

01 – DEMO HOSPITAL EMERGENCY RECORD

Forstater, Alan
DOB: 9/8/1957 M50
Wt/Ht:
MedRec:
AcctNum:

Patient Data

Complaint: Abdominal Pain
Triage Time: Fri Aug 08, 2008 08:56
Urgency: 2 Emergent
Bed: ED WAIT
Initial Vital Signs: 8/8/2008 11:00
BP:90/60
P:120 irreg

R:27
T:102r

ED Attending:
Primary RN: Kristen, Lalowski, Rn
O2 sat:88 on ra
Pain:

TRIAGE (Fri Aug 08, 2008 08:56 NK)

PATIENT: NAME: Alan Forstater, AGE: 50, GENDER: male, DOB: Sun Sep 08, 1957, TIME OF GREET: Fri Aug 08, 2008 08:49, by: Lalowski, Rn Kristen.

(Fri Aug 08, 2008 08:56 NK)

VITAL SIGNS: BP 90/60, Pulse 120 irreg, Resp 27, Temp 102r, O2 Sat 88, on ra, Time 8/8/2008 11:00. (Fri Aug 08, 2008 08:56 NK)

ASSESSMENT: Assessment performed, sob on exertion, N/V — taking immodium. (08:57 NK)

ADMISSION: DEPT: Emergency, BED: WAIT. (Fri Aug 08, 2008 08:56 NK)

COMPLAINT: COMPLAINT: Abdominal Pain. (Fri Aug 08, 2008 08:56 NK)

KNOWN ALLERGIES

Penicillin V Potassium.

CURRENT MEDICATIONS

small white pill for HTN (08:58 NK)

geart pill that he stopped taking a month ago (08:58 NK)

Valium (08:59 NK)

Lomotil (08:59 NK)

Imodium A-D (08:59 NK)

HPI ABDOMINAL PAIN

CHIEF COMPLAINT: Patient presents for the evaluation of **abdominal pain**. (08:56 SRM) **HISTORIAN:** History obtained from patient. (08:56 SRM) **TIME COURSE MALE:** **Onset of symptoms reported as gradual,**

Onset was 2 days prior to arrival . Complaint is worse, constant. (08:56 SRM) **QUALITY:** Pain is **aching, bloating in nature, dull, fullness, pants no longer fit.** (08:56 SRM) **LOCATION**

MALE: No localizing symptoms. **Pain is diffuse.** (08:56 SRM) **ASSOCIATED WITH:** **Associated with chills, intermittently, Associated with constipation.** No associated diarrhea, **Associated with fever, Associated with nausea, vomiting, X 1–2, Associated with recent change in weight, Weight gain.**

(08:56 SRM) **NOTES:** **Recently discharged from hospital after 2 day stay for gastroenteritis. Home on Lomotil (now feels "stopped up").** (09:05 SRM)

HPI DICTATION ONLY (09:13 SRM)

CHIEF COMPLAINT: **Pt underwent significant deterioration despite IVF resuscitation, atbx and pressors. Semi electively intubated to protect airway and support respiratory effort.**

ROS

CONSTITUTIONAL: **Historian reports chills, fever.** (08:58 SRM)

Historian reports chills, fever, weakness. (09:06 SRM)

EYES: **Historian reports vision changes.** (09:06 SRM)

CARDIOVASCULAR: **Historian reports dyspnea on exertion,** No chest pain. (09:06 SRM)

RESPIRATORY: **Historian reports cough, SOB.** (09:06 SRM)

01 – DEMO HOSPITAL EMERGENCY RECORD

Forstater, Alan
DOB: 9/8/1957 M50
Wt/Ht:
MedRec:
AcctNum:

GI: Historian reports abdominal pain, nausea, vomiting, constipation, No diarrhea. (08:58 SRM)

Historian reports abdominal pain, nausea, vomiting, constipation, No diarrhea. (09:06 SRM)

GENITOURINARY MALE: Historian reports retention, No dysuria. (09:06 SRM)

NEUROLOGIC: Historian reports lethargy, dizziness. (09:06 SRM)

PAST MEDICAL HISTORY (08:57 SRM)

MEDICAL HISTORY: History of cardiac disease. including arrhythmia, "irreg heart. History of diabetes, gastrointestinal disease. including irritable bowel syndrome, History of hypertension.

