Flowsheets (all recorded) (continued)

Complex Assessment (continued) (continued)

Row Name	06/17/18 1708	06/17/18 1610	06/17/18 1540	06/17/18 1538	06/17/18 1535
Cardiac Regularity	—	—	—	Regular -RG	—
Cardiac Rhythm	—	—	—	Sinus bradycardia -RG	—
Cardiac Monitor					
Telemetry Monitor On	—	—	—	Yes -RG	—
Telemetry Box Number	—	—	—	5175 -RG	—
Peripheral Vascular					
RLE Edema	—	—	—	+2 -RG	—
LLE Edema	—	—	—	+2 -RG	—
Integumentary					
Skin Color	—	—	—	Pale -RG	—
Psychosocial					
Needs Expressed	—	—	—	Denies -RG	—
Provider Notification					
Reason for Communication	—	Critical lab value -KW	—	—	—
Lab Value	—	H&H 5.6/19 -KW	—	—	—
RBAC?	—	Yes -KW	—	—	—
Notification Time	—	1611 -KW	—	—	—
Provider Name	—	DR. KRUG -KW	—	—	—
Provider Role	—	Attending physician -KW	—	—	—
Method of Communication	—	Face to face -KW	—	—	—
Response	—	In department -KW	—	—	—

Row Name	06/17/18 1532	06/17/18 1502	06/17/18 1437
Oxygen Therapy			
SpO2	—	100 % -RG	98 % -NS
O2 Device	—	None (Room air) -RG	—
Pulse Oximetry Type	—	Continuous -RG	—
[REMOVED] Anesthesia Airway Nasal Cannula			
AN Airway Properties	Placement Date: 06/12/18 -AH Placement Time: 1253 -AH Airway Device: Nasal Cannula -AH Removal Date: 06/17/18 -RG, N/E		
[REMOVED] Urethral Catheter 16 Fr			
Urethral Catheter Properties	Placement Date: 01/16/18 -RD Placement Time: 2140 -RD Inserted by: Denmark, RN -RD Present on arrival to hospital?: No -RD Patient location at time of placement:: ER -RD Catheter Indicator: Acute urinary retention -RD Tube Size (Fr.): 16 Fr -RD Catheter Balloon Size: 10 mL -RD Catheter Secured: Yes -RD Urine Returned: Yes -RD Removal Date: 06/17/18 -RG, N/E		
Provider Notification			
Reason for Communication	Critical lab value -RG	—	—
Lab Value	POC TROP 0.09 AND BNP 2307 -RG	—	—
RBAC?	Yes -RG	—	—
Notification Time	1532 -RG	—	—
Provider Name	DR.KRUG -RG	—	—
Provider Role	Attending physician -RG	—	—
Method of Communication	Face to face -RG	—	—
Response	See orders -RG	—	—

Flowsheets (all recorded)

Blood Administration

Row Name	06/21/18 11:36:09	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07	06/20/18 19:43:22
Vitals					
BP	123/59 -DI (r) CI (t)	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)	124/53 -DI (r) TW (t)	113/55 -DI (r) TW (t)
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)	98.4 °F (36.9 °C) -DI (r) TW (t)	98.2 °F (36.8 °C) -DI (r) TW (t)
Temp src	Oral -CI	Oral -CI	Oral -TW	Oral -TW	Oral -TW
Pulse	60 -DI (r) CI (t)	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)	66 -DI (r) TW (t)
Resp	18 -CI	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)	16 -DI (r) TW (t)
Row Name	**06/20/18 15:50:04**	**06/20/18 14:02:02**	**06/20/18 1000**	**06/20/18 0909**	**06/20/18 0900**
Vitals					
BP	154/80 -DI (r) LF (t)	104/66 -DI (r) LF (t)	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG
Temp	98.3 °F (36.8 °C) -DI (r) LF (t)	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—	—
Pulse	62 -DI (r) LF (t)	61 -DI (r) LF (t)	61 -DG	59 -DG	60 -DG
Resp	17 -DI (r) LF (t)	—	18 -DG	—	17 -DG
Row Name	**06/20/18 0800**	**06/20/18 0730**	**06/20/18 0600**	**06/20/18 0500**	**06/20/18 0400**
Vitals					
BP	138/62 -DG	—	129/57 -EE	130/50 -EE	119/51 -EE
Temp	—	98.3 °F (36.8 °C) -HT	—	—	98 °F (36.7 °C) -JP
Temp src	—	Oral -HT	—	—	Oral -JP
Pulse	58 -DG	—	59 -EE	57 -EE	56 -EE
Resp	18 -DG	—	20 -EE	20 -EE	19 -EE
Row Name	**06/20/18 0300**	**06/20/18 0200**	**06/20/18 0000**	**06/19/18 2300**	**06/19/18 2200**
Vitals					
BP	122/58 -EE	(!) 111/47 -EE	—	128/56 -EE	132/51 -EE
Temp	—	—	97.5 °F (36.4 °C) -JP	—	—
Temp src	—	—	Axillary -JP	—	—
Pulse	57 -EE	64 -EE	59 -EE	61 -EE	62 -EE
Resp	21 -EE	16 -EE	22 -EE	21 -EE	22 -EE
Row Name	**06/19/18 2100**	**06/19/18 2000**	**06/19/18 1900**	**06/19/18 1800**	**06/19/18 1700**
Vitals					
BP	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI	132/52 -JI
Temp	—	98.4 °F (36.9 °C) -JP	—	—	—
Temp src	—	Oral -JP	—	—	—
Pulse	61 -EE	63 -EE	64 -EE	61 -JI	59 -JI
Resp	16 -EE	21 -EE	19 -EE	25 -JI	21 -JI
Row Name	**06/19/18 1644**	**06/19/18 1600**	**06/19/18 1500**	**06/19/18 1430**	**06/19/18 1428**
Vitals					
BP	—	134/58 -JI	130/51 -JI	142/60 -JI	—
Temp	97.9 °F (36.6 °C) -FT	—	—	—	97.7 °F (36.5 °C) -FT
Temp src	Oral -FT	—	—	—	Oral -FT
Pulse	—	58 -JI	56 -JI	57 -JI	—
Resp	—	20 -JI	22 -JI	19 -JI	—
Row Name	**06/19/18 1335**	**06/19/18 1330**	**06/19/18 1325**	**06/19/18 1321**	**06/19/18 1118**
Vitals					
BP	123/59 -LFA	128/55 -LFA	(!) 95/46 -LFA	110/53 -CR	—
Pulse	54 -LFA	54 -LFA	53 -LFA	53 -CR	—
Resp	22 -LFA	19 -LFA	21 -LFA	18 -CR	—
Blood Product Identifiers					
Blood Bank ID Number (from Wristband)	—	—	—	—	90803 -PM
Row Name	**06/19/18 1114**	**06/19/18 1000**	**06/19/18 0900**	**06/19/18 0808**	**06/19/18 0800**
Vitals					
BP	123/54 -PM	(!) 124/49 -JI	(!) 119/44 -JI	(!) 126/47 -JI	(!) 126/47 -JI
Temp	—	—	—	—	98.6 °F (37 °C) -DF
Temp src	—	—	—	—	Oral -DF
Pulse	51 -PM	50 -JI	51 -JI	55 -JI	56 -JI
Resp	13 -PM	20 -JI	18 -JI	—	18 -JI
Row Name	**06/19/18 0700**	**06/19/18 0600**	**06/19/18 0500**	**06/19/18 0400**	**06/19/18 0300**
Vitals					

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/19/18 0700	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300
BP	143/52 -JI	(!) 109/40 -RM	(!) 124/49 -RM	127/55 -RM	120/59 -RM
Temp	—	—	—	98.2 °F (36.8 °C) -MJ	—
Pulse	63 -JI	52 -RM	53 -RM	55 -RM	55 -RM
Resp	18 -JI	17 -RM	17 -RM	20 -RM	16 -RM

Row Name	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200
Vitals					
BP	113/50 -RM	(!) 109/44 -RM	(!) 123/43 -RM	127/59 -RM	—
Temp	—	—	98.1 °F (36.7 °C) -MJ	—	—
Pulse	54 -RM	53 -RM	56 -RM	59 -RM	55 -RM
Resp	19 -RM	19 -RM	21 -RM	20 -RM	21 -RM

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727
Vitals					
BP	—	—	—	132/60 -RM	—
Temp	—	98.4 °F (36.9 °C) -MJ	—	—	98.1 °F (36.7 °C) -JD
Temp src	—	—	—	—	Oral -JD
Pulse	56 -RM	56 -RM	56 -RM	56 -RM	—
Resp	21 -RM	22 -RM	22 -RM	20 -RM	—
SuspectedTransfusion Reaction					
Blood Specimen Collection	—	Unit -RM	—	—	—

Row Name	06/18/18 1600	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1230
Vitals					
BP	142/57 -JI	151/56 -JI	134/53 -JI	(!) 130/45 -JI	—
Temp	—	—	—	—	97.7 °F (36.5 °C) -JD
Temp src	—	—	—	—	Oral -JD
Pulse	52 -JI	54 -JI	58 -JI	57 -JI	—
Resp	20 -JI	18 -JI	19 -JI	15 -JI	—

Row Name	06/18/18 1200	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831
Vitals					
BP	140/56 -JI	(!) 128/46 -JI	131/52 -JI	137/54 -JI	—
Temp	—	—	—	—	97.8 °F (36.6 °C) -JD
Temp src	—	—	—	—	Oral -JD
Pulse	52 -JI	50 -JI	51 -JI	(!) 49 -JI	—
Resp	18 -JI	17 -JI	16 -JI	16 -JI	—

Row Name	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445
Vitals					
Pre, During, Post Vital Signs	—	—	1st HR -RM	15 min after start -RM	Pre-Transfusion -RM
BP	(!) 123/49 -JI	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM	120/52 -RM
Temp	—	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM
Temp src	—	—	Axillary -RM	—	Axillary -RM
Pulse	(!) 48 -JI	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM	(!) 47 -RM
Resp	17 -JI	17 -JI	13 -RM	18 -RM	18 -RM
Blood Product Identifiers					
Blood Bank ID Number (from Wristband)	—	—	—	—	90803 -RM
$ Blood Admin Charge					
$$ Blood Administration Charge $$	—	—	Unit complete -RM	—	—
TRANSFUSE RED BLOOD CELLS					
Transfusion Start Date	—	—	—	—	06/18/18 -RM
Rate	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -RM	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -RM
Completed Volume	—	—	500 -RM	—	—
Suspected Reaction?	—	—	No -RM	—	No -RM

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100
Vitals					
Pre, During, Post Vital Signs	Post Transfusion -RM	2nd HR -RM	1st HR -RM	15 min after start -RM	—
BP	117/50 -RM	(!) 109/43 -RM	(!) 102/39 -RM	—	123/51 -RM
Pulse	(!) 49 -RM	(!) 49 -RM	51 -RM	54 -RM	57 -RM
Resp	19 -RM	18 -RM	19 -RM	20 -RM	21 -RM
$ Blood Admin Charge					
$$ Blood Administration Charge $$	—	Unit complete -RM	—	—	—
TRANSFUSE RED BLOOD CELLS					
Rate	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -RM	—	—	—
Completed Volume	—	500 -RM	—	—	—
Suspected Reaction?	—	No -RM	—	—	—

Row Name	06/18/18 0051	06/18/18 0030	06/18/18 0000	06/17/18 2300	06/17/18 2225
Vitals					
Pre, During, Post Vital Signs	Pre-Transfusion -RM	—	—	—	—
BP	140/52 -RM	—	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF
Temp	98.1 °F (36.7 °C) -RM	—	—	—	98 °F (36.7 °C) -AF
Temp src	Oral -RM	—	—	—	Oral -AF
Pulse	57 -RM	—	55 -RM	54 -RM	53 -AF
Resp	20 -RM	—	20 -RM	17 -RM	18 -AF
Pre-Transfusion Documentation					
Previous Transfusion Reaction?	No -RM	—	—	—	—
Pre-Meds Given?	Yes -RM	—	—	—	—
Consent Obtained?	Yes -RM	—	—	—	—
Education Provided ?	Yes;Patient -RM	—	—	—	—
Blood Product Identifiers					
Blood Product Type	Red blood cells (packed cells) -RM	—	—	—	—
Special Requirements	Leukocyte reduced cells;Saline Washed Product -RM	—	—	—	—
Blood Bank ID Number (from Wristband)	90803 -RM	—	—	—	—
Patient Blood Type	O Pos -RM	—	—	—	—
Donor Blood Type	O Pos -RM	—	—	—	—
Expiration Date	07/20/18 -RM	—	—	—	—
Expiration Time	2359 -RM	—	—	—	—
TRANSFUSE RED BLOOD CELLS					
Transfusion Start Date	06/18/18 -RM	06/18/18 -RM	—	—	—
Rate	* There are multiple administrations at this time. Please see the MAR for detailed information. -RM	—	—	—	—
SuspectedTransfusion Reaction					
Blood Specimen Collection	—	—	Unit -RM	—	—

Row Name	06/17/18 2123	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1723
Vitals					
BP	—	134/59 -BR	126/55 -BR	132/56 -BR	—
Temp	—	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	—
Temp src	—	Oral -BR	Oral -BR	Oral -BR	—
Pulse	—	57 -BR	51 -BR	55 -BR	—
Resp	—	16 -BR	18 -BR	18 -BR	—

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/17/18 2123	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1723
Blood Product Identifiers					
Blood Bank ID Number (from Wristband)	—	—	—	—	r90803 -BR
TRANSFUSE RED BLOOD CELLS					
Rate	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -NI	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -BR
Line	—	—	—	—	[REMOVED] Peripheral IV 06/17/18 20 G Right Antecubital -BR

Row Name	06/17/18 1720	06/17/18 1708	06/17/18 1537	06/17/18 1502	06/17/18 1437
Vitals					
Pre, During, Post Vital Signs	Pre-Transfusion -BR	—	—	—	—
BP	129/53 -BR	(!) 115/49 -BR	114/51 -RG	112/52 -RG	—
Temp	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR	97.8 °F (36.6 °C) -RG	97.7 °F (36.5 °C) -RG	—
Temp src	Oral -BR	Oral -BR	—	Oral -RG	—
Pulse	55 -BR	55 -BR	55 -RG	54 -RG	56 -NS
Resp	18 -BR	18 -BR	22 -RG	25 -RG	—
Pre-Transfusion Documentation					
Previous Transfusion Reaction?	No -BR	—	—	—	—
Consent Obtained?	Yes -BR	—	—	—	—
Education Provided ?	Yes -BR	—	—	—	—
Blood Product Identifiers					
Blood Product Type	Red blood cells (packed cells) -BR	—	—	—	—
Special Requirements	None -BR	—	—	—	—
Blood Bank ID Number (from Wristband)	r90803 -BR	—	—	—	—
Patient Blood Type	O Pos -BR	—	—	—	—
Donor Blood Type	O Pos -BR	—	—	—	—
Expiration Date	07/20/18 -BR	—	—	—	—
Expiration Time	2359 -BR	—	—	—	—
TRANSFUSE RED BLOOD CELLS					
Transfusion Start Date	06/17/18 -BR	—	—	—	—
Completed Volume	350 -BR	—	—	—	—

Flowsheets (all recorded)

Intake/Output

Row Name	06/21/18 11:36:09	06/21/18 1000	06/21/18 0830	06/21/18 07:35:36	06/21/18 0545
Intake (mL)					
P.O.	—	240 mL -JK	—	—	—
Percent Meals Eaten (%)	—	100 % -JK	—	—	—
Simple Vitals					
Pulse	60 -DI (r) CI (t)	—	—	62 -DI (r) CI (t)	—
Resp	18 -CI	—	—	18 -CI	—
Numeric Pain Intensity Score 1	—	—	0 -AM	—	0 -TS

Row Name	06/21/18 04:07:21	06/20/18 23:57:07	06/20/18 2133	06/20/18 2000	06/20/18 19:43:22
Intake (mL)					
P.O.	0 mL -TW	0 mL -TW	—	—	0 mL -TW
Percent Meals Eaten (%)	0 % -TW	0 % -TW	—	—	0 % -TW
Snacks Eaten (%)	0 -TW	0 -TW	—	—	0 -TW
Supplement Consumed (%)	0 -TW	0 -TW	—	—	0 -TW
Simple Vitals					
Pulse	63 -DI (r) TW (t)	109 -DI (r) TW (t)	—	—	66 -DI (r) TW (t)
Resp	18 -DI (r) TW (t)	16 -DI (r) TW (t)	—	—	16 -DI (r) TW (t)
Numeric Pain Intensity Score 1	—	—	0 -TS	—	—
Urine Output					
Urine Occurrence	1 -TW	1 -TW	—	1 -TW	0 -TW
Stool Output					
Stool Occurrence	0 -TW	0 -TW	—	0 -TW	0 -TW
Stool Appearance	Unable to assess -TW	Unable to assess -TW	—	Unable to assess -TW	Unable to assess -TW
Emesis Output					
Emesis Occurrence	0 -TW	0 -TW	—	0 -TW	0 -TW

Row Name	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02	06/20/18 1000	06/20/18 0912
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB ADD-vantage					
Piggyback Dose	—	—	—	—	*4.5 g -DG
Simple Vitals					
Pulse	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)	61 -DG	—
Resp	17 -DI (r) LF (t)	—	—	18 -DG	—
Stool Output					
Bowel Incontinence	—	No -MS	—	—	—
Stool Amount	—	Unable to assess -MS	—	—	—
Stool Appearance	—	Unable to assess -MS	—	—	—
Stool Color	—	Unable to assess -MS	—	—	—

Row Name	06/20/18 0909	06/20/18 0900	06/20/18 0830	06/20/18 0800	06/20/18 0730
Simple Vitals					
Pulse	59 -DG	60 -DG	—	58 -DG	—
Resp	—	17 -DG	—	18 -DG	—
Numeric Pain Intensity Score 1	—	—	0 Simultaneous filing. User may be unaware of other data. -MS	—	2 -DG
Urine Output					
Urine	—	—	—	—	200 mL -HT
Stool Output					
Bowel Incontinence	—	—	—	No -DG	—

Row Name	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200
Simple Vitals					
Pulse	59 -EE	57 -EE	56 -EE	57 -EE	64 -EE
Resp	20 -EE	20 -EE	19 -EE	21 -EE	16 -EE
Urine Output					
Urine	—	350 mL -EE	— -EE	—	—

Row Name	06/20/18 0118	06/20/18 0000	06/19/18 2300	06/19/18 2200	06/19/18 2100

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	06/20/18 0118	06/20/18 0000	06/19/18 2300	06/19/18 2200	06/19/18 2100
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB ADD-vantage					
Piggyback Dose	*4.5 g 100 ml sodium chloride not available in Omnicel -EE	—	—	—	—
Simple Vitals					
Pulse	—	59 -EE	61 -EE	62 -EE	61 -EE
Resp	—	22 -EE	21 -EE	22 -EE	16 -EE

Row Name	06/19/18 2000	06/19/18 1900	06/19/18 1800	06/19/18 1700	06/19/18 1654
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB ADD-vantage					
Piggyback Dose	—	—	—	—	*4.5 g -JI
Simple Vitals					
Pulse	63 -EE	64 -EE	61 -JI	59 -JI	—
Resp	21 -EE	19 -EE	25 -JI	21 -JI	—
Numeric Pain Intensity Score 1	0 -EE	—	—	—	—
Urine Output					
Urine	400 mL -JP	—	—	—	—
Urine Occurrence	1 -EE	—	—	—	—
Bladder Status (use only for bladder training)	Continent -EE	—	—	—	—
Stool Output					
Bowel Incontinence	No -EE	—	—	—	—
Stool Amount	Unable to assess -EE	—	—	—	—
Stool Appearance	Unable to assess -EE	—	—	—	—
Stool Color	Unable to assess -EE	—	—	—	—

Row Name	06/19/18 1600	06/19/18 1500	06/19/18 1433	06/19/18 1430	06/19/18 1335
Simple Vitals					
Pulse	58 -JI	56 -JI	—	57 -JI	54 -LFA
Resp	20 -JI	22 -JI	—	19 -JI	22 -LFA
Numeric Pain Intensity Score 1	0 -JI	—	—	—	—
Urine Output					
Urine Occurrence	—	—	1 -JI	—	—

Row Name	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1311	06/19/18 1311
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -CM
Volume (mL)	—	—	—	200 mL -CM	—
Simple Vitals					
Pulse	54 -LFA	53 -LFA	53 -CR	—	—
Resp	19 -LFA	21 -LFA	18 -CR	—	—
Numeric Pain Intensity Score 1	—	—	0 -CR	—	—

Row Name	06/19/18 1303	06/19/18 1129	06/19/18 1114	06/19/18 1039	06/19/18 1037
sodium chloride 0.9% (NS) infusion					
Rate	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -PM	—	—	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Dose	—	—	—	*0 mL EGD. -JI	—
Simple Vitals					
Pulse	—	—	51 -PM	—	—
Resp	—	—	13 -PM	—	—
propofol					
propofol Bolus Dose	130 mg -CM	—	—	—	—

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	06/19/18 1303	06/19/18 1129	06/19/18 1114	06/19/18 1039	06/19/18 1037
(mg)					
propofol Rate	* There are multiple administrations at this time. Please see the MAR for detailed information. -CM	—	—	—	—
propofol Concentration	* There are multiple administrations at this time. Please see the MAR for detailed information. -CM	—	—	—	—
Urine Output					
Urine	—	—	—	—	300 mL -JI

Row Name	06/19/18 1000	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700
Simple Vitals					
Pulse	50 -JI	51 -JI	55 -JI	56 -JI	63 -JI
Resp	20 -JI	18 -JI	—	18 -JI	18 -JI
Numeric Pain Intensity Score 1	—	—	—	0 -JI	—
Urine Output					
Urine	—	450 mL -DF	—	—	—

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0445	06/19/18 0400	06/19/18 0300
Intake (mL)					
P.O.	—	—	—	250 mL -RM	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	—	*4.5 g -RM	—	—
Piggyback Volume (mL)	0 -RM	—	100 -RM	—	—
Simple Vitals					
Pulse	52 -RM	53 -RM	—	55 -RM	55 -RM
Resp	17 -RM	17 -RM	—	20 -RM	16 -RM
magnesium sulfate					
Latest MgSO4 serum level	—	—	2.3	—	—
pantoprazole					
pantoprazole Volume (mL)	200 mL -RM	—	—	—	—
Urine Output					
Urine	—	250 mL -RM	—	—	300 mL -RM
Bladder Status (use only for bladder training)	—	—	—	Continent -RM	—
Stool Output					
Bowel Incontinence	—	—	—	No -RM	—
Stool Amount	—	—	—	Unable to assess -RM	—
Stool Appearance	—	—	—	Unable to assess -RM	—
Stool Color	—	—	—	Unable to assess -RM	—

Row Name	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200
Simple Vitals					
Pulse	54 -RM	53 -RM	56 -RM	59 -RM	55 -RM
Resp	19 -RM	19 -RM	21 -RM	20 -RM	21 -RM
Urine Output					
Urine	—	—	200 mL -MJ	—	—
Bladder Status (use only for bladder training)	Continent -RM	—	Continent -RM	—	Continent -RM
Stool Output					
Bowel Incontinence	No -RM	—	No -RM	—	No -RM
Stool Amount	Unable to assess -RM	—	Unable to assess -RM	—	Unable to assess -RM
Stool Appearance	Unable to assess -RM	—	Unable to assess -RM	—	Unable to assess -RM
Stool Color	Unable to assess -RM	—	Unable to assess -RM	—	Unable to assess -RM

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1819	06/18/18 1804
Intake (mL)					
Percent Meals Eaten (%)	—	—	—	100 % Dinner. -JI	—
sodium chloride 0.9% (NS) infusion					
Volume (mL)	—	1400 mL -RM	—	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	—	—	—	*4.5 g -JI
Piggyback Volume (mL)	—	200 -RM	—	—	—
Simple Vitals					
Pulse	56 -RM	56 -RM	56 -RM	—	—
Resp	21 -RM	22 -RM	22 -RM	—	—
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	—	—
pantoprazole					
pantoprazole Volume (mL)	—	200 mL -RM	—	—	—
Urine Output					
Urine Occurrence	—	0 -RM	—	—	—
Bladder Status (use only for bladder training)	—	Continent -RM	—	—	—
Stool Output					
Stool Occurrence	—	0 -RM	—	—	—
Bowel Incontinence	—	No -RM	—	—	—
Stool Amount	—	Unable to assess -RM	—	—	—
Stool Appearance	—	Unable to assess -RM	—	—	—
Stool Color	—	Unable to assess -RM	—	—	—
Emesis Output					
Emesis Occurrence	—	0 -RM	—	—	—
Emesis Appearance	—	— na -RM	—	—	—

Row Name	06/18/18 1803	06/18/18 1800	06/18/18 1600	06/18/18 1500	06/18/18 1400
Intake (mL)					
Saline Flush (mL)	40 mL -JI	—	—	—	—
Simple Vitals					
Pulse	—	56 -RM	52 -JI	54 -JI	58 -JI
Resp	—	20 -RM	20 -JI	18 -JI	19 -JI
Numeric Pain Intensity Score 1	—	—	0 -JI	—	—

Row Name	06/18/18 1345	06/18/18 1303	06/18/18 1300	06/18/18 1247	06/18/18 1205
Intake (mL)					
Percent Meals Eaten (%)	—	95 % Lunch -JI	—	—	—
Saline Flush (mL)	—	—	—	20 mL -JI	—
Simple Vitals					
Pulse	—	—	57 -JI	—	—
Resp	—	—	15 -JI	—	—
Urine Output					
Urine Occurrence	1 -JI	—	—	—	1 -JI

Row Name	06/18/18 1200	06/18/18 1100	06/18/18 1000	06/18/18 0916	06/18/18 0907
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	—	—	—	*4.5 g -JI
Simple Vitals					
Pulse	52 -JI	50 -JI	51 -JI	—	—
Resp	18 -JI	17 -JI	16 -JI	—	—
Numeric Pain Intensity Score 1	0 -JI	—	—	—	—
Urine Output					
Urine	—	—	—	150 mL -JI	—

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	06/18/18 0900	06/18/18 0848	06/18/18 0800	06/18/18 0700	06/18/18 0640
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Dose	—	—	—	—	*250 mL -RM
Simple Vitals					
Pulse	(!) 49 -JI	—	(!) 48 -JI	(!) 46 -JI	—
Resp	16 -JI	—	17 -JI	17 -JI	—
Numeric Pain Intensity Score 1	—	—	0 -JI	—	—
Urine Output					
Urine	—	300 mL -JI	—	—	—

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400	06/18/18 0300
Weights					
Weight	104.9 kg (231 lb 4.2 oz) -RM	—	—	—	—
Weight Method	Actual -RM	—	—	—	—
sodium chloride 0.9% (NS) infusion					
Volume (mL)	495 mL -RM	—	—	—	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Volume (mL)	250 -RM	—	—	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	—	—	*4.5 g -RM	—
Piggyback Volume (mL)	0 -RM	100 -RM	—	—	—
Simple Vitals					
Pulse	(!) 46 -RM	(!) 47 -RM	(!) 47 -RM	(!) 49 -RM	(!) 49 -RM
Resp	13 -RM	18 -RM	18 -RM	19 -RM	18 -RM
Numeric Pain Intensity Score 1	0 -RM	0 -RM	—	0 -RM	0 -RM
pantoprazole					
pantoprazole Volume (mL)	20 mL -RM	100 mL -RM	—	—	—
Urine Output					
Urine	300 mL -RM	275 mL -RM	—	—	200 mL -RM
Urine Occurrence	—	0 -RM	—	—	—
Bladder Status (use only for bladder training)	—	Continent -RM	—	—	—
Stool Output					
Stool Occurrence	—	0 -RM	—	—	—
Bowel Incontinence	—	No -RM	—	—	—
Stool Amount	—	Unable to assess -RM	—	—	—
Stool Appearance	—	Unable to assess -RM	—	—	—
Stool Color	—	Unable to assess -RM	—	—	—
Emesis Output					
Emesis Occurrence	—	0 -RM	—	—	—
Emesis Appearance	—	— na -RM	—	—	—
TRANSFUSE RED BLOOD CELLS					
Completed Volume	—	—	—	—	500 -RM
TRANSFUSE RED BLOOD CELLS					
Completed Volume	500 -RM	—	—	—	—

Row Name	06/18/18 0200	06/18/18 0115	06/18/18 0103	06/18/18 0100	06/18/18 0051
sodium chloride 0.9% (NS) infusion					
Rate	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -RM	—	—
Simple Vitals					
Pulse	51 -RM	54 -RM	—	57 -RM	57 -RM
Resp	19 -RM	20 -RM	—	21 -RM	20 -RM

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	06/18/18 0200	06/18/18 0115	06/18/18 0103	06/18/18 0100	06/18/18 0051
Numeric Pain Intensity Score 1	0 -RM	—	—	0 -RM	—

Row Name	06/18/18 0030	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037
Weights					
Weight	—	—	—	103.4 kg (227 lb 15.3 oz) -AF	—
Weight Method	—	—	—	Actual -AF	—
BSA (Calculated - sq m)	—	—	—	2.21 sq meters -AF	—
sodium chloride 0.9% (NS) infusion					
Volume (mL)	—	0 mL -RM	—	—	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Volume (mL)	—	0 -RM	—	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Volume (mL)	—	0 -RM	—	—	—
Simple Vitals					
Pulse	—	55 -RM	54 -RM	53 -AF	57 -BR
Resp	—	20 -RM	17 -RM	18 -AF	16 -BR
Numeric Pain Intensity Score 1	—	0 -RM	0 -RM	0 -RM	0 -BR
magnesium sulfate					
Latest MgSO4 serum level	2.1	—	—	—	—
pantoprazole					
pantoprazole Volume (mL)	—	—	—	100 mL -RM	—
Urine Output					
Urine	—	300 mL -RM	—	—	—
Urine Occurrence	—	—	—	0 -RM	—
Bladder Status (use only for bladder training)	—	Continent -RM	—	Continent -RM	—
Stool Output					
Stool (mL)	—	0 mL -RM	—	—	—
Stool Occurrence	—	—	—	0 -RM	—
Bowel Incontinence	—	No -RM	—	No -RM	—
Stool Amount	—	Unable to assess -RM	—	Unable to assess -RM	—
Stool Appearance	—	Unable to assess -RM	—	Unable to assess -RM	—
Stool Color	—	Unable to assess -RM	—	Unable to assess -RM	—
Emesis Output					
Emesis	—	0 mL -RM	—	—	—
Emesis Occurrence	—	—	—	0 -RM	—
Emesis Appearance	—	— na -RM	—	— na -RM	—
Output					
Blood	—	0 mL -RM	—	—	—

Row Name	06/17/18 1859	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1718
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	—	—	—	*4.5 g -BR
vancomycin (VANCOCIN) 1,500 mg in NS 250 mL IVPB					
Piggyback Dose	*1500 mg -BR	—	—	—	—
Simple Vitals					
Pulse	—	51 -BR	55 -BR	55 -BR	—
Resp	—	18 -BR	18 -BR	18 -BR	—
Numeric Pain Intensity Score 1	—	0 -BR	—	—	—
TRANSFUSE RED BLOOD CELLS					
Completed Volume	—	—	—	350 -BR	—

Row Name	06/17/18 1708	06/17/18 1706	06/17/18 1537	06/17/18 1535	06/17/18 1533

Flowsheets (all recorded) (continued)

Intake/Output (continued)

Row Name	06/17/18 1708	06/17/18 1706	06/17/18 1537	06/17/18 1535	06/17/18 1533
Weights					
Weight	—	—	—	95.3 kg (210 lb) -RG	—
Weight Method	—	—	—	Stated -RG	—
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -RG
Simple Vitals					
Pulse	55 -BR	—	55 -RG	—	—
Resp	18 -BR	—	22 -RG	—	—
Numeric Pain Intensity Score 1	—	0 -BR	—	—	—

Row Name	06/17/18 1514	06/17/18 1504	06/17/18 1502	06/17/18 1437
Simple Vitals				
Pulse	—	—	54 -RG	56 -NS
Resp	—	—	25 -RG	—
Numeric Pain Intensity Score 1	—	0 -RG	—	—
magnesium sulfate				
Latest MgSO4 serum level	2.3	—	—	—

[REMOVED] Urethral Catheter 16 Fr

Urethral Catheter Properties	Placement Date: 01/16/18 -RD Placement Time: 2140 -RD Inserted by: Denmark, RN -RD Present on arrival to hospital?: No -RD Patient location at time of placement:: ER -RD Catheter Indicator: Acute urinary retention -RD Tube Size (Fr.): 16 Fr -RD Catheter Balloon Size: 10 mL -RD Catheter Secured: Yes -RD Urine Returned: Yes -RD Removal Date: 06/17/18 -RG, N/E

[REMOVED] Anesthesia Airway Nasal Cannula

AN Airway Properties	Placement Date: 06/12/18 -AH Placement Time: 1253 -AH Airway Device: Nasal Cannula -AH Removal Date: 06/17/18 -RG, N/E

Flowsheets (all recorded)

IV Assessment

Row Name	06/20/18 2300	06/20/18 1400	06/20/18 1200	06/20/18 0800	06/20/18 0400
[REMOVED] Peripheral IV 06/17/18 20 G Left Hand					
IV Properties	Placement Date: 06/17/18 -CD Placement Time: 1640 -CD Type of Catheter: Straight -CD Size (Gauge): 20 G -CD Orientation: Left -CD Location: Hand -CD Removal Date: 06/21/18 -AM Removal Time: 1300 -AM Catheter Intact on removal?: Yes -AM Removal Reason : Patient discharged -AM				
Site Assessment	Clean;Dry;Intact -TS	Clean;Dry;Intact -MS	—	Clean;Dry;Intact -DG	Clean;Dry;Intact -EE
Phlebitis Scale	0 -TS	0 -MS	—	0 -DG	—
Infiltration/Extravasation Scale	0 -TS	0 -MS	—	0 -DG	—
Line Assessment	Saline locked -TS	Patent;Saline locked -MS	—	Blood return noted;Patent;Saline locked -DG	—
Dressing Assesment	—	Clean;Dry;Intact -MS	—	Clean;Dry;Intact -DG	—
IV Interventions	—	Flushed -MS	—	Flushed -DG	—
IV Additional Comments	—	—	unchanged -DG	—	No changes -EE

Row Name	06/20/18 0000	06/19/18 2000	06/19/18 0800	06/19/18 0400	06/19/18 0000
Dominant Hand					
Which is your dominant hand?	—	—	Right -JI	—	—
[REMOVED] Peripheral IV 06/17/18 20 G Left Hand					
IV Properties	Placement Date: 06/17/18 -CD Placement Time: 1640 -CD Type of Catheter: Straight -CD Size (Gauge): 20 G -CD Orientation: Left -CD Location: Hand -CD Removal Date: 06/21/18 -AM Removal Time: 1300 -AM Catheter Intact on removal?: Yes -AM Removal Reason : Patient discharged -AM				
Site Assessment	Clean;Dry;Intact -EE	Clean;Dry;Intact -EE	Clean;Dry;Intact -JI	—	—
Phlebitis Scale	—	0 -EE	0 -JI	—	—
Infiltration/Extravasation Scale	—	0 -EE	0 -JI	—	—
Line Assessment	—	Blood return noted -EE	Blood return noted;Infusing -JI	—	—
Dressing Assesment	—	Clean;Dry;Intact -EE	Clean;Dry;Intact -JI	—	—
IV Interventions	—	Flushed -EE	Flushed -JI	—	—
IV Additional Comments	No changes -EE	—	—	assessment unchanged -RM	assessment unchanged -RM

Row Name	06/18/18 2000	06/18/18 1345	06/18/18 0800	06/18/18 0400	06/18/18 0000
Blood Specimen Collection Status					
Blood Specimen Collection	Unit -RM	—	—	—	Unit -RM
Dominant Hand					
Which is your dominant hand?	Right -RM	—	Right -JI	—	Right -RM
[REMOVED] Peripheral IV 06/17/18 20 G Right Antecubital					
IV Properties	Placement Date: 06/17/18 -RG Placement Time: 1510 -RG Present on arrival to hospital?: No -RG Type of Catheter: Straight -RG Size (Gauge): 20 G -RG Orientation: Right -RG Location: Antecubital -RG Site Prep: Chlorhexidine ;Alcohol -RG Inserted by: RGT -RG Removal Date: 06/18/18 -JI Removal Time: 1345 -JI Catheter Intact on removal?: Yes -JI Removal Reason : Other (Comment) -JI Remaining intact at discharge?: Yes -JI				
Site Assessment	—	Clean;Dry;Intact -JI	Clean;Dry;Intact -JI	—	Clean;Dry;Intact -RM
Phlebitis Scale	—	0 -JI	0 -JI	—	0 -RM
Infiltration/Extravasation Scale	—	0 -JI	0 -JI	—	0 -RM
Line Assessment	—	Blood return noted;Patent;Saline locked -JI	Blood return noted;Infusing -JI	—	Blood return noted;Infusing;Patent -RM
Dressing Interventions	—	—	—	—	Dressing reinforced -RM
IV Interventions	—	—	Flushed -JI	—	Flushed -RM
IV Additional Comments	—	— Accidently pulled out. -JI	—	assessment uncahnged -RM	—
[REMOVED] Peripheral IV 06/17/18 20 G Left Hand					
IV Properties	Placement Date: 06/17/18 -CD Placement Time: 1640 -CD Type of Catheter: Straight -CD Size (Gauge): 20 G -CD Orientation: Left -CD Location: Hand -CD Removal Date: 06/21/18 -AM Removal Time: 1300 -AM Catheter Intact on removal?: Yes -AM Removal Reason : Patient discharged -AM				
Site Assessment	Clean;Intact;Dry -RM	—	Clean;Dry;Intact -JI	—	Clean;Dry;Intact -RM
Phlebitis Scale	0 -RM	—	0 -JI	—	0 -RM
Infiltration/Extravasation Scale	0 -RM	—	0 -JI	—	0 -RM
Line Assessment	Blood return	—	Blood return	—	Blood return

Flowsheets (all recorded) (continued)

IV Assessment (continued)

Row Name	06/18/18 2000	06/18/18 1345	06/18/18 0800	06/18/18 0400	06/18/18 0000
	noted;Infusing -RM		noted;Infusing -JI		noted;Infusing;Patent -RM
Dressing Assesment	Clean;Dry;Intact -RM	—	Clean;Dry;Intact -JI	—	Clean;Dry;Intact -RM
Dressing Interventions	—	—	—	—	Dressing reinforced -RM
IV Interventions	Flushed -RM	—	Flushed -JI	—	Flushed -RM
IV Additional Comments	—	—	—	assessment unchanged -RM	—

[REMOVED] Peripheral IV 06/12/18 20 G Right Hand

IV Properties	Placement Date: 06/12/18 -MD Placement Time: 1200 -MD Present on arrival to hospital?: No -MD Type of Catheter: Straight -MD Size (Gauge): 20 G -MD Orientation: Right -MD Location: Hand -MD Site Prep: Chlorhexidine -MD Insertion attempts: 1 -MD Successful IV Attempt?: Yes -MD Patient Tolerance: Tolerated well -MD IV Access Problem: No -MD Removal Date: 06/17/18 -RG, N/E

Flowsheets (all recorded)

Assessment

Row Name	06/21/18 11:36:09	06/21/18 1000	06/21/18 0830	06/21/18 0800	06/21/18 07:35:36
Neurological					
Level of Consciousness	—	—	Alert -AM	—	—
Neuro (WDL)	—	—	WDL -AM	—	—
Respiratory					
Respiratory Pattern	—	—	Regular -AM	—	—
Bilateral Breath Sounds	—	—	Clear -AM	—	—
Respiratory (WDL)	—	—	WDL -AM	—	—
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	—	—	95 % -DI (r) CI (t)
O2 Device	None (Room air) -CI	—	None (Room air) -AM	—	None (Room air) -CI
Incentive Spirometer					
Is pt using incentive spirometer?	—	Yes, independent -JK	—	Yes, independent -CI	—
Cardiac					
Cardiac (WDL)	—	—	WDL -AM	—	—
Cardiac					
Telemetry Monitor On	—	—	—	Other (Comment) dc -CI	—
Telemetry Audible	—	—	—	No -CI	—
Telemetry Alarms Set	—	—	—	— -CI	—
Telemetry Box Number	—	—	—	— -CI	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	X -AM	—	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -AM	—	—
LLE Capillary Refill	—	—	Less than/equal to 3 seconds -AM	—	—
Edema	—	—	Left lower extremity;Right lower extremity -AM	—	—
RLE Edema	—	—	+2 -AM	—	—
LLE Edema	—	—	+2 -AM	—	—
RUE Neurovascular Assessment					
R Radial Pulse	—	—	+2 -AM	—	—
LUE Neurovascular Assessment					
L Radial Pulse	—	—	+2 -AM	—	—
RLE Neurovascular Assessment					
RLE Color	—	—	Appropriate for ethnicity -AM	—	—
RLE Temperature/Moisture	—	—	Warm -AM	—	—
RLE Sensation	—	—	Present -AM	—	—
R Pedal Pulse	—	—	+2 -AM	—	—
LLE Neurovascular Assessment					
LLE Color	—	—	Appropriate for ethnicity -AM	—	—
LLE Temperature/Moisture	—	—	Warm -AM	—	—
LLE Sensation	—	—	Present -AM	—	—
L Pedal Pulse	—	—	+2 -AM	—	—
Integumentary					
Integumentary (WDL)	—	—	WDL -AM	—	—
Braden Scale					
Sensory Perceptions	—	—	4 -AM	—	—
Moisture	—	—	4 -AM	—	—
Activity	—	—	3 -AM	—	—
Mobility	—	—	4 -AM	—	—
Nutrition	—	—	3 -AM	—	—
Friction and Shear	—	—	3 -AM	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/21/18 11:36:09	06/21/18 1000	06/21/18 0830	06/21/18 0800	06/21/18 07:35:36
Braden Scale Score	—	—	21 -AM	—	—
Musculoskeletal					
Musculoskeletal (WDL)	—	—	WDL -AM	—	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	0 -AM	—	—
Mobility	—	—	0 -AM	—	—
Medications	—	—	1 -AM	—	—
Mental Status/LOC/Awareness	—	—	0 -AM	—	—
Toileting Needs	—	—	0 -AM	—	—
Volume/Electrolyte Status	—	—	0 -AM	—	—
Communication/Sensory	—	—	1 -AM	—	—
Behavior	—	—	0 -AM	—	—
Hester Davis Fall Risk Total	—	—	5 -AM	—	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	1 -AM	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	WDL -AM	—	—
Abdomen Inspection	—	—	Soft;Rounded -AM	—	—
Bowel Sounds (All Quadrants)	—	—	Active -AM	—	—
Genitourinary					
Genitourinary (WDL)	—	—	WDL -AM	—	—
Urinary Source	—	—	Voiding -AM	—	—
Psychosocial					
Psychosocial (WDL)	—	—	WDL -AM	—	—
Charting Type					
Charting Type	—	—	Shift assessment -AM	—	—

Row Name	06/21/18 0545	06/21/18 04:07:21	06/20/18 23:57:07	06/20/18 2133	06/20/18 2000
Neurological					
Level of Consciousness	—	—	—	Alert -TS	—
Neuro (WDL)	—	—	—	WDL -TS	—
CAM Delirium Assessment					
Feature 1: Acute Onset of Fluctuating Course	—	—	—	Negative -TS	—
CAM Delirium Assessment	—	—	—	Negative -TS	—
HEENT					
HEENT (WDL)	—	—	—	X -TS	—
R Eye	—	—	—	Impaired vision -TS	—
L Eye	—	—	—	Impaired vision -TS	—
Nose	—	—	—	Intact;Other (Comment) scant bloody mucus when blowing nose -TS	—
Teeth	—	—	—	Missing teeth -TS	—
Respiratory					
Respiratory Pattern	—	—	—	Regular -TS	—
Chest Assessment	—	—	—	Chest expansion symmetrical -TS	—
Bilateral Breath Sounds	—	—	—	Clear;Diminished -TS	—
Respiratory (WDL)	—	—	—	X -TS	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/21/18 0545	06/21/18 04:07:21	06/20/18 23:57:07	06/20/18 2133	06/20/18 2000
O2 Device	—	None (Room air) -TW	None (Room air) -TW	None (Room air) -TS	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	Yes, independent -TW	Yes, independent -TW	Yes (independent) -TS	—
Cardiac					
Cardiac (WDL)	—	—	—	WDL -TS	—
Heart Sounds	—	—	—	S1, S2 -TS	—
Cardiac Symptoms	—	—	—	None -TS	—
Cardiac					
Telemetry Monitor On	—	Yes -TW	Yes -TW	Yes -TS	—
Telemetry Audible	—	Yes -TW	Yes -TW	Yes -TS	—
Telemetry Alarms Set	—	Yes -TW	Yes -TW	Yes -TS	—
Telemetry Box Number	—	5208 -TW	5208 -TW	5208 -TS	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	—	X -TS	—
Cyanosis	—	—	—	None -TS	—
Capillary Refill	—	—	—	Less than/equal to 2 seconds (All extremities) -TS	—
RUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
LUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
RLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
LLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
Pulses	—	—	—	R pedal;L pedal;R radial;L radial -TS	—
Edema	—	—	—	Right lower extremity;Left lower extremity -TS	—
RLE Edema	—	—	—	+2 -TS	—
LLE Edema	—	—	—	+2 -TS	—
RUE Neurovascular Assessment					
RUE Color	—	—	—	Appropriate for ethnicity -TS	—
RUE Temperature/Moisture	—	—	—	Warm;Dry -TS	—
RUE Sensation	—	—	—	Present -TS	—
R Radial Pulse	—	—	—	+2 -TS	—
LUE Neurovascular Assessment					
LUE Color	—	—	—	Appropriate for ethnicity -TS	—
LUE Temperature/Moisture	—	—	—	Warm;Dry -TS	—
LUE Sensation	—	—	—	Present -TS	—
L Radial Pulse	—	—	—	+2 -TS	—
RLE Neurovascular Assessment					
RLE Color	—	—	—	Appropriate for ethnicity -TS	—
RLE Temperature/Moisture	—	—	—	Warm;Dry -TS	—
RLE Sensation	—	—	—	Present -TS	—
R Pedal Pulse	—	—	—	+2 -TS	—
LLE Neurovascular Assessment					
LLE Color	—	—	—	Appropriate for ethnicity -TS	—
LLE Temperature/Moisture	—	—	—	Warm;Dry -TS	—
LLE Sensation	—	—	—	Present -TS	—
L Pedal Pulse	—	—	—	+2 -TS	—
Integumentary					

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/21/18 0545	06/21/18 04:07:21	06/20/18 23:57:07	06/20/18 2133	06/20/18 2000
Integumentary (WDL)	—	—	—	X -TS	—
Skin Color	—	—	—	Appropriate for ethnicity -TS	—
Skin Condition/Temp	—	—	—	Dry;Warm -TS	—
Skin Integrity	—	—	—	Bruising -TS	—
Skin Location	—	—	—	BUE -TS	—
Skin Turgor	—	—	—	Non-tenting -TS	—
Braden Scale					
Sensory Perceptions	—	—	—	4 -TS	—
Moisture	—	—	—	4 -TS	—
Activity	—	—	—	3 -TS	—
Mobility	—	—	—	4 -TS	—
Nutrition	—	—	—	3 -TS	—
Friction and Shear	—	—	—	3 -TS	—
Braden Scale Score	—	—	—	21 -TS	—
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	WDL -TS	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	—	0 -TS	—
Mobility	—	—	—	0 -TS	—
Medications	—	—	—	1 -TS	—
Mental Status/LOC/Awareness	—	—	—	0 -TS	—
Toileting Needs	—	—	—	0 -TS	—
Volume/Electrolyte Status	—	—	—	0 -TS	—
Communication/Sensory	—	—	—	1 -TS	—
Behavior	—	—	—	0 -TS	—
Hester Davis Fall Risk Total	—	—	—	5 -TS	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	0 -TS	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	WDL -TS	—
Abdomen Inspection	—	—	—	Rounded -TS	—
Bowel Sounds (All Quadrants)	—	—	—	Active -TS	—
Stool Assessment					
Stool Appearance	—	Unable to assess -TW	Unable to assess -TW	—	Unable to assess -TW
Genitourinary					
Genitourinary (WDL)	—	—	—	WDL -TS	—
Urinary Source	—	—	—	Voiding -TS	—
Psychosocial					
Psychosocial (WDL)	—	—	—	WDL -TS	—
Needs Expressed	—	—	—	Denies -TS	—
Ability to Express Feelings	—	—	—	Able to express -TS	—
Ability to Express Needs	—	—	—	Able to express -TS	—
Ability to Express Thoughts	—	—	—	Able to express -TS	—
Charting Type					
Charting Type	Reassessment unchanged -TS	—	—	Shift assessment -TS	—

Row Name	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02	06/20/18 1200
Neurological					
Level of Consciousness	—	—	Alert -MS	—	—
Neuro (WDL)	—	—	WDL -MS	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02	06/20/18 1200
HEENT					
HEENT (WDL)	—	—	X -MS	—	—
R Eye	—	—	Impaired vision -MS	—	—
L Eye	—	—	Impaired vision -MS	—	—
Nose	—	—	Intact -MS	—	—
Respiratory					
Respiratory Pattern	—	—	Regular -MS	—	—
Chest Assessment	—	—	Chest expansion symmetrical -MS	—	—
Bilateral Breath Sounds	—	—	Clear;Diminished -MS	—	—
R Breath Sounds	—	—	Clear -MS	—	—
L Breath Sounds	—	—	Diminished -MS	—	—
Respiratory (WDL)	—	—	X -MS	—	—
Cough	—	—	None -MS	—	—
Oxygen Therapy					
SpO2	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)	—
O2 Device	None (Room air) -TW	—	None (Room air) -MS	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	Yes, independent -TW	—	—	—	—
Cardiac					
Cardiac (WDL)	—	—	WDL -MS	—	—
Heart Sounds	—	—	S1, S2 -MS	—	—
Cardiac Symptoms	—	—	None -MS	—	—
Cardiac					
Telemetry Monitor On	Yes -TW	—	—	—	—
Telemetry Audible	Yes -TW	—	—	—	—
Telemetry Alarms Set	Yes -TW	—	—	—	—
Telemetry Box Number	5208 -TW	—	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	X -MS	—	—
Cyanosis	—	—	None -MS	—	—
Capillary Refill	—	—	Less than/equal to 2 seconds (All extremities) -MS	—	—
RUE Capillary Refill	—	—	Less than/equal to 3 seconds -MS	—	—
LUE Capillary Refill	—	—	Less than/equal to 3 seconds -MS	—	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -MS	—	—
LLE Capillary Refill	—	—	Less than/equal to 3 seconds -MS	—	—
Pulses	—	—	R radial;L radial;R pedal;L pedal -MS	—	—
Edema	—	—	Right lower extremity;Left lower extremity -MS	—	—
RLE Edema	—	—	+2 -MS	—	—
LLE Edema	—	—	+2 -MS	—	—
RUE Neurovascular Assessment					
RUE Color	—	—	Appropriate for ethnicity -MS	—	—
RUE Temperature/Moisture	—	—	Warm;Dry -MS	—	—
RUE Sensation	—	—	Present -MS	—	—
R Radial Pulse	—	—	+2 -MS	—	—
LUE Neurovascular Assessment					
LUE Color	—	—	Appropriate for ethnicity -MS	—	—
LUE Temperature/Moisture	—	—	Warm;Dry -MS	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02	06/20/18 1200
LUE Sensation	—	—	Present -MS	—	—
L Radial Pulse	—	—	+2 -MS	—	—
RLE Neurovascular Assessment					
RLE Color	—	—	Appropriate for ethnicity -MS	—	—
RLE Temperature/Moisture	—	—	Warm;Dry -MS	—	—
RLE Sensation	—	—	Present -MS	—	—
R Pedal Pulse	—	—	+2 -MS	—	—
LLE Neurovascular Assessment					
LLE Color	—	—	Appropriate for ethnicity -MS	—	—
LLE Temperature/Moisture	—	—	Warm;Dry -MS	—	—
LLE Sensation	—	—	Present -MS	—	—
L Pedal Pulse	—	—	+2 -MS	—	—
Integumentary					
Integumentary (WDL)	—	—	X -MS	—	—
Skin Color	—	—	Appropriate for ethnicity -MS	—	—
Skin Condition/Temp	—	—	Dry;Warm -MS	—	—
Skin Integrity	—	—	Bruising -MS	—	—
Skin Location	—	—	BUE -MS	—	—
Skin Turgor	—	—	Non-tenting -MS	—	—
Musculoskeletal					
Musculoskeletal (WDL)	—	—	WDL -MS	—	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	WDL -MS	—	—
Abdomen Inspection	—	—	Rounded -MS	—	—
Tenderness	—	—	Soft;No guarding;Nontender -MS	—	—
Last BM Date	—	—	06/19/18 -MS	—	—
Passing Flatus	—	—	Yes -MS	—	—
GI Symptoms	—	—	None -MS	—	—
Stool Assessment					
Bowel Incontinence	—	—	No -MS	—	—
Stool Appearance	Unable to assess -TW	—	Unable to assess -MS	—	—
Stool Color	—	—	Unable to assess -MS	—	—
Stool Amount	—	—	Unable to assess -MS	—	—
Genitourinary					
Genitourinary (WDL)	—	—	WDL -MS	—	—
Urinary Source	—	—	Voiding -MS	—	—
Psychosocial					
Psychosocial (WDL)	—	—	WDL -MS	—	—
Needs Expressed	—	—	Denies -MS	—	—
Ability to Express Feelings	—	—	Able to express -MS	—	—
Ability to Express Needs	—	—	Able to express -MS	—	—
Ability to Express Thoughts	—	—	Able to express -MS	—	—
Charting Type					
Charting Type	—	—	Shift assessment -MS	—	Reassessment no changes -DG

Row Name	06/20/18 1027	06/20/18 1000	06/20/18 0900	06/20/18 0800	06/20/18 0600
Neurological					
Level of Consciousness	—	—	—	Alert -DG	—
HEENT					
HEENT (WDL)	—	—	—	X -DG	—
Head and Face	—	—	—	Symmetrical -DG	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/20/18 1027	06/20/18 1000	06/20/18 0900	06/20/18 0800	06/20/18 0600
R Eye	—	—	—	Impaired vision -DG	—
L Eye	—	—	—	Impaired vision -DG	—
Nose	—	—	—	Other (Comment) intermittent nose bleed (minimal) -DG	—
Teeth	—	—	—	Missing teeth -DG	—
Respiratory					
Respiratory Pattern	—	—	—	Regular -DG	—
Chest Assessment	—	—	—	Chest expansion symmetrical -DG	—
Bilateral Breath Sounds	—	—	—	Diminished -DG	—
Respiratory Interventions					
Respiratory Interventions	—	—	—	Cough and deep breathe -DG	—
Cough and Deep Breathe					
Cough and Deep Breathe	—	—	—	Yes -DG	—
Oxygen Therapy					
SpO2	—	(!) 88 % -DG	(!) 87 % -DG	(!) 88 % -DG	93 % -EE
O2 Device	—	—	—	None (Room air) -DG	—
Pulse Oximetry Type	—	—	—	Continuous -DG	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	Yes (independent) -DG	—
Incentive Spirometry Tx					
Respiratory Effort	—	—	—	Good -DG	—
Treatment Tolerance	—	—	—	Tolerated well -DG	—
Cardiac					
Heart Sounds	—	—	—	S1, S2 -DG	—
Cardiac Symptoms	—	—	—	None -DG	—
Cardiac					
Cardiac Regularity	—	—	—	Irregular -DG	—
Bedside Cardiac Monitor On	—	—	—	Yes -DG	—
Bedside Cardiac Audible	—	—	—	Yes -DG	—
Bedside Cardiac Alarms Set	—	—	—	Yes -DG	—
Telemetry Monitor On	—	—	—	No -DG	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	—	X -DG	—
Cyanosis	—	—	—	None -DG	—
Capillary Refill	—	—	—	Less than/equal to 2 seconds (All extremities) -DG	—
RUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -DG	—
LUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -DG	—
RLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -DG	—
LLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -DG	—
Pulses	—	—	—	R radial;L radial;R pedal;L pedal -DG	—
Edema	—	—	—	Right lower extremity;Left lower extremity -DG	—
RLE Edema	—	—	—	+2 -DG	—
LLE Edema	—	—	—	+2 -DG	—
RUE Neurovascular Assessment					
RUE Color	—	—	—	Ashen -DG	—
RUE	—	—	—	Warm;Dry -DG	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/20/18 1027	06/20/18 1000	06/20/18 0900	06/20/18 0800	06/20/18 0600
Temperature/Moisture					
RUE Sensation	—	—	—	Present -DG	—
R Radial Pulse	—	—	—	+2 -DG	—
LUE Neurovascular Assessment					
LUE Color	—	—	—	Appropriate for ethnicity -DG	—
LUE Temperature/Moisture	—	—	—	Warm;Dry -DG	—
LUE Sensation	—	—	—	Present -DG	—
L Radial Pulse	—	—	—	+2 -DG	—
RLE Neurovascular Assessment					
RLE Color	—	—	—	Appropriate for ethnicity -DG	—
RLE Temperature/Moisture	—	—	—	Warm;Dry -DG	—
RLE Sensation	—	—	—	Present -DG	—
R Pedal Pulse	—	—	—	+1 -DG	—
LLE Neurovascular Assessment					
LLE Color	—	—	—	Appropriate for ethnicity -DG	—
LLE Temperature/Moisture	—	—	—	Warm;Dry -DG	—
LLE Sensation	—	—	—	Present -DG	—
L Pedal Pulse	—	—	—	+1 -DG	—
Integumentary					
Integumentary (WDL)	—	—	—	X -DG	—
Skin Color	—	—	—	Appropriate for ethnicity -DG	—
Skin Integrity	—	—	—	Bruising -DG	—
Skin Location	—	—	—	BUE -DG	—
Braden Scale					
Sensory Perceptions	—	—	—	4 -DG	—
Moisture	—	—	—	4 -DG	—
Activity	—	—	—	3 -DG	—
Mobility	—	—	—	4 -DG	—
Nutrition	—	—	—	3 -DG	—
Friction and Shear	—	—	—	3 -DG	—
Braden Scale Score	—	—	—	21 -DG	—
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	WDL -DG	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	—	0 -DG	—
Mobility	—	—	—	0 -DG	—
Medications	—	—	—	1;3 -DG	—
Mental Status/LOC/Awareness	—	—	—	0 -DG	—
Toileting Needs	—	—	—	0 -DG	—
Volume/Electrolyte Status	—	—	—	0 -DG	—
Communication/Sensory	—	—	—	1 -DG	—
Behavior	—	—	—	0 -DG	—
Hester Davis Fall Risk Total	—	—	—	8 -DG	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	0 -DG	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	WDL -DG	—
Stool Assessment					
Bowel Incontinence	—	—	—	No -DG	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/20/18 1027	06/20/18 1000	06/20/18 0900	06/20/18 0800	06/20/18 0600
Genitourinary					
Genitourinary (WDL)	—	—	—	WDL -DG	—
Psychosocial					
Psychosocial (WDL)	—	—	—	WDL -DG	—
Provider Notification					
Reason for Communication	Consult called -DG	—	—	—	—
Notification Time	1028 -DG	—	—	—	—
Provider Name	Whatley -DG	—	—	—	—
Provider Role	Consulting physician -DG	—	—	—	—
Method of Communication	Perfect Serve -DG	—	—	—	—
Response	Other (Comment) consulted by Dhaval G Patel, MD -DG	—	—	—	—
Charting Type					
Charting Type	—	—	—	Shift assessment -DG	—
Cardiac					
Cardiac Rhythm	—	—	—	Normal sinus rhythm -DG	—
Ectopy	—	—	—	Premature ventricular contractions -DG	—
Ectopy Frequency	—	—	—	Frequent -DG	—

