal	14:33	19:04	21:02	21:58	00:34
Continent No c/o N/V					WNL WNL
Genitourinary	14:33	19:04	21:02	21:58	00:34
Continent Adequate UOP					WNL WNL
Func/Musculoskel	14:33	19:04	21:02	21:58	00:34
No act restrict					WNL for age
No use of device					no devices
Weakness					generalized
CARE PROVIDERS	LF44	APR	APR	LSD4	CEL

FIELDS, LIZZIE(LF44)TA
SANSCRAITE, LAUREN(LSD4)TA
LAWTON, CLAUDIA(CEL)RN
RIESMEYER, ALEXANDER P(APR)TA

IOP Nursing Form	04/15				04/16
Skin	14:33	19:04	21:02	21:58	00:34
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score					3=slight limited 3=occasnly moist 3=walks occasion 3=slight limited 2=prob adequate 2=poten.problm 16
Skin					WNL
Comfort	14:33	19:04	21:02	21:58	00:34
Pain score					0 sleeping
RiskPrecautions	14:33	19:04	21:02	21:58	00:34
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet					no no yes no fall assess
Any of above					no
Precautions			falls		falls
Act/Observ Level	14:33	19:04	21:02	21:58	00:34
Activity Level			unit restriction		unit restriction
ObservationLevel			Q15mins check		Q15mins check
Misc Events	14:33	19:04	21:02	21:58	00:34
Misc events			&		&
04/15/14 21:02 Misc events(APR): Pt. disoriented but redirectable, wandering into other pt's rooms. Had visit with family.					
04/16/14 00:34 Misc events(CEL): pt asleep, arousable to name confused pleasant and cooperative, continue to monitor closely					
Obs pt behavior	14:33	19:04	21:02	21:58	00:34
Appearance			unkempt dressed approp		dressed approp
Behavior			cooperative		cooperative
Speech			normal rate soft		normal volume
Mood			unable to assess		empty
Interact w/staff Invested in tx			positive no		positive no
Interact w/peers			appropBoundaries		appropBoundaries
InteractW/family			visit		
Motor			unsteady gait		
Affect			flat		
Hallucinations			none		
Thought process			disorganized		
Thought content			appropriate		
Delusions			none		
CARE PROVIDERS			APR		CEL

LAWTON, CLAUDIA(CEL)RN RIESMEYER, ALEXANDER P(APR)TA

IOP Nursing Form	04/15				04/16
Obs pt behavior Cont.	14:33	19:04	21:02	21:58	00:34
LevelOfConscious			awake somnolent		somnolent
Orientation			to person		to person
Impairment			to time to place to situation		to time to place to situation
Concentration			distractible		distractible
Pay attention			able		able
Problem list	14:33	19:04	21:02	21:58	00:34
Dementia Disorientation Confusion			present present present		present present present
Interventions	14:33	19:04	21:02	21:58	00:34
Support via 1:1			done		done
MaintainRiskPrec			falls		falls
Safety plan OthInterventions			done provide limits provideStructure		done provide limits provideStructure
Monitor response					done
Provided			redirection clear direction		distraction
Environ interv			decrease stimuli		decrease stimuli
PatientResponses	14:33	19:04	21:02	21:58	00:34
Class/activities			not applicable		
Recovery/goal wk			not applicable		
Followed direct			done		done
Interaction			minimal		minimal
Med adherence			voluntary		voluntary
Oth responses			unabl2concentrat		sleeping
Illness/disease			unableToVerbaliz		verbal understan
Structure/milieu			no response		positiv response
Self-monitorTech					in use
AdhereSafetyPlan			done		done
No self-harm			none		none
Shift Sign	14:33	19:04	21:02	21:58	00:34
For shift, RN					managed care
CARE PROVIDERS			APR		CEL

LAWTON, CLAUDIA(CEL)RN RIESMEYER, ALEXANDER P(APR)TA

[redacted]

OPT OUT:

IOP Nursing Form	04/16				
Chart Review	05:16	06:00	10:24	13:12	13:31
Chart check		done			
ADL	05:16	06:00	10:24	13:12	13:31
Mouth care				assist	
Room neatness				dependent	
Ambulate				assist independent	
Turn, position				independent	
Toileting				prompt	
Sleep	05:16	06:00	10:24	13:12	13:31
No. hrs of sleep	8.00				
Diet	05:16	06:00	10:24	13:12	13:31
Breakfast amt			50%		
Lunch amt					40%
Neuro/EENT	05:16	06:00	10:24	13:12	13:31
Follows commands NoSensoryDeficit					
NormHear&/orAid Abs of drainage					
Norm closure Abs of swelling No visual impair					
Patent nares No bleed/disch					
Behavior/neuro					
Disoriented					
Respiratory	05:16	06:00	10:24	13:12	13:31
Respiratory					
Cardiovascular	05:16	06:00	10:24	13:12	13:31
Angina/chestPain					
Gastrointestinal	05:16	06:00	10:24	13:12	13:31
Continent No c/o N/V					
Genitourinary	05:16	06:00	10:24	13:12	13:31
Continent Adequate UOP					
Func/Musculoskel	05:16	06:00	10:24	13:12	13:31
No act restrict					
No use of device					
Weakness					
Skin	05:16	06:00	10:24	13:12	13:31
Sens perception Moisture Activity Mobility					
CARE PROVIDERS	H	CEL	MMM	MMM	MMM

HUDSON, JESSE(H)TA LAWTON, CLAUDIA(CEL)RN MADDOX, MORGAN M(MMM)TA

CONTINUED

IOP Nursing Form	04/18				
Skin Cont.	05:16	06:00	10:24	13:12	13:31
Nutrition Friction & shear Total score					
Skin					
Comfort	05:16	06:00	10:24	13:12	13:31
Pain score					
EdmonsonFallRisk	05:16	06:00	10:24	13:12	13:31
Age					
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted					
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory					
No medications Cardiac meds Psych meds Inc in meds/prns					
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium					
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets					
Dec po 24 hours					
SleepDisturbance					
History of falls					
Total score					
RiskPrecautions	05:16	06:00	10:24	13:12	13:31
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet				no no yes fall assess	
Any of above				no	
Precautions				falls	
Act/Observ Level	05:16	06:00	10:24	13:12	13:31
Activity Level				unit restriction	
ObservationLevel				Q15mins check	
CARE PROVIDERS				MVM	

MADDOX, MORGAN M(MMV)TA

IOP Nursing Form	04/16				
Misc Events	05:16	06:00	10:24	13:12	13:31
Misc events				&	
04/16/14 13:12 Misc events(MMM): Patient has been present in the milieu mostly. Cooerative with staff and following direction. Enjoyed a visit with her daughter.					
Obs pt behavior	05:16	06:00	10:24	13:12	13:31
Appearance				dressed approp	
Behavior				cooperative good eye contact	
Speech				normal rate normal volume	
Mood				euthymic	
Interact w/staff Invested in tx				positive no	
Interact w/peers				appropBoundaries	
InteractW/family				visit	
Motor				unsteady gait	
Affect				congruent w/mood	
Hallucinations				none	
Thought process				disorganized	
Thought content				appropriate	
Delusions				none	
LevelOfConscious				somnolent	
Orientation				to person	
Impairment				to time to place to situation	
Concentration				distractible	
Pay attention				unable able	
Problem list	05:16	06:00	10:24	13:12	13:31
Dementia Disorientation Confusion				present present present	
Interventions	05:16	06:00	10:24	13:12	13:31
Support via 1:1				done	
MaintainRiskPrec				falls	
Safety plan OthInterventions				done provide limits provideStructure	
Monitor response				done	
Provided CARE PROVIDERS				reality orient positiveReinforc distraction redirection supp fam contact reassurance MMM	

MADDOX, MORGAN M(MMM)TA

IOP Nursing Form	04/16				
Interventions-Cont.	**05:10**	**06:00**	**10:24**	**13:12**	**13:31**
				clear direction	
Environ interv				decrease stimuli	
Provided ed				leisure skills	
Leisure skills				&	
04/16/14 13:12 Leisure skills(MMM): encouraged recreation therapy					
PatientResponses	**05:16**	**06:00**	**10:24**	**13:12**	**13:31**
Followed direct				done	
Interaction				minimal	
Med adherence					
Oth responses				sleeping	
Interacted w/				peer group	
Illness/disease				unableToVerbaliz	
Structure/milieu				positiv response	
Self-monitorTech					
AdhereSafetyPlan				done	
No self-harm				none	
Shift Sign	**05:16**	**06:00**	**10:24**	**13:12**	**13:31**
For shift, RN					
CARE PROVIDERS				MMM	

MADDOX, MORGAN M(MMM)TA

IOP Nursing Form	04/16			04/17	
Chart Review	15:52	18:08	22:16	05:06	05:45
Chart check	done			done	
ADL	15:52	18:08	22:16	05:06	05:45
Ambulate	independent				
Turn, position	independent				
Toileting	independent				
Sleep	15:52	18:08	22:16	05:06	05:45
No. hrs of sleep			1.25		8
Diet	15:52	18:08	22:16	05:06	05:45
Breakfast amt					
Dinner amt		25%			
Neuro/EENT	15:52	18:08	22:16	05:06	05:45
Follows commands NoSensoryDeficit	WNL WNL				
NormHear&/orAid Abs of drainage	WNL WNL				
Norm closure Abs of swelling No visual impair	WNL WNL WNL				
Patent nares No bleed/disch	WNL WNL				
Behavior/neuro	calm				
Disoriented	situation to place to time				
Respiratory	15:52	18:08	22:16	05:06	05:45
Respiratory	no distress			no distress	
Cardiovascular	15:52	18:08	22:16	05:06	05:45
Angina/chestPain	none			none	
Gastrointestinal	15:52	18:08	22:16	05:06	05:45
Continent No c/o N/V	WNL WNL			WNL WNL	
Genitourinary	15:52	18:08	22:16	05:06	05:45
Continent Adequate UOP	WNL WNL			WNL	
Func/Musculoskel	15:52	18:08	22:16	05:06	05:45
No act restrict	WNL for age				
No use of device	no devices				
Weakness	generalized			generalized	
Skin	15:52	18:08	22:16	05:06	05:45
Sens perception Moisture Activity Mobility	3=slight limited 3=occasnly moist 3=walks occasion 3=slight limited			3=slight limited 3=occasnly moist 3=walks occasion 3=slight limited	
CARE PROVIDERS	YS60	MMM	LSD4	KDJ	LSD4

JENKINS, KIMBERLY D(KDJ)RN
YATES, SARAH(YS60)RN
MADDOX, MORGAN M(MMM)TA
SANSCRAITE, LAUREN(LSD4)TA

IOP Nursing Form	04/16			04/17	
Skin-Cont.	15:52	18:08	22:16	05:00	05:45
Nutrition Friction & shear Total score	2=prob adequate 2=poten.prob m 16			2=prob adequate 2=poten.problm 16	
Skin	WNL			WNL	
Comfort	15:52	18:08	22:16	05:06	05:45
Pain score	0 sleeping			0 sleeping	
EdmonsonFallRisk	15:52	18:08	22:16	05:06	05:45
Age	50 to 79 (10)				
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted	no (0) no (0) no (0) yes (13)				
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory	no (0) no (0) yes (10) no (0) no (0)				
No medications Cardiac meds Psych meds Inc in meds/prns	yes (10) yes (10) & yes (8) no (0)				
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium	no (0) no (0) no (0) yes (12)				
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets	Yes (7) no (0) no (0) N/A (0) Yes (15)				
Dec po 24 hours	appetite norm(0)				
SleepDisturbance	NoDisturbance(8)				
History of falls	No history (8)				
Total score	111				

04/16/14 15:52 Cardiac meds(YS60): simvastatin

RiskPrecautions	15:52	18:08	22:16	05:06	05:45
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet	no no yes no fall assess			no no yes no fall assess	
Any of above	no			no	
Precautions	falls			falls	
CARE PROVIDERS	YS60			KDJ	

JENKINS, KIMBERLY D(KDJ)RN YATES, SARAH(YS60)RN

IOP Nursing Form	04/16			04/17	
Act/Observ Level	15:52	18:08	22:16	05:00	05:45
Activity Level	unit restriction			unit restriction	
ObservationLevel	Q15mins check			Q15mins check	
Misc Events	15:52	18:08	22:16	05:06	05:45
Misc events	&			&	
04/16/14 15:52 Misc events(YS60): Pt is resting in her room. I gave her 120 ml of juice, still continuing to push po fluids.					
04/17/14 05:06 Misc events(KDJ): pt has been asleep throughout the night. no behavioral concerns. safety maintained.					
Obs pt behavior	15:52	18:08	22:16	05:06	05:45
Appearance	dressed approp				
Behavior	cooperative				
Speech	normal rate soft				
Mood	unable to assess			unable to assess	
Interact w/staff Invested in tx	positive no				
Interact w/peers	appropBoundaries				
Motor	unsteady gait			unsteady gait	
Affect	congruent w/mood				
Hallucinations	none				
Thought process	disorganized			unable to assess	
Thought content	appropriate				
Delusions	none				
LevelOfConscious	somnolent			somnolent	
Orientation	to person				
Impairment	to time to place to situation				
Concentration	distractible				
Pay attention	able				
Problem list	15:52	18:08	22:16	05:06	05:45
Dementia Disorientation Confusion	present present present				
Interventions	15:52	18:08	22:16	05:06	05:45
Support via 1:1	done				
MaintainRiskPreo	falls			falls	
Safety plan OthInterventions	done provide limits provideStructure				
Monitor response	done			done	
Provided	distraction				
Environ interv	decrease stimuli			decrease stimuli	
CARE PROVIDERS	YS60			KDJ	

JENKINS, KIMBERLY D(KDJ)RN YATES, SARAH(YS60)RN

[redacted]

REQUESTED:04/19/14 05:40
OPT OUT:
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IOP Nursing Form	04/16			04/17	
PatientResponses	15:52	18:08	22:16	05:06	05:45
Followed direct	done				
Interaction	minimal				
Med adherence	voluntary				
Oth responses	sleeping			sleeping	
Illness/disease	verbal understan				
Structure/milieu	positiv response				
Self-monitorTech	in use				
AdhereSafetyPlan	done			done	
No self-harm	none			none	
Shift Sign	15:52	18:08	22:16	05:06	05:45
For shift, RN	reviewed doc managed care			reviewed doc managed care	
CARE PROVIDERS	YS60			KDJ	

JENKINS, KIMBERLY D(KDJ)RN YATES, SARAH(YS60)RN

IOP Nursing Form	04/17				
Chart Review	09:28	13:32	18:51	21:30	22:50
Chart check				done	
ADL	09:28	13:32	18:51	21:30	22:50
Ambulate			independent	independent	
Turn, position			independent	independent	
Toileting			independent	independent	
Sleep	09:28	13:32	18:51	21:30	22:50
No. hrs of sleep					2
Diet	09:28	13:32	18:51	21:30	22:50
Breakfast amt	100%				
Lunch amt		70%			
Dinner amt			50%		
Neuro/EENT	09:28	13:32	18:51	21:30	22:50
Follows commands NoSensoryDeficit				WNL WNL	
NormHear&/orAid Abs of drainage				WNL WNL	
Norm closure Abs of swelling No visual impair				WNL WNL WNL	
Patent nares No bleed/disch				WNL WNL	
Behavior/neuro				calm	
Disoriented				situation to place to time	
Respiratory	09:28	13:32	18:51	21:30	22:50
Respiratory				no distress	
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt				WNL WNL WNL WNL WNL	
Cough				none	
Cardiovascular	09:28	13:32	18:51	21:30	22:50
Angina/chestPain				none	
Gastrointestinal	09:28	13:32	18:51	21:30	22:50
Continent No c/o N/V				WNL WNL	
Genitourinary	09:28	13:32	18:51	21:30	22:50
Continent Adequate UOP				WNL WNL	
CARE PROVIDERS	NS77	NS77	SEN9	YS60	SEN9

NICKS, SEQUOYA(SEN9)TA SMITH, NYASHIA(NS77)TA YATES, SARAH(YS60)RN

IOP Nursing Form	04/17				
Func/Musculoskel	09:28	13:32	18:51	21:30	22:50
No act restrict				WNL for age	
No use of device				no devices	
Weakness				generalized	
Skin	09:28	13:32	18:51	21:30	22:50
Sens perception Moisture Activity Mobility Nutrition Friction & shear Total score				3=slight limited 3=occasnly moist 3=walks occasion 3=slight limited 2=prob adequate 2=poten.problm 16	
Skin				WNL denies impairmnt	
Comfort	09:28	13:32	18:51	21:30	22:50
Pain score				0 sleeping	
EdmonsonFallRisk	09:28	13:32	18:51	21:30	22:50
Age				50 to 79 (*0)	
AlertOriented AgitationAnxiety IntrmitlyConfusd ConfusdDisornted				no (0) no (0) no (0) yes (13)	
Independent Catheter/ostomy ElimWassistance Altered Elim IncontAmbulatory				no (0) no (0) yes (10) no (0) no (0)	
No medications Cardiac meds Psych meds Inc in meds/prns				yes (10) yes (10) yes (8) no (0)	
BipolarSchizoaff Subst/alc abuse MajorDepress d/o DementiaDelirium				no (0) no (0) no (0) yes (12)	
IndSteadyImmobil ProperDevice use VertigoHypoWeak Unsteady/Aware Unsteady/Forgets				Yes (7) no (0) no (0) N/A (0) Yes (15)	
Dec po 24 hours				appetite norm(0)	
SleepDisturbance				NoDisturbance(8)	
History of falls				No history (8)	
Total score				111	
CARE PROVIDERS				YS60	

YATES, SARAH(YS60)RN

IOP Nursing Form	04/17				
RiskPrecautions	09:28	13:32	18:51	21:30	22:50
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet				no no yes no fall assess	
Any of above				no	
Precautions				falls	
Act/Observ Level	09:28	13:32	18:51	21:30	22:50
Activity Level			unit restriction	unit restriction	
ObservationLevel			Q15mins check	Q15mins check	
Misc Events	09:28	13:32	18:51	21:30	22:50
Misc events			&		
04/17/14 18:51 Misc events(SEN9): Pt was cooperative today. no behavioral issue. pt was very concern about her daughter.					
Obs pt behavior	09:28	13:32	18:51	21:30	22:50
Appearance			dressed approp	dressed approp	
Behavior			cooperative	cooperative	
Speech			normal rate soft	normal rate soft	
Mood			euthymic	euthymic	
Interact w/staff Invested in tx			positive	positive no	
Interact w/peers			appropBoundaries	appropBoundaries	
Motor			unsteady gait	unsteady gait	
Affect			congruent w/mood	congruent w/mood	
Hallucinations			none	none	
Thought process			disorganized	disorganized	
Thought content			preoccupation	preoccupation	
Delusions			none	none	
LevelOfConscious			awake	awake	
Orientation			to person	to person	
Impairment			to time to place to situation	to time to place to situation	
Concentration			distractible	distractible	
Pay attention			unable	unable	
Problem list	09:28	13:32	18:51	21:30	22:50
Dementia Disorientation Confusion			present present present	present present present	
CARE PROVIDERS			SEN9	YS60	

NICKS, SEQUOYA(SEN9)TA YATES, SARAH(YS60)RN

IOP Nursing Form	04/17				
Interventions	09:28	13:32	18:51	21:30	22:50
Support via 1:1			done	done	
MaintainRiskPrec			falls	falls	
Safety plan OthInterventions			done provide limits provideStructure	done provide limits provideStructure	
Monitor response			done	done	
Provided			distraction redirection reassurance clear direction	reality orient positiveReinforc reassurance clear direction	
Environ interv				decrease stimuli	
Provided ed				medication	
PatientResponses	09:28	13:32	18:51	21:30	22:50
Followed direct			done	done	
Interaction			minimal	minimal	
Med adherence				voluntary	
Oth responses				sleeping	
Interacted w/			peer group	peer group	
Structure/milieu			positiv response	positiv response	
AdhereSafetyPlan			done	done	
No self-harm			none	none	
Shift Sign	09:28	13:32	18:51	21:30	22:50
For shift, RN				reviewed doc managed care	
CARE PROVIDERS			SEN9	YS60	

NICKS, SEQUOYA(SEN9)TA YATES, SARAH(YS60)RN

IOP Nursing Form	04/18				
Chart Review	04:59	05:47	09:10	11:01	13:17
Chart check		done	done		
Sleep	04:59	05:47	09:10	11:01	13:17
No. hrs of sleep	8.00				
Diet	04:59	05:47	09:10	11:01	13:17
Breakfast amt				40%	
Lunch amt					40%
Neuro/EENT	04:59	05:47	09:10	11:01	13:17
Follows commands NoSensoryDeficit			WNL WNL		
NormHear&/orAid Abs of drainage			WNL WNL		
Norm closure Abs of swelling No visual impair			WNL WNL WNL		
Patent nares No bleed/disch			WNL WNL		
Behavior/neuro			calm		
Disoriented			situation to place to time		
Respiratory	04:59	05:47	09:10	11:01	13:17
Respiratory			no distress		
Spont respers NonLaboredEffort No cough,dyspnea Natural airway No O2 requiremnt			WNL WNL WNL WNL WNL		
Cough			none		
Cardiovascular	04:59	05:47	09:10	11:01	13:17
Angina/chestPain			none		
Gastrointestinal	04:59	05:47	09:10	11:01	13:17
Continent No c/o N/V			WNL WNL		
Genitourinary	04:59	05:47	09:10	11:01	13:17
Continent			WNL		
Func/Musculoskel	04:59	05:47	09:10	11:01	13:17
No act restrict			WNL for age		
No use of device			no devices		
Weakness			generalized		
Skin	04:59	05:47	09:10	11:01	13:17
Sens perception Moisture Activity Mobility			3=slight limited 3=occasnly moist 3=walks occasion 3=slight limited		
CARE PROVIDERS	H	KDJ	LQ11	NS77	NS77

HUDSON, JESSE(H)TA
SMITH, NYASHIA(NS77)TA
JENKINS, KIMBERLY D(KDJ)RN
QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/18				
Skin-Cont.	04:59	05:47	09:10	11:01	13:17
Nutrition Friction & shear Total score			2=prob adequate 2=poten.problm 16		
Skin			WNL		
Comfort	04:59	05:47	09:10	11:01	13:17
Pain score			0 Numeric Value		
RiskPrecautions	04:59	05:47	09:10	11:01	13:17
Fall past 24 hr C/o dizziness Unsteady gait New med/dose chg Any yes, complet			no no yes no fall assess		
Any of above			no		
Precautions			falls		
Act/Observ Level	04:59	05:47	09:10	11:01	13:17
Activity Level			unit restriction		
ObservationLevel			Q15mins check		
Misc Events	04:59	05:47	09:10	11:01	13:17
Misc events			&		
04/18/14 09:10 Misc events(LQ11): Disoriented but more alert. Calm and cooperative.					
Obs pt behavior	04:59	05:47	09:10	11:01	13:17
Appearance			dressed approp		
Behavior			cooperative		
Speech			normal rate soft		
Mood			euthymic		
Interact w/staff Invested in tx			positive no		
Interact w/peers			appropBoundaries		
Motor			unsteady gait		
Affect			congruent w/mood		
Hallucinations			none		
Thought process			disorganized		
Thought content			preoccupation		
Delusions			none		
LevelOfConscious			awake		
Orientation			to person		
Impairment			to time to place to situation		
Concentration			distractible		
Pay attention			unable		
CARE PROVIDERS			LQ11		

QUINN, LESLIE(LQ11)RN

IOP Nursing Form	04/18				
Problem list	04:59	05:47	09:10	11:01	13:17
Dementia Disorientation Confusion			present present present		
Interventions	04:59	05:47	09:10	11:01	13:17
Support via 1:1			done		
MaintainRiskPrec			falls		
Safety plan OthInterventions			done provideStructure		
Monitor response			done		
PatientResponses	04:59	05:47	09:10	11:01	13:17
Followed direct			done		
Interaction			minimal		
Med adherence			voluntary		
Oth responses			sleeping		
Interacted w/			peer group		
Illness/disease			unableToVerbaliz		
Structure/milieu			positiv response		
AdhereSafetyPlan			done		
No self-harm			none		
Shift Sign	04:59	05:47	09:10	11:01	13:17
For shift, RN			reviewed doc managed care		
CARE PROVIDERS			LQ11		

QUINN, LESLIE(LQ11)RN

[redacted]

OPT OUT:

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IOP Nursing Form	04/18
Chart Review	14:33
Chart check	done
CARE PROVIDERS	DR30

REYNOLDS, DAWN(DR30)RN

[redacted]

REQUESTED:04/18/14 05:40
OPT OUT:
Page: 1

FLOWSHEET	04/18
Discharge - IOP	10:40
ReviewRx&D/Cinst	caretaker
OpportunityQuest	caretaker
Undrstnd D/Cinst	caretaker
UnderstndRx inst	caretaker
ResourceInfoCard	caretaker
TakeMedsAsOrderd	yes
DenyHarm to self	yes
DenyHarm others	yes
Discharge at	04/18/2014 16:40
DepartdUnit with	caretaker escort by IOP
Departd mode	ambulatory
Returned to pt	personal possess valuables
Review&understnd	DC instructions F/U appointment
CARE PROVIDERS	PB33

BLEVINS, PHIL(PB33)RN

[redacted]

REQUESTED:04/18/14 08:40
OPT OUT:

FLOWSHEET	04/02		04/03		
Vital Signs	10:47	20:23	06:15	08:30	13:18
Temp in C	36.7C oral		37.1C oral		
RESPIRATIONS	16 visual		18 visual		
O2 SAT %	99% room air		96% room air		
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	 148/78 arm L 77 brachial 122/81 arm L 93 brachial		**149/73 arm L** & 97 brachial 136/75 arm L 63 brachial		
PAIN LEVEL	0 Numeric Value		0 Numeric Value		

04/03/14 06:15 BP Lying(LSD4): RN notified

I&O SUMMARY	16:47	20:23	06:15	08:30	13:18
Intake Total		240 240		480 480	240 720
NET		240 240		480 480	240 720
INTAKE	16:47	20:23	06:15	08:30	13:18
Oral		240 240		480 480	240 720
Intake Total		240 240		480 480	240 720
CARE PROVIDERS	SEN9	SEN9	LSD4	MMM	MMM

MADDOX, MORGAN M(MMM)TA NICKS, SEQUOYA(SEN9)TA SANSCRAITE, LAUREN(LSD4)TA

[redacted]

REQUESTED:04/10/14 05:40
OPT OUT:
Page: 2

FLOWSHEET	04/03	04/04			
Vital Signs	18:09	05:53	12:52	14:57	17:19
HEIGHT WEIGHT in Kg BSA BMI				157.5cm 45.5kg 1.41 18.3	
Temp in C	37.1C oral	36.8C oral			36.8C oral
RESPIRATIONS	16 visual	16 visual			16 visual
O2 SAT %	94% room air	96% room air			
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	 117/73 arm L 84 brachial 116/75 arm L 82 brachial	138/74 arm L 81 brachial 121/63 arm L 87 brachial			 153/83 arm L 73 carotid 156/66 arm L 91 brachial
PAIN LEVEL	0 Numeric Value	0 Numeric Value			0 Numeric Value
I&O SUMMARY	18:09	05:53	12:52	14:57	17:19
Intake Total	240 240		600 600		
NET	240 240		600 600		
INTAKE	18:09	05:53	12:52	14:57	17:19
Oral	240 240		600 600		
Intake Total	240 240		600 600		
CARE PROVIDERS	MMM	LSD4	MMM	KM11	SEN9

MADDEN, KATHERINE(KM11)RN
SANSCRAITE, LAUREN(LSD4)TA
MADDOX, MORGAN M(MMM)TA
NICKS, SEQUOYA(SEN9)TA

[redacted]
REQUESTED:04/13/14 05:40
OPT OUT:
Page: 3

FLOWSHEET	04/04	04/05			
Vital Signs	17:46	05:57	08:02	12:07	17:30
Temp in C		36.8C oral			
RESPIRATIONS		16 visual			
O2 SAT %		97% room air			
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing		137/79 arm R 99 brachial 126/67 arm R 86 brachial			
PAIN LEVEL		0 Numeric Value			
I&O SUMMARY	17:46	05:57	08:02	12:07	17:30
Intake Total	240 240		240 240	360 600	300 300
NET	240 240		240 240	360 600	300 300
INTAKE	17:46	05:57	08:02	12:07	17:30
Oral	240 240		240 240	360 600	300 300
Intake Total	240 240		240 240	360 600	300 300
CARE PROVIDERS	SEN9	AM69	ANB9	ANB9	BLA0

BEERS, ANGELA(ANB9)RN
KOHLER, CATHERINE(BLA0)RN
MCCRAY, AMY(AM69)TA
NICKS, SEQUOYA(SEN9)TA

FLOWSHEET	04/05		04/06		
Vital Signs	17:52	20:22	05:59	09:52	13:37
Temp in C	36.9C		36.8C oral		
RESPIRATIONS	16		16 visual		
O2 SAT %			98% room air		
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	 99/62 **101** 94/63 82		**151/83 arm L** & 88 brachial 137/80 arm L 80 brachial		
PAIN LEVEL	0 Numeric Value		0 Numeric Value		
04/06/14 05:59 BP Lying(APR): RN notified					
I&O SUMMARY	17:52	20:22	05:59	09:52	13:37
Intake Total		120 420		120 120	240 360
NET		120 420		120 120	240 360
INTAKE	17:52	20:22	05:59	09:52	13:37
Oral		120 420		120 120	240 360
Intake Total		120 420		120 120	240 360
CARE PROVIDERS	BBT6	APR	APR	CH99	CH99

BERRY, BRIAN(BBT6)TA HARRIS, CHEVALIER(CH99)TA RIESMEYER, ALEXANDER P(APR)TA

FLOWSHEET	04/06				04/07
Vital Signs	18:18	20:29	20:36	21:00	05:13
Temp in C	36.8C oral				36.7C temporal
RESPIRATIONS	18 visual				18 visual
O2 SAT %	95% room air				100% room air
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	 160/79 arm R 72 brachial 132/79 arm R 95 brachial				**179/84 arm L** & 74 brachial 170/82 arm L & 75 brachial
PAIN LEVEL	0 Numeric Value				0 Numeric Value

04/07/14 05:13 BP Lying(H: The nurse wasm made aware.

04/07/14 05:13 BP Sitting(H: The nurse was made aware.

I&O SUMMARY	18:18	20:29	20:36	21:00	05:13
Intake Total		100 100	120 220	240 460	
NET		100 100	120 220	240 460	
INTAKE	18:18	20:29	20:36	21:00	05:13
Oral		100 100	120 220	240 460	
Intake Total		100 100	120 220	240 460	
CARE PROVIDERS	RCTA	BLA0	BLA0	BLA0	H

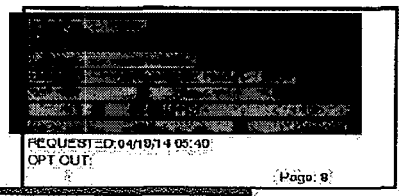
HUDSON, JESSE(H)TA KOHLER, CATHERINE(BLA0)RN ROBINSON, TANOVA C(RCTA)TA

FLOWSHEET	04/07				
Vital Signs	08:38	13:16	17:51	17:53	21:13
Temp in C				36.8C oral	
RESPIRATIONS				16 visual	
O2 SAT %				97% room air	
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing				 120/85 arm L 87 brachial 94/61 arm L 87 brachial	
PAIN LEVEL				0 Numeric Value	
I&O SUMMARY	08:38	13:16	17:51	17:53	21:13
Intake Total	560 560	240 800	240 240		120 360
NET	560 560	240 800	240 240		120 360
INTAKE	08:38	13:16	17:51	17:53	21:13
Oral	560 560	240 800	240 240		120 360
Intake Total	560 560	240 800	240 240		120 360
CARE PROVIDERS	MMM	MMM	MMM	MMM	AM69

MADDOX, MORGAN M(MMM)TA MCCRAY, AMY(AM69)TA

FLOWSHEET	04/08				
Vital Signs	06:01	08:17	13:29	18:12	20:47
Temp in C	36.7C oral			37.1C oral	
RESPIRATIONS	16 visual			16 visual	
O2 SAT %	98% room air			94% room air	
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	**142/84 arm L** 97 brachial 142/80 arm L **101 brachial**			 124/82 arm L 74 brachial 114/77 arm L 74 brachial	
PAIN LEVEL	0 Numeric Value			0 Numeric Value	
I&O SUMMARY	06:01	08:17	13:29	18:12	20:47
Intake Total		480 480	360 840	240 240	240 480
NET		480 480	360 840	240 240	240 480
INTAKE	06:01	08:17	13:29	18:12	20:47
Oral		480 480	360 840	240 240	240 480
Intake Total		480 480	360 840	240 240	240 480
CARE PROVIDERS	AM69	MMM	MMM	MMM	YS60

MADDOX, MORGAN M(MMM)TA MCCRAY, AMY(AM69)TA YATES, SARAH(YS60)RN



FLOWSHEET	04/08	04/09			
Vital Signs	21:45	05:57	11:14	14:52	16:33
Temp in C		36.6C oral			36.4C oral
RESPIRATIONS		16 visual			16 visual
O2 SAT %		96% room air			
BP Lying Pulse Lying BP Sitting Pulse Sitting		136/82 arm L 100 brachial 137/87 arm L 102 brachial			107/72 arm L 73 brachial
PAIN LEVEL		0 Numeric Value			0 Numeric Value
I&O SUMMARY	21:45	05:57	11:14	14:52	16:33
Intake Total	300 780		660 660	500 1160	
NET	300 780		660 660	500 1160	
INTAKE	21:45	05:57	11:14	14:52	16:33
Oral	300 780		660 660	500 1160	
Intake Total	300 780		660 660	500 1160	
CARE PROVIDERS	AM69	AM69	NSAA	NSAA	SEN9

MCCRAY, AMY(AM69)TA NICKS, SEQUOYA(SEN9)TA STANLEY, NADINE(NSAA)TA

FLOWSHEET	04/09	04/10			
Vital Signs	18:07	05:30	09:31	13:57	16:28
Temp in C		36.7C oral			36.7C temporal
RESPIRATIONS		18 visual			18 visual
O2 SAT %		95% room air			
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing		135/78 arm R 85 brachial 101/68 arm R 80 brachial (modified)			105/71 arm L 88 brachial 101/71 arm L 98 brachial
PAIN LEVEL		0 Numeric Value			0 Numeric Value
I&O SUMMARY	18:07	05:36	09:31	13:57	16:28
Intake Total	360 360		560 560	420 980	
NET	360 360		560 560	420 980	
INTAKE	18:07	05:36	09:31	13:57	16:28
Oral	360 360		560 560	420 980	
Intake Total	360 360		560 560	420 980	
CARE PROVIDERS	SEN9	APR	NSAA	NSAA	SEN9

NICKS, SEQUOYA(SEN9)TA RIESMEYER, ALEXANDER P(APR)TA STANLEY, NADINE(NSAA)TA

FLOWSHEET	04/11				
Vital Signs	**05:25**	**06:12**	**09:12**	**09:20**	**11:34**
Temp in C	36.6C temporal				
RESPIRATIONS	16 visual				
O2 SAT %	96% room air			97% room air	
Manual BP		**164/86 arm R**			
BP Lying Pulse Lying BP Sitting Pulse Sitting	**178/99 arm R** & 98 brachial &			 152/79 arm R 78 brachial	
PAIN LEVEL	0 Numeric Value			0 Wong-Baker(face)	

04/11/14 05:25 BP Lying(H: The nurse was made aware.

04/11/14 05:25 BP Sitting(H: Pt. was unable to sit up.

Glucose	**05:25**	**06:12**	**09:12**	**09:20**	**11:34**
GLUCOSE PCX, WHO			**165 H**		
I&O SUMMARY	**05:25**	**06:12**	**09:12**	**09:20**	**11:34**
Intake Total					120 120
NET					120 120
INTAKE	**05:25**	**06:12**	**09:12**	**09:20**	**11:34**
Oral					120 120
Intake Total					120 120

CARE PROVIDERS	H	BLA0	SID	PB33	LWD3

BLEVINS, PHIL(PB33)RN
KOHLER, CATHERINE(BLA0)RN
CC SYSTEM, ID(SID)
WELLS, LASONYA(LWD3)TA
HUDSON, JESSE(H)TA

FLOWSHEET	04/11		04/12		
Vital Signs	17:52	21:30	06:18	06:37	13:30
Temp in C	&		36.9C oral		
RESPIRATIONS	18 visual		18 visual		
O2 SAT %			97% room air		
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	**167/90 arm R** & **103 brachial** &		**162/84 arm R** & 81 brachial 145/73 arm R 88 brachial		
PAIN LEVEL	sleeping Numeric Value		0 Numeric Value		

04/11/14 17:52 Temp in C(SEN9): Pt was asleep

04/11/14 17:52 BP Lying(SEN9): Nofitied R.N. Sarah

04/11/14 17:52 Pulse Lying(SEN9): Nofitied R.N.

04/12/14 06:18 BP Lying(TW2): RN notified

I&O SUMMARY	17:52	21:30	06:18	06:37	13:30
Intake Total		240 240		240 240	0 0
NET		240 240		240 240	0 0
INTAKE	17:52	21:30	06:18	06:37	13:30
Oral		240 240		240 240	
NaCl 0.9%					0 0
Intake Total		240 240		240 240	0 0
CARE PROVIDERS	SEN9	SEN9	TW2	CHOR	LB33

BLIZZARD, LAUREN(LB33)RN
WILSON, TIFFNEY(TW2)TA
HORLBACK, CHRISTOPHER(CHOR)RN
NICKS, SEQUOYA(SEN9)TA

FLOWSHEET	04/12			04/13	
Vital Signs	20:52	21:55	21:57	01:25	05:23
Temp in C	36.4C oral				36.2C temporal
RESPIRATIONS	16 visual				16 visual
O2 SAT %	98% room air				100% room air
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	 173/77 arm L 69 brachial 154/82 arm L 69 brachial				**153/75 arm R** & 68 brachial. 150/80 arm R 85 brachial
PAIN LEVEL	0 Numeric Value				0 Numeric Value

04/13/14 05:23 BP Lying(H: The nurse was made aware.

I&O SUMMARY	20:52	21:55	21:57	01:25	05:23
Intake Total		420 420	120 540	1000 1000	
NET		420 420	120 540	1000 1000	
INTAKE	20:52	21:55	21:57	01:25	05:23
Oral		420 420	120 540		
NaCl 0.9%				1000 1000	
Intake Total		420 420	120 540	1000 1000	
CARE PROVIDERS	RCTA	RCTA	RCTA	TAB6	H

BLACK, TAMMY(TAB6)RN HUDSON, JESSE(H)TA ROBINSON, TANOVA C(RCTA)TA

FLOWSHEET	04/13			04/14	
Vital Signs	**09:45**	**13:11**	**23:21**	**05:28**	**08:25**
Temp in C			36.7C	36.7C temporal	
RESPIRATIONS			16 visual	16 visual	
O2 SAT %			98% room air	100% room air	
BP Lying Pulse Lying BP Sitting Pulse Sitting			 132/79 arm L 70 brachial	**149/84 arm R** & 81 brachial 127/84 arm R 79 brachial	
PAIN LEVEL			0 Numeric Value	0 Numeric Value	

04/14/14 05:28 BP Lying(H: The nurse was made aware.

I&O SUMMARY	**09:45**	**13:11**	**23:21**	**05:28**	**08:25**
Intake Total	60 60	30 90			240 240
NET	60 60	30 90			240 240
INTAKE	**09:45**	**13:11**	**23:21**	**05:28**	**08:25**
Oral	60 60	30 90			240 240
Intake Total	60 60	30 90			240 240
CARE PROVIDERS	LB33	RROB	RCTA	H	PB33

BLEVINS, PHIL(PB33)RN
ROBINSON, RAGINE(RROB)TA
BLIZZARD, LAUREN(LB33)RN
ROBINSON, TANOVA C(RCTA)TA
HUDSON, JESSE(H)TA

FLOWSHEET	04/14				
Vital Signs	13:42	14:30	14:42	18:12	22:35
Temp in C				36.8C oral	
RESPIRATIONS				16 visual	
O2 SAT %					
BP Lying Pulse Lying BP Sitting Pulse Sitting				 114/67 arm L 91 brachial	
PAIN LEVEL				0 Numeric Value	
I&O SUMMARY	13:42	14:30	14:42	18:12	22:35
Intake Total	360 600	240 840	120 960		120 120
NET	360 600	240 840	120 960		120 120
INTAKE	13:42	14:30	14:42	18:12	22:35
Oral	360 600	240 & 840	120 960		120 120
Intake Total	360 600	240 840	120 960		120 120
04/14/14 14:30 Oral(PB33): juice x 2					
CARE PROVIDERS	NS77	PB33	PB33	SEN9	SEN9

BLEVINS, PHIL(PB33)RN NICKS, SEQUOYA(SEN9)TA SMITH, NYASHIA(NS77)TA

[redacted]

REQUESTED:04/18/14 05:40
OPT OUT:

FLOWSHEET	04/15				
Vital Signs	05:08	09:57	14:33	18:04	19:05
Temp in C	36.7C temporal			36.7C oral	
RESPIRATIONS	16 visual			16 visual	
O2 SAT %	100% room air			94% room air	
BP Lying Pulse Lying BP Sitting Pulse Sitting BP Standing Pulse Standing	**148/91 arm R** & 65 brachial 138/73 arm R 66 brachial			 128/80 arm R 95 brachial 103/69 arm R 95 brachial	
PAIN LEVEL	0 Numeric Value			0 Numeric Value	
04/15/14 05:08 BP Lying(H: The nurse was made aware.					
I&O SUMMARY	05:08	09:57	14:33	18:04	19:05
Intake Total		120 120	240 360		20 20
NET		120 120	240 360		20 20
INTAKE	05:08	09:57	14:33	18:04	19:05
Oral		120 & 120	240 360		
OTHER SUPPLEMENT					20 20
Intake Total		120 120	240 360		20 20
04/15/14 09:57 Oral(LF44): pt.drank 240 of boost					
CARE PROVIDERS	H	LF44	LF44	APR	APR

FIELDS, LIZZIE(LF44)TA HUDSON, JESSE(H)TA RIESMEYER, ALEXANDER P(APR)TA

[redacted]

OPT OUT:

FLOWSHEET	04/15				04/16
Vital Signs	20:22	20:43	20:50	20:51	05:33
Temp in C					38.8C temporal
RESPIRATIONS					16 visual
O2 SAT %					96% room air
BP Lying Pulse Lying BP Sitting Pulse Sitting					131/74 arm R 80 brachial 125/81 arm R 90 brachial
PAIN LEVEL					0 Numeric Value
I&O SUMMARY	20:22	20:43	20:50	20:51	05:33
Intake Total	118 138	118 256	236 492	236 728	
NET	118 138	118 256	236 492	236 728	
INTAKE	20:22	20:43	20:50	20:51	05:33
Oral	118 118	118 236	236 472	236 708	
OTHER SUPPLEMENT					
Intake Total	118 138	118 256	236 492	236 728	
CARE PROVIDERS	YS60	YS60	YS60	YS60	H

HUDSON, JESSE(H)TA YATES, SARAH(YS60)RN

FLOWSHEET	04/16				
Vital Signs	10:23	13:31	15:45	18:08	19:03
Temp in C				36.9C oral	
RESPIRATIONS				16 visual	
O2 SAT %				96% room air	
BP Sitting Pulse Sitting BP Standing Pulse Standing				129/81 arm L 80 brachial 107/75 arm L 80 brachial	
PAIN LEVEL				0 Numeric Value	
I&O SUMMARY	10:23	13:31	15:45	18:08	19:03
Intake Total	360 360	120 480	120 120	240 360	120 480
NET	360 360	120 480	120 120	240 360	120 480
INTAKE	10:23	13:31	15:45	18:08	19:03
Oral	120 120	120 240	120 120	240 360	120 480
OTHER SUPPLEMENT	240 240				
Intake Total	360 360	120 480	120 120	240 360	120 480
CARE PROVIDERS	MMM	MMM	YS60	MMM	YS60

MADDOX, MORGAN M(MMM)TA YATES, SARAH(YS60)RN

[redacted]

OPT OUT:

FLOWSHEET	04/16		04/17		
Vital Signs	20:32	20:33	06:07	09:28	13:32
Temp in C			37.0C oral		
RESPIRATIONS			16 visual		
O2 SAT %			96% room air		
BP Lying Pulse Lying BP Sitting Pulse Sitting			130/80 arm R 71 brachial 128/80 arm R 87 brachial		
PAIN LEVEL			0 Numeric Value		
I&O SUMMARY	20:32	20:33	06:07	09:28	13:32
Intake Total	120 600	120 720		360 360	280 640
NET	120 600	120 720		360 360	280 640
INTAKE	20:32	20:33	06:07	09:28	13:32
Oral				360 360	280 640
OTHER SUPPLEMENT	120 120	120 240			
Intake Total	120 600	120 720		360 360	280 640
CARE PROVIDERS	NN37	NN37	LSD4	NS77	NS77

NZIOKA, NANCY(NN37)RN SANSCRAITE, LAUREN(LSD4)TA SMITH, NYASHIA(NS77)TA

FLOWSHEET	04/17				
Vital Signs	15:43	15:46	16:54	18:01	18:49
Temp in C				36.8C temporal	
RESPIRATIONS				18 visual	
BP Sitting Pulse Sitting BP Standing Pulse Standing				99/64 arm R 90 101/68 arm R **103 brachial** &	
04/17/14 18:01 Pulse Standing(VC96): Notified nurse					
I&O SUMMARY	15:43	16:46	16:54	18:01	18:49
Intake Total	120 120	120 240	120 360		240 600
NET	120 120	120 240	120 360		240 600
INTAKE	15:43	15:46	16:54	18:01	18:49
Oral	120 120	120 240	120 360		
OTHER SUPPLEMENT					240 & 240
Intake Total	120 120	120 240	120 360		240 600
04/17/14 18:49 OTHER SUPPLEMENT(SEN9): boost					
CARE PROVIDERS	YS60	YS60	YS60	VC96	SEN9

COOK, VERDEANIS(VC96)TA NICKS, SEQUOYA(SEN9)TA YATES, SARAH(YS60)RN

FLOWSHEET	04/17		04/18		
Vital Signs	19:09	20:25	05:09	07:05	11:01
Temp in C			36.7C temporal		
RESPIRATIONS			16 visual		
BP Sitting Pulse Sitting BP Standing Pulse Standing			138/88 arm R 66 brachial 116/80 arm R 86 brachial		
PAIN LEVEL			0 Numeric Value		
I&O SUMMARY	19:09	20:25	05:09	07:05	11:01
Intake Total	120 720	240 960		120 120	600 720
NET	120 720	240 960		120 120	600 720
INTAKE	19:09	20:25	05:09	07:05	11:01
Oral	120 480	240 720		120 120	600 720
Intake Total	120 720	240 960		120 120	600 720
CARE PROVIDERS	YS60	YS60	H	TW2	NS77

HUDSON, JESSE(H)TA
YATES, SARAH(YS60)RN
SMITH, NYASHIA(NS77)TA
WILSON, TIFFNEY(TW2)TA

[redacted]

FLOWSHEET	04/18	
I&O SUMMARY	13:16	18:07
Intake Total	240 960	420 420
NET	240 960	420 420
INTAKE	13:16	18:07
Oral	240 960	420 420
Intake Total	240 960	420 420
CARE PROVIDERS	NS77	CD51

DANNELLY, CARRIE(CD51)TA SMITH, NYASHIA(NS77)TA

I & O

NaCl 0.9%
(O) Perform Date: 04/15/14 19:03 Chart Date: 04/15/14 19:04 Chart Inits.: APR
Value: 10
(I) Inact Date: 04/15/14 19:05 Inact Inits.: APR

NaCl 0.9%
(O) Perform Date: 04/15/14 19:04 Chart Date: 04/15/14 19:04 Chart Inits.: APR
Value: 20
(I) Inact Date: 04/15/14 19:05 Inact Inits.: APR

Legend Charting

Pulse Standing Do Not Delete
(O) Perform Date: 04/10/14 05:36 Chart Date: 04/10/14 05:39 Chart Inits.: APR
Value: 130 Brachl
Annotation: RN notified
(M) Perform Date: 04/10/14 05:36 Chart Date: 04/10/14 05:43 Chart Inits.: APR
Value: (80 Brachl)
Annotation: ()

Misc events Do Not Delete
(O) Perform Date: 04/11/14 10:07 Chart Date: 04/11/14 10:13 Chart Inits.: PB33
Value:
Annotation: Pt transported to JW main Hospital for Stat EEG.
(M) Perform Date: 04/11/14 10:07 Chart Date: 04/11/14 10:14 Chart Inits.: PB33
Value:
Annotation: (Pt incontinent of stool. Pt was cleaned and brief changed and Pt was then transported to JW main Hospital for Stat EEG.)
(M) Perform Date: 04/11/14 10:07 Chart Date: 04/11/14 10:14 Chart Inits.: PB33
Value:
Annotation: (Pt incontinent of stool. Pt was cleaned and brief changed and Pt was then transported to JW main Hospital for Stat EEG.)

