

University Hall Hospital
Newly Accredited, State of the Art Care Facility

Welcome to today's class. You have been transported to a hospital room in which you and your fellow students will care for a HPS patient.

Description of Roles for this experience:

Assessment Nurse: Nurse responsible to assess the HPS patient.

Documentation Nurse: Nurse responsible to document everything the nurse team does for the HPS patient on the board.

Medication Nurse: Nurse responsible to give medications as needed.

Clinical Instructor: Assures patient safety while guiding the nurses to manage the HPS patient's care.

Audience/Observers: Those who are not directly at the bedside but remain in the "audience". The HPS patient cannot "hear" the audience but the nurses and clinical instructor can hear any suggestions or comments the Audience makes. When the nurses or clinical instructor speak to the audience, the patient cannot hear this, however the patient can hear when the nurses or clinical instructor talk to each other.

Scenario—It is 1300. You are the nurse on the ground floor medical unit in the newly accredited, state of the art, University Hall Hospital. It is your turn for admission. The emergency room has sent up the patient to room 122 Bed 1. He has been transferred to the floor bed where he awaits the nurse that is going to care for him. You have 30 minutes to assess him, obtain further information, orient him to the room, provide care, and comfort for the patient.

Report from the ER Nurse:

Mr. Coff N. Flem, a 68 year old retired short haul truck driver came to the ER via private car at 0500 with his wife of 41 years. He is being admitted with a COPD exacerbation and possible pneumonia. He is a full code. His wife told us that he has not been feeling well for the past 3 days and that his breathing became labored after going to the bathroom at about 3:30 AM. Mr. Flem refused to come to the hospital via squad so Mrs. Flem helped him into the car and brought him to University Hall Hospital. He has a history of smoking, hypertension, emphysema and diabetes controlled with diet. When he came to the emergency room, he preferred to sit in a tripod position and his oxygen saturation was 87%. He had wheezes and rhonchi scattered throughout his chest. He has a productive cough. ABG's were drawn then he was given a respiratory treatment of albuterol (Proventil) and ipratropium bromide (Atrovent) via hand held nebulizer (HHN) (@0515) and he was started on oxygen 2 liters via nasal cannula which improved his oxygen saturation to 90%. An intravenous (IV) has been started in his right hand with Normal Saline running at 100 ml/hr. His doctor had the hospitalist (Dr. G. M Breth) see him and orders have been written. The orders have been sent to pharmacy, he has received HHN (proventil and albuterol) at 0515 and 0930, solumedrol 60 mg IVP at 0700, Zinacef at 0825 and he was given a light breakfast after the RN gave him 2 units of regular insulin. His wife had to go home by 0830 as she provides daycare for 3 of their 7 grandchildren. He was held in the ER until the hospitalist had seen him and the bed on the unit became available. His most recent vital signs (1200) were BP 164/86, HR 100 and regular, RR 28, temp 38.2 C. Blood glucose at 1245 was 298 which was not covered since transportation was here to take him to his room.

Lab and Diagnostic Results:

Chest X-ray (0600) shows a density in his left lung field.

Electrocardiogram: No changes from old chart, Normal sinus rhythm with rare PVC's noted

Arterial blood gases (0512) pH 7.32 pCO₂ 51 pO₂ 67 HCO₃ 25.

Basic metabolic profile (BMP) (0530) Na 134, K 3.6, Glucose 178, BUN 28, Creatinine 1.2, osmolality 305, Cl 102

Complete blood count (CBC) (0530): RBC 5.9, hematocrit 54%, hemoglobin 19, WBC 13,000.

Urinalysis (UA) specific gravity (0600): 1.023, ketone: negative, protein: negative, glucose: trace, rest of U/A within normal limits

Sputum (C&S) culture and sensitivity (0900): results pending

University Hall Hospital
Medical Record

Patient Kardex Information

Patient: *Coff N. Flem* Age: 68 Date of Birth: 8/1/1940 Sex: M
Marital Status: *Married* Religion: HT. 5'10" WT. 68 kgs.
Diagnosis: *COPD exacerbation with possible pneumonia*
Code Status: *Full Code* Allergies: *NKDA*

Previous Medical History:

Smoker 1 pack/day since age 12 Pack Years: _____
HTN (22 years)
Emphysema and Asthma (9 years)
Type II diabetes controlled with diet (2 years)
Pneumonia in 2005, 2006

Home Medications:

Metoprolol tartrate (Lopressor) 50 mg twice a day
albuterol (Proventil or Ventolin) MDI 2 puffs four times a day
Triamcinolone acetonide (Azmacort) MDI 2 puffs four times a day
Furosemide (Lasix) 20 mg twice a day
Lisinopril (Prinivil) 20 mg daily

Social:

Emergency Contact: _____

Retired (age 62) short haul truck driver
Married with 4 children, and 7 grandchildren

Health Promotion:

Pneumovax: _____ Influenza: _____ Smoking Cessation Information _____

Other Information:

Nursing Plan of Care

University Hall Hospital
Medical Record

Physician Orders

Date: October 13, 2008

Time: 0935

Full admit to the ground floor medical unit with diagnosis: COPD exacerbation with possible pneumonia

IV: Normal Saline 0.9% at 125 ml/hr

Diet: No added salt, no concentrated sweets

Continuous pulse oximetry

Oxygen therapy 1.5-3 Liters per nasal cannula, keep oxygen sat \geq 90%

Cough and Deep Breath

Incentive Spirometry

Activity: BRP and Up to chair as tolerated

Diagnostic Tests and Labs:

Arterial blood gas if not completed in ER

Basic metabolic profile in AM

CBC with differential in AM

Sputum culture and sensitivity if not obtained in ER

Finger stick blood sugars before meals and at bedtime

Chest x-ray in AM

Medications:

metoprolol tartrate (Lopressor) 50 mg twice a day orally

levalbuterol hydrochloride (Xopenex) 1.25 mg/3 ml HFN every 8 hours.

furosemide (Lasix) 20 mg twice a day IVP

lisinopril (Prinivil) 20 mg daily orally

methylprednisolone sodium succinate (Solu-Medrol) 60 mg IVP every 6 hours

heparin sodium (Heparin) 5000 units subcutaneous every 12 hours

cefuroxime sodium (Zinacef) 750 mg every 8 hours IVPB

insulin regular (Humulin R) sliding scale subcutaneous before meals and bedtime

< 60 Give $\frac{1}{2}$ amp of 50% dextrose

60-150 No coverage

151-200 2 units

201-250 4 units

251-300 6 units

301-350 8 units

>350 Give 12 units and call MD

acetaminophen (Tylenol) 650 mg PO every 4-6 hours PRN for pain or temp > 101.

zolpidem (Ambien) 5 mg PO PRN as needed for sleep at bedtime

MD Signature: **GM Breth MD** 10/13/2008

0935

RN Signature:
Date and Time:

**University Hall Hospital
Medical Record
Medication Administration Record (MAR)**

Medication	Schedule	Documentation
10/13/2008 Normal Saline (0.9% NaCl) 1000 mL 125 mL/hr	2400	0515 hung 1000 mL / N. Nurse RN
	0800	
	1600	
10/13/2008 metoprolol tartrate (Lopressor) 50 mg twice a day orally	0900	
	2100	
10/13/2008 levalbuterol hydrochloride (Xopenex) 1.25 mg/3 ml nebulizer every 8 hours and PRN.	2400	0515 N. Nurse RN
	0800	0930 N. Nurse RN
	1600	
	PRN	
10/13/2008 furosemide (Lasix) 20 mg twice a day IVP	0900	
	1800	
10/13/2008 lisinopril (Prinivil) 20 mg daily orally	0900	
	2100	
10/13/2008 methylprednisolone sodium succinate (Solu-Medrol) 60 mg IVP every 6 hours	2400	XXXX
	0600	0700 N. Nurse RN
	1200	
	1800	
10/13/2008 heparin sodium (Heparin) 5000 units subcutaneous every 12 hours	0900	
	2100	
10/13/2008 cefuroxime sodium (Zinacef) 750 mg every 8 hours IVPB	2400	XXXX
	0800	0825 N. Nurse RN
	1600	
10/13/2008 insulin regular (Humulin R) sliding scale subcutaneous before meals and bedtime PRN Blood Glucose/Coverage < 60 Give ½ amp of D50W 60-150 No coverage 151-200 2 units 201-250 4 units 251-300 6 units 301-350 8 units >350 Give 12 units and call MD	0730	Blood glucose: 178 2 units RA N. Nurse RN @ 0825
	1130	Blood glucose: _____
	1630	Blood glucose: _____
	2100	Blood glucose: _____
PRN MEDICATIONS		
10/13/2008 acetaminophen (Tylenol) 650 mg PO every 4-6 hours PRN for pain or temp > 101.	PRN (4-6 hours as needed)	
10/13/2008 zolpidem (Ambien) 5 mg PO PRN as needed for sleep at bedtime	PRN (at hs as needed)	