Row Name	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200	06/20/18 0000
Neurological					
Level of Consciousness	—	Alert -EE	—	—	Alert -EE
Oxygen Therapy					
SpO2	94 % -EE	94 % -EE	97 % -EE	91 % -EE	90 % -EE
Charting Type					
Charting Type	—	Reassessment unchanged -EE	—	—	Reassessment unchanged -EE

Row Name	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900
Neurological					
Level of Consciousness	—	—	—	Alert -EE	—
HEENT					
HEENT (WDL)	—	—	—	X -EE	—
Head and Face	—	—	—	Symmetrical -EE	—
Nose	—	—	—	Intact -EE	—
Mucous Membrane(s)	—	—	—	Moist;Pink -EE	—
Teeth	—	—	—	Missing teeth -EE	—
Respiratory					
Respiratory Pattern	—	—	—	Regular -EE	—
Chest Assessment	—	—	—	Chest expansion symmetrical -EE	—
Bilateral Breath Sounds	—	—	—	Diminished -EE	—
Ventilator Patient	—	—	—	No -EE	—
Respiratory Interventions					
Respiratory Interventions	—	—	—	Cough and deep breathe -EE	—
Cough and Deep Breathe					
Cough and Deep Breathe	—	—	—	Yes -EE	—
Oxygen Therapy					
SpO2	97 % -EE	96 % -EE	94 % -EE	94 % -EE	94 % -EE
O2 Device	—	—	—	Nasal cannula -EE	—
O2 Flow Rate (L/min)	—	—	—	2 L/min -EE	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900
Pulse Oximetry Type	—	—	—	Continuous -EE	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	Yes (independent) -EE	—
Incentive Spirometry Tx					
Respiratory Effort	—	—	—	Good -EE	—
Treatment Tolerance	—	—	—	Tolerated well -EE	—
Cardiac					
Heart Sounds	—	—	—	S1, S2 -EE	—
Cardiac Symptoms	—	—	—	None -EE	—
Cardiac					
Cardiac Regularity	—	—	—	Irregular -EE	—
Bedside Cardiac Monitor On	—	—	—	Yes -EE	—
Bedside Cardiac Audible	—	—	—	Yes -EE	—
Bedside Cardiac Alarms Set	—	—	—	Yes -EE	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	—	X -EE	—
Cyanosis	—	—	—	None -EE	—
Capillary Refill	—	—	—	Less than/equal to 2 seconds (All extremities) -EE	—
RUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -EE	—
LUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -EE	—
RLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -EE	—
LLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -EE	—
Pulses	—	—	—	R radial;L radial;R pedal;L pedal -EE	—
Edema	—	—	—	Right lower extremity;Left lower extremity -EE	—
RLE Edema	—	—	—	+2 -EE	—
LLE Edema	—	—	—	+2 -EE	—
RUE Neurovascular Assessment					
RUE Color	—	—	—	Appropriate for ethnicity -EE	—
RUE Temperature/Moisture	—	—	—	Warm;Dry -EE	—
RUE Sensation	—	—	—	Present -EE	—
R Radial Pulse	—	—	—	+2 -EE	—
LUE Neurovascular Assessment					
LUE Color	—	—	—	Appropriate for ethnicity -EE	—
LUE Temperature/Moisture	—	—	—	Warm;Dry -EE	—
LUE Sensation	—	—	—	Present -EE	—
L Radial Pulse	—	—	—	+2 -EE	—
RLE Neurovascular Assessment					
RLE Color	—	—	—	Appropriate for ethnicity -EE	—
RLE Temperature/Moisture	—	—	—	Warm;Dry -EE	—
RLE Sensation	—	—	—	Present -EE	—
R Pedal Pulse	—	—	—	+1 -EE	—
R Homans' Sign	—	—	—	Negative -EE	—
RLE DVT Prophylaxis	—	—	—	Sequential compression device -EE	—
LLE Neurovascular Assessment					

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900
LLE Color	—	—	—	Appropriate for ethnicity -EE	—
LLE Temperature/Moisture	—	—	—	Warm;Dry -EE	—
LLE Sensation	—	—	—	Present -EE	—
L Pedal Pulse	—	—	—	+1 -EE	—
L Homans' Sign	—	—	—	Negative -EE	—
LLE DVT Prophylaxis	—	—	—	Sequential compression device -EE	—
Integumentary					
Integumentary (WDL)	—	—	—	X -EE	—
Skin Color	—	—	—	Appropriate for ethnicity -EE	—
Skin Integrity	—	—	—	Bruising -EE	—
Skin Location	—	—	—	BUE -EE	—
Skin Turgor	—	—	—	Epidermis thin with loss of subcutaneous tissue -EE	—
Braden Scale					
Sensory Perceptions	—	—	—	4 -EE	—
Moisture	—	—	—	4 -EE	—
Activity	—	—	—	3 -EE	—
Mobility	—	—	—	4 -EE	—
Nutrition	—	—	—	3 -EE	—
Friction and Shear	—	—	—	3 -EE	—
Braden Scale Score	—	—	—	21 -EE	—
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	WDL -EE	—
Fall Risk/ Unable to assess					
Unable to assess Fall Risk Factors Due To:	—	—	—	Other (Specify) -EE	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	—	0 -EE	—
Mobility	—	—	—	1;2 -EE	—
Medications	—	—	—	1 -EE	—
Mental Status/LOC/Awareness	—	—	—	0 -EE	—
Toileting Needs	—	—	—	0 -EE	—
Volume/Electrolyte Status	—	—	—	2 -EE	—
Communication/Sensory	—	—	—	1 -EE	—
Behavior	—	—	—	0 -EE	—
Hester Davis Fall Risk Total	—	—	—	10 -EE	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	4 -EE	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	WDL -EE	—
Stool Assessment					
Bowel Incontinence	—	—	—	No -EE	—
Stool Appearance	—	—	—	Unable to assess -EE	—
Stool Color	—	—	—	Unable to assess -EE	—
Stool Amount	—	—	—	Unable to assess -EE	—
Genitourinary					
Genitourinary (WDL)	—	—	—	WDL -EE	—
Urine Assessment					
Bladder Status (use only for bladder training)	—	—	—	Continent -EE	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900
Psychosocial					
Psychosocial (WDL)	—	—	—	WDL -EE	—
Needs Expressed	—	—	—	Denies -EE	—
Charting Type					
Charting Type	—	—	—	Shift assessment -EE	—
Cardiac					
Cardiac Rhythm	—	—	—	Normal sinus rhythm -EE	—
Ectopy	—	—	—	Premature ventricular contractions -EE	—
Ectopy Frequency	—	—	—	Frequent -EE	—

Row Name	06/19/18 1800	06/19/18 1700	06/19/18 1600	06/19/18 1500	06/19/18 1430
Oxygen Therapy					
SpO2	92 % -JI	96 % -JI	95 % -JI	96 % -JI	96 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -JI
Pulse Oximetry Type	—	—	—	—	Continuous -JI
Charting Type					
Charting Type	—	—	Reassessment -JI	—	—

Row Name	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1117
Oxygen Therapy					
SpO2	100 % -LFA	97 % -LFA	92 % -LFA	93 % -CR	—
Braden Scale					
Sensory Perceptions	—	—	—	—	4 -PM
Moisture	—	—	—	—	4 -PM
Activity	—	—	—	—	3 -PM
Mobility	—	—	—	—	4 -PM
Nutrition	—	—	—	—	3 -PM
Friction and Shear	—	—	—	—	3 -PM
Braden Scale Score	—	—	—	—	21 -PM

Row Name	06/19/18 1114	06/19/18 1031	06/19/18 1000	06/19/18 0900	06/19/18 0800
Neurological					
Level of Consciousness	—	—	—	—	Alert -JI
HEENT					
HEENT (WDL)	—	—	—	—	X -JI
R Eye	—	—	—	—	Impaired vision -JI
L Eye	—	—	—	—	Impaired vision -JI
Teeth	—	—	—	—	Missing teeth -JI
Respiratory					
Respiratory Pattern	—	—	—	—	Regular -JI
Chest Assessment	—	—	—	—	Chest expansion symmetrical -JI
Bilateral Breath Sounds	—	—	—	—	Diminished -JI
Ventilator Patient	—	—	—	—	No -JI
Cough	—	—	—	—	Spontaneous -JI
Oxygen Therapy					
SpO2	98 % -PM	—	92 % -JI	95 % -JI	97 % -JI
O2 Device	Nasal cannula -PM	None (Room air) -JI	—	—	Nasal cannula -JI
O2 Flow Rate (L/min)	3 L/min -PM	—	—	—	2 L/min -JI
Pulse Oximetry Type	—	—	—	—	Continuous -JI
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	—	Yes (independent) -JI
Cardiac					
Heart Sounds	—	—	—	—	S1, S2 -JI
Cardiac					
Cardiac Regularity	—	—	—	—	Irregular -JI
Bedside Cardiac Monitor On	—	—	—	—	Yes -JI

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/19/18 1114	06/19/18 1031	06/19/18 1000	06/19/18 0900	06/19/18 0800
Bedside Cardiac Audible	—	—	—	—	Yes -JI
Bedside Cardiac Alarms Set	—	—	—	—	Yes -JI
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	—	—	X -JI
Cyanosis	—	—	—	—	None -JI
Capillary Refill	—	—	—	—	Less than/equal to 2 seconds (All extremities) -JI
Pulses	—	—	—	—	R radial;L radial;R pedal;L pedal -JI
Edema	—	—	—	—	Right lower extremity -JI
RLE Edema	—	—	—	—	+2 -JI
LLE Edema	—	—	—	—	+2 -JI
RUE Neurovascular Assessment					
R Radial Pulse	—	—	—	—	+2 -JI
LUE Neurovascular Assessment					
L Radial Pulse	—	—	—	—	+2 -JI
RLE Neurovascular Assessment					
R Pedal Pulse	—	—	—	—	+1 -JI
LLE Neurovascular Assessment					
L Pedal Pulse	—	—	—	—	+1 -JI
Integumentary					
Integumentary (WDL)	—	—	—	—	X -JI
Skin Color	—	—	—	—	Appropriate for ethnicity -JI
Skin Integrity	—	—	—	—	Bruising -JI
Skin Location	—	—	—	—	BUE -JI
Skin Turgor	—	—	—	—	Epidermis thin with loss of subcutaneous tissue -JI
Braden Scale					
Sensory Perceptions	—	—	—	—	4 -JI
Moisture	—	—	—	—	4 -JI
Activity	—	—	—	—	3 -JI
Mobility	—	—	—	—	4 -JI
Nutrition	—	—	—	—	3 -JI
Friction and Shear	—	—	—	—	3 -JI
Braden Scale Score	—	—	—	—	21 -JI
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	—	WDL -JI
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	—	—	0 -JI
Mobility	—	—	—	—	1;2 -JI
Medications	—	—	—	—	1 -JI
Mental Status/LOC/Awareness	—	—	—	—	0 -JI
Toileting Needs	—	—	—	—	0 -JI
Volume/Electrolyte Status	—	—	—	—	2 -JI
Communication/Sensory	—	—	—	—	1 -JI
Behavior	—	—	—	—	0 -JI
Hester Davis Fall Risk Total	—	—	—	—	10 -JI
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	—	4 -JI

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/19/18 1114	06/19/18 1031	06/19/18 1000	06/19/18 0900	06/19/18 0800
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	—	WDL -JI
Genitourinary					
Genitourinary (WDL)	—	—	—	—	WDL -JI
Charting Type					
Charting Type	—	—	—	—	Shift assessment -JI
Cardiac					
Cardiac Rhythm	—	—	—	—	Normal sinus rhythm -JI

Row Name	06/19/18 0700	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300
Oxygen Therapy					
SpO2	96 % -JI	94 % -RM	96 % -RM	98 % -RM	92 % -RM
O2 Device	—	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	—	—	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	—	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	—	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	—	—	No -RM	No -RM	No -RM
Stool Assessment					
Bowel Incontinence	—	—	—	No -RM	—
Stool Appearance	—	—	—	Unable to assess -RM	—
Stool Color	—	—	—	Unable to assess -RM	—
Stool Amount	—	—	—	Unable to assess -RM	—
Urine Assessment					
Bladder Status (use only for bladder training)	—	—	—	Continent -RM	—
Charting Type					
Charting Type	—	—	—	Reassessment -RM	—
Current Legal Status					
Current Legal Status	—	—	—	Vol -RM	—

Row Name	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200
Oxygen Therapy					
SpO2	93 % -RM	92 % -RM	94 % -RM	97 % -RM	99 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM
Stool Assessment					
Bowel Incontinence	No -RM	—	No -RM	—	No -RM
Stool Appearance	Unable to assess -RM	—	Unable to assess -RM	—	Unable to assess -RM
Stool Color	Unable to assess -RM	—	Unable to assess -RM	—	Unable to assess -RM
Stool Amount	Unable to assess -RM	—	Unable to assess -RM	—	Unable to assess -RM
Urine Assessment					
Bladder Status (use only for bladder training)	Continent -RM	—	Continent -RM	—	Continent -RM
Charting Type					
Charting Type	Reassessment -RM	—	Reassessment -RM	—	Reassessment -RM
Current Legal Status					
Current Legal Status	Vol -RM	—	Vol -RM	—	Vol -RM

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1600
Neurological					
Level of Consciousness	—	Alert -RM	—	—	—
HEENT					
HEENT (WDL)	—	X -RM	—	—	—
Head and Face	—	Symmetrical -RM	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1600
R Eye	—	Impaired vision -RM	—	—	—
L Eye	—	Impaired vision -RM	—	—	—
R Ear	—	Intact -RM	—	—	—
L Ear	—	Intact -RM	—	—	—
Nose	—	Intact -RM	—	—	—
Mucous Membrane(s)	—	Moist;Pink -RM	—	—	—
Teeth	—	Missing teeth -RM	—	—	—
Eye Blink Rate					
R. Eye	—	Blink Rate >6/min or 1 every 10 seconds -RM	—	—	—
L. Eye	—	Blink Rate >6/min or 1 every 10 seconds -RM	—	—	—
Respiratory					
Respiratory Pattern	—	Regular -RM	—	—	—
Chest Assessment	—	Chest expansion symmetrical -RM	—	—	—
Bilateral Breath Sounds	—	Diminished -RM	—	—	—
R Breath Sounds	—	Diminished -RM	—	—	—
L Breath Sounds	—	Diminished -RM	—	—	—
Ventilator Patient	—	No -RM	—	—	—
Cough	—	Spontaneous;Strong -RM	—	—	—
Respiratory Interventions					
Respiratory Interventions	—	Cough and deep breathe -RM	—	—	—
Cough and Deep Breathe					
Cough and Deep Breathe	—	Yes -RM	—	—	—
Oxygen Therapy					
SpO2	99 % -RM	96 % -RM	(!) 89 % -RM	94 % -RM	(!) 87 % -JI
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	—	—
POX Probe Site Changed	No -RM	No -RM	No -RM	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	Yes (independent) -RM	—	—	—
Cardiac					
Heart Sounds	—	S1, S2 -RM	—	—	—
Cardiac Symptoms	—	None -RM	—	—	—
Cardiac					
Cardiac Regularity	—	Irregular -RM	—	—	—
Bedside Cardiac Monitor On	—	Yes -RM	—	—	—
Bedside Cardiac Audible	—	Yes -RM	—	—	—
Bedside Cardiac Alarms Set	—	Yes -RM	—	—	—
Telemetry Monitor On	—	No -RM	—	—	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	X -RM	—	—	—
Cyanosis	—	None -RM	—	—	—
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -RM	—	—	—
RUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
RLE Capillary Refill	—	Less than/equal to 3	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1600
		seconds -RM			
LLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
Pulses	—	L pedal;R pedal;L radial;R radial -RM	—	—	—
Edema	—	Right lower extremity;Left lower extremity -RM	—	—	—
RLE Edema	—	+2 -RM	—	—	—
LLE Edema	—	+2 -RM	—	—	—
RUE Neurovascular Assessment					
RUE Color	—	Appropriate for ethnicity -RM	—	—	—
RUE Temperature/Moisture	—	Warm;Dry -RM	—	—	—
RUE Sensation	—	Present -RM	—	—	—
R Radial Pulse	—	+2 -RM	—	—	—
LUE Neurovascular Assessment					
LUE Color	—	Appropriate for ethnicity -RM	—	—	—
LUE Temperature/Moisture	—	Warm;Dry -RM	—	—	—
LUE Sensation	—	Present -RM	—	—	—
L Radial Pulse	—	+2 -RM	—	—	—
RLE Neurovascular Assessment					
RLE Color	—	Appropriate for ethnicity -RM	—	—	—
RLE Temperature/Moisture	—	Warm;Dry -RM	—	—	—
RLE Sensation	—	Present -RM	—	—	—
R Pedal Pulse	—	+1 -RM	—	—	—
R Homans' Sign	—	Negative -RM	—	—	—
LLE Neurovascular Assessment					
LLE Color	—	Appropriate for ethnicity -RM	—	—	—
LLE Temperature/Moisture	—	Warm;Dry -RM	—	—	—
LLE Sensation	—	Present -RM	—	—	—
L Pedal Pulse	—	+1 -RM	—	—	—
L Homans' Sign	—	Negative -RM	—	—	—
Integumentary					
Integumentary (WDL)	—	X -RM	—	—	—
Skin Color	—	Appropriate for ethnicity -RM	—	—	—
Skin Integrity	—	Bruising -RM	—	—	—
Skin Location	—	BUE -RM	—	—	—
Skin Turgor	—	Epidermis thin with loss of subcutaneous tissue -RM	—	—	—
Braden Scale					
Sensory Perceptions	—	4 -RM	—	—	—
Moisture	—	4 -RM	—	—	—
Activity	—	3 -RM	—	—	—
Mobility	—	4 -RM	—	—	—
Nutrition	—	3 -RM	—	—	—
Friction and Shear	—	3 -RM	—	—	—
Braden Scale Score	—	21 -RM	—	—	—
Musculoskeletal					
Musculoskeletal (WDL)	—	WDL -RM	—	—	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	0 -RM	—	—	—
Mobility	—	1 -RM	—	—	—
Medications	—	0 -RM	—	—	—
Mental	—	0 -RM	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1600
Status/LOC/Awareness					
Toileting Needs	—	2 -RM	—	—	—
Volume/Electrolyte Status	—	2 -RM	—	—	—
Communication/Sensory	—	1 -RM	—	—	—
Behavior	—	0 -RM	—	—	—
Hester Davis Fall Risk Total	—	9 -RM	—	—	—
Stool Assessment					
Bowel Incontinence	—	No -RM	—	—	—
Stool Appearance	—	Unable to assess -RM	—	—	—
Stool Color	—	Unable to assess -RM	—	—	—
Stool Amount	—	Unable to assess -RM	—	—	—
Emesis Assessment					
Emesis Appearance	—	— na -RM	—	—	—
Genitourinary					
Genitourinary (WDL)	—	WDL -RM	—	—	—
Urine Assessment					
Bladder Status (use only for bladder training)	—	Continent -RM	—	—	—
Psychosocial					
Psychosocial (WDL)	—	WDL -RM	—	—	—
Needs Expressed	—	Denies -RM	—	—	—
Charting Type					
Charting Type	—	Shift assessment -RM	—	—	—
Current Legal Status					
Current Legal Status	—	Vol -RM	—	—	—
Cardiac					
Cardiac Rhythm	—	Normal sinus rhythm;Sinus bradycardia -RM	—	—	—
Ectopy	—	Premature ventricular contractions -RM	—	—	—
Ectopy Frequency	—	Frequent -RM	—	—	—

Row Name	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1200	06/18/18 1100
Oxygen Therapy					
SpO2	95 % -JI	91 % -JI	93 % -JI	—	97 % -JI
Charting Type					
Charting Type	—	—	—	Reassessment -JI	—

Row Name	06/18/18 1025	06/18/18 1000	06/18/18 0900	06/18/18 0800	06/18/18 0700
Neurological					
Level of Consciousness	—	—	—	Alert -JI	—
HEENT					
HEENT (WDL)	—	—	—	X -JI	—
R Eye	—	—	—	Impaired vision -JI	—
L Eye	—	—	—	Impaired vision -JI	—
Teeth	—	—	—	Missing teeth -JI	—
Respiratory					
Respiratory Pattern	—	—	—	Regular -JI	—
Chest Assessment	—	—	—	Chest expansion symmetrical -JI	—
Bilateral Breath Sounds	—	—	—	Diminished -JI	—
Ventilator Patient	—	—	—	No -JI	—
Cough	—	—	—	Strong;Spontaneous -JI	—
Oxygen Therapy					

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 1025	06/18/18 1000	06/18/18 0900	06/18/18 0800	06/18/18 0700
SpO2	—	98 % -JI	100 % -JI	91 % -JI	95 % -JI
O2 Device	—	—	—	Nasal cannula -JI	—
O2 Flow Rate (L/min)	—	—	—	5 L/min -JI	—
Pulse Oximetry Type	—	—	—	Continuous -JI	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	Yes (independent) -JI	—
Cardiac					
Heart Sounds	—	—	—	S1, S2 -JI	—
Cardiac					
Cardiac Regularity	—	—	—	Irregular -JI	—
Bedside Cardiac Monitor On	—	—	—	Yes -JI	—
Bedside Cardiac Audible	—	—	—	Yes -JI	—
Bedside Cardiac Alarms Set	—	—	—	Yes -JI	—
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	—	X -JI	—
Cyanosis	—	—	—	None -JI	—
Capillary Refill	—	—	—	Less than/equal to 2 seconds (All extremities) -JI	—
Pulses	—	—	—	R radial;L radial;R pedal;L pedal -JI	—
RLE Edema	—	—	—	+2 -JI	—
LLE Edema	—	—	—	+2 -JI	—
RUE Neurovascular Assessment					
R Radial Pulse	—	—	—	+2 -JI	—
LUE Neurovascular Assessment					
L Radial Pulse	—	—	—	+2 -JI	—
RLE Neurovascular Assessment					
R Pedal Pulse	—	—	—	+1 -JI	—
LLE Neurovascular Assessment					
L Pedal Pulse	—	—	—	+1 -JI	—
Integumentary					
Integumentary (WDL)	—	—	—	WDL -JI	—
Skin Color	—	—	—	Appropriate for ethnicity -JI	—
Braden Scale					
Sensory Perceptions	—	—	—	4 -JI	—
Moisture	—	—	—	4 -JI	—
Activity	—	—	—	3 -JI	—
Mobility	—	—	—	4 -JI	—
Nutrition	—	—	—	3 -JI	—
Friction and Shear	—	—	—	3 -JI	—
Braden Scale Score	—	—	—	21 -JI	—
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	WDL -JI	—
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	—	0 -JI	—
Mobility	—	—	—	1 -JI	—
Medications	—	—	—	3 -JI	—
Mental Status/LOC/Awareness	—	—	—	0 -JI	—
Toileting Needs	—	—	—	0 -JI	—
Volume/Electrolyte Status	—	—	—	2 -JI	—
Communication/Senso	—	—	—	1 -JI	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 1025	06/18/18 1000	06/18/18 0900	06/18/18 0800	06/18/18 0700
ry					
Behavior	—	—	—	0 -JI	—
Hester Davis Fall Risk Total	—	—	—	10 -JI	—
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	1 -JI	—
Gastrointestinal					
Gastrointestinal (WDL)	—	—	—	WDL -JI	—
Genitourinary					
Genitourinary (WDL)	—	—	—	WDL -JI	—
Psychosocial					
Psychosocial (WDL)	—	—	—	WDL -JI	—
Provider Notification					
Reason for Communication	Patient request Clarify order for Ramipril. -JI	—	—	—	—
Notification Time	1025 -JI	—	—	—	—
Provider Name	Sajja -JI	—	—	—	—
Provider Role	Consulting physician -JI	—	—	—	—
Method of Communication	Perfect Serve -JI	—	—	—	—
Response	Waiting for response -JI	—	—	—	—
Charting Type					
Charting Type	—	—	—	Shift assessment -JI	—
Cardiac					
Cardiac Rhythm	—	—	—	Normal sinus rhythm;Sinus bradycardia -JI	—

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400	06/18/18 0339
tPA Time out					
Weight	104.9 kg (231 lb 4.2 oz) -RM	—	—	—	—
Oxygen Therapy					
SpO2	97 % -RM	97 % -RM	—	97 % -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	100 -RM	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	90 -RM	—
POX Probe Site Changed	No -RM	No -RM	—	No -RM	—
Incentive Spirometer					
Is pt using incentive spirometer?	Yes (independent) -RM	—	—	Yes (independent) -RM	—
Cardiac					
Telemetry Monitor On	No -RM	—	—	No -RM	—
Stool Assessment					
Bowel Incontinence	—	No -RM	—	—	—
Stool Appearance	—	Unable to assess -RM	—	—	—
Stool Color	—	Unable to assess -RM	—	—	—
Stool Amount	—	Unable to assess -RM	—	—	—
Emesis Assessment					
Emesis Appearance	—	— na -RM	—	—	—
Urine Assessment					
Bladder Status (use only for bladder training)	—	Continent -RM	—	—	—
Provider Notification					
Reason for Communication	Critical lab value -RM	—	—	—	Critical lab value -RM
Lab Value	inr 3.06 -RM	—	—	—	trop 0.05 -RM

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400	06/18/18 0339
RBAC?	Yes -RM	—	—	—	Yes -RM
Notification Time	0602 -RM	—	—	—	0338 -RM
Provider Name	Kingsley Agbeyebe -RM	—	—	—	Andrew Goodner -RM
Provider Role	Hospitalist -RM	—	—	—	PA -RM
Method of Communication	Perfect Serve -RM	—	—	—	Perfect Serve -RM
Response	Waiting for response -RM	—	—	—	Waiting for response Hospitalist called to request I advise CVM. -RM
Charting Type					
Charting Type	Reassessment -RM	—	—	Reassessment -RM	—
Current Legal Status					
Current Legal Status	Vol -RM	—	—	Vol -RM	—

Row Name	06/18/18 0334	06/18/18 0300	06/18/18 0200	06/18/18 0100	06/18/18 0000
Neurological					
Level of Consciousness	—	—	—	—	Alert -RM
Swallow Screening					
Patient Alert	—	—	—	—	Yes -RM
Continue Screen?	—	—	—	—	If yes-continue screen -RM
Dx Aspiration PNA	—	—	—	—	No -RM
Continue Screen?	—	—	—	—	If no-continue screen -RM
Pt Drooling?	—	—	—	—	No -RM
Continue Screen? (If screening to continue, give 1 Tsp of water)	—	—	—	—	If no-continue screen -RM
Any Cough?	—	—	—	—	No -RM
Voice gurgle/wet?	—	—	—	—	No -RM
Continue Screen? (If screening to continue, provide sips of cup of water)	—	—	—	—	If no to above questions-continue screen -RM
Any Cough?	—	—	—	—	No -RM
Voice gurgle/wet?	—	—	—	—	No -RM
Continue Screen?	—	—	—	—	If no to above questions-continue screen -RM
Did Patient Pass Swallow Screen?	—	—	—	—	Yes-passed screen -RM
HEENT					
HEENT (WDL)	—	—	—	—	WDL -RM
Eye Blink Rate					
R. Eye	—	—	—	—	Blink Rate >6/min or 1 every 10 seconds -RM
L. Eye	—	—	—	—	Blink Rate >6/min or 1 every 10 seconds -RM
Respiratory					
Respiratory Pattern	—	—	—	—	Regular -RM
Chest Assessment	—	—	—	—	Chest expansion symmetrical -RM
R Breath Sounds	—	—	—	—	Diminished -RM
L Breath Sounds	—	—	—	—	Diminished -RM
Ventilator Patient	—	—	—	—	No -RM
Cough	—	—	—	—	Strong;Loose -RM
Respiratory Interventions					
Respiratory Interventions	—	—	—	—	Cough and deep breathe;Incentive spirometry -RM
Cough and Deep Breathe					
Cough and Deep Breathe	—	—	—	—	Yes -RM

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 0334	06/18/18 0300	06/18/18 0200	06/18/18 0100	06/18/18 0000
Oxygen Therapy					
SpO2	—	92 % -RM	(!) 87 % -RM	(!) 88 % -RM	92 % -RM
O2 Device	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	—	5 L/min -RM	5 L/min -RM	—	—
Pulse Oximetry Type	—	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	—	No -RM	No -RM	No -RM	Yes -RM
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	Yes (independent) -RM	—	Yes (independent) -RM
Incentive Spirometry Tx					
Respiratory Effort	—	—	—	—	Good -RM
Treatment Tolerance	—	—	—	—	Tolerated well -RM
Incentive Spirometry Goal (mL)	—	—	—	—	1500 mL -RM
Incentive Spirometry Achieved X 10 efforts (mL)	—	—	—	—	1500-2000 mL -RM
Cardiac					
Heart Sounds	—	—	—	—	S1, S2 -RM
Cardiac Symptoms	—	—	—	—	None -RM
Cardiac					
Cardiac Regularity	—	—	—	—	Irregular -RM
Bedside Cardiac Monitor On	—	—	—	—	Yes -RM
Bedside Cardiac Audible	—	—	—	—	Yes -RM
Bedside Cardiac Alarms Set	—	—	—	—	Yes -RM
Telemetry Monitor On	—	—	No -RM	—	No -RM
Peripheral Vascular					
RUE Capillary Refill	—	—	—	—	Less than/equal to 3 seconds -RM
LUE Capillary Refill	—	—	—	—	Less than/equal to 3 seconds -RM
RLE Capillary Refill	—	—	—	—	Less than/equal to 3 seconds -RM
LLE Capillary Refill	—	—	—	—	Less than/equal to 3 seconds -RM
RUE Neurovascular Assessment					
RUE Color	—	—	—	—	Appropriate for ethnicity -RM
RUE Temperature/Moisture	—	—	—	—	Warm;Dry -RM
RUE Sensation	—	—	—	—	Present -RM
R Radial Pulse	—	—	—	—	+2 -RM
LUE Neurovascular Assessment					
LUE Color	—	—	—	—	Appropriate for ethnicity -RM
LUE Temperature/Moisture	—	—	—	—	Warm;Dry -RM
LUE Sensation	—	—	—	—	Present -RM
L Radial Pulse	—	—	—	—	+2 -RM
RLE Neurovascular Assessment					
RLE Color	—	—	—	—	Appropriate for ethnicity -RM
RLE Temperature/Moisture	—	—	—	—	Warm;Dry -RM
RLE Sensation	—	—	—	—	Present -RM
R Pedal Pulse	—	—	—	—	+1 -RM
RLE DVT Prophylaxis	—	—	—	—	Sequential compression device -RM

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 0334	06/18/18 0300	06/18/18 0200	06/18/18 0100	06/18/18 0000
LLE Neurovascular Assessment					
LLE Color	—	—	—	—	Appropriate for ethnicity -RM
LLE Temperature/Moisture	—	—	—	—	Warm;Dry -RM
LLE Sensation	—	—	—	—	Present -RM
L Pedal Pulse	—	—	—	—	+1 -RM
LLE DVT Prophylaxis	—	—	—	—	Sequential compression device -RM
Integumentary					
Integumentary (WDL)	—	—	—	—	WDL -RM
Skin Color	—	—	—	—	Appropriate for ethnicity -RM
Braden Scale					
Sensory Perceptions	—	—	—	—	4 -RM
Moisture	—	—	—	—	4 -RM
Activity	—	—	—	—	3 -RM
Mobility	—	—	—	—	4 -RM
Nutrition	—	—	—	—	3 -RM
Friction and Shear	—	—	—	—	3 -RM
Braden Scale Score	—	—	—	—	21 -RM
Musculoskeletal					
Musculoskeletal (WDL)	—	—	—	—	WDL -RM
Hester Davis Fall Risk Assessment					
Last Known Fall	—	—	—	—	0 -RM
Mobility	—	—	—	—	1 -RM
Medications	—	—	—	—	3 -RM
Mental Status/LOC/Awareness	—	—	—	—	0 -RM
Toileting Needs	—	—	—	—	0 -RM
Volume/Electrolyte Status	—	—	—	—	2 -RM
Communication/Sensory	—	—	—	—	1 -RM
Behavior	—	—	—	—	0 -RM
Hester Davis Fall Risk Total	—	—	—	—	10 -RM
Get-Up-And-Go Test					
Get-Up-And-Go Test: "Rising from Chair"	—	—	—	—	1 -RM
Stool Assessment					
Bowel Incontinence	—	—	—	—	No -RM
Stool Appearance	—	—	—	—	Unable to assess -RM
Stool Color	—	—	—	—	Unable to assess -RM
Stool Amount	—	—	—	—	Unable to assess -RM
Emesis Assessment					
Emesis Appearance	—	—	—	—	— na -RM
Urine Assessment					
Bladder Status (use only for bladder training)	—	—	—	—	Continent -RM
Psychosocial					
Psychosocial (WDL)	—	—	—	—	WDL -RM
Needs Expressed	—	—	—	—	Physical;Emotional -RM
Provider Notification					
Reason for Communication	Critical lab value -RM	—	—	—	—
Lab Value	trop 0.05 -RM	—	—	—	—
RBAC?	Yes -RM	—	—	—	—
Notification Time	0334 -RM	—	—	—	—
Provider Name	Joy -RM	—	—	—	—

Flowsheets (all recorded) (continued)

Assessment (continued)

Row Name	06/18/18 0334	06/18/18 0300	06/18/18 0200	06/18/18 0100	06/18/18 0000
Provider Role	NP -RM	—	—	—	—
Method of Communication	Perfect Serve -RM	—	—	—	—
Response	Waiting for response -RM	—	—	—	—
Charting Type					
Charting Type	—	—	Reassessment -RM	—	Admission -RM
Current Legal Status					
Current Legal Status	—	—	Vol -RM	—	Vol -RM
Cardiac					
Cardiac Rhythm	—	—	—	—	Sinus bradycardia -RM
Ectopy	—	—	—	—	Premature ventricular contractions -RM
Ectopy Frequency	—	—	—	—	Occasional -RM

Flowsheets (all recorded)

Assessment (continued)

Row Name	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823	06/17/18 1738
tPA Time out					
Weight	—	103.4 kg (227 lb 15.3 oz) -AF	—	—	—
Oxygen Therapy					
SpO2	90 % -RM	92 % -AF	100 % -BR	100 % -BR	100 % -BR
O2 Device	Nasal cannula -RM	Nasal cannula -AF	—	None (Room air) -BR	None (Room air) -BR
O2 Flow Rate (L/min)	—	2 L/min -AF	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	—	—
POX Probe Site Changed	No -RM	No -RM	—	—	—
Stool Assessment					
Bowel Incontinence	—	No -RM	—	—	—
Stool Appearance	—	Unable to assess -RM	—	—	—
Stool Color	—	Unable to assess -RM	—	—	—
Stool Amount	—	Unable to assess -RM	—	—	—
Emesis Assessment					
Emesis Appearance	—	— na -RM	—	—	—
Urine Assessment					
Bladder Status (use only for bladder training)	—	Continent -RM	—	—	—

Row Name	06/17/18 1708	06/17/18 1610	06/17/18 1540	06/17/18 1538	06/17/18 1535
Neurological					
Level of Consciousness	—	—	—	Alert -RG	—
tPA Time out					
Weight	—	—	—	—	95.3 kg (210 lb) -RG
Swallow Screening					
Patient Alert	—	—	Yes -RG	—	—
Continue Screen?	—	—	If yes-continue screen -RG	—	—
Dx Aspiration PNA	—	—	No -RG	—	—
Continue Screen?	—	—	If no-continue screen -RG	—	—
Pt Drooling?	—	—	No -RG	—	—
Continue Screen? (If screening to continue, give 1 Tsp of water)	—	—	If no-continue screen -RG	—	—
Any Cough?	—	—	No -RG	—	—
Voice gurgle/wet?	—	—	No -RG	—	—
Continue Screen? (If screening to continue, provide sips of cup of water)	—	—	If no to above questions-continue screen -RG	—	—
Any Cough?	—	—	No -RG	—	—
Voice gurgle/wet?	—	—	No -RG	—	—
Continue Screen?	—	—	If no to above questions-continue screen -RG	—	—
Did Patient Pass Swallow Screen?	—	—	Yes-passed screen -RG	—	—
Respiratory					
Respiratory Pattern	—	—	—	Labored -RG	—
Chest Assessment	—	—	—	Chest expansion symmetrical -RG	—
Bilateral Breath Sounds	—	—	—	Diminished -RG	—
Oxygen Therapy					
SpO2	100 % -BR	—	—	—	—
O2 Device	None (Room air) -BR	—	—	None (Room air) -RG	—
Cardiac					

Flowsheets (all recorded) (continued)

Assessment (continued) (continued)

Row Name	06/17/18 1708	06/17/18 1610	06/17/18 1540	06/17/18 1538	06/17/18 1535
Cardiac Regularity	—	—	—	Regular -RG	—
Telemetry Monitor On	—	—	—	Yes -RG	—
Telemetry Box Number	—	—	—	5175 -RG	—
Peripheral Vascular					
RLE Edema	—	—	—	+2 -RG	—
LLE Edema	—	—	—	+2 -RG	—
Integumentary					
Skin Color	—	—	—	Pale -RG	—
Psychosocial					
Needs Expressed	—	—	—	Denies -RG	—
Provider Notification					
Reason for Communication	—	Critical lab value -KW	—	—	—
Lab Value	—	H&H 5.6/19 -KW	—	—	—
RBAC?	—	Yes -KW	—	—	—
Notification Time	—	1611 -KW	—	—	—
Provider Name	—	DR. KRUG -KW	—	—	—
Provider Role	—	Attending physician -KW	—	—	—
Method of Communication	—	Face to face -KW	—	—	—
Response	—	In department -KW	—	—	—
Cardiac					
Cardiac Rhythm	—	—	—	Sinus bradycardia -RG	—

Row Name	06/17/18 1532	06/17/18 1502	06/17/18 1437
Oxygen Therapy			
SpO2	—	100 % -RG	98 % -NS
O2 Device	—	None (Room air) -RG	—
Pulse Oximetry Type	—	Continuous -RG	—
[REMOVED] Anesthesia Airway Nasal Cannula			
AN Airway Properties	Placement Date: 06/12/18 -AH Placement Time: 1253 -AH Airway Device: Nasal Cannula -AH Removal Date: 06/17/18 -RG, N/E		
[REMOVED] Urethral Catheter 16 Fr			
Urethral Catheter Properties	Placement Date: 01/16/18 -RD Placement Time: 2140 -RD Inserted by: Denmark, RN -RD Present on arrival to hospital?: No -RD Patient location at time of placement:: ER -RD Catheter Indicator: Acute urinary retention -RD Tube Size (Fr.): 16 Fr -RD Catheter Balloon Size: 10 mL -RD Catheter Secured: Yes -RD Urine Returned: Yes -RD Removal Date: 06/17/18 -RG, N/E		
Provider Notification			
Reason for Communication	Critical lab value -RG	—	—
Lab Value	POC TROP 0.09 AND BNP 2307 -RG	—	—
RBAC?	Yes -RG	—	—
Notification Time	1532 -RG	—	—
Provider Name	DR.KRUG -RG	—	—
Provider Role	Attending physician -RG	—	—
Method of Communication	Face to face -RG	—	—
Response	See orders -RG	—	—

Flowsheets (all recorded)

CCP Vitals, Intake and Output

Row Name	06/21/18 11:36:09	06/21/18 1000	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21
Vitals					
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	—	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	—	Oral -CI	Oral -TW
Pulse	60 -DI (r) CI (t)	—	—	62 -DI (r) CI (t)	63 -DI (r) TW (t)
Heart Rate Source	Monitor -CI	—	—	Monitor -CI	Monitor -TW
Resp	18 -CI	—	—	18 -CI	18 -DI (r) TW (t)
Respiration Source	visual -CI	—	—	visual -CI	visual -TW
BP	123/59 -DI (r) CI (t)	—	—	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)
BP Location	Right arm -CI	—	—	Right arm -CI	Right arm -TW
BP Method	Portable -CI	—	—	Portable -CI	Portable -TW
Patient Position	Supine -CI	—	—	Supine -CI	Supine -TW
SpO2	96 % -DI (r) CI (t)	—	—	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)
O2 Device	None (Room air) -CI	—	None (Room air) -AM	None (Room air) -CI	None (Room air) -TW
Intake (mL)					
P.O.	—	240 mL -JK	—	—	0 mL -TW
Percent Meals Eaten (%)	—	100 % -JK	—	—	0 % -TW
Snacks Eaten (%)	—	—	—	—	0 -TW
Supplement Consumed (%)	—	—	—	—	0 -TW
Unmeasured Output					
Urine Occurrence	—	—	—	—	1 -TW
Stool Occurrence	—	—	—	—	0 -TW
Emesis Occurrence	—	—	—	—	0 -TW
Stool Appearance					
Stool Appearance	—	—	—	—	Unable to assess -TW

Row Name	06/20/18 23:57:07	06/20/18 2133	06/20/18 2000	06/20/18 19:43:22	06/20/18 15:50:04
Vitals					
Temp	98.4 °F (36.9 °C) -DI (r) TW (t)	—	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)
Temp src	Oral -TW	—	—	Oral -TW	—
Pulse	109 -DI (r) TW (t)	—	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)
Heart Rate Source	Monitor -TW	—	—	Monitor -TW	—
Resp	16 -DI (r) TW (t)	—	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)
Respiration Source	visual -TW	—	—	visual -TW	—
BP	124/53 -DI (r) TW (t)	—	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)
BP Location	Right arm -TW	—	—	Right arm -TW	—
BP Method	Portable -TW	—	—	Portable -TW	—
Patient Position	Supine -TW	—	—	Supine -TW	—
SpO2	93 % -DI (r) TW (t)	—	—	93 % -DI (r) TW (t)	**(!) 89 %** -DI (r) LF (t)
O2 Device	None (Room air) -TW	None (Room air) -TS	—	None (Room air) -TW	—
Intake (mL)					
P.O.	0 mL -TW	—	—	0 mL -TW	—
Percent Meals Eaten (%)	0 % -TW	—	—	0 % -TW	—
Snacks Eaten (%)	0 -TW	—	—	0 -TW	—
Supplement Consumed (%)	0 -TW	—	—	0 -TW	—
Unmeasured Output					
Urine Occurrence	1 -TW	—	1 -TW	0 -TW	—
Stool Occurrence	0 -TW	—	0 -TW	0 -TW	—
Emesis Occurrence	0 -TW	—	0 -TW	0 -TW	—
Stool Appearance					
Stool Appearance	Unable to assess -TW	—	Unable to assess -TW	Unable to assess -TW	—

Row Name	06/20/18 1458	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909	06/20/18 0900
Vitals					
Temp	—	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—	—
Pulse	—	61 -DI (r) LF (t)	61 -DG	59 -DG	60 -DG
Resp	—	—	18 -DG	—	17 -DG
BP	—	104/66 -DI (r) LF (t)	122/54 -DG	**(!) 122/49** -DG	**(!) 122/49** -DG

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	06/20/18 1458	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909	06/20/18 0900
MAP (mmHg)	—	—	71 mm Hg -DG	—	68 mm Hg -DG
SpO2	—	92 % -DI (r) LF (t)	(!) 88 % -DG	—	(!) 87 % -DG
O2 Device	None (Room air) -MS	—	—	—	—
Stool Appearance					
Stool Appearance	Unable to assess -MS	—	—	—	—
Row Name	**06/20/18 0800**	**06/20/18 0730**	**06/20/18 0600**	**06/20/18 0500**	**06/20/18 0400**
Vitals					
Temp	—	98.3 °F (36.8 °C) -HT	—	—	98 °F (36.7 °C) -JP
Temp src	—	Oral -HT	—	—	Oral -JP
Pulse	58 -DG	—	59 -EE	57 -EE	56 -EE
Resp	18 -DG	—	20 -EE	20 -EE	19 -EE
BP	138/62 -DG	—	129/57 -EE	130/50 -EE	119/51 -EE
MAP (mmHg)	81 mm Hg -DG	—	74 mm Hg -EE	70 mm Hg -EE	67 mm Hg -EE
SpO2	(!) 88 % -DG	—	93 % -EE	94 % -EE	94 % -EE
O2 Device	None (Room air) -DG	—	—	—	—
Output (mL)					
Urine	—	200 mL -HT	—	350 mL -EE	— -EE
Row Name	**06/20/18 0300**	**06/20/18 0200**	**06/20/18 0000**	**06/19/18 2300**	**06/19/18 2200**
Vitals					
Temp	—	—	97.5 °F (36.4 °C) -JP	—	—
Temp src	—	—	Axillary -JP	—	—
Pulse	57 -EE	64 -EE	59 -EE	61 -EE	62 -EE
Resp	21 -EE	16 -EE	22 -EE	21 -EE	22 -EE
BP	122/58 -EE	(!) 111/47 -EE	—	128/56 -EE	132/51 -EE
MAP (mmHg)	73 mm Hg -EE	62 mm Hg -EE	—	—	73 mm Hg -EE
SpO2	97 % -EE	91 % -EE	90 % -EE	97 % -EE	96 % -EE
Row Name	**06/19/18 2100**	**06/19/18 2000**	**06/19/18 1900**	**06/19/18 1800**	**06/19/18 1700**
Vitals					
Temp	—	98.4 °F (36.9 °C) -JP	—	—	—
Temp src	—	Oral -JP	—	—	—
Pulse	61 -EE	63 -EE	64 -EE	61 -JI	59 -JI
Resp	16 -EE	21 -EE	19 -EE	25 -JI	21 -JI
BP	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI	132/52 -JI
MAP (mmHg)	77 mm Hg -EE	76 mm Hg -EE	77 mm Hg -EE	72 mm Hg -JI	73 mm Hg -JI
SpO2	94 % -EE	94 % -EE	94 % -EE	92 % -JI	96 % -JI
O2 Device	—	Nasal cannula -EE	—	—	—
Output (mL)					
Urine	—	400 mL -JP	—	—	—
Unmeasured Output					
Urine Occurrence	—	1 -EE	—	—	—
Stool Appearance					
Stool Appearance	—	Unable to assess -EE	—	—	—
Row Name	**06/19/18 1644**	**06/19/18 1600**	**06/19/18 1500**	**06/19/18 1433**	**06/19/18 1430**
Vitals					
Temp	97.9 °F (36.6 °C) -FT	—	—	—	—
Temp src	Oral -FT	—	—	—	—
Pulse	—	58 -JI	56 -JI	—	57 -JI
Resp	—	20 -JI	22 -JI	—	19 -JI
BP	—	134/58 -JI	130/51 -JI	—	142/60 -JI
MAP (mmHg)	—	76 mm Hg -JI	69 mm Hg -JI	—	82 mm Hg -JI
SpO2	—	95 % -JI	96 % -JI	—	96 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
Unmeasured Output					
Urine Occurrence	—	—	—	1 -JI	—
Row Name	**06/19/18 1428**	**06/19/18 1335**	**06/19/18 1330**	**06/19/18 1325**	**06/19/18 1321**
Vitals					
Temp	97.7 °F (36.5 °C) -FT	—	—	—	—
Temp src	Oral -FT	—	—	—	—
Pulse	—	54 -LFA	54 -LFA	53 -LFA	53 -CR
Resp	—	22 -LFA	19 -LFA	21 -LFA	18 -CR

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	06/19/18 1428	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321
BP	—	123/59 -LFA	128/55 -LFA	(!) 95/46 -LFA	110/53 -CR
SpO2	—	100 % -LFA	97 % -LFA	92 % -LFA	93 % -CR

Row Name	06/19/18 1311	06/19/18 1311	06/19/18 1129	06/19/18 1114	06/19/18 1039
Vitals					
Pulse	—	—	—	51 -PM	—
Heart Rate Source	—	—	—	Monitor -PM	—
Resp	—	—	—	13 -PM	—
BP	—	—	—	123/54 -PM	—
Patient Position	—	—	—	Sitting -PM	—
SpO2	—	—	—	98 % -PM	—
O2 Device	—	—	—	Nasal cannula -PM	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Dose	—	—	—	—	*0 mL EGD. -JI
sodium chloride 0.9% (NS) infusion					
Rate	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -CM	* There are multiple administrations at this time. Please see the MAR for detailed information. -PM	—	—
Volume (mL)	200 mL -CM	—	—	—	—

Row Name	06/19/18 1037	06/19/18 1031	06/19/18 1000	06/19/18 0900	06/19/18 0808
Vitals					
Pulse	—	—	50 -JI	51 -JI	55 -JI
Resp	—	—	20 -JI	18 -JI	—
BP	—	—	(!) 124/49 -JI	(!) 119/44 -JI	(!) 126/47 -JI
MAP (mmHg)	—	—	68 mm Hg -JI	62 mm Hg -JI	—
SpO2	—	—	92 % -JI	95 % -JI	—
O2 Device	—	None (Room air) -JI	—	—	—
Output (mL)					
Urine	300 mL -JI	—	—	450 mL -DF	—

Row Name	06/19/18 0800	06/19/18 0700	06/19/18 0600	06/19/18 0500	06/19/18 0400
Vitals					
Temp	98.6 °F (37 °C) -DF	—	—	—	98.2 °F (36.8 °C) -MJ
Temp src	Oral -DF	—	—	—	—
Pulse	56 -JI	63 -JI	52 -RM	53 -RM	55 -RM
Heart Rate Source	—	—	—	Monitor -RM	Monitor -RM
Resp	18 -JI	18 -JI	17 -RM	17 -RM	20 -RM
BP	(!) 126/47 -JI	143/52 -JI	(!) 109/40 -RM	(!) 124/49 -RM	127/55 -RM
BP Location	—	—	—	Right arm -RM	Right arm -RM
BP Method	—	—	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM
MAP (mmHg)	66 mm Hg -JI	76 mm Hg -JI	(!) 56 mm Hg -RM	68 mm Hg -RM	73 mm Hg -RM
Patient Position	—	—	—	Sitting -RM	Supine -RM
SpO2	97 % -JI	96 % -JI	94 % -RM	96 % -RM	98 % -RM
O2 Device	Nasal cannula -JI	—	—	Nasal cannula -RM	Nasal cannula -RM
Intake (mL)					
P.O.	—	—	—	—	250 mL -RM
Output (mL)					
Urine	—	—	—	250 mL -RM	—
Stool Appearance					
Stool Appearance	—	—	—	—	Unable to assess -RM

Row Name	06/19/18 0300	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300
Vitals					
Temp	—	—	—	98.1 °F (36.7 °C) -MJ	—
Pulse	55 -RM	54 -RM	53 -RM	56 -RM	59 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	16 -RM	19 -RM	19 -RM	21 -RM	20 -RM
BP	120/59 -RM	113/50 -RM	(!) 109/44 -RM	(!) 123/43 -RM	127/59 -RM
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM
MAP (mmHg)	73 mm Hg -RM	62 mm Hg -RM	61 mm Hg -RM	61 mm Hg -RM	75 mm Hg -RM
Patient Position	Lying right side -RM	Lying right side -RM	Lying left side -RM	Lying left side -RM	Lying left side -RM

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	06/19/18 0300	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300
SpO2	92 % -RM	93 % -RM	92 % -RM	94 % -RM	97 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Output (mL)					
Urine	300 mL -RM	—	—	200 mL -MJ	—
Stool Appearance					
Stool Appearance	—	Unable to assess -RM	—	Unable to assess -RM	—

Row Name	06/18/18 2200	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1819
Vitals					
Temp	—	—	98.4 °F (36.9 °C) -MJ	—	—
Pulse	55 -RM	56 -RM	56 -RM	56 -RM	—
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	—
Resp	21 -RM	21 -RM	22 -RM	22 -RM	—
BP Location	Right arm -RM	—	—	—	—
BP Method	Non-invasive Cuff -RM	—	—	—	—
Patient Position	Supine -RM	—	—	—	—
SpO2	99 % -RM	99 % -RM	96 % -RM	(!) 89 % -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—
Intake (mL)					
Percent Meals Eaten (%)	—	—	—	—	100 % Dinner. -JI
Unmeasured Output					
Urine Occurrence	—	—	0 -RM	—	—
Stool Occurrence	—	—	0 -RM	—	—
Emesis Occurrence	—	—	0 -RM	—	—
Stool Appearance					
Stool Appearance	Unable to assess -RM	—	Unable to assess -RM	—	—
sodium chloride 0.9% (NS) infusion					
Volume (mL)	—	—	1400 mL -RM	—	—

Row Name	06/18/18 1803	06/18/18 1800	06/18/18 1727	06/18/18 1600	06/18/18 1500
Vitals					
Temp	—	—	98.1 °F (36.7 °C) -JD	—	—
Temp src	—	—	Oral -JD	—	—
Pulse	—	56 -RM	—	52 -JI	54 -JI
Resp	—	20 -RM	—	20 -JI	18 -JI
BP	—	132/60 -RM	—	142/57 -JI	151/56 -JI
MAP (mmHg)	—	75 mm Hg -RM	—	76 mm Hg -JI	79 mm Hg -JI
SpO2	—	94 % -RM	—	(!) 87 % -JI	95 % -JI
Intake (mL)					
Saline Flush (mL)	40 mL -JI	—	—	—	—

Row Name	06/18/18 1400	06/18/18 1345	06/18/18 1303	06/18/18 1300	06/18/18 1247
Vitals					
Pulse	58 -JI	—	—	57 -JI	—
Resp	19 -JI	—	—	15 -JI	—
BP	134/53 -JI	—	—	(!) 130/45 -JI	—
MAP (mmHg)	72 mm Hg -JI	—	—	65 mm Hg -JI	—
SpO2	91 % -JI	—	—	93 % -JI	—
Intake (mL)					
Percent Meals Eaten (%)	—	—	95 % Lunch -JI	—	—
Saline Flush (mL)	—	—	—	—	20 mL -JI
Unmeasured Output					
Urine Occurrence	—	1 -JI	—	—	—

Row Name	06/18/18 1230	06/18/18 1205	06/18/18 1200	06/18/18 1100	06/18/18 1000
Vitals					
Temp	97.7 °F (36.5 °C) -JD	—	—	—	—
Temp src	Oral -JD	—	—	—	—
Pulse	—	—	52 -JI	50 -JI	51 -JI
Resp	—	—	18 -JI	17 -JI	16 -JI
BP	—	—	140/56 -JI	(!) 128/46 -JI	131/52 -JI