Speech Do Not Delete
(O) Perform Date: 04/14/14 12:50 Chart Date: 04/14/14 13:05 Chart Inits.: CB22
Value: SlowSoft
Annotation: asked to siple questions today
(M) Perform Date: 04/14/14 12:50 Chart Date: 04/14/14 13:19 Chart Inits.: CB22
Value: SlowSoft
Annotation: (answered to simple questions today)

Care Providers:
APR RIESMEYER, ALEXANDER P, TA
CB22 BALTIMORE, CARMEN, RN
PB33 BLEVINS, PHIL, RN

MUSC Health
INSTITUTE OF PSYCHIATRY

DCORDERS

Institute of Psychiatry
Physician Discharge Orders

Form Origination Date: 9/09
Version: 10 Version Date: 10/11

Patient Nam [redacted]
MRN
PA

ALL ELEMENTS OF THIS FORM MUST BE COMPLETED

1. Principal Discharge Diagnosis: Alzheimer's Dementia with behavioral disturbance

Axis I Alzheimer's Dementia vs. Dementia vs. Delirium
Axis II deffered
Axis III UTI, hyperlipidemia
Axis IV chronic mental illness & psychosocial problems
Axis V 20

2. Reason for Hospitalization: 66 y/o female with hx of AD who presents to ED via EMS w/ worsening agitation and behavioral disturbance per family. Pt tells strangers she is being abused which led to police involv.

a. Admission Date 4/02/14

ADMISSION EVALUATION AND LABORATORIES

Mental Status on Admission: Orientation only to person
Appearance / Behavior older than stated age/ eye contact
Speech / Motor nml rate & vol/tremulous & cogwheeling
Mood / Affect euthymic/mood congruent, constricted
Thought Content and Process No SI or HI/ linear and goal-oriented
Concentration / Memory
Insight / Judgment

Laboratory Results and Pertinent Physical Findings
4/5- CK 316. 4/4 T4 & TSH WNL. Lipid profile cholesterol 201, LDL 130, Creatine Kinase 342. 4/2: ammonia, valproic acid, metabolic panel all grossly WNL. 4/2 Hem Panel RBC 4.05, Hgb 11.7, Hct 35.7%. 3/31: Hepatic Fxn Panel WNL.

HOSPITAL COURSE (include rationale for medication changes if applicable)
Patient was admitted to SCU from ED for worsening agitation and aggressive behavior as reported by daugher. Patient placed on proper percautions and safety restrictions.
1) Dementia 2/2 Alzheimer's w/ behavioral disturbances: Pt given a few doses of 2.5mg IM Zyprexa in ER and started on Depakote in the ER as well for her significant agitation. Upon admission to the IOP, she was continued on outpt meds of Aricept 10mg daily & Namenda 10mg PO BID. Aricept switched to Exelon 2/2 vomiting, and Exelon later d/c'd due to ongoing poor po intake.
2) Abnormal movements: On ltinital exam in the ER, she had no abnormal movements noted. However, on 4/02, she had significant cogwheeling, hyperreflexia, tremulousness, and occasional myoclonus (so significant that it would occasionally disturb her gait). This was concerning, given acute change. We checked her CK, which came back at 342 initally on 04/03. By 4/04, her movements seemed to be improving (off of antipsychotics). Serial CK's trended down and were wnl (175) by 4/10. Over the next few days, we noticed ongoing decrease in tremors, reflexes, cogwheeling, and myoclonus. However, on 4/11 she had an episode that appeared consistent with partial seizure activity (slowly lowered to floor by staff, jerking of LUE, fasiculations under left eye, incont B&B, not able to engage patient) followed by what seemed to be post-ictal symptoms (more pronounced confusion and aphasia, lethargy, etc). She was sent for a STAT EEG which didn't show any seizure activity. No further episodes, but had long pd of lethargy with poor po intake since (requiring Boost supplements and IVFs intermittently). Doing somewhat better x sev days, now ready for d/c.
3) Delirium 2/2 UIT: She was treated empirically with Bactrium DS PO BID x 10 days. Repeat UA showed clearance of UTI.
4) Hx of Depression: She was continued on outpt med of Lexapro 10mg PO daily.
5) HPL: Microvascular disease was noted on an old MRI, perhaps more advanced than typically seen in her age group. Thus, we checked a lipid panel, which revealed elevated total cholesterol and LDL. Due to her elevated CK, we initially held off on initiating statin therapy until CK level decreases. Later, Zocor 10 mg po qhs was added.

☐ Hospital course continued on Addendum

b. Discharge Date 4/18/14
c. Discharge Unit SCU 4N (843) 792-9041
d. Condition at discharge: ☐ See above
Cognitive status: Poor
Functional status: Poor
☐ Involuntarily committed to:

3. Discharge Attending: Mary Craig MD
☐ check if responsible for discharge summary, or specify name of responsible
4. Discharge Resident/PA-C/NP Erin Seery, MD
☒ check if responsible for discharge summary, or specify name of responsible
5. Discharge Service Geriatric Psychiatry, 4N

Physician Signature Erin Seery Pager ID 15520 Date 4/18/14 Time 10 AM/PM

iop_all_orders_dischgeneral
OTE 901157 Rev. 10/11

MUSC Health
INSTITUTE OF PSYCHIATRY

DCORDERS

Institute of Psychiatry
Physician Discharge Orders

Form Origination Date: 9/09
Version: 10 Version Date: 10/11

Patient Na[redacted]
MRN
P[redacted]

6. Did the patient have any of the following diagnoses during this admission?
If yes to any, additional questions will pop up and MUST be completed.

Acute myocardial infarction	☒ No	☐ Yes	
Asthma (Pediatric)	☒ No	☐ Yes	
Cerebral vascular accident (CVA)	☒ No	☐ Yes	
Chronic Obstructive Pulmonary Disease (COPD)	☒ No	☐ Yes	☐ Not Active
Congestive Heart Failure (CHF) or history of CHF	☒ No	☐ Yes	
Diabetes mellitus	☒ No	☐ Yes	
Pneumonia	☒ No	☐ Yes	

NURSE INSTRUCTIONS – If any of above checked yes, include appropriate discharge instructions to the patient

7. Has the patient used tobacco in the past 365 days?
☒ No
☐ Yes → counsel patient / caregiver ☐ I have counseled patient / caregiver on harmful effects of smoking & offered smoking cessation advice

→ NURSE INSTRUCTIONS – Emphasize tobacco cessation in your discharge instructions and give patient / caregiver education material

8. Patient Disposition:
a) Discharge or Transfer to:

☐ Assisted living	☐ Hospital / acute care facility	☐ Rehabilitation facility
☒ Home or self-care	☐ Long term acute care facility - LTAC	☐ TCU
☐ Home with hospice	☐ Nursing home / skilled nursing facility	☐ VA / Federal hospital / military
☐ Hospice facility	☐ Psychiatric facility / unit	☐ Left against medical advice
☐ Involuntarily committed		

Address [redacted] North Charleston, SC [redacted]
Phone [redacted]

If discharge to home (check applicable):
☐ b) Home health services: ☐ Nursing ☐ OT ☐ PT ☐ Speech ☐ MSW ☐ Other
Provider: Contact #:
Reason (specify services needed at home and why):

Initial home health orders are signed by discharge attending.
Follow-up home health orders are signed by: ☐ MUSC discharging attending above
☐ Other (specify):

☐ c) Infusion therapy, only if applicable (specify meds and durations in med rec form): ☐
Provider: Contact #:

☐ d) Durable medical equipment – List medical equipment:
☐ Bedside commode ☐ Crutches ☐ Food pump
☐ Walker ☐ Walker with wheels ☐ Wheelchair
☐ CPAP ☐ Oxygen ☐ Other
Provider: Contact #:

☐ e) Resume previous home health services for condition / diagnosis unrelated to current hospitalization

Physician Signature [signature] Pager ID 15520 Date 4/18/14 Time 10 AM/PM

lop_all_orders_dischgeneral OTE 901157 Rev. 10/11

MUSC Health
INSTITUTE OF PSYCHIATRY

DCORDERS

Institute of Psychiatry Physician Discharge Orders

Form Origination Date: 9/09
Version: 10 Version Date: 10/11

Patient N[redacted]
MRN

PATIENT IDENTIFICATION LABEL

10. Level of activity after discharge: No restrictions
(specify restrictions): _____

11. Diet after discharge: Regular (specify other diet): _____

12. Appointments after discharge:

a) Review patient physicians and potential need for follow up:

- Primary Care Clinician: _____
- MUSC Referring Physician: _____
- Referring Physicians external to MUSC: _____
- Admitting Physician: _____
- Attending Physician: Mary Craig MD

b) Review consultants seen during hospitalization and potential need for follow up: (list consultants seen during hospitalization)

Consulting Service	Attending	Follow-up needed?
None		☐ No ☐ Yes
		☐ No ☐ Yes
		☐ No ☐ Yes

c) Has patient had any foreign objects (packing, foley, central line, tubes, etc.) that need removal at a later time or monitored as an outpatient? ☒ N/A

d) Follow up appointments to be arranged by Social Worker

13. Call for the following: (specify the condition & who to call; use plain words)
Go to the local Emergency Room for an emergency.
For questions and issues related to discharge instructions or medications, contact us at the Hospital Nursing Unit phone number.
agitation, aggression, psychosis

14. IV Access (verify that access line is to be removed or if maintain, verify that this is the case)
☒ Remove all prior to discharge ☐ Maintain (specify): _____

15. Allergies: ☒ NKA ☐ Other (specify) _____

16. Medications: ☒ See IOP Discharge Medication Orders

Physician Signature _____ Pager ID 15520 Date 4/18/14 Time 16 ☐AM/PM

iop_all_orders_dischgeneral

OTE 901157 Rev. 10/11

MUSC Health
INSTITUTE OF PSYCHIATRY

DCORDERS

Institute of Psychiatry
Physician Discharge Orders

Form Origination Date: 9/09
Version: 10 Version Date: 10/11

Patient Na[redacted]
MRN
PATIENT IDENTIFICATION LABEL

7. Transition Enhancement:

a) Dictation job number [redacted] on telephone 2-7007, Work type 4 - discharge summary, 8 – STAT for transfer summary)

b) Fax a copy of ☒ discharge orders and medication reconciliation form to provider listed on patient instruction page, for whom an Authorization to Disclose Protected Health Information has been signed. Faxed by Bonnie Steele Date / Time 4-18-14 @ 1608

c) Labs / Studies still pending at the time of discharge:
F/U on Creatine Kinase over time due to her hx elevation and starting her on Zocor, as well as repeat lipid panel in few mo.

d) Special issues that need to be discussed at follow-up visits:

FOLLOW-UP PROVIDER TREATMENT CONSIDERATIONS	
☒ Possible medication adjustment(s) titration of Depakote as needed	☒ Laboratory studies follow up lipid panel
☒ Side effects for special consideration low PLT, low Na+, elevated LFTs	☒ Medical conditions of special note f/u efficacy of Zocor (check lipids)
☐ Next depot injection due on	☐ Medication, alcohol, or drug use of particular concern

FURTHER RECOMMENDATIONS FOR PATIENT AND/OR GUARDIAN (any reasons for concern, safety issues)
take medication as directed and go to all outpatient appointments. NOTE: No evidence was found during admission that patient had been recently assaulted or abused (i.e. no bruising or sign of injury). When patient was less delirious, she stated that her daughter was the nicest person and "I never said that she hurt me." No APS case was filed by officer and we felt patient was safe

e) Code status at discharge: ☒ Full code ☐ Allow natural death ☐ Other (specify):

f) Patient phone number in case follow-up needed: See page 2

g) Return to work / school status ☒ N/A or Choose one or free text [link to complete excuse form]

Physician Signature [signature] Pager ID 15520 Date 4/18/14 Time 10 AM/PM

Attending Signature [signature] Pager ID 14170 Date 4/18/14 Time 9:30 AM/PM

iop_all_orders_dischgeneral

OTE 901157 Rev. 10/11

Discharge Summary Format

1. Patient full name and spelling, MUH PATCOM #, MUH MRN #
2. Date of admission & date of discharge
3. Attending physicians full name and spelling, service
4. Person dictating (spelling)
5. Chief complaint on admission
6. Admitting diagnosis
7. Procedures during hospitalization
8. Consultations during hospitalization
9. Brief HPI and pertinent ROS
10. PMH
11. PSH
12. Admission medications
13. Allergies (did allergies change during hospitalization?)
14. Social history / Family history (pertinent)
15. Admission PE and diagnostic tests (pertinent)
16. Hospital course (problem based, formatted in separate paragraphs)
17. Discharge diagnosis (list primary and all secondary diagnoses)
18. Cancer staging if applicable (T_ N_ M_ = Stage __)
19. Discharge medications
20. Disposition, condition on discharge, activity, diet
21. Appointments
22. Labs / studies pending at time of discharge
23. Code status at discharge
24. MOST IMPORTANT – MUSC Referring physician, External Referring physicians, Primary care clinicians (spell name & location)

[redacted]

"IOPPHYSORDER"

MUSC Health
INSTITUTE OF PSYCHIATRY

This form [redacted] e cursor to text field

IS NOT TO B[redacted] form
[redacted]ting the PRINT button
[redacted]ote.

Patient Name [redacted]

MRN [redacted]

PATIENT IDENTIFICATION LABEL

Institute of Psychiatry (IOP)
Discharge Medication Orders

Form Origination Date: 7/07
Version: 3

Version Date: 4/12

MEDICATION	DIRECTIONS FOR USE	INDICATION(S) & SPECIAL INSTRUCTIONS	SOURCE
Simvastatin 10 mg	1 every bedtime	cholesterol	☒ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
Escitalopram 10 mg	1 every day	mood/depression	☒ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
Memantine 10 mg	1 twice each day	memory	☒ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
Divalproex 125 mg -	1 by mouth every 12 hours	mood/agitation	☒ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
Tylenol 325 mg	2 by mouth every 6 hrs as needed	pain	☐ Prescription given ☐ Samples given ☐ Use home supply ☒ Buy over the counter
			☐ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
			☐ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
			☐ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
			☐ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
			☐ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter
			☐ Prescription given ☐ Samples given ☐ Use home supply ☐ Buy over the counter

I have been counseled about my medications, and understand the importance of taking them.

Patient Signature: _____ Date: _____ Time: _____

Stop the following medications: Aricept (Donepezil)

Additional comments: _____

IMPORTANT NOTICES TO PATIENT:

1. I have reviewed your hospital medications and reconciled them with the outpatient medications listed on the admission Medication Reconciliation form.
2. This is a list of ALL the medications you should be taking. Please bring this list to your doctor's appointments and pharmacy.
3. Do NOT take any medications that are not on this list. Please consult your outpatient provider before making any changes to your medication regimen. Thank you.

Signature & Title _____ Printed Name ERIN SEERY Pager ID 15520 Date 4/18/14 Time 10 AM/PM

Photocopy to patient / Original to medical record

iopdcmedorder

OTE 700277 Rev. 4/12

[redacted]

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPPHYSORDER

IOP Attending Physician Admit Note

Form Origination Date: 12/06
Version: 5 Version Date: 2/13

[redacted]

Patient Name
MRN
PATIENT IDENTIFICATION LABEL

Attending Note ☑ Patient seen, IOP Assessment (OTE 700239) reviewed by me.
Hx (quality, assoc sx, stressors, compliance, modifying factors, timing & context)

CC agitation, worsening
Duration x ~ 1 month
Severity ☐ Mild ☐ Moderate ☑ ~~Severe~~

HPI must be personally documented by rendering clinician 66 y/o w/ hx Alzheimer's dementia w/ behav dist adm yesterday to SCH ext 2° boarding in the ER since 3/29/14. Psych consult on 3/30 used as primary source hx 2° pt's advanced dementia. Per records reviewed, she has had cognitive issues since 2008. Dx c AD (c prominent language issues) in 2013 p Neuropsych testing. According to records, she has had progressive decline in ADL's + ↑ need for care over past yr or so. Then in past month has become more agitated + aggressive. She's been combative c (D), who is caretaker; she's also been calling police, wandering from home, + alleging abuse. No triggers to behav change + no relieving factors. Assoc c progressive cog decline. Allergies: NKDA PMHx: None noted.
Soc Hx: 1 yr college, M x 24 yrs (then separated), 2 grown children FHx: (+) dementia (M) BRCA (S)

☑ ROS in IOP Assessment/Physician Core Assessment on 3/30/14 (date) validated as recorded— all others negative unless otherwise specified
☑ PFSH in IOP Assessment/Physician Core Assessment on 3/30/14 (date) validated as recorded— unless otherwise noted
☐ VS reviewed as recorded in ADB 37.1, 18, ↓149/73, ↓97, T136/75, T163
General Appearance Disheveled, hypervigilant, but cooperative.
☐ normal gait & station; if Abn, specify unsteady, normal arm swing, ? myoclonus while walking
☐ normal strength / tone / bulk; if Abn, specify tremulous c ↑ reflexes throughout, some fasciculations on myoclonic jerking
☐ normal speech rate, volume, prosody; if Abn, specify soft, stumbled over words
☐ euthymic mood & appropriate, congruent affect; if Abn, specify "Okay" but blunted affect.
☐ thought process clear with coherent associations; if Abn, specify disorganized / circumstantial.
☐ thought content appropriate; if Abn, specify paranoid (+) cog
☑ normal perceptions; if Abn, specify Ø AVH on exam.
☐ grossly oriented; if Abn, specify Ox self only.
☐ intact memory by interview; if Abn, specify poor ST + LT memory.
☐ normal attention & conc; if Abn, specify poor conc c ↑ vigilance + easily distracted.
☐ normal language skills; if Abn, specify impaired language (moderate)
☐ average knowledge base; if Abn, specify ↓ 2° dementia

Judgment ☐ good ☐ fair ☐ poor Insight ☐ good ☐ fair ☑ poor
Other exam findings:

Continued on Next Page

Initials DS

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPPHYSORDER

IOP Attending Physician Admit Note

Form Origination Date: 12/06
Version: 5
Version Date: 2/13

[redacted] DOB:10/08/1947 W F

Patient Name [redacted]
MRN

PATIENT IDENTIFICATION LABEL

☑ Agree with diagnoses unless otherwise noted

Patient Risk

- ☐ Patient secluded / restrained at time of admission
- ☑ Failed outpatient treatment
- ☑ Inability to provide self-care
- ☐ Other:
- ☐ Homicidal ideations
- ☐ Suicidal ideations
- ☐ Withdrawal
- ☑ History of violence
- ☑ Psychosis
- ☑ Current medical problems

Data / Plans

- ☑ Assess behavior and mental state
- ☐ Observe for withdrawal
- ☑ Develop aftercare plan
- ☑ Reviewed lab findings documented in this data base
- ☑ Ordered labs – refer to Physician Admission Orders
- ☑ Enroll in treatment program
- ☑ Med management
- ☐ Treat uncontrolled diabetes
- ☑ Maintain safety
- ☑ Organic workup
- ☐ Treat uncontrolled hypertension

Other Plan

(1) Dementia 2° AD w/ behavioral disturbances → Con't Aricept 10 mg daily + Namenda 10 mg po bid. Given microvascular disease on MRI will ✓ fasting lipids. Also, last TSH as outpt in 2012 was high normal. ✓ TSH/Free T4

(2) Abnormal movements – review of records indicates this is acute change for her. ✓ CK. May warrant EEG if doesn't resolve.

(3) Delirium 2° UTI → con't trx w/ Bactrim DS po bid x 7 more days (started in ER).

(4) Hx depression – con't Lexapro 10 mg po qAM.

9/23/10 - Head MRI - old cerebral white matter ischemic changes 5/19/99 - ANA(+) 1:80 (speckled pattern)
5/31/13 - PET scan brain: B temporoparietal hypometabolism, + 2 small regions frontal hypometabolism

Additional information if applicable 3/29 - B12 617 3/30 - UA (+) nitrite, Leuk Est: 13 WBC's, few bacteria
3/29 143/109 18 <100 Cat 9.8 Folate 9.4 3/31 - LFT's wnl 4/02 - Ammonia WNL
3.6 / 26 / 0.7 7.7 / 33.9 / 231 11.2 Depakote - 27.2

JP — JBroadway MD — 14582 — 4/03/14 — 1055 (AM) PM

Initials | Signature & Title | Pager ID | Date | Time

iop_all_docu_Iopatientnote

QTS 700240 Rev. 3/7/13

[redacted]
REQUESTED:04/19/14 05:40
OPT OUT:
Page: 1

FLOWSHEET	04/02	04/03		04/04	04/05
Pt/Fam Teaching	21:16	14:51	18:20	19:50	12:57
Department	Nursing	Nursing	Rec Therapy	Rec Therapy	Nursing
Persons Taught	patient	patient	patient	patient	patient
Learning Needs	coping/w illness health promotion medications patient safety	medications nutrition patient safety	activity/rehab coping/w illness health promotion othr learnNeeds &	activity/rehab coping/w illness coping/w tx health promotion	medications nutrition patient safety
ReadinessToLearn	cognition	cognition	cognition emotional physical &	cognition	cognition
Teaching Method	verbal inst written inst	verbal inst	audio demo verbal inst	audio demo verbal inst oth teach method	verbal inst
Comprehension	cont reinforce unable to state	cont reinforce	cont reinforce	cont reinforce return demo	cont reinforce
Comments			&	&	

04/03/14 18:20 Learning Needs(VIR3): A Walk in the Atrium

04/03/14 18:20 ReadinessToLearn(VIR3): confused, illogical, anxious, unsteady

04/03/14 18:20 Comments(VIR3): Pt pos. yet min. engaged in deep breathing,seated chair exercises w/sig. diff (coord/ROM) & walking a couple laps in the Atrium w/assist . Pt had pos responses/outcome to intervention for benefits of exercise & nature to improve mood & overall well being.

04/04/14 19:50 Comments(LKP9): pt attended relaxation group;pt able to participate & follow direction during guided imagery session (forest w/ flowing brook nature sound in background);pt stated it was beneficial although had some confusion & illogical thinking

IOP Fall Prevntn	21:16	14:51	18:20	19:50	12:57
Department	Nursing				Nursing
Persons Taught	patient				patient
BP Changes Explained	call4Assist/Dzzy dizziness ino fall risk meds side effect sit until steady slow arising avoid med equip clear walkway fallCanHppen2BR footwear precaut useAssistDevices				call4Assist/Dzzy dizziness ino fall risk meds side effect sit until steady slow arising avoid med equip clear walkway fallCanHppen2BR footwear precaut
CARE PROVIDERS	NN37	KM11	VIR3	LKP9	ANB9

BEERS, ANGELA(ANB9)RN MADDEN, KATHERINE(KM11)RN NZIOKA, NANCY(NN37)RN
PORTER, LAUREN K(LKP9)REC THERAP RYAN, VICTORIA(VIR3)REC THERAP

FLOWSHEET	04/02	04/03		04/04	04/05
OP Fall Prevntn-Cont.	21:16	14:51	18:20	19:50	12:57
Handout given	Preventing Falls Safety Brochure				
ReadinessToLearn	cognition				cognition
Teaching Method	verbal inst written inst				verbal inst
Comprehension	cont reinforce unable to state				cont reinforce
CARE PROVIDERS	NN37				ANB9

BEERS, ANGELA(ANB9)RN NZIOKA, NANCY(NN37)RN

FLOWSHEET	04/05	04/06		04/07	04/08
Pt/Fam Teaching	18:51	17:24	19:32	08:39	12:46
Department	Rec Therapy	Rec Therapy	Rec Therapy		Nursing
Persons Taught	patient	patient	patient		patient
Learning Needs	activity/rehab coping/w illness coping/w tx	activity/rehab coping/w illness coping/w tx health promotion	activity/rehab coping/w illness coping/w tx		disch planning medications nutrition patient safety plan of care
ReadinessToLearn	cognition	cognition	cognition		cognition
Teaching Method	demo verbal inst written inst	audio demo verbal inst	audio demo verbal inst video		verbal inst
Comprehension	cont reinforce return demo state understand	cont reinforce return demo	cont reinforce return demo state understand		cont reinforce
Comments	&	&	&		

04/05/14 18:51 Comments(LKP9): pt attended "happiness" group;pt able to participate & follow direction during activity using facts & quotes about happiness & answering corresponding questions to promote meaningful discussion;positive response,improved communication

04/06/14 17:24 Comments(LKP9): pt attended exercise intervention on unit;while listening to music,pt able to participate yet had difficulty following direction during walking as well as stationary balance exercises to promote stability & fall prevention;overall positive outcome

04/06/14 19:32 Comments(LKP9): pt attended "music for mood improvement";pt able to ID (motown,otis redding) as music to promote a positive state of mind & increase levels optimism;pt attentive to peers selections as well;positive response to music intervention

IOP Fall Prevntn	18:51	17:24	19:32	08:39	12:46
Department				Therapeutic Asst	Nursing
Persons Taught				patient	patient
BP Changes Explained ReadinessToLearn				call4Assist/Dzzy dizziness inc fall risk meds side effect sit until steady slow arising avoid med equip clear walkway fallCanHppen2BR footwear precaut useAssistDevices cognition	call4Assist/Dzzy dizziness inc fall risk meds side effect sit until steady slow arising avoid med equip clear walkway footwear precaut cognition
Teaching Method				verbal inst	verbal inst
CARE PROVIDER3	LKP9	LKP9	LKP9	MMM	VICS

MADDOX, MORGAN M(MMM)TA PORTER, LAUREN K(LKP9)REC THERAP VICK, STANISHA(VICS)RN

FLOWSHEET	04/05	04/06		04/07	04/08
IOP Fall Prevntn-Cont.	18:51	17:24	19:32	08:39	12:46
Comprehension				cont reinforce unable to state	cont reinforce
CARE PROVIDERS				MMM	VICS

MADDOX, MORGAN M(MMM)TA VICK, STANISHA(VICS)RN

FLOWSHEET	04/08	04/09			04/10
Pt/Fam Teaching	14:37	13:06	19:40	19:52	14:24
Department	Rec Therapy		Rec Therapy	Rec Therapy	
Persons Taught	patient		patient	patient	
Learning Needs	othr learnNeeds &		activity/rehab coping/w illness health promotion othr learnNeeds &	activity/rehab coping/w illness health promot on othr learnNeeds &	
ReadinessToLearn	no barriers		cognition emotional &	cognition	
Teaching Method	demo verbal inst		demo verbal inst	audio demo verbal inst	
Comprehension	cont reinforce		cont reinforce	cont reinforce	
Comments	&		&	&	

04/08/14 14:37 Learning Needs(RR): Music and Memories

04/08/14 14:37 Comments(RR): Pt attended session on Music and Memories and with minimal guidance was able to identify her favorite artist and song. Pt identified that she felt happy during the song and recalled a memory where she saw elvis in charleston when she was a teenager.

04/09/14 19:40 Learning Needs(VIR3): Fitness

04/09/14 19:40 ReadinessToLearn(VIR3): confused, anxious

04/09/14 19:40 Comments(VIR3): Pt positively & actively engaged in deep breathing, seated chair exercises w/ sig difficulty following sequence of movements, & walking several laps in the hallway. Pt had positive responses/outcome to intervention for improved mood & overall well being.

04/09/14 19:52 Learning Needs(VIR3): Nature & Music

04/09/14 19:52 Comments(VIR3): Pt positively & actively engaged in group intervention in Atrium for benefits of being in Nature & listening to music. Pt had positive responses/outcome for improved mood,cognition,socialization, reminiscing & overall well being.

IOP Fall Prevntn	14:37	13:06	19:40	19:52	14:24
Department		Nursing			Therapeutic Asst
Persons Taught		patient			patient
BP Changes		dizziness inc fall risk meds side effect sit until steady slow arising			call4Assist/Dzzy dizziness inc fall risk meds side effect sit until steady slow arising
Explained		clear walkway fallCanHppen2BR footwear precaut			avoid med equip clear walkway fallCanHppen2BR
CARE PROVIDERS	RR	LB33	VIR3	VIR3	NSAA

BLIZZARD, LAUREN(LB33)RN
STANLEY, NADINE(NSAA)TA
RAYNOR, ROBERT(RR)REC THERAP
RYAN, VICTORIA(VIR3)REC THERAP

FLOWSHEET	04/08	04/09			04/10
IOP Fall Prevntn-Cont.	14:37	13:06	19:40	19:52	14:24
ReadinessToLearn		useAssistDevices cognition			footwear precaut useAssistDevices cognition
Teaching Method		verbal inst			verbal inst
Comprehension		cont reinforce			cont reinforce
CARE PROVIDERS		LB33			NSAA

BLIZZARD, LAUREN(LB33)RN STANLEY, NADINE(NSAA)TA

[redacted]

OPT OUT:

FLOWSHEET	04/10		04/11	04/12	04/13
PI/Fam Teaching	18:24	19:25	19:12	10:48	10:57
Department	Rec Therapy	Nursing	Rec Therapy	Nursing	
Persons Taught	patient	patient	patient	patient	
Learning Needs	activity/rehab coping/w illness health promotion othr learnNeeds &	coping/w illness health promotion medications nutrition patient safety	activity/rehab coping/w illness coping/w tx	medications	
ReadinessToLearn	no barriers	cognition	cognition	cognition	
Teaching Method	demo verbal inst	verbal inst	demo verbal inst oth teach method	verbal inst	
Comprehension	cont reinforce	cont reinforce unable to state	cont reinforce return demo	cont reinforce unable to state	
Comments	&		&		

04/10/14 18:24 Learning Needs(VIR3): Mindfulness

04/10/14 18:24 Comments(VIR3): Pt positively engaged in group intervention for mindfulness. Pt had positive response/outcome to intervention for benefits of nature/sensory stimulation to bring gratitude into the present moment & note the all the good things we see and feel in nature.

04/11/14 19:12 Comments(LKP9): pt attended reminiscence therapy group;pt able to participate & follow direction during activity utilizing descriptions & pictures of popular movies,music,& TV shows from the past;fair memory recall,responded more to pictures rather than descriptions

IDP Fall Prevntn	18:24	19:25	19:12	10:48	10:57
Department		Nursing		Nursing	Nursing
Persons Taught		patient		patient	patient
BP Changes		call4Assist/Dzzy dizziness inc fall risk meds side effect sit until steady slow arising		call4Assist/Dzzy dizziness inc fall risk	dizziness inc fall risk meds side effect sit until steady slow arising
Explained		avoid med equip clear walkway fallCanHppen2BR footwear precaut useAssistDevices		avoid med equip clear walkway footwear precaut	clear walkway fallCanHppen2BR footwear precaut useAssistDevices
ReadinessToLearn		cognition		cognition	cognition
Teaching Method		verbal inst		verbal inst	verbal inst
Comprehension		cont reinforce unable to state		cont reinforce unable to state	cont reinforce
CARE PROVIDERS	VIR3	NN37	LKP9	LQ11	LB33

BLIZZARD, LAUREN(LB33)RN
NZIOKA, NANCY(NN37)RN
PORTER, LAUREN K(LKP9)REC THERAP
QUINN, LESLIE(LQ11)RN
RYAN, VICTORIA(VIR3)REC THERAP

FLOWSHEET	04/15		04/16		04/17
Pt/Fam Teaching	10:47	14:42	13:15	17:24	19:22
Department	Nursing	Rec Therapy		Rec Therapy	Rec Therapy
Persons Taught	patient	patient		patient	patient
Learning Needs	medcations patient safety	othr learnNeeds &		activity/rehab coping/w illness health promotion othr learnNeeds &	activity/rehab coping/w illness health promotion othr learnNeeds &
ReadinessToLearn	cognition	cognition		no barriers	cognition physical &
Teaching Method	verbal inst	audio verbal inst		demo verbal inst	demo verbal inst
Comprehension	cont reinforce unable to state	reinforce		cont reinforce	cont reinforce
Comments		&		&	&

04/15/14 14:42 Learning Needs(RR): Music and Memories

04/15/14 14:42 Comments(RR) Attended session on music and memories, but was unable to specify her favorite artist & song. Overall quiet during the session, but reported that she felt good after listening to her tune. Pt was unable to verbalize any memories that related to her song.

04/16/14 17:24 Learning Needs(VIR3): Fitness

04/16/14 17:24 Comments(VIR3): Pt positively & actively engaged in deep breathing & seated chair exercises w/min diff in coord & ltd ROM. Pt had positive response/outcome to intervention for improved mood, cognition & overall well being.

04/17/14 19:22 Learning Needs(VIR3): Fitness

04/17/14 19:22 ReadinessToLearn(VIR3): better communication still ltd, struggles to find the words, walks w/RT assist.

04/17/14 19:22 Comments(VIR3): Pt positively & actively engaged in walking & talking w/RT for 4 laps in the hallway. Pt had positive response/outcome for improved mood, cognition, balance, & stamina.

IOP Fall Prevntn	10:47	14:42	13:15	17:24	19:22
Department	Nursing		Therapeutic Asst		
Persons Taught	patient		patient		
BP Changes	call4Assist/Dzzy dizziness inc fall risk		call4Assist/Dzzy dizziness inc fall risk meds side effect sit until steady slow arising		
Explained	avoid med equip clear walkway footwear precaut		avoid med equip clear walkway fallCanHppen2BR footwear precaut		
CARE PROVIDERS	LQ11	RR	MMM	VIR3	VIR3

MADDOX, MORGAN M(MMM)TA QUINN, LESLIE(LQ11)RN RAYNOR, ROBERT(RR)REC THERAP
RYAN, VICTORIA(VIR3)REC THERAP

FLOWSHEET	04/15		04/16		04/17
IOP Fall Prevntn-Cont.	10:47	14:42	13:15	17:24	19:22
ReadinessToLearn	cognition		useAssistDevices cognition		
Teaching Method	verbal inst		verbal inst		
Comprehension	cont reinforce unable to state		cont reinforce unable to state		
CARE PROVIDERS	LQ11		MMM		

MADDOX, MORGAN M(MMM)TA QUINN, LESLIE(LQ11)RN

[redacted]

OPT OUT:

[redacted]

FLOWSHEET	04/18
Pt/Fam Teaching	09:14
Department	Nursing
Persons Taught	patient
Learning Needs	medcations nutrition
ReadinessToLearn	cognition
Teaching Method	verbal inst
Comprehension	cont reinforce unable to state
IOP Fall Prevntn	09:14
Department	Nursing
Persons Taught	patient
BP Changes ReadinessToLearn	call4Assist/Dzzy dizziness inc fall risk cognition
Teaching Method	verbal inst
Comprehension	cont reinforce unable to state
CARE PROVIDERS	LQ11

QUINN, LESLIE(LQ11)RN

[redacted]

[redacted]

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPPATFAMED

Institute of Psychiatry
Interdisciplinary Patient/Family Education Flowsheet
Fall Prevention
Page 1 of 1

Form Origination Date: 12/04
Version: 1

Version Date: 12/04

[redacted]
EAdm:

Learning Needs
1. Diagnosis/Signs/Symptoms
2. Test/Procedures
3. Treatments
4. Pre/Post-op Care
5. Pain Management
6. Patient's Plan of Care
7. Activity/Rehab
8. Medications
9. Nutrition
10. Food/Drug Interactions
11. Herb/Drug Interactions
12. Health Promotion
13. Patient Safety
14. Medical Equipment
15. Community Resources
16. Advance Directives
17. Hospice/Palliative Care
18. Other (specify)

Person(s) Taught
1. Patient
2. Parent
3. Family Member (name)
4. Guardian (name)
5. Other (name)

Readiness to Learn
1. No barriers
2. Cognition
3. Physical (pain, fatigue, etc.)
4. Emotional (anxiety, depression, etc.)
5. Lacks motivation
6. Unreceptive
7. Other (specify)

Department
1. Nursing
2. Physician
3. Social Work
4. Pharmacy
5. Dietary
6. Recreational Therapy
7. School
8. Pastoral Care
9. Occupational Therapy
10. Other (specify)

Outcome
1. Able to state understanding and/or return demonstration
2. Able to state understanding and/or return demonstration, continue to reinforce
3. Unable to state understanding or return demonstration, continue to reinforce
4. Family involvement necessary.
5. Unable to teach (explain)

Date/ Initials	Learning Needs	Person(s) Taught	Readiness to Learn	Dept	Outcome	Content Taught / Comments (names of teaching materials used, other concerns, etc.)
4/2/14 YBS	8, 13	1	2	1	3	Explained that BP changes may be a medication side effect causing dizziness and risk of falling. Instructed to change positions slowly and when getting out of bed to sit one minute before standing. If dizzy, instructed to sit and call staff for help.
	13					Explained that many falls happen when walking to the bathroom. Instructed to call staff to help if dizzy.
	13					Explained the importance of wearing properly fitting, non-skid footwear.
	13					Explained the importance of maintaining an uncluttered pathway.
	13, 14					Instructed on the proper use of assistive devices (e.g. cane, walker).
	13					Explained how to prevent falls when medical equipment, such as IV pole or urinary drainage catheter, might be an obstacle.
	13					"Preventing Falls" handout given. Explained that this handout identifies safety measures in the hospital and at home.
4/02/14 YBS	8	1	2	2	5	2° severe dementia

Initials/Signature	Initials/Signature	Initials/Signature
YBS, Yalena G. Talley, RN	/	/
BB Bernadina MD	/	/
/	/	/

iop_all_pated_fallprevention

OTE 700029 12/04

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPPATFAMED

Institute of Psychiatry
Interdisciplinary Patient/Family Education Flowsheet

Form Origination Date: 1/00
Version: 1

Version Date: 1/00

[redacted]

Learning Needs
1. New diagnosis
2. Chronic illness
3. Parenting skills
4. Tests, procedures, treatments
5. Nutritional needs
6. Meds / Food-Drug
7. Community resources
8. Health promotion / safety
9. Financial concerns
10. Behavior management
11. Other

Person(s) Taught
A. Patient
B. Parent / Guardian
C. Family member (name)
E. Other (name)

Readiness to Learn (Limitations/Barriers)
A. No limitations / barriers
B. Anxiety
C. Language
D. Reading ability
E. Cognitive / sensory
F. Physical
G. Unreceptive
H. Psychosis
I. Communication
J. Other (specify)

Learning Influences (Document in Readiness to Learn column)
1. Culture
2. Religion / spirituality

Discipline
1. Physician
2. Nursing
3. Social work
4. Psychology
5. Pharmacy
6. Dietary
7. RT
8. School
9. Occupational Therapy
10. External agency
11. Other (specify)

Teaching Method(s)
1. Written
2. Verbal
3. Demonstration
4. Videos
5. Other

Outcome
A. Able to verbalize or demonstr understanding of content. No review necessary.
B. Needs reinforcement (explain in Comments).
C. Poor understanding. Repeat all (explain in Comments).
D. Family involvement necessary.
E. Unable to teach (explain in Comments).

Date / Time / Initials	Learning Needs / Content Taught	Person Taught	Readiness to Learn	Discipline	Teaching Method	Outcome	Comments (names of teaching materials used, other concerns, etc.)
4/2/14 17:10 YAS	10. Stress Management	A	E	2	2	C	
4/3/14 12:00 NVH	S W Pole	A	E	3	2	C	
4/03/14 1:30pm JB	2, 4, 6.						
4/3/14 1215 JB	11. RT TRAC, ASSESS	A	B, E	7	2	C	ANXIOUS / CONFUSED/ DISORIENTED

Initials / Signature

YAS / Yalena A. Talley, RN
NVH / Nancy Holbrook, MSW
JB / JBroadway MD

Initials / Signature

JB / JB

Initials / Signature

JB / Jo Anne Bryant, CTRS

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPPTINSTRUC

Institute of Psychiatry Discharge Instructions – Patient Appointments

Page 1 of 1

Form Origination Date: 9/09
Version: 7 Version Date: 5/13

[redacted]

Patient Na[redacted]
MRN

PATIENT IDENTIFICATION LABEL

FOLLOW-UP PLAN and APPOINTMENTS: It is important that all follow-up appointments be kept, and if you cannot keep an appointment at the time scheduled; please call the provider to reschedule. A checkmark indicates that this Discharge Order has been faxed to the provider listed below for whom an Authorization to Disclose Protected Health Information has been signed (as indicated by a checkmark in the "A" column).

A	Faxed	Name / Agency	Address	Phone Number	Fax Number	Appointment Date and Time
X		Dr. Seary MUSC psychiatry clinic	326 Calhoun St Charleston South Carolina	843-792-9162	843-792-7374	May 1, 2014 at 2:30
X		Dr. Karen Thomas/ Bill Price PA	180 Wingo Way #306, Mt Pleasant, SC 29464	(843) 884-1777	843-606-8000	April 24, 2014 1:00pm

Additional Information:

Pt is being D/C home with her daughter. Daughter encouraged to have her mother in adult day care. Daughter give list of facilities. Pt needs 24 hour supervision due to her confusion.

Clinician Signature [signature] Date 4/18/14 Time 9 30 AM/PM

iop_all_orders_dcappointments

OTE 901160 5/13

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPPTINSTRUC

Institute of Psychiatry Discharge Instructions – Patient Appointments

Form Origination Date: 9/09
Version: 7 Version Date: 5/13

[redacted]
Patient Name:
MRN
PATIENT IDENTIFICATION LABEL

FOLLOW-UP PLAN and APPOINTMENTS: It is important that all follow-up appointments be kept, and if you cannot keep an appointment at the time scheduled; please call the provider to reschedule. A checkmark indicates that this Discharge Order has been faxed to the provider listed below for whom an Authorization to Disclose Protected Health Information has been signed (as indicated by a checkmark in the "A" column).

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X		Dr. Seary MUSC psychiatry clinic	326 Calhoun St Charleston South Carolina	843-792-9162	843-792-7374	May 1, 2014 at 2:30
X		Dr. Karen Thomas/ Bill Price PA	180 Wingo Way #306, Mt Pleasant, SC 29464	(843) 884-1777	843-606-8000	April 24, 2014 1:00pm

Additional Information:

Clinician Signature _____ Date _____ Time _____ AM/PM

iop_all_orders_dcappointments OTE 901160 5/13

[redacted]

MUSC Health

PTINSTRUC

Institute of Psychiatry Discharge Instructions

Form Origination Date: 9/09
Version: 10

Version Date: 10/11

[redacted] BEL

MUSC Patient PASS: A Transition Record
Patient Preparation to Address Situations (after discharge) Successfully

I was hospitalized at MUSC Hospital from 4/02/14 **through** 4/18/14 **for the following problems:**
66 y/o female with hx of AD who presents to ED via EMS w/ worsening agitation and behavioral

My level of activity after discharge is:
No restrictions

My diet after discharge is:
Regular

If I have the following problems.....
Go to the local Emergency Room for an emergency.
For questions and issues related to discharge instructions or medications, contact us at the Hospital Nursing Unit phone number.

The tests and issues I need to talk with my doctor(s) about at my first office visit:
F/U on Creatine Kinase over time due to her hx elevation and starting her on Zocor, as well as repeat lipid panel in few mo.

Further recommendations for patient and / or guardian:
take medication as directed and go to all outpatient appointments. NOTE: No evidence was found during admission that patient had been recently assaulted or abused (i.e. no bruising or sign of injury). When patient was less delirious, she stated that her daughter was the nicest person and "I never said that she hurt me." No APS case was filed by officer and we felt patient was safe to be d/c to daughter's care.

See separate sheet for scheduled appointments.

Important contact information:

	Name	Phone Number
My Primary Doctor		
My Hospital Doctor	Mary Craig MD	792-9041
My MHC Case Manager		
My Social Worker	Nancy Holbach, MSW	792-9041
Hospital Nursing Unit	SCU 4N	792-9041

	Name	Type of Service	Contact Person	Phone/Fax Number
My Pharmacy				

Important discharge instructions:

I have received information and listing of available agencies and have been offered a choice regarding agencies available in my area. ☐ N/A

I have reviewed my discharge and medication instructions, understand the information, and have received copies.

Patient / Caregiver

Nurse Signature Reynolds, RN Date 4/18/14 Time 1255 AM PM

Original to record Copy to Patient

iop_all_orders_dischgeneral

OTE 901167 Rev. 10/11

[redacted]

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPNOTE"

CLINICAL SOCIAL WORK HISTORY & EVALUATION

Form Origination Date: 10/11
Version: 1 Version Date: 10/11

[redacted] 7 W F

PATIENT IDENTIFICATION LABEL

PATIENT NAME: [redacted] Date of Birth: 10/8/1947 Age: 66 yo

Information From: ☐ Patient ☐ Prior / outside records ☐ MD / Nursing Assessment ☐ Other person / source _____

Presenting Problem: 66yo female c history of Alzheimer's dementia sent to ED for worsening agitation + behavioral disturbances. Neuropsy testing done. Having trouble getting ADLs done. Pt dependent on her brother unable to toilet, feed, or bathe herself. Pt. more combative trying to do ADLs. Called police. 2x on dtr. accusing her of abuse. Poor short term memory. Tells others she is abused

Referred By: MUSC ED

SIGNIFICANT RELATIONSHIPS (spouse / partner, children, parents, siblings, other) (☐ Unknown ☐ Unable to assess)

Name	Relationship	Contact Info	Lives With
[redacted]	MUH dtr	[redacted] - (cell 1st)	☒ Yes ☐ No
Stanley Sam Hoggins	[redacted] /POA MUH dtr	[redacted] - cell	☐ Yes ☐ No
			☒ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Relationship strengths / issues / concerns of note: Pt. cared for by brother + dtr. Pt. was married for several yrs. A danger to herself + others. Had dtr. arrested + dtr does not know why she was arrested or why the police believed her.

LIVING ENVIRONMENT (☐ Unknown ☐ Unable to assess)

☒ Parent's or own home _____ ☐ Relative's home _____
☐ Foster home _____ ☐ Group / community home _____
☐ Other _____ ☐ Homeless _____

Environment strengths / issues / concerns of note: Dtr. left Europe to come take care of pt. + her husb. remains in Europe caring for his dying father. If f-in-l dies, dtr. cannot go because of being arrested

EMPLOYMENT / VOCATIONAL / FINANCIAL (☐ Unknown ☐ Unable to assess ☐ Not applicable, i.e. patient is a youth)

Currently Employed ☒ No ☐ Yes (where) _____
Work history / issues of note sold furniture, homemaker, never cooked or cleaned worked 15 yrs.

Military Service: ☒ No ☐ Yes (Branch) _____

Source of Income & Support: ☐ Employment ☐ Spouse ☐ Parent / relative ☐ Disability ☐ None
☐ Other SSA $918 a month $934 now

EDUCATIONAL (primarily youth patients)

Currently in school ☒ No ☐ Yes (name) _____ Current or highest grade / degree MUH 11th 13th
Special classes _____ Grades repeated _____ 1yr. at willmore
Academic performance _____
Behavioral problems ☐ No ☐ Yes _____

Initials MUH

iop_all_docu_sw_section_eval OTE 700748 10/11

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPNOTE"

CLINICAL SOCIAL WORK HISTORY & EVALUATION

Form Origination Date: 10/11
Version: 1 Version Date: 10/11

[redacted] W F

[redacted] EL

MEDICAL (☐ Unknown ☐ Unable to assess ☐ None known)

Medical issues of significance ☒ See MD / Nursing Assessment

DEVELOPMENTAL (Youth patients or delayed adults)

Any prenatal or birth problems? ☐ No ☐ Yes (explain)

Any delays in development? ☐ No ☐ Yes (explain)

LEGAL (☐ Unknown ☐ Unable to assess ☒ None known)

Current legal issues

On probation?

