

Faculty Name: _____

1. ADMISSION INFORMATION

Date of Care: 11/6/18	Pt. Name: H.O.	Admission Date: 10/25/18	Age: 94	Gender: F	Growth and Development (Erikson):	Ethnicity: Jap.	Occupation: Retired	Spiritual Beliefs:
Reason for Hospitalization/Chief Complaint (in pt's own words): Pt. does not speak English.		Surgical Procedures/Date: 11-2-18 Repair of duodenal perforation.		Medical Diagnoses History: (Present and past diagnoses, Physician's History and Physical notes in the chart, nursing intake assessment, with length of history if possible) - Bile duct obstruction (current) - Past - Anterior infract (11-13-14)				
Admitting Medical Diagnosis: Hyperbilirubinemia		History of Present Illness: Dx. perforated duodenum after a laparoscopic cholecystoduodenal fistula.						

ADVANCE DIRECTIVES (Nursing Admission Assessment):

Living Will: ☐ Yes ☒ No	Durable Power of Attorney: ☐ Yes ☒ No	Code status: ☒ Full Code ☐ DNR (Do Not Resuscitate)
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2. MEDICATIONS

ALLERGIES:

Drug	Classification	Dosage	Route	Frequency (time due)	Purpose	Nursing Considerations
1. DIFLUCAN (Fluconazole)		200mg	PO	daily		
2. ZOSYN	antibiotic	3.375g	IVPB	q 8 hrs		
3. metoprolol (LUPRESSOR)		25mg	PO	q 12 hrs		
4. amLODINE (Norvasc)		5mg	PO	daily		
5. albuterol (ACCUNEB)		2.5mg	neb	q 4 hrs.		
6. ondansetron (ZOFRAM)		4mg	IV push	PRN / q 6 hrs.		
7. morphine		2mg	IV push	q hr / PRN		
8. hydralazine		5mg	IV push	q 6 hr. / PRN		

3. LABORATORY DATA

Test	Norms	On admission	Current value	Test	Norms	On admission	Current value
WBC	3.5-10.5	12.19	18.66	Sodium	135-145	138	
Hemoglobin	12.0-15.5	11.7	9.0	Potassium	3.5-5.5	4.0	1.34
Hematocrit	34.9-44.5	35.8	27.3	Calcium	8.4-10.2	8.5	4.3
Platelets	150-450	189	138	BUN	4-15	27	7.5
PT	NA			Creatinine	0.55-1.30	1.48	15
INR	NA			Magnesium	1.7-2.8		0.89
							1.7

Bilirubin 0.2-1.2 3.6

PATIENT PROFILE DATABASE

aPTT			Blood Glucose	212
HA1c			Urinalysis	
BNP	0-99 pg/mL	(477) ↑	Cultures blood/sputum	

DIAGNOSTIC TESTS

Chest X-ray: SP NG tube removal. Persistent large right pleural effusion.

Abnormal studies: EKG: Abnormal premature supraventricular complexes forces of septal leads.

Abnormal studies: Sinus rhythm w/ 1st degree A-V block w/ premature supraventricular complexes

4. PHYSIOLOGICAL DATA-VITAL SIGNS

Vital Signs: Temp 97.2 °F/°C ☐ Axillary ☒ Tympanic ☐ Oral ☐ Core ☐ Rectal

Pulse 73 ☐ Apical ☐ Radial

Respiratory Rate 21 ☐ Even/regular ☒ Labored/SOB ☒ Dyspnea on Exertion

BP 140/71 ☒ Supine ☐ Sitting ☐ Standing

Admission weight: 44 Kg

Yesterday's weight: _____

Today's weight: _____

Height 152 cm

2 L nasal cannula

5. NEUROLOGICAL/SENSORY

Orientation: ☒ Time ☒ Place ☒ Person ☐ Purpose

Sensation: ☒ Normal ☐ Impaired ☐ Absent

Pain: Grade 4 /10 Scale used: ☒ 0-10 Numeric ☐ FLACC ☐ Wong-Baker

FACES

Pain Location: upper abdomen

Character: ☐ Sharp ☐ Dull ☒ Ache ☐ Heavy ☐ Pinprick ☐ Cramp ☐ Other _____

What makes the pain worse: moving

What makes the pain better: resting

Level of Consciousness: ☒ Alert ☐ Lethargic ☐ Obtunded ☐ Stuporous ☐ Semicomatose ☐ Coma