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	06/18/18 1230	06/18/18 1205	06/18/18 1200	06/18/18 1100	06/18/18 1000
MAP (mmHg)	—	—	77 mm Hg -JI	66 mm Hg -JI	72 mm Hg -JI
SpO2	—	—	—	97 % -JI	98 % -JI
Unmeasured Output					
Urine Occurrence	—	1 -JI	—	—	—

Row Name	06/18/18 0916	06/18/18 0900	06/18/18 0848	06/18/18 0831	06/18/18 0800
Vitals					
Temp	—	—	—	97.8 °F (36.6 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	—	**(!) 49** -JI	—	—	**(!) 48** -JI
Resp	—	16 -JI	—	—	17 -JI
BP	—	137/54 -JI	—	—	**(!) 123/49** -JI
MAP (mmHg)	—	75 mm Hg -JI	—	—	66 mm Hg -JI
SpO2	—	100 % -JI	—	—	91 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
Output (mL)					
Urine	150 mL -JI	—	300 mL -JI	—	—

Row Name	06/18/18 0700	06/18/18 0640	06/18/18 0600	06/18/18 0500	06/18/18 0445
Vitals					
Temp	—	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM
Temp src	—	—	Axillary -RM	—	Axillary -RM
Pulse	**(!) 46** -JI	—	**(!) 46** -RM	**(!) 47** -RM	**(!) 47** -RM
Heart Rate Source	—	—	Monitor -RM	Monitor -RM	—
Resp	17 -JI	—	13 -RM	18 -RM	18 -RM
BP	**(!) 115/49** -JI	—	**(!) 126/48** -RM	122/52 -RM	120/52 -RM
BP Location	—	—	Right arm -RM	Right arm -RM	—
BP Method	—	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—
MAP (mmHg)	65 mm Hg -JI	—	68 mm Hg -RM	69 mm Hg -RM	—
Patient Position	—	—	Supine -RM	Lying left side -RM	—
SpO2	95 % -JI	—	97 % -RM	97 % -RM	—
O2 Device	—	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Weight	—	—	104.9 kg (231 lb 4.2 oz) -RM	—	—
Weight Method	—	—	Actual -RM	—	—
Output (mL)					
Urine	—	—	300 mL -RM	275 mL -RM	—
Unmeasured Output					
Urine Occurrence	—	—	—	0 -RM	—
Stool Occurrence	—	—	—	0 -RM	—
Emesis Occurrence	—	—	—	0 -RM	—
Stool Appearance					
Stool Appearance	—	—	—	Unable to assess -RM	—
sodium chloride 0.9% (NS) infusion					
Volume (mL)	—	—	495 mL -RM	—	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Dose	—	*250 mL -RM	—	—	—
Bolus Volume (mL)	—	—	250 -RM	—	—

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0103
Vitals					
Pulse	**(!) 49** -RM	**(!) 49** -RM	51 -RM	54 -RM	—
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	—	—
Resp	19 -RM	18 -RM	19 -RM	20 -RM	—
BP	117/50 -RM	**(!) 109/43** -RM	**(!) 102/39** -RM	—	—
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	—	—
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—	—
MAP (mmHg)	67 mm Hg -RM	60 mm Hg -RM	**(!) 55 mm Hg** -RM	—	—
Patient Position	Sitting -RM	Supine -RM	Lying right side -RM	—	—
SpO2	97 % -RM	92 % -RM	**(!) 87 %** -RM	—	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—	—
Output (mL)					
Urine	—	200 mL -RM	—	—	—

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0103
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -RM

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0000	06/17/18 2300	06/17/18 2225
Vitals					
Temp	—	98.1 °F (36.7 °C) -RM	—	—	98 °F (36.7 °C) -AF
Temp src	—	Oral -RM	—	—	Oral -AF
Pulse	57 -RM	57 -RM	55 -RM	54 -RM	53 -AF
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -AF
Resp	21 -RM	20 -RM	20 -RM	17 -RM	18 -AF
BP	123/51 -RM	140/52 -RM	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF
BP Location	Right arm -RM	—	Right arm -RM	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM
MAP (mmHg)	69 mm Hg -RM	—	62 mm Hg -RM	(!) 58 mm Hg -RM	—
Patient Position	Lying left side -RM	—	Lying left side -RM	Sitting -RM	Sitting -RM
SpO2	(!) 88 % -RM	—	92 % -RM	90 % -RM	92 % -AF
O2 Device	Nasal cannula -RM	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -AF
Height	—	—	—	—	67" (1.702 m) -AF
Weight	—	—	—	—	103.4 kg (227 lb 15.3 oz) -AF
Weight Method	—	—	—	—	Actual -AF
Output (mL)					
Urine	—	—	300 mL -RM	—	—
Emesis	—	—	0 mL -RM	—	—
Stool (mL)	—	—	0 mL -RM	—	—
Blood	—	—	0 mL -RM	—	—
Unmeasured Output					
Urine Occurrence	—	—	—	—	0 -RM
Stool Occurrence	—	—	—	—	0 -RM
Emesis Occurrence	—	—	—	—	0 -RM
Stool Appearance					
Stool Appearance	—	—	Unable to assess -RM	—	Unable to assess -RM
sodium chloride 0.9% (NS) infusion					
Volume (mL)	—	—	0 mL -RM	—	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Volume (mL)	—	—	0 -RM	—	—

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1708
Vitals					
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR
Temp src	Oral -BR	Oral -BR	Oral -BR	Oral -BR	Oral -BR
Pulse	57 -BR	51 -BR	55 -BR	55 -BR	55 -BR
Heart Rate Source	Monitor -BR	Monitor -BR	Monitor -BR	—	Monitor -BR
Resp	16 -BR	18 -BR	18 -BR	18 -BR	18 -BR
Respiration Source	visual -BR	visual -BR	visual -BR	—	visual -BR
BP	134/59 -BR	126/55 -BR	132/56 -BR	129/53 -BR	(!) 115/49 -BR
BP Location	Right arm -BR	Right arm -BR	Right arm -BR	—	Right arm -BR
BP Method	Portable -BR	Portable -BR	Portable -BR	—	Portable -BR
Patient Position	Sitting -BR	Sitting -BR	Sitting -BR	—	Standing -BR
SpO2	100 % -BR	100 % -BR	100 % -BR	—	100 % -BR
O2 Device	—	None (Room air) -BR	None (Room air) -BR	—	None (Room air) -BR

Row Name	06/17/18 1538	06/17/18 1537	06/17/18 1535	06/17/18 1533	06/17/18 1502
Vitals					
Temp	—	97.8 °F (36.6 °C) -RG	—	—	97.7 °F (36.5 °C) -RG
Temp src	—	—	—	—	Oral -RG
Pulse	—	55 -RG	—	—	54 -RG
Heart Rate Source	—	—	—	—	Monitor -RG
Resp	—	22 -RG	—	—	25 -RG
Respiration Source	—	—	—	—	visual -RG
BP	—	114/51 -RG	—	—	112/52 -RG

Flowsheets (all recorded) (continued)

CCP Vitals, Intake and Output (continued)

Row Name	06/17/18 1538	06/17/18 1537	06/17/18 1535	06/17/18 1533	06/17/18 1502
BP Location	—	—	—	—	Left arm -RG
BP Method	—	—	—	—	Non-invasive Cuff -RG
Patient Position	—	—	—	—	Supine -RG
SpO2	—	—	—	—	100 % -RG
O2 Device	None (Room air) -RG	—	—	—	None (Room air) -RG
Weight	—	—	95.3 kg (210 lb) -RG	—	—
Weight Method	—	—	Stated -RG	—	—
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -RG	—

Row Name	06/17/18 1437
Vitals	
Pulse	56 -NS
SpO2	98 % -NS
[REMOVED] Urethral Catheter 16 Fr	
Urethral Catheter Properties	Placement Date: 01/16/18 -RD Placement Time: 2140 -RD Inserted by: Denmark, RN -RD Present on arrival to hospital?: No -RD Patient location at time of placement:: ER -RD Catheter Indicator: Acute urinary retention -RD Tube Size (Fr.): 16 Fr -RD Catheter Balloon Size: 10 mL -RD Catheter Secured: Yes -RD Urine Returned: Yes -RD Removal Date: 06/17/18 -RG, N/E

Flowsheets (all recorded)

Screenings

Row Name	06/21/18 0830	06/20/18 2133	06/20/18 0800	06/19/18 2000	06/19/18 1118
Advance Directives (For Healthcare)					
Advance Directive	—	—	—	—	Patient does not have advance directive -PM
Braden Scale					
Sensory Perceptions	4 -AM	4 -TS	4 -DG	4 -EE	—
Moisture	4 -AM	4 -TS	4 -DG	4 -EE	—
Activity	3 -AM	3 -TS	3 -DG	3 -EE	—
Mobility	4 -AM	4 -TS	4 -DG	4 -EE	—
Nutrition	3 -AM	3 -TS	3 -DG	3 -EE	—
Friction and Shear	3 -AM	3 -TS	3 -DG	3 -EE	—
Braden Scale Score	21 -AM	21 -TS	21 -DG	21 -EE	—
Nurse-Driven Mobility Guidelines					
Get-Up-And-Go Test: "Rising from Chair"	1 -AM	0 -TS	0 -DG	4 -EE	—

Row Name	06/19/18 1117	06/19/18 0800	06/18/18 2136	06/18/18 2000	06/18/18 1259
ADL Screening					
Which is your dominant hand?	—	Right -JI	—	Right -RM	—
Values/Beliefs					
Cultural Preferences Affecting Hospitalization	—	—	No -RM	—	—
Spiritual Preferences Affecting Hospitalization	—	—	No -RM	—	—
Braden Scale					
Sensory Perceptions	4 -PM	4 -JI	—	4 -RM	—
Moisture	4 -PM	4 -JI	—	4 -RM	—
Activity	3 -PM	3 -JI	—	3 -RM	—
Mobility	4 -PM	4 -JI	—	4 -RM	—
Nutrition	3 -PM	3 -JI	—	3 -RM	—
Friction and Shear	3 -PM	3 -JI	—	3 -RM	—
Braden Scale Score	21 -PM	21 -JI	—	21 -RM	—
Discharge Planning					
Living Situation Prior to Admission	—	—	—	—	Home -KG
Primary Caregiver	—	—	—	—	Family (relationship) primary caregiver is self -KG
Is Discharge Transport arranged?	—	—	—	—	Yes -KG
Nurse-Driven Mobility Guidelines					
Get-Up-And-Go Test: "Rising from Chair"	—	4 -JI	—	—	—

Row Name	06/18/18 0800	06/18/18 0127	06/18/18 0000	06/17/18 1540	06/17/18 1537
Advance Directives (For Healthcare)					
Have you reviewed your Advance Directive and is it valid for this stay?	—	—	Not applicable -RM	—	—
Advance Directive	—	—	Patient does not have advance directive -RM	—	—
Healthcare Agent Appointed	—	—	Yes -RM	—	—
Pre-existing Allow Natural Death Order	—	—	No -RM	—	—
Information Provided on Healthcare Directives	—	—	No -RM	—	—
Patient Requests Assistance (Retired)	—	—	No -RM	—	—
Nutrition Screen Scoring (Retired)					
Weight Loss in the	—	—	1 -RM	—	—

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	06/18/18 0800	06/18/18 0127	06/18/18 0000	06/17/18 1540	06/17/18 1537
past 3 months (Retired)					
BMI (Body Mass Index)-Retired	—	—	0 -RM	—	—
Appetite (Retired)	—	—	0 -RM	—	—
Ability to eat/retain food (Retired)	—	—	0 -RM	—	—
Stress factors (Retired)	—	—	1 -RM	—	—
Total Nutrition Screen Score (Retired)	—	—	2 -RM	—	—
ADL Screening					
Patient's Vision Adequate to Safely Complete Daily Activities	—	—	Yes -RM	—	—
Patient's Judgement Adequate to Safely Complete Daily Activities	—	—	Yes -RM	—	—
Patient's Memory Adequate to Safely Complete Daily Activities	—	—	Yes -RM	—	—
Patient Able to Express Needs/Desires	—	—	Yes -RM	—	—
Which is your dominant hand?	Right -JI	—	Right -RM	—	—
Dressing	—	—	Independent -RM	—	—
Grooming	—	—	Independent -RM	—	—
Feeding	—	—	Independent -RM	—	—
Bathing	—	—	Independent -RM	—	—
Toileting	—	—	Independent -RM	—	—
In/Out Bed	—	—	Independent -RM	—	—
Walks in Home	—	—	Independent -RM	—	—
Weakness of Legs	—	—	None -RM	—	—
Weakness of Arms/Hands	—	—	None -RM	—	—
Hearing - Right Ear	—	—	Functional -RM	—	—
Hearing - Left Ear	—	—	Functional -RM	—	—
Assistive Devices					
Assistive Devices	—	—	Eyeglasses -RM	—	—
Therapy Consults (RETIRED)					
PT Evaluation Needed (RETIRED)	—	—	2 -RM	—	—
OT Evalulation Needed (RETIRED)	—	—	2 -RM	—	—
SLP Evaluation Needed (RETIRED)	—	—	2 -RM	—	—
Values/Beliefs					
Cultural Preferences Affecting Hospitalization	—	No -RM	No -RM	—	—
Spiritual Preferences Affecting Hospitalization	—	No -RM	No -RM	—	—
Nursing Referrals					
Spiritual Health Consult	—	—	No -RM	—	—
Social Services Consult	—	—	No -RM	—	—
Patient Belongings at Bedside					
Belongings at Bedside	—	—	Vision;Electronic device -RM	—	—
Belongings sent to security (Retired)	—	—	No -RM	—	—

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	06/18/18 0800	06/18/18 0127	06/18/18 0000	06/17/18 1540	06/17/18 1537
(RETIRED)Belongings Sent Home	—	—	Yes -RM	—	—
Suicide/Harm Risk					
Ever harm self (Retired)	—	—	No -RM	—	No -RG
Current thoughts (Retired)	—	—	No -RM	—	No -RG
Self harm plan (Retired)	—	—	No -RM	—	No -RG
Patient information obtained from	—	—	Patient -RM	—	Patient -RG
Suicide Risk Re-Assessment					
Any changes in Suicide Risk Assessment?	—	—	No -RM	—	—
Braden Scale					
Sensory Perceptions	4 -JI	—	4 -RM	—	—
Moisture	4 -JI	—	4 -RM	—	—
Activity	3 -JI	—	3 -RM	—	—
Mobility	4 -JI	—	4 -RM	—	—
Nutrition	3 -JI	—	3 -RM	—	—
Friction and Shear	3 -JI	—	3 -RM	—	—
Braden Scale Score	21 -JI	—	21 -RM	—	—
Pressure Ulcer Present on Admission (IF YES, DOCUMENT BY GOING TO: 1) NOTES ACTIVITY 2) PROGRESS NOTES 3) TYPE "PRESSURE ULCER ON ADMISSION" IN SMART TEXT BOX 4) CLICK CO-SIGN WITH MD SIGNATURE)					
Pressure ulcer present on admission	—	—	No -RM	—	—
Discharge Planning					
Living Situation Prior to Admission	—	—	Home -RM	—	—
Primary Caregiver	—	—	None -RM	—	—
Is Discharge Transport arranged?	—	—	Yes -RM	—	—
Anticipated assistance needed at discharge	—	—	No -RM	—	—
Barriers to discharge	—	—	No Barriers -RM	—	—
Discharge plan consult/Discharge referrals needed	—	—	none -RM	—	—
Nurse-Driven Mobility Guidelines					
Get-Up-And-Go Test: "Rising from Chair"	1 -JI	—	1 -RM	—	—
Swallow Screening					
Patient Alert	—	—	Yes -RM	Yes -RG	—
Continue Screen?	—	—	If yes-continue screen -RM	If yes-continue screen -RG	—
Dx Aspiration PNA	—	—	No -RM	No -RG	—
Continue Screen?	—	—	If no-continue screen -RM	If no-continue screen -RG	—
Pt Drooling?	—	—	No -RM	No -RG	—
Continue Screen? (If screening to continue, give 1 Tsp of water)	—	—	If no-continue screen -RM	If no-continue screen -RG	—
Any Cough?	—	—	No -RM	No -RG	—
Voice gurgle/wet?	—	—	No -RM	No -RG	—
Continue Screen? (If screening to continue, provide sips of cup of water)	—	—	If no to above questions-continue screen -RM	If no to above questions-continue screen -RG	—
Any Cough?	—	—	No -RM	No -RG	—
Voice gurgle/wet?	—	—	No -RM	No -RG	—
Continue Screen?	—	—	If no to above questions-continue screen -RM	If no to above questions-continue screen -RG	—
Did Patient Pass Swallow Screen?	—	—	Yes-passed screen -RM	Yes-passed screen -RG	—

Flowsheets (all recorded) (continued)

Screenings (continued)

Row Name	06/18/18 0800	06/18/18 0127	06/18/18 0000	06/17/18 1540	06/17/18 1537
Abuse Assessment					
Safe in Home	—	—	Yes -RM	—	UTA -RG
Do you feel threatened or unsafe in a relationship?	—	—	No -RM	—	—
Are you in immediate danger?	—	—	No -RM	—	—
Do you feel neglected?	—	—	No -RM	—	—
Physical harm?	—	—	No -RM	—	—
Verbal harm	—	—	No -RM	—	—
Abuse Re-Assessment					
Any new signs/symptoms of abuse?	—	—	No -RM	—	—

WS Kennestone Hospital
677 Church Street
Marietta GA 30060-1101
Inpatient Record

Maurice, Eugene George
MRN: 561253820, DOB: 1/2/1949, Sex: M
Adm: 6/17/2018, D/C: 6/21/2018

Flowsheets (all recorded)

Daily Cares/Safety

Row Name	06/21/18 1200	06/21/18 1000	06/21/18 0800	06/21/18 04:07:21	06/20/18 23:57:07
Precautions					
Precautions	—	None -JK	—	None -TW	None -TW
Safe Environment					
Arm Bands On	ID;Allergies -CI	ID;Allergies -JK	ID;Allergies -CI	ID;Allergies -TW	ID;Allergies -TW
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -CI	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JK	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -CI	Overbed table in reach -TW	Overbed table in reach -TW
Safety Alarm Verfied	No alarm -CI	No alarm -JK	No alarm -CI	No alarm -TW	No alarm -TW
Side Rails/Bed Safety	3/4 -CI	3/4 -JK	3/4 -CI	3/4 -TW	3/4 -TW
Fall Risk Interventions					
Fall Prevention Interventions	Frequent Visual Checks/Rounding -CI	Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Yellow Armband, Socks -JK	Yellow Armband, Socks -CI	Yellow Armband, Socks -TW	Yellow Armband, Socks -TW
Fall Prevention Education Reviewed with :	Patient -CI	Patient -JK	Patient -CI	Patient -TW	Patient -TW
Mobility					
Mobility Intervention	Resting in bed -CI	Stand at bedside;Ambulate in room;Back to bed -JK	Resting in bed -CI	Ambulate in hall -TW	Ambulate in room -TW
Assistive Device	None -CI	None -JK	None -CI	None -TW	None -TW
Level of Assistance	Independent -CI	Independent -JK	Independent -CI	Independent -TW	Standby assist, set-up cues, supervision of patient - no hands on -TW
Distance Ambulated (ft)	—	20 ft -JK	—	700 ft -TW	20 ft -TW
Ambulation Response	Tolerated well -CI	Tolerated well -JK	Tolerated well -CI	Tolerated well -TW	Tolerated well -TW
Active Range of Motion	Active -CI	Active -JK	Active;All extremities -CI	All extremities -TW	Active;All extremities -TW
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -CI	—	Yes -CI	Yes -TW	Yes -TW
Repositioned	Turns self;Semi Fowler's -CI	Sitting -JK	Turns self -CI	Turns self -TW	Turns self -TW
Heels/Feet	Foot of bed elevated -CI	—	Foot of bed elevated -CI	Foot of bed elevated -TW	Heels elevated off bed -TW
Anti-Embolism Devices					
Anti-Embolism Devices	Temporarily "Off" -CI	Temporarily "Off" -JK	Temporarily "Off" -CI	Temporarily "Off" -TW	Temporarily "Off" -TW
Patient Refused	Yes -CI	Yes -JK	Yes -CI	Yes -TW	Yes -TW
Nutrition					
Feeding	Able to feed self -CI	Able to feed self -JK	—	Able to feed self -TW	Able to feed self -TW
Appetite	—	Good -JK	—	Good -TW	Good -TW
Diet Supplements	—	—	—	None -TW	None -TW
Percent Meals Eaten (%)	—	100 % -JK	—	0 % -TW	0 % -TW
Snacks Eaten (%)	—	—	—	0 -TW	0 -TW
Supplement Consumed (%)	—	—	—	0 -TW	0 -TW
Hygiene					
Hygiene Performed	Patient/family refused -CI	—	—	Patient/family refused -TW	Patient/family refused -TW
Performed by	Self -CI	—	Self -CI	Self -TW	Self -TW
Incentive Spirometer					
Is pt using incentive spirometer?	—	Yes, independent -JK	Yes, independent -CI	Yes, independent -TW	Yes, independent -TW
Family/Significant Other Communication					
Family/Significant	—	—	—	Other (Comment) -TW	Other (Comment) -TW

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/21/18 1200	06/21/18 1000	06/21/18 0800	06/21/18 04:07:21	06/20/18 23:57:07
Other Update					
Telemetry Details					
Telemetry Monitor On	—	—	Other (Comment) dc -CI	Yes -TW	Yes -TW
Telemetry Audible	—	—	No -CI	Yes -TW	Yes -TW
Telemetry Box Number	—	—	— -CI	5208 -TW	5208 -TW
Telemetry Alarms Set	—	—	— -CI	Yes -TW	Yes -TW
Row Name	**06/20/18 2133**	**06/20/18 19:43:22**	**06/20/18 0800**	**06/20/18 0600**	**06/20/18 0400**
Precautions					
Precautions	—	None -TW	—	—	—
Safe Environment					
Arm Bands On	—	ID;Allergies -TW	—	ID -JP	ID -JP
Safety Checks	—	Overbed table in reach -TW	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JP
Safety Alarm Verfied	—	No alarm -TW	—	No alarm -JP	No alarm -JP
Side Rails/Bed Safety	—	3/4 -TW	—	3/4 -JP	3/4 -JP
Fall Risk Interventions					
Fall Prevention Interventions	—	Yellow Armband, Socks -TW	—	Yellow Armband, Socks -JP	Yellow Armband, Socks -JP
Fall Prevention Education Reviewed with :	—	Patient -TW	—	Patient;Family -JP	Patient;Family -JP
Mobility					
Mobility Intervention	Ambulate in room -TW	Resting in bed -TW	—	Resting in bed -JP	Resting in bed -JP
Assistive Device	None -TW	—	—	—	—
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -TW	Standby assist, set-up cues, supervision of patient - no hands on -TW	—	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP
Distance Ambulated (ft)	20 ft -TW	—	—	—	—
Ambulation Response	Tolerated well -TW	Tolerated well -TW	—	—	—
Active Range of Motion	Active;All extremities -TW	Active;All extremities -TW	—	Active;All extremities -JP	Active;All extremities -JP
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -TW	Yes -TW	—	Yes -JP	Yes -JP
Repositioned	Turns self -TW	Turns self -TW	—	Turns self -JP	Turns self -JP
Heels/Feet	Heels elevated off bed -TW	Heels elevated off bed -TW	—	Heels elevated off bed -JP	Heels elevated off bed -JP
Anti-Embolism Devices					
Anti-Embolism Devices	—	Temporarily "Off" -TW	Off -DG	—	—
Patient Refused	—	Yes -TW	Yes -DG	—	—
Nutrition					
Feeding	—	Able to feed self -TW	—	—	—
Appetite	—	Good -TW	—	—	—
Diet Supplements	—	None -TW	—	—	—
Percent Meals Eaten (%)	—	0 % -TW	—	—	—
Snacks Eaten (%)	—	0 -TW	—	—	—
Supplement Consumed (%)	—	0 -TW	—	—	—
Hygiene					
Hygiene Performed	—	Patient/family refused -TW	—	—	—
Performed by	—	Self -TW	—	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	Yes (independent) -TS	Yes, independent -TW	Yes (independent) -DG	—	—

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 0800	06/20/18 0600	06/20/18 0400
Incentive Spirometry Tx					
Respiratory Effort	—	—	Good -DG	—	—
Treatment Tolerance	—	—	Tolerated well -DG	—	—
Family/Significant Other Communication					
Family/Significant Other Update	—	Called -TW	—	—	—
Telemetry Details					
Telemetry Monitor On	Yes -TS	Yes -TW	No -DG	—	—
Telemetry Audible	Yes -TS	Yes -TW	—	—	—
Telemetry Box Number	5208 -TS	5208 -TW	—	—	—
Telemetry Alarms Set	Yes -TS	Yes -TW	—	—	—

Row Name	06/20/18 0200	06/20/18 0000	06/19/18 2200	06/19/18 2000	06/19/18 1600
Safe Environment					
Arm Bands On	ID -JP	ID -JP	ID -JP	ID -JP	ID -FT
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JP	Overbed table in reach;Wheels on bed locked;Bed in lowest position;NonSkid Footwear on;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -FT
Safety Alarm Verfied	No alarm -JP	No alarm -JP	No alarm -JP	No alarm -JP	No alarm -FT
Side Rails/Bed Safety	3/4 -JP	3/4 -JP	3/4 -JP	3/4 -JP	3/4 -FT
Fall Risk Interventions					
Fall Prevention Interventions	Yellow Armband, Socks -JP	Yellow Armband, Socks -JP	Yellow Armband, Socks;Needed items within reach -JP	Yellow Armband, Socks;Needed items within reach -JP	Yellow Armband, Socks;Needed items within reach -FT
Fall Prevention Education Reviewed with :	Patient;Family -JP	Patient;Family -JP	Patient;Family -JP	Patient;Family -JP	Patient;Family -FT
Mobility					
Mobility Intervention	Resting in bed -JP	Resting in bed -JP	Resting in bed -JP	Resting in bed -JP	Resting in bed -FT
Assistive Device	—	—	—	—	None -FT
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -FT
Active Range of Motion	Active;All extremities -JP	Active;All extremities -JP	Active;All extremities -JP	Active;All extremities -JP	Active;All extremities -FT
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -JP	Yes -JP	Yes -JP	Yes -JP	Yes -FT
Repositioned	Turns self -JP	Turns self -JP	Turns self -JP	Turns self -JP	Turns self -FT
Heels/Feet	Heels elevated off bed -JP	Heels elevated off bed -JP	Heels elevated off bed -JP	Heels elevated off bed -JP	Heels elevated off bed -FT
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	—	Off -EE	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	Yes (independent) -EE	—
Incentive Spirometry Tx					
Respiratory Effort	—	—	—	Good -EE	—
Treatment Tolerance	—	—	—	Tolerated well -EE	—

Row Name	06/19/18 1429	06/19/18 1118	06/19/18 1000	06/19/18 0800	06/19/18 0600
Safe Environment					
Arm Bands On	ID -FT	—	ID -DF	ID -DF	ID;Allergies -MJ
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -FT	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -DF	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -DF	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ
Safety Alarm Verfied	No alarm -FT	—	No alarm -DF	No alarm -DF	No alarm -MJ
Side Rails/Bed Safety	3/4 -FT	—	3/4 -DF	3/4 -DF	3/4 -MJ

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/19/18 1429	06/19/18 1118	06/19/18 1000	06/19/18 0800	06/19/18 0600
Fall Risk Interventions					
Fall Prevention Interventions	Yellow Armband, Socks;Needed items within reach -FT	—	Frequent Visual Checks/Rounding;Needed items within reach -DF	Frequent Visual Checks/Rounding;Needed items within reach -DF	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ
Fall Prevention Education Reviewed with :	Patient;Family -FT	—	Patient -DF	Patient -DF	Patient -MJ
Mobility					
Mobility Intervention	Ambulate in room;Resting in bed -FT	—	Resting in bed -DF	Resting in bed -DF	Resting in bed -MJ
Assistive Device	None -FT	—	—	—	—
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -FT	—	Standby assist, set-up cues, supervision of patient - no hands on -DF	Standby assist, set-up cues, supervision of patient - no hands on -DF	Standby assist, set-up cues, supervision of patient - no hands on -MJ
Active Range of Motion	Active;All extremities -FT	—	Active;All extremities -DF	Active;All extremities -DF	Active;All extremities -MJ
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -FT	—	Yes -DF	Yes -DF	Yes -MJ
Repositioned	Turns self -FT	—	Turns self -DF	Turns self -DF	Turns self -MJ
Heels/Feet	Heels elevated off bed -FT	—	—	—	—
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	—	Off -JI	—
Patient Refused	—	—	—	Yes -JI	—
Hygiene					
Skin Prep for Procedure	—	No -PM	—	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	Yes (independent) -JI	—

Row Name	06/19/18 0400	06/19/18 0200	06/19/18 0000	06/18/18 2200	06/18/18 2000
Precautions					
Precautions	Fall;Bleeding -RM	Fall;Bleeding -RM	Fall;Bleeding -RM	Fall;Bleeding -RM	Fall;Bleeding -RM
Safe Environment					
Arm Bands On	ID;Allergies -RM	ID;Allergies -RM	ID;Allergies -MJ	ID;Allergies -MJ	ID;Allergies -MJ
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ
Safety Alarm Verfied	No alarm -RM	No alarm -RM	No alarm -MJ	No alarm -MJ	No alarm -MJ
Side Rails/Bed Safety	3/4 -RM	3/4 -RM	3/4 -MJ	3/4 -MJ	3/4 -MJ
Fall Risk Interventions					
Fall Prevention Interventions	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -RM	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -RM	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ
Fall Prevention Education Reviewed with :	Patient -RM	Patient -RM	Patient -MJ	Patient -MJ	Patient -MJ
Functional Abilities on Admission					
Eating	—	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Oral Hygiene	—	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Toileting Hygiene	—	—	—	—	06. Independent -

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/19/18 0400	06/19/18 0200	06/19/18 0000	06/18/18 2200	06/18/18 2000
					Patient completes the activity by him/herself with no assistance from a helper. -RM
Wash upper body	—	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Functional Abilities Discharge Goals					
Eating discharge goal	—	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Oral Hygiene disharge goal	—	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Toileting Hygiene discharge goal	—	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Wash Upper Body discharge goal	—	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Mobility					
Mobility Intervention	Resting in bed -RM	Resting in bed -RM	Resting in bed -MJ	Resting in bed -MJ	Resting in bed -MJ
Assistive Device	—	—	—	—	None -RM
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -RM	Standby assist, set-up cues, supervision of patient - no hands on -RM	Standby assist, set-up cues, supervision of patient - no hands on -MJ	Standby assist, set-up cues, supervision of patient - no hands on -MJ	Standby assist, set-up cues, supervision of patient - no hands on -MJ
Active Range of Motion	Active;All extremities -RM	Active;All extremities -RM	Active;All extremities -MJ	Active;All extremities -MJ	Active;All extremities -RM
Transport Method	—	—	—	—	Bed -RM
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -RM	Yes -RM	Yes -MJ	Yes -MJ	Yes -MJ
Repositioned	Turns self -RM	Turns self -RM	Turns self -MJ	Turns self -MJ	Turns self -MJ
Heels/Feet	—	—	—	—	Heels elevated off bed -RM
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	—	—	Off -RM
Patient Refused	—	—	—	—	Yes -RM
Nutrition					
Feeding	—	—	—	—	Able to feed self -RM
Hygiene					
Hygiene Performed	—	—	—	—	Hand hygiene -RM
Performed by	—	—	—	—	Self -RM
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	—	Yes (independent) -RM
Family/Significant Other Communication					
Family/Significant Other Update	—	—	—	—	Updated;Visiting -RM
Telemetry Details					
Telemetry Monitor On	—	—	—	—	No -RM
Comfort and Environment Interventions					
Comfort	—	—	—	—	Repositioned -RM

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/19/18 0400	06/19/18 0200	06/19/18 0000	06/18/18 2200	06/18/18 2000
Less Restrictive Restraint Alternatives					
Alternatives Utilized	—	—	—	—	Family/Visitor at Bedside;More Frequent Safety Checks -RM
Safety Equipment at Bedside					
Safety Equipment at Bedside	—	—	—	—	Suction -RM
Entertainment					
Therapy Interventions	—	—	—	—	Television -RM

Row Name	06/18/18 1819	06/18/18 1600	06/18/18 1400	06/18/18 1345	06/18/18 1303
Safe Environment					
Arm Bands On	—	ID;Allergies -JD	ID;Allergies -JD	—	—
Safety Checks	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	—	—
Safety Alarm Verfied	—	No alarm -JD	No alarm -JD	—	—
Side Rails/Bed Safety	—	3/4 -JD	3/4 -JD	—	—
Fall Risk Interventions					
Fall Prevention Interventions	—	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	—	—
Fall Prevention Education Reviewed with :	—	Patient;Family -JD	Patient;Family -JD	—	—
Mobility					
Mobility Intervention	—	Chair -JD	Chair -JD	Bathroom privileges;Back to bed -JI	—
Assistive Device	—	None -JD	—	None -JI	—
Level of Assistance	—	Standby assist, set-up cues, supervision of patient - no hands on -JD	Standby assist, set-up cues, supervision of patient - no hands on -JD	Standby assist, set-up cues, supervision of patient - no hands on -JI	—
Patient Position					
Repositioned	—	Up in chair -JD	Up in chair -JD	—	—
Nutrition					
Percent Meals Eaten (%)	100 % Dinner. -JI	—	—	—	95 % Lunch -JI

Row Name	06/18/18 1205	06/18/18 1000	06/18/18 0800	06/18/18 0600	06/18/18 0400
Precautions					
Precautions	—	—	—	Fall;Bleeding -RM	Fall;Bleeding -RM
Safe Environment					
Arm Bands On	—	ID;Allergies -JD	ID;Allergies -JD	ID;Allergies;Blood bank -RM	ID;Allergies;Blood bank -RM
Safety Checks	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM
Safety Alarm Verfied	—	No alarm -JD	No alarm -JD	No alarm -RM	No alarm -RM
Side Rails/Bed Safety	—	3/4 -JD	3/4 -JD	3/4 -RM	3/4 -RM
Fall Risk Interventions					
Fall Prevention Interventions	—	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Orient to environment -RM	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Orient to environment -RM
Fall Prevention Education Reviewed with :	—	Patient;Family -JD	Patient;Family -JD	Patient;Family;Education Activity Updated -RM	Patient;Family;Education Activity Updated -RM

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/18/18 1205	06/18/18 1000	06/18/18 0800	06/18/18 0600	06/18/18 0400
Functional Abilities on Admission					
Eating	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Oral Hygiene	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Toileting Hygiene	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Wash upper body	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Functional Abilities Discharge Goals					
Eating discharge goal	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Oral Hygiene disharge goal	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Toileting Hygiene discharge goal	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Wash Upper Body discharge goal	—	—	—	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM
Mobility					
Mobility Intervention	Ambulate in room;Bathroom privileges;Chair -JI	Bathroom privileges -JD	Bathroom privileges -JD	Ambulate in room;Up ad lib -RM	Ambulate in room;Up ad lib -RM
Assistive Device	None -JI	None -JD	None -JD	None -RM	None -RM
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -JI	Independent -JD	Independent -JD	Independent -RM	Independent -RM
Active Range of Motion	—	Active;All extremities -JD	Active;All extremities -JD	Active;All extremities -RM	Active;All extremities -RM
Transport Method	—	—	—	Bed -RM	Bed -RM
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	Yes -JD	Yes -JD	Yes Simultaneous filing. User may be unaware of other data. -LT	Yes -RM
Repositioned	—	Turns self -JD	Turns self -JD	Turns self Simultaneous filing. User may be unaware of other data. -LT	Turns self -RM
Heels/Feet	—	Heels elevated off bed -JD	Heels elevated off bed -JD	Heels elevated off bed -RM	Heels elevated off bed -RM
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	Off -JI	—	—
Patient Refused	—	—	Yes -JI	—	—
Nutrition					
Feeding	—	—	—	Able to feed self -RM	Able to feed self -RM

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/18/18 1205	06/18/18 1000	06/18/18 0800	06/18/18 0600	06/18/18 0400
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	Yes (independent) -JI	Yes (independent) -RM	Yes (independent) -RM
Telemetry Details					
Telemetry Monitor On	—	—	—	No -RM	No -RM
Comfort and Environment Interventions					
Comfort	—	—	—	Repositioned -RM	Repositioned -RM
Less Restrictive Restraint Alternatives					
Alternatives Utilized	—	—	—	More Frequent Safety Checks -RM	More Frequent Safety Checks -RM
Safety Equipment at Bedside					
Safety Equipment at Bedside	—	—	—	Suction -RM	Suction -RM

Row Name	06/18/18 0200	06/18/18 0000	06/17/18 1538
Precautions			
Precautions	Fall;Bleeding -RM	Fall;Bleeding -RM	—
Safe Environment			
Arm Bands On	ID;Allergies;Blood bank -RM	ID;Allergies;Blood bank -RM	—
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM	—
Safety Alarm Verfied	No alarm -RM	No alarm -RM	—
Side Rails/Bed Safety	3/4 -RM	3/4 -RM	—
Fall Risk Interventions			
Fall Prevention Interventions	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Orient to environment -RM	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Orient to environment -RM	—
Fall Prevention Education Reviewed with :	Patient;Family;Education Activity Updated -RM	Patient;Family;Education Activity Updated -RM	—
Functional Abilities on Admission			
Eating	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	—
Oral Hygiene	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	—
Toileting Hygiene	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	—
Wash upper body	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	—
Functional Abilities Discharge Goals			
Eating discharge goal	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	—
Oral Hygiene disharge	06. Independent -	06. Independent -	—

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/18/18 0200	06/18/18 0000	06/17/18 1538
goal	Patient completes the activity by him/herself with no assistance from a helper. -RM	Patient completes the activity by him/herself with no assistance from a helper. -RM	
Toileting Hygiene discharge goal	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	—
Wash Upper Body discharge goal	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	06. Independent - Patient completes the activity by him/herself with no assistance from a helper. -RM	—
Mobility			
Mobility Intervention	Ambulate in room;Up ad lib -RM	Ambulate in room;Up ad lib -RM	—
Assistive Device	None -RM	None -RM	—
Level of Assistance	Independent -RM	Independent -RM	—
Active Range of Motion	Active;All extremities -RM	Active;All extremities -RM	—
Transport Method	Bed -RM	Bed -RM	—
Patient Position			
Head of Bed Elevated > / = 30 degrees	Yes -RM	Yes -LT	—
Repositioned	Turns self -RM	Turns self -LT	—
Heels/Feet	Heels elevated off bed -RM	Heels elevated off bed -RM	—
Anti-Embolism Devices			
Anti-Embolism Devices	—	Off -RM	—
Bilateral Sequential	—	Yes -RM	—
Nutrition			
Feeding	Able to feed self -RM	Able to feed self -RM	—
Hygiene			
Hygiene Performed	—	Peri care;Hand hygiene -RM	—
Performed by	—	Self -RM	—
Incentive Spirometer			
Is pt using incentive spirometer?	Yes (independent) -RM	Yes (independent) -RM	—
Incentive Spirometry Tx			
Respiratory Effort	—	Good -RM	—
Treatment Tolerance	—	Tolerated well -RM	—
Incentive Spirometry Goal (mL)	—	1500 mL -RM	—
Incentive Spirometry Achieved X 10 efforts (mL)	—	1500-2000 mL -RM	—
Family/Significant Other Communication			
Family/Significant Other Update	—	Updated -RM	—
Telemetry Details			
Telemetry Monitor On	No -RM	No -RM	Yes -RG
Telemetry Box Number	—	—	5175 -RG
Comfort and Environment Interventions			
Comfort	Repositioned -RM	Repositioned -RM	—
Less Restrictive Restraint Alternatives			
Alternatives Utilized	More Frequent Safety Checks -RM	More Frequent Safety Checks -RM	—
Safety Equipment at Bedside			
Safety Equipment at	Suction -RM	Suction -RM	—

Flowsheets (all recorded) (continued)

Daily Cares/Safety (continued)

Row Name	06/18/18 0200	06/18/18 0000	06/17/18 1538
Bedside			

Flowsheets (all recorded)

Vital Signs

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07
Vital Signs					
Automatic Restart Vitals Timer	Yes -CI	—	Yes -CI	Yes -DI (r) TW (t)	Yes -DI (r) TW (t)
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)
Heart Rate Source	Monitor -CI	—	Monitor -CI	Monitor -TW	Monitor -TW
Resp	18 -CI	—	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)
Respiration Source	visual -CI	—	visual -CI	visual -TW	visual -TW
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)	124/53 -DI (r) TW (t)
Calculated MAP	80.33 -DI (r) CI (t)	—	88.33 -DI (r) CI (t)	79 -DI (r) TW (t)	76.67 -DI (r) TW (t)
BP Location	Right arm -CI	—	Right arm -CI	Right arm -TW	Right arm -TW
BP Method	Portable -CI	—	Portable -CI	Portable -TW	Portable -TW
Patient Position	Supine -CI	—	Supine -CI	Supine -TW	Supine -TW
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)	98.4 °F (36.9 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	Oral -TW	Oral -TW
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)
O2 Device	None (Room air) -CI	None (Room air) -AM	None (Room air) -CI	None (Room air) -TW	None (Room air) -TW
Vitals Sepsis Score					
Vitals Sepsis Risk Score	0 -CI	—	0 -CI	0 -DI (r) TW (t)	1 -DI (r) TW (t)

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02
Vital Signs					
Automatic Restart Vitals Timer	—	Yes -DI (r) TW (t)	Yes -DI (r) LF (t)	—	—
Pulse	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)
Heart Rate Source	—	Monitor -TW	—	—	—
Resp	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)	—	—
Respiration Source	—	visual -TW	—	—	—
BP	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)	—	104/66 -DI (r) LF (t)
Calculated MAP	—	74.33 -DI (r) TW (t)	104.67 -DI (r) LF (t)	—	78.67 -DI (r) LF (t)
BP Location	—	Right arm -TW	—	—	—
BP Method	—	Portable -TW	—	—	—
Patient Position	—	Supine -TW	—	—	—
Temp	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)	—	98.2 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	—	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)
O2 Device	None (Room air) -TS	None (Room air) -TW	—	None (Room air) -MS	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	0 -DI (r) TW (t)	0 -DI (r) LF (t)	—	—

Row Name	06/20/18 1000	06/20/18 0909	06/20/18 0900	06/20/18 0800	06/20/18 0730
Vital Signs					
Automatic Restart Vitals Timer	Yes -DG	—	Yes -DG	Yes -DG	—
Pulse	61 -DG	59 -DG	60 -DG	58 -DG	—
Resp	18 -DG	—	17 -DG	18 -DG	—
BP	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG	138/62 -DG	—
MAP (mmHg)	71 mm Hg -DG	—	68 mm Hg -DG	81 mm Hg -DG	—
Calculated MAP	76.67 -DG	73.33 -DG	73.33 -DG	87.33 -DG	—
Temp	—	—	—	—	98.3 °F (36.8 °C) -HT
Temp src	—	—	—	—	Oral -HT
Oxygen Therapy					
SpO2	(!) 88 % -DG	—	(!) 87 % -DG	(!) 88 % -DG	—
O2 Device	—	—	—	None (Room air) -DG	—
Pulse Oximetry Type	—	—	—	Continuous -DG	—

Row Name	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200
Vital Signs					
Automatic Restart Vitals Timer	Yes -EE	Yes -EE	Yes -JP	Yes -EE	Yes -EE

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200
Pulse	59 -EE	57 -EE	56 -EE	57 -EE	64 -EE
Resp	20 -EE	20 -EE	19 -EE	21 -EE	16 -EE
BP	129/57 -EE	130/50 -EE	119/51 -EE	122/58 -EE	**(!) 111/47** -EE
MAP (mmHg)	74 mm Hg -EE	70 mm Hg -EE	67 mm Hg -EE	73 mm Hg -EE	62 mm Hg -EE
Calculated MAP	81 -EE	76.67 -EE	73.67 -EE	79.33 -EE	68.33 -EE
Temp	—	—	98 °F (36.7 °C) -JP	—	—
Temp src	—	—	Oral -JP	—	—
Oxygen Therapy					
SpO2	93 % -EE	94 % -EE	94 % -EE	97 % -EE	91 % -EE
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	0 -JP	—	—

Row Name	06/20/18 0000	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000
Vital Signs					
Automatic Restart Vitals Timer	Yes -EE	Yes -EE	Yes -EE	Yes -EE	Yes -JP
Pulse	59 -EE	61 -EE	62 -EE	61 -EE	63 -EE
Resp	22 -EE	21 -EE	22 -EE	16 -EE	21 -EE
BP	—	128/56 -EE	132/51 -EE	130/60 -EE	135/58 -EE
MAP (mmHg)	—	—	73 mm Hg -EE	77 mm Hg -EE	76 mm Hg -EE
Calculated MAP	—	80 -EE	78 -EE	83.33 -EE	83.67 -EE
Temp	97.5 °F (36.4 °C) -JP	—	—	—	98.4 °F (36.9 °C) -JP
Temp src	Axillary -JP	—	—	—	Oral -JP
Oxygen Therapy					
SpO2	90 % -EE	97 % -EE	96 % -EE	94 % -EE	94 % -EE
O2 Device	—	—	—	—	Nasal cannula -EE
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -EE
Pulse Oximetry Type	—	—	—	—	Continuous -EE
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	—	—	1 -JP

Row Name	06/19/18 1900	06/19/18 1800	06/19/18 1700	06/19/18 1644	06/19/18 1600
Vital Signs					
Automatic Restart Vitals Timer	Yes -EE	Yes -JI	Yes -JI	—	Yes -JI
Pulse	64 -EE	61 -JI	59 -JI	—	58 -JI
Resp	19 -EE	25 -JI	21 -JI	—	20 -JI
BP	133/61 -EE	128/56 -JI	132/52 -JI	—	134/58 -JI
MAP (mmHg)	77 mm Hg -EE	72 mm Hg -JI	73 mm Hg -JI	—	76 mm Hg -JI
Calculated MAP	85 -EE	80 -JI	78.67 -JI	—	83.33 -JI
Temp	—	—	—	97.9 °F (36.6 °C) -FT	—
Temp src	—	—	—	Oral -FT	—
Oxygen Therapy					
SpO2	94 % -EE	92 % -JI	96 % -JI	—	95 % -JI

Row Name	06/19/18 1500	06/19/18 1430	06/19/18 1428	06/19/18 1335	06/19/18 1330
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	—	Yes -LFA	Yes -LFA
Pulse	56 -JI	57 -JI	—	54 -LFA	54 -LFA
Resp	22 -JI	19 -JI	—	22 -LFA	19 -LFA
BP	130/51 -JI	142/60 -JI	—	123/59 -LFA	128/55 -LFA
MAP (mmHg)	69 mm Hg -JI	82 mm Hg -JI	—	—	—
Calculated MAP	77.33 -JI	87.33 -JI	—	80.33 -LFA	79.33 -LFA
Temp	—	—	97.7 °F (36.5 °C) -FT	—	—
Temp src	—	—	Oral -FT	—	—
Oxygen Therapy					
SpO2	96 % -JI	96 % -JI	—	100 % -LFA	97 % -LFA
O2 Device	—	Nasal cannula -JI	—	—	—
O2 Flow Rate (L/min)	—	2 L/min -JI	—	—	—
Pulse Oximetry Type	—	Continuous -JI	—	—	—

Row Name	06/19/18 1325	06/19/18 1321	06/19/18 1114	06/19/18 1031	06/19/18 1000

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/19/18 1325	06/19/18 1321	06/19/18 1114	06/19/18 1031	06/19/18 1000
Vital Signs					
Automatic Restart Vitals Timer	Yes -LFA	Yes -CR	Yes -PM	—	Yes -JI
Pulse	53 -LFA	53 -CR	51 -PM	—	50 -JI
Heart Rate Source	—	—	Monitor -PM	—	—
Resp	21 -LFA	18 -CR	13 -PM	—	20 -JI
BP	**(!) 95/46** -LFA	110/53 -CR	123/54 -PM	—	**(!) 124/49** -JI
MAP (mmHg)	—	—	—	—	68 mm Hg -JI
Calculated MAP	**(!) 62.33** -LFA	72 -CR	77 -PM	—	74 -JI
Patient Position	—	—	Sitting -PM	—	—
Oxygen Therapy					
SpO2	92 % -LFA	93 % -CR	98 % -PM	—	92 % -JI
O2 Device	—	—	Nasal cannula -PM	None (Room air) -JI	—
O2 Flow Rate (L/min)	—	—	3 L/min -PM	—	—

Row Name	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700	06/19/18 0600
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	—	Yes -DF	Yes -JI	Yes -RM
Pulse	51 -JI	55 -JI	56 -JI	63 -JI	52 -RM
Resp	18 -JI	—	18 -JI	18 -JI	17 -RM
BP	**(!) 119/44** -JI	**(!) 126/47** -JI	**(!) 126/47** -JI	143/52 -JI	**(!) 109/40** -RM
MAP (mmHg)	62 mm Hg -JI	—	66 mm Hg -JI	76 mm Hg -JI	**(!) 56 mm Hg** -RM
Calculated MAP	69 -JI	73.33 -JI	73.33 -JI	82.33 -JI	**(!) 63** -RM
Temp	—	—	98.6 °F (37 °C) -DF	—	—
Temp src	—	—	Oral -DF	—	—
Oxygen Therapy					
SpO2	95 % -JI	—	97 % -JI	96 % -JI	94 % -RM
O2 Device	—	—	Nasal cannula -JI	—	—
O2 Flow Rate (L/min)	—	—	2 L/min -JI	—	—
Pulse Oximetry Type	—	—	Continuous -JI	—	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	0 -DF	—	—

Row Name	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200	06/19/18 0100
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -MJ	Yes -RM	Yes -RM	Yes -RM
Pulse	53 -RM	55 -RM	55 -RM	54 -RM	53 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	17 -RM	20 -RM	16 -RM	19 -RM	19 -RM
BP	**(!) 124/49** -RM	127/55 -RM	120/59 -RM	113/50 -RM	**(!) 109/44** -RM
MAP (mmHg)	68 mm Hg -RM	73 mm Hg -RM	73 mm Hg -RM	62 mm Hg -RM	61 mm Hg -RM
Calculated MAP	74 -RM	79 -RM	79.33 -RM	71 -RM	65.67 -RM
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM
Patient Position	Sitting -RM	Supine -RM	Lying right side -RM	Lying right side -RM	Lying left side -RM
Temp	—	98.2 °F (36.8 °C) -MJ	—	—	—
Oxygen Therapy					
SpO2	96 % -RM	98 % -RM	92 % -RM	93 % -RM	92 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM
Patient Observation					
Observations	—	Resting in bed, alert -RM	—	Resting in bed, alert -RM	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	0 -MJ	—	—	—

Row Name	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100	06/18/18 2000
Vital Signs					

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100	06/18/18 2000
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Pulse	56 -RM	59 -RM	55 -RM	56 -RM	56 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	21 -RM	20 -RM	21 -RM	21 -RM	22 -RM
BP	(!) 123/43 -RM	127/59 -RM	—	—	—
MAP (mmHg)	61 mm Hg -RM	75 mm Hg -RM	—	—	—
Calculated MAP	69.67 -RM	81.67 -RM	—	—	—
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	—	—
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—	—
Patient Position	Lying left side -RM	Lying left side -RM	Supine -RM	—	—
Temp	98.1 °F (36.7 °C) -MJ	—	—	—	98.4 °F (36.9 °C) -MJ
Oxygen Therapy					
SpO2	94 % -RM	97 % -RM	99 % -RM	99 % -RM	96 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM
Patient Observation					
Observations	Resting in bed, alert -RM	—	Resting in bed, alert -RM	—	Resting in bed, alert -RM
Vitals Sepsis Score					
Vitals Sepsis Risk Score	1 -RM	—	—	—	—

Row Name	06/18/18 1900	06/18/18 1800	06/18/18 1727	06/18/18 1600	06/18/18 1500
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	—	Yes -JI	Yes -JI
Pulse	56 -RM	56 -RM	—	52 -JI	54 -JI
Heart Rate Source	Monitor -RM	—	—	—	—
Resp	22 -RM	20 -RM	—	20 -JI	18 -JI
BP	—	132/60 -RM	—	142/57 -JI	151/56 -JI
MAP (mmHg)	—	75 mm Hg -RM	—	76 mm Hg -JI	79 mm Hg -JI
Calculated MAP	—	84 -RM	—	85.33 -JI	87.67 -JI
Temp	—	—	98.1 °F (36.7 °C) -JD	—	—
Temp src	—	—	Oral -JD	—	—
Oxygen Therapy					
SpO2	(!) 89 % -RM	94 % -RM	—	(!) 87 % -JI	95 % -JI
O2 Device	Nasal cannula -RM	—	—	—	—
Pulse Oximetry Type	Continuous -RM	—	—	—	—
SpO2 Alarm Limit High	100 -RM	—	—	—	—
SpO2 Alarm Limit Low	90 -RM	—	—	—	—
POX Probe Site Changed	No -RM	—	—	—	—

Row Name	06/18/18 1400	06/18/18 1300	06/18/18 1230	06/18/18 1200	06/18/18 1100
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	—	Yes -JI	Yes -JI
Pulse	58 -JI	57 -JI	—	52 -JI	50 -JI
Resp	19 -JI	15 -JI	—	18 -JI	17 -JI
BP	134/53 -JI	(!) 130/45 -JI	—	140/56 -JI	(!) 128/46 -JI
MAP (mmHg)	72 mm Hg -JI	65 mm Hg -JI	—	77 mm Hg -JI	66 mm Hg -JI
Calculated MAP	80 -JI	73.33 -JI	—	84 -JI	73.33 -JI
Temp	—	—	97.7 °F (36.5 °C) -JD	—	—
Temp src	—	—	Oral -JD	—	—
Oxygen Therapy					
SpO2	91 % -JI	93 % -JI	—	—	97 % -JI

Row Name	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800	06/18/18 0700
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	—	Yes -JI	Yes -JI
Pulse	51 -JI	(!) 49 -JI	—	(!) 48 -JI	(!) 46 -JI

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800	06/18/18 0700
Resp	16 -JI	16 -JI	—	17 -JI	17 -JI
BP	131/52 -JI	137/54 -JI	—	**(!) 123/49** -JI	**(!) 115/49** -JI
MAP (mmHg)	72 mm Hg -JI	75 mm Hg -JI	—	66 mm Hg -JI	65 mm Hg -JI
Calculated MAP	78.33 -JI	81.67 -JI	—	73.67 -JI	71 -JI
Temp	—	—	97.8 °F (36.6 °C) -JD	—	—
Temp src	—	—	Oral -JD	—	—
Oxygen Therapy					
SpO2	98 % -JI	100 % -JI	—	91 % -JI	95 % -JI
O2 Device	—	—	—	Nasal cannula -JI	—
O2 Flow Rate (L/min)	—	—	—	5 L/min -JI	—
Pulse Oximetry Type	—	—	—	Continuous -JI	—

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400	06/18/18 0300
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Pulse	**(!) 46** -RM	**(!) 47** -RM	**(!) 47** -RM	**(!) 49** -RM	**(!) 49** -RM
Heart Rate Source	Monitor -RM	Monitor -RM	—	Monitor -RM	Monitor -RM
Resp	13 -RM	18 -RM	18 -RM	19 -RM	18 -RM
BP	**(!) 126/48** -RM	122/52 -RM	120/52 -RM	117/50 -RM	**(!) 109/43** -RM
MAP (mmHg)	68 mm Hg -RM	69 mm Hg -RM	—	67 mm Hg -RM	60 mm Hg -RM
Calculated MAP	74 -RM	75.33 -RM	74.67 -RM	72.33 -RM	65 -RM
BP Location	Right arm -RM	Right arm -RM	—	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM
Patient Position	Supine -RM	Lying left side -RM	—	Sitting -RM	Supine -RM
Temp	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM	—	—
Temp src	Axillary -RM	—	Axillary -RM	—	—
Oxygen Therapy					
SpO2	97 % -RM	97 % -RM	—	97 % -RM	92 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	—	—	—	—	5 L/min -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	—	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	—	No -RM	No -RM
Patient Observation					
Observations	—	Resting in bed -RM	—	—	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	0 -RM	—	0 -RM	—	—