Probation officer

Past legal history of significance ☐ See MD / Nursing Assessment

PSYCHIATRIC

Current outpatient provider(s)

Previous treatment ☐ See MD / Nursing Assessment for listing

Dr. Seery in May, 2013

SUBSTANCE ABUSE (☐ Unknown ☐ Unable to assess)

Substance Abuse issues ☒ See MD / Nursing Assessment
☒ None known ☐ Yes (explain)

DISCHARGE PLANNING

Community agency contacts

Other support systems

Placement on discharge
☐ Return to previous placement
☐ Going to new placement, already secured
☒ Placement yet to be determined wants Mt. Pleasant Manor

Anticipated follow-up
☐ Mental Health Center
☐ Institute of Psychiatry
☐ Private practitioner
☒ Primary care physician Dr. Karen Thomas
☐ To be determined ☐ Other

Potential adherence difficulties with discharge recommendations for
☐ Psychiatric aftercare, due to
☐ Medical aftercare, due to
☐ Medication compliance, due to
☐ Other

SOCIAL WORK FORMULATION—TREATMENT / INTERVENTION RECOMMENDATIONS

☒ Coordinate with outpatient provider(s) and any involved agencies
☒ Involve family members / significant others in patient's care. If no involvement, reason
☒ Help with provision of information / education to patient / family on diagnosis and recommended interventions
☒ Address safety issues prior to patient's discharge (involve patient and any available members of his / her support system)
☐
☐

Initials NJH Signature / Title: Nancy Hallbach, MSW Pager: 1-2262 Date: 2/3/14 Time: 10:08 AM PM

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OTE 700748 10/11

MUSC Health
INSTITUTE OF PSYCHIATRY

Social Work Note

IOPNOTE
Institute of Psychiatry
Progress Note

Form Origination Date: 5/07
Version: 2
Version Date: 5/08

[redacted] W F

[redacted] LABEL

Prohibited abbr[redacted] AZT, HCTZ, NEO)

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

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

Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5 mg NOT: .5 mg

Date	Time	
		Social Work Note
4/3/14	11:20	[redacted] was called by SW - [redacted] is dtr & caregiver for pt. She wants pt to go to Mt Pleasant Manor. Told the POA needs to go do the Medicaid - Nursing Home application immediately so pt can be placed. Dtr. moved from Europe to care for her mother 1½ yrs. ago. The pt. report her dtr to the police twice & then arrested her. She does not know the charges. She had to have a lawyer hired. Her husband is in Europe caring for his dying father. She sounded like she was very upset when she reported she could not go to the funeral because of the arrest. SW suggested she go to a Alz. support group & go to the Alz. Assoc. for support. She stated she has had a rough yr & a half. Dtr. wants pt. to go to Mt Pleasant Manor for permanent placement. Dtr. report she realized pt. had dementia starting 4yrs ago when she was 52 yo & was taken on a trip to Mexico. It was a disaster." She took pt. to every dr. in Mexico. Maybe pt. knew something was wrong at that time. Pt started working, selling furniture & her (H) divorced her. Was fired from Morris Sokol Furniture for smelling bad. (D) had to give up her work Visa which is very hard to get to care for (M) here. Pt has been "terrified of life" since divorce. She never could cook or clean when married. Had 1 yr. of college when she got pregnant. Pt's brother, Sammy, is POA because (D) had been in Europe. Nancy Holbrook, MSW
4/4/14	13[illegible]	Spoke with pt's brother Sam Huggins. He will be out of country until 4/14/14. He referred all calls to pt's daughter. Explained Mt Pleasant Manor is out of network. Pt's family is working on applying for medicaid. Che Dennis LMSW

iop_all_docu_iopprgrecrd3left

OTC 700346 Rev. 5/08 (based on OTE 700222)

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

IOPNOTE

Institute of Psychiatry
GENERAL ATTENDING NOTE
Page 1 of 2

Patient [redacted] F
MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: "I was laying here hoping I'd have someone to talk to"
PI/EXAM: Slept 8 hours, ate 75/75/50 %, and drank 960 cc based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.8
Blood pressure ____ Heart rate ____ Respiratory rate 16 Weight ____
☐ Orthostatic vital signs: Sitting blood pressure 138/74 Sitting heart rate 81 Gait slow
Narrative Description Standing blood pressure 121/63 Standing heart rate 87 Motor +hyperreflexia

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, patient was cooperative with staff, confused and disoriented but easily directed. She had a visit from her daughter. No behavioral issues. On rounds patient was pleasant and cooperative. She continued to have difficulty with speech. She was able to state she was in a hospital when given 3 choices. She was unable to state month, year. She did not appear to know the circumstances of her hospitalization. She did not have any overt paranoia.

Appearance/Activity disheveled restless
Speech soft + fluent aphasia
Mood/Affect "ok" constricted
Thought/Assoc. illogical loose
Content/Pscyhotic Appropriate w/o SI, HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc distractible

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108
TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500
Radiology/Other: M.E.
DIAGNOSES/PLAN: ~~4/03 - CK~~ 4/04 - Lipids sig Chol 201, LDL 130. CK - 342. 4/04 JB

1)Dementia with behavioral disturbance: continue aricept 10mg, namenda 10mg bid, lexapro 10mg q day. Depakote 125mg bid.
2) UTI: continue Bactrim 800-160mg bid (thru 4/9)
3) Hyperreflexia/rigidity: unknown cause appears relatively recent in onset, will continue to monitor, somewhat improved from yesterday. CK mildly elevated. Repeat in AM.
4) Mild HPL: will hold off on statin now given CK↑. JB 4/04/14

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI, hyperreflexia, cogwheel rigidity
Consult considerations: none
REASON FOR CONTINUED STAY: monitoring for behaviors, paranoia.
Discharge planning:
Floor Time:
Resident Physician Signature [signature] Pager ID 1552 Date 4/4/14 Time 10 AM/PM
☑ Patient seen and examined with resident physician, ☑ I agree with the assessment and plan as documented above
Rendering Physician Signature [signature] Pager ID 14582 Date 04/04/2014 Time 10:03 am AM/PM
Jessica Broadway, MD
lopatlprognote
OTE 604239 Rev. 7/03

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPNOTE
Institute of Psychiatry
GENERAL ATTENDING NOTE

Page 1 of 1

Form Origination Date: 7/03
Version: 4

Version Date: 6/13

[redacted] 7 W F

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: Dementia
PI/EXAM: Slept 8 hours and ate 50/50/30 % based on unit staff report Intake 840
☐ Vital signs reviewed as recorded in medical record (of note, Temperature 36.8
Blood pressure _____ Heart rate _____ Respiratory rate 16 Weight _____)
☑ Orthostatic vital signs: Sitting blood pressure 137/79 Sitting heart rate 99
Standing blood pressure 126/67 Standing heart rate 86

Narrative Description
Disorganized, paranoid
Slow Emotion, difficulty
following simple commands.
Took meds & appears

Appearance/Activity Alert, disheveled
Speech illogical
Mood/Affect "good" (contracted)
Thought impaired / disorganized
Cognition/Memory oriented x 1
Judgment/Insight poor

SOCIAL: Tired of home
TESTING: + trazodone
Radiology/Other: _____
DIAGNOSES/PLAN: DX: AD dementia
Behavior disturbance

Plan: Continue current plan
Monitor for sx's of delirium

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI, acute
Consult considerations: _____
REASON FOR CONTINUED STAY: failed OP Rx / dangerous behaviors
Discharge planning: _____

Resident Physician Signature _____ Pager ID _____ Date _____ Time _____ AM/PM
☐ Patient seen and examined with resident physician Floor time: _____
☐ Patient seen and examined with resident physician and I agree with the assessment and plan as documented above
Attending Physician Signature [signature] Pager ID 11780 Date 4-5-2014 Time 1135 AM/PM

iop_all_docu_iopattprognote

OTE 700424 6/13

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPNOTE
Institute of Psychiatry
GENERAL ATTENDING NOTE

Page 1 of 1

Form Origination Date: 7/03
Version: 4

Version Date: 6/13

[redacted] W F

Patient Name _____
MRN _____
PATIENT IDENTIFICATION LABEL

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: V Dementia 2020 M/S
PI/EXAM: Slept 8 hours and ate 100/50/75 % based on unit staff report 95%
☐ Vital signs reviewed as recorded in medical record (of note, Temperature 36.8
Blood pressure _____ Heart rate _____ Respiratory rate 16 Weight _____)
☐ Orthostatic vital signs: Sitting blood pressure 114/74 Sitting heart rate 91
Standing blood pressure 97/63 Standing heart rate 96

Narrative Description
Requires assistance c almost all tasks; paranoid about daughter Severe STM impairment Wonders into wrong rooms (+) meds & ADLs.

Appearance/Activity Awake
Speech illogical
Mood/Affect euthymic / Constricted
Thought Severely impaired.
Cognition/Memory Severe impairment
Judgment/Insight impaired

SOCIAL: Lives c daughter
TESTING: She has no recalls of the events c her daughter.
Radiology/Other:
DIAGNOSES/PLAN: DX: Hi Dementia
Behavior Disturbance

Plan: Continue current plan

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications:
Consult considerations:
REASON FOR CONTINUED STAY: Failed OP treatment / paranoid
Discharge planning:

Resident Physician Signature _____ Pager ID _____ Date _____ Time _____ AM/PM
☐ Patient seen and examined with resident physician Floor time: _____
☐ Patient seen and examined with resident physician and I agree with the assessment and plan as documented above
Attending Physician Signature [signature] Pager ID 11780 Date 4-6-2014 Time 1100 AM/PM

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

IOPNOTE

Institute of Psychiatry
GENERAL ATTENDING NOTE
Page 1 of 2

STAMP PLATE AREA

Patient Nam [redacted]
MRN

☒ Patient seen by me; nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: "I want my daughter to pick me up"
PI/EXAM: Slept 8 hours, ate 100/0/5 % , and drank 820 cc based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.7
Blood pressure ____ Heart rate ____ Respiratory rate 16 Weight ____
☐ Orthostatic vital signs: Sitting blood pressure 179/84 Sitting heart rate 74 Gait slow
Narrative Description Standing blood pressure 170/82 Standing heart rate 75 Motor less hyperreflexic

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, pt kept to herself, she appeared confused. She didn't eat lunch or dinner. She did eat PM snack. No behavioral issues. On rounds patient was pleasant. She had dressed herself in a business casual outfit with dress shoes. She denies depression, anxiety and feels she is treated well here. She had difficulty with answering orientation questions. Her muscle rigidity had significantly improved as did her hyperreflexia.

Appearance/Activity disheveled restless
Speech soft + fluent aphasia
Mood/Affect "ok" constricted
Thought/Assoc. disorganized loose
Content/Pscyhotic Approp w/o SI. HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc fair

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108
TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.
Radiology/Other: 4/5: CK: 316
DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, but no behavioral outbursts. Continue namenda 10mg bid, lexapro 10mg q day. Depakote 125mg bid. Plan to increase aricept to 10mg qam and 5mg qhs for memory.
2) UTI: continue Bactrim 800-160mg bid (thru 4/9)
3) Hyperreflexia/rigidity: unknown cause appears relatively recent in onset. Rigidity has improved with time, she's mildly hyperreflexic. CK still mildly elevated, will repeat again
4) HPL - given CVD on MRI in past, feel treatment is warranted. However, given elevated CK, will hold off for now.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI, hyperreflexia; HPL
Consult considerations: none
REASON FOR CONTINUED STAY: medication titration, monitoring hyperflexia and rigidity
Discharge planning: MUSC geri clinic Floor Time:
Resident Physician Signature _____ Pager ID 15520 Date 4/7/14 Time 11 AM/PM
☑ Patient seen and examined with resident physician, ☑ I agree with the assessment and plan as documented above
Rendering Physician Signature _____ Pager ID 14582 Date 04/07/2014 Time 11:21 am AM/PM
Jessica Broadway, MD
iopattprognote OTE 804239 Rev. 7/03

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPNOTE

Institute of Psychiatry Progress Note
Form Origination Date: 5/07
Version: 2 Version Date:5/08

[redacted]

Patien[redacted]Y
MRN

PATIENT IDENTIFICATION LABEL

Prohibited abbreviations:

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

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

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

Date	Time	
		Social Work Note
4/7/14	11[15]	Called pt's daughter [redacted] Left message requesting she call. CLW-LCSW-CP
	12[45]	Spoke w/ pts daughter urged her to complete OSS form. She would like placement of her mother. Explained MUSC is acute care hospital and Medicare is paying for her care we will assist w/ placement while she dsw pt here. SLW did CLTC. Confirmation on chart. CLW-LCSW
4/10/14	12[30]	SLW met w/ pt's daughter discussed medicaid application SLW told pt's daughter her mother will require 24 hour supervision SLW suggested that family consider adult day care for pt while daughter is at work. SLW discussed w/ daughter that pt will probably be ready for D/C the beginning of next week. Pt's daughter will discuss w/ her brother and her uncle who have power of attorney pt's need for 24 hr. supervision CLW-LCSW
	2[00]	SLW faxed paper work to CLTC application CLW-LCSW
4/11/14	2[50]	Tara Brown RN from CLTC came and did assessment on pt. She will submit for level of care. CLW-LCSW
	3[00]	SLW left message for pt's daughter to call CLW
4/11/14		SLW spoke w/ pt's daughter. She will come to visit. Pt has taken a turn for worse discussed options. Family would like placement. CLW-LCSW

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"IOPNOTE"

Institute of Psychiatry
GENERAL ATTENDING NOTE
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STAMP PLATE AREA

[redacted]

Patient Name [redacted]

MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed

Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)

Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: nausea

PI/EXAM: Slept 6.75 hours, ate 25/50/50 %, and drank 820 cc based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.7

Blood pressure _____ Heart rate _____ Respiratory rate 16 Weight _____

☐ Orthostatic vital signs: Sitting blood pressure 142/84 Sitting heart rate 97 Gait slow

Narrative Description Standing blood pressure 142/80 Standing heart rate 101 Motor less hyperreflexic

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, patient remains confused and has difficulty understanding directions. No behavioral outbursts. Awoke early in AM concerned about roommate. Appetite improved. On rounds patient appeared ill and then required a bucket due to sudden emesis. She then went to the bathroom and had a well formed bowel movement. She reported feeling and did not participate further in the interview.

:M JB 4/08/14

Appearance/Activity disheveled ~~restless~~ hypokinetic

Speech soft + fluent aphasia

Mood/Affect not reported constricted

Thought/Assoc. disorganized / loose

Content/Pscyhotic Approp w/o SI, HI no AVH on exam

Cognition/Memory O x self only poor recent and remc

Judgement/Insight poor/poor Attn/Conc fair

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108

TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.

Radiology/Other: 4/5: CK: 316 4/7: CK 213

DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, but no behavioral outbursts. Continue namenda 10mg bid, lexapro 10mg q day. Depakote 125mg bid. DC aricept given nausea/emesis. Add exelon patch 9.5mg daily (4/9)
2) UTI: continue Bactrim 800-160mg bid (thru 4/9)
3) Hyperreflexia/rigidity: unknown cause appears relatively recent in onset. Rigidity has improved with time, she's mildly hyperreflexic. CK 213, trending down
4) HPL - given CVD on MRI in past, feel treatment is warranted. However, given elevated CK, will hold off for now.
5) Nausea/Emesis: May be related to increased dose of aricept last night. Add zofran 8mg q6hprn, monitor fluid intake. Dc aricept in favor of exelon.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal

☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications: UTI, hyperreflexia, HPL

Consult considerations: none

REASON FOR CONTINUED STAY: medication titration.

Discharge planning: MUSC geri clinic

Floor Time:

Resident Physician Signature _____ Pager ID 5520 Date 4/8/14 Time 11 AM/PM

☑ Patient seen and examined with resident physician, ☑ I agree with the assessment and plan as documented above

Rendering Physician Signature _____ Pager ID 14582 Date 04/08/2014 Time 11:04 am AM/PM

Jessica Broadway, MD

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STAMP PLATE AREA

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Patie[redacted]

MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed

Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)

Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: "I want to go home"

PI/EXAM: Slept 6.75 hours, ate 25/25/40 %, and drank 1620 cc based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note. Temperature 36.6

Blood pressure _____ Heart rate _____ Respiratory rate 16 Weight _____

☐ Orthostatic vital signs: Sitting blood pressure 136/82 Sitting heart rate 100 Gait slow

Narrative Description — Standing blood pressure 137/87 Standing heart rate 102 Motor less hyperreflexic

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, patient has been calm and cooperative. No behavioral issues. On rounds patient was pleasant. She denied feeling ill and did not remember emesis. She denied depression and anxiety. She reports the desire to go home with her daughter. Social worker spoke with daughter who would patient placed due to difficulty in caring for her.

Appearance/Activity disheveled restless
Speech soft fluent aphasia
Mood/Affect "fine" constricted
Thought/Assoc. disorganized loose
Content/Psychotic Aoprob w/o SI, HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc fair

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108

TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.

Radiology/Other: 4/5: CK: 316 4/7: CK 213

DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, but no behavioral outbursts. Continue namenda 10mg bid, lexapro 10mg q day. Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. Continue exelon patch 9.5mg daily (4/9)
2) UTI: continue Bactrim 800-160mg bid (thru 4/9). Consider repeat UA to ensure resolution.
3) Hyperreflexia/rigidity: appears resolved
4) HPL - given CVD on MRI in past, feel treatment is warranted. However, given elevated CK, will hold off for now. Consider repeat CK.
5) Nausea/Emesis: appears resolved, will continue to monitor.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications: UTI, hyperreflexia, HPL

Consult considerations: none

REASON FOR CONTINUED STAY: medication titration, no safe placement

Discharge planning: MUSC gen clinic Floor Time:

Resident Physician Signature _____ Pager ID 1572 Date 4/9/14 Time 11 AM/PM

☑ Patient seen and examined with resident physician, ☑ I agree with the assessment and plan as documented above

Rendering Physician Signature _____ Pager ID 14582 Date 04/09/2014 Time 11:12 am AM/PM
Jessica Broadway, MD

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GENERAL ATTENDING NOTE
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STAMP PLATE AREA

[redacted]

Adm:04/02/14 [redacted]

Patient Name [redacted]

MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed

Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)

Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: "I want to go home"

PI/EXAM: Slept 7.25 hours, ate 25/25/40 %, and drank 1520 cc based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.7

Blood pressure _____ Heart rate _____ Respiratory rate 18 Weight _____

☐ Orthostatic vital signs: Sitting blood pressure 135/78 Sitting heart rate 85 Gait slow

Narrative Description — Standing blood pressure 101/68 Standing heart rate 80 Motor less hyperreflexic

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she was without behavioral outbursts. She has been pleasant and confused. On rounds patient was pleasant except when discussing events prior to admission. Patient was upset when told she had accused her daughter of abusing her. She denies that abuse ever took place. She denies depression and anxiety.

Appearance/Activity disheveled restless
Speech soft fluent aphasia
Mood/Affect "fine" constricted
Thought/Assoc. disorganized loose
Content/Psychotic Aoorop w/o SI, HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc fair

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108

TESTING: 4/2: CBC: sig hgb 11.7, 3/30; UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.

Radiology/Other: 4/5: CK: 316 4/7: CK 213

DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, but no behavioral outbursts. Continue namenda 10mg bid, lexapro 10mg q day. Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. Continue exelon patch 9.5mg daily (4/9)
2) UTI: resolved, completed Bactrim 800-160mg bid (thru 4/9). Will repeat UA to ensure resolution. JB 4/10/14 ME R
3) Hyperreflexia/rigidity: appears resolved
4) HPL - given CVD on MRI in past, feel treatment is warranted. However, given elevated CK, will hold off for now. Consider repeat CK.
5) Nausea/Emesis: appears resolved, will continue to monitor.
6) Disposition: unlikely to be able to return home, ppd placed 4/8 read as negative. Will speak with daughter about adult day care options that may allow patient to return home.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications: UTI(resolved), HPL

Consult considerations: none

REASON FOR CONTINUED STAY: no safe placement

Discharge planning: MUSC geri clinic Floor Time:

Resident Physician Signature _____ Pager ID 5520 Date 4/10/14 Time 10 AM/PM

☑ Patient seen and examined with resident physician, ☑ I agree with the assessment and plan as documented above

Rendering Physician Signature _____ Pager ID 14582 Date 04/10/2014 Time 10:04 am AM/PM
Jessica Broadway, MD

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STAMP PLATE AREA



Patient [redacted]
MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☒ Unstable ☐ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: patient mumbling to herself.
PI/EXAM: Slept 8 hours, ate 90/100/0 %, and drank 980 cc based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.6
Blood pressure 178/99 Heart rate 98 Respiratory rate 16 Weight
☐ Orthostatic vital signs: Sitting blood pressure Sitting heart rate Gait Galt: unsteady
Narrative Description Standing blood pressure Standing heart rate Motor ?tonic clonic LUE

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she was without behavioral outbursts. Daughter visited yesterday. She had an episode of emesis and received prn zofran. On rounds patient was being helped to dining area to eat breakfast by staff. While in the doorway she slumped to her knees while being held by staff. She appeared to have clonic movements of her body and did not respond to staff for ~30 seconds. Patient then became more alert and responsive. She was unable to say her name but nodded when asked if she was "Ms. Meyer". She tried to speak but appeared more aphasic. She appeared to have some stereotyped behaviors afterwards in LUE and was not able to follow commands (as she had been able to do on previous day). She also had fasiculations of her face. FSBS was 165 and she was mildly hypertensive at 152/79 with pulse 76.

Appearance/Activity disheveled. psychomotor retarded
Speech soft, mumbled more aphasic
Mood/Affect UTA - aphasic constricted
Thought/Assoc. disorganized loose
Content/Psychotic unable to answer no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc distractible

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108
TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.
Radiology/Other: 4/5: CK: 316 4/7: CK 213, 4/10: CK 175
DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, but no behavioral outbursts. Continue namenda 10mg bid, lexapro 10mg q day. Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. Continue exelon patch 9.5mg daily (4/9)
2) UTI: resolved, completed Bactrim 800-160mg bid (thru 4/9). Repeat UA pending.
3) ?seizure: stat EEG ordered. Hyperreflexia and stereotyped movements present as are some muscle fasiculations. Will follow up on EEG and consider titrating depakote to therapeutic dose.
4) HPL - given CVD on MRI in past, treatment is warranted. CK 175 (wnl). Will start Zocor 10mg po qhs (start 4/11)
5) Nausea/Emesis: unlikely related to Exelon. May be related to underlying neurological condition, emesis does seem related to sporadic elevated BP's
6) Hypertension: Patient has had sporadic elevated BP's. Does not appear to be essential HTN, will continue to monitor
7) elevated FSBS: (165) Will check hgaic
8) Disposition: may be able to be dc home once stable. Family still deciding which family member will be responsible for caretaking. ppd placed 4/8 read as negative, in case placement is an option or adult day care is an option. Family given information on adult daycare.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI(resolved), HPL, ?seizure, emesis

Consult considerations: none
REASON FOR CONTINUED STAY: no safe placement, new onset ?neurological issue, emesis

Discharge planning: MUSC geri clinic home w/ adult day care? Floor Time:
Resident Physician Signature Pager ID Date Time AM/PM
☑ Patient seen and examined with resident physician, ☐ I agree with the assessment and plan as documented above
Rendering Physician Signature Pager ID 14582 Date 04/11/2014 Time 10:55 am AM/PM
Jessica Broadway, MD

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GENERAL ATTENDING NOTE
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STAMP PLATE AREA

Patient Nam [redacted]
MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☒ Unstable ☐ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No.
Chief Complaint: "I'm good."
PI/EXAM: Slept 8 hours, ate 0 x 3 % ; and drank 600 cc based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.9
Blood pressure ____ Heart rate ____ Respiratory rate 16 Weight ____
☐ Orthostatic vital signs: Sitting blood pressure 162/84 Sitting heart rate 81 Gait Gait not observe
Narrative Description Standing blood pressure 145/73 Standing heart rate 88 Motor no tremor/jerking today

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she was very lethargic and had what appeared to be possible seizure yest AM. In afternoon, she continued to be lethargic and have some jerking movements of her LUE and twitching under her eyes. Had episode of BM incontinence x 2 yesterday (once during ? seizure and once in evening while napping and having jerking movements). Slept well. This AM on rounds, she is lying calmly in bed. Able to speak more clearly than yesterday post-event. Also more alert and engaged than yest AM. She appears to have very dry mucous membranes and pill fragments still stuck in her mouth.

Appearance/Activity disheveled psychomotor retarded
Speech soft, mumbled aphasic, but better
Mood/Affect "Fine, I'm okay." little brighter
Thought/Assoc. disorganized loose
Content/Psychotic Approp w/o SI. HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc distractible

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108
TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.
Radiology/Other: 4/5: CK: 316 4/7: CK 213, 4/10: CK 175

DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, but no behavioral outbursts. Continue namenda 10mg bid, lexapro 10mg q day. Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. Continue exelon patch 9.5mg daily (4/9). Given difficulty swallowing pills (2/2 difficulty processing), will write order to crush all meds.
2) UTI: resolved, completed Bactrim 800-160mg bid (thru 4/9). Repeat UA collected yesterday, but doesn't appear to have ever been run by lab. Will f/u.
3) Possible Seizure activity: Stat EEG done yesterday reportedly consistent w/ moderate encephalopathy, but no seizure activity or focus. Will await final report.
4) HPL - given CVD on MRI in past, treatment is warranted. CK 175 (wnl). Continue Zocor 10mg po qhs (start 4/11)
5) Nausea/Emesis: unlikely related to Exelon. May be related to underlying neurological condition. Emesis does seem related to sporadic elevated BP's
6) Hypertension: Patient has had sporadic elevated BP's. Does not appear to be essential HTN, will continue to monitor
7) elevated FSBS: (165) HgbA1c pending (again drawn yesterday, I saw it myself, but not showing up in system). Will f/u with lab.
8) Poor po intake - start boost supplements with meals, start IVF 1000 cc 0.9%NS at 150cc/hr (4/12).
9) Disposition: May be able to be dc home once stable. Family still deciding which family member will be responsible for care-taking. PPD placed 4/8 read as negative, in case placement is an option or adult day care is an option. Family given information on adult daycare.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI(resolved), HPL, ?seizure, emesis
Consult considerations: none
REASON FOR CONTINUED STAY: poor po intake, varying mental status, bizarre movements yesterday
Discharge planning: MUSC geri clinic home w/ adult day care? Floor Time:
Resident Physician Signature ____ Pager ID ____ Date ____ Time ____ AM/PM
☐ Patient seen and examined with resident physician, ☐ I agree with the assessment and plan as documented above
Rendering Physician Signature JBroadway MD Pager ID 14582 Date 04/12/2014 Time 12:04 pm AM/PM
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GENERAL ATTENDING NOTE
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STAMP PLATE AREA

[redacted]

Patient Nam[redacted]
MRN [redacted]

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: "I'm fine." (+1000 cc IVF)
PI/EXAM: Slept 6.5 hours, ate 0/0/50 %, and drank 540 cc based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.2
Blood pressure ____ Heart rate ____ Respiratory rate 16 Weight ____
☐ Orthostatic vital signs: Sitting blood pressure 153/75 Sitting heart rate 68 Gait Gait not observe ____
Narrative Description Standing blood pressure 150/80 Standing heart rate 85 Motor no tremor/jerking today

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she was unable to swallow medications yesterday due to difficulty processing. Pt rec'd IVF yesterday due to poor po intake. Tolerated well. Continues to seem more confused last few days.

Appearance/Activity disheveled psychomotor retarded
Speech soft, mumbled aphasic, but better
Mood/Affect euthymic blunted
Thought/Assoc. disorganized incoherent
Content/Psychotic Approp w/o SI. HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc distractible

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108
TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.
Radiology/Other: 4/5: CK: 316 4/7: CK 213, 4/10: CK 175 4/12 - UA + blood, 20 protein, few bacteria and mucous; HgbA1c 5.3%

DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, but no behavioral outbursts. Continue Namenda 10mg bid, Lexapro 10mg q day. Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. Continue exelon patch 9.5mg daily (4/9). Given difficulty swallowing pills (2/2 difficulty processing), crushing all meds.
2) UTI: resolved, completed Bactrim 800-160mg bid (thru 4/9). Repeat UA inconsistent with ongoing infection.
3) Possible Seizure activity: Stat EEG done 4/11 reportedly consistent w/ moderate encephalopathy, but no seizure activity or focus. Will await final report.
4) HPL - given CVD on MRI in past, treatment is warranted. CK 175 (wnl). Continue Zocor 10mg po qhs (start 4/11)
5) Nausea/Emesis: seems unlikely r/t Exelon, but possible, so will d/c Exelon.
6) Hypertension: Patient has had sporadic elevated BP's. Does not appear to be essential HTN, will continue to monitor
7) elevated FSBS after shaking event, but HgbA1c was wnl, so no evidence of DM2. Must have been related to "event," which appeared like a seizure but did not show on EEG.
8) Poor po intake - boost supplements with meals, given IVF on 4/12. Will d/c Exelon to see if appetite improves.
9) Disposition: May be able to be dc home once stable. Family still deciding which family member will be responsible for care-taking. PPD placed 4/8 read as negative, in case placement is an option or adult day care is an option. Family given information on adult daycare.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI(resolved), HPL, ?seizure, emesis

Consult considerations: none
REASON FOR CONTINUED STAY: poor po intake, varying mental status
consider hospice if po intake doesn't improve soon
Discharge planning: MUSC geri clinic home w/ adult day care? Floor Time:
Resident Physician Signature ____ Pager ID ____ Date ____ Time ____ AM/PM
☐ Patient seen and examined with resident physician, ☐ I agree with the assessment and plan as documented above
Rendering Physician Signature JBroadway Pager ID 14582 Date 04/13/2014 Time 06:59 am AM/PM
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Institute of Psychiatry
GENERAL ATTENDING NOTE
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STAMP PLATE AREA

[redacted]

Patient Name [redacted]

MRN .

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed

Condition: ☒ Unstable ☐ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)

Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: no complaints, patient somewhat lethargic

PI/EXAM: Slept 8 hours, ate 0/30/NR %, and drank 90 cc based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.2
Blood pressure _____ Heart rate _____ Respiratory rate 16 Weight _____

☐ Orthostatic vital signs: Sitting blood pressure 153/75 Sitting heart rate 68 Gait . Gait not observe _____
Standing blood pressure 150/80 Standing heart rate 85 Motor no tremor/jerking today

Narrative Description

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she took meds voluntarily. Stated she was hungry but would not eat breakfast. Intake only 90 cc yesterday and needed IVF this weekend due to poor po intake. On rounds patient was sleeping in bed. She awoke to voice, and denied complaints. She appeared lethargic and mildly dehydrated. She received 2mg lorazepam at 3pm yesterday for anxiety.

Appearance/Activity disheveled psychomotor retarded
Speech soft, mumbled aphasic
Mood/Affect "ok" blunted
Thought/Assoc. disorganized incoherant
Content/Pscyhotic Aoorop w/o SI HI no AVH on exam
Cognition/Memory O x self only poor recent and remt
Judgement/Insight poor/poor Attn/Conc distractible

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108

TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL-130.

Radiology/Other: 4/5: CK: 316 4/7: CK 213, 4/10: CK 175 4/12 - UA + blood, 20 protein, few bacteria and mucous; HgbA1c 5.3%

DIAGNOSES/PLAN:

1)Dementia with behavioral disturbance: Continued confusion, now more lethargic, but no behavioral outbursts. Continue Namenda 10mg bid, Lexapro 10mg q day. Depakote 125mg bid. Antcipt DC'd due to emesis on 4/8. DC'd exelon patch 9.5mg daily (4/13) due to poor po intake. Given difficulty swallowing pills (2/2 difficulty processing), crushing all meds. Will change PRN's to lower dosas(haldol 2mg q6pm, ativan 1mg q6pm).
2) UTI: resolved, completed Bactrim 800-160mg bid (thru 4/8). Repeat UA inconsistent with ongoing infection.
3) Possible Seizure activity: Stat EEG done 4/11 reportedly consistent w/ moderate encephalopathy, but no seizure activity or focus. Will continue to monitor
4) HPL: Continue Zocor 10mg po qhs (start 4/11)
5) Nausea/Emesis: seems unlikely r/t Exelon, but possible. Exelon d/c'd. Continue to monitor.
6) Hypertension: Patient has had sporadic elevated BP's. Does not appear to be essential HTN, will continue to monitor
7) elevated FSBS after shaking event, but HgbA1c was wnl, so no evidence of DM2.
8) Poor po intake: boost supplements with meals, given IVF on 4/12. Exelon D/C'd to see if appetite improves. Will give IVF at today given poor po intake. Will also check CK, CBC, CMP.
9) Disposition: May be able to be dc home once stable. Family still deciding which family member will be responsible for care-taking. PPD placed 4/8 read as negative, in case placement is an option or adult day care is an option. Family given information on adult daycare.

IL KB 4/14/14

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications: UTI(resolved), HPL

Consult considerations: none

REASON FOR CONTINUED STAY: poor po intake, varying mental status
consider hospice if po intake doesn't improve soon

Discharge planning: MUSC geri clinic home w/ adult day care? Floor Time:

Resident Physician Signature [signature] Pager ID 15520 Date 4/14/14 Time 11 AM/PM

☑ Patient seen and examined with resident physician. ☑ I agree with the assessment and plan as documented above

Rendering Physician Signature [signature] Pager ID 14582 Date 04/14/2014 Time 11:12 am AM/PM
Jessica Broadway, MD

iopatprognote

OTE 804239 Rev. 7/03

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

IOPNOTE

Institute of Psychiatry
GENERAL ATTENDING NOTE
Page 1 of 2

STAMP PLATE AREA



Patient Name [redacted]
MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☒ Unstable ☐ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: no complaints, patient somewhat lethargic (1L IV)
PI/EXAM: Slept 8 hours, ate 15/15/10 %, and drank 1080 cc based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.2
Blood pressure ____ Heart rate ____ Respiratory rate 16 Weight ____
☐ Orthostatic vital signs: Sitting blood pressure 148/91 Sitting heart rate 65 Gait Gait not observe
Narrative Description Standing blood pressure 138/73 Standing heart rate 66 Motor +hyperreflexia

66.yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she took meds voluntarily. Staff helped her shower. No behavioral issues. On rounds patient was in the day area. She was more awake than yesterday, but still sleepy. She denied complaints. Old friend (who works at hospital) provided collateral hx that patient has really taken a significant decline for the worse in past few months.

Appearance/Activity disheveled psychomotor retarded
Speech soft, mumbled aphasic
Mood/Affect "ok" blunted
Thought/Assoc. disorganized incoherant
Content/Pscyhotic Aporop w/o SI, HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc distractible

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108
TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.
Radiology/Other: 4/5: CK: 316 4/7: CK 213, 4/10: CK 175 4/12 - UA + blood, 20 protein, few bacteria and mucous; HgbA1c 5.3%
DIAGNOSES/PLAN: 4/14 - CBC, CMP, CK pending still

1)Dementia with behavioral disturbance: Continued confusion, somewhat less lethargic, but no behavioral outbursts. Continue Namenda 10mg bid, Lexapro 10mg q day, Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. DC'd exelon patch 9.5mg daily (4/13) due to poor po intake. Given difficulty swallowing pills (2/2 difficulty processing), crushing all meds. PRN's haldol 2mg q6pm, ativan 1mg q6prn.
2) Possible Seizure activity: Stat EEG done 4/11 reportedly consistent w/ moderate encephalopathy, but no seizure activity or focus. No further symptoms
3) HPL: Continue Zocor 10mg po qhs (start 4/11)
4) Nausea/Emesis: seems unlikely r/t Exelon, but possible, Exelon d/c'd. Continue to monitor.
5) Hypertension: Patient has had sporadic elevated BP's. Does not appear to be essential HTN, will continue to monitor
6) Poor po intake: boost supplements with meals, given IVF on 4/14. Intake improved yesterday on her own. Follow up CK, CBC, CMP
7) Disposition: May be able to be dc home once stable. Family still deciding which family member will be responsible for care-taking. PPD placed 4/8 read as negative, in case placement is an option or adult day care is an option. Family given information on adult daycare.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI(resolved), HPL
Consult considerations: none
REASON FOR CONTINUED STAY: poor po intake, varying mental status
consider hospice if po intake doesn't improve soon
Discharge planning: MUSC geri clinic home w/ adult day care? Floor Time:
Resident Physician Signature ____ Pager ID ____ Date ____ Time ____ AM/PM
☑ Patient seen and examined with resident physician, ☐ I agree with the assessment and plan as documented above
Rendering Physician Signature Jessica Broadway, MD Pager ID 14582 Date 04/15/2014 Time 11:54 am AM/PM
iopatlprognote OTE 804239 Rev. 7/03

MUSC Health
INSTITUTE OF PSYCHIATRY

"IOPNOTE"

Institute of Psychiatry Progress Note.
Form Origination Date: 5/07
Version: 2 Version Date:5/08

Patient Na [redacted] F
MRN [redacted]
PATIENT IDENTIFICATION

Prohibited abbreviations:

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

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

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

Date	Time	
4/15/14	3[00]	Pt's daughter and friend visited. Very distressed about condition of pt. Pt's brother faxed DNR - copy on chart. Chu Deu LPN
4/17/14	2[00]	Pt is much improved. Discussed w/ daughter and pt's brother pt being D/C home due to not meeting criteria for hospitalization. Suggested short term placement as private pay for at Mt. Pleasant Manor or Irving a sitter for pt. [illegible] LPN
4/18/14	10[30]	Spoke w/ pt's daughter She will be picking up ~~dinner~~ error her mother. Talked w/ her brother discussed options of reverse mortage selling off her possessions to raise money to pay for sitter, adult day care or long term care. Chu Deu LPN

iop_all_docu_iopprgrecrd OTE 700345 Rev. 5/08 (based on OTE 700222)

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IOPNOTE

Institute of Psychiatry
GENERAL ATTENDING NOTE
Page 1 of 2

STAMP PLATE AREA

Patient Nam [redacted]
MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No
Chief Complaint: "I'm doing ok, I'd like to call my daughter to pick me up
PI/EXAM: Slept 8 hours, ate 15/15/10 %, and drank 1088 cc based on unit staff report
☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.8
Blood pressure ____ Heart rate ____ Respiratory rate 16 Weight ____
☐ Orthostatic vital signs: Sitting blood pressure 131/74 Sitting heart rate 80 Gait Gait not observe ____
Narrative Description Standing blood pressure 125/81 Standing heart rate 90 Motor less hyperreflexia

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she was lethargic in the AM. She had a good visit with a family member. She was able to eat dinner on her own. On rounds patient was much more alert and even better able to communicate with team. She reports that she was feeling sick before, but she feels good today. She was observed eating yogurt on her own. She reports the desire to return home with her daughter.

Appearance/Activity disheveled psychomotor retarded
Speech soft less aphasic
Mood/Affect "good" blunted
Thought/Assoc. disorganized incoherent
Content/Psychotic Approp w/o SI; HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc fair

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108
TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.
Radiology/Other: 4/5: CK: 316 4/7: CK 213, 4/10: CK 175 4/12 - UA + blood, 20 protein, few bacteria and mucous; HgbA1c 5.3%
DIAGNOSES/PLAN: 4/14 -CBCno change CMP: sig cl 101 CK: 320

1)Dementia with behavioral disturbance: Continued confusion, much more alert and no behavioral outbursts since admission. Continue Namenda 10mg bid, Lexapro 10mg q day. Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. DC'd exelon patch 9.5mg daily (4/13) due to poor po intake. Given difficulty swallowing pills (2/2 difficulty processing), may be able to transition back to regular pills crushing all meds. PRN's haldol 2mg q6prn, ativan 1mg q6pm.
2) Possible Seizure activity: Stat EEG done 4/11 reportedly consistent w/ moderate encephalopathy, but no seizure activity or focus. No further symptoms
3) HPL: Continue Zocor 10mg po qhs (start 4/11)
4) Nausea/Emesis: seems unlikely r/t Exelon, but possible, Exelon d/c'd. No recent emesis. Continue to monitor.
5) Hypertension: Patient has had sporadic elevated BP's. Does not appear to be essential HTN, will continue to monitor
6) Poor po intake: boost supplements with meals, labs WNL with exception for slightly elevated CK. Intake improving as lethargy resolves
7) Disposition: May be able to be dc home once stable. Family still deciding which family member will be responsible for care-taking. PPD placed 4/8 read as negative, in case placement is an option or adult day care is an option. Family given information on adult daycare.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☒ family meeting
Medical Diagnoses/Complications: UTI(resolved), HPL

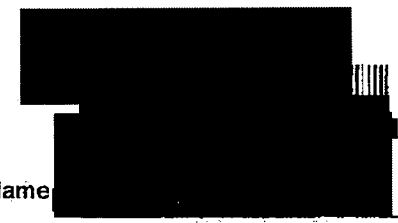
Consult considerations: none
REASON FOR CONTINUED STAY: poor po intake, varying mental status
consider hospice if po intake doesn't improve soon
Discharge planning: MUSC ger clinic home w/ adult day care? Floor Time:
Resident Physician Signature ____ Pager ID 1572 Date 4/16/14 Time 11 AM/PM
☑ Patient seen and examined with resident physician, ☑ I agree with the assessment and plan as documented above
Rendering Physician Signature ____ Pager ID 14582 Date 04/16/2014 Time 11:45 am AM/PM
Jessica Broadway, MD
iopattprognote
OTE 804239 Rev. 7/03

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IOPNOTE

Institute of Psychiatry
GENERAL ATTENDING NOTE
Page 1 of 2

STAMP PLATE AREA



Patient Name [redacted]

MRN

☒ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed

Condition: ☐ Unstable ☒ Unstable, but stabilizing ☐ Stable (but symptomatic) ☐ Stable (asymptomatic)

Patient secluded/restrained in past 24 hours: ☐ Yes ☒ No

Chief Complaint: "I'm good, I want to go home"

PI/EXAM: Slept 8 hours, ate 15/15/10 %, and drank 1200 cc based on unit staff report

☒ Vital signs reviewed as recorded in medical record (of note, Temperature 36.8
Blood pressure _____ Heart rate _____ Respiratory rate 16 Weight _____

☐ Orthostatic vital signs: Sitting blood pressure 130/80 Sitting heart rate 71 Gait . Gait not observe _____
Narrative Description Standing blood pressure 128/80 Standing heart rate 87 Motor less hyperreflexia

66 yo female with Dementia adm due to increasing aggressive behavior with family. Per 24 hour report, she was lethargic in the AM. She had a good visit with a family member. She was able to eat dinner on her own. On rounds patient was much more alert and even better able to communicate with team. She reports she is doing well and would like to go home with her daughter. She did not remember daughter's visit yesterday.

Appearance/Activity disheveled psychomotor retarded
Speech soft aphasic
Mood/Affect "good" . blunted
Thought/Assoc. disorganized incoherant
Content/Pscyhotic Approp w/o SI, HI no AVH on exam
Cognition/Memory O x self only poor recent and remc
Judgement/Insight poor/poor Attn/Conc fair

SOCIAL: 4/2: ammonia: 33, depakote: 27.2 CMP: sig Cl 108

TESTING: 4/2: CBC: sig hgb 11.7, 3/30: UA: nitrite +, blood small, WBC: 13, leuk est: 500 4/04 - CK 342; Lipids w/ chol 201, LDL 130.

Radiology/Other: 4/5: CK: 316 4/7: CK 213, 4/10: CK 175 4/12 - UA + blood, 20 protein, few bacteria and mucous; HgbA1c 5.3%

DIAGNOSES/PLAN: 4/14 -CBCno change CMP: sig cl 101 CK: 320

1)Dementia with behavioral disturbance: Continued confusion, much more alert and no behavioral outbursts since admission. Continue Namenda 10mg bid, Lexapro 10mg q day. Depakote 125mg bid. Aricept DC'd due to emesis on 4/8. DC'd exelon patch 9.5mg daily (4/13) due to poor po intake. Crushing meds. PRN's haldol 2mg q6prn, ativan 1mg q6prn. no prn'sneeded
2) Possible Seizure activity: Stat EEG done 4/11 reportedly consistent w/ moderate encephalopathy, but no seizure activity or focus. No further symptoms
3) HPL: Continue Zocor 10mg po qhs (start 4/11)
4) Nausea/Emesis: seems unlikely r/t Exelon, but possible, Exelon d/c'd. No recent emesis. Continue to monitor.
5) Hypertension: Patient has had sporadic elevated BP's. Does not appear to be essential HTN, will continue to monitor
6) Poor po intake: boost supplements with meals, labs WNL with exception for slightly elevated CK. Intake improving as lethargy resolves, she is now able to feed herself, but still eating less. Will consider appetite stimulant.
7) Disposition: M Family had reported plan to get patient into Mt. Pleasant Manor, however this is unlikely after SW followed up with the admissions office. Will likely DC home to daughter with plan for adult daycare to help for respite.

☒ monitor behavior and mental state ☒ continue psychosocial milieu ☒ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting

Medical Diagnoses/Complications: UTI(resolved), HPL

Consult considerations: none

REASON FOR CONTINUED STAY: poor po intake, varying mental status
~~no safe discharge~~ likely home tomorrow

Discharge planning: MUSC ped clinic Seen home w/ adult day care? Floor Time:

Resident Physician Signature _____ Pager ID [redacted] Date 4/17/14 Time 8:21 AM/PM

☑ Patient seen and examined with resident physician, ☑ I agree with the assessment and plan as documented above

Rendering Physician Signature _____ Pager ID 14582 Date 04/17/2014 Time 10:37 am AM/PM
Jessica Broadway, MD

iopattprognote

OTE 804239 Rev. 7/03

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPNOTE
Institute of Psychiatry
GENERAL ATTENDING NOTE

Page 1 of 1

Form Origination Date: 7/03
Version: 4
Version Date: 6/13

[redacted]

Patient Name [redacted]
MRN
PATIENT IDENTIFICATION LABEL

☑ Patient seen by me, nursing report presented, management reviewed with interdisciplinary team, chart history reviewed
Condition: ☐ Unstable ☐ Unstable, but stabilizing ☑ Stable (but symptomatic) ☐ Stable (asymptomatic)
Patient secluded/restrained in past 24 hours: ☐ Yes ☑ No
Chief Complaint: "when my ⓑ gets here I will be happy"
PI/EXAM: Slept 10 hours and ate 100/70/50% based on unit staff report 1000 cc
☐ Vital signs reviewed as recorded in medical record (of note, Temperature 36.7
Blood pressure _____ Heart rate _____ Respiratory rate _____ Weight _____)
☑ Orthostatic vital signs: Sitting blood pressure 138/86 Sitting heart rate 66
Standing blood pressure 110/80 Standing heart rate 84

Narrative Description
Seems less lethargic, eats on own & ↓ROOMING. Aphasic. Cooperative c care. ↓ Tremor or abn. movements. Mildly psychomotor retarded.

Appearance/Activity in daytime w. disheveled.
Speech soft, minimal responses.
Mood/Affect "OK" blunted, brief affect
Thought ↓ Auth & paranoia content ↓ SI/HI
Cognition/Memory oriented to situation, not date
Judgment/Insight both poor.

SOCIAL:
TESTING:
Radiology/Other:
DIAGNOSES/PLAN: AD c beh. dist., Delirium 2° UTI on admit
(1) AD - Namenda 10 BID
(2) Behavior dist. - Depakote ER 500 BID and Seroquel 10 QD.
↑ wfo behaviors/aggression. Ready for DC. Tolerating medications.

☑ monitor behavior and mental state ☑ continue psychosocial milieu ☑ maintain safety ☐ observe for withdrawal
☐ obtain further information/medical records ☐ family meeting
Medical Diagnoses/Complications: UTI (resolved), HPL

Consult considerations:
REASON FOR CONTINUED STAY: N/A
Discharge planning: D/C home today c daughter. F/u DK. Seroq.