SURGICAL HISTORY: History of appendectomy, cholecystectomy.

VITAL SIGNS

VITAL SIGNS: BP: 90/60, Pulse: 120 irreg, Resp: 27, Temp: 102r, O2 sat: 88 on ra, Time: 8/8/2008 11:00.

(11:00 NK)

Pulse: 130 rrr, O2 sat: 94 on 100% NRB, Time: Fri Aug 08, 2008 09:09. (09:09 NK)

PHYSICAL EXAM

CONSTITUTIONAL: Patient is febrile, Tachycardic, Patient is lethargic, ill appearing.

Patient appears uncomfortable, to be in pain. Patient has moderate pain distress, toxic appearing. (08:58 SRM)

EYES: Sclera are normal. Conjunctiva are normal. (08:58 SRM)

ENT: Posterior pharynx normal. (08:58 SRM)

NECK: No meningeal signs, Cervical spine nontender. (08:58 SRM)

RESPIRATORY CHEST: Chest is nontender. Breath sounds normal, No respiratory distress. (08:58 SRM)

CARDIOVASCULAR: Rate is tachycardic. Rhythm is irregularly irregular. (08:58 SRM)

ABDOMEN: Tenderness, is diffuse, Absent bowel sounds, Rectal examination for blood shows, trace positive for heme. (08:58 SRM)

UPPER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema. Normal range of motion. (08:58 SRM)

LOWER EXTREMITY: Inspection normal, No cyanosis, No clubbing, No edema. Normal range of motion, No calf tenderness. (08:58 SRM)

NEURO: No focal motor deficits, No focal sensory deficits, Speech normal, Memory normal. (09:07 SRM)

SKIN: Skin is dry. (08:58 SRM)

LAB INTERPRETATION (09:07 SRM)

INTERPRETATION: Elevated WBC, Decreased Hemoglobin, Decreased Hematocrit, Elevated BUN, Elevated Glucose, Elevated Creatinine. Normal PT, PTT, O2 saturation reading 94%, O2 AMT: 100%, pH: 7.14, PCO2: 22, Sat: 90, Moderate hypoxemia, Metabolic acidosis.

EKG INTERPRETATION (09:04 SRM)

12 LEAD EKG INTERPRETATION: No previous EKG available, 12 Lead EKG Interpretation shows rhythm is Atrial Fibrillation – rapid, Rate 132, beats per minute, ST Segments: non-specific changes.

RADIOLOGY INTERPRETATION

CHEST: Interpretation of chest X-ray shows, infiltrate present, of the left lower lobe. (09:05 SRM)

ABDOMEN: Obstructive Series interpretation shows, Ileus present. (09:05 SRM)

Interpretation of CT Abdomen/Pelvis shows, Ischemic bowel, diverticulitis with abscess. (09:22 SRM)

01 – DEMO HOSPITAL EMERGENCY RECORD

Forstater, Alan
DOB: 9/8/1957 M50
Wt/Ht:
MedRec:
AcctNum:

MEDICATION ADMINISTRATION SUMMARY (09:26)

Drug Name	Dose	Route	Status	Time
DOPamine Hydrochloride	titrate to SBP 100 mcg/kg/min	Intravenous	Given	09:21 8/8/2008
Metronidazole	500 milligram(s)	IVPB	Given	09:12 8/8/2008
Gentamicin Sulfate, Injectable	120 milligram(s)	IVPB	Given	09:11 8/8/2008
Maxipime	1 gram(s)	IVPB	Given	09:08 8/8/2008
Cipro	500 milligram(s)	IVPB	Given	09:08 8/8/2008

Detailed record available in Medication Service section.