Row Name	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051	06/18/18 0000
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Pulse	51 -RM	54 -RM	57 -RM	57 -RM	55 -RM
Heart Rate Source	Monitor -RM	—	Monitor -RM	Monitor -RM	Monitor -RM
Resp	19 -RM	20 -RM	21 -RM	20 -RM	20 -RM
BP	**(!) 102/39** -RM	—	123/51 -RM	140/52 -RM	**(!) 115/45** -RM
MAP (mmHg)	**(!) 55 mm Hg** -RM	—	69 mm Hg -RM	—	62 mm Hg -RM
Calculated MAP	**(!) 60** -RM	—	75 -RM	81.33 -RM	68.33 -RM
BP Location	Right arm -RM	—	Right arm -RM	—	Right arm -RM
BP Method	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM
Patient Position	Lying right side -RM	—	Lying left side -RM	—	Lying left side -RM
Temp	—	—	—	98.1 °F (36.7 °C) -RM	—
Temp src	—	—	—	Oral -RM	—
Oxygen Therapy					
SpO2	**(!) 87 %** -RM	—	**(!) 88 %** -RM	—	92 % -RM
O2 Device	Nasal cannula -RM	—	Nasal cannula -RM	—	Nasal cannula -RM
O2 Flow Rate (L/min)	5 L/min -RM	—	—	—	—
Pulse Oximetry Type	Continuous -RM	—	Continuous -RM	—	Continuous -RM
SpO2 Alarm Limit High	100 -RM	—	100 -RM	—	100 -RM
SpO2 Alarm Limit Low	90 -RM	—	90 -RM	—	90 -RM
POX Probe Site	No -RM	—	No -RM	—	Yes -RM

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051	06/18/18 0000
Changed					
Patient Observation					
Observations	—	—	—	—	Resting in bed, alert -RM
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	—	0 -RM	—

Row Name	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823	06/17/18 1738
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -AF	Yes -BR	Yes -BR	Yes -BR
Patient placed on monitor	—	—	Yes -BR	Yes -BR	Yes -BR
Pulse	54 -RM	53 -AF	57 -BR	51 -BR	55 -BR
Heart Rate Source	Monitor -RM	Monitor -AF	Monitor -BR	Monitor -BR	Monitor -BR
Resp	17 -RM	18 -AF	16 -BR	18 -BR	18 -BR
Respiration Source	—	—	visual -BR	visual -BR	visual -BR
BP	**(!) 110/41** -RM	**(!) 128/41** -AF	134/59 -BR	126/55 -BR	132/56 -BR
MAP (mmHg)	**(!) 58 mm Hg** -RM	—	—	—	—
Calculated MAP	**(!) 64** -RM	70 -AF	84 -BR	78.67 -BR	81.33 -BR
BP Location	Right arm -RM	Right arm -RM	Right arm -BR	Right arm -BR	Right arm -BR
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Portable -BR	Portable -BR	Portable -BR
Patient Position	Sitting -RM	Sitting -RM	Sitting -BR	Sitting -BR	Sitting -BR
Temp	—	98 °F (36.7 °C) -AF	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR
Temp src	—	Oral -AF	Oral -BR	Oral -BR	Oral -BR
Oxygen Therapy					
SpO2	90 % -RM	92 % -AF	100 % -BR	100 % -BR	100 % -BR
O2 Device	Nasal cannula -RM	Nasal cannula -AF	—	None (Room air) -BR	None (Room air) -BR
O2 Flow Rate (L/min)	—	2 L/min -AF	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	—	—
POX Probe Site Changed	No -RM	No -RM	—	—	—
Patient Observation					
Observations	—	REsting in bed, sitting up, alert -RM	—	—	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	0 -AF	0 -BR	0 -BR	0 -BR

Row Name	06/17/18 1720	06/17/18 1708	06/17/18 1538	06/17/18 1537	06/17/18 1502
Vital Signs					
Automatic Restart Vitals Timer	Yes -BR	Yes -BR	—	Yes -RG	Yes -RG
Patient placed on monitor	—	Yes -BR	—	—	Yes -RG
Pulse	55 -BR	55 -BR	—	55 -RG	54 -RG
Heart Rate Source	—	Monitor -BR	—	—	Monitor -RG
Resp	18 -BR	18 -BR	—	22 -RG	25 -RG
Respiration Source	—	visual -BR	—	—	visual -RG
BP	129/53 -BR	**(!) 115/49** -BR	—	114/51 -RG	112/52 -RG
Calculated MAP	78.33 -BR	71 -BR	—	72 -RG	72 -RG
BP Location	—	Right arm -BR	—	—	Left arm -RG
BP Method	—	Portable -BR	—	—	Non-invasive Cuff -RG
Orthostatic BP?	—	—	—	—	No -RG
Patient Position	—	Standing -BR	—	—	Supine -RG
Temp	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR	—	97.8 °F (36.6 °C) -RG	97.7 °F (36.5 °C) -RG
Temp src	Oral -BR	Oral -BR	—	—	Oral -RG
Oxygen Therapy					
SpO2	—	100 % -BR	—	—	100 % -RG
O2 Device	—	None (Room air) -BR	None (Room air) -RG	—	None (Room air) -RG
Pulse Oximetry Type	—	—	—	—	Continuous -RG
Vitals Sepsis Score					

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/17/18 1720	06/17/18 1708	06/17/18 1538	06/17/18 1537	06/17/18 1502
Vitals Sepsis Risk Score	0 -BR	0 -BR	—	1 -RG	1 -RG

Row Name	06/17/18 1437
Vital Signs	
Pulse	56 -NS
Oxygen Therapy	
SpO2	98 % -NS

Flowsheets (all recorded)

PA Risk Score

Row Name	06/21/18 1305	06/21/18 1301	06/21/18 1205	06/21/18 1201	06/21/18 1108
Sepsis Risk Score					
Sepsis Risk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE
Readmission Risk Score					
Readmission	—	—	—	22 -UE	—
Unplanned Admission Risk					
LACE Unplanned Admission	—	—	—	13 -UE	—

Row Name	06/21/18 1101	06/21/18 1008	06/21/18 1001	06/21/18 0908	06/21/18 0901
Sepsis Risk Score					
Sepsis Risk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/21/18 0809	06/21/18 0804	06/21/18 0802	06/21/18 0707	06/21/18 0703
Sepsis Risk Score					
Sepsis Risk Score	—	—	1 -UE	—	—
Sepsis Risk Score Change	—	1 -UE	—	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—	—	1 -UE	—

Row Name	06/21/18 0701	06/21/18 0606	06/21/18 0601	06/21/18 0507	06/21/18 0501
Sepsis Risk Score					
Sepsis Risk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/21/18 0406	06/21/18 0401	06/21/18 0316	06/21/18 0312	06/21/18 0308
Sepsis Risk Score					
Sepsis Risk Score	—	1 -UE	—	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	—

Row Name	06/21/18 0244	06/21/18 0238	06/21/18 0206	06/21/18 0109	06/21/18 0103
Sepsis Risk Score					
Sepsis Risk Score	—	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—	—	1 -UE	—

Row Name	06/21/18 0006	06/21/18 0001	06/20/18 2306	06/20/18 2301	06/20/18 2205
Sepsis Risk Score					
Sepsis Risk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE
Readmission Risk Score					
Readmission	—	26 -UE	—	—	—
Unplanned Admission Risk					
LACE Unplanned Admission	—	13 -UE	—	—	—

Row Name	06/20/18 2201	06/20/18 2106	06/20/18 2101	06/20/18 2006	06/20/18 2001
Sepsis Risk Score					
Sepsis Risk Score	1 -UE	—	1 -UE	—	1 -UE

Flowsheets (all recorded) (continued)

PA RIsk Score (continued)

Row Name	06/20/18 2201	06/20/18 2106	06/20/18 2101	06/20/18 2006	06/20/18 2001
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/20/18 1905	06/20/18 1901	06/20/18 1805	06/20/18 1801	06/20/18 1705
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE

Row Name	06/20/18 1701	06/20/18 1605	06/20/18 1601	06/20/18 1505	06/20/18 1501
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/20/18 1406	06/20/18 1401	06/20/18 1305	06/20/18 1301	06/20/18 1207
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE

Row Name	06/20/18 1201	06/20/18 1105	06/20/18 1101	06/20/18 1006	06/20/18 1001
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—
Readmission Risk Score					
Readmission	26 -UE	—	—	—	—
Unplanned Admission Risk					
LACE Unplanned Admission	15 -UE	—	—	—	—

Row Name	06/20/18 0907	06/20/18 0901	06/20/18 0810	06/20/18 0804	06/20/18 0803
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	—

Row Name	06/20/18 0706	06/20/18 0702	06/20/18 0701	06/20/18 0605	06/20/18 0601
Sepsis Risk Score					
Sepsis Risk Score	—	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—	—	1 -UE	—

Row Name	06/20/18 0505	06/20/18 0501	06/20/18 0405	06/20/18 0401	06/20/18 0313
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE

Row Name	06/20/18 0302	06/20/18 0206	06/20/18 0110	06/20/18 0104	06/20/18 0005
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	1 -UE	—	1 -UE	—
Sepsis Risk Score	1 -UE	—	—	1 -UE	—

Flowsheets (all recorded) (continued)

PA RIsk Score (continued)

Row Name	06/20/18 0302	06/20/18 0206	06/20/18 0110	06/20/18 0104	06/20/18 0005
Change					
Sepsis RS Last Reviewed	—	—	1 -UE	—	1 -UE

Row Name	06/20/18 0001	06/19/18 2306	06/19/18 2301	06/19/18 2205	06/19/18 2201
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—
Readmission Risk Score					
Readmission	26 -UE	—	—	—	—
Unplanned Admission Risk					
LACE Unplanned Admission	15 -UE	—	—	—	—

Row Name	06/19/18 2106	06/19/18 2101	06/19/18 2006	06/19/18 2001	06/19/18 1905
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE

Row Name	06/19/18 1901	06/19/18 1805	06/19/18 1801	06/19/18 1705	06/19/18 1701
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/19/18 1606	06/19/18 1601	06/19/18 1509	06/19/18 1504	06/19/18 1501
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	—

Row Name	06/19/18 1406	06/19/18 1401	06/19/18 1305	06/19/18 1301	06/19/18 1207
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE

Row Name	06/19/18 1201	06/19/18 1106	06/19/18 1101	06/19/18 1006	06/19/18 1001
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—
Readmission Risk Score					
Readmission	27 -UE	—	—	—	—
Unplanned Admission Risk					
LACE Unplanned Admission	14 -UE	—	—	—	—

Row Name	06/19/18 0907	06/19/18 0901	06/19/18 0810	06/19/18 0805	06/19/18 0803
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	—

Flowsheets (all recorded) (continued)

PA Risk Score (continued)

Row Name	06/19/18 0707	06/19/18 0702	06/19/18 0701	06/19/18 0605	06/19/18 0601
Sepsis Risk Score					
Sepsis Risk Score	—	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—	—	1 -UE	—

Row Name	06/19/18 0508	06/19/18 0503	06/19/18 0502	06/19/18 0405	06/19/18 0401
Sepsis Risk Score					
Sepsis Risk Score	—	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—	—	1 -UE	—

Row Name	06/19/18 0302	06/19/18 0251	06/19/18 0206	06/19/18 0109	06/19/18 0103
Sepsis Risk Score					
Sepsis Risk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—	—	1 -UE	—

Row Name	06/19/18 0005	06/19/18 0001	06/18/18 2307	06/18/18 2301	06/18/18 2206
Sepsis Risk Score					
Sepsis Risk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE
Readmission Risk Score					
Readmission	—	25 -UE	—	—	—
Unplanned Admission Risk					
LACE Unplanned Admission	—	12 -UE	—	—	—

Row Name	06/18/18 2201	06/18/18 2105	06/18/18 2101	06/18/18 2006	06/18/18 2001
Sepsis Risk Score					
Sepsis Risk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/18/18 1905	06/18/18 1901	06/18/18 1805	06/18/18 1801	06/18/18 1705
Sepsis Risk Score					
Sepsis Risk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	1 -UE

Row Name	06/18/18 1701	06/18/18 1606	06/18/18 1601	06/18/18 1509	06/18/18 1503
Sepsis Risk Score					
Sepsis Risk Score	1 -UE	—	1 -UE	—	—
Sepsis Risk Score Change	1 -UE	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/18/18 1501	06/18/18 1406	06/18/18 1401	06/18/18 1305	06/18/18 1301
Sepsis Risk Score					
Sepsis Risk Score	1 -UE	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	—	1 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	1 -UE	—	1 -UE	—

Row Name	06/18/18 1205	06/18/18 1201	06/18/18 1107	06/18/18 1101	06/18/18 1005

Flowsheets (all recorded) (continued)

PA RIsk Score (continued)

Row Name	06/18/18 1205	06/18/18 1201	06/18/18 1107	06/18/18 1101	06/18/18 1005
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	1 -UE	—
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	2 -UE
Readmission Risk Score					
Readmission	—	24 -UE	—	—	—
Unplanned Admission Risk					
LACE Unplanned Admission	—	11 -UE	—	—	—

Row Name	06/18/18 1001	06/18/18 0912	06/18/18 0901	06/18/18 0808	06/18/18 0803
Sepsis Risk Score					
Sepsis RIsk Score	2 -UE	—	2 -UE	—	1 -UE
Sepsis Risk Score Change	2 -UE	—	2 -UE	—	1 -UE
Sepsis RS Last Reviewed	—	2 -UE	—	1 -UE	—

Row Name	06/18/18 0707	06/18/18 0703	06/18/18 0701	06/18/18 0606	06/18/18 0601
Sepsis Risk Score					
Sepsis RIsk Score	—	—	1 -UE	—	1 -UE
Sepsis Risk Score Change	—	1 -UE	—	—	1 -UE
Sepsis RS Last Reviewed	1 -UE	—	—	1 -UE	—

Row Name	06/18/18 0506	06/18/18 0501	06/18/18 0406	06/18/18 0401	06/18/18 0305
Sepsis Risk Score					
Sepsis RIsk Score	—	1 -UE	—	1 -UE	2 -UE
Sepsis Risk Score Change	—	1 -UE	—	1 -UE	—
Sepsis RS Last Reviewed	1 -UE	—	1 -UE	—	2 -UE

Row Name	06/18/18 0252	06/18/18 0206	06/18/18 0109	06/18/18 0103	06/18/18 0007
Sepsis Risk Score					
Sepsis RIsk Score	—	2 -UE	—	1 -UE	—
Sepsis Risk Score Change	2 -UE	—	—	1 -UE	—
Sepsis RS Last Reviewed	—	—	1 -UE	—	1 -UE

Row Name	06/18/18 0001	06/17/18 2301	06/17/18 2201	06/17/18 2101	06/17/18 2001
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	1 -UE	1 -UE	1 -UE	1 -UE
Sepsis Risk Score Change	1 -UE	—	—	—	—
Readmission Risk Score					
Readmission	25 -UE	—	—	—	—
Unplanned Admission Risk					
LACE Unplanned Admission	11 -UE	—	—	—	—

Row Name	06/17/18 1901	06/17/18 1801	06/17/18 1701	06/17/18 1601	06/17/18 1501
Sepsis Risk Score					
Sepsis RIsk Score	1 -UE	1 -UE	2 -UE	1 -UE	1 -UE

Flowsheets (all recorded)

Pain Assessment

Row Name	06/21/18 0830	06/21/18 0545	06/21/18 0030	06/20/18 2133	06/20/18 0830
Pain Assessment					
Currently in Pain	No -AM	No -TS	Resting quietly -TS	No -TS	Unable to Assess Simultaneous filing. User may be unaware of other data. -MS
Pain Intervention(s)	Declines -AM	Rest -TS	Rest -TS	Rest;Declines -TS	Rest -MS
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -AM	0 -TS	—	0 -TS	0 Simultaneous filing. User may be unaware of other data. -MS
Clinical Progression 1	—	—	—	—	Resolved -MS
FACES Pain Rating 1					
FACES Pain Rating	—	—	0-No hurt -TS	—	—

Row Name	06/20/18 0730	06/19/18 2000	06/19/18 1600	06/19/18 1321	06/19/18 0800
Pain Assessment					
Currently in Pain	Yes -DG	Resting quietly -EE	No -JI	—	No -JI
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	2 -DG	0 -EE	0 -JI	0 -CR	0 -JI
Pain Onset 1	Gradual -DG	—	—	—	—
Pain Location 1	Back -DG	—	—	—	—
Pain Location Orientation 1	Anterior -DG	—	—	—	—
Pain Quality 1	Aching -DG	—	—	—	—
Pain Type 1	Acute pain -DG	—	—	—	—
Aggravating Factors	Movement -DG	—	—	—	—
Alleviating Factors 1	Medication;Positioning -DG	—	—	—	—
Pain Assessment History					
Previous experiences with pain?	—	No -EE	—	—	—
History of Chronic Pain?	—	No -EE	—	—	—

Row Name	06/19/18 0400	06/19/18 0200	06/19/18 0000	06/18/18 2200	06/18/18 2100
Pain Assessment					
Currently in Pain	—	—	—	—	No -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	—	0 -RM
Pain Assessment History					
Previous experiences with pain?	—	—	—	—	No -RM
Patient Observation					
Observations	Resting in bed, alert -RM	Resting in bed, alert -RM	Resting in bed, alert -RM	Resting in bed, alert -RM	—

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1600	06/18/18 1200	06/18/18 0800
Pain Assessment					
Currently in Pain	No -RM	No -RM	No -JI	No -JI	No -JI
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -JI	0 -JI	0 -JI
Pain Assessment History					
Previous experiences with pain?	No -RM	No -RM	—	—	—
Patient's Stated Pain Goal	0 (No Pain) -RM	—	—	—	—
Patient Observation					
Observations	Resting in bed, alert -RM	—	—	—	—

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0400	06/18/18 0300	06/18/18 0200
Pain Assessment					
Currently in Pain	No -RM	No -RM	No -RM	No -RM	No -RM

Flowsheets (all recorded) (continued)

Pain Assessment (continued)

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0400	06/18/18 0300	06/18/18 0200
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	0 -RM	0 -RM
Pain Assessment History					
Previous experiences with pain?	No -RM	No -RM	No -RM	No -RM	No -RM
History of Chronic Pain?	No -RM	No -RM	No -RM	No -RM	No -RM
Patient Observation					
Observations	—	Resting in bed -RM	—	—	—

Row Name	06/18/18 0100	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037
Pain Timer					
Restart Pain Timer	—	—	—	—	Yes -BR
Pain Assessment					
Currently in Pain	No -RM	No -RM	No -RM	No -RM	—
Patient's Stated Pain Goal	—	—	—	—	0 (No Pain) -BR
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	0 -RM	0 -BR
Pain Assessment History					
Previous experiences with pain?	No -RM	No -RM	No -RM	No -RM	—
History of Chronic Pain?	No -RM	No -RM	No -RM	No -RM	—
Patient Observation					
Observations	—	Resting in bed, alert -RM	—	REsting in bed, sitting up, alert -RM	—

Row Name	06/17/18 1823	06/17/18 1706	06/17/18 1504
Pain Timer			
Restart Pain Timer	Yes -BR	Yes -BR	Yes -RG
Pain Reassessment after Intervention Complete	Yes -BR	—	—
Pain Assessment			
Currently in Pain	—	—	No -RG
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -RG
Patient's Stated Pain Goal	0 (No Pain) -BR	0 (No Pain) -BR	—
Numeric Pain Intensity Scale			
Numeric Pain Intensity Score 1	0 -BR	0 -BR	0 -RG

Flowsheets (all recorded)

VTE Screening

Row Name	06/18/18 0100
Score 1 for each factor (RETIRED)	
(RETIRED) History of prior major surgery (within past 1 month)	0 -RM
(RETIRED) Pregnancy or postpartum (less than 1 month)	0 -RM
(RETIRED) Varicose Veins	0 -RM
(RETIRED) Age 41 to 59 years	0 -RM
(RETIRED) Inflammatory Bowel Disease	0 -RM
(RETIRED) Obesity (BMI 30 to 40)	0 -RM
(RETIRED) Oral Contraceptives	0 -RM
(RETIRED) Hormone Therapy	0 -RM
(RETIRED) Abnormal Pulmonary Function, COPD or Pneumonia (less than 1 month)	0 -RM
(RETIRED) Medical Patient (on bedrest)	1 -RM
(RETIRED) MI (less than 1 month)	0 -RM
(RETIRED) CHF (less than 1 month)	1 -RM
(RETIRED) Sepsis (less than 1 month)	0 -RM
(RETIRED) Swollen Legs (current)	0 -RM
(RETIRED) Total Score	2 -RM
(RETIRED) Score 2 for each factor	
(RETIRED) Major surgery (greater than 60 minutes, current admission)	0 -RM
(RETIRED) Laproscopic surgery (greater than 60 minutes)	0 -RM
(RETIRED) Arthroscopic surgery (greater than 60 minutes)	0 -RM
(RETIRED) Age 60 - 74 years	2 -RM
(RETIRED) Morbid Obesity (BMI greater than 40 to 50)	0 -RM
(RETIRED) Immobilizing cast or splint	0 -RM
(RETIRED) Central venous catheter	0 -RM
(RETIRED) Malignancy (previous)	0 -RM
(RETIRED) Total Score	2 -RM
(RETIRED) Score 3 for each factor	
(RETIRED) History of SVT, DVT/PE	0 -RM
(RETIRED) Family History of DVT/PE	0 -RM
(RETIRED) Age 75	0 -RM

Flowsheets (all recorded) (continued)

VTE Screening (continued)

Row Name	06/18/18 0100
years and over	
(RETIRED) Prior Major Surgery	0 -RM
(RETIRED) BMI > 50	0 -RM
(RETIRED) Venous stasis syndrome	0 -RM
(RETIRED) Hypercoagulable states	0 -RM
(RETIRED) Total Score	0 -RM

(RETIRED) Score 5 for each factor

Row Name	06/18/18 0100
(RETIRED) Major surgery (greater than 3 hours)	0 -RM
(RETIRED) Elective Major Lower Extremity Arthroplasty	0 -RM
(RETIRED) Hip, pelvis, or leg fracture (less than 1 month)	0 -RM
(RETIRED) Stroke (less than 1 month)	0 -RM
(RETIRED) Major trauma (less than 1 month)	0 -RM
(RETIRED) Acute Spinal Cord Injury (less than 1 month)	0 -RM
(RETIRED) Paralysis (less than 1 month)	0 -RM
(RETIRED) Mechanical ventilation	0 -RM
(RETIRED) Total Score	0 -RM

Total Risk Factor Score

Row Name	06/18/18 0100
VTE Total Risk Factor Score	4 -RM
VTE Low Risk Attribute	No -RM

VTE Prophylaxis Meets Requirements

Row Name	06/18/18 0100
Is Recommended VTE Prophylaxis ordered?	Yes -RM

Flowsheets (all recorded)

Anthropometrics

Row Name	06/18/18 0600	06/17/18 2225	06/17/18 1535
Anthropometrics			
Height	—	67" (1.702 m) -AF	—
Weight	104.9 kg (231 lb 4.2 oz) -RM	103.4 kg (227 lb 15.3 oz) -AF	95.3 kg (210 lb) -RG
Weight Method	Actual -RM	Actual -AF	Stated -RG
Weight Change	1.45 -RM	8.55 -AF	0 -RG
BMI (Calculated)	—	35.7 -AF	—

Flowsheets (all recorded)

(RETIRED) Travel Screening

Row Name	06/19/18 1117	06/18/18 0133
RETIRED - Travel outside the U.S.		
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	No -PM	No -RM

Flowsheets (all recorded)

Severe Sepsis Screen

Row Name	06/21/18 0900	06/20/18 2300	06/20/18 1027	06/20/18 0800	06/19/18 2000
Severe Sepsis Screening Tool					
Current Sepsis Treatment AND On IV Pressors?	No- Continue Screening -AM	No- Continue Screening -TS	—	No- Continue Screening -DG	No- Continue Screening -EE
Infection					
Suspected / Documented Infection?	No- Screen for antibiotic therapy -AM	No- Screen for antibiotic therapy -TS	—	Yes- Continue Screening -DG	No- Screen for antibiotic therapy -EE
Antibiotic Therapy (Non-Prophylactic)	—	No- Stop screen if no to BOTH suspected infection and antibiotic -TS	—	Yes- Continue Screening -DG	No- Stop screen if no to BOTH suspected infection and antibiotic -EE
SIRS Criteria					
Temperature > 101.0 °F (38.3 °C)	No- Continue Screening -AM	—	—	No- Continue Screening -DG	No- Continue Screening -EE
Temperature < 96.8 °F (36 °C)	—	—	—	No- Continue Screening -DG	No- Continue Screening -EE
Heart Rate > 90 bpm?	—	—	—	No- Continue Screening -DG	No- Continue Screening -EE
Respiratory Rate > 20 per minute?	—	—	—	No- Continue Screening -DG	No- Continue Screening -EE
Acutely Altered Mental Status ?	—	—	—	No- Continue Screening -DG	No- Continue Screening -EE
Glucose > 140 in the absence of Diabetes	—	—	—	No- Continue Screening -DG	Yes- Continue Screening -EE
WBC Count > 12,000 or < 4,000 or Bands > 10%	—	—	—	No- Continue Screening -DG	No- Continue Screening -EE
2 or more SIRS criteria Present?	—	—	—	No- Stop Screening -DG	No- Stop Screening -EE
Screening Results					
Positive For Severe Sepsis ?	—	—	—	No- Negative for Severe Sepsis -DG	No- Negative for Severe Sepsis -EE
Sepsis Interventions	—	—	—	—	MD Previously Notified -EE
Provider Notification					
Reason for Communication	—	—	Consult called -DG	—	—
Notification Time	—	—	1028 -DG	—	—
Provider Name	—	—	Whatley -DG	—	—
Provider Role	—	—	Consulting physician -DG	—	—
Method of Communication	—	—	Perfect Serve -DG	—	—
Response	—	—	Other (Comment) consulted by Dhaval G Patel, MD -DG	—	—

Row Name	06/19/18 0800	06/18/18 2000	06/18/18 1025	06/18/18 0800	06/18/18 0600
Severe Sepsis Screening Tool					
Current Sepsis Treatment AND On IV Pressors?	No- Continue Screening -JI	No- Continue Screening -RM	—	No- Continue Screening -JI	—
Infection					
Suspected / Documented Infection?	No- Screen for antibiotic therapy -JI	No- Screen for antibiotic therapy -RM	—	No- Screen for antibiotic therapy -JI	—
Antibiotic Therapy (Non-Prophylactic)	No- Stop screen if no to BOTH suspected infection and antibiotic -JI	No- Stop screen if no to BOTH suspected infection and antibiotic -RM	—	No- Stop screen if no to BOTH suspected infection and antibiotic -JI	—
Screening Results					
Positive For Severe Sepsis ?	—	No- Negative for Severe Sepsis -RM	—	—	—
Sepsis Interventions	—	MD Previously Notified -RM	—	—	—
Provider Notification					
Reason for	—	—	Patient request Clarify	—	Critical lab value -RM

Flowsheets (all recorded) (continued)

Severe Sepsis Screen (continued)

Row Name	06/19/18 0800	06/18/18 2000	06/18/18 1025	06/18/18 0800	06/18/18 0600
Communication			order for Ramipril. -JI		
Lab Value	—	—	—	—	inr 3.06 -RM
RBAC?	—	—	—	—	Yes -RM
Notification Time	—	—	1025 -JI	—	0602 -RM
Provider Name	—	—	Sajja -JI	—	Kingsley Agbeyebe -RM
Provider Role	—	—	Consulting physician -JI	—	Hospitalist -RM
Method of Communication	—	—	Perfect Serve -JI	—	Perfect Serve -RM
Response	—	—	Waiting for response -JI	—	Waiting for response -RM

Row Name	06/18/18 0339	06/18/18 0334	06/18/18 0000	06/17/18 1610	06/17/18 1532
Severe Sepsis Screening Tool					
Current Sepsis Treatment AND On IV Pressors?	—	—	No- Continue Screening -RM	—	—
Screening Results					
Positive For Severe Sepsis ?	—	—	No- Negative for Severe Sepsis -RM	—	—
Sepsis Interventions	—	—	MD Previously Notified -RM	—	—
Provider Notification					
Reason for Communication	Critical lab value -RM	Critical lab value -RM	—	Critical lab value -KW	Critical lab value -RG
Lab Value	trop 0.05 -RM	trop 0.05 -RM	—	H&H 5.6/19 -KW	POC TROP 0.09 AND BNP 2307 -RG
RBAC?	Yes -RM	Yes -RM	—	Yes -KW	Yes -RG
Notification Time	0338 -RM	0334 -RM	—	1611 -KW	1532 -RG
Provider Name	Andrew Goodner -RM	Joy -RM	—	DR. KRUG -KW	DR.KRUG -RG
Provider Role	PA -RM	NP -RM	—	Attending physician -KW	Attending physician -RG
Method of Communication	Perfect Serve -RM	Perfect Serve -RM	—	Face to face -KW	Face to face -RG
Response	Waiting for response Hospitalist called to request I advise CVM. -RM	Waiting for response -RM	—	In department -KW	See orders -RG

Flowsheets (all recorded)

Focused Assessment

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07
Breathing					
Respiratory Pattern	—	Regular -AM	—	—	—
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)
Circulation					
R Radial Pulse	—	+2 -AM	—	—	—
L Radial Pulse	—	+2 -AM	—	—	—
R Pedal Pulse	—	+2 -AM	—	—	—
L Pedal Pulse	—	+2 -AM	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -AM	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -AM	—	—	—
Disability					
Level of Consciousness	—	Alert -AM	—	—	—

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02
Breathing					
Chest Assessment	Chest expansion symmetrical -TS	—	—	Chest expansion symmetrical -MS	—
Respiratory Pattern	Regular -TS	—	—	Regular -MS	—
R Breath Sounds	—	—	—	Clear -MS	—
L Breath Sounds	—	—	—	Diminished -MS	—
SpO2	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)
Circulation					
R Radial Pulse	+2 -TS	—	—	+2 -MS	—
L Radial Pulse	+2 -TS	—	—	+2 -MS	—
R Pedal Pulse	+2 -TS	—	—	+2 -MS	—
L Pedal Pulse	+2 -TS	—	—	+2 -MS	—
Capillary Refill	Less than/equal to 2 seconds (All extremities) -TS	—	—	Less than/equal to 2 seconds (All extremities) -MS	—
RUE Capillary Refill	Less than/equal to 3 seconds -TS	—	—	Less than/equal to 3 seconds -MS	—
LUE Capillary Refill	Less than/equal to 3 seconds -TS	—	—	Less than/equal to 3 seconds -MS	—
RLE Capillary Refill	Less than/equal to 3 seconds -TS	—	—	Less than/equal to 3 seconds -MS	—
LLE Capillary Refill	Less than/equal to 3 seconds -TS	—	—	Less than/equal to 3 seconds -MS	—
Skin Color	Appropriate for ethnicity -TS	—	—	Appropriate for ethnicity -MS	—
Disability					
Level of Consciousness	Alert -TS	—	—	Alert -MS	—

Row Name	06/20/18 1000	06/20/18 0900	06/20/18 0800	06/20/18 0600	06/20/18 0500
Breathing					
Chest Assessment	—	—	Chest expansion symmetrical -DG	—	—
Respiratory Pattern	—	—	Regular -DG	—	—
SpO2	(!) 88 % -DG	(!) 87 % -DG	(!) 88 % -DG	93 % -EE	94 % -EE
Circulation					
R Radial Pulse	—	—	+2 -DG	—	—
L Radial Pulse	—	—	+2 -DG	—	—
R Pedal Pulse	—	—	+1 -DG	—	—
L Pedal Pulse	—	—	+1 -DG	—	—
Capillary Refill	—	—	Less than/equal to 2 seconds (All extremities) -DG	—	—
RUE Capillary Refill	—	—	Less than/equal to 3 seconds -DG	—	—
LUE Capillary Refill	—	—	Less than/equal to 3 seconds -DG	—	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -DG	—	—

Flowsheets (all recorded) (continued)

Focused Assessment (continued)

Row Name	06/20/18 1000	06/20/18 0900	06/20/18 0800	06/20/18 0600	06/20/18 0500
LLE Capillary Refill	—	—	Less than/equal to 3 seconds -DG	—	—
Skin Color	—	—	Appropriate for ethnicity -DG	—	—
Disability					
Level of Consciousness	—	—	Alert -DG	—	—

Row Name	06/20/18 0400	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300
Breathing					
SpO2	94 % -EE	97 % -EE	91 % -EE	90 % -EE	97 % -EE
Disability					
Level of Consciousness	Alert -EE	—	—	Alert -EE	—

Row Name	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800
Breathing					
Chest Assessment	—	—	Chest expansion symmetrical -EE	—	—
Respiratory Pattern	—	—	Regular -EE	—	—
SpO2	96 % -EE	94 % -EE	94 % -EE	94 % -EE	92 % -JI
Circulation					
R Radial Pulse	—	—	+2 -EE	—	—
L Radial Pulse	—	—	+2 -EE	—	—
R Pedal Pulse	—	—	+1 -EE	—	—
L Pedal Pulse	—	—	+1 -EE	—	—
Capillary Refill	—	—	Less than/equal to 2 seconds (All extremities) -EE	—	—
RUE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
LUE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
LLE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
Skin Color	—	—	Appropriate for ethnicity -EE	—	—
Disability					
Level of Consciousness	—	—	Alert -EE	—	—

Row Name	06/19/18 1700	06/19/18 1600	06/19/18 1500	06/19/18 1430	06/19/18 1335
Breathing					
SpO2	96 % -JI	95 % -JI	96 % -JI	96 % -JI	100 % -LFA

Row Name	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1114	06/19/18 1000
Breathing					
SpO2	97 % -LFA	92 % -LFA	93 % -CR	98 % -PM	92 % -JI

Row Name	06/19/18 0900	06/19/18 0800	06/19/18 0700	06/19/18 0600	06/19/18 0500
Breathing					
Chest Assessment	—	Chest expansion symmetrical -JI	—	—	—
Respiratory Pattern	—	Regular -JI	—	—	—
SpO2	95 % -JI	97 % -JI	96 % -JI	94 % -RM	96 % -RM
Circulation					
R Radial Pulse	—	+2 -JI	—	—	—
L Radial Pulse	—	+2 -JI	—	—	—
R Pedal Pulse	—	+1 -JI	—	—	—
L Pedal Pulse	—	+1 -JI	—	—	—
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -JI	—	—	—
Skin Color	—	Appropriate for ethnicity -JI	—	—	—

Flowsheets (all recorded) (continued)

Focused Assessment (continued)

Row Name	06/19/18 0900	06/19/18 0800	06/19/18 0700	06/19/18 0600	06/19/18 0500
Disability					
Level of Consciousness	—	Alert -JI	—	—	—

Row Name	06/19/18 0400	06/19/18 0300	06/19/18 0200	06/19/18 0100	06/19/18 0000
Breathing					
SpO2	98 % -RM	92 % -RM	93 % -RM	92 % -RM	94 % -RM

Row Name	06/18/18 2300	06/18/18 2200	06/18/18 2100	06/18/18 2000	06/18/18 1900
Breathing					
Chest Assessment	—	—	—	Chest expansion symmetrical -RM	—
Respiratory Pattern	—	—	—	Regular -RM	—
R Breath Sounds	—	—	—	Diminished -RM	—
L Breath Sounds	—	—	—	Diminished -RM	—
SpO2	97 % -RM	99 % -RM	99 % -RM	96 % -RM	(!) 89 % -RM
Circulation					
R Radial Pulse	—	—	—	+2 -RM	—
L Radial Pulse	—	—	—	+2 -RM	—
R Pedal Pulse	—	—	—	+1 -RM	—
L Pedal Pulse	—	—	—	+1 -RM	—
Capillary Refill	—	—	—	Less than/equal to 2 seconds (All extremities) -RM	—
RUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -RM	—
LUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -RM	—
RLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -RM	—
LLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -RM	—
Skin Color	—	—	—	Appropriate for ethnicity -RM	—
Disability					
Level of Consciousness	—	—	—	Alert -RM	—

Row Name	06/18/18 1800	06/18/18 1600	06/18/18 1500	06/18/18 1400	06/18/18 1300
Breathing					
SpO2	94 % -RM	(!) 87 % -JI	95 % -JI	91 % -JI	93 % -JI

Row Name	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0800	06/18/18 0700
Breathing					
Chest Assessment	—	—	—	Chest expansion symmetrical -JI	—
Respiratory Pattern	—	—	—	Regular -JI	—
SpO2	97 % -JI	98 % -JI	100 % -JI	91 % -JI	95 % -JI
Circulation					
R Radial Pulse	—	—	—	+2 -JI	—
L Radial Pulse	—	—	—	+2 -JI	—
R Pedal Pulse	—	—	—	+1 -JI	—
L Pedal Pulse	—	—	—	+1 -JI	—
Capillary Refill	—	—	—	Less than/equal to 2 seconds (All extremities) -JI	—
Skin Color	—	—	—	Appropriate for ethnicity -JI	—
Disability					
Level of Consciousness	—	—	—	Alert -JI	—

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0400	06/18/18 0300	06/18/18 0200
Breathing					
SpO2	97 % -RM	97 % -RM	97 % -RM	92 % -RM	(!) 87 % -RM

Row Name	06/18/18 0100	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037
Breathing					

Flowsheets (all recorded) (continued)

Focused Assessment (continued)

Row Name	06/18/18 0100	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037
Chest Assessment	—	Chest expansion symmetrical -RM	—	—	—
Respiratory Pattern	—	Regular -RM	—	—	—
R Breath Sounds	—	Diminished -RM	—	—	—
L Breath Sounds	—	Diminished -RM	—	—	—
SpO2	(!) 88 % -RM	92 % -RM	90 % -RM	92 % -AF	100 % -BR
Circulation					
R Radial Pulse	—	+2 -RM	—	—	—
L Radial Pulse	—	+2 -RM	—	—	—
R Pedal Pulse	—	+1 -RM	—	—	—
L Pedal Pulse	—	+1 -RM	—	—	—
RUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
Skin Color	—	Appropriate for ethnicity -RM	—	—	—
Disability					
Level of Consciousness	—	Alert -RM	—	—	—

Row Name	06/17/18 1823	06/17/18 1738	06/17/18 1708	06/17/18 1538	06/17/18 1502
Airway					
Airway (WDL)	—	—	—	WDL -RG	—
Breathing					
Chest Assessment	—	—	—	Chest expansion symmetrical -RG	—
Respiratory Pattern	—	—	—	Labored -RG	—
SpO2	100 % -BR	100 % -BR	100 % -BR	—	100 % -RG
Circulation					
Circulation (WDL)	—	—	—	X -RG	—
Skin Color	—	—	—	Pale -RG	—
Disability					
Disability (WDL)	—	—	—	WDL -RG	—
Level of Consciousness	—	—	—	Alert -RG	—

Row Name	06/17/18 1437
Breathing	
SpO2	98 % -NS

Flowsheets (all recorded)

Intra Procedure Sedation

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07
Vitals					
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)	98.4 °F (36.9 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	Oral -TW	Oral -TW
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)
Heart Rate Source	Monitor -CI	—	Monitor -CI	Monitor -TW	Monitor -TW
Resp	18 -CI	—	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)	124/53 -DI (r) TW (t)
Patient Position	Supine -CI	—	Supine -CI	Supine -TW	Supine -TW
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)
O2 Device	None (Room air) -CI	None (Room air) -AM	None (Room air) -CI	None (Room air) -TW	None (Room air) -TW

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02
Vitals					
Temp	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)	—	98.2 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	—	—
Pulse	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)
Heart Rate Source	—	Monitor -TW	—	—	—
Resp	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)	—	—
BP	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)	—	104/66 -DI (r) LF (t)
Patient Position	—	Supine -TW	—	—	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)
O2 Device	None (Room air) -TS	None (Room air) -TW	—	None (Room air) -MS	—

Row Name	06/20/18 1000	06/20/18 0909	06/20/18 0900	06/20/18 0800	06/20/18 0730
Vitals					
Temp	—	—	—	—	98.3 °F (36.8 °C) -HT
Temp src	—	—	—	—	Oral -HT
Pulse	61 -DG	59 -DG	60 -DG	58 -DG	—
Resp	18 -DG	—	17 -DG	18 -DG	—
BP	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG	138/62 -DG	—
Oxygen Therapy					
SpO2	(!) 88 % -DG	—	(!) 87 % -DG	(!) 88 % -DG	—
O2 Device	—	—	—	None (Room air) -DG	—
Pulse Oximetry Type	—	—	—	Continuous -DG	—

Row Name	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200
Vitals					
Temp	—	—	98 °F (36.7 °C) -JP	—	—
Temp src	—	—	Oral -JP	—	—
Pulse	59 -EE	57 -EE	56 -EE	57 -EE	64 -EE
Resp	20 -EE	20 -EE	19 -EE	21 -EE	16 -EE
BP	129/57 -EE	130/50 -EE	119/51 -EE	122/58 -EE	(!) 111/47 -EE
Oxygen Therapy					
SpO2	93 % -EE	94 % -EE	94 % -EE	97 % -EE	91 % -EE

Row Name	06/20/18 0000	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000
Vitals					
Temp	97.5 °F (36.4 °C) -JP	—	—	—	98.4 °F (36.9 °C) -JP
Temp src	Axillary -JP	—	—	—	Oral -JP
Pulse	59 -EE	61 -EE	62 -EE	61 -EE	63 -EE
Resp	22 -EE	21 -EE	22 -EE	16 -EE	21 -EE
BP	—	128/56 -EE	132/51 -EE	130/60 -EE	135/58 -EE
Oxygen Therapy					
SpO2	90 % -EE	97 % -EE	96 % -EE	94 % -EE	94 % -EE
O2 Device	—	—	—	—	Nasal cannula -EE
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -EE
Pulse Oximetry Type	—	—	—	—	Continuous -EE

Row Name	06/19/18 1900	06/19/18 1800	06/19/18 1700	06/19/18 1644	06/19/18 1600
Vitals					
Temp	—	—	—	97.9 °F (36.6 °C) -FT	—

Flowsheets (all recorded) (continued)

Intra Procedure Sedation (continued)

Row Name	06/19/18 1900	06/19/18 1800	06/19/18 1700	06/19/18 1644	06/19/18 1600
Temp src	—	—	—	Oral -FT	—
Pulse	64 -EE	61 -JI	59 -JI	—	58 -JI
Resp	19 -EE	25 -JI	21 -JI	—	20 -JI
BP	133/61 -EE	128/56 -JI	132/52 -JI	—	134/58 -JI
Oxygen Therapy					
SpO2	94 % -EE	92 % -JI	96 % -JI	—	95 % -JI

Row Name	06/19/18 1500	06/19/18 1430	06/19/18 1428	06/19/18 1340	06/19/18 1335
Vitals					
Temp	—	—	97.7 °F (36.5 °C) -FT	—	—
Temp src	—	—	Oral -FT	—	—
Pulse	56 -JI	57 -JI	—	—	54 -LFA
Resp	22 -JI	19 -JI	—	—	22 -LFA
BP	130/51 -JI	142/60 -JI	—	—	123/59 -LFA
Oxygen Therapy					
SpO2	96 % -JI	96 % -JI	—	—	100 % -LFA
O2 Device	—	Nasal cannula -JI	—	—	—
O2 Flow Rate (L/min)	—	2 L/min -JI	—	—	—
Pulse Oximetry Type	—	Continuous -JI	—	—	—
Aldrete Phase 1					
Activity	—	—	—	2 -LFA	—
Respiration	—	—	—	2 -LFA	—
Circulation	—	—	—	2 -LFA	—
Consciousness	—	—	—	2 -LFA	—
O2 Saturation	—	—	—	2 -LFA	—

Row Name	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1114	06/19/18 1031
Vitals					
Pulse	54 -LFA	53 -LFA	53 -CR	51 -PM	—
Heart Rate Source	—	—	—	Monitor -PM	—
Resp	19 -LFA	21 -LFA	18 -CR	13 -PM	—
BP	128/55 -LFA	**(!) 95/46** -LFA	110/53 -CR	123/54 -PM	—
Patient Position	—	—	—	Sitting -PM	—
Oxygen Therapy					
SpO2	97 % -LFA	92 % -LFA	93 % -CR	98 % -PM	—
O2 Device	—	—	—	Nasal cannula -PM	None (Room air) -JI
O2 Flow Rate (L/min)	—	—	—	3 L/min -PM	—

Row Name	06/19/18 1000	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700
Vitals					
Temp	—	—	—	98.6 °F (37 °C) -DF	—
Temp src	—	—	—	Oral -DF	—
Pulse	50 -JI	51 -JI	55 -JI	56 -JI	63 -JI
Resp	20 -JI	18 -JI	—	18 -JI	18 -JI
BP	**(!) 124/49** -JI	**(!) 119/44** -JI	**(!) 126/47** -JI	**(!) 126/47** -JI	143/52 -JI
Oxygen Therapy					
SpO2	92 % -JI	95 % -JI	—	97 % -JI	96 % -JI
O2 Device	—	—	—	Nasal cannula -JI	—
O2 Flow Rate (L/min)	—	—	—	2 L/min -JI	—
Pulse Oximetry Type	—	—	—	Continuous -JI	—

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
Vitals					
Temp	—	—	98.2 °F (36.8 °C) -MJ	—	—
Pulse	52 -RM	53 -RM	55 -RM	55 -RM	54 -RM
Heart Rate Source	—	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	17 -RM	17 -RM	20 -RM	16 -RM	19 -RM
BP	**(!) 109/40** -RM	**(!) 124/49** -RM	127/55 -RM	120/59 -RM	113/50 -RM
Patient Position	—	Sitting -RM	Supine -RM	Lying right side -RM	Lying right side -RM
Oxygen Therapy					
SpO2	94 % -RM	96 % -RM	98 % -RM	92 % -RM	93 % -RM
O2 Device	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	—	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	90 -RM	90 -RM

Flowsheets (all recorded) (continued)

Intra Procedure Sedation (continued)

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
POX Probe Site Changed	—	No -RM	No -RM	No -RM	No -RM

Row Name	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100
Vitals					
Temp	—	98.1 °F (36.7 °C) -MJ	—	—	—
Pulse	53 -RM	56 -RM	59 -RM	55 -RM	56 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	19 -RM	21 -RM	20 -RM	21 -RM	21 -RM
BP	**(!) 109/44** -RM	**(!) 123/43** -RM	127/59 -RM	—	—
Patient Position	Lying left side -RM	Lying left side -RM	Lying left side -RM	Supine -RM	—
Oxygen Therapy					
SpO2	92 % -RM	94 % -RM	97 % -RM	99 % -RM	99 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727	06/18/18 1600
Vitals					
Temp	98.4 °F (36.9 °C) -MJ	—	—	98.1 °F (36.7 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	56 -RM	56 -RM	56 -RM	—	52 -JI
Heart Rate Source	Monitor -RM	Monitor -RM	—	—	—
Resp	22 -RM	22 -RM	20 -RM	—	20 -JI
BP	—	—	132/60 -RM	—	142/57 -JI
Oxygen Therapy					
SpO2	96 % -RM	**(!) 89 %** -RM	94 % -RM	—	**(!) 87 %** -JI
O2 Device	Nasal cannula -RM	Nasal cannula -RM	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	—	—
POX Probe Site Changed	No -RM	No -RM	—	—	—

Row Name	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1230	06/18/18 1200
Vitals					
Temp	—	—	—	97.7 °F (36.5 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	54 -JI	58 -JI	57 -JI	—	52 -JI
Resp	18 -JI	19 -JI	15 -JI	—	18 -JI
BP	151/56 -JI	134/53 -JI	**(!) 130/45** -JI	—	140/56 -JI
Oxygen Therapy					
SpO2	95 % -JI	91 % -JI	93 % -JI	—	—

Row Name	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800
Vitals					
Temp	—	—	—	97.8 °F (36.6 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	50 -JI	51 -JI	**(!) 49** -JI	—	**(!) 48** -JI
Resp	17 -JI	16 -JI	16 -JI	—	17 -JI
BP	**(!) 128/46** -JI	131/52 -JI	137/54 -JI	—	**(!) 123/49** -JI
Oxygen Therapy					
SpO2	97 % -JI	98 % -JI	100 % -JI	—	91 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
O2 Flow Rate (L/min)	—	—	—	—	5 L/min -JI
Pulse Oximetry Type	—	—	—	—	Continuous -JI

Row Name	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400
Vitals					
Temp	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM	—
Temp src	—	Axillary -RM	—	Axillary -RM	—
Pulse	**(!) 46** -JI	**(!) 46** -RM	**(!) 47** -RM	**(!) 47** -RM	**(!) 49** -RM
Heart Rate Source	—	Monitor -RM	Monitor -RM	—	Monitor -RM

Flowsheets (all recorded) (continued)

Intra Procedure Sedation (continued)

Row Name	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400
Resp	17 -JI	13 -RM	18 -RM	18 -RM	19 -RM
BP	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM	120/52 -RM	117/50 -RM
Patient Position	—	Supine -RM	Lying left side -RM	—	Sitting -RM
Oxygen Therapy					
SpO2	95 % -JI	97 % -RM	97 % -RM	—	97 % -RM
O2 Device	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	—	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	100 -RM	100 -RM	—	100 -RM
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	—	90 -RM
POX Probe Site Changed	—	No -RM	No -RM	—	No -RM

Row Name	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051
Vitals					
Temp	—	—	—	—	98.1 °F (36.7 °C) -RM
Temp src	—	—	—	—	Oral -RM
Pulse	(!) 49 -RM	51 -RM	54 -RM	57 -RM	57 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	—	Monitor -RM	Monitor -RM
Resp	18 -RM	19 -RM	20 -RM	21 -RM	20 -RM
BP	(!) 109/43 -RM	(!) 102/39 -RM	—	123/51 -RM	140/52 -RM
Patient Position	Supine -RM	Lying right side -RM	—	Lying left side -RM	—
Oxygen Therapy					
SpO2	92 % -RM	(!) 87 % -RM	—	(!) 88 % -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	—	Nasal cannula -RM	—
O2 Flow Rate (L/min)	5 L/min -RM	5 L/min -RM	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	Continuous -RM	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	100 -RM	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	90 -RM	—
POX Probe Site Changed	No -RM	No -RM	—	No -RM	—

Row Name	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823
Vitals					
Temp	—	—	98 °F (36.7 °C) -AF	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR
Temp src	—	—	Oral -AF	Oral -BR	Oral -BR
Pulse	55 -RM	54 -RM	53 -AF	57 -BR	51 -BR
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -AF	Monitor -BR	Monitor -BR
Resp	20 -RM	17 -RM	18 -AF	16 -BR	18 -BR
BP	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF	134/59 -BR	126/55 -BR
Patient Position	Lying left side -RM	Sitting -RM	Sitting -RM	Sitting -BR	Sitting -BR
Oxygen Therapy					
SpO2	92 % -RM	90 % -RM	92 % -AF	100 % -BR	100 % -BR
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -AF	—	None (Room air) -BR
O2 Flow Rate (L/min)	—	—	2 L/min -AF	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	—	—
POX Probe Site Changed	Yes -RM	No -RM	No -RM	—	—

Row Name	06/17/18 1738	06/17/18 1720	06/17/18 1708	06/17/18 1538	06/17/18 1537
Vitals					
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR	—	97.8 °F (36.6 °C) -RG
Temp src	Oral -BR	Oral -BR	Oral -BR	—	—
Pulse	55 -BR	55 -BR	55 -BR	—	55 -RG
Heart Rate Source	Monitor -BR	—	Monitor -BR	—	—
Resp	18 -BR	18 -BR	18 -BR	—	22 -RG
BP	132/56 -BR	129/53 -BR	(!) 115/49 -BR	—	114/51 -RG
Patient Position	Sitting -BR	—	Standing -BR	—	—
Oxygen Therapy					
SpO2	100 % -BR	—	100 % -BR	—	—
O2 Device	None (Room air) -BR	—	None (Room air) -BR	None (Room air) -RG	—

Row Name	06/17/18 1502	06/17/18 1437
Vitals		
Temp	97.7 °F (36.5 °C) -RG	—

Flowsheets (all recorded) (continued)

Intra Procedure Sedation (continued)

Row Name	06/17/18 1502	06/17/18 1437
Temp src	Oral -RG	—
Pulse	54 -RG	56 -NS
Heart Rate Source	Monitor -RG	—
Resp	25 -RG	—
BP	112/52 -RG	—
Patient Position	Supine -RG	—
Oxygen Therapy		
SpO2	100 % -RG	98 % -NS
O2 Device	None (Room air) -RG	—
Pulse Oximetry Type	Continuous -RG	—

Flowsheets (all recorded)

Interpretation

Row Name	06/19/18 1258
Medical Interpretation Services Documentation (All fields are required)	
Is patient using Interpretation Services for this encounter?	No -CR

Flowsheets (all recorded)

Vitals/Pain

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 0545	06/21/18 04:07:21
OTHER					
Patient Position	Supine -CI	—	Supine -CI	—	Supine -TW
Vitals					
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	—	121/58 -DI (r) TW (t)
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	—	Oral -TW
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	—	63 -DI (r) TW (t)
Resp	18 -CI	—	18 -CI	—	18 -DI (r) TW (t)
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	—	93 % -DI (r) TW (t)
Vital Signs					
Heart Rate Source	Monitor -CI	—	Monitor -CI	—	Monitor -TW
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -AM	—	0 -TS	—

Row Name	06/21/18 0030	06/20/18 23:57:07	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04
OTHER					
Patient Position	—	Supine -TW	—	Supine -TW	—
FACES Pain Rating	0-No hurt -TS	—	—	—	—
Vitals					
BP	—	124/53 -DI (r) TW (t)	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)
Temp	—	98.4 °F (36.9 °C) -DI (r) TW (t)	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	Oral -TW	—
Pulse	—	109 -DI (r) TW (t)	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)
Resp	—	16 -DI (r) TW (t)	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)
SpO2	—	93 % -DI (r) TW (t)	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)
Vital Signs					
Heart Rate Source	—	Monitor -TW	—	Monitor -TW	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	0 -TS	—	—

Row Name	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909	06/20/18 0900	06/20/18 0830
Vitals					
BP	104/66 -DI (r) LF (t)	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG	—
Temp	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—	—	—
Pulse	61 -DI (r) LF (t)	61 -DG	59 -DG	60 -DG	—
Resp	—	18 -DG	—	17 -DG	—
SpO2	92 % -DI (r) LF (t)	(!) 88 % -DG	—	(!) 87 % -DG	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	—	0 Simultaneous filing. User may be unaware of other data. -MS

Row Name	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500	06/20/18 0400
Vitals					
BP	138/62 -DG	—	129/57 -EE	130/50 -EE	119/51 -EE
Temp	—	98.3 °F (36.8 °C) -HT	—	—	98 °F (36.7 °C) -JP
Temp src	—	Oral -HT	—	—	Oral -JP
Pulse	58 -DG	—	59 -EE	57 -EE	56 -EE
Resp	18 -DG	—	20 -EE	20 -EE	19 -EE
SpO2	(!) 88 % -DG	—	93 % -EE	94 % -EE	94 % -EE
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	2 -DG	—	—	—
Pain Location 1	—	Back -DG	—	—	—
Pain Location Orientation 1	—	Anterior -DG	—	—	—

Row Name	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300	06/19/18 2200
Vitals					

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300	06/19/18 2200
BP	122/58 -EE	(!) 111/47 -EE	—	128/56 -EE	132/51 -EE
Temp	—	—	97.5 °F (36.4 °C) -JP	—	—
Temp src	—	—	Axillary -JP	—	—
Pulse	57 -EE	64 -EE	59 -EE	61 -EE	62 -EE
Resp	21 -EE	16 -EE	22 -EE	21 -EE	22 -EE
SpO2	97 % -EE	91 % -EE	90 % -EE	97 % -EE	96 % -EE

Row Name	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800	06/19/18 1700
Vitals					
BP	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI	132/52 -JI
Temp	—	98.4 °F (36.9 °C) -JP	—	—	—
Temp src	—	Oral -JP	—	—	—
Pulse	61 -EE	63 -EE	64 -EE	61 -JI	59 -JI
Resp	16 -EE	21 -EE	19 -EE	25 -JI	21 -JI
SpO2	94 % -EE	94 % -EE	94 % -EE	92 % -JI	96 % -JI
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -EE	—	—	—

Row Name	06/19/18 1644	06/19/18 1600	06/19/18 1500	06/19/18 1430	06/19/18 1428
Vitals					
BP	—	134/58 -JI	130/51 -JI	142/60 -JI	—
Temp	97.9 °F (36.6 °C) -FT	—	—	—	97.7 °F (36.5 °C) -FT
Temp src	Oral -FT	—	—	—	Oral -FT
Pulse	—	58 -JI	56 -JI	57 -JI	—
Resp	—	20 -JI	22 -JI	19 -JI	—
SpO2	—	95 % -JI	96 % -JI	96 % -JI	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -JI	—	—	—

Row Name	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1114
OTHER					
Patient Position	—	—	—	—	Sitting -PM
Pain Assessment	—	—	—	0-10 -CR	—
Vitals					
BP	123/59 -LFA	128/55 -LFA	(!) 95/46 -LFA	110/53 -CR	123/54 -PM
Pulse	54 -LFA	54 -LFA	53 -LFA	53 -CR	51 -PM
Resp	22 -LFA	19 -LFA	21 -LFA	18 -CR	13 -PM
SpO2	100 % -LFA	97 % -LFA	92 % -LFA	93 % -CR	98 % -PM
Vital Signs					
Heart Rate Source	—	—	—	—	Monitor -PM
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	0 -CR	—