Resident Physician Signature _____ Pager ID _____ Date _____ Time _____ AM/PM
☐ Patient seen and examined with resident physician Floor time: _____
☐ Patient seen and examined with resident physician and I agree with the assessment and plan as documented above
Attending Physician Signature [signature] Pager ID 14170 Date 4/12/14 Time 1125 AM/PM

iop_all_docu_iopattprognote

OTE 700424 Rev. 6/19/13

MUSC Health

PPDTRACKING

Tuberculosis Skin Test (TST) Tracking Form

Form Origination Date: 12/04
Version #: 4 Version Date: 8/07

[redacted]

Patient MRN [redacted]

PATIENT IDENTIFICATION LABEL

Date Administered: 04/08/14

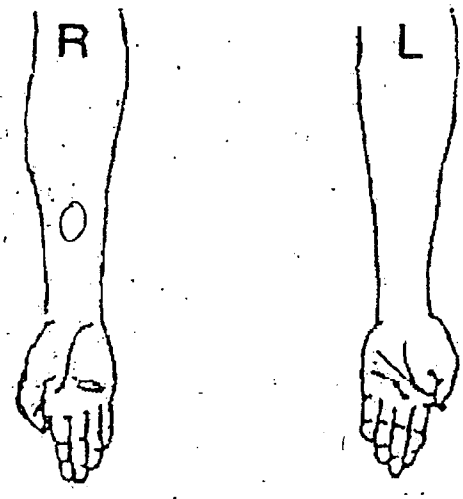
Time Administered: 1430 AM/PM

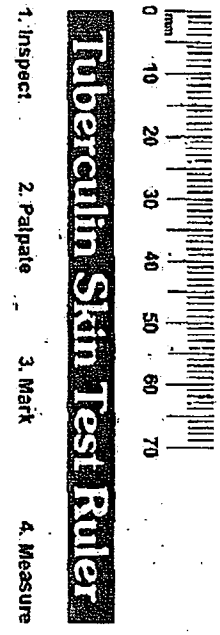
RN Signature: Ashley J. Mack, RN

DRAW ON ARMS BELOW LABELING SITE(S) OF ADMINISTRATION FOR TST AND FOR CONTROLS IF ORDERED

TST=TUBERCULOSIS SKIN TEST C=CANDIDA T=TETANUS

Lot # C4513BB Exp: may 27, 2016





RECORD RESULTS BELOW BETWEEN 48 AND 72 HOURS AFTER PLACEMENT:

Measure only palpable induration (raised area) across widest areas, NOT erythema (redness)

TST	DATE 4/10/14 TIME 1434 AM/PM	0 mm	RN SIGNATURE [redacted] RN
CANDIDA	DATE _____ TIME _____ AM/PM	_____ mm	RN SIGNATURE
TETANUS	DATE _____ TIME _____ AM/PM	_____ mm	RN SIGNATURE

all_all_docu_ppdtracking

OTE 900163 Rev. 8/07

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPTRTMTPLN

Treatment Plan: Fall Risk

Page 1 of 1

[redacted] 1947 W F

Form Origination Date: 6/12
Version: 1

Version Date: 6/12

[redacted] EAdm:04/02/14 675

Patient Issues / Displayed Behaviors	Team Interventions	Staff Responsible for Interventions (Initial)	Patient Outcomes	Target Date	Evaluation of Patient Outcomes
☐ History of falls	☑ Fall Risk Assessment completed	MD RN SW RT	☑ Remain free of falls during hospitalization	4/9/14	☐ Not met ☐ Partial ☐ Met Date _____ Comments: _____
☑ Unsteady gait	☑ Fall risk level determined	MD RN SW RT			
☐ Vertigo	☐ Appropriate colored dot stickers placed according to policy	MD RN SW RT	☐ Verbalize understanding of possible medication side effects in terms of fall risk		☐ Not met ☐ Partial ☐ Met Date _____ Comments: _____
☐ Visual / auditory impairment	☑ Monitor patient Q 15 minutes	MD RN SW RT			
☑ Altered mental status AEB: _____	☐ Environment free of clutter and spills	MD RN SW RT	☐ Call on and utilize staff for assistance when needed		☐ Not met ☐ Partial ☐ Met Date _____ Comments: _____
	☐ Path between patient's bed and bathroom is free of obstacles	MD RN SW RT			
	☑ Medication education provided / discussed	MD RN SW RT	☐ Verbalize understanding of fall precautions		☐ Not met ☐ Partial ☐ Met Date _____ Comments: _____
☐ Medication side effect	☐ Assist with ADLs as needed	MD RN SW RT			
☐ Patient on warfarin	☐ Offer assistance with toileting frequently	MD RN SW RT			
☐ Patient is insulin-dependent diabetic	☐ Walk beside patient when transitioning off unit	MD RN SW RT	☐ Other: _____		☐ Not met ☐ Partial ☐ Met Date _____ Comments: _____
☐ Patient is detoxing	☐ Reorient patient as needed	MD RN SW RT			
☐ Patient has hypertension with unstable blood pressure	☐ Provide a shower chair	MD RN SW RT			
	☐ Secure locks on wheelchair	MD RN SW RT			
	☐ Secure footwear	MD RN SW RT			
☐ Other: _____	☐ Provide nonskid socks	MD RN SW RT			
	☐ Orient patient to unit and patient room	MD RN SW RT			
	☐ Other: _____	MD RN SW RT			

Date: 4/2/14 Time: 17:00 AM / PM Staff Signature: Yalena D. Talley, W Initials: YDT

Date: _____ Time: _____ AM / PM Staff Signature: _____ Initials: _____

Date: 4/03/14 Time: 1330 AM / PM Staff Signature: Broadway, D Initials: DB

Date: _____ Time: _____ AM / PM Staff Signature: _____ Initials: _____

Date: _____ Time: _____ AM / PM Staff Signature: _____ Initials: _____

Date: _____ Time: _____ AM / PM Staff Signature: _____ Initials: _____

iop_tx_plan_fall_risk

OTE 901599 6/12

Page 1 of 4

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPTRTMTPLN

Treatment Plan: Cognitive Impairment

Page 1 of 1

Form Origination Date: 6/12
Version: 1 Version Date: 6/12

P:105025522 DOB:10/08/1947 W F
MEYER
RHONDA
Adm:04/02/14 M:1083675
PATIENT IDENTIFICATION LABEL

Limitations of patient for this problem: _____
Strengths to be maximized for this problem: _____
Goal: ☑ Decrease or eliminate agitation ☑ Decrease or eliminate wandering and intrusive behavior ☐ Increase participation in self care and structured activities

Patient Issues / Displayed Behaviors	Team Interventions	Date Opened	Staff Responsible for Interventions (Initial)	Patient Outcomes	Target Date	Evaluation of Patient Outcomes
☑ Confusion ☐ Disorientation ☐ Poor recent memory ☐ Poor remote memory ☑ Unable to participate in interview ☐ Poor judgment ☑ Unable to communicate needs effectively	☐ Visual precautions or 1:1 precautions ☑ Monitor patient Q 15 minutes ☑ Reality orientation ☑ Medication initiation and / or management ☑ Medication education ☐ Coordinate care with _____ ☑ Assist with activities of daily living ☐ Assess nutritional status, encourage adequate PO intake, monitor, record ☐ Record sleep patterns Q 30 minutes ☐ Assess for interaction and environmental triggers ☐ Implement fall protocol ☑ Recreational therapy groups ☑ Assist family / caregiver with placement if needed for safety ☐ Other _____	4/2	MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT MD RN SW RT	☐ Stable or improved orientation ☐ Stable or improved judgment ☑ Participates in activities of daily living calmly and safely ☐ Expresses an understanding of diagnosis and agrees to ongoing treatment ☐ Sleeps 6-8 hours per night with no more than 2 hours of daytime sleep ☐ Consumes adequate PO to maintain weight while in the hospital ☐ Drinks adequate fluid to prevent signs and symptoms of dehydration while in the hospital ☐ Verbalizes an understanding of the need for medication compliance and takes medications while in the hospital ☑ Attends / participates in group activities as appropriate ☑ Discharge plan includes measures to address safety (e.g., at home, assisted living, home health, etc.) ☐ Other _____	4/9	☐ Not met or ☐ Pa (see Master Plan Re ☐ Met Date _____ ☐ Not met or ☐ Partial (see Master Plan Review) ☐ Met Date _____ ☐ Not met or ☐ Partial (see Master Plan Review) ☐ Met Date _____ ☐ Not met or ☐ Partial (see Master Plan Re ☐ Met Date _____ ☐ Not met or ☐ Pan.. (see Master Plan Review) ☐ Met Date _____ ☐ Not met or ☐ Partial (see Master Plan Review) ☐ Met Date _____ ☐ Not met or ☐ Partial (see Master Plan Review) ☐ Met Date _____ ☐ Not met or ☐ Par (see Master Plan Rev. ☐ Met Date _____ ☐ Not met or ☒ Partial (see Master Plan Review) ☐ Met Date exercise 4/3/14 ☐ Not met or ☐ Partial (see Master Plan Review) ☒ Met Date 4/18/14 ☐ Not met or ☐ Partia (see Master Plan Re ☐ Met Date _____
☐ Lack of insight into severity of illness and / or treatment complications						
☐ Sleep / wake cycle disturbance						
☐ Poor PO intake with weight loss and / or dehydration						
☐ Delusions / paranoia						
☑ Agitation / aggression ☐ Verbal ☑ Physical ☑ Restless / pacing						
☐ Other _____						

Date: 4/2/14 Time: 1802 AM / PM Staff Signature: Helena H. Talley, RN Initials: HHT
Date: 4/3/14 Time: 1200 AM / PM Staff Signature: Mary LaBlack MSW Initials: MLB
Date: 4/8/14 Time: 13 AM / PM Staff Signature: [illegible] Initials: [illegible]
Date: 4/9/14 Time: 1915 AM / PM Staff Signature: [illegible] Initials: LD
Date: _____ Time: _____ AM / PM Staff Signature: _____ Initials: _____
Date: 4-4-14 Time: 2000 AM / PM Staff Signature: [illegible] Initials: [illegible]
4/18/14 190 PM

iop_tx_plan_cog_impair OTE 901595 6/12

MUSC Health
INSTITUTE OF PSYCHIATRY

IOPTRTMTPLN

Institute of Psychiatry Individual Treatment Plan

Form Origination Date: 2/01
Version: 3 Version Date: 6/09

[redacted]

DSM-IV CODE:

ICD-9:
Axis I: Alzheimer's Dementia, Dementia vs Delirium
Axis II: deferred
Axis III: UTI
Axis IV: Chronic mental illness
Axis V: GAF 20

Strengths and Limitations:

	Good	Fair	Poor	N/A
Communication	☐	☐	☑	☐
Stable living environment	☑	☐	☐	☐
Supportive relationship(s)	☑	☐	☐	☐
Stable at school/work	☐	☐	☐	☑
Physical health	☑	☐	☐	☐
Social skills	☐	☐	☑	☐
Intellectual ability	☑	☐	☐	☐
Insight	☐	☐	☑	☐
Motivation for treatment	☐	☐	☑	☐
Living skills	☑	☐	☐	☐
Literacy level	☑	☐	☐	☐

PROBLEM/NEED IDENTIFIED: (prioritize problems and document in behavioral terms) Problem #1 must be the reason for admission (refer to back for problem statements)	Date Problem Identified
1. Suff. risk harm due to inability to care for self	4/2/14
2.	
3.	

Treatment Goals:
- ☑ Patient will be discharged from hospital without harm to self
- ☐ Reduction of overall level, frequency, and intensity of _____ so daily functioning is not impaired
- ☐ Reestablish independence with ADLs, appetite, sleep, or mechanism in place to assist client at home
- ☑ Patient and/or caregiver will be connected with outpatient treatment, available community support by discharge
- ☐ Nutrition rehabilitation and restoration of normal eating patterns to correct biological sequelae of malnutrition
- ☐ Precipitating factors stabilized as evidenced by:
- ☐ Medication or other somatic intervention stabilized with outpatient follow-up
- ☐ Other: _____

Discharge Criteria:
- ☐ Patient denies suicidal/homicidal ideation
- ☑ Patient and/or caregiver connected with community resources
- ☐ Physiological stability: weight stabilization
- ☐ Stabilization of major stressor: _____
- ☐ Other: _____
- ☐ Improvement in severe disorganization/psychotic signs/symptoms
- ☐ Medical stabilization
- ☐ Target D/C weight: _____
- ☐ Improvement in symptoms: _____

Estimated Duration of Treatment Episode: ☐ 1–5 days ☑ 6–10 days ☐ 11–15 days ☐ 2–4 weeks ☐ > 4 weeks

Preliminary Aftercare Plan:
Disposition: ~~☑ Home~~ ☐ Boarding home ☐ Therapeutic group home ☑ Nursing home ☐ Other: _____

Aftercare: ☐ Pharmacotherapy/outpatient ☐ Psychotherapy/outpatient ☐ Structured partial treatment program ☐ Structured residential treatment program ☐ Home-based ☐ Intensive outpatient

☐ Other: _____

Signature of Patient and/or Caregiver: _____

Staff Signature*: _____
Date: _____ Time: _____

Physician's Signature: J Broadway MD

RN Signature: Yalena H. Talley, RN
Date: 4/2/2014 Time: 17:04

(See reverse for guidelines)
iop_all_docu_individualtreatmentplan

*Signature of staff member who reviewed TP with pt/caregiver
OTE 700423 Rev. 6/09

General Instructions for Individual Treatment Plan Cover Sheet

Time Frame: To be completed by Treatment Team next day

DSM-IV + ICD-9: Must be completed for Partial/Day Program Patients

Axis Formulation: Complete I–V for all patients

Strength and Limitations: Assessment must reflect level of care being considered

Signatures:
Attending physician participating in treatment planning
RN participating in treatment planning
Patient/caregiver's signature
Signature of staff member reviewing treatment plan with patient/caregiver

Problem/Needs Status:

First Problem: must be the reason for admission and must meet criteria for inpatient admission, such as:

- Pt has failed outpatient treatment
- Pt is at risk for suicide and/or homicide
- Severe psychosis (e.g., delusions influence behavior)
- Other such as poor psychosocial supports; psychiatric/general medical condition that makes outpatient treatment unsafe

Treatment Review: Identified problems must be reviewed when a change occurs or at least by the time of discharge

Refer to the list below for assistance in formulating the first problem statement. It is to be used as a *guideline only*.

Patient at risk for suicide
Self-harm risks due to inability to care for self
Self-harm risks due to unstable physical condition
Self-harm risks due to failed outpatient treatment
Risk for self-harm related to eating disorder and unstable physical condition
Severely underweight/severe malnutrition (30% or more below ideal body weight)
Severe _____ such that daily functioning is impaired
Severely disorganized/psychotic; unable to care for self without constant supervision
Patient at risk for homicide/significant aggression towards _____
Risk to others related to increased agitation

The IOP treatment plan consists of two major components:

1. **the Individual Treatment Plan Form (see other side) and the**
2. **Problem Forms.**

For each problem identified on the Individual Treatment Plan Form, you should have a corresponding Problem Form.

[redacted]

orderHistDC - [redacted]
DEPT: ROOM: *P411-L* MR: [redacted]
FROM: 04/02/14 16:38 TO: 04/18/14 20:09

REQUESTED:04/18/14 05:40
CPT OUT:

ALLERGY

Charted	Allergy name	Type	Reaction	Severity	Comment
03/30 17:48	NKA (NEEDS REVIEW)	Drug Allergy			

DIAGNOSIS

(Unknown)

CON

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
73	Complete	**CONSULT: OT Evaluation and Treatment: 66 y/o with early onset dementia, recent significant cognitive decline, wondering if she could benefit from skilled OT**	ONCE	ROUTINE	1 Time	04/16 12:03	04/16 12:03

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/16/14 12:03
Modified by: , - 04/16/14 16:04
Acknowledge: RN GAINES, RANDI - 04/16/14 13:13
Mode: Direct

Details: 66 y/o with early onset dementia, recent significant cognitive decline, wondering if she could benefit from skilled OT

DTY

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
62	D/C'ed	**Boost Plus**	MEAL	ROUTINE		04/12 12:02	04/18 16:40

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/12/14 12:02
Modified by: , - 04/18/14 20:08
Acknowledge: RN ELIZZARD, LAUREN - 04/12/14 13:39
Mode: Direct

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
13	D/C'ed	**Regular Diet**	MEAL	ROUTINE		04/02 16:47	04/18 16:40

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: , - 04/18/14 20:08
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:29
Mode: Direct

...

EKG

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
29	Complete	**Adult EKG: Dementia, depression**	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN TALLEY, YALENA - 04/02/14 18:09
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:29
Mode: Direct

Indication 1: CAD

GLAB

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
70	Complete	**Creatine Kinase**	ONCE	ROUTINE	1 Time	04/14 10:38	04/14 10:38

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/14/14 10:38
Modified by: CC SYSTEM, ID - 04/15/14 14:05
Acknowledge: RN QUINN, LESLIE - 04/15/14 09:59
Mode: Direct

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
68	Complete	**CBC**	ONCE	ROUTINE	1 Time	04/14 10:37	04/14 10:37

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/14/14 10:38
Modified by: CC SYSTEM, ID - 04/15/14 13:35
Acknowledge: RN QUINN, LESLIE - 04/15/14 09:59
Mode: Direct

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
67	Complete	**Metabolic Panel, Comprehensive - CMP**	ONCE	ROUTINE	1 Time	04/14 10:37	04/14 10:37

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/14/14 10:38
Modified by: CC SYSTEM, ID - 04/15/14 14:05
Acknowledge: RN QUINN, LESLIE - 04/15/14 09:59
Mode: Direct

CONTINUED

[redacted]

orderHistDC - [redacted]
DEPT: ROOM: *P411-L* MR: [redacted]
FROM: 04/02/14 16:38 TO: 04/18/14 20:00

CPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
60	Complete	**Hemoglobin A1C**	ONCE	ROUTINE	1 Time	04/12 12:00	04/12 12:00
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/12/14 12:01					
		Modified by: CC SYSTEM, ID - 04/12/14 15:44					
		Acknowledge: RN ELIZZARD, LAUREN - 04/12/14 13:38					
		Mode: Direct					
59	Complete	**Urinalysis**	ONCE	ROUTINE	1 Time	04/12 12:00	04/12 12:00
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L 04/12/14 12:01					
		Modified by: CC SYSTEM, ID - 04/12/14 16:37					
		Acknowledge: RN ELIZZARD, LAUREN - 04/12/14 13:39					
		Mode: Direct					
		i&o cath please					
57	Canceled	**Hemoglobin A1C**	ONCE	ROUTINE	1 Time	04/11 09:43	04/14 10:33
		Reason for action: Cancel Reason: LAB ERROR.					
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/11/14 09:43					
		Modified by: STAFFID, SACKN - 04/14/14 10:33					
		Acknowledge: RN ELEVINS, PHIL - 04/11/14 09:57					
		Mode: Direct					
55	Complete	**Glucose POC, Whole Blood (POCT)**	ONCE	ROUTINE	1 Once	04/11 09:12	04/11 09:12
		Ordered by: CC SYSTEM, ID					
		Entered by: CC SYSTEM, ID - 04/11/14 09:13					
		Modified by: CC SYSTEM, ID - 04/11/14 09:13					
		Mode: Written					
53	Canceled	**Urinalysis**	ONCE	ROUTINE	1 Time	04/10 10:52	04/14 10:42
		Reason for action: Cancel Reason: LAB ERROR.					
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/10/14 10:52					
		Modified by: STAFFID, SACKN - 04/14/14 10:42					
		Acknowledge: RN PEERS, ANGELA - 04/10/14 11:48					
		Mode: Direct					
		clean catch (with staff help cleaning) or I&O cath if needed.					
52	Complete	**Creatine Kinase**	ONCE	ROUTINE	1 Time	04/10 09:52	04/10 09:52
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/10/14 09:52					
		Modified by: CC SYSTEM, ID - 04/10/14 19:22					
		Acknowledge: RN PEERS, ANGELA - 04/10/14 10:11					
		Mode: Direct					
44	Complete	**Creatine Kinase**	ONCE	ROUTINE	1 Time	04/07 10:27	04/07 10:27
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/07/14 10:27					
		Modified by: CC SYSTEM, ID - 04/07/14 15:22					
		Acknowledge: RN QUINN, LESLIE 04/07/14 10:37					
		Mode: Direct					
40	Complete	**Creatine Kinase**	ONCE	TIMED	1 Time	04/05 06:00	04/05 06:00
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/04/14 11:19					
		Modified by: CC SYSTEM, ID - 04/05/14 08:16					
		Acknowledge: RN REYNOLDS, DAWN - 04/04/14 12:46					
		Mode: Direct					
39	Complete	**Creatine Kinase**	ONCE	ROUTINE	1 Time	04/03 11:18	04/03 11:18
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/03/14 11:19					
		Modified by: CC SYSTEM, ID - 04/04/14 08:24					
		Acknowledge: RN MADDEN, KATHERINE - 04/03/14 12:16					
		Mode: Direct					
38	Complete	**Lipid Profile**	ONCE	ROUTINE	1 Time	04/03 11:14	04/03 11:14
		Ordered by: MD BROADWAY, JESSICA L					
		Entered by: MD BROADWAY, JESSICA L - 04/03/14 11:15					
		Modified by: CC SYSTEM, ID - 04/04/14 08:24					
		Acknowledge: RN MADDEN, KATHERINE - 04/03/14 12:17					
		Mode: Direct					
		fasting in AM please					

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REQUESTED:04/18/14 05:40
CPT OUT:

[redacted]

FROM: 04/02/14 16:38 TO: 04/18/14 20:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
37	Complete	**Thyroid Stimulating Hormone (TSH)**	ONCE	ROUTINE	1 Time	04/03 11:13	04/03 11:13
		Ordered by: MD BROADWAY, JESSICA L Entered by: MD BROADWAY, JESSICA L - 04/03/14 11:14 Modified by: CC SYSTEM, ID - 04/04/14 08:20 Acknowledge: RN MADDEN, KATHERINE - 04/03/14 12:17 Mode: Direct					
36	Complete	**Thyroxine, Free (Free T4)**	ONCE	ROUTINE	1 Time	04/03 11:13	04/03 11:13
		Ordered by: MD BROADWAY, JESSICA L Entered by: MD BROADWAY, JESSICA L - 04/03/14 11:14 Modified by: CC SYSTEM, ID - 04/04/14 08:19 Acknowledge: RN MADDEN, KATHERINE - 04/03/14 12:17 Mode: Direct					
74	D/C'ed	**Syphilis Ab IgG with Reflex RPR**	ONCE	ROUTINE	1 Time	04/18 08:48	04/18 08:54
		Ordered by: SEERY, ERIN B Entered by: SEERY, ERIN B - 04/18/14 08:48 Modified by: SEERY, ERIN B - 04/18/14 08:54 v2 Acknowledge: RN REYNOLDS, DAWN 04/18/14 12:03 Mode: Direct					

HEO

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
43	D/C'ed	**PATIENT SPECIFIC DATA: weight: 45.5kg/100.3lb;**	CONTIN	ROUTINE		04/04 14:57	04/18 16:40
		Ordered by: MD BROADWAY, JESSICA L Entered by: MD BROADWAY, JESSICA L - 04/07/14 10:20 Modified by: , - 04/18/14 20:08 Mode: Direct Patient's weight (kgs or lbs): 45.5 Instructions: weight: 45.5kg/100.3lb;					
42	D/C'ed	**PATIENT SPECIFIC DATA: height: 157.5cm/62in;**	CONTIN	ROUTINE		04/04 14:57	04/18 16:40
		Ordered by: MD BROADWAY, JESSICA L Entered by: MD BROADWAY, JESSICA L - 04/07/14 10:20 Modified by: , - 04/18/14 20:08 Mode: Direct Patient's height (cms or ins): 157.5 Instructions: height: 157.5cm/62in;					
8	D/C'ed	**DIAGNOSIS: [primary] Dementia with behavioral disturbances**	CONTIN	ROUTINE		04/02 16:47	04/18 16:40
		Ordered by: NP LICHT, JANNA D Entered by: NP LICHT, JANNA D 04/02/14 16:47 Modified by: , - 04/18/14 20:08 Mode: Direct Enter a diagnosis search (part of a name or an ICD9 code): [primary] Dementia with behavioral disturbances					

MD

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
4	Complete	**Estimated Length of Stay: Greater Than 5 Midnights**	CONTINUOUS	ROUTINE	1 Time	04/02 16:47	04/02 16:47
		Ordered by: NP LICHT, JANNA D Entered by: NP LICHT, JANNA D - 04/02/14 16:47 Modified by: , - 04/02/14 16:58 Acknowledge: RN KZIOKA, NANCY - 04/02/14 17:33 Mode: Direct Certify The Expected Length Of Stay To Be: Greater Than 5 Midnights					

NEUR

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
56	Complete	**NEUR EEG Stat: pt with early onset dementia but no known hx seizures observed at 9:10 AM today to have potential seizure (partial). Continues to have LUE movements, L eye fasiculations, more pronounced confusion and**	ONCE	STAT	1 Time	04/11 09:19	04/11 09:19

CONTINUED

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[redacted]
REQUESTED:04/18/14 05:40
OPT OUT:

FROM: 04/02/14 16:38 TO: 04/18/14 20:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop

aphasia, and elevated BP. Please eval for seizure.
Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/11/14 09:19
Modified by: RN JEFFERSON, GEORGIA - 04/11/14 11:31
Acknowledge: RN ELEVINS, PHIL - 04/11/14 09:26
Mode: Direct
Brief History And Purpose For Exam: pt with early onset dementia but no known hx seizures observed at 9:10 AM today to have potential seizure (partial). Continues to have LUE movements, L eye fasiculations, more pronounced confusion and aphasia, and elevated BP. Please eval for seizure.

NSG

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
51	Complete	NSG: Record: Results of PPD test on tracking form between 48 and 72 hours after placement and place tracking form in chart.	ONCE	TIMED	1 Time	04/10 12:06	04/10 12:06

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/08/14 12:06
Modified by: RN PEERS, ANGELA - 04/10/14 07:03
Acknowledge: RN REYNOLDS, DAWN - 04/08/14 12:39
Mode: Direct
Nurse Instructions to Record: Results of PPD test on tracking form between 48 and 72 hours after placement and place tracking form in chart.

50	Complete	NSG: Record: Record intradermal injection site for tuberculin	ONCE	ROUTINE	1 Time	04/08 12:06	04/08 12:06

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/08/14 12:06
Modified by: RN NZIOKA, NANCY - 04/08/14 17:39
Acknowledge: RN REYNOLDS, DAWN - 04/08/14 12:27
Mode: Direct
Nurse Instructions to Record: Record intradermal injection site for tuberculin

49	Complete	Place: tuberculin skin test	ONCE	ROUTINE	1 Time	04/08 12:06	04/08 12:06

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/08/14 12:06
Modified by: RN NZIOKA, NANCY - 04/08/14 17:39
Acknowledge: RN REYNOLDS, DAWN - 04/08/14 12:27
Mode: Direct
Nurse Instructions to Record: tuberculin skin test

21	Complete	NSG COLLECT: Urine HCG Point of Care	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN TALLEY, YALENA - 04/02/14 18:09
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:30
Mode: Direct

12	Complete	CORE MEASURES:: Complete the Adult Pneumococcal Screening in Clindoc if indicated, administer Pneumococcal Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN NZIOKA, NANCY - 04/02/14 17:35
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:30
Mode: Direct
Details: Complete the Adult Pneumococcal Screening in Clindoc if indicated, administer Pneumococcal Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.

CONTINUED

[redacted]

[redacted]

CPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
11	Complete	CORE MEASURES:: Complete the Adult Influenza Screening in clindoc if indicated, administer Influenza Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN NZIOKA, NANCY - 04/02/14 17:35
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:29
Mode: Direct

Details: Complete the Adult Influenza Screening in clindoc if indicated, administer Influenza Vaccine. Send RxComm to pharmacy to receive dose or to discontinue if patient does not meet criteria or refuses dose.

5	Complete	ASSESSMENT:: Urine pregnancy test pending	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN VALLEY, YALENA - 04/02/14 18:09
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:29
Mode: Direct

Details: Urine pregnancy test pending

72	D/C'ed	Nurse Instruction: << We are withholding life support - DNR >>	PRN	ROUTINE		04/15 12:04	Indefinite

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/15/14 12:05
Modified by: , - 04/18/14 20:08
Acknowledge: RN QUINN, LESLIE - 04/15/14 12:06
Mode: Direct

Details: << We are withholding life support - DNR >>

71	D/C'ed	Allow Natural Death or Limited Resuscitation: Continue all care to maintain patient's comfort and hygiene. ---1) The attending physician must be consulted prior to writing this order. This order must be co-signed by an attending physician within 24 hours. ---2) This order must be reviewed prior to : anesthesia, surgery or other invasive procedures. ---3) This order must be reviewed every 7 days. ---4) The Withholding Life-Supportive Care and Do-Not-Resuscitate Progress Note outlining rationale must be writt	CONTINUOUS	ROUTINE		04/15 12:04	04/18 16:40

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/15/14 12:05
Modified by: , - 04/18/14 20:08
Acknowledge: RN QUINN, LESLIE - 04/15/14 12:06
Mode: Direct

Details: Continue all care to maintain patient's comfort and hygiene. ---1) The attending physician must be consulted prior to writing this order. This order must be co-signed by an attending physician within 24 hours. ---2) This order must be reviewed prior to
Additional Comments: anesthesia, surgery or other invasive procedures. ---3) This order must be reviewed every 7 days. ---4) The Withholding Life-Supportive Care and Do-Not-Resuscitate Progress Note outlining rationale must be written prior to writing a DNR order.

CONTINUED

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REQUESTED:04/19/14 05:40
CPT OUT:

FROM: 04/02/14 16:38 TO: 04/18/14 20:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
63	D/C'ed	**Nurse Instruction: please crush all meds, as pt has difficulty processing to swallow meds and has spots where pills are getting stuck. : : :**	AS DIRECTED	ROUTINE		04/12 12:04	04/18 16:40

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/12/14 12:04
Modified by: , - 04/18/14 20:08
Acknowledge: RN ELIZZARD, LAUREN - 04/12/14 13:37
Mode: Direct

Enter Details and Frequency (how often): please crush all meds, as pt has difficulty processing to swallow meds and has spots where pills are getting stuck.

20	D/C'ed	**NOTIFICATION PARAMETERS: IOP - Age 18 and older: (see details)**	PRN	ROUTINE		04/02 16:47	Indefinite

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: , - 04/10/14 20:00
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:33
Mode: Direct

Details: (see details)
If SBP: > 160 mmHG or < 80 mmHG
If DBP: > 100 mmHG or < 50 mmHG
If Heart Rate: > 120 bpm or > 60 bpm
If Temp: > 101.5 or < 95 deg. F
If RR: > 25 or < 12 breaths per minute

19	D/C'ed	**SAFETY: Precautions Fall:**	CONTINUOUS	ROUTINE		04/02 16:47	04/18 16:40

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: , - 04/18/14 20:08
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:30
Mode: Direct

18	D/C'ed	**SAFETY: Precautions Violence:**	CONTINUOUS	ROUTINE		04/02 16:47	04/15 12:05

Ordered by: MD BROADWAY, JESSICA L
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: MD BROADWAY, JESSICA L - 04/15/14 12:04
v3 Signature: MD BROADWAY, JESSICA L - 04/15/14 12:05
v3 Acknowledge: RN QUINN, LESLIE - 04/15/14 12:06
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:30
Mode: Direct

17	D/C'ed	**SAFETY: Precautions Elopement:**	CONTINUOUS	ROUTINE		04/02 16:47	04/15 12:05

Ordered by: MD BROADWAY, JESSICA L
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: MD BROADWAY, JESSICA L - 04/15/14 12:04
v3 Signature: MD BROADWAY, JESSICA L - 04/15/14 12:05
v3 Acknowledge: RN QUINN, LESLIE - 04/15/14 12:06
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:30
Mode: Direct

16	D/C'ed	**SAFETY: Observation Level: 15 Minute Checks**	PRN	ROUTINE		04/02 16:47	Indefinite

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: , - 04/18/14 20:08
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:33
Mode: Direct

Select: 15 Minute Checks

15	D/C'ed	**ACTIVITY: Unit Restriction:**	CONTINUOUS	ROUTINE		04/02 16:47	04/18 16:40

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: , - 04/10/14 20:00
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:30
Mode: Direct

CONTINUED

[redacted]

[redacted]
REQUESTED:04/18/14 05:40
CPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
14	D/C'ed	**VITAL SIGNS:: bid x 3 days, then q day :**	CONTINUOUS	ROUTINE		04/02 16:47	04/18 16:40

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: , - 04/18/14 20:06
Acknowledge: RN NZIOKA, NANCY - 04/02/14 17:30
Mode: Direct

Details (Frequency, etc.): bid x 3 days, then q day

REG

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
7	Complete	**Referring Physician: MUSC - 1 W ED -**	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN NZIOKA, NANCY - 04/02/14 17:35
Mode: Direct

Referring Physicians: MUSC - 1 W ED -

6	Complete	**Attending: Dr. Fox**	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN NZIOKA, NANCY - 04/02/14 17:35
Mode: Direct

Attending Name And Pager ID: Dr. Fox

3	Complete	**Admission Status:: Inpatient**	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN NZIOKA, NANCY - 04/02/14 17:35
Mode: Direct

Admission Status: Inpatient

2	Complete	**Admit to: PH3N**	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN NZIOKA, NANCY - 04/02/14 17:35
Mode: Direct

Location: PH3N

1	Complete	**Admission Status:<IOP>: Voluntarily**	ONCE	ROUTINE	1 Time	04/02 16:47	04/02 16:47

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: RN NZIOKA, NANCY - 04/02/14 17:35
Mode: Direct

Select: Voluntarily

RX

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
69	New	**SODIUM CHLORIDE 0.9% IV: 150 ML/HR: IV**	150 ML/HR	NEXT SCH	7 Hours	04/14 11:00	04/14 17:59

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/14/14 10:38
Modified by: MD BROADWAY, JESSICA L - 04/14/14 10:45
Mode: Direct

IV access = Peripheral; ** 1000 mL= x 7 Hours

Dose: 1000 ML
Rate: 150 ML/HR
ROUTE: IV

61	New	**SODIUM CHLORIDE 0.9% IV: 150 ML/HR: IV**	150 ML/HR	NEXT SCH	7 Hours	04/12 13:00	04/12 19:59

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/12/14 12:02
Modified by: MD BROADWAY, JESSICA L - 04/12/14 12:05
Mode: Direct

IV access = Peripheral; ** 1000 mL= x 7 Hours

Dose: 1000 ML
Rate: 150 ML/HR
ROUTE: IV

CONTINUED

[redacted]

[redacted]

REQUESTED:04/19/14 05:40
CPT OUT:

FROM: 04/02/14 16:38 TO: 04/19/14 20:00

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
48	New	TUBERCULIN PPD INJ [APLISOL/TUBERSOL]: 5 UNIT: DERMAL_INTRA	ONCE	1ST NOW	1 Doses	04/08 15:00	04/09 00:01

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/08/14 12:06
Modified by: MD BROADWAY, JESSICA L - 04/08/14 14:07
Mode: Direct
-REFRIGERATE EXPIRES==> **DISCARD IF NOT USED WITHIN 8 HRS** LOT #: EXPIRATION: MANUFACTURER:
NURSES:PLEASE DOCUMENT IN PATIENT RECORD: DATE, VACCINE NAME, DOSE SITE, ROUTE, MANUFA
Dose: 5 UNIT
Route: DERMAL_INTRA

34	New	SULFAMETHOX-TRIMETH 800-160MG [SEPTRA DS]: 1 TAB: PO	Q12HS	NEXT SCH	7 Days	04/02 21:00	04/09 20:59

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: NP LICHT, JANNA D - 04/02/14 16:54
Mode: Direct
Dose: 1 TAB
Route: PO

9	Canceled	INFLUENZA TRI-SPLIT VACCINE INJ: 0.5 ML: IM	ONCALL	NEXT SCH		04/02 16:53	04/02 16:53

Reason for action: Discontinued/Replaced
Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: NP LICHT, JANNA D - 04/02/14 16:53
Mode: Direct
Dose: 0.5 ML
Route: IM
Dose Type: MAINTENANCE

66	D/C'ed	HALOPERIDOL INJ [HALDOL]: 2 MG: IM : *For:Acute psychosis	Q6HP	NEXT SCH	4 Days	04/14 10:36	04/18 16:40

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/14/14 10:38
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Dose: 2 MG
Route: IM
Indication: *For:Acute psychosis

65	D/C'ed	HALOPERIDOL [HALDOL]: 2 MG: PO : *For:Psychosis	Q6HP	NEXT SCH	4 Days	04/14 10:36	04/18 16:40

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/14/14 10:38
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Dose: 2 MG
Route: PO
Indication: *For:Psychosis

64	D/C'ed	LORAZEPAM [ATIVAN]: 1 MG: PO : *For:Acute anxiety	Q6HP	NEXT SCH	4 Days	04/14 09:23	04/18 16:40

Ordered by: SEERY, ERIN B
Entered by: SEERY, ERIN B - 04/14/14 09:23
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Dose: 1 MG
Route: PO
Indication: *For:Acute anxiety

54	D/C'ed	SIMVASTATIN [ZOCOR]: 10 MG: PO : *FOOD-DRUG INTERACTION* EDUCATE PATIENT & DOCUMENT TEACHING. AVOID GRAPEFRUIT JUICE WITH THIS MEDICATION UNLESS INSTRUCTED OTHERWISE BY YOUR PHYSICIAN.	QHS	NEXT SCH	7 Days	04/11 21:00	04/18 16:40

CONTINUED

[redacted]

CPT OUT:

FROM: 04/02/14 16:38 TO: 04/18/14 20:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/11/14 09:03
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct

Dose: 10 MG
Route: PO
RxComment 1: *FOOD-DRUG INTERACTION* EDUCATE PATIENT & DOCUMENT TEACHING. AVOID GRAPEFRUIT JUICE WITH THIS MEDICATION UNLESS INSTRUCTED OTHERWISE BY YOUR PHYSICIAN.

47 D/C'ed **RIVASTIGMINE 9.5 MG/24 HR: 1 PATCH: TOPL : dementia : Adverse rxn to formulary med : vomiting, nausea, significant weight loss : THIS MEDICATION IS NONFORMULARY.** DAILY ROUTINE 4 Days 04/09 08:30 04/13 07:09

Ordered by: MD BROADWAY, JESSICA L
Entered by: ANY VANDENBERG - 04/08/14 09:53
Modified by: MD BROADWAY, JESSICA L - 04/13/14 07:10
v2 Signature: MD BROADWAY, JESSICA L - 04/13/14 07:09
Mode: Direct

exelon

Dose (include unit of measure. Ex: MG, MICROGRAM, etc.) (Do not exceed 45 characters): 1 PATCH
Route: TOPL
Indication: dementia
Provide appropriate clinical justisfication: Adverse rxn to formulary med
COMMENTS: Please indicate in DETAIL any rates, special instructions, additives, or general comments for your order here: vomiting, nausea, significant weight loss
RxComment 1: THIS MEDICATION IS NONFORMULARY.

46 D/C'ed **ONDANSETRON ODT [ZOFRAN ODT]: 8 MG: PO : *For:Nausea and Vomiting : *ORALLY DISINTEGRATING TABLET* PLACE DIRECTLY ON THE TONGUE** Q8HP STAT 10 Days 04/08 09:34 04/18 16:40

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L - 04/08/14 09:36
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct

Dose: 8 MG
Route: PO
Indication: *For:Nausea and Vomiting
RxComment 1: *ORALLY DISINTEGRATING TABLET* PLACE DIRECTLY ON THE TONGUE

41 D/C'ed **DONEPEZIL ODT [ARICEPT ODT]: 5 MG: PO , RxComment 1: DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.** QHS NEXT SCH 13 Hours 04/07 21:00 04/08 09:36

Ordered by: MD BROADWAY, JESSICA L
Entered by: MD BROADWAY, JESSICA L 04/07/14 13:20
Modified by: MD BROADWAY, JESSICA L - 04/08/14 09:36
Mode: Direct

Dose: 5 MG
Route: PO
Dose Type: MAINTENANCE
RxComment 1: DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.

35 D/C'ed **INFLUENZA TRI-SPLIT VACCINE INJ: 45 MCG: IM** ONCALL ROUTINE 16 Days 04/02 16:47 04/18 16:40

Ordered by: NP LICHT, JANNA D
Entered by: JOHNSON, AMY M - 04/02/14 16:53
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Written
POTENTIAL HAZARD:HANDLE AND DISPOSE OF PROPERLY FOR INTRAMUSCULAR USE ONLY **REFRIGERATE** LOT #: EXPIRATION: MANUFACTURER: NURSES:PLEASE DOCUMENT IN PATIENT RECORD: DATE, VACCINE NAME, DOSE

CONTINUED

[redacted]

[redacted]

REQUESTED:04/19/14 05:40
CPT OUT:

FROM: 04/02/14 16:38 TO: 04/18/14 20:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop

SITE, ROUTE
Dose: 45 MCG
Route: IM

33 D/C'ed **DIVALPROEX EC DR TAB [DEPAKOTE EC DR]: 125 MG: PO : DO NOT CRUSH OR CHEW** Q12HB NEXT SCH 16 Days 04/02 21:00 04/18 16:40
Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Dose: 125 MG
Route: PO
Dose Type: MAINTENANCE
RxComment 1: DO NOT CRUSH OR CHEW

32 D/C'ed **ESCITALOPRAM [LEXAPRO]: 10 MG: PO** DAILY NEXT SCH 15 Days 04/03 08:30 04/18 16:40
Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Dose: 10 MG
Route: PO
Dose Type: MAINTENANCE

31 D/C'ed **MEMANTINE [NAMENDA]: 10 MG: PO** BID NEXT SCH 16 Days 04/02 21:00 04/18 16:40
Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Dose: 10 MG
Route: PO
Dose Type: MAINTENANCE

30 D/C'ed **DONEPEZIL ODT [ARICEPT ODT]: 10 MG: PO , RxComment 1: DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.** DAILY NEXT SCH 5 Days 04/03 08:30 04/08 09:36
Ordered by: MD BROADWAY, JESSICA L
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: MD BROADWAY, JESSICA L - 04/08/14 09:36
v3 Signature: MD BROADWAY, JESSICA L - 04/08/14 09:36
Mode: Direct
Dose: 10 MG
Route: PO
Dose Type: MAINTENANCE
RxComment 1: DISSOLVE TABLET COMPLETELY ON TONGUE AND FOLLOW WITH WATER.

28 D/C'ed **DIPHENHYDRAMINE INJ [BENADRYL]: 25 MG: IM : DOSAGE FORM ALERT - FOR INJECTION** Q4HP NEXT SCH 16 Days 04/02 16:47 04/18 16:40
Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Patient has orders for both PO *or* IM routes For:Extra-pyramidal symptoms may be given when haloperidol is used for acute psychosis ...
Dose: 25 MG
Route: IM
RxComment 1: DOSAGE FORM ALERT - FOR INJECTION

27 D/C'ed **DIPHENHYDRAMINE [BENADRYL]: 25 MG: PO** Q4HP NEXT SCH 16 Days 04/02 16:47 04/18 16:40
Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Patient has orders for both PO *or* IM routes For:Extra-pyramidal symptoms may be given when

CONTINUED

[redacted]

REQUESTED:04/18/14 05:40
CPT OUT:

FROM: 04/02/14 16:38 TO: 04/18/14 20:09

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop

haloperidol is used for acute psychosis ...
Dose: 25 MG
Route: PO

26 D/C'ed **LORAZEPAM INJ [ATIVAN]: 2 MG: IM : *For:Acute anxiety** Q4HP NEXT SCH 12 Days 04/02 16:47 04/14 09:23
Ordered by: SEERY, ERIN B
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: SEERY, ERIN B - 04/14/14 09:23
v3 Signature: SEERY, ERIN B - 04/14/14 09:23
Mode: Direct
**Do not administer IM lorazepam within 2 hours of IM olanzapine ...
Dose: 2 MG
Route: IM
Indication: *For:Acute anxiety

25 D/C'ed **LORAZEPAM [ATIVAN]: 2 MG: PO : *For:Acute anxiety** Q4HP NEXT SCH 12 Days 04/02 16:47 04/14 09:23
Ordered by: SEERY, ERIN B
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: SEERY, ERIN B - 04/14/14 09:23
v3 Signature: SEERY, ERIN B - 04/14/14 09:23
Mode: Direct
Dose: 2 MG
Route: PO
Indication: *For:Acute anxiety

24 D/C'ed **HALOPERIDOL INJ [HALDOL]: 5 MG: IM : *For:Acute psychosis** Q4HP NEXT SCH 12 Days 04/02 16:47 04/14 10:38
Ordered by: MD BROADWAY, JESSICA L
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: MD BROADWAY, JESSICA L - 04/14/14 10:38
v3 Signature: MD BROADWAY, JESSICA L - 04/14/14 10:38
Mode: Direct
Patient has orders for both PO *or* IM routes ...
Dose: 5 MG
Route: IM
Indication: *For:Acute psychosis

23 D/C'ed **HALOPERIDOL [HALDOL]: 5 MG: PO : *For:Acute psychosis** Q4HP NEXT SCH 12 Days 04/02 16:47 04/14 10:38
Ordered by: MD BROADWAY, JESSICA L
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: MD BROADWAY, JESSICA L - 04/14/14 10:38
v3 Signature: MD BROADWAY, JESSICA L - 04/14/14 10:38
Mode: Direct
Patient has orders for both PO *or* IM routes ...
Dose: 5 MG
Route: PO
Indication: *For:Acute psychosis

22 D/C'ed **ACETAMINOPHEN [TYLENOL]: 650 MG: PO : *For:Pain : MAX. RECOMMENDED DAILY AMT. ACETAMINOPHEN= 4000MG - FROM ALL SOURCES** Q6HP NEXT SCH 16 Days 04/02 16:47 04/18 16:40
Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct
Dose: 650 MG
Route: PO
Indication (For OTHER Indication Free Text in Box): *For:Pain
RxComment 1: MAX. RECOMMENDED DAILY AMT. ACETAMINOPHEN= 4000MG - FROM ALL SOURCES

CONTINUED

[redacted]

orderHistDC - [redacted]
DEPT: ROOM: *P411-L* MR: [redacted]
FROM: 04/02/14 16:38 TO: 04/18/14 20:00

REQUESTED:04/18/14 05:40
CPT OUT:

Ord#	Status	Order Name	Freq	Priority	Duration	Start	Stop
10	D/C'ed	PNEUMOCOCCAL VACCINE INJ [PNEUMOVAX 23]: 0.5 ML: IM , RxComment 1: FOR INTRAMUSCULAR USE ONLY LOT #: EXPIRATION: MANUFACTURER: NURSES:PLEASE DOCUMENT IN PATIENT RECORD: DATE, VACCINE NAME, DOSE SITE, ROUTE, MANUFACTURER, LOT NUMBER	ONCALL	NEXT SCH	16 Days	04/02 16:47	04/18 16:40

Ordered by: NP LICHT, JANNA D
Entered by: NP LICHT, JANNA D - 04/02/14 16:47
Modified by: STAFFID, ADT - 04/18/14 16:41
Mode: Direct

Dose: 0.5 ML
Route: IM
Dose Type: MAINTENANCE
RxComment 1: FOR INTRAMUSCULAR USE ONLY LOT #: EXPIRATION: MANUFACTURER: NURSES:PLEASE DOCUMENT IN PATIENT RECORD: DATE, VACCINE NAME, DOSE SITE, ROUTE, MANUFACTURER, LOT NUMBER

No unsigned orders found.

LAST PAGE

Page 12 PERM

CSN
46624148

Progress Notes signed by Jason Rocco Molinaro, MD at 5/9/2013 5:31 PM

Author:	Jason Rocco Molinaro, MD	Service:	(none)	Author Type:	Resident
Filed:	5/9/2013 5:31 PM	Note Time:	5/9/2013 4:48 PM	Note Type:	Progress Notes

Sources of Information: Patient, her brother, and her daughter

Chief Complaint
Patient presents with
- Memory Loss

History of Present Illness: Mrs [redacted] is a 65 yo CF with hx of Depression and cognitive impairment who presents for her initial evaluation. She is accompanied by her daughter whom she lives with and her brother who she had previously lived with. Patient has memory impairment and is unable to give me a reliable history so much of the history is obtained from the brother and daughter. She also had problems with anomia and circumlocution during the assessment and this appeared more prominent than her memory loss. She had a difficult time naming simple objects such as a pen and a chair but able to describe what they did. She also has difficulty with visual spacial comprehension as her daughter reports she will see cars stacked up on top of each other on the road.

She begun having word finding difficulty starting in 2008. This was most notable at work. She was evaluated for Dementia at that time by a psychiatrist or psychologist(described doing multiple pen/paper test) but told she did not have Dementia. Since then she has had a gradual decline with several step wise declines mostly after stressors including the death of her father and the death of her sister. The word finding was the first symptom noticed and family still feels it is significantly worse than the her memory. They have also noticed decline in her memory as well. She stopped driving in 2011 after being in a car crash. Also at that time, her family started taking over finances and her brother moved in with her to help care for her. It has progressed to the point she will have a difficult putting on clothes such as not figuring out how to put her arm in her sleep and is unable to do any shopping and only basic household chores. She is continent of bowel and bladder. She had multiple falls at the onset of symptoms in 2008 but since then only occasional falls, none with LOC. She was started on Aricept and Namenda by her PCP, Dr Karen Thomas, and they felt that has helped slow the progression. This was in 2010 or 2011 at which time it was felt that she had Alzheimer disease. She reports having an MRI done by Dr Thomas but is unsure of the results.

She has a questionable history of depression. Her daughter felt she was depressed in 2008 when these symptoms first begun to occur and was started on Lexapro. She doesn't have a long history of depression throughout her life. She denies any depressive symptoms currently. Reports that sleep and appetite are good. Energy level is good. She is more socially isolative and less active but denies any anhedonia. Denies worthlessness or guilt. Denies SI/HI. Patient has good understanding that she has memory problems and understand the progression of her disease and is accepting of this but feels she wants to make the most of her life while she can. Denies any history of mania or psychosis.

She reports that her mother had Dementia but this begun in her mother's 90s and is reported occuring after cardiac issues thus it appears more a Vascular Dementia. She denies any other family members having Dementia. She sister had a some form of brain cancer and passed away from it in 2010.

Past Psychiatric History: No history of depression. Thought to have depression in 2008 and started on Lexapro but appears more related to cognitive deficit. Denies any hospitalizations for mental health.

Past Medical History: No medical problems

Allergies: Review of patient's allergies indicates no known allergies.

Outpatient Encounter Prescriptions as of 5/9/2013

Medication	Sig	Dispense	Refill
• donepezil (ARICEPT) 10 MG tablet	Take 10 mg by mouth nightly.		
• escitalopram (LEXAPRO) 10 MG tablet	Take 10 mg by mouth daily.		
• memantine (NAMENDA) 10 MG tablet	Take 10 mg by mouth 2 (two) times daily.		

Family History:

Family History

Problem	Relation	Age of Onset
• Dementia	Mother	
• Depression	Mother	
• Brain cancer	Sister	
• Breast cancer	Sister	

History

Social History

• Marital Status:	Unknown
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Occupational History

• Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Not on file
• Alcohol Use:	No
• Drug Use:	No
• Sexually Active:	Not on file

Other Topics	Concern
• Not on file	

Social History Narrative

Patient was born and raised in Charleston. She completed 1 year of college at Winthrop. Was married 24 years but are separated. Has 2 grown children. Daughter who lives with her and a grown son.