Coordination: ☐ Symmetrical ☐ Asymmetrical ☒ Unsteady

PERRLA: # _____ mm ☐ Brisk ☐ Sluggish ☐ Fixed ☐ Nystagmus

Strength: 3 Right arm 3 Left arm 2 Right leg 2 Left leg

0=No movement
1=Trace movement
2=Moving, not against gravity
3=Moving against gravity, not against resistance
4=Moving against gravity, some resistance
5=Full power

Glascow Coma Scale: Total of all 3 columns

Eyes 4=Open spontaneously 3=To speech 2=To pain 1=None Total <u>4</u>	Motor 6=Obey command 5=Localizes pain 4=Withdraws 3=Flexion 2=Extension 1=None Total <u>6</u>	Verbal 5=Oriented 4=Confused 3=Inappropriate words 2=Incomprehensible words 1=None Total <u>5</u>
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Hearing: ☒ Normal ☐ Tinnitus ☐ HOH ☐ Hearing Aid ☐ Deaf

Smell: ☒ Normal ☐ Decreased

Touch: ☒ Normal ☐ Decreased

PATIENT PROFILE DATABASE

Vision: ☒ Normal ☐ Glasses ☐ Contacts ☐ Cataracts ☐ Glasses ☐ Glaucoma ☐ Blurred vision ☐ Diplopia

Neurosensory comments:

Nursing Diagnosis:

6. CIRCULATORY/CARDIOVASCULAR

Color: ☒ Pink ☐ Pale ☐ Jaundice ☐ Flushed ☐ Cyanotic ☐ Mottled ☐ Dusky

Capillary refill: ☒ <3 seconds ☐ >3 seconds

Skin: ☒ Dry ☐ Moist ☐ Clammy ☐ Warm ☐ Cold ☐ Hot

Tele monitored rhythm:

Peripheral Edema: ☒ None ☐ +1 ☐ +2 ☐ +3 ☐ +4
☐ Pitting ☐ Non-pitting

Heart Sounds: ☒ S1 ☒ S2 Rhythm: ☐ Regular ☒ Irregular

Location:

Implanted Pacemaker: ☐ Yes ☐ No

Peripheral pulses:

Right radial ☒ Present ☐ Absent Left radial ☒ Present ☐ Absent Right pedal ☒ Present ☐ Absent Left Pedal ☐ Present ☐ Absent

Circulatory Comments:

Nursing Diagnosis:

7. RESPIRATORY/PULMONARY

Breath Sounds: ☒ Clear ☐ Diminished ☐ Absent ☒ Crackles
☐ Wheezes

Pattern: ☒ Regular ☐ Irregular

Location: ☒ Throughout ☐ RUL ☐ RML ☐ RLL ☐ LUL ☐ LLL

Character: ☐ Full ☐ Shallow ☐ Deep ☐ Labored ☐ SOB

Sputum: ☒ White/Clear ☐ Tan ☐ Yellow ☐ Green ☐ Rusty ☐ Pink ☐ Red

Amount: ☒ Small ☐ Moderate ☐ Large

Cough: ☒ None ☐ Nonproductive ☒ Productive ☐ Suctioning required

Pulse Oximeter: 95 %

Oxygen: ☐ Room air O₂ 2 L/min. or O₂ _____ %

Secretions: ☐ Yes ☒ No Consistency: ☐ Frothy ☐ Thick ☐ Thin

Mode: ☒ N/C ☐ Mask ☐ Trach

Suctioning Method: ☐ Oral ☐ Nasotracheal ☐ ETT ☐ Trach
☐ Bulb N/A

ABGs: pH _____ pO₂ _____ pCO₂ N/A HCO₃ _____

Respiratory Comments:

Nursing Diagnosis:

8. NUTRITION/HYDRATION

Diet: ☐ NPO ☐ Regular ☐ Cl. Liquid ☐ Full liquid ☒ Soft ☒ Pureed

Aspiration Risk: ☐ Yes ☒ No

☐ Other dysphagia level 3

Feeding Method: ☐ Self ☐ Assisted ☐ NG ☐ G-Tube ☐ J-Tube

Nausea: ☐ Yes ☒ No

Parenteral Nutrition: ☐ TPN ☐ PPN

Vomiting: ☐ Yes ☒ No

Tube Feeding Formula: N/A Rate: _____ mL/hr.

Flatus: ☒ Yes ☐ No

Residual: ☐ No ☐ Yes Amt N/A mL.

Weight: ☐ Gain _____ # lbs/kg

Mucous Membranes: ☒ Dry ☐ Moist

☐ Loss _____ # lbs/kg ☒ No change

Skin Turgor: ☒ No problem ☐ Tenting ☐ Taut

Intake:

PO 520

IV 250

Output:

Urine 500ml

NG _____

24 hour net I/O: +/-

① = 810 ② = 750

balance = 60

blow d 300

PATIENT PROFILE DATABASE

NG ☒
Blood 300
Other 1 unit
24 hour total _____

Emesis ☒
Stool ☒
Drains ☒
Other _____
24 hour total _____

Nutrition/Hydration comments: Nutrition - adequate

Nursing Diagnosis:

9. GI/FECAL ELIMINATION

Bowel Sounds: ☐ Absent ☐ Hypoactive ☐ Active ☒ Hyperactive

Location: ☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ ☒ Throughout

Abdomen: ☒ Soft ☐ Flat ☐ Distended ☐ Round ☐ Firm ☒ Tender ☐ Flatus

Ostomy: ☒ No ☐ Yes

Incontinence: ☒ Yes ☐ No

Type: ☒ Brown ☒ Black/Tarry ☐ Clay/Gray ☐ Yellow ☐ Green

Last BM: _____ Stool: ☐ Formed ☒ Soft ☐ Hard ☐ Liquid
1

Fecal Elimination Comments:

Nursing Diagnosis:

10. GU/URINARY ELIMINATION

Urine: ☒ Clear ☐ Cloudy ☐ Sediment

Color: ☐ Straw ☒ Yellow ☐ Amber ☐ Pink ☐ Red

Last void: time 6:50 amount _____ mL

Catheter: ☐ None ☐ In/Out ☐ Condom ☒ Foley ☒ Suprapubic
Insertion date: _____

Symptoms: Frequency: ☐ Urgency: ☐ Dysuria: ☐ Nocturia: ☐ Incontinence: ☒ Yes ☐ No

Urinary Elimination Comments: patent and unobstructed flow ensured.

Nursing Diagnosis:

11. REST AND EXERCISE

Activity: ☐ Bed rest ☐ BSC ☐ BRP ☒ Chair ☐ Ambulate

Mobility Aids: ☐ Cane ☐ W/C ☐ Crutches ☒ Walker

Functional level: ☐ Independent ☐ Dependent ☐ Assistance

Gait: ☐ Steady ☒ Unsteady ☐ Unable to ambulate

ROM: ☐ Active ☐ Passive ☒ Assistive ☐ Limited ☐ Full

Sleep Patterns: ☐ Uninterrupted ☐ Interrupted ☐ Insomnia
☒ Day time sleepiness # hrs sleep/night _____

Cast/Brace/Traction: Type _____
Location _____

Restraints: Type _____
Location _____

Rest and Exercise Comments:
- able to sit in chair with max assist

PATIENT PROFILE DATABASE

Nursing Diagnosis:

MORSE FALL SCALE/RISK SCREENING

Variables		Score	To obtain the Morse Fall Score add the score from each category. Morse Fall Score ☐ High Risk 45 and higher ☒ Moderate Risk 25-44 ☐ Low Risk 0-24
History of Falls within last 12 months	No	0	
	Yes	25	
Secondary Diagnosis	No	0	
	Yes	15	
Ambulatory Aids	None/bedrest/nurse assist	0	
	Crutches/cane/walker	15	
	Furniture	30	
IV or IV access	No	0	
	Yes	20	
Gait	Normal/bedrest/wheelchair	0	To obtain the Morse Fall Score add the score from each category. Morse Fall Score ☐ High Risk 45 and higher ☒ Moderate Risk 25-44 ☐ Low Risk 0-24
	Weak	10	
	Impaired	20	
Mental Status	Know own limits	0	
	Overestimates or forgets limits	15	
Total		14	

Rest and Exercise Comments:

Nursing Diagnosis:

12. SKIN INTEGRITY/INTEGUMENTARY

PATIENT PROFILE DATABASE

Skin Condition: ☐ Intact ☐ Skin tear ☐ Bruise ☐ Rash ☐ Burn ☒ Wound/Ulcer (complete documentation)
 Location Scrum Stage 2

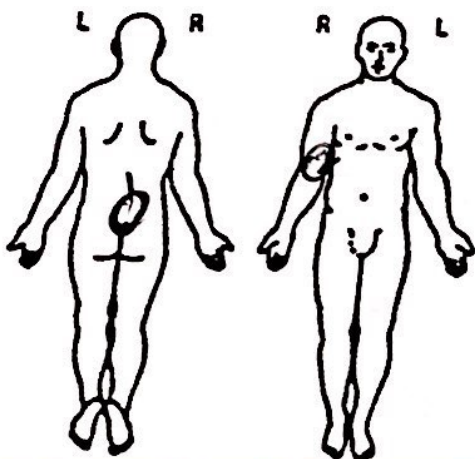
☐ Incision ☐ Other _____

Location#1 P Type of condition _____

Location#2 Patent Type of condition _____

Location#3 _____ Type of condition _____

☐ Drainage _____ ☐ Odor _____
☐ Drainage _____ ☐ Odor _____
☐ Drainage _____ ☐ Odor _____



Indicate location or Intact:

S Surgical site
 B Burn
 E Ecchymosis
 F Fracture/Cast
 Pe Petechiae
 Pressure ulcer & stage _____
 Other _____

M Edema
 R Rash
 D Dressing
 N Inflammation
 G Gangrene/Necrosis

I IV Site
 Patent
 Swollen
 Red
 Infiltrated

A Drains
 None
 Penrose
 Hemovac
 JP

Braden Scale

					Score
Sensory	1. Completely limited	2. Very limited	3. Slightly limited	4. No Impairment	3
Moisture	1. Constantly moist	2. Very moist	3. Occasionally moist	4. Rarely moist	2
Activity	1. Bedfast	2. Chairfast	3. Walks occasionally	4. Walks frequently	2
Mobility	1. Completely immobile	2. Very limited	3. Slightly limited	4. No limitations	2
Nutrition	1. Very poor	2. Probably inadequate	3. Adequate	4. Excellent	3
Friction and Shear	1. Problem	2. Potential problem	3. No apparent problem	Score of 18 or less = at risk	3

IV sites: ☒ Patent ☐ Swollen ☐ Red ☐ Infiltrated Location: Right arm Gauge Needle: _____ Start 15
 date: 11/6/18

Skin Comments:

- Turn pt. q. 2 hrs.
 - remove skin protectant cream applied daily and after each incontinence episode.
 - moderate risk (13-14)

Nursing Diagnosis:

13. HORMONE REGULATION/REPRODUCTION/ENDOCRINE

Thyroid Disease: ☐ Yes ☒ No Estrogen Use: ☐ Yes ☒ No Testosterone use: ☐ Yes ☒ No Steroid use: ☐ Yes ☒ No

Diabetes: ☐ Yes ☒ No ☐ Type I ☒ Type II Number of year with diabetes: _____

14. PSYCHOSOCIAL VARIABLES

Mood/Affect: ☐ Cooperative ☒ Cheerful ☐ Angry ☐ Anxious ☐ Crying ☐ Withdrawn ☐ Flat Affect ☐ Depressed ☐ Fearful
☐ Combative