Row Name	06/19/18 1000	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700
Vitals					
BP	(!) 124/49 -JI	(!) 119/44 -JI	(!) 126/47 -JI	(!) 126/47 -JI	143/52 -JI
Temp	—	—	—	98.6 °F (37 °C) -DF	—
Temp src	—	—	—	Oral -DF	—
Pulse	50 -JI	51 -JI	55 -JI	56 -JI	63 -JI
Resp	20 -JI	18 -JI	—	18 -JI	18 -JI
SpO2	92 % -JI	95 % -JI	—	97 % -JI	96 % -JI
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	0 -JI	—

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
OTHER					
Patient Position	—	Sitting -RM	Supine -RM	Lying right side -RM	Lying right side -RM
Vitals					
BP	(!) 109/40 -RM	(!) 124/49 -RM	127/55 -RM	120/59 -RM	113/50 -RM
Temp	—	—	98.2 °F (36.8 °C) -MJ	—	—
Pulse	52 -RM	53 -RM	55 -RM	55 -RM	54 -RM

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
Resp	17 -RM	17 -RM	20 -RM	16 -RM	19 -RM
SpO2	94 % -RM	96 % -RM	98 % -RM	92 % -RM	93 % -RM
Vital Signs					
Heart Rate Source	—	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM

Row Name	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100
OTHER					
Patient Position	Lying left side -RM	Lying left side -RM	Lying left side -RM	Supine -RM	—
Vitals					
BP	(!) 109/44 -RM	(!) 123/43 -RM	127/59 -RM	—	—
Temp	—	98.1 °F (36.7 °C) -MJ	—	—	—
Pulse	53 -RM	56 -RM	59 -RM	55 -RM	56 -RM
Resp	19 -RM	21 -RM	20 -RM	21 -RM	21 -RM
SpO2	92 % -RM	94 % -RM	97 % -RM	99 % -RM	99 % -RM
Vital Signs					
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	—	0 -RM

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727	06/18/18 1600
Vitals					
BP	—	—	132/60 -RM	—	142/57 -JI
Temp	98.4 °F (36.9 °C) -MJ	—	—	98.1 °F (36.7 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	56 -RM	56 -RM	56 -RM	—	52 -JI
Resp	22 -RM	22 -RM	20 -RM	—	20 -JI
SpO2	96 % -RM	(!) 89 % -RM	94 % -RM	—	(!) 87 % -JI
Vital Signs					
Heart Rate Source	Monitor -RM	Monitor -RM	—	—	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	—	—	0 -JI

Row Name	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1230	06/18/18 1200
Vitals					
BP	151/56 -JI	134/53 -JI	(!) 130/45 -JI	—	140/56 -JI
Temp	—	—	—	97.7 °F (36.5 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	54 -JI	58 -JI	57 -JI	—	52 -JI
Resp	18 -JI	19 -JI	15 -JI	—	18 -JI
SpO2	95 % -JI	91 % -JI	93 % -JI	—	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	—	0 -JI

Row Name	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800
Vitals					
BP	(!) 128/46 -JI	131/52 -JI	137/54 -JI	—	(!) 123/49 -JI
Temp	—	—	—	97.8 °F (36.6 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	50 -JI	51 -JI	(!) 49 -JI	—	(!) 48 -JI
Resp	17 -JI	16 -JI	16 -JI	—	17 -JI
SpO2	97 % -JI	98 % -JI	100 % -JI	—	91 % -JI
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	—	0 -JI

Row Name	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400
OTHER					
Patient Position	—	Supine -RM	Lying left side -RM	—	Sitting -RM
Weight Method	—	Actual -RM	—	—	—
Vitals					
BP	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM	120/52 -RM	117/50 -RM

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400
Temp	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM	—
Temp src	—	Axillary -RM	—	Axillary -RM	—
Pulse	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM	(!) 47 -RM	(!) 49 -RM
Resp	17 -JI	13 -RM	18 -RM	18 -RM	19 -RM
SpO2	95 % -JI	97 % -RM	97 % -RM	—	97 % -RM
Weight	—	104.9 kg (231 lb 4.2 oz) -RM	—	—	—
Vital Signs					
Heart Rate Source	—	Monitor -RM	Monitor -RM	—	Monitor -RM
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	0 -RM	0 -RM	—	0 -RM

Row Name	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051
OTHER					
Patient Position	Supine -RM	Lying right side -RM	—	Lying left side -RM	—
Vitals					
BP	(!) 109/43 -RM	(!) 102/39 -RM	—	123/51 -RM	140/52 -RM
Temp	—	—	—	—	98.1 °F (36.7 °C) -RM
Temp src	—	—	—	—	Oral -RM
Pulse	(!) 49 -RM	51 -RM	54 -RM	57 -RM	57 -RM
Resp	18 -RM	19 -RM	20 -RM	21 -RM	20 -RM
SpO2	92 % -RM	(!) 87 % -RM	—	(!) 88 % -RM	—
Vital Signs					
Heart Rate Source	Monitor -RM	Monitor -RM	—	Monitor -RM	Monitor -RM
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	—	0 -RM	—

Row Name	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823
OTHER					
Patient Position	Lying left side -RM	Sitting -RM	Sitting -RM	Sitting -BR	Sitting -BR
Weight Method	—	—	Actual -AF	—	—
BMI (Calculated)	—	—	35.7 -AF	—	—
BSA (Calculated - sq m)	—	—	2.21 sq meters -AF	—	—
Vitals					
BP	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF	134/59 -BR	126/55 -BR
Temp	—	—	98 °F (36.7 °C) -AF	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR
Temp src	—	—	Oral -AF	Oral -BR	Oral -BR
Pulse	55 -RM	54 -RM	53 -AF	57 -BR	51 -BR
Resp	20 -RM	17 -RM	18 -AF	16 -BR	18 -BR
SpO2	92 % -RM	90 % -RM	92 % -AF	100 % -BR	100 % -BR
Height	—	—	67" (1.702 m) -AF	—	—
Weight	—	—	103.4 kg (227 lb 15.3 oz) -AF	—	—
Vital Signs					
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -AF	Monitor -BR	Monitor -BR
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	0 -BR	0 -BR

Row Name	06/17/18 1738	06/17/18 1720	06/17/18 1708	06/17/18 1706	06/17/18 1537
OTHER					
Patient Position	Sitting -BR	—	Standing -BR	—	—
Vitals					
BP	132/56 -BR	129/53 -BR	(!) 115/49 -BR	—	114/51 -RG
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR	—	97.8 °F (36.6 °C) -RG
Temp src	Oral -BR	Oral -BR	Oral -BR	—	—
Pulse	55 -BR	55 -BR	55 -BR	—	55 -RG
Resp	18 -BR	18 -BR	18 -BR	—	22 -RG
SpO2	100 % -BR	—	100 % -BR	—	—
Vital Signs					

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/17/18 1738	06/17/18 1720	06/17/18 1708	06/17/18 1706	06/17/18 1537
Heart Rate Source	Monitor -BR	—	Monitor -BR	—	—
Numeric Pain Intensity Scale 1					
Numeric Pain Intensity Score 1	—	—	—	0 -BR	—

Row Name	06/17/18 1535	06/17/18 1504	06/17/18 1502	06/17/18 1437
OTHER				
Patient Position	—	—	Supine -RG	—
Weight Method	Stated -RG	—	—	—
Vitals				
BP	—	—	112/52 -RG	—
Temp	—	—	97.7 °F (36.5 °C) -RG	—
Temp src	—	—	Oral -RG	—
Pulse	—	—	54 -RG	56 -NS
Resp	—	—	25 -RG	—
SpO2	—	—	100 % -RG	98 % -NS
Weight	95.3 kg (210 lb) -RG	—	—	—
Vital Signs				
Heart Rate Source	—	—	Monitor -RG	—
Numeric Pain Intensity Scale 1				
Numeric Pain Intensity Score 1	—	0 -RG	—	—

Flowsheets (all recorded)

Fall Risk

Row Name	06/21/18 0830	06/20/18 2133	06/20/18 0800	06/19/18 2000	06/19/18 1117
Hester Davis Fall Risk Assessment					
Last Known Fall	0 -AM	0 -TS	0 -DG	0 -EE	—
Mobility	0 -AM	0 -TS	0 -DG	1;2 -EE	—
Medications	1 -AM	1 -TS	1;3 -DG	1 -EE	—
Mental Status/LOC/Awareness	0 -AM	0 -TS	0 -DG	0 -EE	—
Toileting Needs	0 -AM	0 -TS	0 -DG	0 -EE	—
Volume/Electrolyte Status	0 -AM	0 -TS	0 -DG	2 -EE	—
Communication/Sensory	1 -AM	1 -TS	1 -DG	1 -EE	—
Behavior	0 -AM	0 -TS	0 -DG	0 -EE	—
Hester Davis Fall Risk Total	5 -AM	5 -TS	8 -DG	10 -EE	—
Fall Assessment					
Patient Receiving Sedation	—	—	—	—	Yes -PM
Fall Risk	—	—	—	—	Yes -PM
Fall Band Applied	—	—	—	—	Yes -PM
Yellow socks	—	—	—	—	Yes -PM

Row Name	06/19/18 0800	06/18/18 2000	06/18/18 0800	06/18/18 0000
Hester Davis Fall Risk Assessment				
Last Known Fall	0 -JI	0 -RM	0 -JI	0 -RM
Mobility	1;2 -JI	1 -RM	1 -JI	1 -RM
Medications	1 -JI	0 -RM	3 -JI	3 -RM
Mental Status/LOC/Awareness	0 -JI	0 -RM	0 -JI	0 -RM
Toileting Needs	0 -JI	2 -RM	0 -JI	0 -RM
Volume/Electrolyte Status	2 -JI	2 -RM	2 -JI	2 -RM
Communication/Sensory	1 -JI	1 -RM	1 -JI	1 -RM
Behavior	0 -JI	0 -RM	0 -JI	0 -RM
Hester Davis Fall Risk Total	10 -JI	9 -RM	10 -JI	10 -RM

Flowsheets (all recorded)

Pre-op Checklist

Row Name	06/19/18 1316	06/19/18 1315	06/19/18 1118	06/18/18 0445	06/18/18 0051
Patient Verification					
History and Physical Completed	—	—	Yes -PM	—	—
Consents Confirmed	—	—	Informed -PM	—	—
Advance Directive	—	—	Patient does not have advance directive -PM	—	—
Patient ID and Procedure Verified	—	—	Yes -PM	—	—
Correct Procedure	—	—	Yes -PM	—	—
Documents Match	—	—	Yes -PM	—	—
Pacemaker	—	—	No -PM	—	—
Patient has an ICD?	—	—	No -PM	—	—
Blood Bank ID Number (from Wristband)	—	—	90803 -PM	90803 -RM	90803 -RM
Pre-op Lab/Test Results Available	—	—	N/A -PM	—	—
Preg Test	—	—	n/a -PM	—	—
Blood Glucose Meter (mg/dl)	—	—	175 -PM	—	—
Prep Verification					
Isolation Precautions	—	—	— na -PM	—	—
Allergy Band Applied	—	—	Yes -PM	—	—
Anti-embolism	—	—	n/a -PM	—	—
Pre-op Antibiotic Ordered?	—	—	n/a -PM	—	—
Beta Blocker Therapy Last Dose Date	—	—	06/19/18 -PM	—	—
Beta Blocker Last Dose Time	—	—	0808 -PM	—	—
Anticoag Not Applicable?	—	—	n/a -PM	—	—
VTE Assessment Complete?	—	—	Yes -PM	—	—
Date of last liquid	—	—	06/19/18 -PM	—	—
Time of last liquid	—	—	0808 sips with meds -PM	—	—
Date of last solid	—	—	06/18/18 -PM	—	—
Time of last solid	—	—	1800 -PM	—	—
Void Prior to Procedure	—	—	Yes -PM	—	—
Void Prior to Procedure Time	—	—	1045 -PM	—	—
Enema Given	—	—	Not applicable -PM	—	—
Bowel Prep Results	—	—	Other (comment) na -PM	—	—
Remove all that apply:	—	—	Other (see comment);Glasses/Contacts left in patient room -PM	—	—
Disposition of belongings:	—	—	Other (comment) left in inpatient room -PM	—	—
Side/Site Confirmed	—	—	N/A -PM	—	—
Required items available	—	—	— na -PM	—	—
Transport To	Phase II -CR	Phase II -CR	Procedure Area -PM	—	—
Mode of Transport	Stretcher -CR	Stretcher -CR	Stretcher -PM	—	—
Transport By	RN;Anesthesia Staff -CR	RN;Anesthesia Staff -CR	RN -PM	—	—
Released by (Floor RN or Pre-op RN)	—	—	pamela rn -PM	—	—
Report given to (healthcare professional/RN)	—	—	procedure rn -PM	—	—
Metal Implant Present?	—	—	No -PM	—	—
Skin Prep for Procedure	—	—	No -PM	—	—

Row Name	06/18/18 0000	06/17/18 1723	06/17/18 1720
Patient Verification			

Flowsheets (all recorded) (continued)

Pre-op Checklist (continued)

Row Name	06/18/18 0000	06/17/18 1723	06/17/18 1720
Advance Directive	Patient does not have advance directive -RM	—	—
Blood Bank ID Number (from Wristband)	—	r90803 -BR	r90803 -BR

Flowsheets (all recorded)

Transport

Row Name	06/19/18 1316	06/19/18 1315	06/19/18 1118
Care Handoff			
Report Given to	Given to other (Comment) -CR	Given to other (Comment) -CR	—
Name of person receiving report	RN -CR	RN -CR	—
Name of person giving report	CHERYL -CR	CHERYL -CR	—
Prep Verification			
Transport To	Phase II -CR	Phase II -CR	Procedure Area -PM
Transport By	RN;Anesthesia Staff -CR	RN;Anesthesia Staff -CR	RN -PM
Transport Via	Stretcher -CR	Stretcher -CR	—
Arrived From			
Mode of Transport	Stretcher -CR	Stretcher -CR	Stretcher -PM

Flowsheets (all recorded)

PACU DISCH Assessment

Row Name	06/21/18 1200	06/21/18 11:36:09	06/21/18 1000	06/21/18 0830	06/21/18 0800
PACU DISCH Assessment					
SpO2	—	96 % -DI (r) CI (t)	—	—	—
Resp	—	18 -CI	—	—	—
Pulse	—	60 -DI (r) CI (t)	—	—	—
Temp	—	98.5 °F (36.9 °C) -DI (r) CI (t)	—	—	—
Temp src	—	Oral -CI	—	—	—
RLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -AM	—
LLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -AM	—
Side Rails/Bed Safety	3/4 -CI	—	3/4 -JK	—	3/4 -CI

Row Name	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07	06/20/18 2133	06/20/18 19:43:22
PACU DISCH Assessment					
SpO2	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)	—	93 % -DI (r) TW (t)
Resp	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)	—	16 -DI (r) TW (t)
Pulse	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)	—	66 -DI (r) TW (t)
Temp	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)	98.4 °F (36.9 °C) -DI (r) TW (t)	—	98.2 °F (36.8 °C) -DI (r) TW (t)
Temp src	Oral -CI	Oral -TW	Oral -TW	—	Oral -TW
Skin Condition/Temp	—	—	—	Dry;Warm -TS	—
Skin Color	—	—	—	Appropriate for ethnicity -TS	—
Capillary Refill	—	—	—	Less than/equal to 2 seconds (All extremities) -TS	—
RUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
LUE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
RLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
LLE Capillary Refill	—	—	—	Less than/equal to 3 seconds -TS	—
Side Rails/Bed Safety	—	3/4 -TW	3/4 -TW	—	3/4 -TW

Row Name	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909
PACU DISCH Assessment					
SpO2	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)	(!) 88 % -DG	—
Resp	17 -DI (r) LF (t)	—	—	18 -DG	—
Pulse	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)	61 -DG	59 -DG
Temp	98.3 °F (36.8 °C) -DI (r) LF (t)	—	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—
Skin Condition/Temp	—	Dry;Warm -MS	—	—	—
Skin Color	—	Appropriate for ethnicity -MS	—	—	—
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -MS	—	—	—
RUE Capillary Refill	—	Less than/equal to 3 seconds -MS	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -MS	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -MS	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -MS	—	—	—

Row Name	06/20/18 0900	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500
PACU DISCH Assessment					
SpO2	(!) 87 % -DG	(!) 88 % -DG	—	93 % -EE	94 % -EE
Resp	17 -DG	18 -DG	—	20 -EE	20 -EE
Pulse	60 -DG	58 -DG	—	59 -EE	57 -EE
Cardiac Rhythm	—	Normal sinus rhythm -DG	—	—	—
Temp	—	—	98.3 °F (36.8 °C) -HT	—	—
Temp src	—	—	Oral -HT	—	—
Skin Color	—	Appropriate for ethnicity	—	—	—

Flowsheets (all recorded) (continued)

PACU DISCH Assessment (continued)

Row Name	06/20/18 0900	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500
		-DG			
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -DG	—	—	—
RUE Capillary Refill	—	Less than/equal to 3 seconds -DG	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -DG	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -DG	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -DG	—	—	—
Side Rails/Bed Safety	—	—	—	3/4 -JP	—

Row Name	06/20/18 0400	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300
PACU DISCH Assessment					
SpO2	94 % -EE	97 % -EE	91 % -EE	90 % -EE	97 % -EE
Resp	19 -EE	21 -EE	16 -EE	22 -EE	21 -EE
Pulse	56 -EE	57 -EE	64 -EE	59 -EE	61 -EE
Temp	98 °F (36.7 °C) -JP	—	—	97.5 °F (36.4 °C) -JP	—
Temp src	Oral -JP	—	—	Axillary -JP	—
Side Rails/Bed Safety	3/4 -JP	—	3/4 -JP	3/4 -JP	—

Row Name	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800
PACU DISCH Assessment					
SpO2	96 % -EE	94 % -EE	94 % -EE	94 % -EE	92 % -JI
Resp	22 -EE	16 -EE	21 -EE	19 -EE	25 -JI
Pulse	62 -EE	61 -EE	63 -EE	64 -EE	61 -JI
Cardiac Rhythm	—	—	Normal sinus rhythm -EE	—	—
Temp	—	—	98.4 °F (36.9 °C) -JP	—	—
Temp src	—	—	Oral -JP	—	—
Skin Color	—	—	Appropriate for ethnicity -EE	—	—
Capillary Refill	—	—	Less than/equal to 2 seconds (All extremities) -EE	—	—
RUE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
LUE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
LLE Capillary Refill	—	—	Less than/equal to 3 seconds -EE	—	—
Side Rails/Bed Safety	3/4 -JP	—	3/4 -JP	—	—

Row Name	06/19/18 1700	06/19/18 1644	06/19/18 1600	06/19/18 1500	06/19/18 1430
PACU DISCH Assessment					
SpO2	96 % -JI	—	95 % -JI	96 % -JI	96 % -JI
Resp	21 -JI	—	20 -JI	22 -JI	19 -JI
Pulse	59 -JI	—	58 -JI	56 -JI	57 -JI
Temp	—	97.9 °F (36.6 °C) -FT	—	—	—
Temp src	—	Oral -FT	—	—	—
Side Rails/Bed Safety	—	—	3/4 -FT	—	—

Row Name	06/19/18 1429	06/19/18 1428	06/19/18 1340	06/19/18 1335	06/19/18 1330
PACU DISCH Assessment					
Airway	—	—	Natural -LFA	—	—
LOC	—	—	Awake;Oriented -LFA	—	—
Resp	—	—	Equal -LFA	—	—
O2	—	—	Room Air -LFA	—	—
SpO2	—	—	—	100 % -LFA	97 % -LFA
Resp	—	—	—	22 -LFA	19 -LFA
Expected Outcome	—	—	1 Patent / clear airway maintained -LFA	—	—
Pulse	—	—	—	54 -LFA	54 -LFA
Temp	—	97.7 °F (36.5 °C) -FT	—	—	—
Temp src	—	Oral -FT	—	—	—
Expected Outcome	—	—	1 Vital signs within acceptable limits -LFA	—	—

Flowsheets (all recorded) (continued)

PACU DISCH Assessment (continued)

Row Name	06/19/18 1429	06/19/18 1428	06/19/18 1340	06/19/18 1335	06/19/18 1330
Activity	—	—	2 -LFA	—	—
Respiration	—	—	2 -LFA	—	—
Circulation	—	—	2 -LFA	—	—
Consciousness	—	—	2 -LFA	—	—
O2 Saturation	—	—	2 -LFA	—	—
Aldrete Score (PAR)	—	—	10 -LFA	—	—
Side Rails/Bed Safety	3/4 -FT	—	—	—	—

Row Name	06/19/18 1325	06/19/18 1321	06/19/18 1316	06/19/18 1315	06/19/18 1118
PACU DISCH Assessment					
SpO2	92 % -LFA	93 % -CR	—	—	—
Resp	21 -LFA	18 -CR	—	—	—
Pulse	53 -LFA	53 -CR	—	—	—
Anti-embolism	—	—	—	—	n/a -PM
Report given to (healthcare professional/RN)	—	—	—	—	procedure rn -PM
Transport By	—	—	RN;Anesthesia Staff -CR	RN;Anesthesia Staff -CR	RN -PM
Transport To	—	—	Phase II -CR	Phase II -CR	Procedure Area -PM

Row Name	06/19/18 1114	06/19/18 1000	06/19/18 0900	06/19/18 0808	06/19/18 0800
PACU DISCH Assessment					
SpO2	98 % -PM	92 % -JI	95 % -JI	—	97 % -JI
Resp	13 -PM	20 -JI	18 -JI	—	18 -JI
Pulse	51 -PM	50 -JI	51 -JI	55 -JI	56 -JI
Cardiac Rhythm	—	—	—	—	Normal sinus rhythm -JI
Temp	—	—	—	—	98.6 °F (37 °C) -DF
Temp src	—	—	—	—	Oral -DF
Skin Color	—	—	—	—	Appropriate for ethnicity -JI
Capillary Refill	—	—	—	—	Less than/equal to 2 seconds (All extremities) -JI
Side Rails/Bed Safety	—	3/4 -DF	—	—	3/4 -DF

Row Name	06/19/18 0700	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300
PACU DISCH Assessment					
SpO2	96 % -JI	94 % -RM	96 % -RM	98 % -RM	92 % -RM
Resp	18 -JI	17 -RM	17 -RM	20 -RM	16 -RM
Pulse	63 -JI	52 -RM	53 -RM	55 -RM	55 -RM
Temp	—	—	—	98.2 °F (36.8 °C) -MJ	—
Side Rails/Bed Safety	—	3/4 -MJ	—	3/4 -RM	—

Row Name	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200
PACU DISCH Assessment					
SpO2	93 % -RM	92 % -RM	94 % -RM	97 % -RM	99 % -RM
Resp	19 -RM	19 -RM	21 -RM	20 -RM	21 -RM
Pulse	54 -RM	53 -RM	56 -RM	59 -RM	55 -RM
Temp	—	—	98.1 °F (36.7 °C) -MJ	—	—
Side Rails/Bed Safety	3/4 -RM	—	3/4 -MJ	—	3/4 -MJ

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727
PACU DISCH Assessment					
SpO2	99 % -RM	96 % -RM	(!) 89 % -RM	94 % -RM	—
Resp	21 -RM	22 -RM	22 -RM	20 -RM	—
Pulse	56 -RM	56 -RM	56 -RM	56 -RM	—
Cardiac Rhythm	—	Normal sinus rhythm;Sinus bradycardia -RM	—	—	—
Temp	—	98.4 °F (36.9 °C) -MJ	—	—	98.1 °F (36.7 °C) -JD
Temp src	—	—	—	—	Oral -JD
Skin Color	—	Appropriate for ethnicity -RM	—	—	—
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -RM	—	—	—
RUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—

Flowsheets (all recorded) (continued)

PACU DISCH Assessment (continued)

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727
RLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
Side Rails/Bed Safety	—	3/4 -MJ	—	—	—

Row Name	06/18/18 1600	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1230
PACU DISCH Assessment					
SpO2	(!) 87 % -JI	95 % -JI	91 % -JI	93 % -JI	—
Resp	20 -JI	18 -JI	19 -JI	15 -JI	—
Pulse	52 -JI	54 -JI	58 -JI	57 -JI	—
Temp	—	—	—	—	97.7 °F (36.5 °C) -JD
Temp src	—	—	—	—	Oral -JD
Side Rails/Bed Safety	3/4 -JD	—	3/4 -JD	—	—

Row Name	06/18/18 1200	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831
PACU DISCH Assessment					
SpO2	—	97 % -JI	98 % -JI	100 % -JI	—
Resp	18 -JI	17 -JI	16 -JI	16 -JI	—
Pulse	52 -JI	50 -JI	51 -JI	(!) 49 -JI	—
Temp	—	—	—	—	97.8 °F (36.6 °C) -JD
Temp src	—	—	—	—	Oral -JD
Side Rails/Bed Safety	—	—	3/4 -JD	—	—

Row Name	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445
PACU DISCH Assessment					
SpO2	91 % -JI	95 % -JI	97 % -RM	97 % -RM	—
Resp	17 -JI	17 -JI	13 -RM	18 -RM	18 -RM
Pulse	(!) 48 -JI	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM	(!) 47 -RM
Cardiac Rhythm	Normal sinus rhythm;Sinus bradycardia -JI	—	—	—	—
Temp	—	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM
Temp src	—	—	Axillary -RM	—	Axillary -RM
Skin Color	Appropriate for ethnicity -JI	—	—	—	—
Capillary Refill	Less than/equal to 2 seconds (All extremities) -JI	—	—	—	—
Side Rails/Bed Safety	3/4 -JD	—	3/4 -RM	—	—

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100
PACU DISCH Assessment					
SpO2	97 % -RM	92 % -RM	(!) 87 % -RM	—	(!) 88 % -RM
Resp	19 -RM	18 -RM	19 -RM	20 -RM	21 -RM
Pulse	(!) 49 -RM	(!) 49 -RM	51 -RM	54 -RM	57 -RM
Side Rails/Bed Safety	3/4 -RM	—	3/4 -RM	—	—

Row Name	06/18/18 0051	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037
PACU DISCH Assessment					
SpO2	—	92 % -RM	90 % -RM	92 % -AF	100 % -BR
Resp	20 -RM	20 -RM	17 -RM	18 -AF	16 -BR
Pulse	57 -RM	55 -RM	54 -RM	53 -AF	57 -BR
Cardiac Rhythm	—	Sinus bradycardia -RM	—	—	—
Temp	98.1 °F (36.7 °C) -RM	—	—	98 °F (36.7 °C) -AF	98.2 °F (36.8 °C) -BR
Temp src	Oral -RM	—	—	Oral -AF	Oral -BR
Skin Color	—	Appropriate for ethnicity -RM	—	—	—
RUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
Side Rails/Bed Safety	—	3/4 -RM	—	—	—

Row Name	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1708	06/17/18 1538
PACU DISCH Assessment					

Flowsheets (all recorded) (continued)

PACU DISCH Assessment (continued)

Row Name	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1708	06/17/18 1538
SpO2	100 % -BR	100 % -BR	—	100 % -BR	—
Resp	18 -BR	18 -BR	18 -BR	18 -BR	—
Pulse	51 -BR	55 -BR	55 -BR	55 -BR	—
Cardiac Rhythm	—	—	—	—	Sinus bradycardia -RG
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR	—
Temp src	Oral -BR	Oral -BR	Oral -BR	Oral -BR	—
Skin Color	—	—	—	—	Pale -RG

Row Name	06/17/18 1537	06/17/18 1502	06/17/18 1437
PACU DISCH Assessment			
SpO2	—	100 % -RG	98 % -NS
Resp	22 -RG	25 -RG	—
Pulse	55 -RG	54 -RG	56 -NS
Temp	97.8 °F (36.6 °C) -RG	97.7 °F (36.5 °C) -RG	—
Temp src	—	Oral -RG	—

Flowsheets (all recorded)

Respiratory

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07
Respiratory					
Bilateral Breath Sounds	—	Clear -AM	—	—	—
Respiratory Pattern	—	Regular -AM	—	—	—
O2 Device	None (Room air) -CI	None (Room air) -AM	None (Room air) -CI	None (Room air) -TW	None (Room air) -TW

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 1458	06/20/18 0800	06/19/18 2000
Respiratory					
Bilateral Breath Sounds	Clear;Diminished -TS	—	Clear;Diminished -MS	Diminished -DG	Diminished -EE
L Breath Sounds	—	—	Diminished -MS	—	—
R Breath Sounds	—	—	Clear -MS	—	—
Respiratory Pattern	Regular -TS	—	Regular -MS	Regular -DG	Regular -EE
Chest Assessment	Chest expansion symmetrical -TS	—	Chest expansion symmetrical -MS	Chest expansion symmetrical -DG	Chest expansion symmetrical -EE
O2 Device	None (Room air) -TS	None (Room air) -TW	None (Room air) -MS	None (Room air) -DG	Nasal cannula -EE
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -EE

Row Name	06/19/18 1430	06/19/18 1114	06/19/18 1031	06/19/18 0800	06/19/18 0500
Respiratory					
Bilateral Breath Sounds	—	—	—	Diminished -JI	—
Respiratory Pattern	—	—	—	Regular -JI	—
Chest Assessment	—	—	—	Chest expansion symmetrical -JI	—
O2 Device	Nasal cannula -JI	Nasal cannula -PM	None (Room air) -JI	Nasal cannula -JI	Nasal cannula -RM
O2 Flow Rate (L/min)	2 L/min -JI	3 L/min -PM	—	2 L/min -JI	—

Row Name	06/19/18 0400	06/19/18 0300	06/19/18 0200	06/19/18 0100	06/19/18 0000
Respiratory					
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM

Row Name	06/18/18 2300	06/18/18 2200	06/18/18 2100	06/18/18 2000	06/18/18 1900
Respiratory					
Bilateral Breath Sounds	—	—	—	Diminished -RM	—
L Breath Sounds	—	—	—	Diminished -RM	—
R Breath Sounds	—	—	—	Diminished -RM	—
Respiratory Pattern	—	—	—	Regular -RM	—
Chest Assessment	—	—	—	Chest expansion symmetrical -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM

Row Name	06/18/18 0800	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400
Respiratory					
Bilateral Breath Sounds	Diminished -JI	—	—	—	—
Respiratory Pattern	Regular -JI	—	—	—	—
Chest Assessment	Chest expansion symmetrical -JI	—	—	—	—
O2 Device	Nasal cannula -JI	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	5 L/min -JI	—	—	—	—

Row Name	06/18/18 0300	06/18/18 0200	06/18/18 0100	06/18/18 0000	06/17/18 2300
Respiratory					
L Breath Sounds	—	—	—	Diminished -RM	—
R Breath Sounds	—	—	—	Diminished -RM	—
Respiratory Pattern	—	—	—	Regular -RM	—
Chest Assessment	—	—	—	Chest expansion symmetrical -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	5 L/min -RM	5 L/min -RM	—	—	—

Row Name	06/17/18 2225	06/17/18 1823	06/17/18 1738	06/17/18 1708	06/17/18 1538
Respiratory					
Respiratory (WDL)	—	—	—	—	X -RG
Bilateral Breath Sounds	—	—	—	—	Diminished -RG
Respiratory Pattern	—	—	—	—	Labored -RG
Chest Assessment	—	—	—	—	Chest expansion

Flowsheets (all recorded) (continued)

Respiratory (continued)

Row Name	06/17/18 2225	06/17/18 1823	06/17/18 1738	06/17/18 1708	06/17/18 1538
					symmetrical -RG
O2 Device	Nasal cannula -AF	None (Room air) -BR	None (Room air) -BR	None (Room air) -BR	None (Room air) -RG
O2 Flow Rate (L/min)	2 L/min -AF	—	—	—	—

Row Name	06/17/18 1502
Respiratory	
O2 Device	None (Room air) -RG

Flowsheets (all recorded)

Cardiac/Telemetry

Row Name	06/21/18 0830	06/21/18 0800	06/21/18 0545	06/21/18 04:07:21	06/20/18 23:57:07
Cardiac					
RLE Capillary Refill	Less than/equal to 3 seconds -AM	—	—	—	—
LLE Capillary Refill	Less than/equal to 3 seconds -AM	—	—	—	—
Telemetry Monitor On	—	Other (Comment) dc -CI	—	Yes -TW	Yes -TW
Telemetry Box Number	—	— -CI	—	5208 -TW	5208 -TW
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -AM	—	0 -TS	—	—

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 1458	06/20/18 0830	06/20/18 0800
Cardiac					
Cardiac Regularity	—	—	—	—	Irregular -DG
Cardiac Rhythm	—	—	—	—	Normal sinus rhythm -DG
Capillary Refill	Less than/equal to 2 seconds (All extremities) -TS	—	Less than/equal to 2 seconds (All extremities) -MS	—	Less than/equal to 2 seconds (All extremities) -DG
RUE Capillary Refill	Less than/equal to 3 seconds -TS	—	Less than/equal to 3 seconds -MS	—	Less than/equal to 3 seconds -DG
LUE Capillary Refill	Less than/equal to 3 seconds -TS	—	Less than/equal to 3 seconds -MS	—	Less than/equal to 3 seconds -DG
RLE Capillary Refill	Less than/equal to 3 seconds -TS	—	Less than/equal to 3 seconds -MS	—	Less than/equal to 3 seconds -DG
LLE Capillary Refill	Less than/equal to 3 seconds -TS	—	Less than/equal to 3 seconds -MS	—	Less than/equal to 3 seconds -DG
Telemetry Monitor On	Yes -TS	Yes -TW	—	—	No -DG
Telemetry Box Number	5208 -TS	5208 -TW	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -TS	—	—	0 Simultaneous filing. User may be unaware of other data. -MS	—
Clinical Progression 1	—	—	—	Resolved -MS	—

Row Name	06/20/18 0730	06/19/18 2000	06/19/18 1600	06/19/18 1321	06/19/18 0800
Cardiac					
Cardiac Regularity	—	Irregular -EE	—	—	Irregular -JI
Cardiac Rhythm	—	Normal sinus rhythm -EE	—	—	Normal sinus rhythm -JI
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -EE	—	—	Less than/equal to 2 seconds (All extremities) -JI
RUE Capillary Refill	—	Less than/equal to 3 seconds -EE	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -EE	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -EE	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -EE	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	2 -DG	0 -EE	0 -JI	0 -CR	0 -JI
Pain Onset 1	Gradual -DG	—	—	—	—
Pain Location 1	Back -DG	—	—	—	—
Pain Location Orientation 1	Anterior -DG	—	—	—	—
Pain Quality 1	Aching -DG	—	—	—	—
Pain Type 1	Acute pain -DG	—	—	—	—
Aggravating Factors	Movement -DG	—	—	—	—
Alleviating Factors 1	Medication;Positioning -DG	—	—	—	—

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1600	06/18/18 1200
Cardiac					
Cardiac Regularity	—	Irregular -RM	—	—	—

Flowsheets (all recorded) (continued)

Cardiac/Telemetry (continued)

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1600	06/18/18 1200
Cardiac Rhythm	—	Normal sinus rhythm;Sinus bradycardia -RM	—	—	—
Capillary Refill	—	Less than/equal to 2 seconds (All extremities) -RM	—	—	—
RUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
RLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
LLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	—	—
Telemetry Monitor On	—	No -RM	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	0 -JI	0 -JI

Row Name	06/18/18 0800	06/18/18 0600	06/18/18 0500	06/18/18 0400	06/18/18 0300
Cardiac					
Cardiac Regularity	Irregular -JI	—	—	—	—
Cardiac Rhythm	Normal sinus rhythm;Sinus bradycardia -JI	—	—	—	—
Capillary Refill	Less than/equal to 2 seconds (All extremities) -JI	—	—	—	—
Telemetry Monitor On	—	No -RM	—	No -RM	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -JI	0 -RM	0 -RM	0 -RM	0 -RM

Row Name	06/18/18 0200	06/18/18 0100	06/18/18 0000	06/17/18 2300	06/17/18 2225
Cardiac					
Cardiac Regularity	—	—	Irregular -RM	—	—
Cardiac Rhythm	—	—	Sinus bradycardia -RM	—	—
RUE Capillary Refill	—	—	Less than/equal to 3 seconds -RM	—	—
LUE Capillary Refill	—	—	Less than/equal to 3 seconds -RM	—	—
RLE Capillary Refill	—	—	Less than/equal to 3 seconds -RM	—	—
LLE Capillary Refill	—	—	Less than/equal to 3 seconds -RM	—	—
Telemetry Monitor On	No -RM	—	No -RM	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	0 -RM	0 -RM

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1706	06/17/18 1538	06/17/18 1504
Cardiac					
Cardiac (WDL)	—	—	—	X -RG	—
Cardiac Regularity	—	—	—	Regular -RG	—
Cardiac Rhythm	—	—	—	Sinus bradycardia -RG	—
Telemetry Monitor On	—	—	—	Yes -RG	—
Telemetry Box Number	—	—	—	5175 -RG	—
Chest Pain Present	—	—	—	No -RG	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -BR	0 -BR	0 -BR	—	0 -RG
Patient's Stated Pain Goal	0 (No Pain) -BR	0 (No Pain) -BR	0 (No Pain) -BR	—	—

Flowsheets (all recorded)

Peripheral Vascular

Row Name	06/21/18 0830	06/20/18 2133	06/20/18 1458	06/20/18 0800	06/19/18 2000
Edema					
RLE Edema	+2 -AM	+2 -TS	+2 -MS	+2 -DG	+2 -EE
LLE Edema	+2 -AM	+2 -TS	+2 -MS	+2 -DG	+2 -EE
RUE Neurovascular Assessment					
RUE Capillary Refill	—	Less than/equal to 3 seconds -TS	Less than/equal to 3 seconds -MS	Less than/equal to 3 seconds -DG	Less than/equal to 3 seconds -EE
RUE Color	—	Appropriate for ethnicity -TS	Appropriate for ethnicity -MS	Ashen -DG	Appropriate for ethnicity -EE
RUE Temperature/Moisture	—	Warm;Dry -TS	Warm;Dry -MS	Warm;Dry -DG	Warm;Dry -EE
RUE Sensation	—	Present -TS	Present -MS	Present -DG	Present -EE
R Radial Pulse	+2 -AM	+2 -TS	+2 -MS	+2 -DG	+2 -EE
LUE Neurovascular Assessment					
LUE Capillary Refill	—	Less than/equal to 3 seconds -TS	Less than/equal to 3 seconds -MS	Less than/equal to 3 seconds -DG	Less than/equal to 3 seconds -EE
LUE Color	—	Appropriate for ethnicity -TS	Appropriate for ethnicity -MS	Appropriate for ethnicity -DG	Appropriate for ethnicity -EE
LUE Temperature/Moisture	—	Warm;Dry -TS	Warm;Dry -MS	Warm;Dry -DG	Warm;Dry -EE
LUE Sensation	—	Present -TS	Present -MS	Present -DG	Present -EE
L Radial Pulse	+2 -AM	+2 -TS	+2 -MS	+2 -DG	+2 -EE
RLE Neurovascular Assessment					
RLE Capillary Refill	Less than/equal to 3 seconds -AM	Less than/equal to 3 seconds -TS	Less than/equal to 3 seconds -MS	Less than/equal to 3 seconds -DG	Less than/equal to 3 seconds -EE
RLE Color	Appropriate for ethnicity -AM	Appropriate for ethnicity -TS	Appropriate for ethnicity -MS	Appropriate for ethnicity -DG	Appropriate for ethnicity -EE
RLE Temperature/Moisture	Warm -AM	Warm;Dry -TS	Warm;Dry -MS	Warm;Dry -DG	Warm;Dry -EE
RLE Sensation	Present -AM	Present -TS	Present -MS	Present -DG	Present -EE
R Pedal Pulse	+2 -AM	+2 -TS	+2 -MS	+1 -DG	+1 -EE
R Homans' Sign	—	—	—	—	Negative -EE
RLE DVT Prophylaxis	—	—	—	—	Sequential compression device -EE
LLE Neurovascular Assessment					
LLE Capillary Refill	Less than/equal to 3 seconds -AM	Less than/equal to 3 seconds -TS	Less than/equal to 3 seconds -MS	Less than/equal to 3 seconds -DG	Less than/equal to 3 seconds -EE
LLE Color	Appropriate for ethnicity -AM	Appropriate for ethnicity -TS	Appropriate for ethnicity -MS	Appropriate for ethnicity -DG	Appropriate for ethnicity -EE
LLE Temperature/Moisture	Warm -AM	Warm;Dry -TS	Warm;Dry -MS	Warm;Dry -DG	Warm;Dry -EE
LLE Sensation	Present -AM	Present -TS	Present -MS	Present -DG	Present -EE
L Pedal Pulse	+2 -AM	+2 -TS	+2 -MS	+1 -DG	+1 -EE
L Homans' Sign	—	—	—	—	Negative -EE
LLE DVT Prophylaxis	—	—	—	—	Sequential compression device -EE

Row Name	06/19/18 0800	06/18/18 2000	06/18/18 0800	06/18/18 0000	06/17/18 1538
Peripheral Vascular					
Peripheral Vascular (WDL)	—	—	—	—	X -RG
Edema					
RLE Edema	+2 -JI	+2 -RM	+2 -JI	—	+2 -RG
LLE Edema	+2 -JI	+2 -RM	+2 -JI	—	+2 -RG
RUE Neurovascular Assessment					
RUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	Less than/equal to 3 seconds -RM	—
RUE Color	—	Appropriate for ethnicity -RM	—	Appropriate for ethnicity -RM	—
RUE Temperature/Moisture	—	Warm;Dry -RM	—	Warm;Dry -RM	—
RUE Sensation	—	Present -RM	—	Present -RM	—
R Radial Pulse	+2 -JI	+2 -RM	+2 -JI	+2 -RM	—
LUE Neurovascular Assessment					
LUE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	Less than/equal to 3 seconds -RM	—

Flowsheets (all recorded) (continued)

Peripheral Vascular (continued)

Row Name	06/19/18 0800	06/18/18 2000	06/18/18 0800	06/18/18 0000	06/17/18 1538
LUE Color	—	Appropriate for ethnicity -RM	—	Appropriate for ethnicity -RM	—
LUE Temperature/Moisture	—	Warm;Dry -RM	—	Warm;Dry -RM	—
LUE Sensation	—	Present -RM	—	Present -RM	—
L Radial Pulse	+2 -JI	+2 -RM	+2 -JI	+2 -RM	—
RLE Neurovascular Assessment					
RLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	Less than/equal to 3 seconds -RM	—
RLE Color	—	Appropriate for ethnicity -RM	—	Appropriate for ethnicity -RM	—
RLE Temperature/Moisture	—	Warm;Dry -RM	—	Warm;Dry -RM	—
RLE Sensation	—	Present -RM	—	Present -RM	—
R Pedal Pulse	+1 -JI	+1 -RM	+1 -JI	+1 -RM	—
R Homans' Sign	—	Negative -RM	—	—	—
RLE DVT Prophylaxis	—	—	—	Sequential compression device -RM	—
LLE Neurovascular Assessment					
LLE Capillary Refill	—	Less than/equal to 3 seconds -RM	—	Less than/equal to 3 seconds -RM	—
LLE Color	—	Appropriate for ethnicity -RM	—	Appropriate for ethnicity -RM	—
LLE Temperature/Moisture	—	Warm;Dry -RM	—	Warm;Dry -RM	—
LLE Sensation	—	Present -RM	—	Present -RM	—
L Pedal Pulse	+1 -JI	+1 -RM	+1 -JI	+1 -RM	—
L Homans' Sign	—	Negative -RM	—	—	—
LLE DVT Prophylaxis	—	—	—	Sequential compression device -RM	—

Flowsheets (all recorded)

Provider Notification

Row Name	06/20/18 1027	06/18/18 1025	06/18/18 0600	06/18/18 0339	06/18/18 0334
Provider Notification					
Reason for Communication	Consult called -DG	Patient request Clarify order for Ramipril. -JI	Critical lab value -RM	Critical lab value -RM	Critical lab value -RM
Lab Value	—	—	inr 3.06 -RM	trop 0.05 -RM	trop 0.05 -RM
RBAC?	—	—	Yes -RM	Yes -RM	Yes -RM
Notification Time	1028 -DG	1025 -JI	0602 -RM	0338 -RM	0334 -RM
Provider Name	Whatley -DG	Sajja -JI	Kingsley Agbeyebe -RM	Andrew Goodner -RM	Joy -RM
Provider Role	Consulting physician -DG	Consulting physician -JI	Hospitalist -RM	PA -RM	NP -RM
Method of Communication	Perfect Serve -DG	Perfect Serve -JI	Perfect Serve -RM	Perfect Serve -RM	Perfect Serve -RM
Response	Other (Comment) consulted by Dhaval G Patel, MD -DG	Waiting for response -JI	Waiting for response -RM	Waiting for response Hospitalist called to request I advise CVM. -RM	Waiting for response -RM

Row Name	06/17/18 1610	06/17/18 1532
Provider Notification		
Reason for Communication	Critical lab value -KW	Critical lab value -RG
Lab Value	H&H 5.6/19 -KW	POC TROP 0.09 AND BNP 2307 -RG
RBAC?	Yes -KW	Yes -RG
Notification Time	1611 -KW	1532 -RG
Provider Name	DR. KRUG -KW	DR.KRUG -RG
Provider Role	Attending physician -KW	Attending physician -RG
Method of Communication	Face to face -KW	Face to face -RG
Response	In department -KW	See orders -RG

Flowsheets (all recorded)

Immunizations

Row Name	06/18/18 0133	06/17/18 1538
Tetanus up to date		
Tetanus within last 5 years?	—	No -RG
Influenza Vaccine (Sept - March 31st)		
Have you received the Influenza Vaccine during this Flu season?	Not Flu Season -RM	Not Flu Season -RG
Pneumococcal Vaccine Screening (Year Round)		
Have you received the pneumococcal vaccine?	—	Yes -RG
Last Immunization Greater than 5 years?	—	No -RG

Flowsheets (all recorded)

Swallow Screen

Row Name	06/18/18 0000	06/17/18 1540
Swallow Screening		
Patient Alert	Yes -RM	Yes -RG
Continue Screen?	If yes-continue screen -RM	If yes-continue screen -RG
Dx Aspiration PNA	No -RM	No -RG
Continue Screen?	If no-continue screen -RM	If no-continue screen -RG
Pt Drooling?	No -RM	No -RG
Continue Screen? (If screening to continue, give 1 Tsp of water)	If no-continue screen -RM	If no-continue screen -RG
Any Cough?	No -RM	No -RG
Voice gurgle/wet?	No -RM	No -RG
Continue Screen? (If screening to continue, provide sips of cup of water)	If no to above questions-continue screen -RM	If no to above questions-continue screen -RG
Any Cough?	No -RM	No -RG
Voice gurgle/wet?	No -RM	No -RG
Continue Screen?	If no to above questions-continue screen -RM	If no to above questions-continue screen -RG
Did Patient Pass Swallow Screen?	Yes-passed screen -RM	Yes-passed screen -RG

Flowsheets (all recorded)

Abuse Indicators

Row Name	06/18/18 0000	06/17/18 1537
Abuse Screening		
Safe in Home	Yes -RM	UTA -RG
Do you feel threatened or unsafe in a relationship?	No -RM	—
Are you in immediate danger?	No -RM	—
Do you feel neglected?	No -RM	—
Physical harm?	No -RM	—
Verbal harm	No -RM	—

Flowsheets (all recorded)

Psychosocial Needs

Row Name	06/20/18 2133	06/20/18 1458	06/19/18 2000	06/18/18 2000	06/18/18 0000
Psychosocial					
Needs Expressed	Denies -TS	Denies -MS	Denies -EE	Denies -RM	Physical;Emotional -RM

Row Name	06/17/18 1538
Psychosocial	
Needs Expressed	Denies -RG

Flowsheets (all recorded)

Resubmit Chart for Charges

Row Name	06/22/18 0902
Resubmit Chart for Apollo Charges	
All documentation complete. Send chart for final charges?	Yes -DK

Flowsheets (all recorded)

Quick Look

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 0545	06/21/18 04:07:21
Quick Vitals					
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	—	63 -DI (r) TW (t)
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	—	93 % -DI (r) TW (t)
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	—	121/58 -DI (r) TW (t)
Resp	18 -CI	—	18 -CI	—	18 -DI (r) TW (t)
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	—	Oral -TW
Automatic Restart Vitals Timer	Yes -CI	—	Yes -CI	—	Yes -DI (r) TW (t)
Calculated MAP	80.33 -DI (r) CI (t)	—	88.33 -DI (r) CI (t)	—	79 -DI (r) TW (t)
Pain Assessment					
Currently in Pain	—	No -AM	—	No -TS	—
Numeric Pain Intensity Score 1	—	0 -AM	—	0 -TS	—

Row Name	06/21/18 0030	06/20/18 23:57:07	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04
Quick Vitals					
Pulse	—	109 -DI (r) TW (t)	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)
SpO2	—	93 % -DI (r) TW (t)	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)
BP	—	124/53 -DI (r) TW (t)	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)
Resp	—	16 -DI (r) TW (t)	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)
Temp	—	98.4 °F (36.9 °C) -DI (r) TW (t)	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	Oral -TW	—
Automatic Restart Vitals Timer	—	Yes -DI (r) TW (t)	—	Yes -DI (r) TW (t)	Yes -DI (r) LF (t)
Calculated MAP	—	76.67 -DI (r) TW (t)	—	74.33 -DI (r) TW (t)	104.67 -DI (r) LF (t)
Pain Assessment					
Currently in Pain	Resting quietly -TS	—	No -TS	—	—
Numeric Pain Intensity Score 1	—	—	0 -TS	—	—
FACES Pain Rating	0-No hurt -TS	—	—	—	—

Row Name	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909	06/20/18 0900	06/20/18 0830
Quick Vitals					
Pulse	61 -DI (r) LF (t)	61 -DG	59 -DG	60 -DG	—
SpO2	92 % -DI (r) LF (t)	(!) 88 % -DG	—	(!) 87 % -DG	—
BP	104/66 -DI (r) LF (t)	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG	—
Resp	—	18 -DG	—	17 -DG	—
Temp	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—	—	—
Automatic Restart Vitals Timer	—	Yes -DG	—	Yes -DG	—
Calculated MAP	78.67 -DI (r) LF (t)	76.67 -DG	73.33 -DG	73.33 -DG	—
Pain Assessment					
Currently in Pain	—	—	—	—	Unable to Assess Simultaneous filing. User may be unaware of other data. -MS
Numeric Pain Intensity Score 1	—	—	—	—	0 Simultaneous filing. User may be unaware of other data. -MS
Multiple Pain Sites	—	—	—	—	No -MS

Row Name	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500	06/20/18 0400
Quick Vitals					
Pulse	58 -DG	—	59 -EE	57 -EE	56 -EE
SpO2	(!) 88 % -DG	—	93 % -EE	94 % -EE	94 % -EE
BP	138/62 -DG	—	129/57 -EE	130/50 -EE	119/51 -EE
Resp	18 -DG	—	20 -EE	20 -EE	19 -EE
Temp	—	98.3 °F (36.8 °C) -HT	—	—	98 °F (36.7 °C) -JP
Temp src	—	Oral -HT	—	—	Oral -JP
Automatic Restart Vitals Timer	Yes -DG	—	Yes -EE	Yes -EE	Yes -JP
Calculated MAP	87.33 -DG	—	81 -EE	76.67 -EE	73.67 -EE

Flowsheets (all recorded) (continued)

Quick Look (continued)

Row Name	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500	06/20/18 0400
Pain Assessment					
Currently in Pain	—	Yes -DG	—	—	—
Numeric Pain Intensity Score 1	—	2 -DG	—	—	—

Row Name	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300	06/19/18 2200
Quick Vitals					
Pulse	57 -EE	64 -EE	59 -EE	61 -EE	62 -EE
SpO2	97 % -EE	91 % -EE	90 % -EE	97 % -EE	96 % -EE
BP	122/58 -EE	(!) 111/47 -EE	—	128/56 -EE	132/51 -EE
Resp	21 -EE	16 -EE	22 -EE	21 -EE	22 -EE
Temp	—	—	97.5 °F (36.4 °C) -JP	—	—
Temp src	—	—	Axillary -JP	—	—
Automatic Restart Vitals Timer	Yes -EE	Yes -EE	Yes -EE	Yes -EE	Yes -EE
Calculated MAP	79.33 -EE	68.33 -EE	—	80 -EE	78 -EE

Row Name	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800	06/19/18 1700
Quick Vitals					
Pulse	61 -EE	63 -EE	64 -EE	61 -JI	59 -JI
SpO2	94 % -EE	94 % -EE	94 % -EE	92 % -JI	96 % -JI
BP	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI	132/52 -JI
Resp	16 -EE	21 -EE	19 -EE	25 -JI	21 -JI
Temp	—	98.4 °F (36.9 °C) -JP	—	—	—
Temp src	—	Oral -JP	—	—	—
Automatic Restart Vitals Timer	Yes -EE	Yes -JP	Yes -EE	Yes -JI	Yes -JI
Calculated MAP	83.33 -EE	83.67 -EE	85 -EE	80 -JI	78.67 -JI
Pain Assessment					
Currently in Pain	—	Resting quietly -EE	—	—	—
Numeric Pain Intensity Score 1	—	0 -EE	—	—	—
Previous experiences with pain?	—	No -EE	—	—	—

Row Name	06/19/18 1644	06/19/18 1600	06/19/18 1500	06/19/18 1430	06/19/18 1428
Quick Vitals					
Pulse	—	58 -JI	56 -JI	57 -JI	—
SpO2	—	95 % -JI	96 % -JI	96 % -JI	—
BP	—	134/58 -JI	130/51 -JI	142/60 -JI	—
Resp	—	20 -JI	22 -JI	19 -JI	—
Temp	97.9 °F (36.6 °C) -FT	—	—	—	97.7 °F (36.5 °C) -FT
Temp src	Oral -FT	—	—	—	Oral -FT
Automatic Restart Vitals Timer	—	Yes -JI	Yes -JI	Yes -JI	—
Calculated MAP	—	83.33 -JI	77.33 -JI	87.33 -JI	—
Pain Assessment					
Currently in Pain	—	No -JI	—	—	—
Numeric Pain Intensity Score 1	—	0 -JI	—	—	—

Row Name	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1117
Quick Vitals					
Pulse	54 -LFA	54 -LFA	53 -LFA	53 -CR	—
SpO2	100 % -LFA	97 % -LFA	92 % -LFA	93 % -CR	—
BP	123/59 -LFA	128/55 -LFA	(!) 95/46 -LFA	110/53 -CR	—
Resp	22 -LFA	19 -LFA	21 -LFA	18 -CR	—
Automatic Restart Vitals Timer	Yes -LFA	Yes -LFA	Yes -LFA	Yes -CR	—
Calculated MAP	80.33 -LFA	79.33 -LFA	(!) 62.33 -LFA	72 -CR	—
Pain Assessment					
Numeric Pain Intensity Score 1	—	—	—	0 -CR	—
RETIRED - Travel outside the U.S.					
RETIRED - Has the patient or a household member traveled	—	—	—	—	No -PM

Flowsheets (all recorded) (continued)

Quick Look (continued)