Revlew of Systems: Negative except neurological/psychological issues per hpi

Mental Status Examination:
Vital Signs:
Filed Vitals:

	05/09/13 1303
BP:	148/71
Pulse:	87
Weight:	126 lb (57.153 kg)

Appearance:Appears older than stated age and Appropriately dressed for setting
Behavior/AttitudeGood eye contact and Cooperative with examiner
Motor: No Psychomotor Retardation and No Psychomotor Agitation
Gait:Normal
Speech:Normal rate/rhythm/volume
Language:anomia, circumlocution and difficulty with word finding
Mood:normal
Affect:Mood Congruent
Thought Process:Linear and Coherent
Associations:logical connections
Thought Content:No SI/HI
Auditory Visual Hallucinations:No auditory or visual hallucinations
Level of Consciousness:Able to attend to interview
Orientation:person, place, time/date and situation
Attention/Concentration:Able to attend to interview
Memory:Recent memory impaired
Estimated Intelligence/Fund of Knowledge:Average
Conceptual/Visiospatial:N/A
Judgement:Fair
Insight:Fair

Scales/Objective Measures:

MMSE: 20/30 8/10 on orientation, unable to tell me year or date, 3/3 immediate recall, 1/3 delayed recall, 2/5 spelling word backwards, able to name objects but with significant delay, missed repeat phrase and copy design
Clock: 2/10 only able to get circle correct left off several numbers and put other numbers in the wrong place. Able to put hand on the 11 and 10 but numbers were not in the correct place

Discussion and Formulation: 65 yo CF with cognitive impairment with word finding difficulty more prominent and with earlier onset than memory loss. At this time, I do not have a clear diagnosis. Differential dx include Primary Progressive Aphasia vs early onset AD. Will need to obtain further workup to help clarify the diagnosis. Patient and family presents today to help clarify diagnosis and possible treatment options. They are understanding that this is not a straight forward case and will need additional work up to help clarify diagnosis

Diagnosis:
Axis I: Dementia NOS(Primary Progressive Aphasia vs early on-set AD)

Axis II: Deferred
Axis III: has a past medical history of Depression and Memory impairment.
Axis IV: good social support
Axis V: 41-50 serious symptoms

Initial Treatment Plan:

Reported to have an MRI done by Dr Thomas, will contact her to see if we can obtain results and labs. If we are unable to obtain results, will order PET scan of the brain and labs
Will refer to Dr Wymer for Neuropsych testing
Will continue Aricept 10 mg po qhs and Namenda 10 mg po bid
Discussed power of attorney and health care power of attorney which they have established
We will have her follow up in our clinic to help coordinate care and clarify diagnosis. I have told the family that I will not be here after mid June and that another Fellow will follow her. Will contact her for a follow up appointment.

Electronically signed by Jason Rocco Molinaro, MD on 5/9/2013 5:31 PM

CSN
46624148

Progress Notes signed by Mary Hart Craig, MD at 5/16/2013 2:45 PM

Author:	Mary Hart Craig, MD	Service:	(none)	Author Type:	Physician
Filed:	5/16/2013 2:45 PM	Note Time:	5/16/2013 2:44 PM	Note Type:	Progress Notes

I have personally seen and examined the patient and agree with Jason Rocco Molinaro, MD's findings as stated above.
Assessment and plan reviewed by me.

Electronically signed by Mary Hart Craig, MD on 5/16/2013 2:45 PM

CSN
51972046

Progress Notes signed by Erin Beth Seery, MD at 7/11/2013 5:31 PM

Author:	Erin Beth Seery, MD	Service:	(none)	Author Type:	Resident
Filed:	7/11/2013 5:31 PM	Note Time:	7/11/2013 3:31 PM	Note Type:	Progress Notes

DATE: 7/11/13

START:400pm
STOP:500pm

Sources of Information for today's visit: patient and her daughter

Chief Complaint: "I can't say the things that I want to say"

HISTORY OF PRESENT ILLNESS:
[redacted] is a 65 y.o. female who presents for follow-up today. She and her daughter were approximately 30 minutes late. Patient allowed her daughter to be in the room during evaluation. Patient was evaluated by Dr. Molinaro in May and referred for PET Scan and neuropsychological testing given patient's progressive memory decline. Prior to patient's neuropsych testing she opted to stop all of her medications (namenda, aricept, lexapro). Her daughter reports patient became "frenetic" and very emotionally labile and paranoid. She also became much more confused and needed closer monitoring by the family. Patient has since resumed her medications after urging by the psychologist. Patient's daughter reports patient has "stabilized" after restarting medication. She is much more calm and appropriate with family. She no longer has significant paranoia or agitation. She now is much less tearful, although she does cry more than usual. Patient's daughter feels that patient does appear more depressed to her with poor sleep, poor appetite, weight loss, crying spells, amotivation. No current or recent SI.

Neuropsychological testing indicated severe memory difficulties. In addition to memory complaint, patient has prominent language and visual-spatial difficulties. In session today patient had difficulty with anomia and circumlocution. Per daughter neurologist seen at time of the neuropsych testing confirmed a likely diagnosis of Alzheimer's Dementia. Patient's daughter reports that patient has had more difficulty with tasks at home. She is unable to help with chores and although she is able to use the bathroom and shower on her own, daughter is needed to help "clean up" afterward. Patient is at home most of the day with little interest in previous hobbies. Daughter at times needs to leave patient on her own, usually 2-3hours but has been away up to 6hours. We discussed ways to safety proof the home to avoid patient injuring herself. Patient's daughter reports she has removed knobs from certain drawers. Discussed attempting to keep medication locked away. Patient's daughter reports buying a family puppy and reports that this animal has brought her mother significant enjoyment.

WEIGHT: 118lbs (regular scale)
PAST MEDICAL HISTORY: No past medical history

CURRENT MEDICATIONS:
aricept 10mg
namenda 10mg bid
lexapro 10mg

CURRENT MEDICATION SIDE EFFECTS: some nausea with aricept when restarting at 10mg

MEDICATION RECONCILIATION:
Reviewed all medications and doses, Reviewed medication compliance and Explored strategies to improve compliance

Brief Review of Systems:
Problems with GI/bowel habits: patient's daughter has had to help patient with toileting. Per daughter patient will use the bathroom on her own, but the room requires clean up afterwards. No recent n/v
Problems with urinary symptoms: no
Changes in weight/appetite:Yes, weight loss, from 123-118 in the past 2 months
Changes in memory:Yes, improved memory since restarting medication

Mental Status Examination:
Vital Signs:There were no vitals filed for this visit.
Appearance:appeared her stated age. She was wearing an illfitting buisness suit with a few stains on the collar.

Her hair was unkempt
Behavior/Attitude: patient was calm and cooperative during the appointment
Motor: NO pmr/pma
Gait:deliberate gait, walks slowly
Speech:Normal rate/rhythm/volume and Normal volume, she at times used the wrong word, stating "when i dry" as opposed to "when i die", +circumlocution
Mood:"fine"
Affect:euthymic appearing
Thought Process:Circumstantial
Associations:tangential connections
Thought Content:No SI/HI and without paranoia
Auditory Visual Hallucinations:No auditory or visual hallucinations
Level of Consciousness:Able to attend to interview
Orientation:person
Attention/Concentration:Able to attend to interview, immediate recall: 3/3 delayed recall 2/3
Memory:Remote memory intact
Estimated Intelligence/Fund of Knowledge:Average
Conceptual/Visiospatial:clockface 2/10
Judgement:Impaired
Insight:Impaired

MMSE: 14/30
Able to state city, state, and season, but got all other orientation questions wrong. Unable to spell WORLD forwards, spelled it "WOLD", unable to do serial 7's, unable to state "no if's ands or buts", unable to write a sentence, unable to copy pentagons

Clock: 2/10
Clock was a circle with 7 hashmarks spaced inside the circle. No clock hands used.

Geriatric Depression Scale: 5/15 (normal)

Patient able to ensure safety:Yes
Patient agrees to notify therapist if they cannot maintain safety: Yes

LABS:
Admission on 05/31/2013, Discharged on 05/31/2013

Component	Date	Value	Range	Status
• GLUCOSE PCX, WHOLE BLOOD	05/31/2013	153*	70 - 100 MG/DL	Final
• PERFORMING LAB, ART, POC *MUSC Medical Center, 171 Ashley Avenue, Charleston, SC,29425*	05/31/2013	See Note		Final

RADIOLOGY RESULTS:
Ct Pet Brain Dementia Differentiation Frontotemporal Dementia Alzheimers Disease

5/31/2013 EXAMINATION: BRAIN PET/CT SCAN with DATABASE ANALYSIS 05/31/13 14:56:00
ACCESSION NUMBER: 7063158 COMPARISON: None INDICATION: progressive word finding difficulty

and memory problems DOSE: 6.75 millicuries fluorodeoxyglucose-18 intravenously TECHNIQUE: The patient was imaged on a GE Discovery whole body PET/CT scanner approximately 40 minutes after the intravenous administration of the F18-fluorodeoxyglucose. A standard brain protocol was performed. Multi-slice CT images were acquired for attenuation correction. On a separate Syntermed NeuroQ workstation (version 3.5.2), database analysis was computed. 200+ segments of the brain were compared to a normalized database. Serum glucose level measured 153 mg/dL at the time of injection. FINDINGS: There is significant hypometabolism noted predominantly within the temporoparietal regions of the brain. As a reference, the right parietotemporal cortex measures 7.8 standard deviations below the mean. The left parietotemporal cortex measures 4.8 standard deviations below the mean. Additionally, the right mid frontal cortex measures 2.8 standard deviations below the mean.

5/31/2013 IMPRESSION: Significant bilateral temporoparietal hypometabolism. To a lesser degree, there are also regions of hypometabolism within the right frontal lobe. Given that frontal lobes are affected to a lesser degree than the temporoparietal regions, Alzheimer is the favored diagnosis.

ASSESSMENT: 65 yo female with memory decline since 2008. Per neuropsych testing, patient is severely impaired for her age. In addition to memory complaint, patient has prominent language and visual-spatial difficulties. Per family patient's memory has been much worse in the past few months since patient has stopped namenda and aricept. Patient had improvement in behavior with resuming medication, but has not had an increase in MMSE. Per daughter she appears more depressed and has significant neurovegetative symptoms, but patient outwardly denies depression.

Axis I: Alzheimer's Dementia (recent behavioral disturbance)
Axis II: none
Axis III: none
Axis IV: good social support
Axis V: 41-50 serious symptoms

PLAN:
- Recommend increase in lexapro to 20mg q day. Her daughter will double 10mg tablets and obtain new RX from PCP. This may help with residual neurovegetative symptoms.
- continue aricept 10mg qday and namenda 10mg bid
- provided education to daughter regarding safety proofing her home given patient's poor level of functioning
- confirmed that family now has POA and Health Care POA
-scan patient's MMSE into record
- fax this note to patient's PCP: 843-884-0710
- follow up in 2-3 months

Was psychotherapy a part of today's visit?: No

If so, total time spent on psychotherapy portion exclusive of E&M services?: n/a

If so, what was the essential content of the psychotherapy portion of today's visit?: n/a

Electronically signed by Erin Beth Seery, MD on 7/11/2013 5:31 PM

CSN
51972046

Progress Notes signed by Mary Hart Craig, MD at 7/23/2013 3:35 PM

Author:	Mary Hart Craig, MD	Service:	(none)	Author Type:	Physician
Filed:	7/23/2013 3:35 PM	Note Time:	7/23/2013 3:35 PM	Note Type:	Progress Notes

I have personally seen and examined the patient and agree with Erin Beth Seery, MD's findings as stated above.
Assessment and plan reviewed by me.

Electronically signed by Mary Hart Craig, MD on 7/23/2013 3:35 PM

CSN
61983014

ED Notes signed by Steven Shanks, RN at 3/29/2014 9:46 PM

Author:	Steven Shanks, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/29/2014 9:46 PM	Note Time:	3/29/2014 9:45 PM	Note Type:	ED Notes

Sons contact information: 843-514-5905

Electronically signed by Steven Shanks, RN on 3/29/2014 9:46 PM

CSN
61983014

ED Provider Notes signed by Steven H. Saef, MD MSCR at 3/30/2014 9:49 AM

Author:	Steven H. Saef, MD MSCR	Service:	Emergency Medicine	Author Type:	Physician
Filed:	3/30/2014 9:49 AM	Note Time:	3/29/2014 9:51 PM	Note Type:	ED Provider Notes
Related Notes:	Original Note by Lacey Menkin, MD filed at 3/30/2014 2:24 AM				

History

Chief Complaint

Patient presents with:

- Altered Mental Status

  Patient with known Alzhiemers Disease. The patient has recently been having increasing aggression towards her daughter. The daughter called 911 tonight per EMS because of worsening aggression.

HPI Comments: 66 y/o with history of alzheimer's dementia. Patient with no complaints, BABA. Her brother states she was " out of control " the last 2 days. Wandered out of house, telling neighbors she is being abused by daughter who is primary care giver. Caused daughter to be arrested. Brother states daughter is not abusing patient. Pt is not eating, low appetite, must be forced to eat. Combative about bathing. Physically puts herself at harm. No physical illness.

Patient is a 66 y.o. female presenting with altered mental status. The history is provided by the patient and a relative (Brother, at bedside.). The history is limited by the condition of the patient. No language interpreter was used.

Altered Mental Status

This is a chronic problem. The current episode started in the past 7 days. The problem occurs constantly. The problem has been gradually worsening. Nothing aggravates the symptoms. She has tried nothing for the symptoms.

Past Medical History

Diagnosis	Date
• Depression	
• Memory impairment	

History reviewed. No pertinent past surgical history.

Family History

Problem	Relation	Age of Onset
• Dementia	Mother	
• Depression	Mother	
• Brain cancer	Sister	
• Breast cancer	Sister	

History

Substance Use Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Not on file
• Alcohol Use:	No

Review of Systems

Unable to perform ROS: Dementia

Psychiatric/Behavioral: Positive for altered mental status.

Physical Exam

BP 142/82 | Pulse 91 | Temp(Src) 36.7 °C (98.1 °F) (Oral) | Resp 18 | SpO2 98%

Physical Exam

Nursing note and vitals reviewed.

Constitutional: She is oriented to person, place, and time. She appears well-developed and well-nourished.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales.
Abdominal: Soft. She exhibits no distension. There is no tenderness.
Musculoskeletal: Normal range of motion. She exhibits no edema.
Neurological: She is alert and oriented to person, place, and time. No cranial nerve deficit. She exhibits normal muscle tone.
Skin: Skin is warm and dry. No rash noted. No erythema. No pallor.
Psychiatric: She has a normal mood and affect. Her behavior is normal. Judgment and thought content normal.

ED Course
Procedures

MDM
Number of Diagnoses or Management Options
Agitation: new and requires workup
Memory impairment: new and requires workup

Amount and/or Complexity of Data Reviewed
Clinical lab tests: ordered and reviewed
Discuss the patient with other providers: yes

Risk of Complications, Morbidity, and/or Mortality
Presenting problems: high
Diagnostic procedures: moderate
Management options: high

Patient Progress
Patient progress: stable

Clinical & Imaging Tests: Ordered & Reviewed

Labs
Lab Results

CBC AND DIFFERENTIAL (Final result) Result time: 03/29/14 23:36:12

BASIC METABOLIC PANEL (Edited Result - FINAL) Abnormal Component (Lab Inquiry)

Collection Time	Result Time	BUN	NA	K	CL	CO2 CONTENT (BICARBONATE)
03/29/14 23:24:00	03/29/14 23:52:00	18.0	143.0	3.60	105.0	26

Collection Time	Result Time	ANION GAP	GLUCOSE	CREATININE	CALCIUM	EGFR
03/29/14 23:24:00	03/29/14 23:52:00	12 (H)	100.0	0.7	9.8	>59 The GFR calculation is Age, Sex

and Race adjusted. _ml/min/1.73 sq.m Note: Estimated GFR > or = to 60 is not reported because values are not reliable. The 4 variable MDRD (Modification of Diet in Renal Disease) Equation provides only an ESTIMATE of actual glomerular filtration rate (GFR). This ESTIMATE is only useful in STABLE renal function. This equation has not been specifically studied in non-white, non-black patients, pregnancy or in age greater than 70 or less than 18. Please consult your pharmacist for drug dosing.

Collection Time	Result Time	HEMOLYSIS INDEX
03/29/14 23:24:00	03/29/14 23:52:00	1.0

A Hemolysis Index greater than or equal to 2 represents a hemolyzed sample. Interference may occur with a Hemolysis Index greater than or equal to 2 for the following tests: ALT, Ammonia, Amylase, AST, CK, Total and Direct Bili, Fe/IBC, GGT, Hapt, K, Lac, LDH, Mg, Phos, Uric Acid. Interpret with caution. A Hemolysis Index greater than or equal to 6 represents gross hemolysis, specimens should be recollected.

VITAMIN B12 (Final result) Component (Lab Inquiry)

Collection Time	Result Time	VITAMIN B 12
03/29/14 23:24:00	03/30/14 00:02:00	617

The SiemensAdvia Centaur Immunoassay System (Chemiluminescence Technology) is used to perform this assay. Reference range adapted from Siemens method literature. Results by other manufacturers' assays for this substance may not be equivalent to results by the Siemens assay and should not be interpreted interchangeably due to methodology differences.

FOLATE (Final result) Component (Lab Inquiry)

Collection Time	Result Time	FOLATE
03/29/14 23:24:00	03/30/14 00:02:00	9.4

The Siemens Advia Centaur Immunoassay System (Chemiluminescence Technology) is used to perform this assay.Reference range adapted from Siemens method literature. Results by other manufacturers' assays for this substance may not be equivalent to results by the Siemens assay and should not be interpreted interchangeably due to methodology differences.

HEM PANEL (Final result) Abnormal Component (Lab Inquiry)

Collection Time	Result Time	WBC	RBC	HGB	HCT	MCV
03/29/14 23:24:00	03/29/14 23:36:00	7.74 Effective 02/26/2014, the current critical value range for WBC will change as follows: Age: 0 – 1 day : <2 (changed from <5). Age: 1 day – Adult: No change Test methodology and reagent remain the same.	3.85 (L)	11.2 (L) Effective 02/26/2014, the current critical value range for Hemoglobin will change as follows: Age: Greater than 1 month: 6 to 20 (changed from 6 to 19) Age: Less than one month: 9 to 20 (changed from 10 to 20) Test methodology	33.9 (L) Effective 02/26/2014, the current critical value range for Hematocrit will change as follows: Age: 0-1 month: 25% to 70% (changed from 30% to 65%) Age: 1 month to 6 months: 25% to 60% (changed from 30% to 60%) Age: 6	88.1

			and reagent remain the same.	months to Adult: Unchanged Test methodology and reagent remain the same.

Collection Time	Result Time	MCH	MCHC	RDW
03/29/14 23:24:00	**03/29/14 23:36:00**	**29.1**	**33.0**	**13.0**

PLATELET COUNT (Final result) Component (Lab Inquiry)

Collection Time	Result Time	PLT	MPV
03/29/14 23:24:00	**03/29/14 23:36:00**	**231** Effective 02/26/2014, the current critical value range for Platelet Count will change as follows: Age: 0-1 week: 30 to no upper limit (previously 50 to 999) Age: 1 week-adult: 10 to no upper limit (previously 26 to 999) Test methodology and reagent remain the same.	**10.10**

AUTODIFF (Final result) Component (Lab Inquiry)

Collection Time	Result Time	NEUTRO PCT	LYMPHOCYT E %	MONO PCT	EOS PCT	BASOS PCT
03/29/14 23:24:00	**03/29/14 23:36:00**	**68.1**	**27.0**	**4.5**	**0.3**	**0.1**

Collection Time	Result Time	NEUTRO ABS	LYMPHS ABS	MONOS ABS	EOS ABS	BASOS ABS
03/29/14 23:24:00	**03/29/14 23:36:00**	**5.27**	**2.09**	**0.35**	**0.02**	**0.01**

Imaging

ED Medications: Ordered, Reviewed & Administered

ED Medications

Medications

acetaminophen (TYLENOL) 325 mg tablet 650 mg (not administered)
hydrOXYzine (ATARAX) 25 MG oral tablet 25 mg (not administered)
aluminum & magnesium hydroxide-simethicone (MYLANTA MAXIMUM STRENGTH) suspension 30 mL (not administered)

magnesium hydroxide (MAALOX) oral suspension 30 mL (not administered)
OLANZapine (ZYPREXA) 5 MG tablet 2.5 mg (not administered)
OLANZapine (ZYPREXA) 10 mg injection 2.5 mg (not administered)

Home Medications
No current facility-administered medications on file prior to encounter.

Current Outpatient Prescriptions on File Prior to Encounter

Medication	Sig	Dispense	Refill
• donepezil (ARICEPT) 10 MG tablet	Take 10 mg by mouth nightly.		
• escitalopram (LEXAPRO) 20 MG tablet	TAKE 1 TABLET BY MOUTH EVERY DAY	30 tablet	2
• memantine (NAMENDA) 10 MG tablet	Take 10 mg by mouth 2 (two) times daily.		

ED Consults
No orders of the defined types were placed in this encounter.

EKG Interpretation

Assessment
66 y/o with history of alzheimer's dementia. Patient with no complaints, BABA with brother who reports behavioral agitation
-labs unremarkable
-Psych evaluated in ED and will admit to IOP

Clinical Impression
1. **Memory impairment**
2. Agitation

Plan

1. Admit to IOP

Attestations

I personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. I have reviewed the resident's note and I agree with the evaluation and documentation.

Additional elements of the history and physical include: Psychiatry consulted by Dr. Menkin for severe behavioral emergency with patient being a threat to herself and others. Psychiatry is admitting patient to the IOP. Patient signed in by brother who has her Healthcare POA. /Saef I agree with the findings, assessment, and plan as outlined above by Dr. Menkin

Steven H. Saef 3/29/2014 9:44 AM

Lacey Menkin, MD
Resident
03/30/14 0224

Steven H. Saef, MD MSCR
03/30/14 0949

Electronically signed by Steven H. Saef, MD MSCR on 3/30/2014 9:49 AM

CSN
61983181

IP-Consult signed by Challyn Nicole Malone, MD at 3/30/2014 1:36 AM

Author:	Challyn Nicole Malone, MD	Service:	(none)	Author Type:	Resident
Filed:	3/30/2014 1:36 AM	Note Time:	3/30/2014 12:51 AM	Note Type:	IP-Consult

PHYSICIAN Core Assessment

Location: MUSC ED

Physician/Service notified by: Dr. Menkin
Requested by Attending Dr. Saef
Service requesting consult: ED

Legal Status:voluntarily

Decision Maker: son
Name: Sammy Huggins Telephone #:

REASON FOR CONSULT: Worsening aggression/agitation

HISTORY OF PRESENT ILLNESS: Pt is a 66y/o woman with hx of Alzheimer's dementia who presents to ED

via EMS with worsening agitation and behavioral disturbance. Most of hx was gathered from brother who was interviewed at pt's bedside. Pt was initially seen by Dr.Seery in May of 2013 at that time to be evaluated for worsening memory and language difficulties. Neuropsych testing was performed at that time confirming a likely diagnosis of Alzheimer's dementia. At that time, pt was having difficulty performing tasks at home however was able to use the bathroom on her own and shower herself. Per brother daughter moved in with pt to act as her primary caregiver which she has fulfilled that role since. Over the past year, pt has become more dependent on her daughter for assistance and is now unable to toilet herself, feed herself, or bathe herself. Per brother, for the past month pt has become more combative primarily with her daughter reportedly fighting her whenever she is trying to assist with her ADLs also becoming more violent with digging her fingernails in her daughter's skin. For the past couple of days, pt has called the police twice accusing her daughter of abusing her. She has also begun wandering away from the house and telling random strangers that she is being abused. Per brother, to his knowledge the alleged abuse is false. Pt was brought to the hospital for further evaluation as per brother, family believes that pt is no longer able to be taken care of by her daughter with hopes that a longer care living facility would be appropriate.

On interview, pt states that she is "happy" person although reports that for the past couple of days "things have not been good". When asked what she was referring to, states that "men came into the house" which caused her to be concerned. Per brother, he is unaware of this event. Pt had no recollection why she was in the hospital except that she believed her daughter had something to do with it. She denied any depressive symptoms, mania, anxiety or psychosis. She denies any SI/HI. Pt was appropriate in mood and affect during the interview but was not oriented to month, day of week or year. Pt had difficulty verbalizing her answers however if you were to give her 3 answer choices, she was able to give the right answer most of the time. She was also oriented to president, state, city and hospital. Poor recent and remote memory.

PAST PSYCHIATRIC HISTORY:
Previous therapy: yes
Previous psychiatric treatment and medication trials: yes - aricept, namenda, lexapro
Previous psychiatric hospitalizations: no
Previous diagnoses: yes - Alzheimer's dementia
Previous suicide attempts: no
History of violence: yes
Currently in treatment with PCP, Dr. Karen Thomas. Had seen Dr. Seery last in 7/2013
ECT: no

SUBSTANCE USE HISTORY:
Recreational drugs: Never used

Use of alcohol: denied
History of Delirium Tremens during Alcohol Withdrawal: NA
History of Seizures during Alcohol withdrawal:NA

Tobacco use: non smoker

Legal consequences of substance use: no

PAST MEDICAL HISTORY:
none

FAMILY HISTORY:

Family History

Problem	Relation	Age of Onset
• Dementia	Mother	
• Depression	Mother	
• Brain cancer	Sister	
• Breast cancer	Sister	

SOCIAL HISTORY:
Lives with her daughter. Pt was married for several years. Has one daughter. Denies hx of abuse

ALLERGIES: -
No Known Allergies

CURRENT MEDICATIONS:
Current Outpatient Prescriptions on File Prior to Visit

Medication	Sig	Dispense	Refill
• donepezil (ARICEPT) 10 MG tablet	Take 10 mg by mouth nightly.		
• escitalopram (LEXAPRO) 20 MG tablet	TAKE 1 TABLET BY MOUTH EVERY DAY	30 tablet	2
• memantine (NAMENDA) 10 MG tablet	Take 10 mg by mouth 2 (two) times daily.		

No current facility-administered medications on file prior to visit.

REVIEW OF SYSTEMS:
Comprehensive review of systems was performed with all systems negative.

PHYSICAL EXAM:
Temp: 36.7C P: 91 R: 18 BP: 142/82 02 SAT: 98%

General appearance: alert, appears stated age and cooperative
Head: Normocephalic, without obvious abnormality, atraumatic
Throat: lips, mucosa, and tongue normal; teeth and gums normal
Neck: no adenopathy, no carotid bruit, no JVD, supple, symmetrical, trachea midline and thyroid not enlarged, symmetric, no tenderness/mass/nodules
Back: symmetric, no curvature. ROM normal. No CVA tenderness.
Lungs: clear to auscultation bilaterally
Breasts: normal appearance, no masses or tenderness
Heart: regular rate and rhythm, S1, S2 normal, no murmur, click, rub or gallop
Abdomen: soft, non-tender; bowel sounds normal; no masses, no organomegaly
Extremities: extremities normal, atraumatic, no cyanosis or edema
Pulses: 2+ and symmetric
Skin: Skin color, texture, turgor normal. No rashes or lesions
Lymph nodes: Cervical, supraclavicular, and axillary nodes normal.
Neurologic: Mental status: alertness: alert, orientation: person, place, city, president
Cranial nerves: normal
Motor:grossly normal

Gait: Normal

Mental Status Examination:
Appearance:Appears older than stated age , Well-groomed , Immaculately dressed and Sitting
Behavior/AttitudeGood eye contact and Cooperative with examiner
Motor: No Psychomotor Retardation and No Psychomotor Agitation
Gait:Steady
Speech:Normal rate, Normal volume and Latency
Language: Fluent and no language deficits noted.
Mood:euthymic
Affect:Mood Congruent and Constricted
Thought Process:Linear and Goal-directed
Associations: Logical Connections
Thought Content:No SI/HI
Perceptions:No auditory or visual hallucinations
Level of Consciousness: Alert
Orientation:see HPI
Attention/Concentration:Able to attend to interview
Memory:Poor recent and remote memory
Estimated Intelligence/Fund of Knowledge: Average
Conceptual/Visiospatial: N/A
Judgement:Impaired
Insight:Impaired

LABS:
CBC Hgb 11.2
BMP wnl
B12/folate wnl

Assessment:
Pt is a 66y/o woman with hx of Alzheimer's dementia who presents to ED via EMS with worsening agitation and behavioral disturbance. Per family, pt has had worsening agitation and aggression towards her primary caregiver who is unable to care for patient anymore at this time. Pt has been noted to have dangerous behaviors of wandering outside of the home telling strangers that she is being abused which has led to the police being called to the home several times. She is unable to meet her basic needs of toileting herself, bathing or feeding herself. On interview, she displays symptoms consistent with dementia with language and memory difficulties. Given that pt has become more violent and combative at home along with dangerous behaviors of wandering away from the home with concerns for ability to care for self and danger to self and others, pt meets criteria for inpatient hospitalization at this time. Pt is voluntary. Brother is power of attorney who is agreeable with pt's inpatient admission.

Axis I: Dementia with behavioral disturbance

Axis II: Deferred

Axis III: none

Axis IV: other psychosocial or environmental problems and chronic mental illness

Axis V: 20

PSYCHIATRY RECOMMENDATIONS / PLAN:
Safety: Pt meets criteria for admission to IOP however there are not currently any beds available. ER psych will be working with SW to find alternative placement if possible. In the meantime, maintain precautions. Pts require a sitter 24/7 and should not be allowed out of the ER. Upon admission to SCU, initiate all appropriate precautions including q 15min checks, UR, EP, VP.

Dementia with behavioral disturbance: will continue outpt med regimen of aricept 10mg daily, namenda 10mg bid and lexapro 10mg daily. Primary team to consider possible addition of mood stabilizer to help with agitation such as Depakote. Will defer to medication adjustments per geriatric psych team. Will have PRNs available for acute agitation.

FEN: reg diet

Collateral: may contact brother or daughter for collateral

Dispo: home after stabilization of symptoms with appropriate mental health follow up.

Pt seen and discussed with SAR, Dr. Gentry, who agrees with the treatment plan.

Thank you for this consult.

Challyn Malone, MD
PGY-2
Psychiatry

Electronically signed by Challyn Nicole Malone, MD on 3/30/2014 1:36 AM

CSN
61983014

ED Notes signed by Lisa Butler, RN at 3/30/2014 12:59 PM

Author:	Lisa Butler, RN	Service:	(none)	Author Type:	Registered Nurse

ED Notes signed by Lisa Butler, RN at 3/30/2014 12:59 PM (continued)

Filed: 3/30/2014 12:59 PM Note Time: 3/30/2014 7:10 AM Note Type: ED Notes

Assumed care of pt, verbal bedside report recd

Electronically signed by Lisa Butler, RN on 3/30/2014 12:59 PM

CSN
61983014

ED Notes signed by Lisa Butler, RN at 3/30/2014 1:01 PM

Author: Lisa Butler, RN Service: (none) Author Type: Registered Nurse

Filed: 3/30/2014 1:01 PM Note Time: 3/30/2014 7:35 AM Note Type: ED Notes

Pt in personal clothing, admitted to Psch awaiting bed IOP. Pt continuing to climb OOB no sitter avail

Electronically signed by Lisa Butler, RN on 3/30/2014 1:01 PM

CSN
61983014

ED Notes signed by Lisa Butler, RN at 3/30/2014 1:02 PM

Author: Lisa Butler, RN Service: (none) Author Type: Registered Nurse

Filed: 3/30/2014 1:02 PM Note Time: 3/30/2014 8:00 AM Note Type: ED Notes

MD at bedside.Dr Cummings redirecting pt to remain in bed. Pt sitting upright eating breakfast

Electronically signed by Lisa Butler, RN on 3/30/2014 1:02 PM

CSN
61983014

Consult NW signed by Alvin Lee Lewis, MD at 3/30/2014 9:37 AM

Author: Alvin Lee Lewis, MD Service: (none) Author Type: Physician

Filed: 3/30/2014 9:37 AM Note Time: 3/30/2014 9:36 AM Note Type: Consult NW

Examined pt this am. Seen by resident and agree with assessment and plan of care. Pt is awaiting SCU bed for agitation with dementia. Family at this time is unwilling to provide support for placement.

Electronically signed by Alvin Lee Lewis, MD on 3/30/2014 9:37 AM

CSN
61983014

ED Notes signed by Lisa Butler, RN at 3/30/2014 1:05 PM

Author: Lisa Butler, RN Service: (none) Author Type: Registered Nurse

Filed: 3/30/2014 1:05 PM Note Time: 3/30/2014 10:00 AM Note Type: ED Notes

Assisted pt to BR able to ambulate without difficulty. Pt did not want to get back into her bed once RN escorted her back to her bed in HW1- sitter still unavial

Electronically signed by Lisa Butler, RN on 3/30/2014 1:05 PM

CSN
61983014

ED Notes signed by Lisa Butler, RN at 3/30/2014 1:06 PM

Author:	Lisa Butler, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/30/2014 1:06 PM	Note Time:	3/30/2014 11:30 AM	Note Type:	ED Notes

Pt OOB dancing in hallway, refusing to climb back into bed. RN assisted pt back to bed

Electronically signed by Lisa Butler, RN on 3/30/2014 1:06 PM

CSN
61983014

ED Notes signed by Lisa Butler, RN at 3/30/2014 1:07 PM

Author:	Lisa Butler, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/30/2014 1:07 PM	Note Time:	3/30/2014 12:50 PM	Note Type:	ED Notes

Pt moved from HW1 to HW next to room 22 where TA is sitting.

Electronically signed by Lisa Butler, RN on 3/30/2014 1:07 PM

CSN
61983014

ED Notes signed by Michelle Houck, RN at 3/30/2014 1:17 PM

Author:	Michelle Houck, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/30/2014 1:17 PM	Note Time:	3/30/2014 1:17 PM	Note Type:	ED Notes

Pt to b side hall. Pt agitated, difficult to redirect. MD paged for orders as well as to advise of pt uti

Electronically signed by Michelle Houck, RN on 3/30/2014 1:17 PM

CSN
61983014

ED Notes signed by Michelle Houck, RN at 3/30/2014 1:35 PM

Author:	Michelle Houck, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/30/2014 1:35 PM	Note Time:	3/30/2014 1:34 PM	Note Type:	ED Notes

Family at bedside. Brother

Electronically signed by Michelle Houck, RN on 3/30/2014 1:35 PM

CSN

CSN
61983014

ED Notes signed by Michelle Houck, RN at 3/30/2014 3:32 PM

Author:	Michelle Houck, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/30/2014 3:32 PM	Note Time:	3/30/2014 3:32 PM	Note Type:	ED Notes

[redacted] Please call her first

Electronically signed by Michelle Houck, RN on 3/30/2014 3:32 PM

CSN
61983014

ED Notes signed by Michelle Houck, RN at 3/30/2014 5:10 PM

Author:	Michelle Houck, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/30/2014 5:10 PM	Note Time:	3/30/2014 5:09 PM	Note Type:	ED Notes

Pt much less agitated, sitting up eating dinner, appears to be enjoying her meal "this is goooood!"

Electronically signed by Michelle Houck, RN on 3/30/2014 5:10 PM

CSN
61983014

ED Notes signed by Erica Smith, RN, BSN at 3/31/2014 1:42 PM

Author:	Erica Smith, RN, BSN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/31/2014 1:42 PM	Note Time:	3/31/2014 1:32 PM	Note Type:	ED Notes
Related Notes:	Original Note by Erica Smith, RN, BSN filed at 3/31/2014 1:34 PM				

Assumed care of pt. Moved to ER 13 +steady gait noted. TA at bedside. Pt requests to be moved back into hallway bed. Care transferred back to MH RN. Continue to monitor.

Electronically signed by Erica Smith, RN, BSN on 3/31/2014 1:42 PM

CSN
61983014

ED Notes signed by Michelle Houck, RN at 3/31/2014 4:47 PM

Author:	Michelle Houck, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	3/31/2014 4:47 PM	Note Time:	3/31/2014 3:10 PM	Note Type:	ED Notes

Attempted to move pt to bed 13. Pt became very agitated and upset. Moved back into hallway. On psych rounds earlier advised team that aricept, lexapro, and namenda (home meds) had not been restarted

Electronically signed by Michelle Houck, RN on 3/31/2014 4:47 PM

CSN

CSN
62002046

IP-Consult signed by Sarah Manco, APRN at 3/31/2014 4:33 PM

Author:	Sarah Manco, APRN	Service:	(none)	Author Type:	Nurse Practitioner
Filed:	3/31/2014 4:33 PM	Note Time:	3/31/2014 4:12 PM	Note Type:	IP-Consult

..IOP Admissions/ED PSYCHIATRIC PROGRESS NOTE

S: 66 y/o female with hx of Alzheimer's dementia presented to ED with worsening agitation and behavioral disturbances.

O: Pt anxious, confused, pressured speech. Received zyprexa 2.5 mg yesterday for agitation. No incidents overnight, no prns given. Patient too confused to determine if she is experiencing AVH, SI/HI. Poor appetite, fair sleep.

VITALS: : 36.7 C P: 91 R:16 BP: 142/82 Pain: 0/10
Labs:
No results found for this or any previous visit (from the past 24 hour(s)).]

MSE
Mental Status Examination:
Appearance: disheveled, older than stated age, thin & gaunt looking and unkempt
Behavior: restless and fidgety
Energy:Good
Eye Contact:Fair
Motor: Hyperactive and Tense
Level of Consciousness:Alert
Attitude:Cooperative
Speech:pressured
Mood:anxious
Affect:increased in intensity
Thought Process:circumstantial, disorganized
Thought Content:Normal
Judgement:Significantly impaired
Insight:Significantly impaired
Orientation:disoriented
Concentration:unable to attend to task.
Memory:Impaired remote by interview
Immediate recall 0 of 3
Delayed in recall 0 of 3
Intelligence:Average
Conceptual/Visiospatial:N/A
Impulse Control: poor
Auditory Visual Hallucinations:no

A:ssessment:
Pt is a 66y/o woman with hx of Alzheimer's dementia who presents to ED via EMS with worsening agitation and behavioral disturbance. Per family, pt has had worsening agitation and aggression towards her primary

caregiver who is unable to care for patient anymore at this time. Pt has been noted to have dangerous behaviors of wandering outside of the home telling strangers that she is being abused which has led to the police being called to the home several times. She is unable to meet her basic needs of toileting herself, bathing or feeding herself. On interview, she displays symptoms consistent with dementia with language and memory difficulties. Given that pt has become more violent and combative at home along with dangerous behaviors of wandering away from the home with concerns for ability to care for self and danger to self and others, pt meets criteria for inpatient hospitalization at this time. Pt is voluntary. Brother is power of attorney who is agreeable with pt's inpatient admission.

Axis I: Dementia with behavioral disturbance
Axis II: Deferred
Axis III: none
Axis IV: other psychosocial or environmental problems and chronic mental illness
Axis V: 20

P:
PSYCHIATRY RECOMMENDATIONS / PLAN:
Safety: Pt meets criteria for admission to IOP however there are not currently any beds available. ER psych will be working with SW to find alternative placement if possible. In the meantime, maintain precautions. Pts require a sitter 24/7 and should not be allowed out of the ER. Upon admission to SCU, initiate all appropriate precautions including q 15min checks, UR, EP, VP, Fall Prec. EKG
Dementia with behavioral disturbance: will continue outpt med regimen of aricept 10mg daily, namenda 10mg bid and lexapro 10mg daily. Will add mood stabilizer Depakote 125 mg po bid to help with agitation. Will defer to medication adjustments per geriatric psych team. Will have PRNs available for acute agitation. Will order liver function test.

FEN: reg diet

Case reviewed with Attending Physician Dr. Mullis

Sarah Manco NP
Pager: 11724
Date: 3/31/14

Electronically signed by Sarah Manco, APRN on 3/31/2014 4:33 PM

CSN
62002046

IP-Consult signed by Diana M. Mullis, MD at 3/31/2014 5:59 PM

Author:	Diana M. Mullis, MD	Service:	(none)	Author Type:	Physician
Filed:	3/31/2014 5:59 PM	Note Time:	3/31/2014 5:58 PM	Note Type:	IP-Consult

Title: ATTENDING PHYSICIAN COMMENTS

I have seen and examined this patient. My examination and assessment are consistent with that of Manco,APRN above. I agree with the with the documentation as written with the following

ammendments: none

Date and time of Exam: 3-31-14

Electronically signed by Diana M. Mullis, MD on 3/31/2014 5:59 PM

CSN
61983014

ED Notes signed by Lisa Simmons at 4/1/2014 8:32 AM

Author:	Lisa Simmons	Service:	(none)	Author Type:	ED PATIENT CARE TECH
Filed:	4/1/2014 8:32 AM	Note Time:	4/1/2014 8:30 AM	Note Type:	ED Notes

Pt. Breakfast Arrived @0800 Pt. Stated she was not hungry.

Electronically signed by Lisa Simmons on 4/1/2014 8:32 AM

CSN
62008931

IP-Consult signed by Sarah Manco, APRN at 4/1/2014 10:25 AM

Author:	Sarah Manco, APRN	Service:	(none)	Author Type:	Nurse Practitioner
Filed:	4/1/2014 11:27 AM	Note Time:	4/1/2014 10:07 AM	Note Type:	IP-Consult
Related Notes:	Original Note by Sarah Manco, APRN filed at 4/1/2014 10:25 AM				

..IOP Admissions/ED PSYCHIATRIC PROGRESS NOTE

S: 66 year old female with history of Alzheimer's dementia presented to ER via EMS due to worsening agitation and aggressive behavior towards caregiver (daughter). She accused daughter of abuse and called police twice to report that she was abusing her. She is unable to attend to her ADLs.

O: Appears anxious, confused, is disoriented x 3. She exhibits memory and language difficulties. Cooperative, accepting her medications. Unable to determine if she is experiencing SI/HI, AVH due to disorientation. Appetite poor. No incontinence of bowel or bladder. According to report she slept last night without incident.

VITALS: BP: 157/76 P: 97 R: 18 SP02: 97% Pain: 0/10

Labs:
Recent Results (from the past 24 hour(s))
HEPATIC FUNCTION PANEL
Collection Time
03/31/14 5:20 PM

Result	Value	Range
BILIRUBIN, TOTAL	0.5	0.2 - 1.3 MG/DL
BILIRUBIN, DIRECT	0.1	0.1 - 0.3 MG/DL
ASPARTATE AMINOTRANSFERASE (AST)(SGOT)	20.0	8.0 - 34.0 IU/L

ALANINE AMINOTRANSFERASE (ALT)(SGPT)	16.0	7.0 - 35.0 IU/L
ALKALINE PHOSPHATASE	50.0	25.0 - 100.0 IU/L
TOTAL PROTEIN	7.2	6.0 - 8.0 G/DL
ALBUMIN	4.5	3.5 - 4.8 G/DL
HEMOLYSIS INDEX	0.0	0.0 - 1.9

MSE
Mental Status Examination:
Appearance: unkempt
Behavior: restless and fidgety
Energy:Fair
Eye Contact:Fair
Motor: Tense
Level of Consciousness:Alert
Attitude:Cooperative
Speech:slow
Mood:anxious and sad
Affect:redirectable
Thought Process:disorganized
Thought Content:unable to determine
Judgement:Significantly impaired
Insight:Significantly impaired
Orientation:disoriented x3
Concentration:unable to attend to task.
Memory:Impaired remote by interview
Immediate recall 0 of 3
Delayed in recall 0 of 3
Intelligence:Average
Conceptual/Visiospatial:N/A
Impulse Control: poor
Auditory Visual Hallucinations:unknown

A:**A:ssessment:**
Pt is a 66y/o woman with hx of Alzheimer's dementia who presents to ED via EMS with worsening agitation and behavioral disturbance. Per family, pt has had worsening agitation and aggression towards her primary caregiver who is unable to care for patient anymore at this time. Pt has been noted to have dangerous behaviors of wandering outside of the home telling strangers that she is being abused which has led to the police being called to the home several times. She is unable to meet her basic needs of toileting herself, bathing or feeding herself. On interview, she displays symptoms consistent with dementia with language and memory difficulties. Given that pt has become more violent and combative at home along with dangerous behaviors of wandering away from the home with concerns for ability to care for self and danger to self and others, pt meets criteria for inpatient hospitalization at this time. Pt is voluntary. Brother is power of attorney who is agreeable with pt's inpatient admission.

Axis I: Dementia with behavioral disturbance
Axis II: Deferred
Axis III: none
Axis IV: other psychosocial or environmental problems and chronic mental illness

Axis V: 20

P:

PSYCHIATRY RECOMMENDATIONS / PLAN:
Safety: Pt meets criteria for admission to IOP however there are not currently any beds available. ER psych will be working with SW to find alternative placement if possible. In the meantime, maintain precautions. Pts require a sitter 24/7 and should not be allowed out of the ER. Upon admission to SCU, initiate all appropriate precautions including q 15min checks, UR, EP, VP, Fall Prec. EKG
Dementia with behavioral disturbance: will continue outpt med regimen of aricept 10mg daily, namenda 10mg bid and lexapro 10mg daily. Will add mood stabilizer Depakote 125 mg po bid to help with agitation. Will defer to medication adjustments per geriatric psych team. Will have PRNs available for acute agitation.
FEN: reg diet

Sarah Manco NP
Pager: 11724
Date: 4/1/14

Case reviewed with Attending Physician Dr. Brouette

Patient's chart reviewed, I examined patient and discussed the case with Sarah Manco, APRN . I agree with the above documentation and treatment plan.

Thomas Brouette, MD
#14349

Electronically signed by Thomas Brouette, MD on 4/1/2014 11:27 AM

CSN
61983014

ED Notes signed by Lisa Simmons at 4/1/2014 12:31 PM

Author:	Lisa Simmons	Service:	(none)	Author Type:	ED PATIENT CARE TECH
Filed:	4/1/2014 12:31 PM	Note Time:	4/1/2014 12:31 PM	Note Type:	ED Notes

Pt. Lunch arrived @1218

Electronically signed by Lisa Simmons on 4/1/2014 12:31 PM

CSN
61983014

ED Notes signed by Lisa Simmons at 4/1/2014 12:44 PM

Author:	Lisa Simmons	Service:	(none)	Author Type:	ED PATIENT CARE TECH
Filed:	4/1/2014 12:44 PM	Note Time:	4/1/2014 12:44 PM	Note Type:	ED Notes

Pt. Did not eat any lunch.

Electronically signed by Lisa Simmons on 4/1/2014 12:44 PM

CSN
61983014

ED Notes signed by Lisa Simmons at 4/1/2014 5:02 PM

Author:	Lisa Simmons	Service:	(none)	Author Type:	ED PATIENT CARE TECH
Filed:	4/1/2014 5:02 PM	Note Time:	4/1/2014 5:01 PM	Note Type:	ED Notes

Pt.dinner arrived @1655

Electronically signed by Lisa Simmons on 4/1/2014 5:02 PM

CSN
61983014

ED Notes signed by Carrie Ann Henderson, RN at 4/2/2014 3:51 AM

Author:	Carrie Ann Henderson, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 3:51 AM	Note Time:	4/2/2014 3:50 AM	Note Type:	ED Notes
Related Notes:	Original Note by Carrie Ann Henderson, RN filed at 4/2/2014 3:50 AM				

Electronically signed by Carrie Ann Henderson, RN on 4/2/2014 3:51 AM

CSN
61983014

ED Notes signed by Carrie Ann Henderson, RN at 4/2/2014 3:51 AM

Author:	Carrie Ann Henderson, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 3:51 AM	Note Time:	4/2/2014 3:50 AM	Note Type:	ED Notes

Pt given bedside bath by Michelle, PCT and this RN writing. Pt was given warm blanket, clean linens, clean scrubs and clean booties. Will continue to monitor.

Electronically signed by Carrie Ann Henderson, RN on 4/2/2014 3:51 AM

CSN
61983014

ED Notes signed by Raul Deguzman, RN at 4/2/2014 8:35 AM

Author:	Raul Deguzman, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 8:35 AM	Note Time:	4/2/2014 8:34 AM	Note Type:	ED Notes

Patient is resting comfortably. Parents are at the bedside. Pt denies feeling suicidal. Waiting for psych to D/c pt

Electronically signed by Raul Deguzman, RN on 4/2/2014 8:35 AM

CSN
61983014

ED Notes signed by Raul Deguzman, RN at 4/2/2014 9:25 AM

Author:	Raul Deguzman, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 9:25 AM	Note Time:	4/2/2014 9:24 AM	Note Type:	ED Notes

Patient is resting comfortably. Pt sleeping, easily arousable.

Electronically signed by Raul Deguzman, RN on 4/2/2014 9:25 AM

CSN
61983181

IP-Consult signed by Mary Catherine Park, PAC at 4/2/2014 1:09 PM

Author:	Mary Catherine Park, PAC	Service:	(none)	Author Type:	Physician Assistant
Filed:	4/2/2014 2:56 PM	Note Time:	4/2/2014 12:38 PM	Note Type:	IP-Consult
Related Notes:	Original Note by Mary Catherine Park, PAC filed at 4/2/2014 1:09 PM				

IOP ED PSYCHIATRIC PROGRESS NOTE 4/2/14

S: 66 y/o female with history of Alzheimer's Dementia still boarding in ER for worsening agitation and behavior disturbance. During rounds, patient was sleeping and unable to be aroused. Author returned 2 hours later, and patient still sleeping, and has not eaten. Patient received Zyprexa 2.5 MG IM at around 1700 yesterday. She took Depakote sprinkles this morning around 1000 as scheduled. Patient was alert and only oriented to her first name. She was unable to answer questions due to altered mental status. She was able to follow commands during physical exam and repeatedly state "Im cold." When asked certain questions like "place, date. president, and what does 'cat got your tongue mean'?" patient states she "knows but can't get it out." Unable to agree to safety plan at this time.