Level of education: ☒ None ☐ Elementary ☐ High School ☐ College ☐ Post Graduate

Understands directions: ☒ Yes ☐ No

Decision-making: ☐ None ☐ Concrete ☒ Abstract ☐ Impaired

Judgment: ☐ Appropriate ☒ Inappropriate ☐ Dementia

History/Evidence of: ☐ Physical Abuse ☐ Neglect ☐ Sexual Abuse ☐ Thoughts of suicide or self-harm ☐ Depression ☐

Skin/

Loc: Mid abdomen

Type: surgical incision

Dressing: open to air

Description: surgical incision with staples present,
no redness or drainage noted.

-
- Peripheral IV - Saline lock gauge / 20 gauge angiocath
 - No central line present
 - No midline access present.
- right hand

PATIENT PROFILE DATABASE

Psychiatric history

Recreational drug use: ☐ Drug _____
long _____

How much _____ How

Alcohol use: ☐ How often _____ How
much _____

Tobacco use: In the last 12 months ☐ Yes ☒ No _____
How often _____

Recent life stress or loss: ☐ Yes ☒ No _____

How much _____

Coping methods with current illness/hospitalization: ☐ Good ☒ Fair
☐ Poor

Body Image: ☐ Positive ☐ Negative ☐ Changing

Sexuality: ☒ Heterosexual ☐ Bisexual ☐ Homosexual ☐ Transgender
☐ Transsexual

Ability to write English: ☐ Yes ☒ No

Ability to read English: ☐ Yes ☒ No

Language Barrier: ☐ None ☒ ESL ☐ Speech
Impediment ☐ Intubated ☐ Trached

Support System: ☒ Yes ☐ No
Living Situation: SNF

Psychosocial Comments: Patient is appropriate, cooperative but forgetful

Nursing Diagnosis:

Narrative Charting:

Age/Gender: 94 / F

Admit D/T:

10/25/2018 20:32

Admit Diagnosis: HYPERBILIRUBINEMIA ↑

Secondary Diagnosis:

Attending: ~~Dr. E. S. Johnson~~

Consulting: Arase, Randal P, Radhakrishna, Suman
M

(LOC X3) (Japanese)

Admit as

Inpatient

Preferred Language

Japanese

Past Medical History

type 2 diabetes, dementia, CKD stage III, hypertension

(Allergies)

MED: Bactrim DS, Cipro. LATEX: nka. FOOD: nka. SUB: nka

Code Stat/POLST

Full Code

Advanced Directive

No: Patient/Family declined further information

Diet

Soft (Dysphagia Advanced Level 3)

Activity

As Tolerated

LOC

alert, awakens and responds appropriately

Fall Score

Moderate risk = 13-14

Braden Level

ISO: / PREC:

Isolation/Precautions

INDICATED: not indicated (Patient did not meet any inclusion criteria OR exclusion criterion identified)
PREVIOUS DATE: DATE GIVEN:

PnuemoVax

INDICATED: not indicated (Patient did not meet any inclusion criteria OR exclusion criterion identified)
PREVIOUS DATE: DATE GIVEN:

FluVax

Hemoglobin dropping 6.7 (1 unit blood given)
↑ WBC

VTE

Diagnostic Procedures

Future Labs

TPR/BP

97 %

Pulse Ox

2 liters/min Nasal Cannula

O2 Therapy

Rhythm

Numeric - 7-moderate - 5 Nov 18 2100

Pain

Height/Weight

152.4 cm (5'0", 60.0 in) / 44 kg (97 lbs 0 oz)

Accucheck

227 mg/dL

Last HD Tx

HD Access Site

Foley - 31 Dec 40 0000

FoleyCath Insert

Central Ln Insert

Central Ln Site

(R) Periph IV Site

right hand - 11/05/2018 20:00

Tubes & Drains

Jackson Pratt Drain #1, Intake & Output, Urinary Catheter #

Wound Present

sacrum - undefined wound

Room: 514A

MRN: 902-13-02-34

Patient Name: Oda, Haruko