Row Name	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1117
outside the U.S. in the past 21 days?					
Row Name	**06/19/18 1114**	**06/19/18 1000**	**06/19/18 0900**	**06/19/18 0808**	**06/19/18 0800**
Quick Vitals					
Pulse	51 -PM	50 -JI	51 -JI	55 -JI	56 -JI
SpO2	98 % -PM	92 % -JI	95 % -JI	—	97 % -JI
BP	123/54 -PM	**(!) 124/49** -JI	**(!) 119/44** -JI	**(!) 126/47** -JI	**(!) 126/47** -JI
Resp	13 -PM	20 -JI	18 -JI	—	18 -JI
Temp	—	—	—	—	98.6 °F (37 °C) -DF
Temp src	—	—	—	—	Oral -DF
Automatic Restart Vitals Timer	Yes -PM	Yes -JI	Yes -JI	—	Yes -DF
Calculated MAP	77 -PM	74 -JI	69 -JI	73.33 -JI	73.33 -JI
Pain Assessment					
Currently in Pain	—	—	—	—	No -JI
Numeric Pain Intensity Score 1	—	—	—	—	0 -JI
Row Name	**06/19/18 0700**	**06/19/18 0600**	**06/19/18 0500**	**06/19/18 0400**	**06/19/18 0300**
Quick Vitals					
Pulse	63 -JI	52 -RM	53 -RM	55 -RM	55 -RM
SpO2	96 % -JI	94 % -RM	96 % -RM	98 % -RM	92 % -RM
BP	143/52 -JI	**(!) 109/40** -RM	**(!) 124/49** -RM	127/55 -RM	120/59 -RM
Resp	18 -JI	17 -RM	17 -RM	20 -RM	16 -RM
Temp	—	—	—	98.2 °F (36.8 °C) -MJ	—
Automatic Restart Vitals Timer	Yes -JI	Yes -RM	Yes -RM	Yes -MJ	Yes -RM
Calculated MAP	82.33 -JI	**(!) 63** -RM	74 -RM	79 -RM	79.33 -RM
Row Name	**06/19/18 0200**	**06/19/18 0100**	**06/19/18 0000**	**06/18/18 2300**	**06/18/18 2200**
Quick Vitals					
Pulse	54 -RM	53 -RM	56 -RM	59 -RM	55 -RM
SpO2	93 % -RM	92 % -RM	94 % -RM	97 % -RM	99 % -RM
BP	113/50 -RM	**(!) 109/44** -RM	**(!) 123/43** -RM	127/59 -RM	—
Resp	19 -RM	19 -RM	21 -RM	20 -RM	21 -RM
Temp	—	—	98.1 °F (36.7 °C) -MJ	—	—
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Calculated MAP	71 -RM	65.67 -RM	69.67 -RM	81.67 -RM	—
Row Name	**06/18/18 2100**	**06/18/18 2000**	**06/18/18 1900**	**06/18/18 1800**	**06/18/18 1727**
Quick Vitals					
Pulse	56 -RM	56 -RM	56 -RM	56 -RM	—
SpO2	99 % -RM	96 % -RM	**(!) 89 %** -RM	94 % -RM	—
BP	—	—	—	132/60 -RM	—
Resp	21 -RM	22 -RM	22 -RM	20 -RM	—
Temp	—	98.4 °F (36.9 °C) -MJ	—	—	98.1 °F (36.7 °C) -JD
Temp src	—	—	—	—	Oral -JD
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	—
Calculated MAP	—	—	—	84 -RM	—
Pain Assessment					
Currently in Pain	No -RM	No -RM	No -RM	—	—
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	—	—
Previous experiences with pain?	No -RM	No -RM	No -RM	—	—
Row Name	**06/18/18 1600**	**06/18/18 1500**	**06/18/18 1400**	**06/18/18 1300**	**06/18/18 1230**
Quick Vitals					
Pulse	52 -JI	54 -JI	58 -JI	57 -JI	—
SpO2	**(!) 87 %** -JI	95 % -JI	91 % -JI	93 % -JI	—
BP	142/57 -JI	151/56 -JI	134/53 -JI	**(!) 130/45** -JI	—
Resp	20 -JI	18 -JI	19 -JI	15 -JI	—
Temp	—	—	—	—	97.7 °F (36.5 °C) -JD
Temp src	—	—	—	—	Oral -JD
Automatic Restart	Yes -JI	Yes -JI	Yes -JI	Yes -JI	—

Flowsheets (all recorded) (continued)

Quick Look (continued)

Row Name	06/18/18 1600	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1230
Vitals Timer					
Calculated MAP	85.33 -JI	87.67 -JI	80 -JI	73.33 -JI	—
Pain Assessment					
Currently in Pain	No -JI	—	—	—	—
Numeric Pain Intensity Score 1	0 -JI	—	—	—	—

Row Name	06/18/18 1200	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831
Quick Vitals					
Pulse	52 -JI	50 -JI	51 -JI	(!) 49 -JI	—
SpO2	—	97 % -JI	98 % -JI	100 % -JI	—
BP	140/56 -JI	(!) 128/46 -JI	131/52 -JI	137/54 -JI	—
Resp	18 -JI	17 -JI	16 -JI	16 -JI	—
Temp	—	—	—	—	97.8 °F (36.6 °C) -JD
Temp src	—	—	—	—	Oral -JD
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	Yes -JI	Yes -JI	—
Calculated MAP	84 -JI	73.33 -JI	78.33 -JI	81.67 -JI	—
Pain Assessment					
Currently in Pain	No -JI	—	—	—	—
Numeric Pain Intensity Score 1	0 -JI	—	—	—	—

Row Name	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445
Quick Vitals					
Pulse	(!) 48 -JI	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM	(!) 47 -RM
SpO2	91 % -JI	95 % -JI	97 % -RM	97 % -RM	—
BP	(!) 123/49 -JI	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM	120/52 -RM
Resp	17 -JI	17 -JI	13 -RM	18 -RM	18 -RM
Temp	—	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM
Temp src	—	—	Axillary -RM	—	Axillary -RM
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	Yes -RM	Yes -RM	Yes -RM
Calculated MAP	73.67 -JI	71 -JI	74 -RM	75.33 -RM	74.67 -RM
Pain Assessment					
Currently in Pain	No -JI	—	No -RM	No -RM	—
Numeric Pain Intensity Score 1	0 -JI	—	0 -RM	0 -RM	—
Previous experiences with pain?	—	—	No -RM	No -RM	—

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0133	06/18/18 0115
Quick Vitals					
Pulse	(!) 49 -RM	(!) 49 -RM	51 -RM	—	54 -RM
SpO2	97 % -RM	92 % -RM	(!) 87 % -RM	—	—
BP	117/50 -RM	(!) 109/43 -RM	(!) 102/39 -RM	—	—
Resp	19 -RM	18 -RM	19 -RM	—	20 -RM
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	—	Yes -RM
Calculated MAP	72.33 -RM	65 -RM	(!) 60 -RM	—	—
Pain Assessment					
Currently in Pain	No -RM	No -RM	No -RM	—	—
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	—	—
Previous experiences with pain?	No -RM	No -RM	No -RM	—	—
RETIRED - Travel outside the U.S.					
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	—	—	—	No -RM	—

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0000	06/17/18 2300	06/17/18 2225
Quick Vitals					
Pulse	57 -RM	57 -RM	55 -RM	54 -RM	53 -AF
SpO2	(!) 88 % -RM	—	92 % -RM	90 % -RM	92 % -AF

Flowsheets (all recorded) (continued)

Quick Look (continued)

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0000	06/17/18 2300	06/17/18 2225
BP	123/51 -RM	140/52 -RM	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF
Resp	21 -RM	20 -RM	20 -RM	17 -RM	18 -AF
Temp	—	98.1 °F (36.7 °C) -RM	—	—	98 °F (36.7 °C) -AF
Temp src	—	Oral -RM	—	—	Oral -AF
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -AF
Calculated MAP	75 -RM	81.33 -RM	68.33 -RM	(!) 64 -RM	70 -AF
Pain Assessment					
Currently in Pain	No -RM	—	No -RM	No -RM	No -RM
Numeric Pain Intensity Score 1	0 -RM	—	0 -RM	0 -RM	0 -RM
Previous experiences with pain?	No -RM	—	No -RM	No -RM	No -RM

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1708
Quick Vitals					
Pulse	57 -BR	51 -BR	55 -BR	55 -BR	55 -BR
SpO2	100 % -BR	100 % -BR	100 % -BR	—	100 % -BR
BP	134/59 -BR	126/55 -BR	132/56 -BR	129/53 -BR	(!) 115/49 -BR
Resp	16 -BR	18 -BR	18 -BR	18 -BR	18 -BR
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR
Temp src	Oral -BR	Oral -BR	Oral -BR	Oral -BR	Oral -BR
Automatic Restart Vitals Timer	Yes -BR	Yes -BR	Yes -BR	Yes -BR	Yes -BR
Calculated MAP	84 -BR	78.67 -BR	81.33 -BR	78.33 -BR	71 -BR
Pain Assessment					
Numeric Pain Intensity Score 1	0 -BR	0 -BR	—	—	—
Patient's Stated Pain Goal	0 (No Pain) -BR	0 (No Pain) -BR	—	—	—

Row Name	06/17/18 1706	06/17/18 1537	06/17/18 1504	06/17/18 1502	06/17/18 1437
Quick Vitals					
Pulse	—	55 -RG	—	54 -RG	56 -NS
SpO2	—	—	—	100 % -RG	98 % -NS
BP	—	114/51 -RG	—	112/52 -RG	—
Resp	—	22 -RG	—	25 -RG	—
Temp	—	97.8 °F (36.6 °C) -RG	—	97.7 °F (36.5 °C) -RG	—
Temp src	—	—	—	Oral -RG	—
Automatic Restart Vitals Timer	—	Yes -RG	—	Yes -RG	—
Calculated MAP	—	72 -RG	—	72 -RG	—
Pain Assessment					
Currently in Pain	—	—	No -RG	—	—
Numeric Pain Intensity Score 1	0 -BR	—	0 -RG	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -RG	—	—
Patient's Stated Pain Goal	0 (No Pain) -BR	—	—	—	—
Suspicion for infection or exposure?					
Are rigors present?	—	0 -RG	—	—	—
Is there a suspected infection?	—	0 -RG	—	—	—
Mental status change?	—	0 -RG	—	—	—
Suspicion of Infection Sepsis Risk Score	—	0 -RG	—	—	—

Flowsheets (all recorded)

Adult Suicide Risk

Row Name	06/18/18 0000	06/17/18 1537
Suicide/Harm Risk		
Ever harm self (Retired)	No -RM	No -RG
Current thoughts (Retired)	No -RM	No -RG
Self harm plan (Retired)	No -RM	No -RG
Patient information obtained from	Patient -RM	Patient -RG
Suicide Risk (Retired)		
Is patient at risk for suicide? (Retired)	—	No -RG

Flowsheets (all recorded)

Assessment Complete

Row Name	06/17/18 1540
Assessment Complete	
Assessment Completed?	Yes -RG

Flowsheets (all recorded)

Physician to Receive Billing Credit?

Row Name	06/17/18 1506
Physician to Receive Billing Credit?	
Physician to Receive Billing Credit?	Douglas Krug, MD -DK

Flowsheets (all recorded)

Blood Administration

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07
Vitals					
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)	124/53 -DI (r) TW (t)
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)	98.4 °F (36.9 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	Oral -TW	Oral -TW
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)
Resp	18 -CI	—	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)
O2 Device	None (Room air) -CI	None (Room air) -AM	None (Room air) -CI	None (Room air) -TW	None (Room air) -TW
Respiratory Assessment					
Bilateral Breath Sounds	—	Clear -AM	—	—	—

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02
Vitals					
BP	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)	—	104/66 -DI (r) LF (t)
Temp	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)	—	98.2 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	—	—
Pulse	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)
Resp	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)	—	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)
O2 Device	None (Room air) -TS	None (Room air) -TW	—	None (Room air) -MS	—
Respiratory Assessment					
Bilateral Breath Sounds	Clear;Diminished -TS	—	—	Clear;Diminished -MS	—
R Breath Sounds	—	—	—	Clear -MS	—
L Breath Sounds	—	—	—	Diminished -MS	—

Row Name	06/20/18 1000	06/20/18 0909	06/20/18 0900	06/20/18 0800	06/20/18 0730
Vitals					
BP	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG	138/62 -DG	—
Temp	—	—	—	—	98.3 °F (36.8 °C) -HT
Temp src	—	—	—	—	Oral -HT
Pulse	61 -DG	59 -DG	60 -DG	58 -DG	—
Resp	18 -DG	—	17 -DG	18 -DG	—
Oxygen Therapy					
SpO2	(!) 88 % -DG	—	(!) 87 % -DG	(!) 88 % -DG	—
O2 Device	—	—	—	None (Room air) -DG	—
Pulse Oximetry Type	—	—	—	Continuous -DG	—
Respiratory Assessment					
Bilateral Breath Sounds	—	—	—	Diminished -DG	—

Row Name	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200
Vitals					
BP	129/57 -EE	130/50 -EE	119/51 -EE	122/58 -EE	(!) 111/47 -EE
Temp	—	—	98 °F (36.7 °C) -JP	—	—
Temp src	—	—	Oral -JP	—	—
Pulse	59 -EE	57 -EE	56 -EE	57 -EE	64 -EE
Resp	20 -EE	20 -EE	19 -EE	21 -EE	16 -EE
Oxygen Therapy					
SpO2	93 % -EE	94 % -EE	94 % -EE	97 % -EE	91 % -EE

Row Name	06/20/18 0000	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000
Vitals					
BP	—	128/56 -EE	132/51 -EE	130/60 -EE	135/58 -EE
Temp	97.5 °F (36.4 °C) -JP	—	—	—	98.4 °F (36.9 °C) -JP
Temp src	Axillary -JP	—	—	—	Oral -JP
Pulse	59 -EE	61 -EE	62 -EE	61 -EE	63 -EE
Resp	22 -EE	21 -EE	22 -EE	16 -EE	21 -EE

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/20/18 0000	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000
Oxygen Therapy					
SpO2	90 % -EE	97 % -EE	96 % -EE	94 % -EE	94 % -EE
O2 Device	—	—	—	—	Nasal cannula -EE
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -EE
Pulse Oximetry Type	—	—	—	—	Continuous -EE
Respiratory Assessment					
Bilateral Breath Sounds	—	—	—	—	Diminished -EE

Row Name	06/19/18 1900	06/19/18 1800	06/19/18 1700	06/19/18 1644	06/19/18 1600
Vitals					
BP	133/61 -EE	128/56 -JI	132/52 -JI	—	134/58 -JI
Temp	—	—	—	97.9 °F (36.6 °C) -FT	—
Temp src	—	—	—	Oral -FT	—
Pulse	64 -EE	61 -JI	59 -JI	—	58 -JI
Resp	19 -EE	25 -JI	21 -JI	—	20 -JI
Oxygen Therapy					
SpO2	94 % -EE	92 % -JI	96 % -JI	—	95 % -JI

Row Name	06/19/18 1500	06/19/18 1430	06/19/18 1428	06/19/18 1335	06/19/18 1330
Vitals					
BP	130/51 -JI	142/60 -JI	—	123/59 -LFA	128/55 -LFA
Temp	—	—	97.7 °F (36.5 °C) -FT	—	—
Temp src	—	—	Oral -FT	—	—
Pulse	56 -JI	57 -JI	—	54 -LFA	54 -LFA
Resp	22 -JI	19 -JI	—	22 -LFA	19 -LFA
Oxygen Therapy					
SpO2	96 % -JI	96 % -JI	—	100 % -LFA	97 % -LFA
O2 Device	—	Nasal cannula -JI	—	—	—
O2 Flow Rate (L/min)	—	2 L/min -JI	—	—	—
Pulse Oximetry Type	—	Continuous -JI	—	—	—

Row Name	06/19/18 1325	06/19/18 1321	06/19/18 1118	06/19/18 1114	06/19/18 1031
Vitals					
BP	(!) 95/46 -LFA	110/53 -CR	—	123/54 -PM	—
Pulse	53 -LFA	53 -CR	—	51 -PM	—
Resp	21 -LFA	18 -CR	—	13 -PM	—
Blood Product Identifiers					
Blood Bank ID Number (from Wristband)	—	—	90803 -PM	—	—
Oxygen Therapy					
SpO2	92 % -LFA	93 % -CR	—	98 % -PM	—
O2 Device	—	—	—	Nasal cannula -PM	None (Room air) -JI
O2 Flow Rate (L/min)	—	—	—	3 L/min -PM	—

Row Name	06/19/18 1000	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700
Vitals					
BP	(!) 124/49 -JI	(!) 119/44 -JI	(!) 126/47 -JI	(!) 126/47 -JI	143/52 -JI
Temp	—	—	—	98.6 °F (37 °C) -DF	—
Temp src	—	—	—	Oral -DF	—
Pulse	50 -JI	51 -JI	55 -JI	56 -JI	63 -JI
Resp	20 -JI	18 -JI	—	18 -JI	18 -JI
Oxygen Therapy					
SpO2	92 % -JI	95 % -JI	—	97 % -JI	96 % -JI
O2 Device	—	—	—	Nasal cannula -JI	—
O2 Flow Rate (L/min)	—	—	—	2 L/min -JI	—
Pulse Oximetry Type	—	—	—	Continuous -JI	—
Respiratory Assessment					
Bilateral Breath Sounds	—	—	—	Diminished -JI	—

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
Vitals					
BP	(!) 109/40 -RM	(!) 124/49 -RM	127/55 -RM	120/59 -RM	113/50 -RM

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
Temp	—	—	98.2 °F (36.8 °C) -MJ	—	—
Pulse	52 -RM	53 -RM	55 -RM	55 -RM	54 -RM
Resp	17 -RM	17 -RM	20 -RM	16 -RM	19 -RM
Oxygen Therapy					
SpO2	94 % -RM	96 % -RM	98 % -RM	92 % -RM	93 % -RM
O2 Device	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	—	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	—	No -RM	No -RM	No -RM	No -RM

Row Name	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100
Vitals					
BP	(!) 109/44 -RM	(!) 123/43 -RM	127/59 -RM	—	—
Temp	—	98.1 °F (36.7 °C) -MJ	—	—	—
Pulse	53 -RM	56 -RM	59 -RM	55 -RM	56 -RM
Resp	19 -RM	21 -RM	20 -RM	21 -RM	21 -RM
Oxygen Therapy					
SpO2	92 % -RM	94 % -RM	97 % -RM	99 % -RM	99 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727	06/18/18 1600
Vitals					
BP	—	—	132/60 -RM	—	142/57 -JI
Temp	98.4 °F (36.9 °C) -MJ	—	—	98.1 °F (36.7 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	56 -RM	56 -RM	56 -RM	—	52 -JI
Resp	22 -RM	22 -RM	20 -RM	—	20 -JI
SuspectedTransfusion Reaction					
Blood Specimen Collection	Unit -RM	—	—	—	—
Oxygen Therapy					
SpO2	96 % -RM	(!) 89 % -RM	94 % -RM	—	(!) 87 % -JI
O2 Device	Nasal cannula -RM	Nasal cannula -RM	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	—	—
POX Probe Site Changed	No -RM	No -RM	—	—	—
Respiratory Assessment					
Bilateral Breath Sounds	Diminished -RM	—	—	—	—
R Breath Sounds	Diminished -RM	—	—	—	—
L Breath Sounds	Diminished -RM	—	—	—	—

Row Name	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1230	06/18/18 1200
Vitals					
BP	151/56 -JI	134/53 -JI	(!) 130/45 -JI	—	140/56 -JI
Temp	—	—	—	97.7 °F (36.5 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	54 -JI	58 -JI	57 -JI	—	52 -JI
Resp	18 -JI	19 -JI	15 -JI	—	18 -JI
Oxygen Therapy					
SpO2	95 % -JI	91 % -JI	93 % -JI	—	—

Row Name	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800
Vitals					
BP	(!) 128/46 -JI	131/52 -JI	137/54 -JI	—	(!) 123/49 -JI
Temp	—	—	—	97.8 °F (36.6 °C) -JD	—

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800
Temp src	—	—	—	Oral -JD	—
Pulse	50 -JI	51 -JI	(!) 49 -JI	—	(!) 48 -JI
Resp	17 -JI	16 -JI	16 -JI	—	17 -JI
Oxygen Therapy					
SpO2	97 % -JI	98 % -JI	100 % -JI	—	91 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
O2 Flow Rate (L/min)	—	—	—	—	5 L/min -JI
Pulse Oximetry Type	—	—	—	—	Continuous -JI
Respiratory Assessment					
Bilateral Breath Sounds	—	—	—	—	Diminished -JI

Row Name	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400
Vitals					
Pre, During, Post Vital Signs	—	1st HR -RM	15 min after start -RM	Pre-Transfusion -RM	Post Transfusion -RM
BP	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM	120/52 -RM	117/50 -RM
Temp	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM	—
Temp src	—	Axillary -RM	—	Axillary -RM	—
Pulse	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM	(!) 47 -RM	(!) 49 -RM
Resp	17 -JI	13 -RM	18 -RM	18 -RM	19 -RM
Blood Product Identifiers					
Blood Bank ID Number (from Wristband)	—	—	—	90803 -RM	—
TRANSFUSE RED BLOOD CELLS					
Transfusion Start Date	—	—	—	06/18/18 -RM	—
Rate	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -RM	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -RM	—
Completed Volume	—	500 -RM	—	—	—
Suspected Reaction?	—	No -RM	—	No -RM	—
Oxygen Therapy					
SpO2	95 % -JI	97 % -RM	97 % -RM	—	97 % -RM
O2 Device	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	—	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	100 -RM	100 -RM	—	100 -RM
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	—	90 -RM
POX Probe Site Changed	—	No -RM	No -RM	—	No -RM

Row Name	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051
Vitals					
Pre, During, Post Vital Signs	2nd HR -RM	1st HR -RM	15 min after start -RM	—	Pre-Transfusion -RM
BP	(!) 109/43 -RM	(!) 102/39 -RM	—	123/51 -RM	140/52 -RM
Temp	—	—	—	—	98.1 °F (36.7 °C) -RM
Temp src	—	—	—	—	Oral -RM
Pulse	(!) 49 -RM	51 -RM	54 -RM	57 -RM	57 -RM
Resp	18 -RM	19 -RM	20 -RM	21 -RM	20 -RM
Pre-Transfusion Documentation					
Previous Transfusion Reaction?	—	—	—	—	No -RM
Pre-Meds Given?	—	—	—	—	Yes -RM
Consent Obtained?	—	—	—	—	Yes -RM
Education Provided ?	—	—	—	—	Yes;Patient -RM
Blood Product Identifiers					
Blood Product Type	—	—	—	—	Red blood cells (packed cells) -RM
Special Requirements	—	—	—	—	Leukocyte reduced cells;Saline Washed Product -RM
Blood Bank ID	—	—	—	—	90803 -RM

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051
Number (from Wristband)					
Patient Blood Type	—	—	—	—	O Pos -RM
Donor Blood Type	—	—	—	—	O Pos -RM
Expiration Date	—	—	—	—	07/20/18 -RM
Expiration Time	—	—	—	—	2359 -RM
TRANSFUSE RED BLOOD CELLS					
Transfusion Start Date	—	—	—	—	06/18/18 -RM
Rate	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -RM	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -RM
Completed Volume	500 -RM	—	—	—	—
Suspected Reaction?	No -RM	—	—	—	—
Oxygen Therapy					
SpO2	92 % -RM	(!) 87 % -RM	—	(!) 88 % -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	—	Nasal cannula -RM	—
O2 Flow Rate (L/min)	5 L/min -RM	5 L/min -RM	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	Continuous -RM	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	100 -RM	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	90 -RM	—
POX Probe Site Changed	No -RM	No -RM	—	No -RM	—

Row Name	06/18/18 0030	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2123
Vitals					
BP	—	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF	—
Temp	—	—	—	98 °F (36.7 °C) -AF	—
Temp src	—	—	—	Oral -AF	—
Pulse	—	55 -RM	54 -RM	53 -AF	—
Resp	—	20 -RM	17 -RM	18 -AF	—
TRANSFUSE RED BLOOD CELLS					
Rate	—	—	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -NI
TRANSFUSE RED BLOOD CELLS					
Transfusion Start Date	06/18/18 -RM	—	—	—	—
SuspectedTransfusion Reaction					
Blood Specimen Collection	—	Unit -RM	—	—	—
Oxygen Therapy					
SpO2	—	92 % -RM	90 % -RM	92 % -AF	—
O2 Device	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -AF	—
O2 Flow Rate (L/min)	—	—	—	2 L/min -AF	—
Pulse Oximetry Type	—	Continuous -RM	Continuous -RM	Continuous -RM	—
SpO2 Alarm Limit High	—	100 -RM	100 -RM	100 -RM	—
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	90 -RM	—
POX Probe Site Changed	—	Yes -RM	No -RM	No -RM	—
Respiratory Assessment					
R Breath Sounds	—	Diminished -RM	—	—	—
L Breath Sounds	—	Diminished -RM	—	—	—

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1723	06/17/18 1720
Vitals					
Pre, During, Post Vital Signs	—	—	—	—	Pre-Transfusion -BR
BP	134/59 -BR	126/55 -BR	132/56 -BR	—	129/53 -BR
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	—	98.2 °F (36.8 °C) -BR
Temp src	Oral -BR	Oral -BR	Oral -BR	—	Oral -BR
Pulse	57 -BR	51 -BR	55 -BR	—	55 -BR
Resp	16 -BR	18 -BR	18 -BR	—	18 -BR

Flowsheets (all recorded) (continued)

Blood Administration (continued)

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1723	06/17/18 1720
Pre-Transfusion Documentation					
Previous Transfusion Reaction?	—	—	—	—	No -BR
Consent Obtained?	—	—	—	—	Yes -BR
Education Provided ?	—	—	—	—	Yes -BR
Blood Product Identifiers					
Blood Product Type	—	—	—	—	Red blood cells (packed cells) -BR
Special Requirements	—	—	—	—	None -BR
Blood Bank ID Number (from Wristband)	—	—	—	r90803 -BR	r90803 -BR
Patient Blood Type	—	—	—	—	O Pos -BR
Donor Blood Type	—	—	—	—	O Pos -BR
Expiration Date	—	—	—	—	07/20/18 -BR
Expiration Time	—	—	—	—	2359 -BR
TRANSFUSE RED BLOOD CELLS					
Transfusion Start Date	—	—	—	—	06/17/18 -BR
Rate	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -BR	—
Completed Volume	—	—	—	—	350 -BR
Line	—	—	—	[REMOVED] Peripheral IV 06/17/18 20 G Right Antecubital -BR	—
Oxygen Therapy					
SpO2	100 % -BR	100 % -BR	100 % -BR	—	—
O2 Device	—	None (Room air) -BR	None (Room air) -BR	—	—

Row Name	06/17/18 1708	06/17/18 1538	06/17/18 1537	06/17/18 1502	06/17/18 1437
Vitals					
BP	(!) 115/49 -BR	—	114/51 -RG	112/52 -RG	—
Temp	97.8 °F (36.6 °C) -BR	—	97.8 °F (36.6 °C) -RG	97.7 °F (36.5 °C) -RG	—
Temp src	Oral -BR	—	—	Oral -RG	—
Pulse	55 -BR	—	55 -RG	54 -RG	56 -NS
Resp	18 -BR	—	22 -RG	25 -RG	—
Oxygen Therapy					
SpO2	100 % -BR	—	—	100 % -RG	98 % -NS
O2 Device	None (Room air) -BR	None (Room air) -RG	—	None (Room air) -RG	—
Pulse Oximetry Type	—	—	—	Continuous -RG	—
Respiratory Assessment					
Bilateral Breath Sounds	—	Diminished -RG	—	—	—

Flowsheets (all recorded)

Height/Weight

Row Name	06/18/18 0600	06/17/18 2225	06/17/18 1535
Height			
Height	—	67" (1.702 m) -AF	—
Weight			
Weight	104.9 kg (231 lb 4.2 oz) -RM	103.4 kg (227 lb 15.3 oz) -AF	95.3 kg (210 lb) -RG
Weight Method	Actual -RM	Actual -AF	Stated -RG

Flowsheets (all recorded)

ED Admit/Obs Reviewed

Row Name	06/17/18 1823
Case Manager Contact Information	
ED Admit/Obs Reviewed?	Yes IP -BA

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	06/21/18 11:36:09	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07	06/20/18 19:43:22
Vital sign parameters					
BP	123/59 -DI (r) CI (t)	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)	124/53 -DI (r) TW (t)	113/55 -DI (r) TW (t)
Pulse	60 -DI (r) CI (t)	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)	66 -DI (r) TW (t)
Calculated MAP	80.33 -DI (r) CI (t)	88.33 -DI (r) CI (t)	79 -DI (r) TW (t)	76.67 -DI (r) TW (t)	74.33 -DI (r) TW (t)
Resp	18 -CI	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)	16 -DI (r) TW (t)
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)	98.4 °F (36.9 °C) -DI (r) TW (t)	98.2 °F (36.8 °C) -DI (r) TW (t)
Vitals Sepsis Risk Score	0 -CI	0 -CI	0 -DI (r) TW (t)	1 -DI (r) TW (t)	0 -DI (r) TW (t)
Vital Signs					
Automatic Restart Vitals Timer	Yes -CI	Yes -CI	Yes -DI (r) TW (t)	Yes -DI (r) TW (t)	Yes -DI (r) TW (t)

Row Name	06/20/18 15:50:04	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909	06/20/18 0900
Vital sign parameters					
BP	154/80 -DI (r) LF (t)	104/66 -DI (r) LF (t)	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG
Pulse	62 -DI (r) LF (t)	61 -DI (r) LF (t)	61 -DG	59 -DG	60 -DG
Calculated MAP	104.67 -DI (r) LF (t)	78.67 -DI (r) LF (t)	76.67 -DG	73.33 -DG	73.33 -DG
Resp	17 -DI (r) LF (t)	—	18 -DG	—	17 -DG
Temp	98.3 °F (36.8 °C) -DI (r) LF (t)	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—	—
Vitals Sepsis Risk Score	0 -DI (r) LF (t)	—	—	—	—
MAP (mmHg)	—	—	71 mm Hg -DG	—	68 mm Hg -DG
Vital Signs					
Automatic Restart Vitals Timer	Yes -DI (r) LF (t)	—	Yes -DG	—	Yes -DG

Row Name	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500	06/20/18 0400
Vital sign parameters					
BP	138/62 -DG	—	129/57 -EE	130/50 -EE	119/51 -EE
Pulse	58 -DG	—	59 -EE	57 -EE	56 -EE
Calculated MAP	87.33 -DG	—	81 -EE	76.67 -EE	73.67 -EE
Resp	18 -DG	—	20 -EE	20 -EE	19 -EE
Temp	—	98.3 °F (36.8 °C) -HT	—	—	98 °F (36.7 °C) -JP
Vitals Sepsis Risk Score	—	—	—	—	0 -JP
MAP (mmHg)	81 mm Hg -DG	—	74 mm Hg -EE	70 mm Hg -EE	67 mm Hg -EE
Vital Signs					
Automatic Restart Vitals Timer	Yes -DG	—	Yes -EE	Yes -EE	Yes -JP

Row Name	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300	06/19/18 2200
Vital sign parameters					
BP	122/58 -EE	(!) 111/47 -EE	—	128/56 -EE	132/51 -EE
Pulse	57 -EE	64 -EE	59 -EE	61 -EE	62 -EE
Calculated MAP	79.33 -EE	68.33 -EE	—	80 -EE	78 -EE
Resp	21 -EE	16 -EE	22 -EE	21 -EE	22 -EE
Temp	—	—	97.5 °F (36.4 °C) -JP	—	—
MAP (mmHg)	73 mm Hg -EE	62 mm Hg -EE	—	—	73 mm Hg -EE
Vital Signs					
Automatic Restart Vitals Timer	Yes -EE	Yes -EE	Yes -EE	Yes -EE	Yes -EE

Row Name	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800	06/19/18 1700
Vital sign parameters					
BP	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI	132/52 -JI
Pulse	61 -EE	63 -EE	64 -EE	61 -JI	59 -JI
Calculated MAP	83.33 -EE	83.67 -EE	85 -EE	80 -JI	78.67 -JI
Resp	16 -EE	21 -EE	19 -EE	25 -JI	21 -JI
Temp	—	98.4 °F (36.9 °C) -JP	—	—	—
Vitals Sepsis Risk Score	—	1 -JP	—	—	—
MAP (mmHg)	77 mm Hg -EE	76 mm Hg -EE	77 mm Hg -EE	72 mm Hg -JI	73 mm Hg -JI
Vital Signs					
Automatic Restart	Yes -EE	Yes -JP	Yes -EE	Yes -JI	Yes -JI

Flowsheets (all recorded) (continued)

ED Sepsis Screen (continued)

Row Name	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800	06/19/18 1700
Vitals Timer					

Row Name	06/19/18 1644	06/19/18 1600	06/19/18 1500	06/19/18 1430	06/19/18 1428
Vital sign parameters					
BP	—	134/58 -JI	130/51 -JI	142/60 -JI	—
Pulse	—	58 -JI	56 -JI	57 -JI	—
Calculated MAP	—	83.33 -JI	77.33 -JI	87.33 -JI	—
Resp	—	20 -JI	22 -JI	19 -JI	—
Temp	97.9 °F (36.6 °C) -FT	—	—	—	97.7 °F (36.5 °C) -FT
MAP (mmHg)	—	76 mm Hg -JI	69 mm Hg -JI	82 mm Hg -JI	—
Vital Signs					
Automatic Restart Vitals Timer	—	Yes -JI	Yes -JI	Yes -JI	—

Row Name	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1114
Vital sign parameters					
BP	123/59 -LFA	128/55 -LFA	**(!) 95/46** -LFA	110/53 -CR	123/54 -PM
Pulse	54 -LFA	54 -LFA	53 -LFA	53 -CR	51 -PM
Calculated MAP	80.33 -LFA	79.33 -LFA	**(!) 62.33** -LFA	72 -CR	77 -PM
Resp	22 -LFA	19 -LFA	21 -LFA	18 -CR	13 -PM
Vital Signs					
Automatic Restart Vitals Timer	Yes -LFA	Yes -LFA	Yes -LFA	Yes -CR	Yes -PM

Row Name	06/19/18 1000	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700
Vital sign parameters					
BP	**(!) 124/49** -JI	**(!) 119/44** -JI	**(!) 126/47** -JI	**(!) 126/47** -JI	143/52 -JI
Pulse	50 -JI	51 -JI	55 -JI	56 -JI	63 -JI
Calculated MAP	74 -JI	69 -JI	73.33 -JI	73.33 -JI	82.33 -JI
Resp	20 -JI	18 -JI	—	18 -JI	18 -JI
Temp	—	—	—	98.6 °F (37 °C) -DF	—
Vitals Sepsis Risk Score	—	—	—	0 -DF	—
MAP (mmHg)	68 mm Hg -JI	62 mm Hg -JI	—	66 mm Hg -JI	76 mm Hg -JI
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	—	Yes -DF	Yes -JI

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
Vital sign parameters					
BP	**(!) 109/40** -RM	**(!) 124/49** -RM	127/55 -RM	120/59 -RM	113/50 -RM
Pulse	52 -RM	53 -RM	55 -RM	55 -RM	54 -RM
Calculated MAP	**(!) 63** -RM	74 -RM	79 -RM	79.33 -RM	71 -RM
Resp	17 -RM	17 -RM	20 -RM	16 -RM	19 -RM
Temp	—	—	98.2 °F (36.8 °C) -MJ	—	—
Vitals Sepsis Risk Score	—	—	0 -MJ	—	—
MAP (mmHg)	**(!) 56 mm Hg** -RM	68 mm Hg -RM	73 mm Hg -RM	73 mm Hg -RM	62 mm Hg -RM
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -MJ	Yes -RM	Yes -RM

Row Name	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100
Vital sign parameters					
BP	**(!) 109/44** -RM	**(!) 123/43** -RM	127/59 -RM	—	—
Pulse	53 -RM	56 -RM	59 -RM	55 -RM	56 -RM
Calculated MAP	65.67 -RM	69.67 -RM	81.67 -RM	—	—
Resp	19 -RM	21 -RM	20 -RM	21 -RM	21 -RM
Temp	—	98.1 °F (36.7 °C) -MJ	—	—	—
Vitals Sepsis Risk Score	—	1 -RM	—	—	—
MAP (mmHg)	61 mm Hg -RM	61 mm Hg -RM	75 mm Hg -RM	—	—
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727	06/18/18 1600

Flowsheets (all recorded) (continued)

ED Sepsis Screen (continued)

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1727	06/18/18 1600
Vital sign parameters					
BP	—	—	132/60 -RM	—	142/57 -JI
Pulse	56 -RM	56 -RM	56 -RM	—	52 -JI
Calculated MAP	—	—	84 -RM	—	85.33 -JI
Resp	22 -RM	22 -RM	20 -RM	—	20 -JI
Temp	98.4 °F (36.9 °C) -MJ	—	—	98.1 °F (36.7 °C) -JD	—
MAP (mmHg)	—	—	75 mm Hg -RM	—	76 mm Hg -JI
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	—	Yes -JI

Row Name	06/18/18 1500	06/18/18 1400	06/18/18 1300	06/18/18 1230	06/18/18 1200
Vital sign parameters					
BP	151/56 -JI	134/53 -JI	(!) 130/45 -JI	—	140/56 -JI
Pulse	54 -JI	58 -JI	57 -JI	—	52 -JI
Calculated MAP	87.67 -JI	80 -JI	73.33 -JI	—	84 -JI
Resp	18 -JI	19 -JI	15 -JI	—	18 -JI
Temp	—	—	—	97.7 °F (36.5 °C) -JD	—
MAP (mmHg)	79 mm Hg -JI	72 mm Hg -JI	65 mm Hg -JI	—	77 mm Hg -JI
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	Yes -JI	—	Yes -JI

Row Name	06/18/18 1100	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800
Vital sign parameters					
BP	(!) 128/46 -JI	131/52 -JI	137/54 -JI	—	(!) 123/49 -JI
Pulse	50 -JI	51 -JI	(!) 49 -JI	—	(!) 48 -JI
Calculated MAP	73.33 -JI	78.33 -JI	81.67 -JI	—	73.67 -JI
Resp	17 -JI	16 -JI	16 -JI	—	17 -JI
Temp	—	—	—	97.8 °F (36.6 °C) -JD	—
MAP (mmHg)	66 mm Hg -JI	72 mm Hg -JI	75 mm Hg -JI	—	66 mm Hg -JI
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	Yes -JI	—	Yes -JI

Row Name	06/18/18 0700	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400
Vital sign parameters					
BP	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM	120/52 -RM	117/50 -RM
Pulse	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM	(!) 47 -RM	(!) 49 -RM
Calculated MAP	71 -JI	74 -RM	75.33 -RM	74.67 -RM	72.33 -RM
Resp	17 -JI	13 -RM	18 -RM	18 -RM	19 -RM
Temp	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM	—
Vitals Sepsis Risk Score	—	0 -RM	—	0 -RM	—
MAP (mmHg)	65 mm Hg -JI	68 mm Hg -RM	69 mm Hg -RM	—	67 mm Hg -RM
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -RM	Yes -RM	Yes -RM	Yes -RM

Row Name	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051
Vital sign parameters					
BP	(!) 109/43 -RM	(!) 102/39 -RM	—	123/51 -RM	140/52 -RM
Pulse	(!) 49 -RM	51 -RM	54 -RM	57 -RM	57 -RM
Calculated MAP	65 -RM	(!) 60 -RM	—	75 -RM	81.33 -RM
Resp	18 -RM	19 -RM	20 -RM	21 -RM	20 -RM
Temp	—	—	—	—	98.1 °F (36.7 °C) -RM
Vitals Sepsis Risk Score	—	—	—	—	0 -RM
MAP (mmHg)	60 mm Hg -RM	(!) 55 mm Hg -RM	—	69 mm Hg -RM	—
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM

Row Name	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823
Vital sign parameters					
BP	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF	134/59 -BR	126/55 -BR

Flowsheets (all recorded) (continued)

ED Sepsis Screen (continued)

Row Name	06/18/18 0000	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823
Pulse	55 -RM	54 -RM	53 -AF	57 -BR	51 -BR
Calculated MAP	68.33 -RM	(!) 64 -RM	70 -AF	84 -BR	78.67 -BR
Resp	20 -RM	17 -RM	18 -AF	16 -BR	18 -BR
Temp	—	—	98 °F (36.7 °C) -AF	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR
Vitals Sepsis Risk Score	—	—	0 -AF	0 -BR	0 -BR
MAP (mmHg)	62 mm Hg -RM	(!) 58 mm Hg -RM	—	—	—
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -AF	Yes -BR	Yes -BR

Row Name	06/17/18 1738	06/17/18 1720	06/17/18 1708	06/17/18 1537	06/17/18 1502
Suspicion for infection or exposure?					
Are rigors present?	—	—	—	0 -RG	—
Is there a suspected infection?	—	—	—	0 -RG	—
Mental status change?	—	—	—	0 -RG	—
Suspicion of Infection Sepsis Risk Score	—	—	—	0 -RG	—
Vital sign parameters					
BP	132/56 -BR	129/53 -BR	(!) 115/49 -BR	114/51 -RG	112/52 -RG
Pulse	55 -BR	55 -BR	55 -BR	55 -RG	54 -RG
Calculated MAP	81.33 -BR	78.33 -BR	71 -BR	72 -RG	72 -RG
Resp	18 -BR	18 -BR	18 -BR	22 -RG	25 -RG
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR	97.8 °F (36.6 °C) -RG	97.7 °F (36.5 °C) -RG
Vitals Sepsis Risk Score	0 -BR	0 -BR	0 -BR	1 -RG	1 -RG
ED Severe Sepsis Risk Score					
ED Sepsis Screen Total Score	—	—	—	1 -RG	—
Vital Signs					
Automatic Restart Vitals Timer	Yes -BR	Yes -BR	Yes -BR	Yes -RG	Yes -RG

Row Name	06/17/18 1437
Vital sign parameters	
Pulse	56 -NS

Flowsheets (all recorded)

Triage HPI - Respiratory Complaint

Row Name	06/17/18 1436
Respiratory Complaint	
Onset	Over 1 week ago -NS
Chronicity	Chronic -NS
Other Associated Symptoms	SYM FOR MONTHS. PT HAS BEEN SEEN BY MD AND HAS CATH SCHEDULED FOR 2 DAYS FROM NOE -NS

Flowsheets (all recorded)

Vitals Reassessment

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07
Vital Signs					
Automatic Restart Vitals Timer	Yes -CI	—	Yes -CI	Yes -DI (r) TW (t)	Yes -DI (r) TW (t)
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)
Heart Rate Source	Monitor -CI	—	Monitor -CI	Monitor -TW	Monitor -TW
Resp	18 -CI	—	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)
Respiration Source	visual -CI	—	visual -CI	visual -TW	visual -TW
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)	124/53 -DI (r) TW (t)
Calculated MAP	80.33 -DI (r) CI (t)	—	88.33 -DI (r) CI (t)	79 -DI (r) TW (t)	76.67 -DI (r) TW (t)
BP Location	Right arm -CI	—	Right arm -CI	Right arm -TW	Right arm -TW
BP Method	Portable -CI	—	Portable -CI	Portable -TW	Portable -TW
Patient Position	Supine -CI	—	Supine -CI	Supine -TW	Supine -TW
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	98 °F (36.7 °C) -DI (r) TW (t)	98.4 °F (36.9 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	Oral -TW	Oral -TW
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)
O2 Device	None (Room air) -CI	None (Room air) -AM	None (Room air) -CI	None (Room air) -TW	None (Room air) -TW
Vitals Sepsis Score					
Vitals Sepsis Risk Score	0 -CI	—	0 -CI	0 -DI (r) TW (t)	1 -DI (r) TW (t)

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02
Vital Signs					
Automatic Restart Vitals Timer	—	Yes -DI (r) TW (t)	Yes -DI (r) LF (t)	—	—
Pulse	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)
Heart Rate Source	—	Monitor -TW	—	—	—
Resp	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)	—	—
Respiration Source	—	visual -TW	—	—	—
BP	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)	—	104/66 -DI (r) LF (t)
Calculated MAP	—	74.33 -DI (r) TW (t)	104.67 -DI (r) LF (t)	—	78.67 -DI (r) LF (t)
BP Location	—	Right arm -TW	—	—	—
BP Method	—	Portable -TW	—	—	—
Patient Position	—	Supine -TW	—	—	—
Temp	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)	—	98.2 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	—	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)
O2 Device	None (Room air) -TS	None (Room air) -TW	—	None (Room air) -MS	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	0 -DI (r) TW (t)	0 -DI (r) LF (t)	—	—

Row Name	06/20/18 1000	06/20/18 0909	06/20/18 0900	06/20/18 0800	06/20/18 0730
Vital Signs					
Automatic Restart Vitals Timer	Yes -DG	—	Yes -DG	Yes -DG	—
Pulse	61 -DG	59 -DG	60 -DG	58 -DG	—
Resp	18 -DG	—	17 -DG	18 -DG	—
BP	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG	138/62 -DG	—
MAP (mmHg)	71 mm Hg -DG	—	68 mm Hg -DG	81 mm Hg -DG	—
Calculated MAP	76.67 -DG	73.33 -DG	73.33 -DG	87.33 -DG	—
Temp	—	—	—	—	98.3 °F (36.8 °C) -HT
Temp src	—	—	—	—	Oral -HT
Oxygen Therapy					
SpO2	(!) 88 % -DG	—	(!) 87 % -DG	(!) 88 % -DG	—
O2 Device	—	—	—	None (Room air) -DG	—
Pulse Oximetry Type	—	—	—	Continuous -DG	—

Row Name	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200
Vital Signs					
Automatic Restart Vitals Timer	Yes -EE	Yes -EE	Yes -JP	Yes -EE	Yes -EE

Flowsheets (all recorded) (continued)

Vitals Reassessment (continued)

Row Name	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200
Pulse	59 -EE	57 -EE	56 -EE	57 -EE	64 -EE
Resp	20 -EE	20 -EE	19 -EE	21 -EE	16 -EE
BP	129/57 -EE	130/50 -EE	119/51 -EE	122/58 -EE	**(!) 111/47** -EE
MAP (mmHg)	74 mm Hg -EE	70 mm Hg -EE	67 mm Hg -EE	73 mm Hg -EE	62 mm Hg -EE
Calculated MAP	81 -EE	76.67 -EE	73.67 -EE	79.33 -EE	68.33 -EE
Temp	—	—	98 °F (36.7 °C) -JP	—	—
Temp src	—	—	Oral -JP	—	—
Oxygen Therapy					
SpO2	93 % -EE	94 % -EE	94 % -EE	97 % -EE	91 % -EE
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	0 -JP	—	—

Row Name	06/20/18 0000	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000
Vital Signs					
Automatic Restart Vitals Timer	Yes -EE	Yes -EE	Yes -EE	Yes -EE	Yes -JP
Pulse	59 -EE	61 -EE	62 -EE	61 -EE	63 -EE
Resp	22 -EE	21 -EE	22 -EE	16 -EE	21 -EE
BP	—	128/56 -EE	132/51 -EE	130/60 -EE	135/58 -EE
MAP (mmHg)	—	—	73 mm Hg -EE	77 mm Hg -EE	76 mm Hg -EE
Calculated MAP	—	80 -EE	78 -EE	83.33 -EE	83.67 -EE
Temp	97.5 °F (36.4 °C) -JP	—	—	—	98.4 °F (36.9 °C) -JP
Temp src	Axillary -JP	—	—	—	Oral -JP
Oxygen Therapy					
SpO2	90 % -EE	97 % -EE	96 % -EE	94 % -EE	94 % -EE
O2 Device	—	—	—	—	Nasal cannula -EE
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -EE
Pulse Oximetry Type	—	—	—	—	Continuous -EE
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	—	—	1 -JP

Row Name	06/19/18 1900	06/19/18 1800	06/19/18 1700	06/19/18 1644	06/19/18 1600
Vital Signs					
Automatic Restart Vitals Timer	Yes -EE	Yes -JI	Yes -JI	—	Yes -JI
Pulse	64 -EE	61 -JI	59 -JI	—	58 -JI
Resp	19 -EE	25 -JI	21 -JI	—	20 -JI
BP	133/61 -EE	128/56 -JI	132/52 -JI	—	134/58 -JI
MAP (mmHg)	77 mm Hg -EE	72 mm Hg -JI	73 mm Hg -JI	—	76 mm Hg -JI
Calculated MAP	85 -EE	80 -JI	78.67 -JI	—	83.33 -JI
Temp	—	—	—	97.9 °F (36.6 °C) -FT	—
Temp src	—	—	—	Oral -FT	—
Oxygen Therapy					
SpO2	94 % -EE	92 % -JI	96 % -JI	—	95 % -JI

Row Name	06/19/18 1500	06/19/18 1430	06/19/18 1428	06/19/18 1335	06/19/18 1330
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	—	Yes -LFA	Yes -LFA
Pulse	56 -JI	57 -JI	—	54 -LFA	54 -LFA
Resp	22 -JI	19 -JI	—	22 -LFA	19 -LFA
BP	130/51 -JI	142/60 -JI	—	123/59 -LFA	128/55 -LFA
MAP (mmHg)	69 mm Hg -JI	82 mm Hg -JI	—	—	—
Calculated MAP	77.33 -JI	87.33 -JI	—	80.33 -LFA	79.33 -LFA
Temp	—	—	97.7 °F (36.5 °C) -FT	—	—
Temp src	—	—	Oral -FT	—	—
Oxygen Therapy					
SpO2	96 % -JI	96 % -JI	—	100 % -LFA	97 % -LFA
O2 Device	—	Nasal cannula -JI	—	—	—
O2 Flow Rate (L/min)	—	2 L/min -JI	—	—	—
Pulse Oximetry Type	—	Continuous -JI	—	—	—

Row Name	06/19/18 1325	06/19/18 1321	06/19/18 1114	06/19/18 1031	06/19/18 1000

Flowsheets (all recorded) (continued)

Vitals Reassessment (continued)

Row Name	06/19/18 1325	06/19/18 1321	06/19/18 1114	06/19/18 1031	06/19/18 1000
Vital Signs					
Automatic Restart Vitals Timer	Yes -LFA	Yes -CR	Yes -PM	—	Yes -JI
Pulse	53 -LFA	53 -CR	51 -PM	—	50 -JI
Heart Rate Source	—	—	Monitor -PM	—	—
Resp	21 -LFA	18 -CR	13 -PM	—	20 -JI
BP	**(!) 95/46** -LFA	110/53 -CR	123/54 -PM	—	**(!) 124/49** -JI
MAP (mmHg)	—	—	—	—	68 mm Hg -JI
Calculated MAP	**(!) 62.33** -LFA	72 -CR	77 -PM	—	74 -JI
Patient Position	—	—	Sitting -PM	—	—
Oxygen Therapy					
SpO2	92 % -LFA	93 % -CR	98 % -PM	—	92 % -JI
O2 Device	—	—	Nasal cannula -PM	None (Room air) -JI	—
O2 Flow Rate (L/min)	—	—	3 L/min -PM	—	—

Row Name	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700	06/19/18 0600
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	—	Yes -DF	Yes -JI	Yes -RM
Pulse	51 -JI	55 -JI	56 -JI	63 -JI	52 -RM
Resp	18 -JI	—	18 -JI	18 -JI	17 -RM
BP	**(!) 119/44** -JI	**(!) 126/47** -JI	**(!) 126/47** -JI	143/52 -JI	**(!) 109/40** -RM
MAP (mmHg)	62 mm Hg -JI	—	66 mm Hg -JI	76 mm Hg -JI	**(!) 56 mm Hg** -RM
Calculated MAP	69 -JI	73.33 -JI	73.33 -JI	82.33 -JI	**(!) 63** -RM
Temp	—	—	98.6 °F (37 °C) -DF	—	—
Temp src	—	—	Oral -DF	—	—
Oxygen Therapy					
SpO2	95 % -JI	—	97 % -JI	96 % -JI	94 % -RM
O2 Device	—	—	Nasal cannula -JI	—	—
O2 Flow Rate (L/min)	—	—	2 L/min -JI	—	—
Pulse Oximetry Type	—	—	Continuous -JI	—	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	0 -DF	—	—

Row Name	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200	06/19/18 0100
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -MJ	Yes -RM	Yes -RM	Yes -RM
Pulse	53 -RM	55 -RM	55 -RM	54 -RM	53 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	17 -RM	20 -RM	16 -RM	19 -RM	19 -RM
BP	**(!) 124/49** -RM	127/55 -RM	120/59 -RM	113/50 -RM	**(!) 109/44** -RM
MAP (mmHg)	68 mm Hg -RM	73 mm Hg -RM	73 mm Hg -RM	62 mm Hg -RM	61 mm Hg -RM
Calculated MAP	74 -RM	79 -RM	79.33 -RM	71 -RM	65.67 -RM
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM
Patient Position	Sitting -RM	Supine -RM	Lying right side -RM	Lying right side -RM	Lying left side -RM
Temp	—	98.2 °F (36.8 °C) -MJ	—	—	—
Oxygen Therapy					
SpO2	96 % -RM	98 % -RM	92 % -RM	93 % -RM	92 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	0 -MJ	—	—	—

Row Name	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100	06/18/18 2000
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Pulse	56 -RM	59 -RM	55 -RM	56 -RM	56 -RM

Flowsheets (all recorded) (continued)

Vitals Reassessment (continued)

Row Name	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100	06/18/18 2000
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	21 -RM	20 -RM	21 -RM	21 -RM	22 -RM
BP	(!) 123/43 -RM	127/59 -RM	—	—	—
MAP (mmHg)	61 mm Hg -RM	75 mm Hg -RM	—	—	—
Calculated MAP	69.67 -RM	81.67 -RM	—	—	—
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	—	—
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—	—
Patient Position	Lying left side -RM	Lying left side -RM	Supine -RM	—	—
Temp	98.1 °F (36.7 °C) -MJ	—	—	—	98.4 °F (36.9 °C) -MJ
Oxygen Therapy					
SpO2	94 % -RM	97 % -RM	99 % -RM	99 % -RM	96 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM
Vitals Sepsis Score					
Vitals Sepsis Risk Score	1 -RM	—	—	—	—

Row Name	06/18/18 1900	06/18/18 1800	06/18/18 1727	06/18/18 1600	06/18/18 1500
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	—	Yes -JI	Yes -JI
Pulse	56 -RM	56 -RM	—	52 -JI	54 -JI
Heart Rate Source	Monitor -RM	—	—	—	—
Resp	22 -RM	20 -RM	—	20 -JI	18 -JI
BP	—	132/60 -RM	—	142/57 -JI	151/56 -JI
MAP (mmHg)	—	75 mm Hg -RM	—	76 mm Hg -JI	79 mm Hg -JI
Calculated MAP	—	84 -RM	—	85.33 -JI	87.67 -JI
Temp	—	—	98.1 °F (36.7 °C) -JD	—	—
Temp src	—	—	Oral -JD	—	—
Oxygen Therapy					
SpO2	(!) 89 % -RM	94 % -RM	—	(!) 87 % -JI	95 % -JI
O2 Device	Nasal cannula -RM	—	—	—	—
Pulse Oximetry Type	Continuous -RM	—	—	—	—
SpO2 Alarm Limit High	100 -RM	—	—	—	—
SpO2 Alarm Limit Low	90 -RM	—	—	—	—
POX Probe Site Changed	No -RM	—	—	—	—

Row Name	06/18/18 1400	06/18/18 1300	06/18/18 1230	06/18/18 1200	06/18/18 1100
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	—	Yes -JI	Yes -JI
Pulse	58 -JI	57 -JI	—	52 -JI	50 -JI
Resp	19 -JI	15 -JI	—	18 -JI	17 -JI
BP	134/53 -JI	(!) 130/45 -JI	—	140/56 -JI	(!) 128/46 -JI
MAP (mmHg)	72 mm Hg -JI	65 mm Hg -JI	—	77 mm Hg -JI	66 mm Hg -JI
Calculated MAP	80 -JI	73.33 -JI	—	84 -JI	73.33 -JI
Temp	—	—	97.7 °F (36.5 °C) -JD	—	—
Temp src	—	—	Oral -JD	—	—
Oxygen Therapy					
SpO2	91 % -JI	93 % -JI	—	—	97 % -JI

Row Name	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800	06/18/18 0700
Vital Signs					
Automatic Restart Vitals Timer	Yes -JI	Yes -JI	—	Yes -JI	Yes -JI
Pulse	51 -JI	(!) 49 -JI	—	(!) 48 -JI	(!) 46 -JI
Resp	16 -JI	16 -JI	—	17 -JI	17 -JI
BP	131/52 -JI	137/54 -JI	—	(!) 123/49 -JI	(!) 115/49 -JI
MAP (mmHg)	72 mm Hg -JI	75 mm Hg -JI	—	66 mm Hg -JI	65 mm Hg -JI
Calculated MAP	78.33 -JI	81.67 -JI	—	73.67 -JI	71 -JI
Temp	—	—	97.8 °F (36.6 °C) -JD	—	—

Flowsheets (all recorded) (continued)

Vitals Reassessment (continued)

Row Name	06/18/18 1000	06/18/18 0900	06/18/18 0831	06/18/18 0800	06/18/18 0700
Temp src	—	—	Oral -JD	—	—
Oxygen Therapy					
SpO2	98 % -JI	100 % -JI	—	91 % -JI	95 % -JI
O2 Device	—	—	—	Nasal cannula -JI	—
O2 Flow Rate (L/min)	—	—	—	5 L/min -JI	—
Pulse Oximetry Type	—	—	—	Continuous -JI	—

Row Name	06/18/18 0600	06/18/18 0500	06/18/18 0445	06/18/18 0400	06/18/18 0300
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Pulse	**(!) 46** -RM	**(!) 47** -RM	**(!) 47** -RM	**(!) 49** -RM	**(!) 49** -RM
Heart Rate Source	Monitor -RM	Monitor -RM	—	Monitor -RM	Monitor -RM
Resp	13 -RM	18 -RM	18 -RM	19 -RM	18 -RM
BP	**(!) 126/48** -RM	122/52 -RM	120/52 -RM	117/50 -RM	**(!) 109/43** -RM
MAP (mmHg)	68 mm Hg -RM	69 mm Hg -RM	—	67 mm Hg -RM	60 mm Hg -RM
Calculated MAP	74 -RM	75.33 -RM	74.67 -RM	72.33 -RM	65 -RM
BP Location	Right arm -RM	Right arm -RM	—	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM
Patient Position	Supine -RM	Lying left side -RM	—	Sitting -RM	Supine -RM
Temp	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM	—	—
Temp src	Axillary -RM	—	Axillary -RM	—	—
Oxygen Therapy					
SpO2	97 % -RM	97 % -RM	—	97 % -RM	92 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	—	—	—	—	5 L/min -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	—	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	—	No -RM	No -RM
Vitals Sepsis Score					
Vitals Sepsis Risk Score	0 -RM	—	0 -RM	—	—