ORDERS

Hepatic Panel by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
CBC by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
CT Abdomen W/Contrast by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
IVF – .9NS by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Abdomen Series by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Admit Bed order by NK for SRM on Fri Aug 08, 2008 09:01 Status: Active.
Urine dip by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
EKG by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
orthostatics by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Bedside Glucose by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Basic Metabolic Panel by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
old records by NK for SRM on Fri Aug 08, 2008 09:01 Status: Active.
Electrolytes, Serum (Lytes) by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Amylase, Serum by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Lipase by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
nothing by mouth by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Urinalysis, Routine by NK for SRM on Fri Aug 08, 2008 09:02 Status: Active.
Reason: abd pain.

DOCTOR NOTES (09:12 SRM)

TIME: Routine re-evaluation.

PATIENT STATUS: Patient has improved since arrival to emergency department.

D/W: Discussed this case with Dr. Smith, the primary care physician. Discussed with appropriate consultants,

Consult ID, Pulmonology, Surgery.

PATIENT PLAN: The patient requires intensive care, and will be placed in ICU.

BLADDER CATHETERIZATION (09:11 SRM)

TIME OUT: Patient identification confirmed, Sterile procedures observed.

BLADDER CATHETERIZATION: Verbal consent obtained, Performed by attending, Indication for retention, Indication for nurse unable to anchor. Complicated by benign prostatic hypertrophy. Patient prepped and draped in usual sterile fashion, Foley inserted in bladder, 16fr foley catheter inserted, Patient tolerated procedure well.

INTUBATION (09:11 SRM)

INTUBATION: Emergent consent implied, Performed by attending, **Patient's airway is not patent,**

Nasopharyngeal airway in place. Patient being ventilated with bag valve mask, Airway suctioned,

Indication for intubation is respiratory failure, Oral-laryngoscopy intubation used, Patient sedated with benzodiazepine, was pre-oxygenated, Cricoid pressure was applied, Size of tube used is 8.0. in 1 attempt, Tube

01 – DEMO HOSPITAL EMERGENCY RECORD

Forstater, Alan
DOB: 9/8/1957 M50
Wt/Ht:
MedRec:
AcctNum:

visualized through cords. Breath sounds equal after intubation, No complications, NGT placed, Ventilator settings: FIO2: 100%, Tidal Volume: 750 cc, PEEP: +5, RR: 16, End-tidal CO2 reading, Qualitative end tidal CO2 reading taken and confirms endotracheal intubation, Positive CO2 By Detector, Breath sounds heard bilaterally, no gurgling heard over epigastrium, Post intubation O2 saturation reading 100%, Chest x-ray completed and placement confirmed. Patient tolerated procedure well.

DIAGNOSIS (09:21 SRM)

DIFFERENTIAL: Based on history, exam and ancillary studies if indicated: **Impression: bowel obstruction,**
Impression: ischemic bowel.

PRESCRIPTION: No recorded prescriptions

NURSING ASSESSMENT: ABDOMEN (09:02 NK)

CONSTITUTIONAL: History obtained from patient. Patient is cooperative, alert and oriented x 3, Patient's skin is warm and dry, Patient arrives to treatment area ambulatory. Patient **with unsteady gait.**

ABDOMEN: Abdomen is soft to palpation, non-distended, No pulsatile masses noted to abdomen, **Abdominal pain is diffuse,** Pain described as **aching. Pain is continuous,** Vomiting: **Yellow,** Diarrhea: **Loose.**

GENITOURINARY MALE: No complaint of pain, No discharge, No urinary complaints.

NURSING PROCEDURE: IV (09:03 NK)

TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Indications for procedure: fluid replacement, IV established, 18 gauge catheter inserted, into left acromioclavicular, #1 site. in 1 attempt, 0.9NS 1 Liter hung, 1st bag hung, IV bolus of 1000 ml established, After bolus completed rate changed to 100 ml/hr, via primary tubing, via gravity tubing, Labs drawn at time of placement, Specimen labeled in the presence of the patient and sent to lab, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, IV line connections checked and properly labeled, Sterile dressing applied.

NURSING PROCEDURE: RESPIRATORY (09:04 NK)

TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, O2 AMT: 100%, Oxygen delivery device is: non-rebreather mask.