O: Patient sitting in hospital bed shivering
VITALS:148/75 77HR 20RR 95%RA
Labs: New labs ordered at 1200 today and pending (CBC, CMP, Ammonia, AND depakote level)
No labs since 3/31/14

MSE
Mental Status Examination:
Appearance: disheveled, older than stated age and thin & gaunt looking
Behavior: restless and fidgety
Energy:Fair
Eye Contact:Fair
Motor: Tense
Level of Consciousness:Alert
Attitude:Cooperative
Speech:delayed
Mood:euthymic
Affect:blunted
Thought Process:concrete and disorganized

Thought Content:Preoccupation
Judgement:Significantly impaired
Insight:Significantly impaired
Orientation:person
Concentration:unable to attend to task.
Memory:Confabulation
Intelligence:Average
Conceptual/Visiospatial:N/A
Impulse Control: fair
Auditory Visual Hallucinations:no

Physical Exam:
NeuroMuscular: unsteady gait with assistance, NSTLT in all extremities bilat, 4/5 strength in muscle groups in upper and lower extremities bilat, CN II-X intact, Rhomberg negative

Assessment:66y/o woman with hx of Alzheimer's dementia who presents to ED via EMS with worsening agitation and behavioral disturbance. Per family, pt has had worsening agitation and aggression towards her primary caregiver who is unable to care for patient anymore at this time. Pt has been noted to have dangerous behaviors of wandering outside of the home telling strangers that she is being abused which has led to the police being called to the home several times. She is unable to meet her basic needs of toileting herself, bathing or feeding herself. On interview, she displays symptoms consistent with dementia with language and memory difficulties. Given that pt has become more violent and combative at home along with dangerous behaviors of wandering away from the home with concerns for ability to care for self and danger to self and others, pt meets criteria for inpatient hospitalization at this time. Pt is voluntary. Brother is power of attorney who is agreeable with pt's inpatient admission.

Axis I:Alzheimer's Dementia, Dementia vs Delirium
Axis II:deferred
Axis III:UTI
Axis IV:chronic mental illness
Axis V:GAF 20

Plan:Patient still boarding for SCU/SCU Extension at IOP
Lab work pending
Orthostatic vitals q4h
Continue Depakote sprinkles 125 mg BID and Bactrim DS BID
Patient has not received Namenda 10 mg BID, Lexapro 20 mg, or Aricept 10 mg daily- will start those today in Boarding Orders
Appropriate PRNs as ordered by resident

Case reviewed with Attending Physician Dr. Brouette
Catie Park, PA-C pager12375

Below notes should be Addendums to IP consult note by Challyn Malone, MD on 3/30/14

IOP Admissions/ED PSYCHIATRIC PROGRESS NOTE April 1, 2014
S: 66 year old female with history of Alzheimer's dementia presented to ER via EMS due to worsening agitation and aggressive behavior towards caregiver (daughter). She accused daughter of abuse and called police twice

to report that she was abusing her. She is unable to attend to her ADLs.
O: Appears anxious, confused, is disoriented x 3. She exhibits memory and language difficulties. Cooperative, accepting her medications. Unable to determine if she is experiencing SI/HI, AVH due to disorientation. Appetite poor. No incontinence of bowel or bladder. According to report she slept last night without incident.
VITALS: BP: 157/76 P: 97 R: 18 SP02: 97% Pain: 0/10
Labs:
Recent Results (from the past 24 hour(s))
HEPATIC FUNCTION PANEL
Collection Time
03/31/14 5:20 PM

Result	Value	Range
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BILIRUBIN, DIRECT	0.1	0.1 - 0.3 MG/DL
ASPARTATE AMINOTRANSFERASE (AST)(SGOT)	20.0	8.0 - 34.0 IU/L
ALANINE AMINOTRANSFERASE (ALT)(SGPT)	16.0	7.0 - 35.0 IU/L
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TOTAL PROTEIN	7.2	6.0 - 8.0 G/DL
ALBUMIN	4.5	3.5 - 4.8 G/DL
HEMOLYSIS INDEX	0.0	0.0 - 1.9

MSE
Mental Status Examination:
Appearance: unkempt
Behavior: restless and fidgety
Energy:Fair
Eye Contact:Fair
Motor: Tense
Level of Consciousness:Alert
Attitude:Cooperative
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Affect:redirectable
Thought Process:disorganized
Thought Content:unable to determine
Judgement:Significantly impaired
Insight:Significantly impaired
Orientation:disoriented x3
Concentration:unable to attend to task.
Memory:Impaired remote by interview
Immediate recall 0 of 3
Delayed in recall 0 of 3
Intelligence:Average
Conceptual/Visiospatial:N/A
Impulse Control: poor
Auditory Visual Hallucinations:unknown
A:**A:ssessment:**
Pt is a 66y/o woman with hx of Alzheimer's dementia who presents to ED via EMS with worsening agitation and behavioral disturbance. Per family, pt has had worsening agitation and aggression towards her primary caregiver who is unable to care for patient anymore at this time. Pt has been noted to have dangerous

behaviors of wandering outside of the home telling strangers that she is being abused which has led to the police being called to the home several times. She is unable to meet her basic needs of toileting herself, bathing or feeding herself. On interview, she displays symptoms consistent with dementia with language and memory difficulties. Given that pt has become more violent and combative at home along with dangerous behaviors of wandering away from the home with concerns for ability to care for self and danger to self and others, pt meets criteria for inpatient hospitalization at this time. Pt is voluntary. Brother is power of attorney who is agreeable with pt's inpatient admission.

Axis I: Dementia with behavioral disturbance
Axis II: Deferred
Axis III: none
Axis IV: other psychosocial or environmental problems and chronic mental illness
Axis V: 20
P:

PSYCHIATRY RECOMMENDATIONS / PLAN:

Safety: Pt meets criteria for admission to IOP however there are not currently any beds available. ER psych will be working with SW to find alternative placement if possible. In the meantime, maintain precautions. Pts require a sitter 24/7 and should not be allowed out of the ER. Upon admission to SCU, initiate all appropriate precautions including q 15min checks, UR, EP, VP, Fall Prec. EKG
Dementia with behavioral disturbance: will continue outpt med regimen of aricept 10mg daily, namenda 10mg bid and lexapro 10mg daily. Will add mood stabilizer Depakote 125 mg po bid to help with agitation. Will defer to medication adjustments per geriatric psych team. Will have PRNs available for acute agitation.
FEN: reg diet
Sarah Manco NP
Pager: 11724
Date: 4/1/14
Case reviewed with Attending Physician Dr. Brouette
Patient's chart reviewed, I examined patient and discussed the case with Sarah Manco, APRN . I agree with the above documentation and treatment plan.
Thomas Brouette, MD
#14349

IOP Admissions/ED PSYCHIATRIC PROGRESS NOTE March 31, 2014
S: 66 y/o female with hx of Alzheimer's dementia presented to ED with worsening agitation and behavioral disturbances.
O: Pt anxious, confused, pressured speech. Received zyprexa 2.5 mg yesterday for agitation. No incidents overnight, no prns given. Patient too confused to determine if she is experiencing AVH, SI/HI. Poor appetite, fair sleep.
VITALS: : 36.7 C P: 91 R:16 BP: 142/82 Pain: 0/10
Labs:
No results found for this or any previous visit (from the past 24 hour(s)).]
MSE
Mental Status Examination:
Appearance: disheveled, older than stated age, thin & gaunt looking and unkempt
Behavior: restless and fidgety
Energy:Good
Eye Contact:Fair
Motor: Hyperactive and Tense

Level of Consciousness:Alert
Attitude:Cooperative
Speech:pressured
Mood:anxious
Affect:increased in intensity
Thought Process:circumstantial, disorganized
Thought Content:Normal
Judgement:Significantly impaired
Insight:Significantly impaired
Orientation:disoriented
Concentration:unable to attend to task.
Memory:Impaired remote by interview
Immediate recall 0 of 3
Delayed in recall 0 of 3
Intelligence:Average
Conceptual/Visiospatial:N/A
Impulse Control: poor
Auditory Visual Hallucinations:no

Assessment:

Pt is a 66y/o woman with hx of Alzheimer's dementia who presents to ED via EMS with worsening agitation and behavioral disturbance. Per family, pt has had worsening agitation and aggression towards her primary caregiver who is unable to care for patient anymore at this time. Pt has been noted to have dangerous behaviors of wandering outside of the home telling strangers that she is being abused which has led to the police being called to the home several times. She is unable to meet her basic needs of toileting herself, bathing or feeding herself. On interview, she displays symptoms consistent with dementia with language and memory difficulties. Given that pt has become more violent and combative at home along with dangerous behaviors of wandering away from the home with concerns for ability to care for self and danger to self and others, pt meets criteria for inpatient hospitalization at this time. Pt is voluntary. Brother is power of attorney who is agreeable with pt's inpatient admission.

Axis I: Dementia with behavioral disturbance
Axis II: Deferred
Axis III: none
Axis IV: other psychosocial or environmental problems and chronic mental illness
Axis V: 20

P:

PSYCHIATRY RECOMMENDATIONS / PLAN:

Safety: Pt meets criteria for admission to IOP however there are not currently any beds available. ER psych will be working with SW to find alternative placement if possible. In the meantime, maintain precautions. Pts require a sitter 24/7 and should not be allowed out of the ER. Upon admission to SCU, initiate all appropriate precautions including q 15min checks, UR, EP, VP, Fall Prec. EKG

Dementia with behavioral disturbance: will continue outpt med regimen of aricept 10mg daily, namenda 10mg bid and lexapro 10mg daily. Will add mood stabilizer Depakote 125 mg po bid to help with agitation. Will defer to medication adjustments per geriatric psych team. Will have PRNs available for acute agitation. Will order liver function test.

FEN: reg diet

Case reviewed with Attending Physician Dr. Brouette

Sarah Manco NP
Pager: 11724
Date: 3/31/14

Patient's chart reviewed, I examined the patient and discussed the case with Catie Parks, PA-C . After above note written the patient still had difficulty being aroused. I ordered that the patient meds be held. A CMP, CBC, and neurological exam were all unremarkable and there was no asymetitry (i.e no sign of stroke). By later in the afternoon the patient was more awake and could answer questions, complete simple tasks, but still bit confused about where she was and why she is here. I would continue to hold meds at this moment, follow her vitals and if she were to get agitated use very low dose of medication (such as zyprexa 1.25 mg if possible).

Thomas Brouette, MD
#14349

Electronically signed by Thomas Brouette, MD on 4/2/2014 2:56 PM

CSN
61983014

ED Notes signed by Anne Elum, RN at 4/2/2014 2:17 PM

Author:	Anne Elum, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 2:17 PM	Note Time:	4/2/2014 2:16 PM	Note Type:	ED Notes

Pt resting calmly.respirations nonlabored.

Electronically signed by Anne Elum, RN on 4/2/2014 2:17 PM

CSN
61983014

ED Notes signed by Anne Elum, RN at 4/2/2014 2:31 PM

Author:	Anne Elum, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 2:31 PM	Note Time:	4/2/2014 2:31 PM	Note Type:	ED Notes

Pt alert.took meds.awaiting aricept from pharmacy/pharmacist aware.

Electronically signed by Anne Elum, RN on 4/2/2014 2:31 PM

CSN
61983014

ED Notes signed by Anne Elum, RN at 4/2/2014 3:39 PM

Author:	Anne Elum, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 3:39 PM	Note Time:	4/2/2014 3:38 PM	Note Type:	ED Notes

Report faxed to scu ext.pt alert,cooperative;speech clear,respirations nonlabored.

Electronically signed by Anne Elum, RN on 4/2/2014 3:39 PM

CSN
61983014

ED Notes signed by Anne Elum, RN at 4/2/2014 4:05 PM

Author:	Anne Elum, RN	Service:	(none)	Author Type:	Registered Nurse
Filed:	4/2/2014 4:05 PM	Note Time:	4/2/2014 4:04 PM	Note Type:	ED Notes

Pt trying to get out of wc/transport. Stretcher transport called in now.

Electronically signed by Anne Elum, RN on 4/2/2014 4:05 PM

CSN
61985472

Discharge Summary IOP signed by Erin Beth Seery, MD at
Also signed by Mary Hart Craig, MD at

Author:	Erin Beth Seery, MD	Service:	(none)	Author Type:	Resident
Filed:	5/8/2014 7:48 PM	Note Time:	5/8/2014 4:10 PM	Note Type:	Discharge Summary IOP
Related Notes:	Original Note by Erin Beth Seery, MD filed at 5/8/2014 7:48 PM				
Trans ID:	607587838201404210 83	Trans Status:	Available		
Dictation Time:		Trans Time:		Trans Doc Type:	Discharge Summary IOP

MUSC Medical Center
INSTITUTE OF PSYCHIATRY DISCHARGE SUMMARY

PATIENT NAME: [redacted]
MRN: [redacted]
PATCOM: [redacted]
ADMITTED: 04/02/2014
DISCHARGED: 04/18/2014
SERVICE: Senior Care Extension
ATTENDING: Mary H Craig, MD

REFERRING: SELF REFERRAL

PRIMARY CARE PHYSICIAN: PATIENT, NONE PER

REASON FOR CONSULT: Worsening aggression and agitation.

HISTORY OF PRESENT ILLNESS: The patient is a 66-year-old woman with history of Alzheimer dementia who presents to the emergency room via EMS due to worsening agitation and behavioral disturbance. Most of history was gathered from patient's brother who is interviewed at the patient's bedside. Patient was initially seen in May 2013 by Geriatric Psychiatry due to worsening memory and language deficits. Neuro-psych testing was performed with likely diagnosis of Alzheimer disease given presentation as well as PET scan. In the past 6 months, patient has become more dependent on her daughter for assistance and now unable to toilet or feed herself or bathe herself. In the past month, patient had become more combative with family member, very

paranoid when tried to assist with daily ADLs. She was scratching at her daughter several times prior to admission. Patient was calling the police accusing her daughter of abusing her. This led to police coming into the home and taser patient's daughter when she awoke stunned that people were in her home. Given patient's belief that her daughter abused her, police took daughter into custody and then left the patient home alone for 16 hours. Later that same week, patient called the police and reported there was vagrant in her home and daughter was able to show the proper paperwork that the patient had dementia and that the daughter owned part of the home. There is currently a court case pending due to accusations of abuse by patient that appear to be unfounded. The family reported that they can no longer care for patient with her current condition and brought her to the emergency room. On interview on admission, patient reports she is a "happy" person and reports for the last few days, things have not been good. The patient reports, a man came to her house, which caused her concern. The patient did not have any recollection of why she needed to be in the hospital, buthought it may have somthing to do with her daughter. She denied any depressive symptoms, mania, anxiety, psychosis, any suicidal or homicidal ideations. She had appropriate mood and affect on interview but was not oriented to month, date, week or year. She had difficulty verbalizing her answers but was able to choose if we gave her 3 choices. She was oriented to President, state, city and hospital with poor recent and remote memory. As far as her dementia goes, in the past 5 to 7 years, patient has had a progressive decline, primarily first with language and then following with her memory difficulty.

PAST PSYCHIATRIC HISTORY: She has history of being on Aricept, Namenda and Lexapro. No prior hospitalizations. She is followed by her primary care doctor. Had not seen Psychiatry since July 2013.

SUBSTANCE HISTORY: Negative.

PAST MEDICAL HISTORY: Hyperlipidemia.

FAMILY HISTORY: Mother with dementia. Mother with depression. Sister with brain cancer. Sister with breast cancer.

SOCIAL HISTORY: Patient lives with her daughter. She is married for several years. Has no history of abuse.

ALLERGIES: NO KNOWN ALLERGIES.

OUTPATIENT MEDICATIONS: Aricept 10 mg, Lexapro 20 mg, memantine 10 mg b.i.d.

REVIEW OF SYSTEMS:
Review of systems performed and was considered negative.

PHYSICAL EXAM: VITALS: Temperature 36.7, pulse 91, respirations 15, BP 142/82, O2 saturation 98%.
GENERAL: NAD, cooperative.

HEENT: Head normocephalic and atraumatic. Lips with normal mucosa moist.
NECK: No lymphadenopathy.
BACK: Symmetric. No curvature.
LUNGS: Clear to auscultation.
HEART: Regular rate and rhythm. Normal S1, S2. No rubs, murmurs, or gallops.
ABDOMEN: Soft, nontender, normoactive bowel sounds.
EXTREMITIES: Normal, atraumatic. No clubbing, cyanosis or edema. Pulses 2+ and symmetric.
SKIN: No rashes or lesions.
NEUROLOGIC: Patient was alert, was unable to say the month, year, or day but was oriented to the city, location and most recent President. Cranial nerves within normal limits. Motor exam was grossly normal. Gait was slow but normal.

MENTAL STATUS EXAM: Patient was older than the stated age. Well groomed. Immaculately dressed and sitting on the bed. She had good eye contact and was cooperative. No psychomotor agitation or retardation. Gait was steady. Speech was normal rate, volume, and prosody with some latency. Language; she did have a fluent aphasia. Mood was fine. Affect was congruent. Thought process was circumstantial. Associations were logical associations. Thought content was without suicidal or homicidal ideation or evidence of psychosis. She was alert. She was able to attend to interview. Memory was 4 for recent and remote events. She had average fund of knowledge. Judgment and insight both significantly impaired.

LABS ON ADMISSION: CBC showed a hemoglobin of 12.2. BMP normal. Folate and B12 were normal.

HOSPITAL COURSE: The patient was admitted to Senior Care unit Emergency Room for worsening agitation and aggressive behavior as reported by her daughter. Patient was placed on proper precautions and safety restrictions.

1. For her dementia, the patient was given a few doses of 2.5 mg IM Zyprexa in emergency room and was started on Depakote in the ER as well for her significant agitation. Upon admission to the IOP, she was continued on outpatient medications of Aricept 10 mg daily, Namenda 10 mg p.o. b.i.d. Aricept was switched to Exelon secondary vomiting. Exelon was later discontinued due to po poor intake.
2. Abnormal movements: On initial exam in the emergency room, patient had no abnormal movements noted. On 04/02, she had significant cogwheeling, hyperreflexia, tremulousness, and occasional myoclonus so significant that it would occasionally disturb her gait. This was concerning given acute change. We checked a CK which came back at 342 initially on 04/3. By 04/04, her movement seemed improving off antipsychotics. Serial CKs trended down and were normal at 175 by 04/10. Over the next few days, we noticed ongoing decrease in tremors, reflexes,

cogwheeling and myoclonus. However, on 04/11, she had an episode that appeared to be consistent with a partial seizure activity. with jerking left upper extremity and fasciculations in her eye. She was incontinent of bowel and bladder. She hd more pronounced confusion, aphasia, and lethargy following the event. She was sent for a stat EEG which did not show any seizure activity, but did show diffuse slowing. No further episodes occurred during this hospitalization. She did have a long period of lethargy with poor p.o. intake. Following that event, she required Boost supplements and IV fluids intermittently. Her appetite and lethargy improved significantly by the day of discharge

3. The patient was treated for a UTI empirically with Bactrim DS p.o. b.i.d. x10 days. On admission, patient was felt that her behavioral disturbance may be in part due to delirium on top of her dementia. A repeat UA showed clearance of the UTI.
4. For depression, patient was continued on her outpatient medication of Lexapro 10 mg daily. She denied any suicidal ideation and did not appear overtly depressed during this hospital stay.
5. For hyperlipidemia, the patient was noted to have microvascular disease on old MRI, perhaps more advanced for age. We checked a lipid panel which showed elevated cholesterol and LDL. Due to her elevated CK, we initially held off initiating statin therapy, but until the CK level decreased later, Zocor 10 mg at nightly was added.
6. Team met with the patient's daughter on the unit and had family meeting to discuss ongoing care. Once patient's lethargy cleared, she was able to do some ADL with help, was able to feed herself and had adequate p.o. intake. The daughter initially wished to have patient transferred to Mount Pleasant Manor; however, there were no appropriate beds given patient's insurance and was recommend that the patient be discharged home with daughter with plan for Adult Daycare Services.

DISCHARGE MEDICATIONS: Simvastatin 10 mg 1 tab p.o. nightly, Lexapro 10 mg 1 tab p.o. daily, memantine 10 mg 1 tab p.o. b.i.d., divalproex 125 mg 1 tab p.o. q.12 hours, Tylenol 325 mg 2 tabs by mouth every 6 hours as needed for pain. Patient was instructed to stop Aricept. She was given prescriptions for simvastatin, Lexapro, Namenda and Depakote.

The patient will have the following discharge appointments: Dr. Seery, MUSC Geriatric, 792-9162, fax 792-7374, May 1, 2014 at 2:30. She will have a primary care doctor appointment, Dr. Karen Thomas, April 24, 2014 at 1 p.m.

DISCHARGE DIAGNOSES:
Axis I: Delirium, Alzheimer dementia with behavioral disturbance.
Axis II: Deferred.
Axis III: Urinary tract infection and hyperlipidemia.

Axis IV: Chronic mental illness and psychosocial issues.
Axis V: 20.
Also of note, the patient had a PPD placed while on the unit and was found to be negative.

Dictated by: Erin Beth Seery, MD

_____
Erin Beth Seery, MD

_____
Mary H Craig, MD
Attending

607587838/medq/04/21/2014 08:31:07
JOB: 1186908
DD: 04/18/2014 12:53:47
DT: 04/19/2014 12:36:35
Electronically Authenticated and Edited by:
ERIN B. SEERY, MD On 04/22/2014 12:14 PM EDT
Electronically Authenticated by:
MARY HART CRAIG, MD On 05/08/2014 04:04 PM EDT

Electronically signed by Mary Hart Craig, MD on

CSN
62396282

Progress Notes signed by Erin Beth Seery, MD at 6/5/2014 5:33 PM

Author:	Erin Beth Seery, MD	Service:	(none)	Author Type:	Resident
Filed:	6/26/2014 1:40 PM	Note Time:	6/5/2014 5:18 PM	Note Type:	Progress Notes
Related Notes:	Original Note by Erin Beth Seery, MD filed at 6/5/2014 5:33 PM				

DATE: 6/5/14

START:400pm
STOP:430pm
99213

Sources of Information for today's visit: patient and her daughter

Chief Complaint: "I'm happy"

HISTORY OF PRESENT ILLNESS:
Rhonda Meyer is a 66 y.o. female who presents for follow-up today after hospitalization at IOP for agitation and paranoia in April.

At that time patient was calling the police several times and reporting that her daughter was abusing her and at one time stated that daughter was a "vagrant" in her home. This last call to the police ended with her daughter being awoken by police in the middle of the night and tased. She was taken into custody and her mother was left in the home alone. While in the hospital, depakote was initiated. Her aricept was dc'd in favor of exelon due to nasuea and emesis, but the emesis continued. Both these medication were dc'd. She was continued on namenda 10mg bid and lexapro 10mg.

Since discharge patient's daughter reports she has been doing very well. She is happy and healthy and without behavioral agitation or paranoia. She has even regained weight she lose while in the hospital. Patient was smiling today in appointment and states she is "happy". She denied any depress mood, anxiety or paranoid thoughts. She refers to the past issue with her daughter as her daughter being "silly". Per hospital DC summary there was no indication that daughter was in any way abusing patient. Thorough body check was negative for bruising.

Since her hospital stay patient's daughter had her PCP rx home health services which have been very helpful. Pt has in home nursing aids most days, a behaviorist that helps with memory and also help with hygiene. Daughter reports this hygiene service just ended and she would like it renewed. Patient got along very well with the aids and preferred their care for hygiene over her daughter. Agreed to continue RX.

Patient has been taking medication as prescribed. Daughter requests tablets of depakote instead of capsule as the capsules dissolve too quickly and become sticky.

Patient was unable to state month, year, location beyond "hospital". She did not know our current president. She continues to have significant aphasia, but can answer some questions directly.

PAST MEDICAL HISTORY: No past medical history

CURRENT MEDICATIONS:
depakote 125mg bid
namenda 10mg bid
lexapro 10mg

CURRENT MEDICATION SIDE EFFECTS: none

MEDICATION RECONCILIATION:
Reviewed all medications and doses, Reviewed medication compliance and Explored strategies to improve compliance

Brief Review of Systems:
Problems with GI/bowel habits: no changes, has help with hygiene
Problems with urinary symptoms: no
Changes in weight/appetite:weight gain and appetite improving
Changes in memory: stable currently

Mental Status Examination:
Vital Signs:There were no vitals filed for this visit.
Appearance:appeared her stated age. She was wearing a thick white sweater and striped PJ pants, Her hair was neatly in a pony tail

Behavior/Attitude: patient was calm and cooperative during the appointment
Motor: NO pmr/pma
Gait: gait normal
Speech:Normal rate/rhythm/volume and Normal volume,+aphasia +circumlocution
Mood:"happy"
Affect:euthymic appearing
Thought Process:Circumstantial
Associations:tangential connections
Thought Content:No SI/HI and without paranoia
Auditory Visual Hallucinations:No auditory or visual hallucinations
Level of Consciousness:Able to attend to interview
Orientation:person, approximate location
Attention/Concentration:Able to attend to interview,
Memory:poor STM, intact LTM
Estimated Intelligence/Fund of Knowledge:Average
Conceptual/Visiospatial:n/a
Judgement:Impaired
Insight:Impaired

SCALES:
Did not do formal MMSE today

Patient able to ensure safety:Yes
Patient agrees to notify therapist if they cannot maintain safety: Yes

LABS:
Admission on 04/02/2014, Discharged on 04/18/2014

Component	Date	Value	Range	Status
• FREE T4	04/04/2014	1.24	0.80 - 1.90 ng/dL	Final

Comment: The Siemens Advia Centaur Immunoassay System (Chemiluminescence Technology) is used to perform this assay.Reference ranges adapted from Siemens method literature.

Results by other manufacturers' assays for this substance may not be equivalent to results by the Siemens assay and should not be interpreted interchangeably due to methodology differences.

HIGHEST REPORTABLE VALUE IS 7.0 NG/DL.
FREE T4 IS NOT AMENABLE TO SPECIMEN DILUTION.

• THYROID STIMULATING HORMONE	04/04/2014	1.18	0.55 - 4.78 mIU/L	Final

Comment: The Siemens Advia Centaur Immunoassay System (Chemiluminescence Technology) is used to perform this assay. Reference ranges adapted from Siemens method literature. Results by other manufacturers' assays for this substance may not be equivalent to results by the Siemens assay should not be interpreted interchangeably due to methodology differences.

• TRIGLYCERIDES	04/04/2014	91.0	<=150.0 MG/DL	Final

Comment: NORMAL <150 MG/DL
BORDERLINE HIGH 150-199 MG/DL
HIGH 200-499 MG/DL
VERY HIGH 500 MG/DL OR GREATER
ATP III GUIDELINES (NATIONAL CHOLESTEROL EDUCATION PROGRAM)

• CHOLESTEROL	04/04/2014	201.0*	<=200.0 MG/DL	Final

Comment: OPTIMAL < 200 MG/DL
BORDERLINE HIGH 200-239 MG/DL
HIGH 240 MG/DL OR GREATER
ATP III GUIDELINES (NATIONAL CHOLESTEROL EDUCATION PROGRAM)

• HDL	04/04/2014	53	40 - 59 MG/DL	Final

Comment: LOW <40 MG/DL
HIGH 60 MG/DL OR GREATER
ATP III GUIDELINES (NATIONAL CHOLESTEROL EDUCATION PROGRAM)

• NON HDL CHOL	04/04/2014	148		Final

Comment: If triglycerides are >or equal to 200 mg/dL after LDL goal is reached, set secondary goal for non-HDL cholesterol (total - HDL) 30 mg/dL higher than LDL goal.

Comparison of LDL Cholesterol and Non-HDL Cholesterol Goals for Three Risk Categories

Risk Categories	*LDL Goal (mg/dL)*	*Non HDL Goal (mg/dL)*
CHD and CHD Risk Equivalent (10 year risk for CHD >20%)	*<100*	*<130*
Multiple (2+) Risk Factors and 10 year risk greater than or equal to 20%	*<130*	*<160*
0-1 Risk Factor	*<160*	*<190*

• LDL CHOLESTEROL CALCULATED	04/04/2014	130*	<=100 MG/DL	Final

Comment: OPTIMAL <100 MG/DL
NEAR OPTIMAL/ABOVE OPTIMAL 100-129 MG/DL
BORDERLINE HIGH 130-159 MG/DL
HIGH 160-189 MG/DL
VERY HIGH 190 MG/DL OR GREATER
ATP III GUIDELINES (NATIONAL CHOLESTEROL EDUCATION PROGRAM)

• VLDL	04/04/2014	18	<=30 MG/DL	Final
• CREATINE KINASE TOTAL	04/04/2014	342*	20 - 190 IU/L	Final

• HEMOLYSIS INDEX	04/04/2014	0.0	0.0 - 1.9	Final

Comment: A Hemolysis Index greater than or equal to 2 represents a hemolyzed sample. Interference may occur with a Hemolysis Index greater than or equal to 2 for the following tests: ALT, Ammonia, Amylase, AST, CK, Total and Direct Bili, Fe/IBC, GGT, Hapt, K, Lac, LDH, Mg, Phos, Uric Acid. Interpret with caution. A Hemolysis Index greater than or equal to 6 represents gross hemolysis, specimens should be recollected.

• CREATINE KINASE TOTAL	04/05/2014	316*	20 - 190 IU/L	Final
• HEMOLYSIS INDEX	04/05/2014	0.0	0.0 - 1.9	Final

Comment: A Hemolysis Index greater than or equal to 2 represents a hemolyzed sample. Interference may occur with a Hemolysis Index greater than or equal to 2 for the following tests: ALT, Ammonia, Amylase, AST, CK, Total and Direct Bili, Fe/IBC, GGT, Hapt, K, Lac, LDH, Mg, Phos, Uric Acid. Interpret with caution. A Hemolysis Index greater than or equal to 6 represents gross hemolysis, specimens should be recollected.

• CREATINE KINASE TOTAL	04/07/2014	213*	20 - 190 IU/L	Final
• HEMOLYSIS INDEX	04/07/2014	1.0	0.0 - 1.9	Final

Comment: A Hemolysis Index greater than or equal to 2 represents a hemolyzed sample. Interference may occur with a Hemolysis Index greater than or equal to 2 for the following tests: ALT, Ammonia, Amylase, AST, CK, Total and Direct Bili, Fe/IBC, GGT, Hapt, K, Lac, LDH, Mg, Phos, Uric Acid. Interpret with caution. A Hemolysis Index greater than or equal to 6 represents gross hemolysis, specimens should be recollected.

• CREATINE KINASE TOTAL	04/10/2014	175	20 - 190 IU/L	Final
• HEMOLYSIS INDEX	04/10/2014	0.0	0.0 - 1.9	Final

Comment: A Hemolysis Index greater than or equal to 2 represents a hemolyzed sample. Interference may occur with a Hemolysis Index greater than or equal to 2 for the following tests: ALT, Ammonia, Amylase, AST, CK, Total and Direct Bili, Fe/IBC, GGT, Hapt, K, Lac, LDH, Mg, Phos, Uric Acid. Interpret with caution. A Hemolysis Index greater than or equal to 6 represents gross hemolysis, specimens should be recollected.

• GLUCOSE PCX, WHOLE BLOOD	04/11/2014	165*	70 - 100 MG/DL	Final
• PERFORMING LAB, ART, POC	04/11/2014	See Note		Final

MUSC Psychiatry, 67 President Street, POBOX 250861, Charlston, SC,29425

• HEMOGLOBIN A1C	04/12/2014	5.3		Final

Comment: Effective 11/24/2008 HbA1C is measured by ion-exchange high-performance liquid chromotography method (Bio-rad Variant II Turbo A1C Program). Hb SS, Hb SC, Hb CC and other hemoglobinopathies may produce aberrant HbA1C results that do not reflect the patient's true glycemic status. Hb F>10% and conditions that cause reduced erythrocyte survival can cause decreased HbA1C. A HbAC result that is inconsistent with the clinical impression may require referral testing by an alternate method. Contact Laboratory Services at 792-0707 for assistance.

Reference Ranges: A1C

>8%	*Action suggested*
<7%	*Target for diabetic control*
4-6%	*Non-diabetic range*

• GLUCOSE UA	04/12/2014	Negative	<=30.0 MG/DL	Final

• PROTEIN UA	04/12/2014	20.0*	<=10.0 MG/DL	Final
• BILIRUBIN UA	04/12/2014	Negative	Negative	Final
Comment: Interpret a positive bilirubin result with caution; a positive result may be due to possible interfering substances.				
• UROBILINOGEN UA	04/12/2014	<2.0	<=2.0 MG/DL	Final
• PH, UA	04/12/2014	6.0	5.0 - 7.0	Final
• BLOOD UA	04/12/2014	Small*	Negative	Final
• KETONES UA	04/12/2014	10.0	<=10.0 MG/DL	Final
• NITRITE UA	04/12/2014	Negative	Negative	Final
• LEUKOCYTE ESTERASE UA	04/12/2014	Negative	<=25.0 Leu/ul	Final
• SPECIFIC GRAVITY, UA	04/12/2014	1.022	1.003 - 1.030	Final
• COLOR	04/12/2014	Yellow		Final
• WBC URINE	04/12/2014	1	0 - 3 /HPF	Final
• RED BLOOD CELLS UA	04/12/2014	19*	0 - 3 /HPF	Final
• BACTERIA UA	04/12/2014	Few*		Final
• SQUAMOUS EPITHELIAL UA	04/12/2014	1	0 - 5 /HPF	Final
• MUCUS UA	04/12/2014	Few*		Final
• UREA NITROGEN, BLOOD (BUN)	04/15/2014	16.0	8.0 - 20.0 MG/DL	Final
• SODIUM	04/15/2014	139.0	135.0 - 145.0 MMOL/L	Final
• POTASSIUM	04/15/2014	3.60	3.50 - 5.00 MMOL/L	Final
• CHLORIDE	04/15/2014	102.0	98.0 - 107.0 MMOL/L	Final
• CO2 CONTENT (BICARBONATE)	04/15/2014	28	22 - 32 MMOL/L	Final
• ANION GAP	04/15/2014	9	2 - 11 MMOL/L	Final
• GLUCOSE	04/15/2014	101.0*	70.0 - 100.0 MG/DL	Final
• CREATININE	04/15/2014	1.0	0.4 - 1.0 MG/DL	Final
• CALCIUM	04/15/2014	9.0	8.4 - 10.2 MG/DL	Final
• BILIRUBIN, TOTAL	04/15/2014	0.6	0.2 - 1.3 MG/DL	Final
• ASPARTATE AMINOTRANSFERASE (AST)(S*	04/15/2014	24.0	8.0 - 34.0 IU/L	Final
• ALANINE AMINOTRANSFERASE (ALT)(SGP*	04/15/2014	18.0	7.0 - 35.0 IU/L	Final
• ALKALINE PHOSPHATASE	04/15/2014	50.0	25.0 - 100.0 IU/L	Final
• TOTAL PROTEIN	04/15/2014	6.2	6.0 - 8.0 G/DL	Final
• ALBUMIN	04/15/2014	3.7	3.5 - 4.8 G/DL	Final
• EGFR	04/15/2014	55		Final
Comment: The GFR calculation is Age, Sex and Race adjusted. _ml/min/1.73 sq.m				

Note: Estimated GFR > or = to 60 is not reported because values are not reliable.

The 4 variable MDRD (Modification of Diet in Renal Disease) Equation provides only an ESTIMATE of actual glomerular filtration rate (GFR). This ESTIMATE is only useful in STABLE renal function.
This equation has not been specifically studied in non-white, non-black patients, pregnancy or in age greater than 70 or less than 18. Please consult your pharmacist for drug dosing.

• HEMOLYSIS INDEX	04/15/2014	0.0	0.0 - 1.9	Final

Comment: A Hemolysis Index greater than or equal to 2 represents a hemolyzed sample. Interference may occur with a Hemolysis Index greater than or equal to 2 for the following tests: ALT, Ammonia, Amylase, AST, CK, Total and Direct Bili, Fe/IBC, GGT, Hapt, K, Lac, LDH, Mg, Phos, Uric Acid. Interpret with caution. A Hemolysis Index greater than or equal to 6 represents gross hemolysis, specimens should be recollected.

• CREATINE KINASE TOTAL	04/15/2014	320*	20 - 190 IU/L	Final
• HEMOLYSIS INDEX	04/15/2014	0.0	0.0 - 1.9	Final

Comment: A Hemolysis Index greater than or equal to 2 represents a hemolyzed sample. Interference may occur with a Hemolysis Index greater than or equal to 2 for the following tests: ALT, Ammonia, Amylase, AST, CK, Total and Direct Bili, Fe/IBC, GGT, Hapt, K, Lac, LDH, Mg, Phos, Uric Acid. Interpret with caution. A Hemolysis Index greater than or equal to 6 represents gross hemolysis, specimens should be recollected.

• WHITE BLOOD CELL COUNT	04/15/2014	5.66	4.80 - 10.80 K/CUMM	Final

Comment: Effective 02/26/2014, the current critical value range for WBC will change as follows:
Age: 0 – 1 day : <2 (changed from <5).
Age: 1 day – Adult: No change
Test methodology and reagent remain the same.

• RED BLOOD CELL COUNT	04/15/2014	3.88*	4.20 - 5.40 M/CUMM	Final
• HEMOGLOBIN	04/15/2014	11.1*	12.0 - 16.0 GMS/DL	Final

Comment: Effective 02/26/2014, the current critical value range for Hemoglobin will change as follows:
Age: Greater than 1 month: 6 to 20 (changed from 6 to 19)
Age: Less than one month: 9 to 20 (changed from 10 to 20)
Test methodology and reagent remain the same.

• HEMATOCRIT	04/15/2014	33.9*	37.0 - 47.0 %	Final

Comment: Effective 02/26/2014, the current critical value range for Hematocrit will change as follows:
Age: 0-1 month: 25% to 70% (changed from 30% to 65%)
Age: 1 month to 6 months: 25% to 60% (changed from 30% to 60%)
Age: 6 months to Adult: Unchanged
Test methodology and reagent remain the same.

• MEAN CORPUSCULAR VOLUME	04/15/2014	87.4	81.0 - 99.0 FL	Final

• MEAN CORPUSCULAR HEMOGLOBIN	04/15/2014	28.6	27.0 - 31.0 pg	Final
• MEAN CORPUSCULAR HEMOGLOBIN CONC	04/15/2014	32.7	30.7 - 34.4 GMS/DL	Final
• RED CELL DISTRIBUTION WIDTH	04/15/2014	12.9	11.5 - 14.5 %	Final
• PLATELET COUNT	04/15/2014	303	140 - 440 K/CUMM	Final

Comment: Effective 02/26/2014, the current critical value range for Platelet Count will change as follows:
Age: 0-1 week: 30 to no upper limit (previously 50 to 999)
Age: 1 week-adult: 10 to no upper limit (previously 26 to 999)
Test methodology and reagent remain the same.

• MEAN PLATELET VOLUME	04/15/2014	9.60	9.15 - 12.31 FL	Final

RADIOLOGY RESULTS:
Ct Pet Brain Dementia Differentiation Frontotemporal Dementia Alzheimers Disease

5/31/2013 EXAMINATION: BRAIN PET/CT SCAN with DATABASE ANALYSIS 05/31/13 14:56:00 ACCESSION NUMBER: 7063158 COMPARISON: None INDICATION: progressive word finding difficulty and memory problems DOSE: 6.75 millicuries fluorodeoxyglucose-18 intravenously TECHNIQUE: The patient was imaged on a GE Discovery whole body PET/CT scanner approximately 40 minutes after the intravenous administration of the F18-fluorodeoxyglucose. A standard brain protocol was performed. Multi-slice CT images were acquired for attenuation correction. On a separate Syntermed NeuroQ workstation (version 3.5.2), database analysis was computed. 200+ segments of the brain were compared to a normalized database. Serum glucose level measured 153 mg/dL at the time of injection. FINDINGS: There is significant hypometabolism noted predominantly within the temporoparietal regions of the brain. As a reference, the right parietotemporal cortex measures 7.8 standard deviations below the mean. The left parietotemporal cortex measures 4.8 standard deviations below the mean. Additionally, the right mid frontal cortex measures 2.8 standard deviations below the mean.

5/31/2013 IMPRESSION: Significant bilateral temporoparietal hypometabolism. To a lesser degree, there are also regions of hypometabolism within the right frontal lobe. Given that frontal lobes are affected to a lesser degree than the temporoparietal regions, Alzheimer is the favored diagnosis.

ASSESSMENT: 66 yo female with Dementia presenting for follow up appointment after hospitalization in April. Patient has been doing well, gaining weight back. No depression, anxiety or agitation symptoms

Axis I: Alzheimer's Dementia (recent behavioral disturbance)
Axis II: none
Axis III: none
Axis IV: good social support
Axis V: 30

PLAN:

- continue lexapro 10mg q day. Will also continue divalproex tablet 125mg bid for mood
- continue namenda 10mg bid for dementia, patient unable to tolerate aricept/exelon
- Wrote Rx for home health care for hygiene.
- follow up in 2-3 months with new provider

Was psychotherapy a part of today's visit?: No

If so, total time spent on psychotherapy portion exclusive of E&M services?: n/a

If so, what was the essential content of the psychotherapy portion of today's visit?: n/a

I have personally reviewed, discussed and seen and examined the patient with Dr. Seery at the time of the visit and I agree with the assessment and plans as described above. MARY HART CRAIG, MD

Electronically signed by Mary Hart Craig, MD on 6/26/2014 1:40 PM

CSN
1007654216

Progress Notes signed by Jessica Broadway, MD at 8/23/2014 2:03 PM

Author:	Jessica Broadway, MD	Service:	(none)	Author Type:	Physician
Filed:	8/23/2014 2:03 PM	Note Time:	8/22/2014 12:53 PM	Note Type:	Progress Notes
Related Notes:	Original Note by George A Hneich, MD filed at 8/22/2014 1:18 PM				

Geriatric Psychiatry Outpatient Visit
Date of Visit: 8/21/14
Sources of Information for today's visit: patient and daughter [redacted]

Chief Complaint: She had a chief complaint of Follow-up and additional complaints of Medication Refill and Memory Loss.

HISTORY OF PRESENT ILLNESS:

Rhonda Meyer is a 66 y.o. female who presents for follow-up today; first appointment with writer after transfer from Dr. Seery, who last saw pt in 6/2014 after hospitalization at IOP for agitation and paranoia in 4/2014. She presents with her daughter [redacted], who was a reliable historian as pt is unable to provide reliable history due to dementia. While in the hospital, depakote was initiated and continued by Dr. Seery in 6/2014, and daughter states has helped significant with behavioral disturbance and states pt has tolerated it well. She has been continued on Namenda 10mg bid, as she had side effects with trials of both Aricept and Exelon, and again daughter states Namenda has worked well. She was also continued on Lexapro 10mg for mood regulation and control of behavioral disturbance, without any side effects.

Since last visit daughter reports pt has been doing well. She has for the most part been happy and healthy and without behavioral agitation or paranoia. The one exception occurred a couple of weeks ago when she took pt to a wedding that daughter describes as very loud and high-stimulating (loud music and large crowd), which made the pt progressively more agitated. However, upon removal from the environment the pt returned to her baseline. Patient was smiling today in appointment and

states she feels "happy". She denied any depressed mood, anxiety or paranoid thoughts. Daughter denies any concern for SI/HI on the part of the pt.

Pt continues with home health services care which daughter states have been very helpful. Pt has in home nursing aids most days, a behaviorist that helps with memory and also help with hygiene. Patient has been taking all medications as prescribed. Of note, per Dr. Seery pt is taking tablets of depakote instead of capsule as daughter feels the capsules dissolve too quickly and become sticky. Patient was unable to state month, year, location beyond "hospital". She did not know our current president. She continues to have significant aphasia and circumlocution, but can answer more basic questions directly.

PAST MEDICAL HISTORY: has a past medical history of Depression and Memory impairment.

CURRENT MEDICATIONS:

Outpatient Prescriptions Marked as Taking for the 8/21/14 encounter (Office Visit) with George A Hneich, MD

Medication	Sig	Dispense	Refill
• divalproex (DEPAKOTE) 125 MG delayed release enteric coated tablet	Take 1 tablet by mouth 2 times daily.	180 tablet	1
• escitalopram oxalate (LEXAPRO) 10 MG tablet	Take 1 tablet by mouth daily.	90 tablet	1
• memantine (NAMENDA) 10 MG tablet	Take 1 tablet by mouth 2 times daily.	180 tablet	1

No Facility-Administered Medications for the 8/21/14 encounter (Office Visit) with George A Hneich, MD.

CURRENT MEDICATION SIDE EFFECTS: none

MEDICATION RECONCILIATION:
Reviewed all medications and doses, Assess for effectiveness, Assessed for side effects and Reviewed medication compliance

Brief Review of Systems:
Problems with GI/bowel habits: No
Problems with urinary symptoms: No
Changes in weight/appetite:No
Changes in memory:No

Mental Status Examination:

Mental Status Examination:

Vital Signs:There were no vitals filed for this visit.

Appearance:appeared her stated age, wearing a dress and well-kempt

Behavior/Attitude: patient was calm and cooperative during the appointment

Motor: No pmr/pma

Gait: gait normal

Speech:Normal rate/rhythm/volume and Normal volume,+aphasia +circumlocution

Mood:"good"

Affect: mood-congruent

Thought Process:Circumstantial

Associations:tangential connections

Thought Content:No SI/HI and without paranoia

Auditory Visual Hallucinations:No auditory or visual hallucinations

Level of Consciousness: Awake and alert

Orientation:person, approximate location

Attention/Concentration:Able to attend to interview,

Memory:poor STM, fair LTM

Estimated Intelligence/Fund of Knowledge:Average

Conceptual/Visiospatial: n/a

Judgement:Impaired

Insight:Impaired

Patient able to ensure safety:Yes
Patient agrees to notify therapist if they cannot maintain safety: Yes

SCALES:

Did not do formal MMSE today

Lab Results

Component	Value	Date
VALPROATE	27.2*	4/2/2014

Lab Results

Component	Value	Date
NA	139.0	4/15/2014
K	3.60	4/15/2014
CL	102.0	4/15/2014
CO2CT	28	4/15/2014
BUN	16.0	4/15/2014
CREATININE	1.0	4/15/2014
GLUCOSE	101.0*	4/15/2014
CALCIUM	9.0	4/15/2014
AST	24.0	4/15/2014
ALT	18.0	4/15/2014
ALKPHOS	50.0	4/15/2014
BILITOT	0.6	4/15/2014
PROT	6.2	4/15/2014
ALBUMIN	3.7	4/15/2014

Lab Results

Component	Value	Date
WBC	5.66	4/15/2014
RBC	3.88*	4/15/2014

HCT	33.9*	4/15/2014
PLT	303	4/15/2014
MCH	28.6	4/15/2014
NEUTROABS	3.81	4/2/2014

Lab Results

Component	Value	Date
CHOL	201.0*	4/4/2014
TRIG	91.0	4/4/2014
HDL	53	4/4/2014
LDLCALC	130*	4/4/2014

No components found with this basename: LABPT, INR

Lab Results

Component	Value	Date
TSH	1.18	4/4/2014
FREET4	1.24	4/4/2014
HGBA1C	5.3	4/12/2014
VITAMINB12	617	3/29/2014
FOLATE	9.4	3/29/2014

Lab Results

Component	Value	Date
LABPH	6.0	4/12/2014
COLORU	Yellow	4/12/2014
LABSPEC	1.022	4/12/2014
GLUCOSEU	Negative	4/12/2014
KETONESU	10.0	4/12/2014
PROTEINUA	20.0*	4/12/2014
BILIRUBINUR	Negative	4/12/2014
UROBILINOGEN	<2.0	4/12/2014
SQUAMOUSEPIT	1	4/12/2014
BLOODU	Small*	4/12/2014
WBCU	1	4/12/2014
NITRITE	Negative	4/12/2014
LEUKOCYTESUR	Negative	4/12/2014
BACTERIA	Few*	4/12/2014
MUCUS	Few*	4/12/2014

No results found for this basename: COCAINE, AMPHETAMINE, LABBARB, LABBENZ, CANNABINOIDS, LABPHEN, LABOPIA, EHTYL

Radiology Results:

CT PET brain 5/2013: Impression- Significant bilateral temporoparietal hypometabolism. To a lesser degree, there are also regions of hypometabolism within the right frontal lobe. Given that frontal lobes are affected to a lesser degree than the temporoparietal regions, Alzheimer is the favored diagnosis.

ASSESSMENT: 66 yo female with Dementia presenting for follow up appointment. Recent hospitalization in April 2/2 behavioral disturbance, which has been improved on current medication regimen. No depression, anxiety or agitation symptoms today.

Axis I: Alzheimer's Dementia with behavioral disturbance

Axis II: none

Axis III: none

Axis IV: good social support

Axis V: 30

PLAN:

- Safety: Reviewed safety plan with pt and daughter, which includes notifying provider if pt develops SI/HI or exhibits behaviors that can cause threat to self or others. If provider is not available or after hours, pt and daughter verbalized understanding to call 911, or go to the nearest ER.

- Continue Lexapro 10mg daily and Depakote 125mg bid for mood/behavioral disturbance.