Row Name	06/18/18 0200	06/18/18 0115	06/18/18 0100	06/18/18 0051	06/18/18 0000
Vital Signs					
Automatic Restart Vitals Timer	Yes -RM	Yes -RM	Yes -RM	Yes -RM	Yes -RM
Pulse	51 -RM	54 -RM	57 -RM	57 -RM	55 -RM
Heart Rate Source	Monitor -RM	—	Monitor -RM	Monitor -RM	Monitor -RM
Resp	19 -RM	20 -RM	21 -RM	20 -RM	20 -RM
BP	**(!) 102/39** -RM	—	123/51 -RM	140/52 -RM	**(!) 115/45** -RM
MAP (mmHg)	**(!) 55 mm Hg** -RM	—	69 mm Hg -RM	—	62 mm Hg -RM
Calculated MAP	**(!) 60** -RM	—	75 -RM	81.33 -RM	68.33 -RM
BP Location	Right arm -RM	—	Right arm -RM	—	Right arm -RM
BP Method	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM
Patient Position	Lying right side -RM	—	Lying left side -RM	—	Lying left side -RM
Temp	—	—	—	98.1 °F (36.7 °C) -RM	—
Temp src	—	—	—	Oral -RM	—
Oxygen Therapy					
SpO2	**(!) 87 %** -RM	—	**(!) 88 %** -RM	—	92 % -RM
O2 Device	Nasal cannula -RM	—	Nasal cannula -RM	—	Nasal cannula -RM
O2 Flow Rate (L/min)	5 L/min -RM	—	—	—	—
Pulse Oximetry Type	Continuous -RM	—	Continuous -RM	—	Continuous -RM
SpO2 Alarm Limit High	100 -RM	—	100 -RM	—	100 -RM
SpO2 Alarm Limit Low	90 -RM	—	90 -RM	—	90 -RM
POX Probe Site Changed	No -RM	—	No -RM	—	Yes -RM
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	—	0 -RM	—

Row Name	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823	06/17/18 1738
Vital Signs					
Automatic Restart	Yes -RM	Yes -AF	Yes -BR	Yes -BR	Yes -BR

Flowsheets (all recorded) (continued)

Vitals Reassessment (continued)

Row Name	06/17/18 2300	06/17/18 2225	06/17/18 2037	06/17/18 1823	06/17/18 1738
Vitals Timer					
Patient placed on monitor	—	—	Yes -BR	Yes -BR	Yes -BR
Pulse	54 -RM	53 -AF	57 -BR	51 -BR	55 -BR
Heart Rate Source	Monitor -RM	Monitor -AF	Monitor -BR	Monitor -BR	Monitor -BR
Resp	17 -RM	18 -AF	16 -BR	18 -BR	18 -BR
Respiration Source	—	—	visual -BR	visual -BR	visual -BR
BP	**(!) 110/41** -RM	**(!) 128/41** -AF	134/59 -BR	126/55 -BR	132/56 -BR
MAP (mmHg)	**(!) 58 mm Hg** -RM	—	—	—	—
Calculated MAP	**(!) 64** -RM	70 -AF	84 -BR	78.67 -BR	81.33 -BR
BP Location	Right arm -RM	Right arm -RM	Right arm -BR	Right arm -BR	Right arm -BR
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Portable -BR	Portable -BR	Portable -BR
Patient Position	Sitting -RM	Sitting -RM	Sitting -BR	Sitting -BR	Sitting -BR
Temp	—	98 °F (36.7 °C) -AF	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR
Temp src	—	Oral -AF	Oral -BR	Oral -BR	Oral -BR
Oxygen Therapy					
SpO2	90 % -RM	92 % -AF	100 % -BR	100 % -BR	100 % -BR
O2 Device	Nasal cannula -RM	Nasal cannula -AF	—	None (Room air) -BR	None (Room air) -BR
O2 Flow Rate (L/min)	—	2 L/min -AF	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	—	—
POX Probe Site Changed	No -RM	No -RM	—	—	—
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	0 -AF	0 -BR	0 -BR	0 -BR

Row Name	06/17/18 1720	06/17/18 1708	06/17/18 1538	06/17/18 1537	06/17/18 1502
Vital Signs					
Automatic Restart Vitals Timer	Yes -BR	Yes -BR	—	Yes -RG	Yes -RG
Patient placed on monitor	—	Yes -BR	—	—	Yes -RG
Pulse	55 -BR	55 -BR	—	55 -RG	54 -RG
Heart Rate Source	—	Monitor -BR	—	—	Monitor -RG
Resp	18 -BR	18 -BR	—	22 -RG	25 -RG
Respiration Source	—	visual -BR	—	—	visual -RG
BP	129/53 -BR	**(!) 115/49** -BR	—	114/51 -RG	112/52 -RG
Calculated MAP	78.33 -BR	71 -BR	—	72 -RG	72 -RG
BP Location	—	Right arm -BR	—	—	Left arm -RG
BP Method	—	Portable -BR	—	—	Non-invasive Cuff -RG
Orthostatic BP?	—	—	—	—	No -RG
Patient Position	—	Standing -BR	—	—	Supine -RG
Temp	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR	—	97.8 °F (36.6 °C) -RG	97.7 °F (36.5 °C) -RG
Temp src	Oral -BR	Oral -BR	—	—	Oral -RG
Oxygen Therapy					
SpO2	—	100 % -BR	—	—	100 % -RG
O2 Device	—	None (Room air) -BR	None (Room air) -RG	—	None (Room air) -RG
Pulse Oximetry Type	—	—	—	—	Continuous -RG
Vitals Sepsis Score					
Vitals Sepsis Risk Score	0 -BR	0 -BR	—	1 -RG	1 -RG

Row Name	06/17/18 1437
Vital Signs	
Pulse	56 -NS
Oxygen Therapy	
SpO2	98 % -NS

Flowsheets (all recorded)

Pain Reassessment

Row Name	06/21/18 0830	06/21/18 0545	06/21/18 0030	06/20/18 2133	06/20/18 0830
Pain Reassessment					
Pain Intervention(s)	Declines -AM	Rest -TS	Rest -TS	Rest;Declines -TS	Rest -MS
Numeric Pain Intensity Score 1	0 -AM	0 -TS	—	0 -TS	0 Simultaneous filing. User may be unaware of other data. -MS
FACES Pain Rating	—	—	0-No hurt -TS	—	—

Row Name	06/20/18 0730	06/19/18 2000	06/19/18 1600	06/19/18 1321	06/19/18 0800
Pain Reassessment					
Numeric Pain Intensity Score 1	2 -DG	0 -EE	0 -JI	0 -CR	0 -JI

Row Name	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1600	06/18/18 1200
Pain Reassessment					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	0 -JI	0 -JI

Row Name	06/18/18 0800	06/18/18 0600	06/18/18 0500	06/18/18 0400	06/18/18 0300
Pain Reassessment					
Numeric Pain Intensity Score 1	0 -JI	0 -RM	0 -RM	0 -RM	0 -RM

Row Name	06/18/18 0200	06/18/18 0100	06/18/18 0000	06/17/18 2300	06/17/18 2225
Pain Reassessment					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	0 -RM	0 -RM

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1706	06/17/18 1504
Pain Timer				
Restart Pain Timer	Yes -BR	Yes -BR	Yes -BR	Yes -RG
Pain Reassessment after Intervention Complete	—	Yes -BR	—	—
Pain Reassessment				
Which Pain Reassessment Tool?	Numeric (0-10) -BR	Numeric (0-10) -BR	Numeric (0-10) -BR	—
Numeric Pain Intensity Score 1	0 -BR	0 -BR	0 -BR	0 -RG
Patient's Stated Pain Goal	0 (No Pain) -BR	0 (No Pain) -BR	0 (No Pain) -BR	—

Flowsheets (all recorded)

Ventilator Documentation

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 04:07:21	06/20/18 23:57:07
Respiratory Assessment					
Respiratory Pattern	—	Regular -AM	—	—	—
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	63 -DI (r) TW (t)	109 -DI (r) TW (t)
Resp	18 -CI	—	18 -CI	18 -DI (r) TW (t)	16 -DI (r) TW (t)
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	121/58 -DI (r) TW (t)	124/53 -DI (r) TW (t)
Bilateral Breath Sounds	—	Clear -AM	—	—	—
Readings					
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	93 % -DI (r) TW (t)	93 % -DI (r) TW (t)

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02
Respiratory Assessment					
Respiratory Pattern	Regular -TS	—	—	Regular -MS	—
Pulse	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)
Resp	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)	—	—
BP	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)	—	104/66 -DI (r) LF (t)
Chest Assessment	Chest expansion symmetrical -TS	—	—	Chest expansion symmetrical -MS	—
R Breath Sounds	—	—	—	Clear -MS	—
L Breath Sounds	—	—	—	Diminished -MS	—
Cough	—	—	—	None -MS	—
Bilateral Breath Sounds	Clear;Diminished -TS	—	—	Clear;Diminished -MS	—
Readings					
SpO2	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)	—	92 % -DI (r) LF (t)

Row Name	06/20/18 1000	06/20/18 0909	06/20/18 0900	06/20/18 0800	06/20/18 0600
Respiratory Assessment					
Respiratory Pattern	—	—	—	Regular -DG	—
Pulse	61 -DG	59 -DG	60 -DG	58 -DG	59 -EE
Resp	18 -DG	—	17 -DG	18 -DG	20 -EE
BP	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG	138/62 -DG	129/57 -EE
Chest Assessment	—	—	—	Chest expansion symmetrical -DG	—
Bilateral Breath Sounds	—	—	—	Diminished -DG	—
Readings					
SpO2	(!) 88 % -DG	—	(!) 87 % -DG	(!) 88 % -DG	93 % -EE
iFlolan Therapy Assessment					
MAP (mmHg)	71 mm Hg -DG	—	68 mm Hg -DG	81 mm Hg -DG	74 mm Hg -EE

Row Name	06/20/18 0500	06/20/18 0400	06/20/18 0300	06/20/18 0200	06/20/18 0000
Respiratory Assessment					
Pulse	57 -EE	56 -EE	57 -EE	64 -EE	59 -EE
Resp	20 -EE	19 -EE	21 -EE	16 -EE	22 -EE
BP	130/50 -EE	119/51 -EE	122/58 -EE	(!) 111/47 -EE	—
Readings					
SpO2	94 % -EE	94 % -EE	97 % -EE	91 % -EE	90 % -EE
iFlolan Therapy Assessment					
MAP (mmHg)	70 mm Hg -EE	67 mm Hg -EE	73 mm Hg -EE	62 mm Hg -EE	—

Row Name	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900
Respiratory Assessment					
Respiratory Pattern	—	—	—	Regular -EE	—
Pulse	61 -EE	62 -EE	61 -EE	63 -EE	64 -EE
Resp	21 -EE	22 -EE	16 -EE	21 -EE	19 -EE
BP	128/56 -EE	132/51 -EE	130/60 -EE	135/58 -EE	133/61 -EE
Chest Assessment	—	—	—	Chest expansion symmetrical -EE	—
Bilateral Breath Sounds	—	—	—	Diminished -EE	—
Readings					
SpO2	97 % -EE	96 % -EE	94 % -EE	94 % -EE	94 % -EE
iFlolan Therapy Assessment					

Flowsheets (all recorded) (continued)

Ventilator Documentation (continued)

Row Name	06/19/18 2300	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900
MAP (mmHg)	—	73 mm Hg -EE	77 mm Hg -EE	76 mm Hg -EE	77 mm Hg -EE

Row Name	06/19/18 1800	06/19/18 1700	06/19/18 1600	06/19/18 1500	06/19/18 1430
Respiratory Assessment					
Pulse	61 -JI	59 -JI	58 -JI	56 -JI	57 -JI
Resp	25 -JI	21 -JI	20 -JI	22 -JI	19 -JI
BP	128/56 -JI	132/52 -JI	134/58 -JI	130/51 -JI	142/60 -JI
Readings					
SpO2	92 % -JI	96 % -JI	95 % -JI	96 % -JI	96 % -JI
iFlolan Therapy Assessment					
MAP (mmHg)	72 mm Hg -JI	73 mm Hg -JI	76 mm Hg -JI	69 mm Hg -JI	82 mm Hg -JI

Row Name	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321	06/19/18 1114
Respiratory Assessment					
Pulse	54 -LFA	54 -LFA	53 -LFA	53 -CR	51 -PM
Resp	22 -LFA	19 -LFA	21 -LFA	18 -CR	13 -PM
BP	123/59 -LFA	128/55 -LFA	**(!) 95/46** -LFA	110/53 -CR	123/54 -PM
Readings					
SpO2	100 % -LFA	97 % -LFA	92 % -LFA	93 % -CR	98 % -PM

Row Name	06/19/18 1000	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700
Respiratory Assessment					
Respiratory Pattern	—	—	—	Regular -JI	—
Pulse	50 -JI	51 -JI	55 -JI	56 -JI	63 -JI
Resp	20 -JI	18 -JI	—	18 -JI	18 -JI
BP	**(!) 124/49** -JI	**(!) 119/44** -JI	**(!) 126/47** -JI	**(!) 126/47** -JI	143/52 -JI
Chest Assessment	—	—	—	Chest expansion symmetrical -JI	—
Cough	—	—	—	Spontaneous -JI	—
Bilateral Breath Sounds	—	—	—	Diminished -JI	—
Readings					
SpO2	92 % -JI	95 % -JI	—	97 % -JI	96 % -JI
iFlolan Therapy Assessment					
MAP (mmHg)	68 mm Hg -JI	62 mm Hg -JI	—	66 mm Hg -JI	76 mm Hg -JI

Row Name	06/19/18 0600	06/19/18 0500	06/19/18 0400	06/19/18 0300	06/19/18 0200
Respiratory Assessment					
Pulse	52 -RM	53 -RM	55 -RM	55 -RM	54 -RM
Resp	17 -RM	17 -RM	20 -RM	16 -RM	19 -RM
BP	**(!) 109/40** -RM	**(!) 124/49** -RM	127/55 -RM	120/59 -RM	113/50 -RM
Readings					
SpO2	94 % -RM	96 % -RM	98 % -RM	92 % -RM	93 % -RM
iFlolan Therapy Assessment					
MAP (mmHg)	**(!) 56 mm Hg** -RM	68 mm Hg -RM	73 mm Hg -RM	73 mm Hg -RM	62 mm Hg -RM

Row Name	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100
Respiratory Assessment					
Pulse	53 -RM	56 -RM	59 -RM	55 -RM	56 -RM
Resp	19 -RM	21 -RM	20 -RM	21 -RM	21 -RM
BP	**(!) 109/44** -RM	**(!) 123/43** -RM	127/59 -RM	—	—
Readings					
SpO2	92 % -RM	94 % -RM	97 % -RM	99 % -RM	99 % -RM
iFlolan Therapy Assessment					
MAP (mmHg)	61 mm Hg -RM	61 mm Hg -RM	75 mm Hg -RM	—	—

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1600	06/18/18 1500
Respiratory Assessment					
Respiratory Pattern	Regular -RM	—	—	—	—
Pulse	56 -RM	56 -RM	56 -RM	52 -JI	54 -JI
Resp	22 -RM	22 -RM	20 -RM	20 -JI	18 -JI
BP	—	—	132/60 -RM	142/57 -JI	151/56 -JI
Chest Assessment	Chest expansion symmetrical -RM	—	—	—	—

Flowsheets (all recorded) (continued)

Ventilator Documentation (continued)

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1800	06/18/18 1600	06/18/18 1500
R Breath Sounds	Diminished -RM	—	—	—	—
L Breath Sounds	Diminished -RM	—	—	—	—
Cough	Spontaneous;Strong -RM	—	—	—	—
Bilateral Breath Sounds	Diminished -RM	—	—	—	—
Readings					
SpO2	96 % -RM	(!) 89 % -RM	94 % -RM	(!) 87 % -JI	95 % -JI
iFlolan Therapy Assessment					
MAP (mmHg)	—	—	75 mm Hg -RM	76 mm Hg -JI	79 mm Hg -JI

Row Name	06/18/18 1400	06/18/18 1300	06/18/18 1200	06/18/18 1100	06/18/18 1000
Respiratory Assessment					
Pulse	58 -JI	57 -JI	52 -JI	50 -JI	51 -JI
Resp	19 -JI	15 -JI	18 -JI	17 -JI	16 -JI
BP	134/53 -JI	(!) 130/45 -JI	140/56 -JI	(!) 128/46 -JI	131/52 -JI
Readings					
SpO2	91 % -JI	93 % -JI	—	97 % -JI	98 % -JI
iFlolan Therapy Assessment					
MAP (mmHg)	72 mm Hg -JI	65 mm Hg -JI	77 mm Hg -JI	66 mm Hg -JI	72 mm Hg -JI

Row Name	06/18/18 0900	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500
Respiratory Assessment					
Respiratory Pattern	—	Regular -JI	—	—	—
Pulse	(!) 49 -JI	(!) 48 -JI	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM
Resp	16 -JI	17 -JI	17 -JI	13 -RM	18 -RM
BP	137/54 -JI	(!) 123/49 -JI	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM
Chest Assessment	—	Chest expansion symmetrical -JI	—	—	—
Cough	—	Strong;Spontaneous -JI	—	—	—
Bilateral Breath Sounds	—	Diminished -JI	—	—	—
Readings					
SpO2	100 % -JI	91 % -JI	95 % -JI	97 % -RM	97 % -RM
iFlolan Therapy Assessment					
MAP (mmHg)	75 mm Hg -JI	66 mm Hg -JI	65 mm Hg -JI	68 mm Hg -RM	69 mm Hg -RM

Row Name	06/18/18 0445	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115
Respiratory Assessment					
Pulse	(!) 47 -RM	(!) 49 -RM	(!) 49 -RM	51 -RM	54 -RM
Resp	18 -RM	19 -RM	18 -RM	19 -RM	20 -RM
BP	120/52 -RM	117/50 -RM	(!) 109/43 -RM	(!) 102/39 -RM	—
Readings					
SpO2	—	97 % -RM	92 % -RM	(!) 87 % -RM	—
iFlolan Therapy Assessment					
MAP (mmHg)	—	67 mm Hg -RM	60 mm Hg -RM	(!) 55 mm Hg -RM	—

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0013	06/18/18 0000	06/17/18 2300
Respiratory Assessment					
Respiratory Pattern	—	—	—	Regular -RM	—
Pulse	57 -RM	57 -RM	—	55 -RM	54 -RM
Resp	21 -RM	20 -RM	—	20 -RM	17 -RM
BP	123/51 -RM	140/52 -RM	—	(!) 115/45 -RM	(!) 110/41 -RM
Chest Assessment	—	—	—	Chest expansion symmetrical -RM	—
R Breath Sounds	—	—	—	Diminished -RM	—
L Breath Sounds	—	—	—	Diminished -RM	—
Cough	—	—	—	Strong;Loose -RM	—
Readings					
SpO2	(!) 88 % -RM	—	—	92 % -RM	90 % -RM
iFlolan Therapy Assessment					
MAP (mmHg)	69 mm Hg -RM	—	—	62 mm Hg -RM	(!) 58 mm Hg -RM

Flowsheets (all recorded) (continued)

Ventilator Documentation (continued)

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0013	06/18/18 0000	06/17/18 2300
Transport Assist					
## RCP Transport (30 min)	—	—	With RCP in attendance -SJ	—	—
Patient O2/Ventilator support	—	—	On NIV -SJ	—	—
Patient transport destination	—	—	Admitted unit -SJ	—	—
How tolerated?	—	—	Without event -SJ	—	—

Row Name	06/17/18 2225	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1720
Respiratory Assessment					
Pulse	53 -AF	57 -BR	51 -BR	55 -BR	55 -BR
Resp	18 -AF	16 -BR	18 -BR	18 -BR	18 -BR
BP	**(!) 128/41** -AF	134/59 -BR	126/55 -BR	132/56 -BR	129/53 -BR
Readings					
SpO2	92 % -AF	100 % -BR	100 % -BR	100 % -BR	—
Adult IBW/VT Calculations					
Height	67" (1.702 m) -AF	—	—	—	—
IBW/kg (Calculated)	66.1 -AF	—	—	—	—
Range Vt 4mL/kg	264.4 mL/kg -AF	—	—	—	—
Low Range Vt 6mL/kg	396.6 mL/kg -AF	—	—	—	—
Adult Moderate Range Vt 8mL/kg	528.8 mL/kg -AF	—	—	—	—
Adult High Range Vt 10mL/kg	661 mL/kg -AF	—	—	—	—

Row Name	06/17/18 1708	06/17/18 1538	06/17/18 1537	06/17/18 1502	06/17/18 1437
[REMOVED] Anesthesia Airway Nasal Cannula					
AN Airway Properties	Placement Date: 06/12/18 -AH Placement Time: 1253 -AH Airway Device: Nasal Cannula -AH Removal Date: 06/17/18 -RG, N/E				
Respiratory Assessment					
Respiratory Pattern	—	Labored -RG	—	—	—
Pulse	55 -BR	—	55 -RG	54 -RG	56 -NS
Resp	18 -BR	—	22 -RG	25 -RG	—
BP	**(!) 115/49** -BR	—	114/51 -RG	112/52 -RG	—
Chest Assessment	—	Chest expansion symmetrical -RG	—	—	—
Bilateral Breath Sounds	—	Diminished -RG	—	—	—
Readings					
SpO2	100 % -BR	—	—	100 % -RG	98 % -NS

Flowsheets (all recorded)

DCP Assessment

Row Name	06/20/18 1241	06/18/18 1259	06/18/18 1000	06/18/18 0000
Patient Information				
Living Situation Prior to Admission	—	Home -KG	—	Home -RM
Marital Status	—	Married -KG	—	—
Primary Caregiver	—	Family (relationship) primary caregiver is self -KG	—	None -RM
Caregiver Name(s)	—	Shirley Maurice (spouse) -KG	—	—
Caregiver Phone Number(s)	—	678-398-9479 -KG	—	—
Legal Information				
Advance Directives Status	—	Patient declined information -KG	—	—
Current State				
Functional Status	—	Independent -KG	—	—
Personal Responsibilities	—	Housekeeping;Cooking;Money Mgmt;Driving;Yardwork;Medication Management -KG	—	—
Home Equipment	—	None -KG	—	—
Type of Home Services	—	None -KG	—	—
Bladder Control	—	Continent -KG	—	—
Bowel Control	—	Continent -KG	—	—
Cognition	—	Oriented to person;Oriented to place;Oriented to time -KG	—	—
Communication/Literacy	—	Understands speaking;Talks;Understands English -KG	—	—
Income Information				
Income Source	—	Disability/SSI -KG	—	—
Discharge Plan				
Case Management Barriers to Discharge	—	No Barriers -KG	—	—
Is Discharge Transport arranged?	—	Yes -KG	—	Yes -RM
Family Concurs	—	Yes -KG	—	—
Patient Concurs	—	Yes -KG	—	—
Discharge Facility Type	—	Home -KG	—	—
Barriers to discharge	—	—	—	No Barriers -RM
Patient Discharge Risk Level				
Readmission Risk	—	Mod LACE Score of 6-11) -KG	—	—
Readmission Risk Score	—	11 -KG	—	—
Notes				
DC Plan/Observations	06/20/2018 Home with self care pending medical progress. -KG	Home with self care. -KG	—	—
IA/UM Assessments Completed				
Initial Assessment Complete	—	Yes -KG	—	—
UM Assessment Complete	—	—	Yes -VT	—

Flowsheets (all recorded)

Daily Cares

Row Name	06/21/18 1200	06/21/18 1000	06/21/18 0800	06/21/18 04:07:21	06/20/18 23:57:07
Safe Environment					
Arm Bands On	ID;Allergies -CI	ID;Allergies -JK	ID;Allergies -CI	ID;Allergies -TW	ID;Allergies -TW
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -CI	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JK	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -CI	Overbed table in reach -TW	Overbed table in reach -TW
Safety Alarm Verfied	No alarm -CI	No alarm -JK	No alarm -CI	No alarm -TW	No alarm -TW
Side Rails/Bed Safety	3/4 -CI	3/4 -JK	3/4 -CI	3/4 -TW	3/4 -TW
Fall Risk Interventions					
Fall Prevention Interventions	Frequent Visual Checks/Rounding -CI	Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Yellow Armband, Socks -JK	Yellow Armband, Socks -CI	Yellow Armband, Socks -TW	Yellow Armband, Socks -TW
Fall Prevention Education Reviewed with :	Patient -CI	Patient -JK	Patient -CI	Patient -TW	Patient -TW
Mobility					
Mobility Intervention	Resting in bed -CI	Stand at bedside;Ambulate in room;Back to bed -JK	Resting in bed -CI	Ambulate in hall -TW	Ambulate in room -TW
Assistive Device	None -CI	None -JK	None -CI	None -TW	None -TW
Level of Assistance	Independent -CI	Independent -JK	Independent -CI	Independent -TW	Standby assist, set-up cues, supervision of patient - no hands on -TW
Distance Ambulated (ft)	—	20 ft -JK	—	700 ft -TW	20 ft -TW
Ambulation Response	Tolerated well -CI	Tolerated well -JK	Tolerated well -CI	Tolerated well -TW	Tolerated well -TW
Active Range of Motion	Active -CI	Active -JK	Active;All extremities -CI	All extremities -TW	Active;All extremities -TW
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -CI	—	Yes -CI	Yes -TW	Yes -TW
Repositioned	Turns self;Semi Fowler's -CI	Sitting -JK	Turns self -CI	Turns self -TW	Turns self -TW
Heels/Feet	Foot of bed elevated -CI	—	Foot of bed elevated -CI	Foot of bed elevated -TW	Heels elevated off bed -TW
Hygiene					
Hygiene Performed	Patient/family refused -CI	—	—	Patient/family refused -TW	Patient/family refused -TW
Performed by	Self -CI	—	Self -CI	Self -TW	Self -TW
Anti-Embolism Devices					
Anti-Embolism Devices	Temporarily "Off" -CI	Temporarily "Off" -JK	Temporarily "Off" -CI	Temporarily "Off" -TW	Temporarily "Off" -TW
Patient Refused	Yes -CI	Yes -JK	Yes -CI	Yes -TW	Yes -TW
Nutrition					
Feeding	Able to feed self -CI	Able to feed self -JK	—	Able to feed self -TW	Able to feed self -TW
Appetite	—	Good -JK	—	Good -TW	Good -TW
Diet Supplements	—	—	—	None -TW	None -TW
Percent Meals Eaten (%)	—	100 % -JK	—	0 % -TW	0 % -TW
Snacks Eaten (%)	—	—	—	0 -TW	0 -TW
Supplement Consumed (%)	—	—	—	0 -TW	0 -TW
Precautions					
Precautions	—	None -JK	—	None -TW	None -TW
Family/Significant Other Communication					
Family/Significant Other Update	—	—	—	Other (Comment) -TW	Other (Comment) -TW
Telemetry Details					
Telemetry Monitor On	—	—	Other (Comment) dc -CI	Yes -TW	Yes -TW

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	06/21/18 1200	06/21/18 1000	06/21/18 0800	06/21/18 04:07:21	06/20/18 23:57:07
Telemetry Audible	—	—	No -CI	Yes -TW	Yes -TW
Telemetry Box Number	—	—	— -CI	5208 -TW	5208 -TW
Telemetry Alarms Set	—	—	— -CI	Yes -TW	Yes -TW
Incentive Spirometer					
Is pt using incentive spirometer?	—	Yes, independent -JK	Yes, independent -CI	Yes, independent -TW	Yes, independent -TW

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 0800	06/20/18 0600	06/20/18 0400
Safe Environment					
Arm Bands On	—	ID;Allergies -TW	—	ID -JP	ID -JP
Safety Checks	—	Overbed table in reach -TW	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JP
Safety Alarm Verfied	—	No alarm -TW	—	No alarm -JP	No alarm -JP
Side Rails/Bed Safety	—	3/4 -TW	—	3/4 -JP	3/4 -JP
Fall Risk Interventions					
Fall Prevention Interventions	—	Yellow Armband, Socks -TW	—	Yellow Armband, Socks -JP	Yellow Armband, Socks -JP
Fall Prevention Education Reviewed with :	—	Patient -TW	—	Patient;Family -JP	Patient;Family -JP
Mobility					
Mobility Intervention	Ambulate in room -TW	Resting in bed -TW	—	Resting in bed -JP	Resting in bed -JP
Assistive Device	None -TW	—	—	—	—
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -TW	Standby assist, set-up cues, supervision of patient - no hands on -TW	—	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP
Distance Ambulated (ft)	20 ft -TW	—	—	—	—
Ambulation Response	Tolerated well -TW	Tolerated well -TW	—	—	—
Active Range of Motion	Active;All extremities -TW	Active;All extremities -TW	—	Active;All extremities -JP	Active;All extremities -JP
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -TW	Yes -TW	—	Yes -JP	Yes -JP
Repositioned	Turns self -TW	Turns self -TW	—	Turns self -JP	Turns self -JP
Heels/Feet	Heels elevated off bed -TW	Heels elevated off bed -TW	—	Heels elevated off bed -JP	Heels elevated off bed -JP
Hygiene					
Hygiene Performed	—	Patient/family refused -TW	—	—	—
Performed by	—	Self -TW	—	—	—
Anti-Embolism Devices					
Anti-Embolism Devices	—	Temporarily "Off" -TW	Off -DG	—	—
Patient Refused	—	Yes -TW	Yes -DG	—	—
Nutrition					
Feeding	—	Able to feed self -TW	—	—	—
Appetite	—	Good -TW	—	—	—
Diet Supplements	—	None -TW	—	—	—
Percent Meals Eaten (%)	—	0 % -TW	—	—	—
Snacks Eaten (%)	—	0 -TW	—	—	—
Supplement Consumed (%)	—	0 -TW	—	—	—
Precautions					
Precautions	—	None -TW	—	—	—
Family/Significant Other Communication					
Family/Significant Other Update	—	Called -TW	—	—	—

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	06/20/18 2133	06/20/18 19:43:22	06/20/18 0800	06/20/18 0600	06/20/18 0400
Telemetry Details					
Telemetry Monitor On	Yes -TS	Yes -TW	No -DG	—	—
Telemetry Audible	Yes -TS	Yes -TW	—	—	—
Telemetry Box Number	5208 -TS	5208 -TW	—	—	—
Telemetry Alarms Set	Yes -TS	Yes -TW	—	—	—
Incentive Spirometer					
Is pt using incentive spirometer?	Yes (independent) -TS	Yes, independent -TW	Yes (independent) -DG	—	—

Row Name	06/20/18 0200	06/20/18 0000	06/19/18 2200	06/19/18 2000	06/19/18 1600
Safe Environment					
Arm Bands On	ID -JP	ID -JP	ID -JP	ID -JP	ID -FT
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -JP	Overbed table in reach;Wheels on bed locked;Bed in lowest position;NonSkid Footwear on;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JP	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -FT
Safety Alarm Verfied	No alarm -JP	No alarm -JP	No alarm -JP	No alarm -JP	No alarm -FT
Side Rails/Bed Safety	3/4 -JP	3/4 -JP	3/4 -JP	3/4 -JP	3/4 -FT
Fall Risk Interventions					
Fall Prevention Interventions	Yellow Armband, Socks -JP	Yellow Armband, Socks -JP	Yellow Armband, Socks;Needed items within reach -JP	Yellow Armband, Socks;Needed items within reach -JP	Yellow Armband, Socks;Needed items within reach -FT
Fall Prevention Education Reviewed with :	Patient;Family -JP	Patient;Family -JP	Patient;Family -JP	Patient;Family -JP	Patient;Family -FT
Mobility					
Mobility Intervention	Resting in bed -JP	Resting in bed -JP	Resting in bed -JP	Resting in bed -JP	Resting in bed -FT
Assistive Device	—	—	—	—	None -FT
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -JP	Standby assist, set-up cues, supervision of patient - no hands on -FT
Active Range of Motion	Active;All extremities -JP	Active;All extremities -JP	Active;All extremities -JP	Active;All extremities -JP	Active;All extremities -FT
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -JP	Yes -JP	Yes -JP	Yes -JP	Yes -FT
Repositioned	Turns self -JP	Turns self -JP	Turns self -JP	Turns self -JP	Turns self -FT
Heels/Feet	Heels elevated off bed -JP	Heels elevated off bed -JP	Heels elevated off bed -JP	Heels elevated off bed -JP	Heels elevated off bed -FT
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	—	Off -EE	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	Yes (independent) -EE	—

Row Name	06/19/18 1429	06/19/18 1118	06/19/18 1000	06/19/18 0800	06/19/18 0600
Safe Environment					
Arm Bands On	ID -FT	—	ID -DF	ID -DF	ID;Allergies -MJ
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -FT	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -DF	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -DF	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ
Safety Alarm Verfied	No alarm -FT	—	No alarm -DF	No alarm -DF	No alarm -MJ
Side Rails/Bed Safety	3/4 -FT	—	3/4 -DF	3/4 -DF	3/4 -MJ
Fall Risk Interventions					
Fall Prevention Interventions	Yellow Armband, Socks;Needed items within reach -FT	—	Frequent Visual Checks/Rounding;Needed items within reach -DF	Frequent Visual Checks/Rounding;Needed items within reach -DF	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ
Fall Prevention Education Reviewed	Patient;Family -FT	—	Patient -DF	Patient -DF	Patient -MJ

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	06/19/18 1429	06/19/18 1118	06/19/18 1000	06/19/18 0800	06/19/18 0600
with :					
Mobility					
Mobility Intervention	Ambulate in room;Resting in bed -FT	—	Resting in bed -DF	Resting in bed -DF	Resting in bed -MJ
Assistive Device	None -FT	—	—	—	—
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -FT	—	Standby assist, set-up cues, supervision of patient - no hands on -DF	Standby assist, set-up cues, supervision of patient - no hands on -DF	Standby assist, set-up cues, supervision of patient - no hands on -MJ
Active Range of Motion	Active;All extremities -FT	—	Active;All extremities -DF	Active;All extremities -DF	Active;All extremities -MJ
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -FT	—	Yes -DF	Yes -DF	Yes -MJ
Repositioned	Turns self -FT	—	Turns self -DF	Turns self -DF	Turns self -MJ
Heels/Feet	Heels elevated off bed -FT	—	—	—	—
Hygiene					
Skin Prep for Procedure	—	No -PM	—	—	—
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	—	Off -JI	—
Patient Refused	—	—	—	Yes -JI	—
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	Yes (independent) -JI	—

Row Name	06/19/18 0400	06/19/18 0200	06/19/18 0000	06/18/18 2200	06/18/18 2000
Safe Environment					
Arm Bands On	ID;Allergies -RM	ID;Allergies -RM	ID;Allergies -MJ	ID;Allergies -MJ	ID;Allergies -MJ
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -MJ
Safety Alarm Verfied	No alarm -RM	No alarm -RM	No alarm -MJ	No alarm -MJ	No alarm -MJ
Side Rails/Bed Safety	3/4 -RM	3/4 -RM	3/4 -MJ	3/4 -MJ	3/4 -MJ
Fall Risk Interventions					
Fall Prevention Interventions	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -RM	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -RM	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -MJ
Fall Prevention Education Reviewed with :	Patient -RM	Patient -RM	Patient -MJ	Patient -MJ	Patient -MJ
Mobility					
Mobility Intervention	Resting in bed -RM	Resting in bed -RM	Resting in bed -MJ	Resting in bed -MJ	Resting in bed -MJ
Assistive Device	—	—	—	—	None -RM
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -RM	Standby assist, set-up cues, supervision of patient - no hands on -RM	Standby assist, set-up cues, supervision of patient - no hands on -MJ	Standby assist, set-up cues, supervision of patient - no hands on -MJ	Standby assist, set-up cues, supervision of patient - no hands on -MJ
Active Range of Motion	Active;All extremities -RM	Active;All extremities -RM	Active;All extremities -MJ	Active;All extremities -MJ	Active;All extremities -RM
Transport Method	—	—	—	—	Bed -RM
Patient Position					
Head of Bed Elevated > / = 30 degrees	Yes -RM	Yes -RM	Yes -MJ	Yes -MJ	Yes -MJ
Repositioned	Turns self -RM	Turns self -RM	Turns self -MJ	Turns self -MJ	Turns self -MJ
Heels/Feet	—	—	—	—	Heels elevated off bed -RM
Hygiene					
Hygiene Performed	—	—	—	—	Hand hygiene -RM
Performed by	—	—	—	—	Self -RM

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	06/19/18 0400	06/19/18 0200	06/19/18 0000	06/18/18 2200	06/18/18 2000
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	—	—	Off -RM
Patient Refused	—	—	—	—	Yes -RM
Nutrition					
Feeding	—	—	—	—	Able to feed self -RM
Precautions					
Precautions	Fall;Bleeding -RM	Fall;Bleeding -RM	Fall;Bleeding -RM	Fall;Bleeding -RM	Fall;Bleeding -RM
Family/Significant Other Communication					
Family/Significant Other Update	—	—	—	—	Updated;Visiting -RM
Telemetry Details					
Telemetry Monitor On	—	—	—	—	No -RM
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	—	—	Yes (independent) -RM

Row Name	06/18/18 1819	06/18/18 1600	06/18/18 1400	06/18/18 1345	06/18/18 1303
Safe Environment					
Arm Bands On	—	ID;Allergies -JD	ID;Allergies -JD	—	—
Safety Checks	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	—	—
Safety Alarm Verfied	—	No alarm -JD	No alarm -JD	—	—
Side Rails/Bed Safety	—	3/4 -JD	3/4 -JD	—	—
Fall Risk Interventions					
Fall Prevention Interventions	—	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	—	—
Fall Prevention Education Reviewed with :	—	Patient;Family -JD	Patient;Family -JD	—	—
Mobility					
Mobility Intervention	—	Chair -JD	Chair -JD	Bathroom privileges;Back to bed -JI	—
Assistive Device	—	None -JD	—	None -JI	—
Level of Assistance	—	Standby assist, set-up cues, supervision of patient - no hands on -JD	Standby assist, set-up cues, supervision of patient - no hands on -JD	Standby assist, set-up cues, supervision of patient - no hands on -JI	—
Patient Position					
Repositioned	—	Up in chair -JD	Up in chair -JD	—	—
Nutrition					
Percent Meals Eaten (%)	100 % Dinner. -JI	—	—	—	95 % Lunch -JI

Row Name	06/18/18 1205	06/18/18 1000	06/18/18 0800	06/18/18 0600	06/18/18 0400
Safe Environment					
Arm Bands On	—	ID;Allergies -JD	ID;Allergies -JD	ID;Allergies;Blood bank -RM	ID;Allergies;Blood bank -RM
Safety Checks	—	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	Overbed table in reach;Bed in lowest position;Wheels on bed locked;Call light in reach -JD	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM
Safety Alarm Verfied	—	No alarm -JD	No alarm -JD	No alarm -RM	No alarm -RM
Side Rails/Bed Safety	—	3/4 -JD	3/4 -JD	3/4 -RM	3/4 -RM
Fall Risk Interventions					
Fall Prevention Interventions	—	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	Yellow Armband, Socks;Frequent Visual Checks/Rounding;Needed items within reach -JD	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	06/18/18 1205	06/18/18 1000	06/18/18 0800	06/18/18 0600	06/18/18 0400
				lighting;Orient to environment -RM	lighting;Orient to environment -RM
Fall Prevention Education Reviewed with :	—	Patient;Family -JD	Patient;Family -JD	Patient;Family;Education Activity Updated -RM	Patient;Family;Education Activity Updated -RM
Mobility					
Mobility Intervention	Ambulate in room;Bathroom privileges;Chair -JI	Bathroom privileges -JD	Bathroom privileges -JD	Ambulate in room;Up ad lib -RM	Ambulate in room;Up ad lib -RM
Assistive Device	None -JI	None -JD	None -JD	None -RM	None -RM
Level of Assistance	Standby assist, set-up cues, supervision of patient - no hands on -JI	Independent -JD	Independent -JD	Independent -RM	Independent -RM
Active Range of Motion	—	Active;All extremities -JD	Active;All extremities -JD	Active;All extremities -RM	Active;All extremities -RM
Transport Method	—	—	—	Bed -RM	Bed -RM
Patient Position					
Head of Bed Elevated > / = 30 degrees	—	Yes -JD	Yes -JD	Yes Simultaneous filing. User may be unaware of other data. -LT	Yes -RM
Repositioned	—	Turns self -JD	Turns self -JD	Turns self Simultaneous filing. User may be unaware of other data. -LT	Turns self -RM
Heels/Feet	—	Heels elevated off bed -JD	Heels elevated off bed -JD	Heels elevated off bed -RM	Heels elevated off bed -RM
Anti-Embolism Devices					
Anti-Embolism Devices	—	—	Off -JI	—	—
Patient Refused	—	—	Yes -JI	—	—
Nutrition					
Feeding	—	—	—	Able to feed self -RM	Able to feed self -RM
Precautions					
Precautions	—	—	—	Fall;Bleeding -RM	Fall;Bleeding -RM
Telemetry Details					
Telemetry Monitor On	—	—	—	No -RM	No -RM
Incentive Spirometer					
Is pt using incentive spirometer?	—	—	Yes (independent) -JI	Yes (independent) -RM	Yes (independent) -RM

Row Name	06/18/18 0200	06/18/18 0000	06/17/18 1538
Safe Environment			
Arm Bands On	ID;Allergies;Blood bank -RM	ID;Allergies;Blood bank -RM	—
Safety Checks	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM	Overbed table in reach;Bed in lowest position;Wheels on bed locked;NonSkid Footwear on;Call light in reach -RM	—
Safety Alarm Verfied	No alarm -RM	No alarm -RM	—
Side Rails/Bed Safety	3/4 -RM	3/4 -RM	—
Fall Risk Interventions			
Fall Prevention Interventions	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Orient to environment -RM	"Call, Don't Fall" Doorsign;Frequent Visual Checks/Rounding;Needed items within reach;Adequate room lighting;Orient to environment -RM	—
Fall Prevention Education Reviewed with :	Patient;Family;Education Activity Updated -RM	Patient;Family;Education Activity Updated -RM	—
Mobility			
Mobility Intervention	Ambulate in room;Up ad lib -RM	Ambulate in room;Up ad lib -RM	—

Flowsheets (all recorded) (continued)

Daily Cares (continued)

Row Name	06/18/18 0200	06/18/18 0000	06/17/18 1538
Assistive Device	None -RM	None -RM	—
Level of Assistance	Independent -RM	Independent -RM	—
Active Range of Motion	Active;All extremities -RM	Active;All extremities -RM	—
Transport Method	Bed -RM	Bed -RM	—
Patient Position			
Head of Bed Elevated > / = 30 degrees	Yes -RM	Yes -LT	—
Repositioned	Turns self -RM	Turns self -LT	—
Heels/Feet	Heels elevated off bed -RM	Heels elevated off bed -RM	—
Hygiene			
Hygiene Performed	—	Peri care;Hand hygiene -RM	—
Performed by	—	Self -RM	—
Anti-Embolism Devices			
Anti-Embolism Devices	—	Off -RM	—
Bilateral Sequential	—	Yes -RM	—
Nutrition			
Feeding	Able to feed self -RM	Able to feed self -RM	—
Precautions			
Precautions	Fall;Bleeding -RM	Fall;Bleeding -RM	—
Family/Significant Other Communication			
Family/Significant Other Update	—	Updated -RM	—
Telemetry Details			
Telemetry Monitor On	No -RM	No -RM	Yes -RG
Telemetry Box Number	—	—	5175 -RG
Incentive Spirometer			
Is pt using incentive spirometer?	Yes (independent) -RM	Yes (independent) -RM	—

Flowsheets (all recorded)

Critical Care VS, Intake/Output

Row Name	06/21/18 11:36:09	06/21/18 1000	06/21/18 0830	06/21/18 07:35:36	06/21/18 0545
Vital Signs					
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	—	98 °F (36.7 °C) -DI (r) CI (t)	—
Temp src	Oral -CI	—	—	Oral -CI	—
Pulse	60 -DI (r) CI (t)	—	—	62 -DI (r) CI (t)	—
Heart Rate Source	Monitor -CI	—	—	Monitor -CI	—
Resp	18 -CI	—	—	18 -CI	—
BP	123/59 -DI (r) CI (t)	—	—	137/64 -DI (r) CI (t)	—
BP Location	Right arm -CI	—	—	Right arm -CI	—
BP Method	Portable -CI	—	—	Portable -CI	—
Patient Position	Supine -CI	—	—	Supine -CI	—
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	—	95 % -DI (r) CI (t)	—
O2 Device	None (Room air) -CI	—	None (Room air) -AM	None (Room air) -CI	—
Pain Assessment					
Currently in Pain	—	—	No -AM	—	No -TS
Which Pain Assessment Tool ?	—	—	—	—	Numeric (0-10) -TS
Pain Intervention(s)	—	—	Declines -AM	—	Rest -TS
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -AM	—	0 -TS
Intake (mL)					
P.O.	—	240 mL -JK	—	—	—
Percent Meals Eaten (%)	—	100 % -JK	—	—	—

Row Name	06/21/18 04:07:21	06/21/18 0030	06/20/18 23:57:07	06/20/18 2133	06/20/18 2000
Vital Signs					
Temp	98 °F (36.7 °C) -DI (r) TW (t)	—	98.4 °F (36.9 °C) -DI (r) TW (t)	—	—
Temp src	Oral -TW	—	Oral -TW	—	—
Pulse	63 -DI (r) TW (t)	—	109 -DI (r) TW (t)	—	—
Heart Rate Source	Monitor -TW	—	Monitor -TW	—	—
Resp	18 -DI (r) TW (t)	—	16 -DI (r) TW (t)	—	—
BP	121/58 -DI (r) TW (t)	—	124/53 -DI (r) TW (t)	—	—
BP Location	Right arm -TW	—	Right arm -TW	—	—
BP Method	Portable -TW	—	Portable -TW	—	—
Patient Position	Supine -TW	—	Supine -TW	—	—
Oxygen Therapy					
SpO2	93 % -DI (r) TW (t)	—	93 % -DI (r) TW (t)	—	—
O2 Device	None (Room air) -TW	—	None (Room air) -TW	None (Room air) -TS	—
Pain Assessment					
Currently in Pain	—	Resting quietly -TS	—	No -TS	—
Which Pain Assessment Tool ?	—	FACES -TS	—	Numeric (0-10) -TS	—
Pain Intervention(s)	—	Rest -TS	—	Rest;Declines -TS	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	0 -TS	—
FACES Pain Rating 1					
FACES Pain Rating	—	0-No hurt -TS	—	—	—
Intake (mL)					
P.O.	0 mL -TW	—	0 mL -TW	—	—
Percent Meals Eaten (%)	0 % -TW	—	0 % -TW	—	—
Snacks Eaten (%)	0 -TW	—	0 -TW	—	—
Supplement Consumed (%)	0 -TW	—	0 -TW	—	—
Urine Output					
Urine Occurrence	1 -TW	—	1 -TW	—	1 -TW

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/21/18 04:07:21	06/21/18 0030	06/20/18 23:57:07	06/20/18 2133	06/20/18 2000
Stool Output					
Stool Occurrence	0 -TW	—	0 -TW	—	0 -TW
Stool Appearance	Unable to assess -TW	—	Unable to assess -TW	—	Unable to assess -TW
Emesis Output					
Emesis Occurrence	0 -TW	—	0 -TW	—	0 -TW

Row Name	06/20/18 19:43:22	06/20/18 15:50:04	06/20/18 1458	06/20/18 14:02:02	06/20/18 1000
Vital Signs					
Temp	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)	—	98.2 °F (36.8 °C) -DI (r) LF (t)	—
Temp src	Oral -TW	—	—	—	—
Pulse	66 -DI (r) TW (t)	62 -DI (r) LF (t)	—	61 -DI (r) LF (t)	61 -DG
Heart Rate Source	Monitor -TW	—	—	—	—
Resp	16 -DI (r) TW (t)	17 -DI (r) LF (t)	—	—	18 -DG
BP	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)	—	104/66 -DI (r) LF (t)	122/54 -DG
MAP (mmHg)	—	—	—	—	71 mm Hg -DG
BP Location	Right arm -TW	—	—	—	—
BP Method	Portable -TW	—	—	—	—
Patient Position	Supine -TW	—	—	—	—
Oxygen Therapy					
SpO2	93 % -DI (r) TW (t)	**(!) 89 %** -DI (r) LF (t)	—	92 % -DI (r) LF (t)	**(!) 88 %** -DG
O2 Device	None (Room air) -TW	—	None (Room air) -MS	—	—
QT Monitoring					
QT Interval	—	—	—	—	**(!) 480 ms** -DG
QTC	—	—	—	—	**(!) 484 ms** -DG
Intake (mL)					
P.O.	0 mL -TW	—	—	—	—
Percent Meals Eaten (%)	0 % -TW	—	—	—	—
Snacks Eaten (%)	0 -TW	—	—	—	—
Supplement Consumed (%)	0 -TW	—	—	—	—
Urine Output					
Urine Occurrence	0 -TW	—	—	—	—
Stool Output					
Stool Occurrence	0 -TW	—	—	—	—
Bowel Incontinence	—	—	No -MS	—	—
Stool Amount	—	—	Unable to assess -MS	—	—
Stool Appearance	Unable to assess -TW	—	Unable to assess -MS	—	—
Stool Color	—	—	Unable to assess -MS	—	—
Emesis Output					
Emesis Occurrence	0 -TW	—	—	—	—

Row Name	06/20/18 0912	06/20/18 0909	06/20/18 0900	06/20/18 0830	06/20/18 0800
Vital Signs					
Pulse	—	59 -DG	60 -DG	—	58 -DG
Resp	—	—	17 -DG	—	18 -DG
BP	—	**(!) 122/49** -DG	**(!) 122/49** -DG	—	138/62 -DG
MAP (mmHg)	—	—	68 mm Hg -DG	—	81 mm Hg -DG
Oxygen Therapy					
SpO2	—	—	**(!) 87 %** -DG	—	**(!) 88 %** -DG
O2 Device	—	—	—	—	None (Room air) -DG
Pulse Oximetry Type	—	—	—	—	Continuous -DG
QT Monitoring					
QT Interval	—	—	**(!) 488 ms** -DG	—	**(!) 472 ms** -DG
QTC	—	—	**(!) 492 ms** -DG	—	468 ms -DG
Pain Assessment					
Currently in Pain	—	—	—	Unable to Assess Simultaneous filing. User may be unaware of other data. -MS	—
Which Pain Assessment Tool ?	—	—	—	Numeric (0-10) Simultaneous filing. User	—

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/20/18 0912	06/20/18 0909	06/20/18 0900	06/20/18 0830	06/20/18 0800
				may be unaware of other data. -MS	
Multiple Pain Sites	—	—	—	No -MS	—
Pain Intervention(s)	—	—	—	Rest -MS	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	0 Simultaneous filing. User may be unaware of other data. -MS	—
Clinical Progression 1	—	—	—	Resolved -MS	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB ADD-vantage					
Piggyback Dose	*4.5 g -DG	—	—	—	—
Stool Output					
Bowel Incontinence	—	—	—	—	No -DG

Row Name	06/20/18 0730	06/20/18 0600	06/20/18 0500	06/20/18 0400	06/20/18 0300
Vital Signs					
Temp	98.3 °F (36.8 °C) -HT	—	—	98 °F (36.7 °C) -JP	—
Temp src	Oral -HT	—	—	Oral -JP	—
Pulse	—	59 -EE	57 -EE	56 -EE	57 -EE
Resp	—	20 -EE	20 -EE	19 -EE	21 -EE
BP	—	129/57 -EE	130/50 -EE	119/51 -EE	122/58 -EE
MAP (mmHg)	—	74 mm Hg -EE	70 mm Hg -EE	67 mm Hg -EE	73 mm Hg -EE
Oxygen Therapy					
SpO2	—	93 % -EE	94 % -EE	94 % -EE	97 % -EE
Pain Assessment					
Currently in Pain	Yes -DG	—	—	—	—
Which Pain Assessment Tool ?	Numeric (0-10) -DG	—	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	2 -DG	—	—	—	—
Pain Onset 1	Gradual -DG	—	—	—	—
Pain Location 1	Back -DG	—	—	—	—
Pain Location Orientation 1	Anterior -DG	—	—	—	—
Pain Quality 1	Aching -DG	—	—	—	—
Pain Type 1	Acute pain -DG	—	—	—	—
Aggravating Factors	Movement -DG	—	—	—	—
Alleviating Factors 1	Medication;Positioning -DG	—	—	—	—
Urine Output					
Urine	200 mL -HT	—	350 mL -EE	— -EE	—

Row Name	06/20/18 0200	06/20/18 0118	06/20/18 0000	06/19/18 2300	06/19/18 2200
Vital Signs					
Temp	—	—	97.5 °F (36.4 °C) -JP	—	—
Temp src	—	—	Axillary -JP	—	—
Pulse	64 -EE	—	59 -EE	61 -EE	62 -EE
Resp	16 -EE	—	22 -EE	21 -EE	22 -EE
BP	(!) 111/47 -EE	—	—	128/56 -EE	132/51 -EE
MAP (mmHg)	62 mm Hg -EE	—	—	—	73 mm Hg -EE
Oxygen Therapy					
SpO2	91 % -EE	—	90 % -EE	97 % -EE	96 % -EE
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB ADD-vantage					
Piggyback Dose	—	*4.5 g 100 ml sodium chloride not available in Omnicel -EE	—	—	—

Row Name	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800	06/19/18 1700
Vital Signs					
Temp	—	98.4 °F (36.9 °C) -JP	—	—	—
Temp src	—	Oral -JP	—	—	—
Pulse	61 -EE	63 -EE	64 -EE	61 -JI	59 -JI
Resp	16 -EE	21 -EE	19 -EE	25 -JI	21 -JI

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800	06/19/18 1700
BP	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI	132/52 -JI
MAP (mmHg)	77 mm Hg -EE	76 mm Hg -EE	77 mm Hg -EE	72 mm Hg -JI	73 mm Hg -JI
Oxygen Therapy					
SpO2	94 % -EE	94 % -EE	94 % -EE	92 % -JI	96 % -JI
O2 Device	—	Nasal cannula -EE	—	—	—
O2 Flow Rate (L/min)	—	2 L/min -EE	—	—	—
Pulse Oximetry Type	—	Continuous -EE	—	—	—
Pain Assessment History					
Previous experiences with pain?	—	No -EE	—	—	—
History of Chronic Pain?	—	No -EE	—	—	—
Pain Assessment					
Currently in Pain	—	Resting quietly -EE	—	—	—
Which Pain Assessment Tool ?	—	Numeric (0-10) -EE	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -EE	—	—	—
Urine Output					
Urine	—	400 mL -JP	—	—	—
Urine Occurrence	—	1 -EE	—	—	—
Bladder Status (use only for bladder training)	—	Continent -EE	—	—	—
Stool Output					
Bowel Incontinence	—	No -EE	—	—	—
Stool Amount	—	Unable to assess -EE	—	—	—
Stool Appearance	—	Unable to assess -EE	—	—	—
Stool Color	—	Unable to assess -EE	—	—	—

Row Name	06/19/18 1654	06/19/18 1644	06/19/18 1600	06/19/18 1500	06/19/18 1433
Vital Signs					
Temp	—	97.9 °F (36.6 °C) -FT	—	—	—
Temp src	—	Oral -FT	—	—	—
Pulse	—	—	58 -JI	56 -JI	—
Resp	—	—	20 -JI	22 -JI	—
BP	—	—	134/58 -JI	130/51 -JI	—
MAP (mmHg)	—	—	76 mm Hg -JI	69 mm Hg -JI	—
Oxygen Therapy					
SpO2	—	—	95 % -JI	96 % -JI	—
Pain Assessment					
Currently in Pain	—	—	No -JI	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -JI	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -JI	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB ADD-vantage					
Piggyback Dose	*4.5 g -JI	—	—	—	—
Urine Output					
Urine Occurrence	—	—	—	—	1 -JI

Row Name	06/19/18 1430	06/19/18 1428	06/19/18 1335	06/19/18 1330	06/19/18 1325
Vital Signs					
Temp	—	97.7 °F (36.5 °C) -FT	—	—	—
Temp src	—	Oral -FT	—	—	—
Pulse	57 -JI	—	54 -LFA	54 -LFA	53 -LFA
Resp	19 -JI	—	22 -LFA	19 -LFA	21 -LFA
BP	142/60 -JI	—	123/59 -LFA	128/55 -LFA	(!) 95/46 -LFA
MAP (mmHg)	82 mm Hg -JI	—	—	—	—
Oxygen Therapy					