NURSING PROCEDURE: IV (09:06 NK)

TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Indications for procedure: medication administration, IV established, 20 gauge catheter inserted, into right hand, #2 site. in 1 attempt, 0.9NS 1 Liter hung, Rate change Infusing at KVO, via primary tubing, After procedure, no swelling noted at site, After procedure, no drainage noted at site, After procedure, no redness, Sterile dressing applied.

SAFETY: Side rails up, Cart in lowest position, Family at bedside.

NURSING PROCEDURE: INTUBATION (09:22 NK)

TIME: Patient's identity verified by, hospital ID bracelet, family member, Indications for procedure: unable to maintain airway, Indications for procedure: severe respiratory distress, Pre-intubation O2 Sat 94%, Oxsensor used: Adult/Pediatric, Pre-intubation O2 Amt: 100%, Oxygen delivery device is: non-rebreather mask. with 8.0 endotracheal tube.

MEDICATION SERVICE

Cipro: Order: Cipro (Ciprofloxacin) : 500 milligram(s) : IVPB
Ordered by: Shari Medina

01 – DEMO HOSPITAL EMERGENCY RECORD

Forstater, Alan
DOB: 9/8/1957 M50
Wt/Ht:
MedRec:
AcctNum:

Entered by: Shari Medina Fri Aug 08, 2008 09:04

Documented as given by: Lalowski, Rn Kristen Fri Aug 08, 2008 09:08

IV SITE #1 IVPB or drip, initial infusion, IVPB mixed in: 100ml, Fluid: 0.9NS, via secondary tubing, No swelling during administration, No drainage during administration, Allergies confirmed and medications reviewed prior to administration. (09:08 SRM)

: *Follow Up* : Medication infusion discontinued, at 0945. (09:10 NK)

DOPamine Hydrochloride: Order: DOPamine Hydrochloride (Dopamine Hydrochloride) : titrate to SBP 100 mcg/kg/min : Intravenous

Ordered by: Shari Medina

Entered by: Shari Medina Fri Aug 08, 2008 09:10

Documented as given by: Lalowski, Rn Kristen Fri Aug 08, 2008 09:21

IV SITE #1 IVPB or drip, initial infusion, via pump tubing. (09:21 SRM)

Gentamicin Sulfate, Injectable: Order: Gentamicin Sulfate, Injectable (Gentamicin Sulfate) : 120 milligram(s) : IVPB

Ordered by: Shari Medina

Entered by: Shari Medina Fri Aug 08, 2008 09:11

Documented as given by: Lalowski, Rn Kristen Fri Aug 08, 2008 09:11

IV SITE #1 IVPB or drip, initial infusion, via secondary tubing. (09:11 SRM)

: *Follow Up* : Medication infusion discontinued, at 0945. (09:13 NK)

Maxipime: Order: Maxipime (Cefepime Hydrochloride) : 1 gram(s) : IVPB
POTENTIAL ALLERGY INTERACTION: Penicillin V Potassium

Override Rationale: Benefits outweigh the risks for patient

Ordered by: Shari Medina

Entered by: Shari Medina Fri Aug 08, 2008 09:04

Documented as given by: Lalowski, Rn Kristen Fri Aug 08, 2008 09:08

IV SITE #2, IVPB or drip, initial infusion. Patient advised of actions and side-effects prior to administration,

Allergies confirmed and medications reviewed prior to administration. (09:08 SRM)

: *Follow Up* : Medication infusion discontinued, at 0950. (09:21 NK)

Metronidazole: Order: Metronidazole : 500 milligram(s) : IVPB

Ordered by: Shari Medina

Entered by: Shari Medina Fri Aug 08, 2008 09:10

Documented as given by: Lalowski, Rn Kristen Fri Aug 08, 2008 09:12

IV SITE #2, IVPB or drip. (09:12 SRM)

: *Follow Up* : Medication infusion discontinued, at 0930. (09:11 NK)

Key:

NK=Kristen, Lalowski, Rn SRM=Medina, Shari