- Continue Namenda 10mg bid for cognitive decline. Patient unable to tolerate aricept/exelon in the past. Also provided pt/daughter with rx for Namenda XR 28 mg daily in case she has difficulty obtaining refill for her existing regular-release Namenda rx.

- RTC in 3 months for medication management.

Was psychotherapy a part of today's visit?: No

If so, total time spent on psychotherapy portion exclusive of E&M services?: N/A

If so, what was the essential content of the psychotherapy portion of today's visit?: N/A

George A. Hneich, M.D.
PGY-4 Resident Physician
Department of Psychiatry
Pager #15412
8/22/2014 1:17 PM

Attending Attestation (August 23, 2014 2:03 PM): I personally examined, interviewed, and assessed [redacted] on 8/21/14, along with Dr. Hneich. I have reviewed (and edited as needed) the note written by Dr. Hneich, and the documentation accurately reflects my own findings, as well as the assessment and plan that we discussed.
Jessica Broadway, MD #14582

Electronically signed by Jessica Broadway, MD on 8/23/2014 2:03 PM

CSN
50697701

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

MEDICAL RECORDS
169 Ashley Ave. Suite 269
MSC 349
Charleston, SC 29425-3490

[redacted]

Results

CT PET brain dementia differentiation frontotemporal dementia Alzheimers Disease (Accession 7063158) (Order 20884296)

Imaging Information

Exam Information

Performed Procedure	Study Status	Begin Time	End Time
CT PET BRAIN DEMENTIA DIFFERENTIATION FTD AD	Final	Mon May 13, 2013 3:59 PM	N/A

Staff Information

Technologist	Transcriptionist	Assigned Physician(s)	Assigned Pool(s)
N/A	N/A	N/A	N/A

Verification Information

Signed By	Signed On	Marked as Prelim By	Marked as Prelim On
Marques Bradshaw, MD	May 31, 2013	Zaki Badawy, MD	May 31, 2013

Study Result

EXAMINATION: BRAIN PET/CT SCAN with DATABASE ANALYSIS 05/31/13 14:56:00

ACCESSION NUMBER: 7063158

COMPARISON: None

INDICATION: progressive word finding difficulty and memory problems

DOSE: 6.75 millicuries fluorodeoxyglucose-18 intravenously

TECHNIQUE:
The patient was imaged on a GE Discovery whole body PET/CT scanner approximately 40 minutes after the intravenous administration of the F18-fluorodeoxyglucose. A standard brain protocol was performed. Multi-slice CT images were acquired for attenuation correction. On a separate Syntermed NeuroQ workstation (version 3.5.2), database analysis was computed. 200+ segments of the brain were compared to a normalized database. Serum glucose level measured 153 mg/dL at the time of injection.

FINDINGS:
There is significant hypometabolism noted predominantly within the temporoparietal regions of the brain. As a reference, the right parietotemporal cortex measures 7.8 standard deviations below the mean. The left parietotemporal cortex measures 4.8 standard deviations below the mean. Additionally, the right mid frontal cortex measures 2.8 standard deviations below the mean.

IMPRESSION:
IMPRESSION:

Imaging Information (continued)

Study Result (continued)

Significant bilateral temporoparietal hypometabolism. To a lesser degree, there are also regions of hypometabolism within the right frontal lobe. Given that frontal lobes are affected to a lesser degree than the temporoparietal regions, Alzheimer is the favored diagnosis.

VOICE DICTATED BY: Dr. Zaki Badawy
I have reviewed the study and agree with the findings in this report.

Questionnaire

Order Entry

Question	Answer	Comment
1.Reason for exam:	Dementia with concern for Primary Progressive Aphasia FTD	
2.Please indicate relevant clinical history.	65 yo CF with progressive word finding difficulty and memory problems	
3.Does the patient have any devices, implants, aneurysm clips, joint replacements or metal fragments in his/her body?	No	
4.History of IV contrast allergy?	No	
5.Preferred location:	Main	
6.Date requested for study	5/14/2013	

END OF REPORT

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA
Telephone: 843-792-3641
Facsimile: 843-792-9411

Clinical Neurophysiology Services
Jonathan Edwards, MD, Medical Director
Adam L. Kornegay, MBA, REPT/CNIM, Manager

ADULT INPATIENT ELECTROENCEPHALOGRAM REPORT

Name: [redacted]
DOB: 10/08/1947
Location: 4B

Study Date: April 11, 2014
Patient MRN: 1083675
PatCom [redacted]

Referring MD: Dr. Broadway
Primary MD: none listed

CLINICAL INFORMATION: The patient is a 66 year old female with history of "early onset dementia but no known history seizure observed at 9:10 am today to have potential seizure partial. Continues to have LUE movements, left eye fasciculations, more pronounced confusion and aphasia, and elevated BP. Please eval for seizure

MEDICATIONS: None Listed.

RECORDING CONDITIONS:
This is a routine EEG performed utilizing standard International 10-20 System of electrode placement, with additional channels monitored for eye movement. One channel electrocardiogram was monitored. Data were obtained, stored, and interpreted according to ACNS guidelines (*J Clin Neurophysiol* 2006;*23(2)*:85-183) utilizing referential montage recording, with reformatting to longitudinal, transverse bipolar, and referential montages as necessary for interpretation, along with digital/automated EEG analysis. Patient tolerated entire procedure well. Photic stimulation and hyperventilation were utilized as activation procedures unless otherwise specified below.

E.E.G. DESCRIPTION: No predominant alpha rhythm was noted. The waking EEG consisted of diffuse, polymorphic, low to moderate amplitude, mixed frequency delta, theta and alpha range patterns. Drowsiness was demonstrated by increased prevalence of diffuse symmetric mixed frequency 4-7 Hz slowing. Sleep was not noted. Hyperventilation was performed with poor patient effort demonstrating no notable change in the tracing. Photic stimulation was performed at frequencies between 1 and 21 Hz demonstrating symmetric bioccipital driving responses over a range of frequencies. No overt ECG abnormalities were noted. Minor muscle, motion, and eye movement artifacts were occasionally noted.

E.E.G. INTERPRETATION: Abnormal EEG due to excessive diffuse delta and theta range patterns

CLINICAL CORRELATION:
This EEG is suggestive of moderate encephalopathy but is nonspecific as to etiology. The absence of epileptiform abnormalities does not preclude a clinical diagnosis of seizures. If indicated, a follow-up EEG, to include sleep, may be clinically useful.

Results called to Dr. Broadway at 15:00 on April 11, 2014.

Gabriel U. Martz, MD
Assistant Professor of Neurosciences

Reference: genstw
Date Reported: April 11, 2014
Date Signed: April 11, 2014
Template Created By: bkt

24401 D 4-11-2014

[redacted]

CPT OUT:

Patient Department:	PH4B
Patient Diagnosis:	(Unknown)
Patient Ht/Wt:	157.5cm / 45.5kg
Active Allergies:	NKA

*** STATNEW ***

Requisition Count: 1 of 1

Order #	Order Description	Freq	Priority	Qty	Order Start	Order Stop
80056	NEUR EEG Stat	ONCE	STAT	1	04/11/14 09:19	04/11/14 09:19

Order Detail
1. Brief History And Purpose For Exam: pt with early onset dementia but no known hx seizures observed at 9:10 AM today to have potential seizure (partial). Continues to have LUE movements, L eye fasiculations, more pronounced confusion and aphasia, and elevated BP. Please eval for seizure.

Order Comments:
NONE

Ordered by	Entered by	Entered date
MD BROADWAY, JESSICA L	MD BROADWAY, JESSICA L	04/11/14 09:19

Scheduled for: 04/11/14 09:19 Requisition #: 13577303

Session #: 36575663

Occurrence #: 221867951 PCM

Placer #: 221867965 PCM

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: [redacted] **MRN:** 001083675

Date	Description	Status	Result	Normal	H/L	Site	Comment
4/15/14 11:01 AM	METABOLIC PANEL, COMPREHENSIVE	Finished					
	SODIUM (NA)		139.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		102.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		28 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		9 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		101.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		16.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.0 MG/DL	0.4 - 1.0		GEN LAB	
	ESTIMATED GLOMERULAR		55 mL/min			GEN LAB	*
	CALCIUM		9.0 MG/DL	8.4 - 10.2		GEN LAB	
	BILIRUBIN, TOTAL		0.6 MG/DL	0.2 - 1.3		GEN LAB	
	ASPARTATE AMINOTRANSFERASE		24.0 IU/L	8.0 - 34.0		GEN LAB	
	ALANINE AMINOTRANSFERASE		18.0 IU/L	7.0 - 35.0		GEN LAB	
	ALKALINE PHOSPHATASE		50.0 IU/L	25.0 - 100.0		GEN LAB	
	TOTAL PROTEIN, SERUM		6.2 G/DL	6.0 - 8.0		GEN LAB	
	ALBUMIN, SERUM		3.7 G/DL	3.5 - 4.8		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	CREATINE KINASE	Finished	320 IU/L	20 - 190	H	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		5.66 K/CUMM	4.80 - 10.80		GEN LAB	*
	RED BLOOD CELL COUNT		3.88 M/CUMM	4.20 - 5.40	L	GEN LAB	
	HEMOGLOBIN		11.1 GM/DL	12.0 - 16.0	L	GEN LAB	*

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Date Printed: 10/03/2014

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: [redacted] **MRN:** [redacted]

Date	Description	Status	Result	Normal	H/L	Site	Comment
	HEMATOCRIT		33.9 %	37.0 - 47.0	L	GEN LAB	*
	MCV		87.4 FL	81.0 - 99.0		GEN LAB	
	MCH		28.6 pg	27.0 - 31.0		GEN LAB	
	MCHC		32.7 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		12.9 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		303 K/CUMM	140 - 440		GEN LAB	*
	MPV		9.60 FL	9.15 - 12.31		GEN LAB	
4/12/14 2:30 PM	URINALYSIS	Finished					*
	COLOR		Yellow			GEN LAB	
	PH, URINE		6.0	5.0 - 7.0		GEN LAB	
	BILIRUBIN		Negative	Negative		GEN LAB	*
	BLOOD		Small	Negative	A	GEN LAB	
	NITRITE		Negative	Negative		GEN LAB	
	PROTEIN		20.0 MG/DL	<=10.0	H	GEN LAB	
	SPECIFIC GRAVITY URINE		1.022	1.003 -		GEN LAB	
	GLUCOSE		Negative MG/DL	<=30.0		GEN LAB	
	KETONES		10.0 MG/DL	<=10.0		GEN LAB	
	RED BLOOD CELLS		19 /HPF	0 - 3	H	GEN LAB	
	WBCS/HPF, URINE		1 /HPF	0 - 3		GEN LAB	
	SQUAMOUS EPITHELIAL CELLS		1 /HPF	0 - 5		GEN LAB	
	UROBILINOGEN		<2.0 MG/DL	<=2.0		GEN LAB	
	LEUKOCYTE ESTERASE		Negative LEU/UL	<=25.0		GEN LAB	
	BACTERIA		Few		A	GEN LAB	

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Charleston, SC

843-792-2123

Laboratory Results Report

Patient: [redacted] **MRN:** [redacted]

Date	Description	Status	Result	Normal	H/L	Site	Comment
	MUCOUS		Few		A	GEN LAB	
4/12/14 2:00 PM	HEMOGLOBIN A1C	Finished	5.3 %			GEN LAB	*
4/11/14 9:12 AM	GLUCOSE PCX, WHOLE BLOOD	Finished	165	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*
4/10/14 4:50 PM	CREATINE KINASE	Finished	175 IU/L	20 - 190		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
4/7/14 11:35 AM	CREATINE KINASE	Finished	213 IU/L	20 - 190	H	GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
4/5/14 6:35 AM	CREATINE KINASE	Finished	316 IU/L	20 - 190	H	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
4/4/14 6:17 AM	THYROXINE, FREE (FREE T4)(FT4)(T4	Finished	1.24 NG/DL	0.80 - 1.90		GEN LAB	*
	THYROID STIMULATING HORMONE	Finished	1.18 mIU/L	0.55 - 4.78		GEN LAB	*
	LIPID PROFILE	Finished					*
	CHOLESTEROL		201.0 MG/DL	<=200.0	H	GEN LAB	*
	TRIGLYCERIDES		91.0 MG/DL	<=150.0		GEN LAB	*
	HDL		53 MG/DL	40 - 59		GEN LAB	*
	NON HDL CHOLESTEROL		148 MG/DL			GEN LAB	*
	LDL (CALC)		130 MG/DL	<=100	H	GEN LAB	*
	VLDL (CALC)		18 MG/DL	<=30		GEN LAB	
	CREATINE KINASE	Finished	342 IU/L	20 - 190	H	GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
4/2/14 12:43 PM	AMMONIA	Finished	33 umol/L	7 - 35		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
	VALPROIC ACID (DEPAKOTE)	Finished	27.2 MCG/ML	50.0 - 125.0	L	GEN LAB	*

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Date Printed: 10/03/2014

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: [redacted] **MRN:** [redacted]

Date	Description	Status	Result	Normal	H/L	Site	Comment
	METABOLIC PANEL, COMPREHENSIVE	Finished					
	SODIUM (NA)		141.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		4.30 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		108.0 MMOL/L	98.0 - 107.0	H	GEN LAB	
	CO2 CONTENT (BICARBONATE)		23 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		10 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		101.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		12.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		1.0 MG/DL	0.4 - 1.0		GEN LAB	
	ESTIMATED GLOMERULAR		55 mL/min			GEN LAB	*
	CALCIUM		9.6 MG/DL	8.4 - 10.2		GEN LAB	
	BILIRUBIN, TOTAL		0.7 MG/DL	0.2 - 1.3		GEN LAB	
	ASPARTATE AMINOTRANSFERASE		22.0 IU/L	8.0 - 34.0		GEN LAB	
	ALANINE AMINOTRANSFERASE		14.0 IU/L	7.0 - 35.0		GEN LAB	
	ALKALINE PHOSPHATASE		52.0 IU/L	25.0 - 100.0		GEN LAB	
	TOTAL PROTEIN, SERUM		7.2 G/DL	6.0 - 8.0		GEN LAB	
	ALBUMIN, SERUM		4.4 G/DL	3.5 - 4.8		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		7.08 K/CUMM	4.80 - 10.80		GEN LAB	*
	RED BLOOD CELL COUNT		4.05 M/CUMM	4.20 - 5.40	L	GEN LAB	
	HEMOGLOBIN		11.7 GM/DL	12.0 - 16.0	L	GEN LAB	*
	HEMATOCRIT		35.7 %	37.0 - 47.0	L	GEN LAB	*
	MCV		88.1 FL	81.0 - 99.0		GEN LAB	

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Date Printed: 10/03/2014

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: [redacted] **MRN:** [redacted]

Date	Description	Status	Result	Normal	H/L	Site	Comment
	MCH		28.9 pg	27.0 - 31.0		GEN LAB	
	MCHC		32.8 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		13.3 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		264 K/CUMM	140 - 440		GEN LAB	
	MPV		9.60 FL	9.15 - 12.31		GEN LAB	
	AUTODIFF	Finished					
	NEUTROPHIL %		53.9 %	45.0 - 70.0		GEN LAB	
	LYMPHOCYTE %		39.5 %	20.0 - 45.0		GEN LAB	
	MONOCYTE %		5.5 %	0.0 - 10.0		GEN LAB	
	EOSINOPHIL %		0.8 %	0.0 - 5.0		GEN LAB	
	BASOPHIL %		0.3 %	0.0 - 2.0		GEN LAB	
	ABSOLUTE NEUTROPHIL		3.81 K/CUMM	2.20 - 7.60		GEN LAB	
	ABSOLUTE LYMPHOCYTE		2.80 K/CUMM	1.00 - 4.90		GEN LAB	
	ABSOLUTE MONOCYTE		0.39 K/CUMM	0.00 - 1.10		GEN LAB	
	ABSOLUTE EOSINOPHIL		0.06 K/CUMM	0.00 - 0.50		GEN LAB	
	ABSOLUTE BASOPHIL		0.02 K/CUMM	0.00 - 0.20		GEN LAB	
3/31/14 5:20 PM	HEPATIC FUNCTION PANEL A	Finished					
	BILIRUBIN, TOTAL		0.5 MG/DL	0.2 - 1.3		GEN LAB	
	BILIRUBIN, DIRECT		0.1 MG/DL	0.1 - 0.3		GEN LAB	
	ASPARTATE AMINOTRANSFERASE		20.0 IU/L	8.0 - 34.0		GEN LAB	
	ALANINE AMINOTRANSFERASE		16.0 IU/L	7.0 - 35.0		GEN LAB	
	ALKALINE PHOSPHATASE		50.0 IU/L	25.0 - 100.0		GEN LAB	
	TOTAL PROTEIN, SERUM		7.2 G/DL	6.0 - 8.0		GEN LAB	

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Printed by: PRILLHART, CASSAUNDRA
Date Printed: 10/03/2014

Patient: [redacted] **MRN:** [redacted]

Date	Description	Status	Result	Normal	H/L	Site	Comment
	ALBUMIN, SERUM		4.5 G/DL	3.5 - 4.8		GEN LAB	
	HEMOLYSIS INDEX		0.0	0.0 - 1.9		GEN LAB	*
3/30/14 5:33 AM	URINALYSIS	Finished					
	COLOR		Light-Yellow			GEN LAB	
	PH, URINE		6.5	5.0 - 7.0		GEN LAB	
	BILIRUBIN		Negative	Negative		GEN LAB	*
	BLOOD		Small	Negative	A	GEN LAB	
	NITRITE		Positive	Negative	A	GEN LAB	
	PROTEIN		Negative MG/DL	<=10.0		GEN LAB	
	SPECIFIC GRAVITY URINE		1.006	1.003 -		GEN LAB	
	GLUCOSE		Negative MG/DL	<=30.0		GEN LAB	
	KETONES		Negative MG/DL	<=10.0		GEN LAB	
	RED BLOOD CELLS		6 /HPF	0 - 3	H	GEN LAB	
	WBCS/HPF, URINE		13 /HPF	0 - 3	H	GEN LAB	
	SQUAMOUS EPITHELIAL CELLS		5 /HPF	0 - 5		GEN LAB	
	UROBILINOGEN		<2.0 MG/DL	<=2.0		GEN LAB	
	LEUKOCYTE ESTERASE		500.0 LEU/UL	<=25.0	H	GEN LAB	
	BACTERIA		Few		A	GEN LAB	
	MUCOUS		Few		A	GEN LAB	
3/30/14 2:53 AM	URINALYSIS	Cancelled					*
3/29/14 11:24 PM	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		7.74 K/CUMM	4.80 - 10.80		GEN LAB	*
	RED BLOOD CELL COUNT		3.85 M/CUMM	4.20 - 5.40	L	GEN LAB	
	HEMOGLOBIN		11.2 GM/DL	12.0 - 16.0	L	GEN LAB	*

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Date Printed: 10/03/2014

Medical University of South Carolina

Charleston, SC

843-792-2123

Laboratory Results Report

Patient: [redacted] **MRN:** [redacted]

Date	Description	Status	Result	Normal	H/L	Site	Comment
	HEMATOCRIT		33.9 %	37.0 - 47.0	L	GEN LAB	*
	MCV		88.1 FL	81.0 - 99.0		GEN LAB	
	MCH		29.1 pg	27.0 - 31.0		GEN LAB	
	MCHC		33.0 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		13.0 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		231 K/CUMM	140 - 440		GEN LAB	*
	MPV		10.10 FL	9.15 - 12.31		GEN LAB	
	AUTODIFF	Finished					
	NEUTROPHIL %		68.1 %	45.0 - 70.0		GEN LAB	
	LYMPHOCYTE %		27.0 %	20.0 - 45.0		GEN LAB	
	MONOCYTE %		4.5 %	0.0 - 10.0		GEN LAB	
	EOSINOPHIL %		0.3 %	0.0 - 5.0		GEN LAB	
	BASOPHIL %		0.1 %	0.0 - 2.0		GEN LAB	
	ABSOLUTE NEUTROPHIL		5.27 K/CUMM	2.20 - 7.60		GEN LAB	
	ABSOLUTE LYMPHOCYTE		2.09 K/CUMM	1.00 - 4.90		GEN LAB	
	ABSOLUTE MONOCYTE		0.35 K/CUMM	0.00 - 1.10		GEN LAB	
	ABSOLUTE EOSINOPHIL		0.02 K/CUMM	0.00 - 0.50		GEN LAB	
	ABSOLUTE BASOPHIL		0.01 K/CUMM	0.00 - 0.20		GEN LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		143.0 MMOL/L	135.0 -		GEN LAB	
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		105.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		26 MMOL/L	22 - 32		GEN LAB	

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Printed by: PRILLHART, CASSAUNDRA
Date Printed: 10/03/2014

Medical University of South Carolina

Charleston, SC

843-792-2123

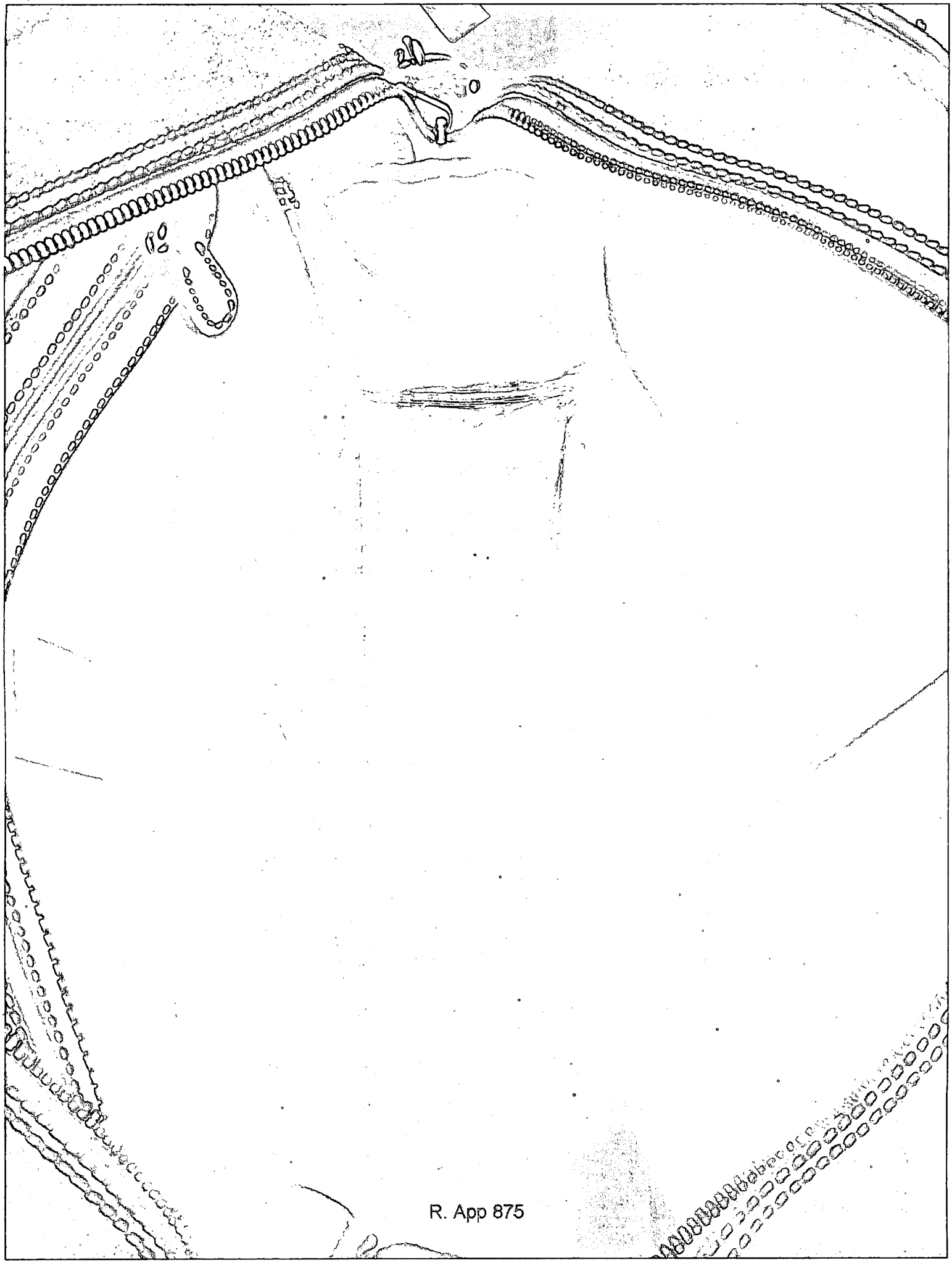
Laboratory Results Report

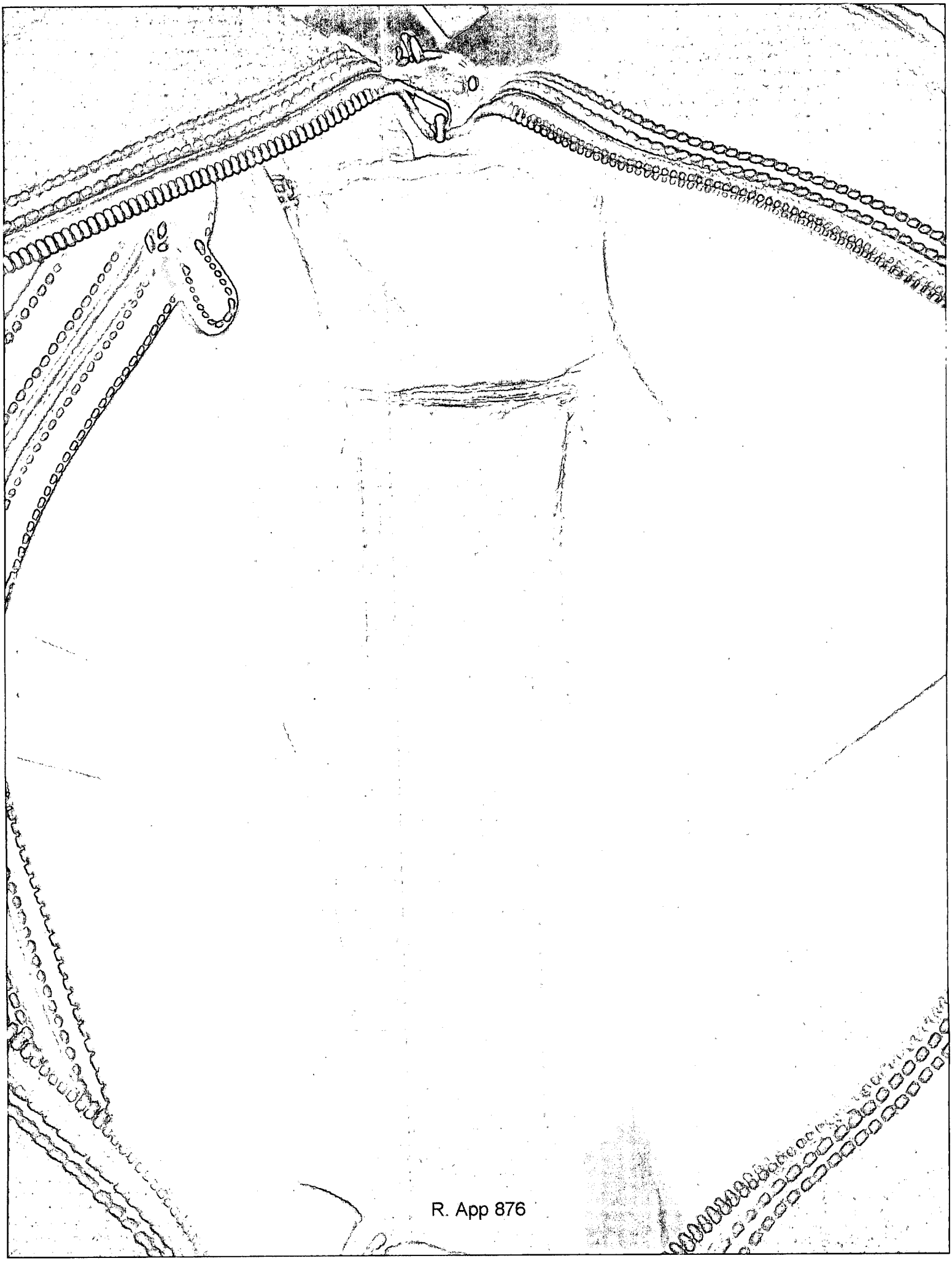
Patient: MEYER, RHONDA **MRN:** 001083675

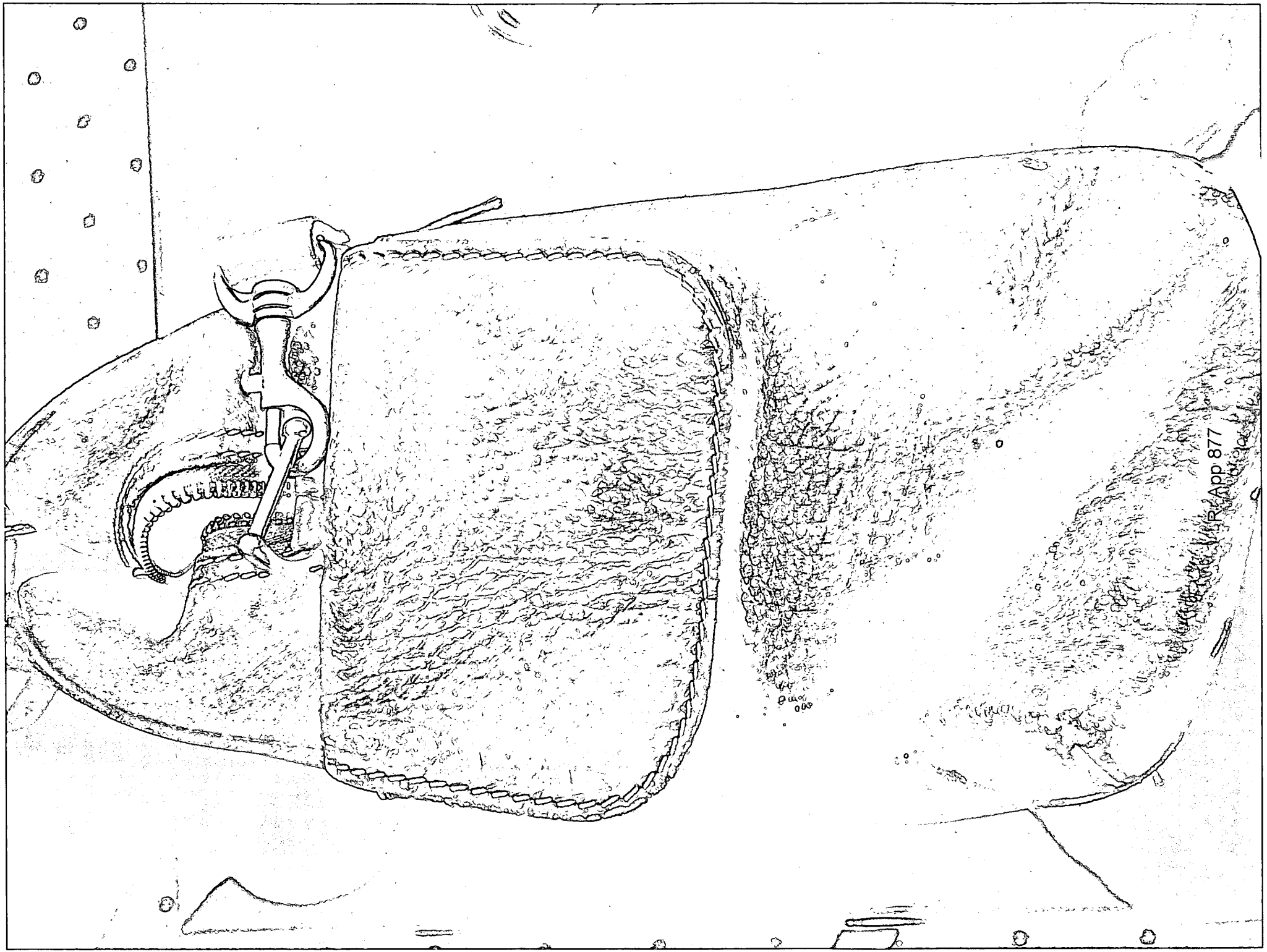
Date	Description	Status	Result	Normal	H/L	Site	Comment
	ANION GAP		12 MMOL/L	2 - 11	H	GEN LAB	
	GLUCOSE, SERUM		100.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		18.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.7 MG/DL	0.4 - 1.0		GEN LAB	
	ESTIMATED GLOMERULAR		>59 mL/min			GEN LAB	*
	CALCIUM		9.8 MG/DL	8.4 - 10.2		GEN LAB	
	HEMOLYSIS INDEX		1.0	0.0 - 1.9		GEN LAB	*
	VITAMIN B12	Finished	617 PG/ML	211 - 911		GEN LAB	*
	FOLATE, SERUM	Finished	9.4 NG/ML	>=5.4		GEN LAB	*
5/31/13 1:44 PM	GLUCOSE PCX, WHOLE BLOOD	Finished	153	70 - 100	H	POCT	
	PERFORMING LAB		See Note			POCT	*

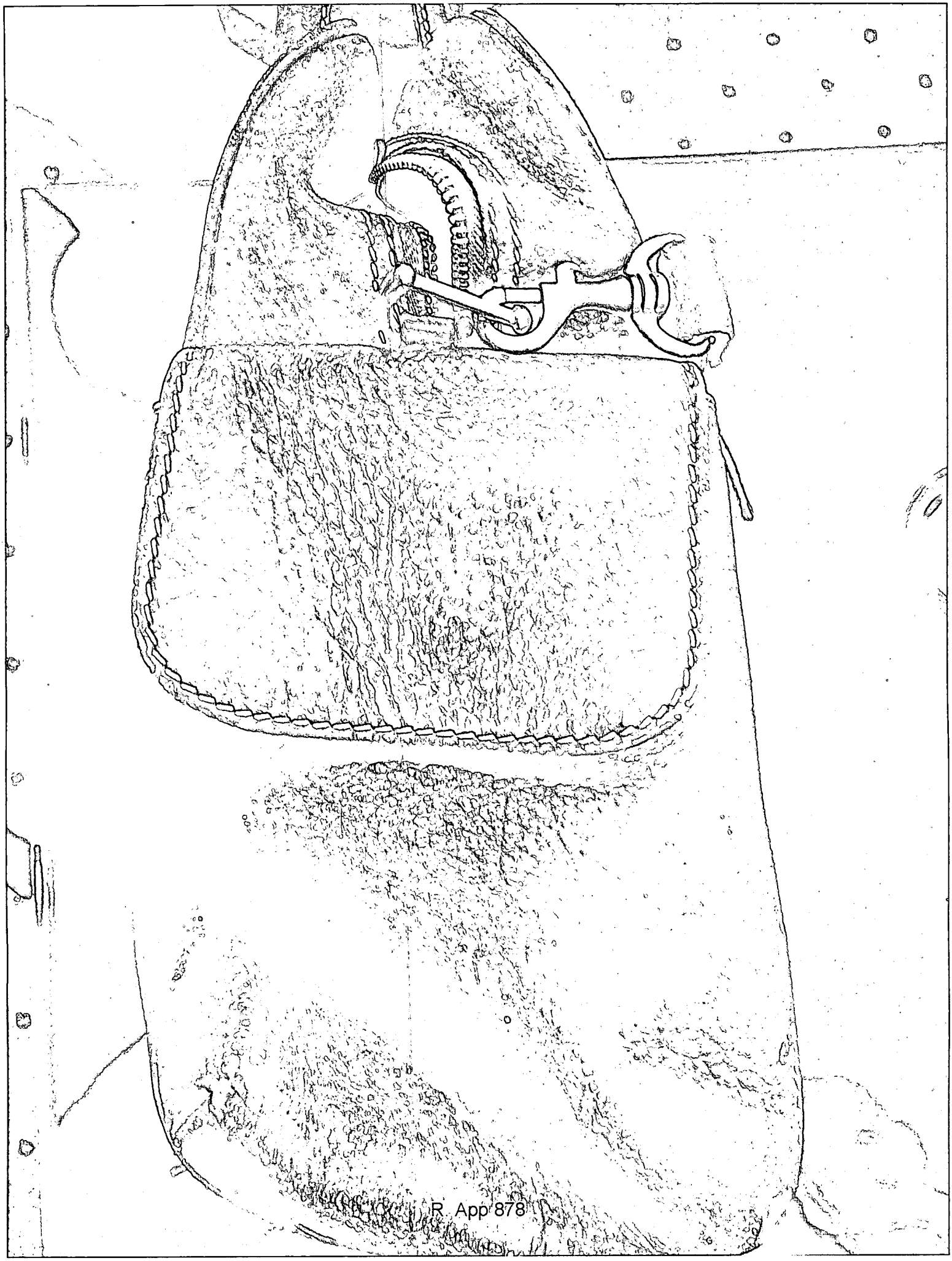
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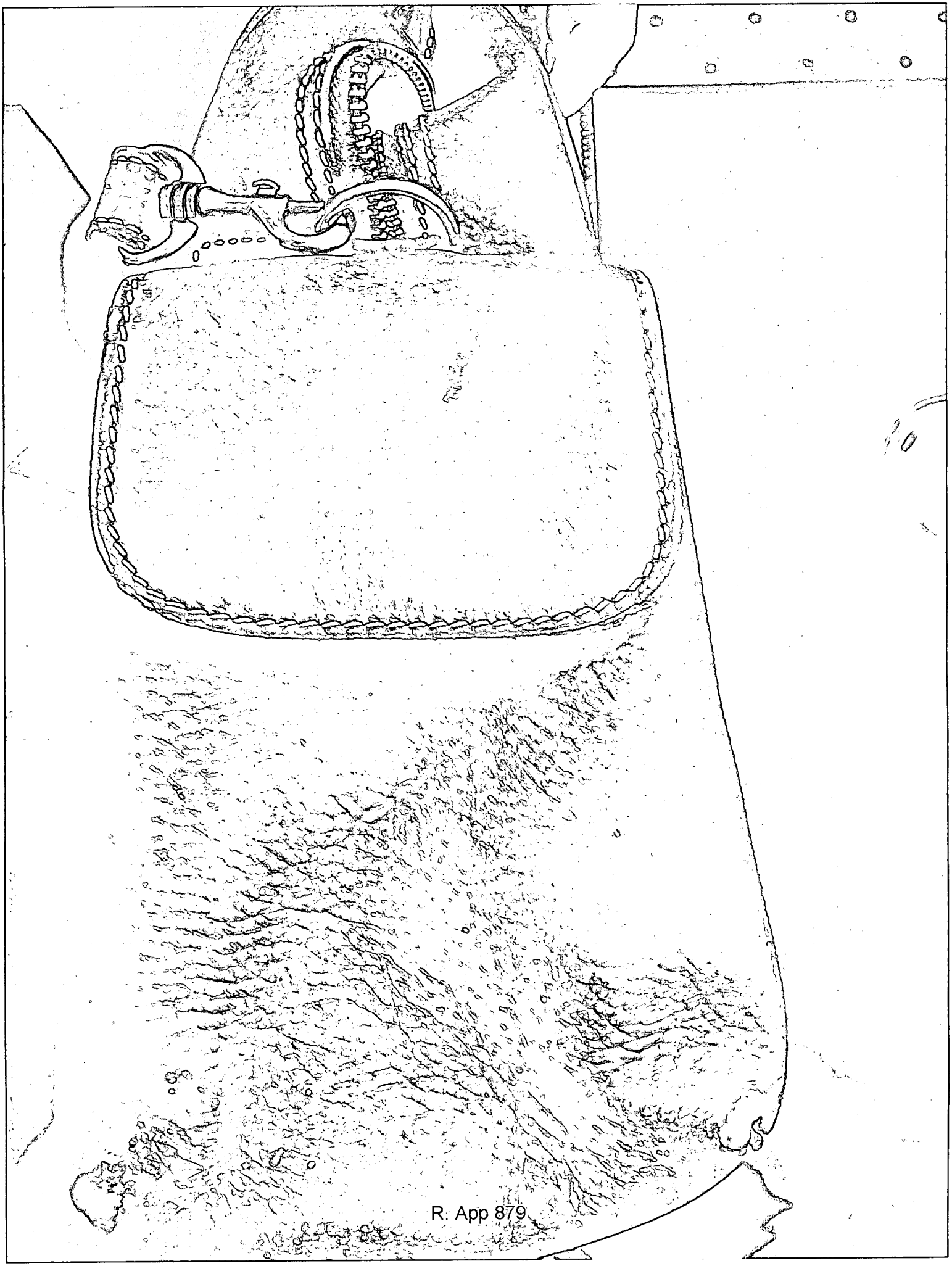
Printed by: PRILLHART, CASSAUNDRA
Date Printed: 10/03/2014

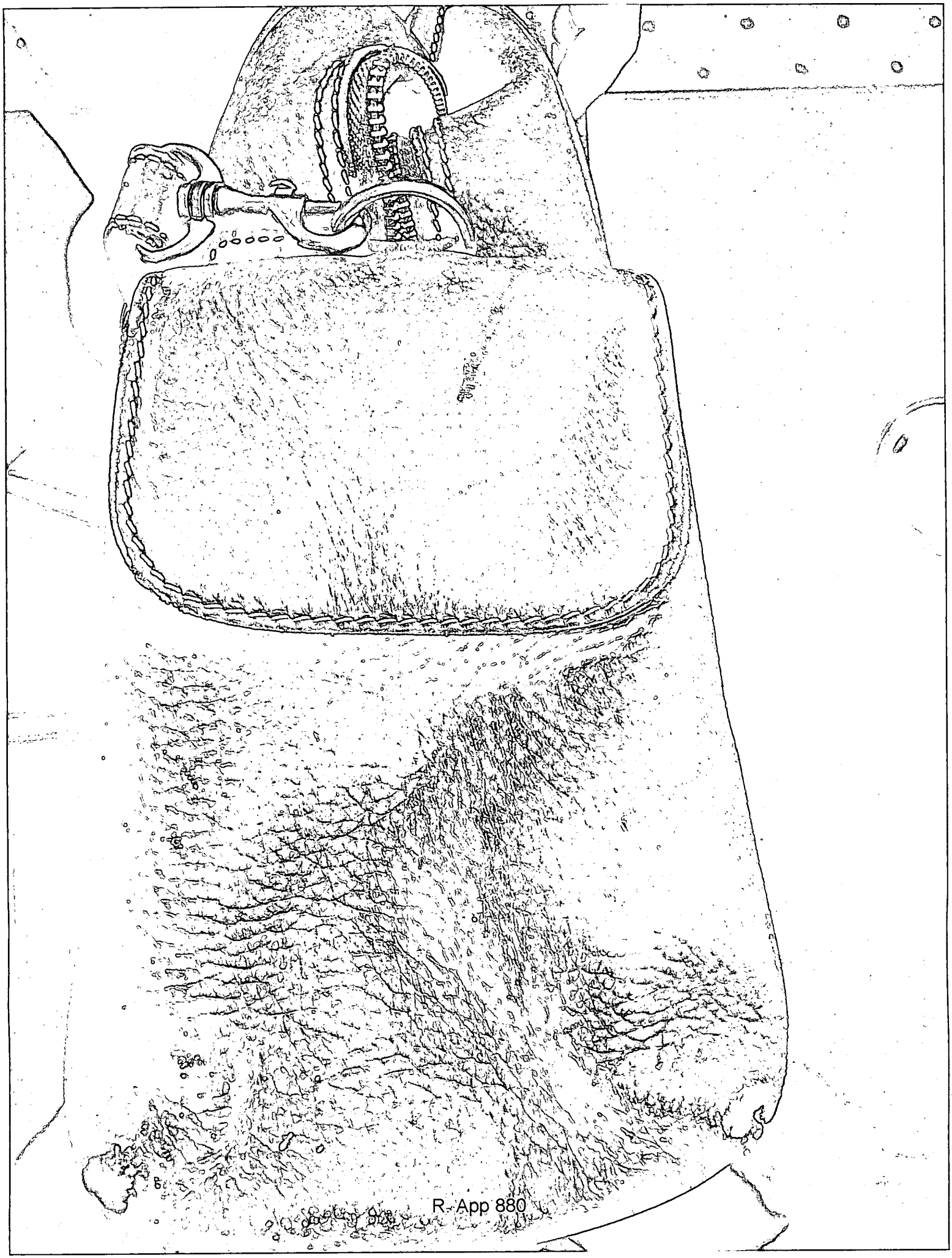


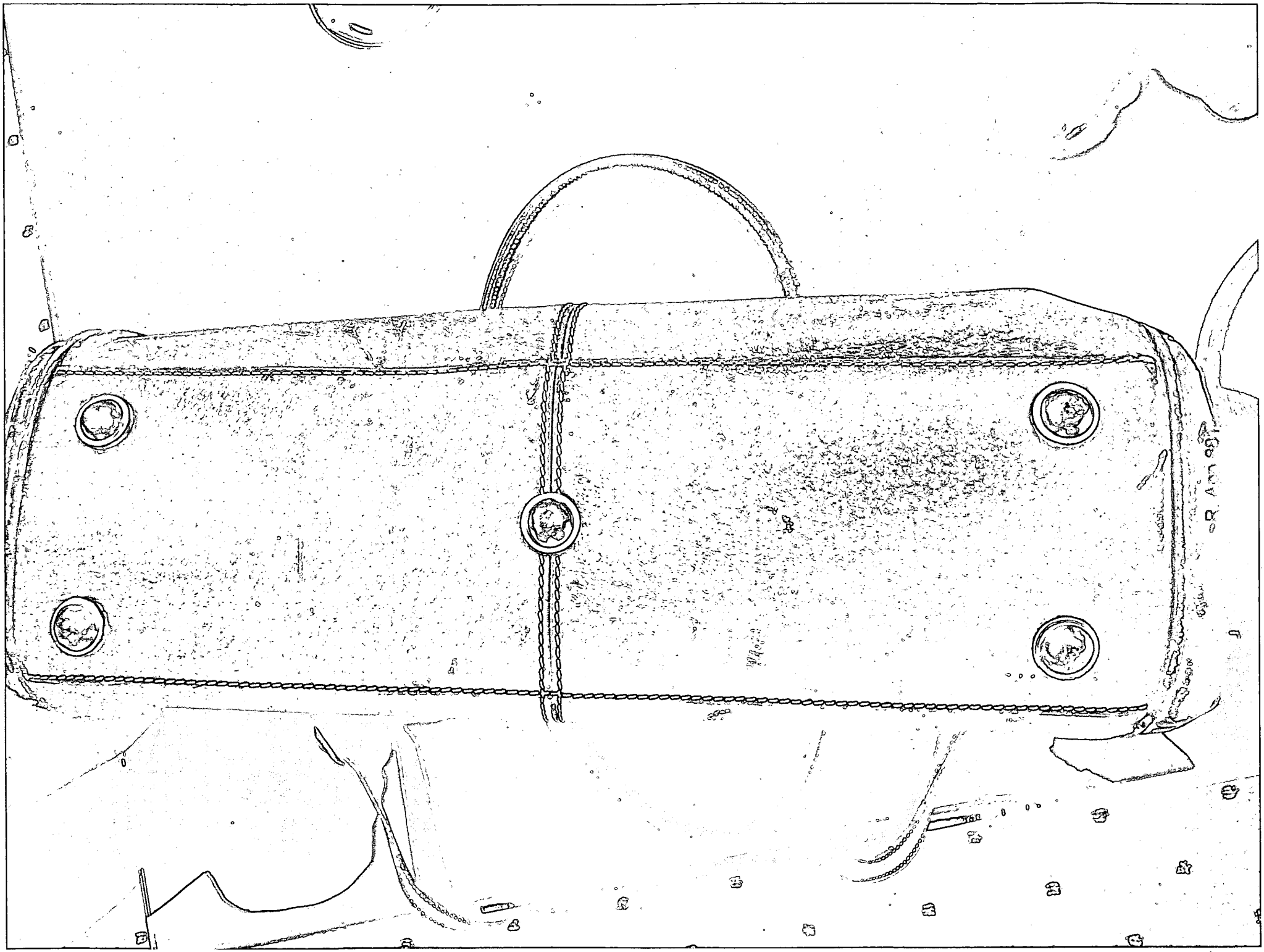


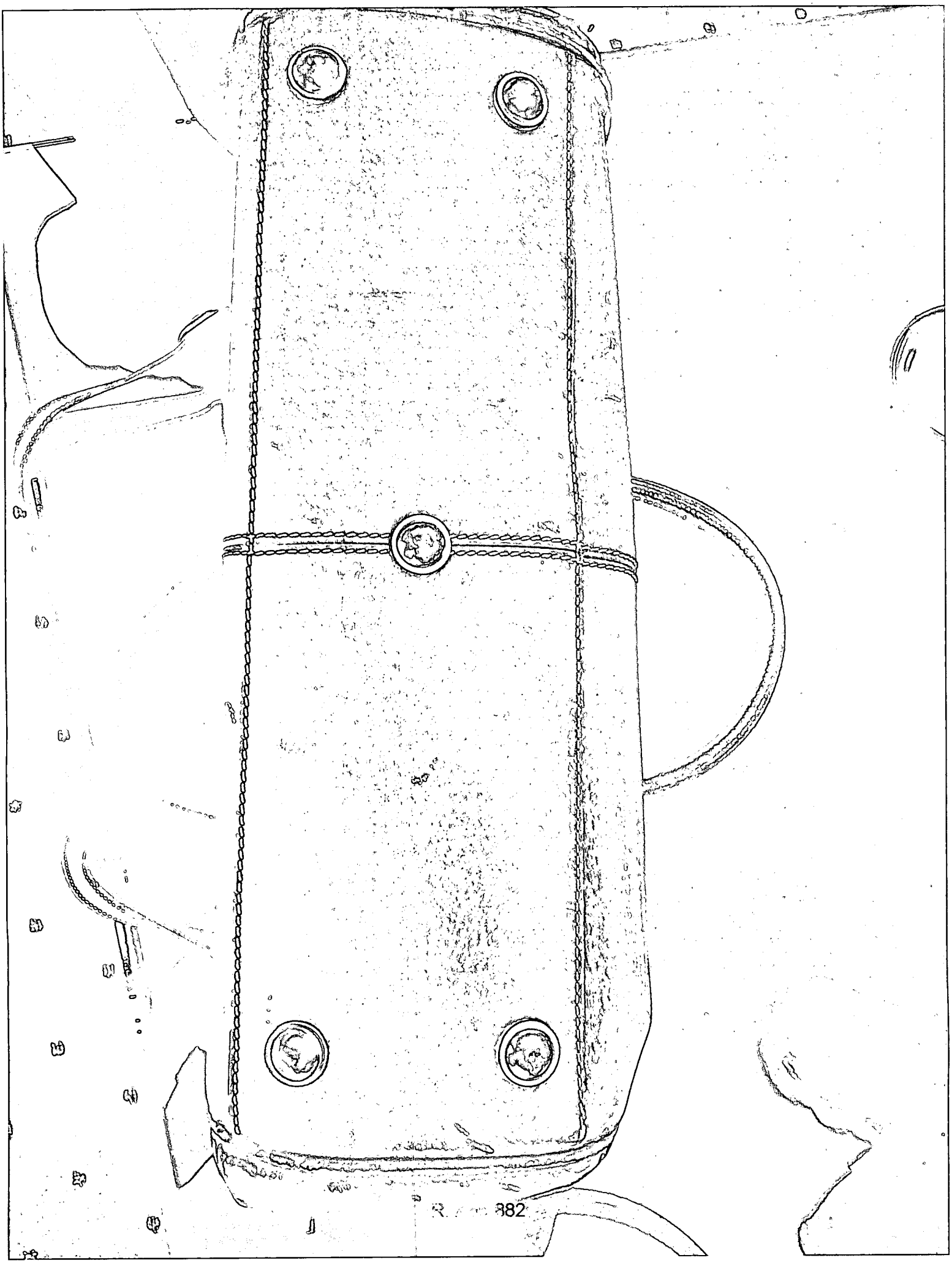


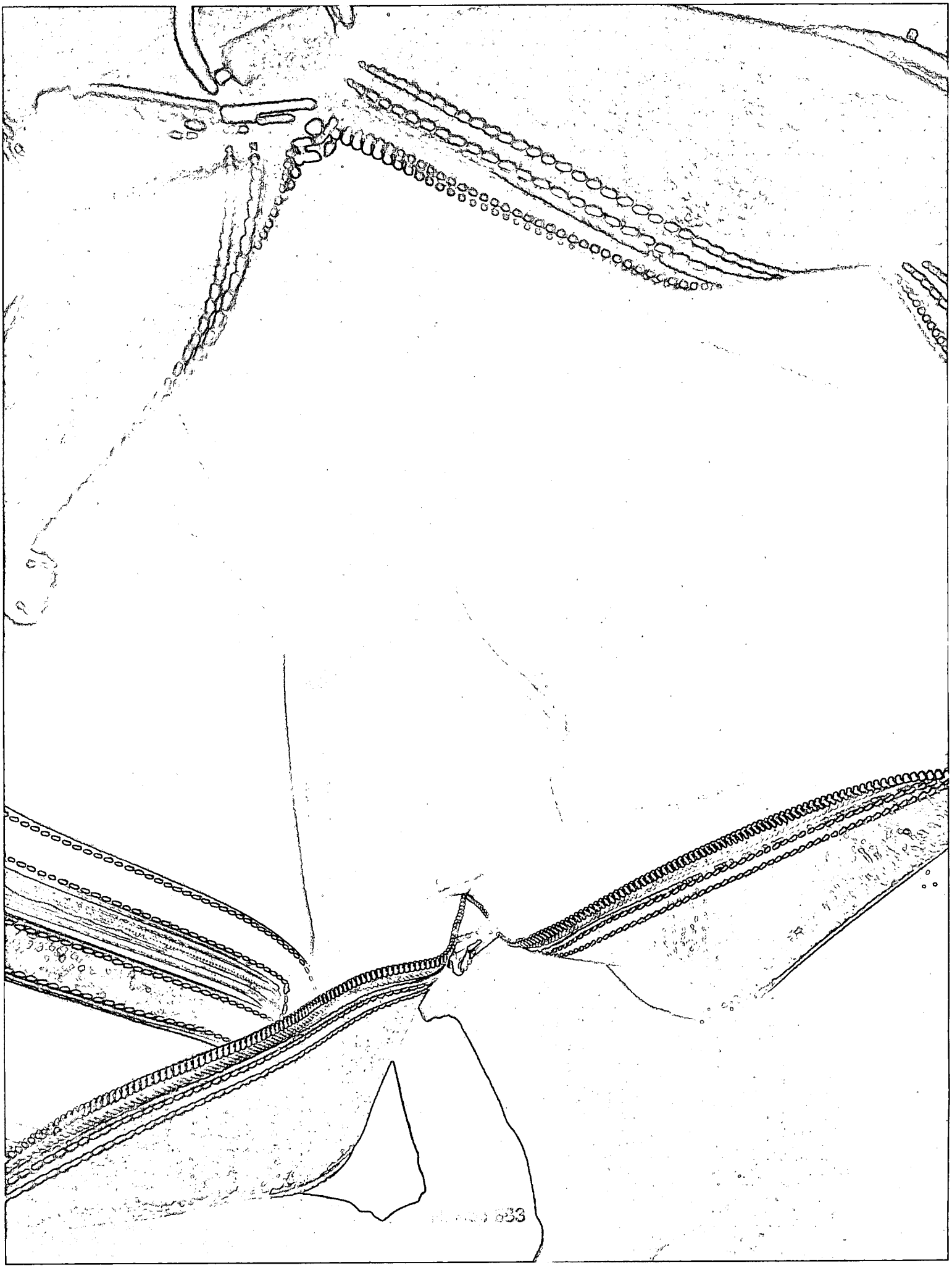


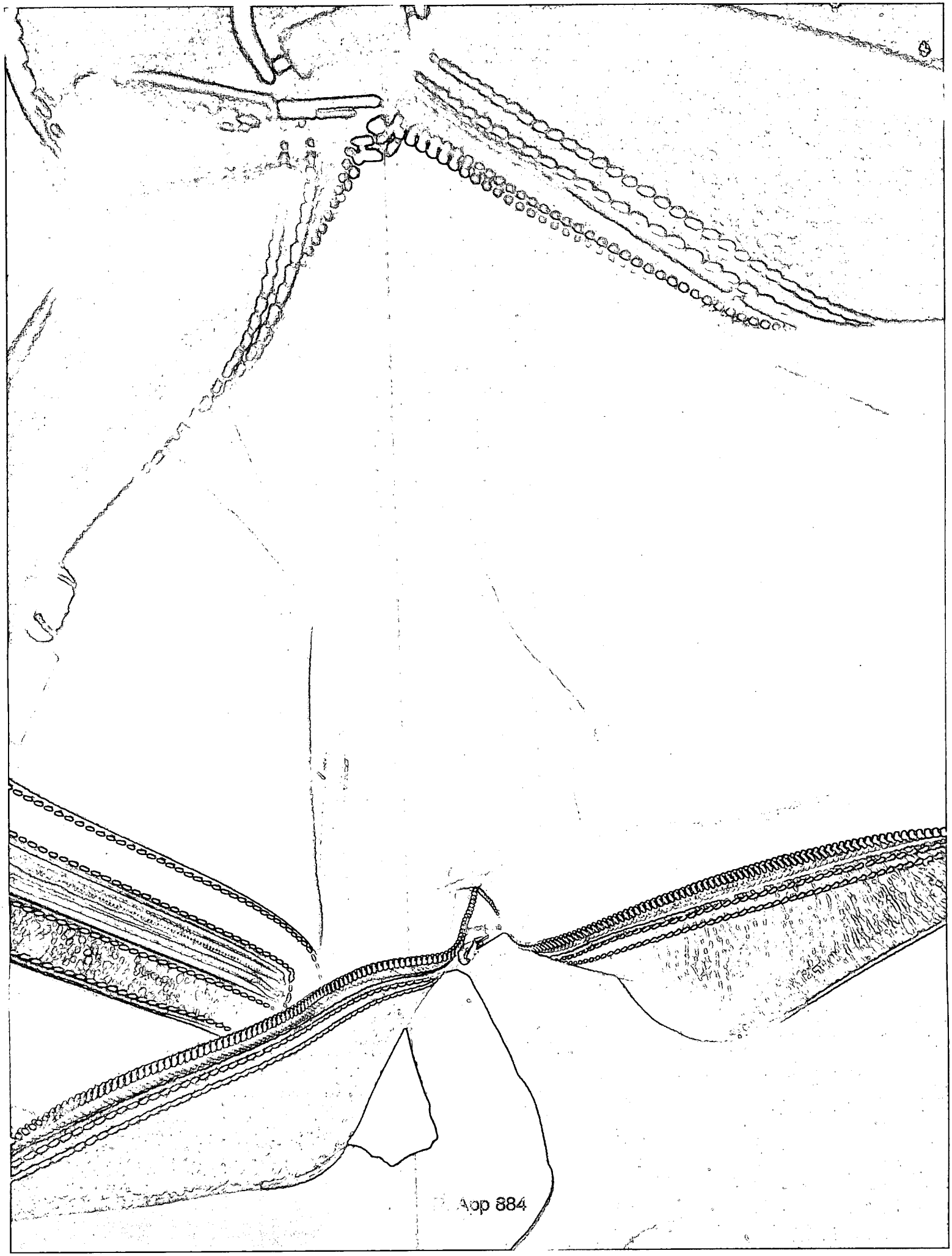




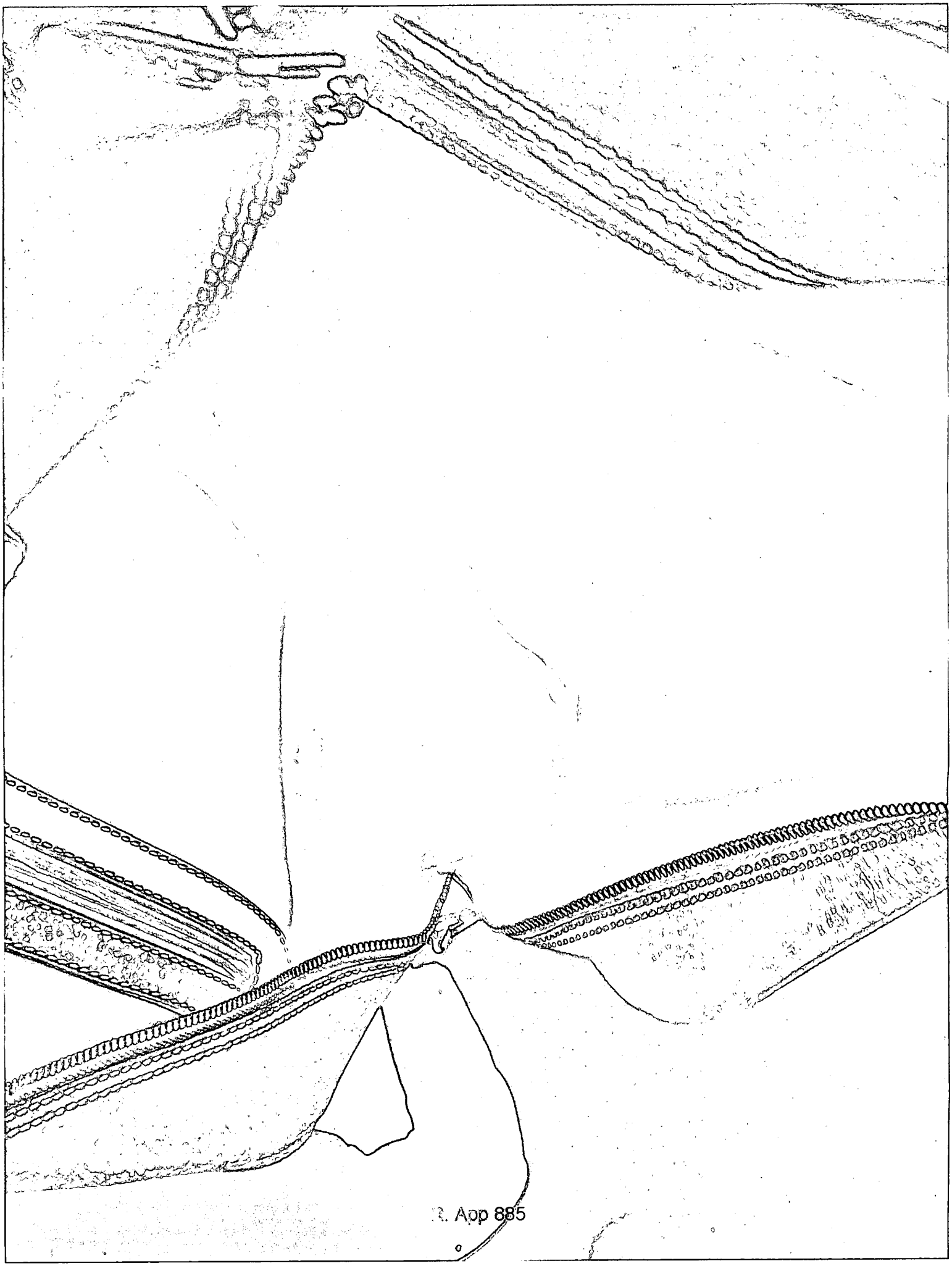


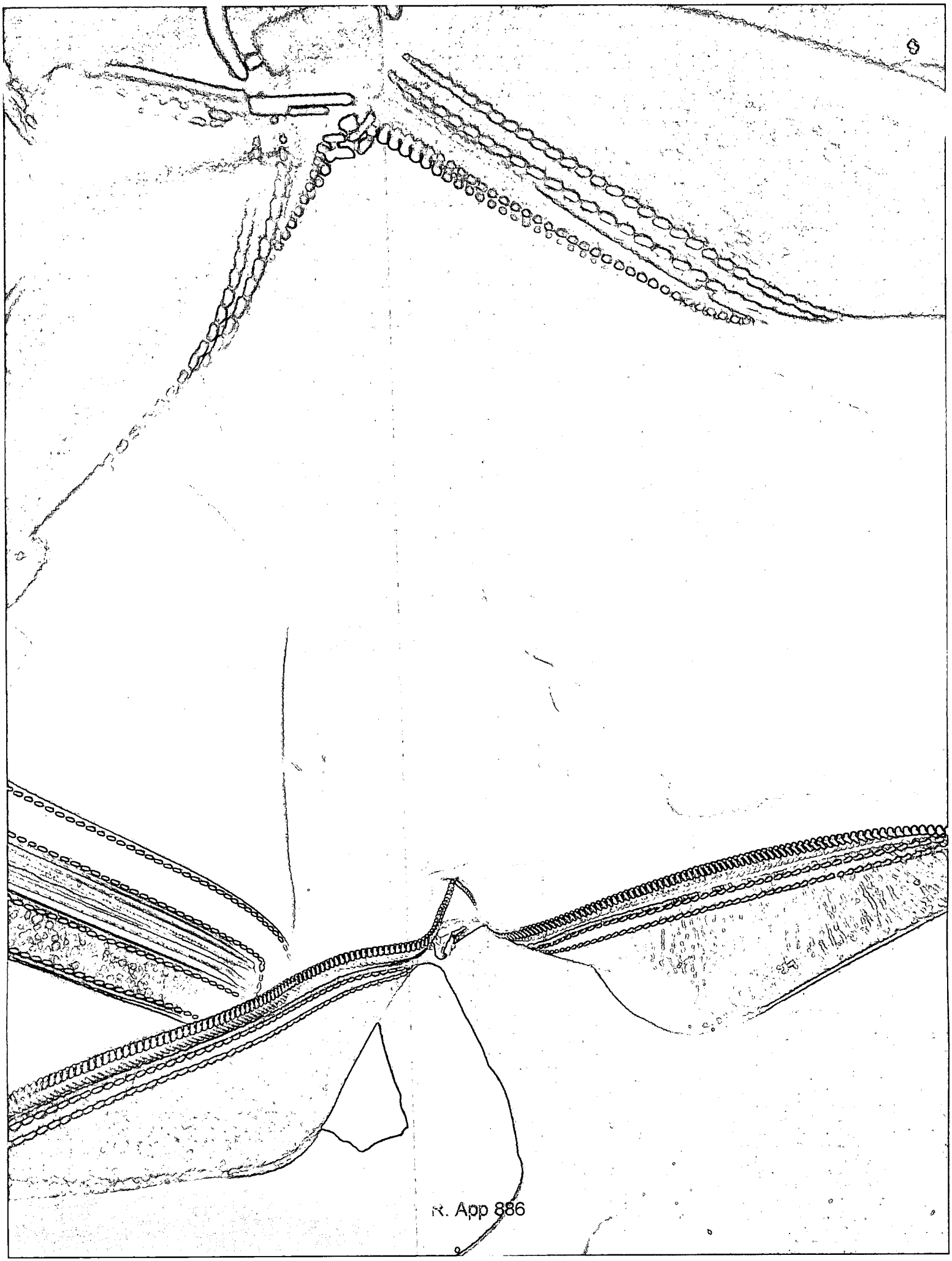


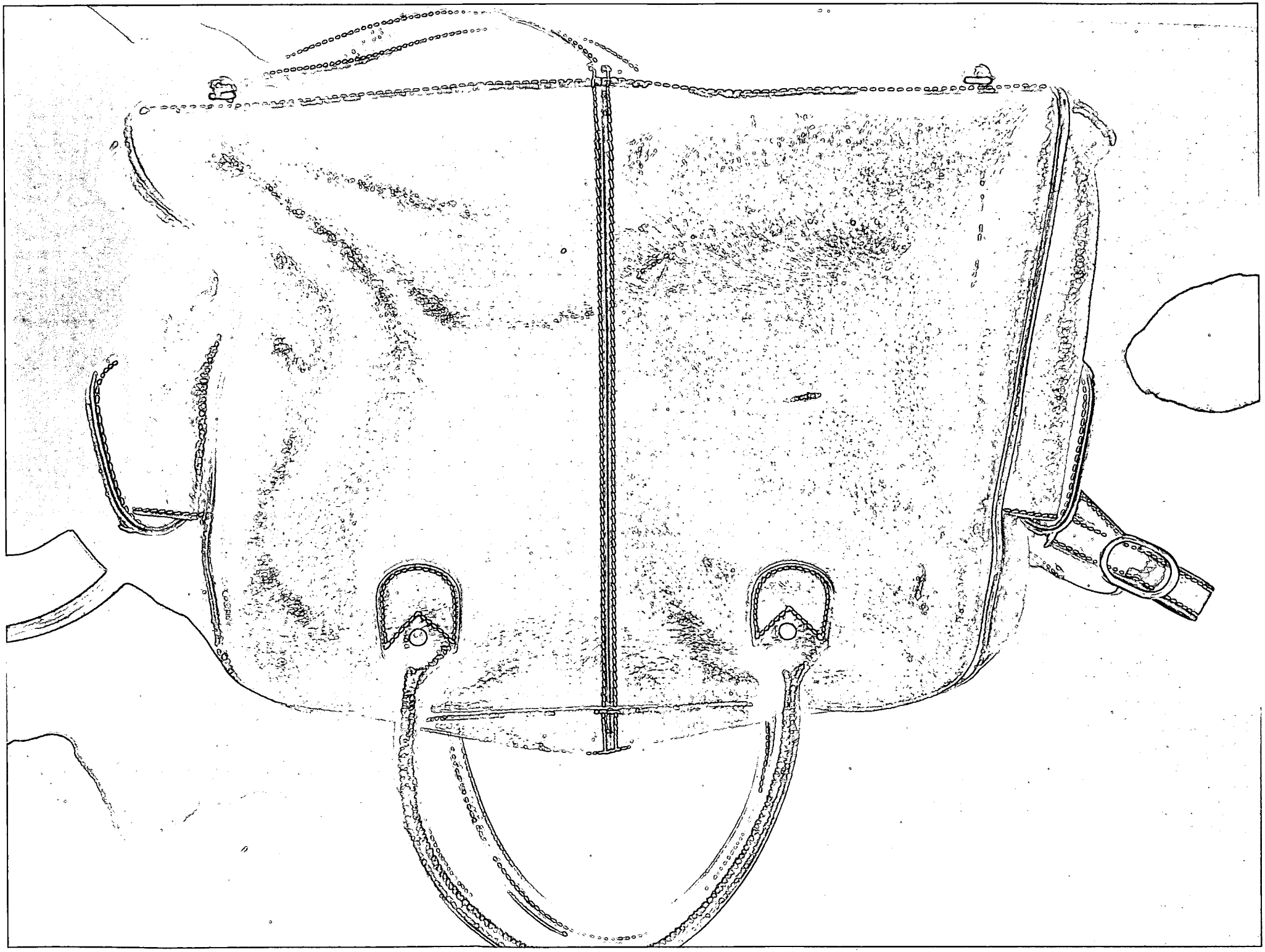


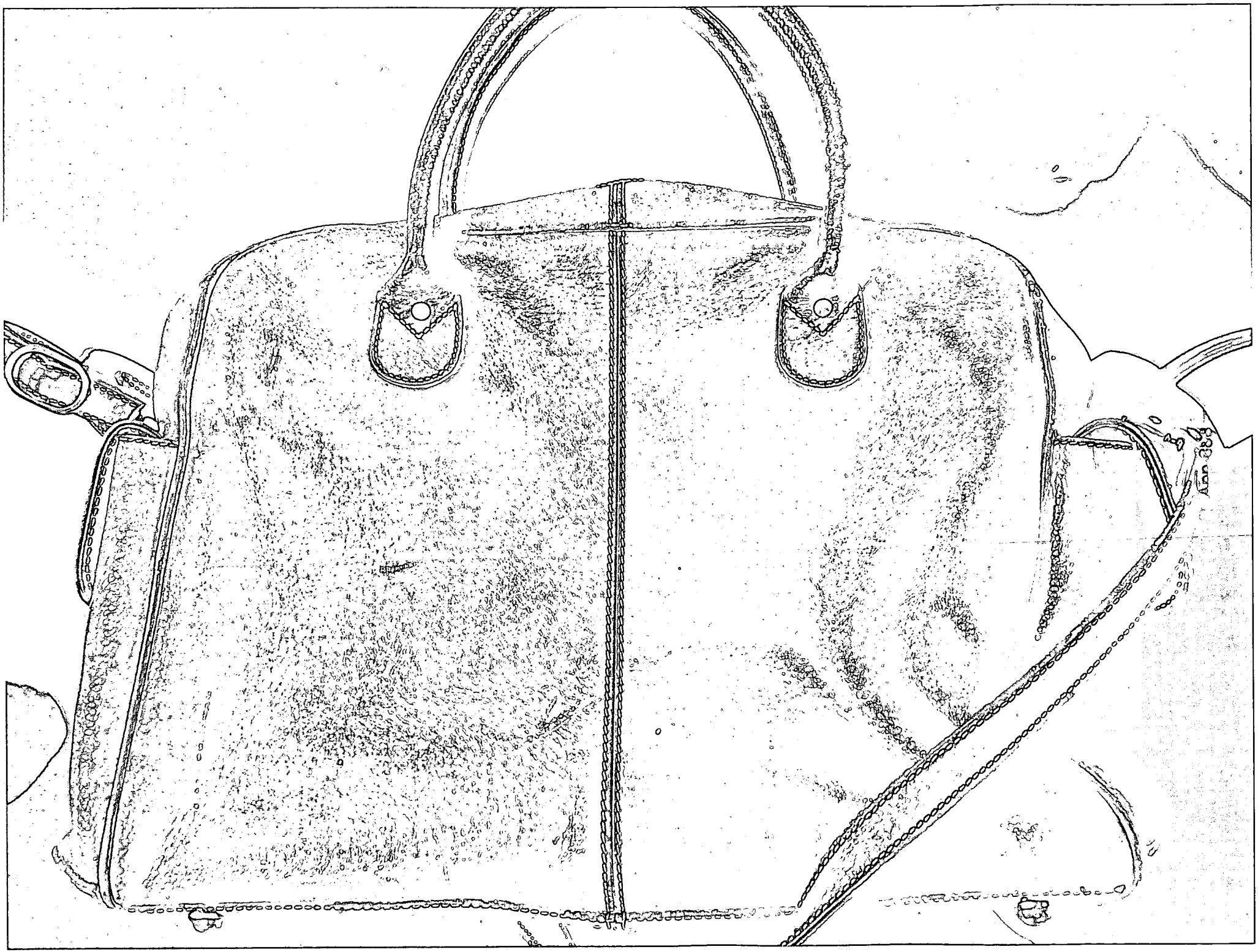


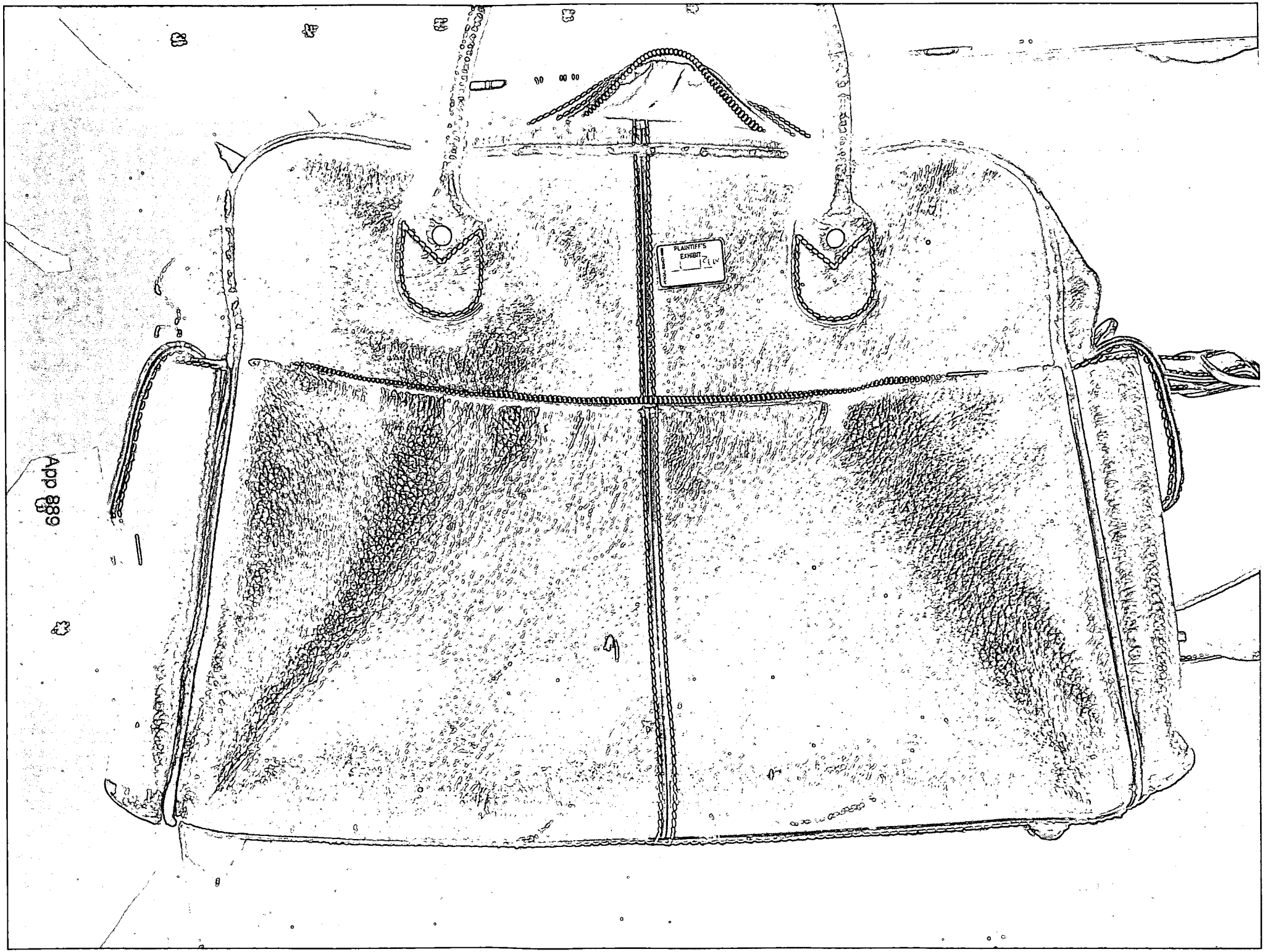
App 884










PLAINTIFF'S
EXHIBIT

Incident Detail Report

Incident Status Closed
Incident Number 201400250157
Incident Date 03/27/2014 22:07:12

Incident Information

Incident Type:	113D04	**Alarm Level:**	
Priority:	LP2-Delta	**Problem:**	113D_Disturbance Verbal Small
Determinant:	113D04	**Agency:**	Law
Base Response #:		**Jurisdiction:**	North Charleston PD-NCPD
Confirmation #:		**Division:**	NCZ4
Taken By:	McFadden, Desmond R	**Battalion:**	NCZ4
Response Area:	NCPD 104	**Response Plan:**	
Disposition:	LAM_Arrest Made	**Command Ch:**	
Cancel Reason:		**Primary TAC:**	
Incident Status:	Closed	**Alternate TAC:**	
Certification:		**Delay Reason:**	
Longitude:	79996448	**Latitude:**	32892719
MGRS:	17SNS9386739838	**UTM:**	17S 593867 3639838

Incident Location

Location Name:		**County:**	Charleston
Address:	[redacted]	**Location Type:**	
Apartment:		**Cross Street:**	[redacted]
		Tow Provider Area:	SPA NCPD DIS 1
Building:		**Map Reference:**	
City, State, Zip:	NORTH CHARLESTON, SC 29405		
ANI/ALI Address:		**ANI/ALI Phone:**	
ANI/ALI City:		**ANI/ALI Received:**	

Call Receipt

Caller Name:	JAKE	**Call Back Phone:**	303[redacted]
Method Received:		**Caller Location:**	
Caller Type:		**Caller Apt/Bldg:**	/
Caller Address:		**Caller County:**	
Caller City, State, Zip:	,		

Time Stamps

Description	Date	Time	User
Phone Pickup	03/27/2014	22:06:40	
1st Key Stroke	03/27/2014	22:07:12	
In Pending Queue	03/27/2014	22:07:21	
Call Taking Complete	03/27/2014	22:09:57	McFadden,
1st Unit Assigned	03/27/2014	22:08:28	
1st Unit Enroute	03/27/2014	22:08:31	
1st Unit Arrived	03/27/2014	22:14:20	
Incident Under Control			
Time Sent to Other CAD			
Incident Closed	03/27/2014	23:39:52	Nettles, Craig A

Elapsed Times

Description	Time
Received to In Queue	00:00:08
Call Taking	00:02:45
In Queue To 1st Assign	00:01:07
Call Received to 1st Assign	00:01:48
Assigned to 1st Enroute	00:00:03
Enroute to 1st Arrived	00:05:49
Incident Duration	01:33:12

Units Assigned

Unit	Assigned	Disposition	Enroute	Staged	Arrived	At Patient	Delay Avail	Complete	Odm. Enroute	Odm. Arrived	Cancel Reason
NC151	03/27/2014 22:08:28		03/27/2014 22:08:31		03/27/2014 22:30:18			03/27/2014 22:49:27			
NC371	03/27/2014 22:09:32	LAM_Arrest Made	03/27/2014 22:09:32		03/27/2014 22:14:20			03/27/2014 22:59:12			
NC321	03/27/2014 22:21:16		03/27/2014 22:21:16		03/27/2014 22:30:18			03/27/2014 22:58:57			
NC902	03/27/2014 22:44:16		03/27/2014 22:44:16		03/27/2014 22:59:13			03/27/2014 23:39:52			

Personnel Assigned

Unit	Name
NC151	Doxey, Anthony M (151) (NCPD0461) - PFC

Pre-Scheduled Information

No Pre-Scheduled Information

Special Equipment

No Special Equipment

Transports

No Transports

Transport Legs

No Transport Legs

Comments

Date	Time	User	Type	Confidential	Comment

Report Generated: 06/17/2014 08:51:10

Jane Doe 202 - 000014

Plaintiff's EXH. 2

03/27/2014	22:07:37	DRM	Response	FAMILY ARGUING ACROSS THE ST, FEMALE POUNDING ON THE DOOR AND SCREAMING
03/27/2014	22:08:21	DRM	Response	[ProQA: Case Entry Complete:] Location: [redacted] Callback: 303-[redacted] Caller's name: JAKE Problem Description: FEMALE POUNDING ON THE DOOR AND SCREAMIN Chief complaint: 113
03/27/2014	22:08:34	DRM	Response	a verbal disturbance.
03/27/2014	22:08:34	DRM	Response	[ProQA Script] Dispatch code: 113D04 1.The caller is not on scene. 2.This incident is in progress. 3.This incident involves a disturbance. 4.It is not known if weapons were involved or mentioned. 5.A SMALL group is involved. 6.This incident involves
03/27/2014	22:09:17	DRM	Response	[ProQA Person Information] , PIndex:1, Race:W, Gender:F, Clothes:WHITE BLOUSE, GREY SKIRT , Age:40'S, Hair:BURNETTEDescription:Suspect
03/27/2014	22:09:32	CAN	Response	Backed up NC151 with NC371
03/27/2014	22:09:38	DRM	Response	[ProQA Script: Additional Questions]7.The suspect/person responsible is on scene. 8.The suspect's description is: 9.It is not known if the suspect arrived in a vehicle. 10.It is not known if alcohol or drugs are involved. 11.N/A 12.N/A
03/27/2014	22:09:49	DRM	Response	. N/A 13. N/A
03/27/2014	22:09:49	DRM	Response	incident involves a verbal disturbance. 8. The suspect/person responsible is on scene. 9. The suspect's description is: 10. It is not known if the suspect arrived in a vehicle. 11. It is not known if alcohol or drugs are involved. 12
03/27/2014	22:09:49	DRM	Response	elected from Case Entry. 2. The caller is not on scene. 3. This incident is in progress. 4. This incident involves a disturbance. 5. It is not known if weapons were involved or mentioned. 6. A SMALL group is involved. 7. This
03/27/2014	22:09:49	DRM	Response	Breathing: Chief complaint:113 Dispatch information Recommended dispatch:113-D-4 Actual dispatch:113-D-4 Medical Response:Delta Responder script Dispatch code:113-D-4 Dispatch level:Delta Key Question Answers 1. ECHO was not s
03/27/2014	22:09:49	DRM	Response	[ProQA Summary:] Case Information Case number:1914005458 Location: [redacted] Callback number:303-[redacted] Problem:FEMALE POUNDING ON THE DOOR AND SCREAMIN Patients:0

				Operator:DRM Four commandment Information Age: Gender: Conscious:
03/27/2014	22:09:54	DRM	Response	NEG ON MEET
03/27/2014	22:16:11	CAN	Response	NC371 NEG ANYONE OUTSIDE, ATTEMPTING TO MAKE CONTACT AT [redacted]
03/27/2014	22:21:07	MXB	Response	NC371 ATT CONTACT W/ COMP, ADV THERE IS A PURSE HERE AND THE TRUNK IS OPEN W/ BOTTLES OF WINE, THERE IS BLOOD ON THE PURSE AS WELL, UNABLE TO LOCATE THE VICTIM AND NEG CONTACT AT THE DOOR
03/27/2014	22:21:16	MXB	Response	Backed up NC371 with NC321
03/27/2014	22:23:06	MXB	Response	COMP ADV IT LOOKS TO BE A DISTURBANCE BTWN MOTHER AND DAUGHTER, ADV THE MOTHER DEMENTIA AND LOCKED THE DAUGHTER OUT OF THE HOUSE, ADV THE DAUGHTER WENT OFF TO THE LEFT OF THE RESD, ADV THE MOTHER SLEEPS ON THE COUCH IN THE LIVING ROOM
03/27/2014	22:24:07	MXB	Response	COMP ADV HE WILL STEP OUT TO MEET W/ OFFICERS
03/27/2014	22:24:11	CAN	Response	NC151 AND NC321 DELAYED BY TRAIN ON MONTAGUE
03/27/2014	22:27:04	CAN	Response	NC151 UNITS BACK EN ROUTE
03/27/2014	22:32:48	MXB	Response	NC151 ADV HAS SOMEONE AT THE FRONT DOOR
03/27/2014	22:33:29	CAN	Response	NC151 CONTACT AT FRONT
03/27/2014	22:33:37	MXB	Response	NC321 ADV MADE CONTACT
03/27/2014	22:41:53	CAN	Response	NC371 95*1
03/27/2014	22:41:57	MXB	Response	NC371 1IC
03/27/2014	22:42:15	Automatic by System	Response	[Address: [redacted]] [Medium] [Knox Box] Knox Box: On top of Shutters_Left Front of the house
03/27/2014	22:44:16	CAN	Response	Backed up NC371 with NC902
03/27/2014	22:46:01	CAN	Response	Requested Case Number(s) issued for North Charleston PD-NCPD: 2014010163.
03/27/2014	22:50:23	CAN	Response	Primary vehicle changed to NC371
03/27/2014	22:59:23	CAN	Response	Secondary Location for NC902: CHARLESTON COUNTY DETENTION CENTER - JAIL, 3841 LEEDS AV,NORTH CHARLESTON, SC 29405.
03/27/2014	22:59:23	Automatic by System	Response	[2nd Address: 3841 LEEDS AV] [Medium] [Knox Box] CHARLESTON COUNTY DETENTION CENTER, ENERGY MANAGEMENT BUILDING **KNOX BOX - SIDE A OF ENERGY BUILDING** ID 454
03/27/2014	22:59:24	Automatic by System	Response	[2nd Premise: 3841 LEEDS AV] [Medium] [Knox Box] CHARLESTON COUNTY DETENTION CENTER, ENERGY MANAGEMENT BUILDING **KNOX BOX - SIDE A OF ENERGY BUILDING** ID 454
03/27/2014	22:59:24	CAN	Response	NC902 BEG MIL 0424 EN ROUTE TO THE JAIL 1 FEMALE
03/27/2014	23:08:41	CAN	Response	NC902 END MIL 431

Address Changes

Date	Time	Location/Address/Apt/Bldg City, State, Zip	User
03/27/2014	22:42:15	/ [redacted] / NORTH CHARLESTON, SC 29405	Nettles, Craig A

Priority Changes

No Priority Changes

Transport Changes

No Transport Changes

Transport Priority Changes

No Transport Priority Changes

Alarm Level Changes

No Alarm Level Changes

Activity Log

Date	Time	Unit	Activity	Location	Log Entry	User
03/27/2014	22:07:21		Incident in Waiting Queue			
03/27/2014	22:07:25		Read Incident		Incident 901 was Marked as Read.	CAN
03/27/2014	22:07:26		Incident in Waiting Queue Timer Clear			
03/27/2014	22:08:28	NC151	Dispatched	[redacted]		CAN
03/27/2014	22:08:31	NC151	Responding	[redacted]	Responding From = CITY HALL LN\MALL DR	CAN
03/27/2014	22:08:34		ProQA		ProQA determinant sent	DRM
03/27/2014	22:09:32	NC371	Dispatched	[redacted]		CAN
03/27/2014	22:09:32	NC371	Responding	[redacted]	Responding From = Rebecca St / Butler St	CAN
03/27/2014	22:09:32	NC151	Unit Backed up	[redacted]	Backed up with NC371	CAN
03/27/2014	22:09:57		UserAction		User clicked Exit/Save	DRM
03/27/2014	22:10:32		UserAction		User clicked Exit/Save	CAN
03/27/2014	22:11:07		Read Comment		Comment for Incident 901 was Marked as Read.	AES
03/27/2014	22:11:09		UserAction		User clicked Exit/Save	AES
03/27/2014	22:11:15		Read Comment		Comment for Incident 901 was Marked as Read.	DRM
03/27/2014	22:11:17		UserAction		User clicked Exit/Save	DRM
03/27/2014	22:14:20	NC371	At Scene	[redacted]		CAN
03/27/2014	22:17:20		Incident Late		Active incident marked as late	
03/27/2014	22:20:17		Read Comment		Comment for Incident 901 was Marked as Read.	MXB
03/27/2014	22:21:16	NC321	Dispatched	[redacted]		MXB

03/27/2014	22:21:16	NC321	Responding	[redacted]	Responding From = 5154 N Rhett Av [KANGAROO EXPRESS]	MXB
03/27/2014	22:21:16	NC371	Unit Backed up	[redacted]	Backed up with NC321	MXB
03/27/2014	22:21:18		Read Comment		Comment for Incident 901 was Marked as Read.	DRM
03/27/2014	22:21:21		UserAction		User clicked Exit/Save	DRM
03/27/2014	22:24:29		UserAction		User clicked Exit/Save	MXB
03/27/2014	22:30:18	NC151	At Scene	[redacted]		CAN
03/27/2014	22:30:18	NC321	At Scene	[redacted]		CAN
03/27/2014	22:35:39	NC151	Reset System Timer		[Reset Reason] Status/ Safety Check [Next Late Check Time] 03/27/2014 23:34:39	CAN
03/27/2014	22:35:39	NC371	Reset System Timer		[Reset Reason] Status/ Safety Check [Next Late Check Time] 03/27/2014 23:34:39	CAN
03/27/2014	22:35:40	NC321	Reset System Timer		[Reset Reason] Status/ Safety Check [Next Late Check Time] 03/27/2014 23:34:40	CAN
03/27/2014	22:39:26		Read Comment		Comment for Incident 901 was Marked as Read.	MXB
03/27/2014	22:39:30		UserAction		User clicked Exit/Save	MXB
03/27/2014	22:41:57		Read Comment		Comment for Incident 901 was Marked as Read.	CAN
03/27/2014	22:42:58		Read Comment		Comment for Incident 901 was Marked as Read.	MXB
03/27/2014	22:42:59		UserAction		User clicked Exit/Save	CAN
03/27/2014	22:44:16	NC902	Dispatched	[redacted]		CAN
03/27/2014	22:44:16	NC902	Responding	[redacted]	Responding From = 7400 Rivers Av [WALMART - RIVERS]	CAN
03/27/2014	22:44:16	NC371	Unit Backed up	[redacted]	Backed up with NC902	CAN
03/27/2014	22:44:21		UserAction		User clicked Exit/Save	CAN
03/27/2014	22:45:45		UserAction		User clicked Exit/Save	MXB
03/27/2014	22:46:18		UserAction		User clicked Exit/Save	CAN
03/27/2014	22:49:27	NC151	Available	[redacted]		CAN
03/27/2014	22:58:57	NC321	Available	[redacted]		CAN
03/27/2014	22:59:12	NC371	Available	[redacted]		CAN
03/27/2014	22:59:13	NC902	At Scene	[redacted]		CAN
03/27/2014	22:59:24	NC902	20 - Responding 2nd Loc	CHARLESTON COUNTY DETENTION CENTER - JAIL	Incident ID = 2821901, 3841 LEEDS AV 32846786, 80014598, BEG MIL 0424 EN ROUTE TO THE JAIL 1 FEMALE	CAN

03/27/2014	23:08:41	NC902	21 - At Scene 2nd Location	CHARLESTON COUNTY DETENTION CENTER - JAIL	Incident ID = 2821901, 3841 LEEDS AV 32846786, 80014598,	CAN
03/27/2014	23:39:49		Read Comment		Comment for Incident 901 was Marked as Read.	MXB
03/27/2014	23:39:52	NC902	Available	3841 LEEDS AV [CHARLESTON COUNTY DETENTION CENTER - JAIL]		CAN
03/27/2014	23:39:52		Response Closed	[redacted]		CAN
03/27/2014	23:39:55		UserAction		User clicked Exit/Save	MXB
03/28/2014	16:21:47		UserAction		User clicked Exit/Save	CJD
03/28/2014	16:22:21		UserAction		User clicked Exit/Save	CJD
03/28/2014	16:23:04		UserAction		User clicked Exit/Save	CJD
06/05/2014	09:55:59		Read Comment		Comment for Incident 901 was Marked as Read.	TVM
06/05/2014	09:56:00		Read Comment		Comment for Incident 901 was Marked as Read.	TVM
06/05/2014	10:06:49		UserAction		User clicked Exit/Save	TVM
06/16/2014	14:07:00		Read Comment		Comment for Incident 901 was Marked as Read.	TVM
06/16/2014	14:21:32		UserAction		User clicked Exit/Save	TVM
06/16/2014	14:21:50		Read Comment		Comment for Incident 901 was Marked as Read.	TVM
06/16/2014	14:21:50		Read Comment		Comment for Incident 901 was Marked as Read.	TVM
06/16/2014	14:47:05		UserAction		User clicked Exit/Save	TVM

Edit Log

Date	Time	Field	Changed From	Changed To	Reason	Table	Workstation	User
03/27/2014	22:07:14	Address	(Blank)	[redacted]	New Entry	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	Longitude	0	79996500	Entry Verified	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	Latitude	0	32892699	Entry Verified	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	City		NORTH CHARLESTON	Updated City	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	Address	[redacted]	[redacted]	Entry Verified	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	ResponsePlanType	0	0	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	Response_Area		NCPD 104	(Response Viewer)	Response_Master_Incident	911DSP19	DRM

03/27/2014	22:07:16	Battalion		NCZ4	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	Division		NCZ4	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:16	Jurisdiction		North Charleston PD-NCPD	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:20	Priority_Number	0	97		Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:20	Priority_Description		Generic		Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:20	Problem		*Law Call Pending	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:07:25	Read Call	False	True	(Response Viewer)	Response_Master_Incident	911DSP25	CAN
03/27/2014	22:07:52	Call_Back_Phone		303-2619	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:08:05	Caller_Name		JAKE	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:08:34	EMD_Used	0	1	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:08:34	ProQA_CaseNumber_Police		1914005458	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:08:34	Determinant		113D04	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:08:34	Incident_Type	CALL_Call Pending More Info	113D04	Updated by ProQA	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:08:34	Priority_Description	Generic	LP2-Delta	Updated by ProQA	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:08:34	Priority_Number	97	2	Updated by ProQA	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:09:50	ProQATerminationStateCode		C	(Response Viewer)	Response_Master_Incident_Ext	911DSP19	DRM
03/27/2014	22:11:07	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP12	AES
03/27/2014	22:11:15	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:20:17	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP24	MXB
03/27/2014	22:21:18	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP19	DRM
03/27/2014	22:39:26	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP24	MXB
03/27/2014	22:41:57	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP25	CAN
03/27/2014	22:42:14	Address	[redacted]	[redacted]	Address Change	Response_Master_Incident	911DSP25	CAN
03/27/2014	22:42:15	Address	[redacted]	[redacted]	(Response Viewer)	Response_Master_Incident	911DSP25	CAN
03/27/2014	22:42:15	Latitude	[redacted]	[redacted]	(Response Viewer)	Response_Master_Incident	911DSP25	CAN

03/27/2014	22:42:15	Longitude	[redacted]	[redacted]	(Response Viewer)	Response_Master_Incident	911DSP25	CAN
03/27/2014	22:42:15	Street_Id	NULL	13824	(Response Viewer)	Response_Master_Incident	911DSP25	CAN
03/27/2014	22:42:15	Address	[redacted] Cir	[redacted]	Change Verified	Response_Master_Incident	911DSP25	CAN
03/27/2014	22:42:58	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP24	MXB
03/27/2014	23:39:49	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911DSP24	MXB
06/05/2014	09:55:59	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911ADMIN09	TVM
06/05/2014	09:56:00	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911ADMIN09	TVM
06/16/2014	14:07:00	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911ADMIN09	TVM
06/16/2014	14:21:50	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911ADMIN09	TVM
06/16/2014	14:21:50	Read Comment	False	True	(Response Viewer)	Response_Master_Incident	911ADMIN09	TVM

Custom Time Stamps

No Custom Time Stamps

Custom Data Fields

No Custom Data Fields

Case Number

Case Number	Method	Radio Name
2014010163	Request	

Attachments

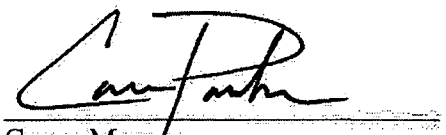
No Attachments

Dispositions

Date	Time	Unit	Disposition	User
03/27/2014	22:59:12		LAM_Arrest Made	Nettles, Craig A

Certificate of Counsel

I hereby certify that the enclosed Record on Appeal contains all material proposed to be included by any of the parties and not any other material.



For Gregg Meyers
Of Counsel, Pierce Sloan LLC
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Attorney for Appellant

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