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/19/18 1430	06/19/18 1428	06/19/18 1335	06/19/18 1330	06/19/18 1325
SpO2	96 % -JI	—	100 % -LFA	97 % -LFA	92 % -LFA
O2 Device	Nasal cannula -JI	—	—	—	—
O2 Flow Rate (L/min)	2 L/min -JI	—	—	—	—
Pulse Oximetry Type	Continuous -JI	—	—	—	—

Row Name	06/19/18 1321	06/19/18 1311	06/19/18 1311	06/19/18 1303	06/19/18 1129
Vital Signs					
Pulse	53 -CR	—	—	—	—
Resp	18 -CR	—	—	—	—
BP	110/53 -CR	—	—	—	—
Oxygen Therapy					
SpO2	93 % -CR	—	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -CR	—	—	—	—
sodium chloride 0.9% (NS) infusion					
Rate	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -CM	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -PM
Volume (mL)	—	200 mL -CM	—	—	—
propofol					
propofol Bolus Dose (mg)	—	—	—	130 mg -CM	—
propofol Rate	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -CM	—
propofol Concentration	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -CM	—

Row Name	06/19/18 1114	06/19/18 1039	06/19/18 1037	06/19/18 1031	06/19/18 1000
Vital Signs					
Pulse	51 -PM	—	—	—	50 -JI
Heart Rate Source	Monitor -PM	—	—	—	—
Resp	13 -PM	—	—	—	20 -JI
BP	123/54 -PM	—	—	—	**(!) 124/49** -JI
MAP (mmHg)	—	—	—	—	68 mm Hg -JI
Patient Position	Sitting -PM	—	—	—	—
Oxygen Therapy					
SpO2	98 % -PM	—	—	—	92 % -JI
O2 Device	Nasal cannula -PM	—	—	None (Room air) -JI	—
O2 Flow Rate (L/min)	3 L/min -PM	—	—	—	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Dose	—	*0 mL EGD. -JI	—	—	—
Urine Output					
Urine	—	—	300 mL -JI	—	—

Row Name	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700	06/19/18 0600
Vital Signs					
Temp	—	—	98.6 °F (37 °C) -DF	—	—
Temp src	—	—	Oral -DF	—	—
Pulse	51 -JI	55 -JI	56 -JI	63 -JI	52 -RM
Resp	18 -JI	—	18 -JI	18 -JI	17 -RM
BP	**(!) 119/44** -JI	**(!) 126/47** -JI	**(!) 126/47** -JI	143/52 -JI	**(!) 109/40** -RM
MAP (mmHg)	62 mm Hg -JI	—	66 mm Hg -JI	76 mm Hg -JI	**(!) 56 mm Hg** -RM
Oxygen Therapy					
SpO2	95 % -JI	—	97 % -JI	96 % -JI	94 % -RM
O2 Device	—	—	Nasal cannula -JI	—	—
O2 Flow Rate (L/min)	—	—	2 L/min -JI	—	—

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/19/18 0900	06/19/18 0808	06/19/18 0800	06/19/18 0700	06/19/18 0600
Pulse Oximetry Type	—	—	Continuous -JI	—	—
QT Monitoring					
QT Interval	—	—	—	—	(!) 560 ms -RM
QTC	—	—	—	—	(!) 521 ms -RM
Pain Assessment					
Currently in Pain	—	—	No -JI	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -JI	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -JI	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Volume (mL)	—	—	—	—	0 -RM
pantoprazole					
pantoprazole Volume (mL)	—	—	—	—	200 mL -RM
Urine Output					
Urine	450 mL -DF	—	—	—	—

Row Name	06/19/18 0500	06/19/18 0445	06/19/18 0400	06/19/18 0300	06/19/18 0200
Vital Signs					
Temp	—	—	98.2 °F (36.8 °C) -MJ	—	—
Pulse	53 -RM	—	55 -RM	55 -RM	54 -RM
Heart Rate Source	Monitor -RM	—	Monitor -RM	Monitor -RM	Monitor -RM
Resp	17 -RM	—	20 -RM	16 -RM	19 -RM
BP	(!) 124/49 -RM	—	127/55 -RM	120/59 -RM	113/50 -RM
MAP (mmHg)	68 mm Hg -RM	—	73 mm Hg -RM	73 mm Hg -RM	62 mm Hg -RM
BP Location	Right arm -RM	—	Right arm -RM	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM
Patient Position	Sitting -RM	—	Supine -RM	Lying right side -RM	Lying right side -RM
Oxygen Therapy					
SpO2	96 % -RM	—	98 % -RM	92 % -RM	93 % -RM
O2 Device	Nasal cannula -RM	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	—	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	—	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	—	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	—	No -RM	No -RM	No -RM
QT Monitoring					
QT Interval	(!) 488 ms -RM	—	(!) 496 ms -RM	(!) 496 ms -RM	(!) 528 ms -RM
QTC	463 ms -RM	—	(!) 479 ms -RM	466 ms -RM	(!) 501 ms -RM
Intake (mL)					
P.O.	—	—	250 mL -RM	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	*4.5 g -RM	—	—	—
Piggyback Volume (mL)	—	100 -RM	—	—	—
magnesium sulfate					
Latest MgSO4 serum level	—	2.3	—	—	—
Urine Output					
Urine	250 mL -RM	—	—	300 mL -RM	—
Bladder Status (use only for bladder training)	—	—	Continent -RM	—	Continent -RM
Stool Output					
Bowel Incontinence	—	—	No -RM	—	No -RM
Stool Amount	—	—	Unable to assess -RM	—	Unable to assess -RM
Stool Appearance	—	—	Unable to assess -RM	—	Unable to assess -RM
Stool Color	—	—	Unable to assess -RM	—	Unable to assess -RM

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/19/18 0500	06/19/18 0445	06/19/18 0400	06/19/18 0300	06/19/18 0200
Patient Observation					
Observations	—	—	Resting in bed, alert -RM	—	Resting in bed, alert -RM
24 Chart Check					
24 hour chart check complete	—	—	Yes -RM	—	Yes -RM

Row Name	06/19/18 0100	06/19/18 0000	06/18/18 2300	06/18/18 2200	06/18/18 2100
Vital Signs					
Temp	—	98.1 °F (36.7 °C) -MJ	—	—	—
Pulse	53 -RM	56 -RM	59 -RM	55 -RM	56 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	19 -RM	21 -RM	20 -RM	21 -RM	21 -RM
BP	**(!) 109/44** -RM	**(!) 123/43** -RM	127/59 -RM	—	—
MAP (mmHg)	61 mm Hg -RM	61 mm Hg -RM	75 mm Hg -RM	—	—
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM	—
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—
Patient Position	Lying left side -RM	Lying left side -RM	Lying left side -RM	Supine -RM	—
Oxygen Therapy					
SpO2	92 % -RM	94 % -RM	97 % -RM	99 % -RM	99 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM
QT Monitoring					
QT Interval	**(!) 536 ms** -RM	**(!) 488 ms** -RM	**(!) 488 ms** -RM	**(!) 496 ms** -RM	**(!) 480 ms** -RM
QTC	**(!) 504 ms** -RM	**(!) 476 ms** -RM	**(!) 484 ms** -RM	**(!) 475 ms** -RM	464 ms -RM
Pain Assessment History					
Previous experiences with pain?	—	—	—	—	No -RM
Pain Assessment					
Currently in Pain	—	—	—	—	No -RM
Which Pain Assessment Tool ?	—	—	—	—	Numeric (0-10) -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	—	0 -RM
Urine Output					
Urine	—	200 mL -MJ	—	—	—
Bladder Status (use only for bladder training)	—	Continent -RM	—	Continent -RM	—
Stool Output					
Bowel Incontinence	—	No -RM	—	No -RM	—
Stool Amount	—	Unable to assess -RM	—	Unable to assess -RM	—
Stool Appearance	—	Unable to assess -RM	—	Unable to assess -RM	—
Stool Color	—	Unable to assess -RM	—	Unable to assess -RM	—
Patient Observation					
Observations	—	Resting in bed, alert -RM	—	Resting in bed, alert -RM	—
24 Chart Check					
24 hour chart check complete	—	Yes -RM	—	Yes -RM	—

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1819	06/18/18 1804	06/18/18 1803
Vital Signs					
Temp	98.4 °F (36.9 °C) -MJ	—	—	—	—
Pulse	56 -RM	56 -RM	—	—	—
Heart Rate Source	Monitor -RM	Monitor -RM	—	—	—
Resp	22 -RM	22 -RM	—	—	—
Oxygen Therapy					
SpO2	96 % -RM	**(!) 89 %** -RM	—	—	—

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/18/18 2000	06/18/18 1900	06/18/18 1819	06/18/18 1804	06/18/18 1803
O2 Device	Nasal cannula -RM	Nasal cannula -RM	—	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	—	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	—	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	—	—	—
POX Probe Site Changed	No -RM	No -RM	—	—	—
QT Monitoring					
QT Interval	(!) **488 ms** -RM	(!) **496 ms** -RM	—	—	—
QTC	(!) **471 ms** -RM	(!) **475 ms** -RM	—	—	—
Pain Assessment History					
Previous experiences with pain?	No -RM	No -RM	—	—	—
Patient's Stated Pain Goal	0 (No Pain) -RM	—	—	—	—
Pain Assessment					
Currently in Pain	No -RM	No -RM	—	—	—
Which Pain Assessment Tool ?	Numeric (0-10) -RM	Numeric (0-10) -RM	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	—	—	—
Intake (mL)					
Percent Meals Eaten (%)	—	—	100 % Dinner. -JI	—	—
Saline Flush (mL)	—	—	—	—	40 mL -JI
sodium chloride 0.9% (NS) infusion					
Volume (mL)	1400 mL -RM	—	—	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	—	—	*4.5 g -JI	—
Piggyback Volume (mL)	200 -RM	—	—	—	—
pantoprazole					
pantoprazole Volume (mL)	200 mL -RM	—	—	—	—
Urine Output					
Urine Occurrence	0 -RM	—	—	—	—
Bladder Status (use only for bladder training)	Continent -RM	—	—	—	—
Stool Output					
Stool Occurrence	0 -RM	—	—	—	—
Bowel Incontinence	No -RM	—	—	—	—
Stool Amount	Unable to assess -RM	—	—	—	—
Stool Appearance	Unable to assess -RM	—	—	—	—
Stool Color	Unable to assess -RM	—	—	—	—
Emesis Output					
Emesis Occurrence	0 -RM	—	—	—	—
Emesis Appearance	— na -RM	—	—	—	—
Patient Observation					
Observations	Resting in bed, alert -RM	—	—	—	—
24 Chart Check					
24 hour chart check complete	Yes -RM	—	—	—	—

Row Name	06/18/18 1800	06/18/18 1727	06/18/18 1600	06/18/18 1500	06/18/18 1400
Vital Signs					
Temp	—	98.1 °F (36.7 °C) -JD	—	—	—
Temp src	—	Oral -JD	—	—	—
Pulse	56 -RM	—	52 -JI	54 -JI	58 -JI
Resp	20 -RM	—	20 -JI	18 -JI	19 -JI
BP	132/60 -RM	—	142/57 -JI	151/56 -JI	134/53 -JI

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/18/18 1800	06/18/18 1727	06/18/18 1600	06/18/18 1500	06/18/18 1400
MAP (mmHg)	75 mm Hg -RM	—	76 mm Hg -JI	79 mm Hg -JI	72 mm Hg -JI
Oxygen Therapy					
SpO2	94 % -RM	—	(!) 87 % -JI	95 % -JI	91 % -JI
QT Monitoring					
QT Interval	**(!) 472 ms** -RM	—	—	—	—
QTC	456 ms -RM	—	—	—	—
Pain Assessment					
Currently in Pain	—	—	No -JI	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -JI	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -JI	—	—

Row Name	06/18/18 1345	06/18/18 1303	06/18/18 1300	06/18/18 1247	06/18/18 1230
Vital Signs					
Temp	—	—	—	—	97.7 °F (36.5 °C) -JD
Temp src	—	—	—	—	Oral -JD
Pulse	—	—	57 -JI	—	—
Resp	—	—	15 -JI	—	—
BP	—	—	**(!) 130/45** -JI	—	—
MAP (mmHg)	—	—	65 mm Hg -JI	—	—
Oxygen Therapy					
SpO2	—	—	93 % -JI	—	—
Intake (mL)					
Percent Meals Eaten (%)	—	95 % Lunch -JI	—	—	—
Saline Flush (mL)	—	—	—	20 mL -JI	—
Urine Output					
Urine Occurrence	1 -JI	—	—	—	—

Row Name	06/18/18 1205	06/18/18 1200	06/18/18 1100	06/18/18 1000	06/18/18 0916
Vital Signs					
Pulse	—	52 -JI	50 -JI	51 -JI	—
Resp	—	18 -JI	17 -JI	16 -JI	—
BP	—	140/56 -JI	**(!) 128/46** -JI	131/52 -JI	—
MAP (mmHg)	—	77 mm Hg -JI	66 mm Hg -JI	72 mm Hg -JI	—
Oxygen Therapy					
SpO2	—	—	97 % -JI	98 % -JI	—
Pain Assessment					
Currently in Pain	—	No -JI	—	—	—
Which Pain Assessment Tool ?	—	Numeric (0-10) -JI	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JI	—	—	—
Urine Output					
Urine	—	—	—	—	150 mL -JI
Urine Occurrence	1 -JI	—	—	—	—

Row Name	06/18/18 0907	06/18/18 0900	06/18/18 0848	06/18/18 0831	06/18/18 0800
Vital Signs					
Temp	—	—	—	97.8 °F (36.6 °C) -JD	—
Temp src	—	—	—	Oral -JD	—
Pulse	—	**(!) 49** -JI	—	—	**(!) 48** -JI
Resp	—	16 -JI	—	—	17 -JI
BP	—	137/54 -JI	—	—	**(!) 123/49** -JI
MAP (mmHg)	—	75 mm Hg -JI	—	—	66 mm Hg -JI
Oxygen Therapy					
SpO2	—	100 % -JI	—	—	91 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
O2 Flow Rate (L/min)	—	—	—	—	5 L/min -JI

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/18/18 0907	06/18/18 0900	06/18/18 0848	06/18/18 0831	06/18/18 0800
Pulse Oximetry Type	—	—	—	—	Continuous -JI
Pain Assessment					
Currently in Pain	—	—	—	—	No -JI
Which Pain Assessment Tool ?	—	—	—	—	Numeric (0-10) -JI
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	—	0 -JI
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	*4.5 g -JI	—	—	—	—
Urine Output					
Urine	—	—	300 mL -JI	—	—

Row Name	06/18/18 0700	06/18/18 0640	06/18/18 0600	06/18/18 0500	06/18/18 0445
Height and Weight					
Weight	—	—	104.9 kg (231 lb 4.2 oz) -RM	—	—
Weight Method	—	—	Actual -RM	—	—
Vital Signs					
Temp	—	—	98.2 °F (36.8 °C) -RM	—	98.6 °F (37 °C) -RM
Temp src	—	—	Axillary -RM	—	Axillary -RM
Pulse	**(!) 46** -JI	—	**(!) 46** -RM	**(!) 47** -RM	**(!) 47** -RM
Heart Rate Source	—	—	Monitor -RM	Monitor -RM	—
Resp	17 -JI	—	13 -RM	18 -RM	18 -RM
BP	**(!) 115/49** -JI	—	**(!) 126/48** -RM	122/52 -RM	120/52 -RM
MAP (mmHg)	65 mm Hg -JI	—	68 mm Hg -RM	69 mm Hg -RM	—
BP Location	—	—	Right arm -RM	Right arm -RM	—
BP Method	—	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—
Patient Position	—	—	Supine -RM	Lying left side -RM	—
Oxygen Therapy					
SpO2	95 % -JI	—	97 % -RM	97 % -RM	—
O2 Device	—	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	—	—	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	—	100 -RM	100 -RM	—
SpO2 Alarm Limit Low	—	—	90 -RM	90 -RM	—
POX Probe Site Changed	—	—	No -RM	No -RM	—
QT Monitoring					
QT Interval	—	—	**(!) 560 ms** -RM	**(!) 544 ms** -RM	—
QTC	—	—	**(!) 496 ms** -RM	**(!) 487 ms** -RM	—
Pain Assessment History					
Previous experiences with pain?	—	—	No -RM	No -RM	—
History of Chronic Pain?	—	—	No -RM	No -RM	—
Pain Assessment					
Currently in Pain	—	—	No -RM	No -RM	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -RM	Numeric (0-10) -RM	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -RM	0 -RM	—
sodium chloride 0.9% (NS) infusion					
Volume (mL)	—	—	495 mL -RM	—	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Dose	—	*250 mL -RM	—	—	—
Bolus Volume (mL)	—	—	250 -RM	—	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Volume (mL)	—	—	0 -RM	100 -RM	—

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/18/18 0700	06/18/18 0640	06/18/18 0600	06/18/18 0500	06/18/18 0445
pantoprazole					
pantoprazole Volume (mL)	—	—	20 mL -RM	100 mL -RM	—
Urine Output					
Urine	—	—	300 mL -RM	275 mL -RM	—
Urine Occurrence	—	—	—	0 -RM	—
Bladder Status (use only for bladder training)	—	—	—	Continent -RM	—
Stool Output					
Stool Occurrence	—	—	—	0 -RM	—
Bowel Incontinence	—	—	—	No -RM	—
Stool Amount	—	—	—	Unable to assess -RM	—
Stool Appearance	—	—	—	Unable to assess -RM	—
Stool Color	—	—	—	Unable to assess -RM	—
Emesis Output					
Emesis Occurrence	—	—	—	0 -RM	—
Emesis Appearance	—	—	—	— na -RM	—
Patient Observation					
Observations	—	—	—	Resting in bed -RM	—

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0103
Vital Signs					
Pulse	(!) 49 -RM	(!) 49 -RM	51 -RM	54 -RM	—
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	—	—
Resp	19 -RM	18 -RM	19 -RM	20 -RM	—
BP	117/50 -RM	(!) 109/43 -RM	(!) 102/39 -RM	—	—
MAP (mmHg)	67 mm Hg -RM	60 mm Hg -RM	(!) 55 mm Hg -RM	—	—
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	—	—
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—	—
Patient Position	Sitting -RM	Supine -RM	Lying right side -RM	—	—
Oxygen Therapy					
SpO2	97 % -RM	92 % -RM	(!) 87 % -RM	—	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—	—
O2 Flow Rate (L/min)	—	5 L/min -RM	5 L/min -RM	—	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	—	—
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	—	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	—	—
POX Probe Site Changed	No -RM	No -RM	No -RM	—	—
QT Monitoring					
QT Interval	(!) 560 ms -RM	(!) 544 ms -RM	(!) 536 ms -RM	—	—
QTC	(!) 501 ms -RM	(!) 497 ms -RM	(!) 494 ms -RM	—	—
Pain Assessment History					
Previous experiences with pain?	No -RM	No -RM	No -RM	—	—
History of Chronic Pain?	No -RM	No -RM	No -RM	—	—
Pain Assessment					
Currently in Pain	No -RM	No -RM	No -RM	—	—
Which Pain Assessment Tool ?	Numeric (0-10) -RM	Numeric (0-10) -RM	Numeric (0-10) -RM	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -RM	0 -RM	—	—
sodium chloride 0.9% (NS) infusion					
Rate	—	—	—	—	* There are multiple administrations at this time. Please see the MAR for detailed information. -RM
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115	06/18/18 0103
Piggyback Dose	*4.5 g -RM	—	—	—	—
Urine Output					
Urine	—	200 mL -RM	—	—	—

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0030	06/18/18 0000	06/17/18 2300
Vital Signs					
Temp	—	98.1 °F (36.7 °C) -RM	—	—	—
Temp src	—	Oral -RM	—	—	—
Pulse	57 -RM	57 -RM	—	55 -RM	54 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	—	Monitor -RM	Monitor -RM
Resp	21 -RM	20 -RM	—	20 -RM	17 -RM
BP	123/51 -RM	140/52 -RM	—	**(!) 115/45** -RM	**(!) 110/41** -RM
MAP (mmHg)	69 mm Hg -RM	—	—	62 mm Hg -RM	**(!) 58 mm Hg** -RM
BP Location	Right arm -RM	—	—	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	—	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM
Patient Position	Lying left side -RM	—	—	Lying left side -RM	Sitting -RM
Oxygen Therapy					
SpO2	**(!) 88 %** -RM	—	—	92 % -RM	90 % -RM
O2 Device	Nasal cannula -RM	—	—	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	—	—	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	—	—	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	—	—	90 -RM	90 -RM
POX Probe Site Changed	No -RM	—	—	Yes -RM	No -RM
QT Monitoring					
QT Interval	**(!) 488 ms** -RM	—	—	**(!) 528 ms** -RM	**(!) 512 ms** -RM
QTC	**(!) 476 ms** -RM	—	—	**(!) 510 ms** -RM	**(!) 490 ms** -RM
Pain Assessment History					
Previous experiences with pain?	No -RM	—	—	No -RM	No -RM
History of Chronic Pain?	No -RM	—	—	No -RM	No -RM
Pain Assessment					
Currently in Pain	No -RM	—	—	No -RM	No -RM
Which Pain Assessment Tool ?	Numeric (0-10) -RM	—	—	Numeric (0-10) -RM	Numeric (0-10) -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	—	—	0 -RM	0 -RM
sodium chloride 0.9% (NS) infusion					
Volume (mL)	—	—	—	0 mL -RM	—
sodium chloride 0.9% (NS) bolus 250 mL					
Bolus Volume (mL)	—	—	—	0 -RM	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Volume (mL)	—	—	—	0 -RM	—
magnesium sulfate					
Latest MgSO4 serum level	—	—	2.1	—	—
Urine Output					
Urine	—	—	—	300 mL -RM	—
Bladder Status (use only for bladder training)	—	—	—	Continent -RM	—
Stool Output					
Stool (mL)	—	—	—	0 mL -RM	—
Bowel Incontinence	—	—	—	No -RM	—
Stool Amount	—	—	—	Unable to assess -RM	—
Stool Appearance	—	—	—	Unable to assess -RM	—
Stool Color	—	—	—	Unable to assess -RM	—
Emesis Output					

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0030	06/18/18 0000	06/17/18 2300
Emesis	—	—	—	0 mL -RM	—
Emesis Appearance	—	—	—	— na -RM	—
Patient Observation					
Observations	—	—	—	Resting in bed, alert -RM	—
Output					
Blood	—	—	—	0 mL -RM	—

Row Name	06/17/18 2225	06/17/18 2037	06/17/18 1859	06/17/18 1823	06/17/18 1738
Height and Weight					
Height	67" (1.702 m) -AF	—	—	—	—
Weight	103.4 kg (227 lb 15.3 oz) -AF	—	—	—	—
Weight Method	Actual -AF	—	—	—	—
BSA (Calculated - sq m)	2.21 sq meters -AF	—	—	—	—
BMI (Calculated)	35.7 -AF	—	—	—	—
Weight in (lb) to have BMI = 25	159.3 -AF	—	—	—	—
Vital Signs					
Temp	98 °F (36.7 °C) -AF	98.2 °F (36.8 °C) -BR	—	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR
Temp src	Oral -AF	Oral -BR	—	Oral -BR	Oral -BR
Pulse	53 -AF	57 -BR	—	51 -BR	55 -BR
Heart Rate Source	Monitor -AF	Monitor -BR	—	Monitor -BR	Monitor -BR
Resp	18 -AF	16 -BR	—	18 -BR	18 -BR
BP	(!) 128/41 -AF	134/59 -BR	—	126/55 -BR	132/56 -BR
BP Location	Right arm -RM	Right arm -BR	—	Right arm -BR	Right arm -BR
BP Method	Non-invasive Cuff -RM	Portable -BR	—	Portable -BR	Portable -BR
Patient Position	Sitting -RM	Sitting -BR	—	Sitting -BR	Sitting -BR
Oxygen Therapy					
SpO2	92 % -AF	100 % -BR	—	100 % -BR	100 % -BR
O2 Device	Nasal cannula -AF	—	—	None (Room air) -BR	None (Room air) -BR
O2 Flow Rate (L/min)	2 L/min -AF	—	—	—	—
Pulse Oximetry Type	Continuous -RM	—	—	—	—
SpO2 Alarm Limit High	100 -RM	—	—	—	—
SpO2 Alarm Limit Low	90 -RM	—	—	—	—
POX Probe Site Changed	No -RM	—	—	—	—
QT Monitoring					
QT Interval	(!) 472 ms -AF	—	—	—	—
QTC	452 ms -AF	—	—	—	—
Pain Assessment History					
Previous experiences with pain?	No -RM	—	—	—	—
History of Chronic Pain?	No -RM	—	—	—	—
Pain Assessment					
Currently in Pain	No -RM	—	—	—	—
Which Pain Assessment Tool ?	Numeric (0-10) -RM	—	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	0 -BR	—	0 -BR	—
vancomycin (VANCOCIN) 1,500 mg in NS 250 mL IVPB					
Piggyback Dose	—	—	*1500 mg -BR	—	—
pantoprazole					
pantoprazole Volume (mL)	100 mL -RM	—	—	—	—
Urine Output					
Urine Occurrence	0 -RM	—	—	—	—
Bladder Status (use only for bladder training)	Continent -RM	—	—	—	—

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/17/18 2225	06/17/18 2037	06/17/18 1859	06/17/18 1823	06/17/18 1738
Stool Output					
Stool Occurrence	0 -RM	—	—	—	—
Bowel Incontinence	No -RM	—	—	—	—
Stool Amount	Unable to assess -RM	—	—	—	—
Stool Appearance	Unable to assess -RM	—	—	—	—
Stool Color	Unable to assess -RM	—	—	—	—
Emesis Output					
Emesis Occurrence	0 -RM	—	—	—	—
Emesis Appearance	— na -RM	—	—	—	—
Patient Observation					
Observations	REsting in bed, sitting up, alert -RM	—	—	—	—
24 Chart Check					
24 hour chart check complete	Yes -RM	—	—	—	—

Row Name	06/17/18 1720	06/17/18 1718	06/17/18 1708	06/17/18 1706	06/17/18 1538
Vital Signs					
Temp	98.2 °F (36.8 °C) -BR	—	97.8 °F (36.6 °C) -BR	—	—
Temp src	Oral -BR	—	Oral -BR	—	—
Pulse	55 -BR	—	55 -BR	—	—
Heart Rate Source	—	—	Monitor -BR	—	—
Resp	18 -BR	—	18 -BR	—	—
BP	129/53 -BR	—	(!) 115/49 -BR	—	—
BP Location	—	—	Right arm -BR	—	—
BP Method	—	—	Portable -BR	—	—
Patient Position	—	—	Standing -BR	—	—
Oxygen Therapy					
SpO2	—	—	100 % -BR	—	—
O2 Device	—	—	None (Room air) -BR	—	None (Room air) -RG
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	0 -BR	—
piperacillin-tazobactam (ZOSYN) 4.5 g in NS 100 mL IVPB (w/adapter)					
Piggyback Dose	—	*4.5 g -BR	—	—	—

Row Name	06/17/18 1537	06/17/18 1535	06/17/18 1533	06/17/18 1514	06/17/18 1504
Height and Weight					
Weight	—	95.3 kg (210 lb) -RG	—	—	—
Weight Method	—	Stated -RG	—	—	—
Vital Signs					
Temp	97.8 °F (36.6 °C) -RG	—	—	—	—
Pulse	55 -RG	—	—	—	—
Resp	22 -RG	—	—	—	—
BP	114/51 -RG	—	—	—	—
Pain Assessment					
Currently in Pain	—	—	—	—	No -RG
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	—	0 -RG
sodium chloride 0.9% (NS) infusion					
Rate	—	—	*0 There are multiple administrations at this time. Please see the MAR for detailed information. -RG	—	—
magnesium sulfate					
Latest MgSO4 serum level	—	—	—	2.3	—

Row Name	06/17/18 1502	06/17/18 1437
Vital Signs		

Flowsheets (all recorded) (continued)

Critical Care VS, Intake/Output (continued)

Row Name	06/17/18 1502	06/17/18 1437
Temp	97.7 °F (36.5 °C) -RG	—
Temp src	Oral -RG	—
Pulse	54 -RG	56 -NS
Heart Rate Source	Monitor -RG	—
Resp	25 -RG	—
BP	112/52 -RG	—
BP Location	Left arm -RG	—
BP Method	Non-invasive Cuff -RG	—
Patient Position	Supine -RG	—

Oxygen Therapy

SpO2	100 % -RG	98 % -NS
O2 Device	None (Room air) -RG	—
Pulse Oximetry Type	Continuous -RG	—

[REMOVED] Urethral Catheter 16 Fr

Urethral Catheter Properties	Placement Date: 01/16/18 -RD Placement Time: 2140 -RD Inserted by: Denmark, RN -RD Present on arrival to hospital?: No -RD Patient location at time of placement:: ER -RD Catheter Indicator: Acute urinary retention -RD Tube Size (Fr.): 16 Fr -RD Catheter Balloon Size: 10 mL -RD Catheter Secured: Yes -RD Urine Returned: Yes -RD Removal Date: 06/17/18 -RG, N/E

Flowsheets (all recorded)

CAGE Questionnaire

Row Name	06/18/18 0134
CAGE Questionnaire	
Have you felt the need to cut down on your drinking?	0 -RM
Have you ever felt annoyed by criticizing of your drinking?	0 -RM
Have you ever felt guilty about your drinking?	0 -RM
Have you ever felt you needed an eye-opener?	0 -RM
CAGE Score Total	0 -RM

Flowsheets (all recorded)

Adult Immunization Screening

Row Name	06/18/18 0133	06/17/18 1538
Pneumococcal Screening - Age >=65		
Age >=65 Pneumococcal CONTRAINDICATIONS [Do any of the following exist?]	NONE - CONTINUE SCREENING -RM	—
Have you ever had a pneumococcal vaccination?	Yes -RM	—
Date of the Vaccine? (if Known)	03/16/16 -RM	—
What type vaccine received ?	Pneumovax -RM	—
When did you receive the vaccine?	Received after age 65 OR less than 5 years ago (Follow up with PCP) -RM	—
Pneumococcal Handout Provided	No (Comment) -RM	—
Screening Complete	Vaccine NOT indicated (up to date status) -RM	—
Influenza Vaccine (Sept - March 31st)		
Have you received the Influenza Vaccine during this Flu season?	Not Flu Season -RM	Not Flu Season -RG
Meets Criteria for Influenza Vaccine?		
Patient Meets Criteria For Influenza Vaccine?	Not Flu Season -RM	—
Screening Complete	Vaccine NOT indicated (up to date status) -RM	—

Flowsheets (all recorded)

Vital Signs

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 0545	06/21/18 04:07:21
Vital Signs					
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	—	Oral -TW
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	—	63 -DI (r) TW (t)
Heart Rate Source	Monitor -CI	—	Monitor -CI	—	Monitor -TW
Resp	18 -CI	—	18 -CI	—	18 -DI (r) TW (t)
Respiration Source	visual -CI	—	visual -CI	—	visual -TW
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	—	121/58 -DI (r) TW (t)
BP Location	Right arm -CI	—	Right arm -CI	—	Right arm -TW
BP Method	Portable -CI	—	Portable -CI	—	Portable -TW
Patient Position	Supine -CI	—	Supine -CI	—	Supine -TW
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	—	93 % -DI (r) TW (t)
O2 Device	None (Room air) -CI	None (Room air) -AM	None (Room air) -CI	—	None (Room air) -TW
Pain Assessment					
Currently in Pain	—	No -AM	—	No -TS	—
Which Pain Assessment Tool ?	—	—	—	Numeric (0-10) -TS	—
Pain Intervention(s)	—	Declines -AM	—	Rest -TS	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -AM	—	0 -TS	—

Row Name	06/21/18 0030	06/20/18 23:57:07	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04
Vital Signs					
Temp	—	98.4 °F (36.9 °C) -DI (r) TW (t)	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	Oral -TW	—
Pulse	—	109 -DI (r) TW (t)	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)
Heart Rate Source	—	Monitor -TW	—	Monitor -TW	—
Resp	—	16 -DI (r) TW (t)	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)
Respiration Source	—	visual -TW	—	visual -TW	—
BP	—	124/53 -DI (r) TW (t)	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)
BP Location	—	Right arm -TW	—	Right arm -TW	—
BP Method	—	Portable -TW	—	Portable -TW	—
Patient Position	—	Supine -TW	—	Supine -TW	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) TW (t)	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)
O2 Device	—	None (Room air) -TW	None (Room air) -TS	None (Room air) -TW	—
Pain Assessment					
Currently in Pain	Resting quietly -TS	—	No -TS	—	—
Which Pain Assessment Tool ?	FACES -TS	—	Numeric (0-10) -TS	—	—
Pain Intervention(s)	Rest -TS	—	Rest;Declines -TS	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -TS	—	—
FACES Pain Rating 1					
FACES Pain Rating	0-No hurt -TS	—	—	—	—

Row Name	06/20/18 1458	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909	06/20/18 0900
Vital Signs					
Temp	—	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—	—
Pulse	—	61 -DI (r) LF (t)	61 -DG	59 -DG	60 -DG
Resp	—	—	18 -DG	—	17 -DG
BP	—	104/66 -DI (r) LF (t)	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG
MAP (mmHg)	—	—	71 mm Hg -DG	—	68 mm Hg -DG
Oxygen Therapy					
SpO2	—	92 % -DI (r) LF (t)	(!) 88 % -DG	—	(!) 87 % -DG
O2 Device	None (Room air) -MS	—	—	—	—

Row Name	06/20/18 0830	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/20/18 0830	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500
Vital Signs					
Temp	—	—	98.3 °F (36.8 °C) -HT	—	—
Temp src	—	—	Oral -HT	—	—
Pulse	—	58 -DG	—	59 -EE	57 -EE
Resp	—	18 -DG	—	20 -EE	20 -EE
BP	—	138/62 -DG	—	129/57 -EE	130/50 -EE
MAP (mmHg)	—	81 mm Hg -DG	—	74 mm Hg -EE	70 mm Hg -EE
Oxygen Therapy					
SpO2	—	(!) 88 % -DG	—	93 % -EE	94 % -EE
O2 Device	—	None (Room air) -DG	—	—	—
Pulse Oximetry Type	—	Continuous -DG	—	—	—
Pain Assessment					
Currently in Pain	Unable to Assess Simultaneous filing. User may be unaware of other data. -MS	—	Yes -DG	—	—
Which Pain Assessment Tool ?	Numeric (0-10) Simultaneous filing. User may be unaware of other data. -MS	—	Numeric (0-10) -DG	—	—
Multiple Pain Sites	No -MS	—	—	—	—
Pain Intervention(s)	Rest -MS	—	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 Simultaneous filing. User may be unaware of other data. -MS	—	2 -DG	—	—
Pain Onset 1	—	—	Gradual -DG	—	—
Pain Location 1	—	—	Back -DG	—	—
Pain Location Orientation 1	—	—	Anterior -DG	—	—
Pain Quality 1	—	—	Aching -DG	—	—
Pain Type 1	—	—	Acute pain -DG	—	—
Aggravating Factors	—	—	Movement -DG	—	—
Alleviating Factors 1	—	—	Medication;Positioning -DG	—	—
Clinical Progression 1	Resolved -MS	—	—	—	—

Row Name	06/20/18 0400	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300
Vital Signs					
Temp	98 °F (36.7 °C) -JP	—	—	97.5 °F (36.4 °C) -JP	—
Temp src	Oral -JP	—	—	Axillary -JP	—
Pulse	56 -EE	57 -EE	64 -EE	59 -EE	61 -EE
Resp	19 -EE	21 -EE	16 -EE	22 -EE	21 -EE
BP	119/51 -EE	122/58 -EE	(!) 111/47 -EE	—	128/56 -EE
MAP (mmHg)	67 mm Hg -EE	73 mm Hg -EE	62 mm Hg -EE	—	—
Oxygen Therapy					
SpO2	94 % -EE	97 % -EE	91 % -EE	90 % -EE	97 % -EE

Row Name	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800
Vital Signs					
Temp	—	—	98.4 °F (36.9 °C) -JP	—	—
Temp src	—	—	Oral -JP	—	—
Pulse	62 -EE	61 -EE	63 -EE	64 -EE	61 -JI
Resp	22 -EE	16 -EE	21 -EE	19 -EE	25 -JI
BP	132/51 -EE	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI
MAP (mmHg)	73 mm Hg -EE	77 mm Hg -EE	76 mm Hg -EE	77 mm Hg -EE	72 mm Hg -JI
Oxygen Therapy					
SpO2	96 % -EE	94 % -EE	94 % -EE	94 % -EE	92 % -JI
O2 Device	—	—	Nasal cannula -EE	—	—
O2 Flow Rate (L/min)	—	—	2 L/min -EE	—	—
Pulse Oximetry Type	—	—	Continuous -EE	—	—
Pain Assessment					
Currently in Pain	—	—	Resting quietly -EE	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -EE	—	—

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800
Pain Assessment History					
Previous experiences with pain?	—	—	No -EE	—	—
History of Chronic Pain?	—	—	No -EE	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -EE	—	—

Row Name	06/19/18 1700	06/19/18 1644	06/19/18 1600	06/19/18 1500	06/19/18 1430
Vital Signs					
Temp	—	97.9 °F (36.6 °C) -FT	—	—	—
Temp src	—	Oral -FT	—	—	—
Pulse	59 -JI	—	58 -JI	56 -JI	57 -JI
Resp	21 -JI	—	20 -JI	22 -JI	19 -JI
BP	132/52 -JI	—	134/58 -JI	130/51 -JI	142/60 -JI
MAP (mmHg)	73 mm Hg -JI	—	76 mm Hg -JI	69 mm Hg -JI	82 mm Hg -JI
Oxygen Therapy					
SpO2	96 % -JI	—	95 % -JI	96 % -JI	96 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -JI
Pulse Oximetry Type	—	—	—	—	Continuous -JI
Pain Assessment					
Currently in Pain	—	—	No -JI	—	—
Which Pain Assessment Tool ?	—	—	Numeric (0-10) -JI	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -JI	—	—

Row Name	06/19/18 1428	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321
Vital Signs					
Temp	97.7 °F (36.5 °C) -FT	—	—	—	—
Temp src	Oral -FT	—	—	—	—
Pulse	—	54 -LFA	54 -LFA	53 -LFA	53 -CR
Resp	—	22 -LFA	19 -LFA	21 -LFA	18 -CR
BP	—	123/59 -LFA	128/55 -LFA	**(!) 95/46** -LFA	110/53 -CR
Oxygen Therapy					
SpO2	—	100 % -LFA	97 % -LFA	92 % -LFA	93 % -CR
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	—	0 -CR

Row Name	06/19/18 1114	06/19/18 1031	06/19/18 1000	06/19/18 0900	06/19/18 0808
Vital Signs					
Pulse	51 -PM	—	50 -JI	51 -JI	55 -JI
Heart Rate Source	Monitor -PM	—	—	—	—
Resp	13 -PM	—	20 -JI	18 -JI	—
BP	123/54 -PM	—	**(!) 124/49** -JI	**(!) 119/44** -JI	**(!) 126/47** -JI
MAP (mmHg)	—	—	68 mm Hg -JI	62 mm Hg -JI	—
Patient Position	Sitting -PM	—	—	—	—
Oxygen Therapy					
SpO2	98 % -PM	—	92 % -JI	95 % -JI	—
O2 Device	Nasal cannula -PM	None (Room air) -JI	—	—	—
O2 Flow Rate (L/min)	3 L/min -PM	—	—	—	—

Row Name	06/19/18 0800	06/19/18 0700	06/19/18 0600	06/19/18 0500	06/19/18 0400
Vital Signs					
Temp	98.6 °F (37 °C) -DF	—	—	—	98.2 °F (36.8 °C) -MJ
Temp src	Oral -DF	—	—	—	—
Pulse	56 -JI	63 -JI	52 -RM	53 -RM	55 -RM
Heart Rate Source	—	—	—	Monitor -RM	Monitor -RM
Resp	18 -JI	18 -JI	17 -RM	17 -RM	20 -RM
BP	**(!) 126/47** -JI	143/52 -JI	**(!) 109/40** -RM	**(!) 124/49** -RM	127/55 -RM
BP Location	—	—	—	Right arm -RM	Right arm -RM

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/19/18 0800	06/19/18 0700	06/19/18 0600	06/19/18 0500	06/19/18 0400
BP Method	—	—	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM
MAP (mmHg)	66 mm Hg -JI	76 mm Hg -JI	(!) 56 mm Hg -RM	68 mm Hg -RM	73 mm Hg -RM
Patient Position	—	—	—	Sitting -RM	Supine -RM
Oxygen Therapy					
SpO2	97 % -JI	96 % -JI	94 % -RM	96 % -RM	98 % -RM
O2 Device	Nasal cannula -JI	—	—	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	2 L/min -JI	—	—	—	—
Pulse Oximetry Type	Continuous -JI	—	—	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	—	—	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	—	—	90 -RM	90 -RM
POX Probe Site Changed	—	—	—	No -RM	No -RM
Pain Assessment					
Currently in Pain	No -JI	—	—	—	—
Which Pain Assessment Tool ?	Numeric (0-10) -JI	—	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -JI	—	—	—	—
24 Chart Check					
24 hour chart check complete	—	—	—	—	Yes -RM
Patient Observation					
Observations	—	—	—	—	Resting in bed, alert -RM

Row Name	06/19/18 0300	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300
Vital Signs					
Temp	—	—	—	98.1 °F (36.7 °C) -MJ	—
Pulse	55 -RM	54 -RM	53 -RM	56 -RM	59 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	16 -RM	19 -RM	19 -RM	21 -RM	20 -RM
BP	120/59 -RM	113/50 -RM	(!) 109/44 -RM	(!) 123/43 -RM	127/59 -RM
BP Location	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM
MAP (mmHg)	73 mm Hg -RM	62 mm Hg -RM	61 mm Hg -RM	61 mm Hg -RM	75 mm Hg -RM
Patient Position	Lying right side -RM	Lying right side -RM	Lying left side -RM	Lying left side -RM	Lying left side -RM
Oxygen Therapy					
SpO2	92 % -RM	93 % -RM	92 % -RM	94 % -RM	97 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM
24 Chart Check					
24 hour chart check complete	—	Yes -RM	—	Yes -RM	—
Patient Observation					
Observations	—	Resting in bed, alert -RM	—	Resting in bed, alert -RM	—

Row Name	06/18/18 2200	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800
Vital Signs					
Temp	—	—	98.4 °F (36.9 °C) -MJ	—	—
Pulse	55 -RM	56 -RM	56 -RM	56 -RM	56 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	—
Resp	21 -RM	21 -RM	22 -RM	22 -RM	20 -RM
BP	—	—	—	—	132/60 -RM
BP Location	Right arm -RM	—	—	—	—
BP Method	Non-invasive Cuff -RM	—	—	—	—
MAP (mmHg)	—	—	—	—	75 mm Hg -RM
Patient Position	Supine -RM	—	—	—	—
Oxygen Therapy					
SpO2	99 % -RM	99 % -RM	96 % -RM	(!) 89 % -RM	94 % -RM

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/18/18 2200	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	—
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	—
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	—
Pain Assessment					
Currently in Pain	—	No -RM	No -RM	No -RM	—
Which Pain Assessment Tool ?	—	Numeric (0-10) -RM	Numeric (0-10) -RM	Numeric (0-10) -RM	—
Pain Goal					
Patient's Stated Pain Goal	—	—	0 (No Pain) -RM	—	—
Pain Assessment History					
Previous experiences with pain?	—	No -RM	No -RM	No -RM	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -RM	0 -RM	0 -RM	—
24 Chart Check					
24 hour chart check complete	Yes -RM	—	Yes -RM	—	—
Patient Observation					
Observations	Resting in bed, alert -RM	—	Resting in bed, alert -RM	—	—

Row Name	06/18/18 1727	06/18/18 1600	06/18/18 1500	06/18/18 1400	06/18/18 1300
Vital Signs					
Temp	98.1 °F (36.7 °C) -JD	—	—	—	—
Temp src	Oral -JD	—	—	—	—
Pulse	—	52 -JI	54 -JI	58 -JI	57 -JI
Resp	—	20 -JI	18 -JI	19 -JI	15 -JI
BP	—	142/57 -JI	151/56 -JI	134/53 -JI	**(!) 130/45** -JI
MAP (mmHg)	—	76 mm Hg -JI	79 mm Hg -JI	72 mm Hg -JI	65 mm Hg -JI
Oxygen Therapy					
SpO2	—	(!) 87 % -JI	95 % -JI	91 % -JI	93 % -JI
Pain Assessment					
Currently in Pain	—	No -JI	—	—	—
Which Pain Assessment Tool ?	—	Numeric (0-10) -JI	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JI	—	—	—

Row Name	06/18/18 1230	06/18/18 1200	06/18/18 1100	06/18/18 1000	06/18/18 0900
Vital Signs					
Temp	97.7 °F (36.5 °C) -JD	—	—	—	—
Temp src	Oral -JD	—	—	—	—
Pulse	—	52 -JI	50 -JI	51 -JI	**(!) 49** -JI
Resp	—	18 -JI	17 -JI	16 -JI	16 -JI
BP	—	140/56 -JI	**(!) 128/46** -JI	131/52 -JI	137/54 -JI
MAP (mmHg)	—	77 mm Hg -JI	66 mm Hg -JI	72 mm Hg -JI	75 mm Hg -JI
Oxygen Therapy					
SpO2	—	—	97 % -JI	98 % -JI	100 % -JI
Pain Assessment					
Currently in Pain	—	No -JI	—	—	—
Which Pain Assessment Tool ?	—	Numeric (0-10) -JI	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JI	—	—	—

Row Name	06/18/18 0831	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/18/18 0831	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500
Vital Signs					
Temp	97.8 °F (36.6 °C) -JD	—	—	98.2 °F (36.8 °C) -RM	—
Temp src	Oral -JD	—	—	Axillary -RM	—
Pulse	—	(!) 48 -JI	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM
Heart Rate Source	—	—	—	Monitor -RM	Monitor -RM
Resp	—	17 -JI	17 -JI	13 -RM	18 -RM
BP	—	(!) 123/49 -JI	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM
BP Location	—	—	—	Right arm -RM	Right arm -RM
BP Method	—	—	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM
MAP (mmHg)	—	66 mm Hg -JI	65 mm Hg -JI	68 mm Hg -RM	69 mm Hg -RM
Patient Position	—	—	—	Supine -RM	Lying left side -RM
Oxygen Therapy					
SpO2	—	91 % -JI	95 % -JI	97 % -RM	97 % -RM
O2 Device	—	Nasal cannula -JI	—	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	—	5 L/min -JI	—	—	—
Pulse Oximetry Type	—	Continuous -JI	—	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	—	—	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	—	—	90 -RM	90 -RM
POX Probe Site Changed	—	—	—	No -RM	No -RM
Pain Assessment					
Currently in Pain	—	No -JI	—	No -RM	No -RM
Which Pain Assessment Tool ?	—	Numeric (0-10) -JI	—	Numeric (0-10) -RM	Numeric (0-10) -RM
Pain Assessment History					
Previous experiences with pain?	—	—	—	No -RM	No -RM
History of Chronic Pain?	—	—	—	No -RM	No -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JI	—	0 -RM	0 -RM
Height and Weight					
Weight	—	—	—	104.9 kg (231 lb 4.2 oz) -RM	—
Weight Method	—	—	—	Actual -RM	—
Patient Observation					
Observations	—	—	—	—	Resting in bed -RM

Row Name	06/18/18 0445	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115
Vital Signs					
Temp	98.6 °F (37 °C) -RM	—	—	—	—
Temp src	Axillary -RM	—	—	—	—
Pulse	(!) 47 -RM	(!) 49 -RM	(!) 49 -RM	51 -RM	54 -RM
Heart Rate Source	—	Monitor -RM	Monitor -RM	Monitor -RM	—
Resp	18 -RM	19 -RM	18 -RM	19 -RM	20 -RM
BP	120/52 -RM	117/50 -RM	(!) 109/43 -RM	(!) 102/39 -RM	—
BP Location	—	Right arm -RM	Right arm -RM	Right arm -RM	—
BP Method	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM	—
MAP (mmHg)	—	67 mm Hg -RM	60 mm Hg -RM	(!) 55 mm Hg -RM	—
Patient Position	—	Sitting -RM	Supine -RM	Lying right side -RM	—
Oxygen Therapy					
SpO2	—	97 % -RM	92 % -RM	(!) 87 % -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—
O2 Flow Rate (L/min)	—	—	5 L/min -RM	5 L/min -RM	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	—
SpO2 Alarm Limit High	—	100 -RM	100 -RM	100 -RM	—
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	90 -RM	—
POX Probe Site Changed	—	No -RM	No -RM	No -RM	—
Pain Assessment					
Currently in Pain	—	No -RM	No -RM	No -RM	—
Which Pain	—	Numeric (0-10) -RM	Numeric (0-10) -RM	Numeric (0-10) -RM	—

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/18/18 0445	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115
Assessment Tool ?					
Pain Assessment History					
Previous experiences with pain?	—	No -RM	No -RM	No -RM	—
History of Chronic Pain?	—	No -RM	No -RM	No -RM	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -RM	0 -RM	0 -RM	—

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0000	06/17/18 2300	06/17/18 2225
Vital Signs					
Temp	—	98.1 °F (36.7 °C) -RM	—	—	98 °F (36.7 °C) -AF
Temp src	—	Oral -RM	—	—	Oral -AF
Pulse	57 -RM	57 -RM	55 -RM	54 -RM	53 -AF
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -AF
Resp	21 -RM	20 -RM	20 -RM	17 -RM	18 -AF
BP	123/51 -RM	140/52 -RM	(!) 115/45 -RM	(!) 110/41 -RM	(!) 128/41 -AF
BP Location	Right arm -RM	—	Right arm -RM	Right arm -RM	Right arm -RM
BP Method	Non-invasive Cuff -RM	—	Non-invasive Cuff -RM	Non-invasive Cuff -RM	Non-invasive Cuff -RM
MAP (mmHg)	69 mm Hg -RM	—	62 mm Hg -RM	(!) 58 mm Hg -RM	—
Patient Position	Lying left side -RM	—	Lying left side -RM	Sitting -RM	Sitting -RM
Oxygen Therapy					
SpO2	(!) 88 % -RM	—	92 % -RM	90 % -RM	92 % -AF
O2 Device	Nasal cannula -RM	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -AF
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -AF
Pulse Oximetry Type	Continuous -RM	—	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	—	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	—	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	—	Yes -RM	No -RM	No -RM
Pain Assessment					
Currently in Pain	No -RM	—	No -RM	No -RM	No -RM
Which Pain Assessment Tool ?	Numeric (0-10) -RM	—	Numeric (0-10) -RM	Numeric (0-10) -RM	Numeric (0-10) -RM
Pain Assessment History					
Previous experiences with pain?	No -RM	—	No -RM	No -RM	No -RM
History of Chronic Pain?	No -RM	—	No -RM	No -RM	No -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	—	0 -RM	0 -RM	0 -RM
Height and Weight					
Height	—	—	—	—	67" (1.702 m) -AF
Weight	—	—	—	—	103.4 kg (227 lb 15.3 oz) -AF
Weight Method	—	—	—	—	Actual -AF
BSA (Calculated - sq m)	—	—	—	—	2.21 sq meters -AF
BMI (Calculated)	—	—	—	—	35.7 -AF
Weight in (lb) to have BMI = 25	—	—	—	—	159.3 -AF
24 Chart Check					
24 hour chart check complete	—	—	—	—	Yes -RM
Patient Observation					
Observations	—	—	Resting in bed, alert -RM	—	REsting in bed, sitting up, alert -RM

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1708
Vital Signs					
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR
Temp src	Oral -BR	Oral -BR	Oral -BR	Oral -BR	Oral -BR

Flowsheets (all recorded) (continued)

Vital Signs (continued)

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1708
Pulse	57 -BR	51 -BR	55 -BR	55 -BR	55 -BR
Heart Rate Source	Monitor -BR	Monitor -BR	Monitor -BR	—	Monitor -BR
Resp	16 -BR	18 -BR	18 -BR	18 -BR	18 -BR
Respiration Source	visual -BR	visual -BR	visual -BR	—	visual -BR
BP	134/59 -BR	126/55 -BR	132/56 -BR	129/53 -BR	**(!) 115/49** -BR
BP Location	Right arm -BR	Right arm -BR	Right arm -BR	—	Right arm -BR
BP Method	Portable -BR	Portable -BR	Portable -BR	—	Portable -BR
Patient Position	Sitting -BR	Sitting -BR	Sitting -BR	—	Standing -BR
Oxygen Therapy					
SpO2	100 % -BR	100 % -BR	100 % -BR	—	100 % -BR
O2 Device	—	None (Room air) -BR	None (Room air) -BR	—	None (Room air) -BR
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -BR	0 -BR	—	—	—

Row Name	06/17/18 1706	06/17/18 1538	06/17/18 1537	06/17/18 1535	06/17/18 1504
Vital Signs					
Temp	—	—	97.8 °F (36.6 °C) -RG	—	—
Pulse	—	—	55 -RG	—	—
Resp	—	—	22 -RG	—	—
BP	—	—	114/51 -RG	—	—
Oxygen Therapy					
O2 Device	—	None (Room air) -RG	—	—	—
Pain Assessment					
Currently in Pain	—	—	—	—	No -RG
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -BR	—	—	—	0 -RG
Height and Weight					
Weight	—	—	—	95.3 kg (210 lb) -RG	—
Weight Method	—	—	—	Stated -RG	—

Row Name	06/17/18 1502	06/17/18 1437
Vital Signs		
Temp	97.7 °F (36.5 °C) -RG	—
Temp src	Oral -RG	—
Pulse	54 -RG	56 -NS
Heart Rate Source	Monitor -RG	—
Resp	25 -RG	—
Respiration Source	visual -RG	—
BP	112/52 -RG	—
BP Location	Left arm -RG	—
BP Method	Non-invasive Cuff -RG	—
Patient Position	Supine -RG	—
Oxygen Therapy		
SpO2	100 % -RG	98 % -NS
O2 Device	None (Room air) -RG	—
Pulse Oximetry Type	Continuous -RG	—

Flowsheets (all recorded)

Prior Functioning ADL Screen

Row Name	06/18/18 0134
Functional ADL Screening Prior to Acute Encounter Assessment	
Prior Functioning: Everyday Activities	3 - Independent -RM

Flowsheets (all recorded)

Scope Times

Row Name	06/19/18 1304
Scope Times	
Scope In	1305 -CR
Scope Out	1310 -CR

Flowsheets (all recorded)

Secondary Triage Complete

Row Name	06/17/18 1538
Information Source	
Information Provided By:	Patient -RG
Secondary Triage Complete	
Secondary Triage Complete	Secondary Triage Complete -RG

Flowsheets (all recorded)

Interdisciplinary Team Conference

Row Name	06/20/18 1102	06/18/18 1100	06/18/18 0000
Interdisciplinary Team Conference			
Overall goal for patient's hospitalization	transfer to floor -NP	control bleed, watch -SK	—
Disciplines represented at the IDC Conference	—	Nursing;Care Coordination -SK	—
Identify and discuss any patient concerns or care management issues	—	Psychosocial needs of the patient and/or family;Patient and/or family educational needs -SK	—
Barriers to discharge	—	—	No Barriers -RM

Flowsheets (all recorded)

Nutrition Follow-up

Row Name	06/20/18 1302
Nutrition Follow-up	
Nutrition follow-up needed	**Yes** 6/26 DTR PO good KC -KC

Flowsheets (all recorded)

Vitals/Pain

Row Name	06/21/18 11:36:09	06/21/18 0830	06/21/18 07:35:36	06/21/18 0545	06/21/18 04:07:21
Vitals					
Temp	98.5 °F (36.9 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) CI (t)	—	98 °F (36.7 °C) -DI (r) TW (t)
Temp src	Oral -CI	—	Oral -CI	—	Oral -TW
Pulse	60 -DI (r) CI (t)	—	62 -DI (r) CI (t)	—	63 -DI (r) TW (t)
Heart Rate Source	Monitor -CI	—	Monitor -CI	—	Monitor -TW
Resp	18 -CI	—	18 -CI	—	18 -DI (r) TW (t)
BP	123/59 -DI (r) CI (t)	—	137/64 -DI (r) CI (t)	—	121/58 -DI (r) TW (t)
Patient Position	Supine -CI	—	Supine -CI	—	Supine -TW
Oxygen Therapy					
SpO2	96 % -DI (r) CI (t)	—	95 % -DI (r) CI (t)	—	93 % -DI (r) TW (t)
O2 Device	None (Room air) -CI	None (Room air) -AM	None (Room air) -CI	—	None (Room air) -TW
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -AM	—	0 -TS	—

Row Name	06/21/18 0030	06/20/18 23:57:07	06/20/18 2133	06/20/18 19:43:22	06/20/18 15:50:04
Vitals					
Temp	—	98.4 °F (36.9 °C) -DI (r) TW (t)	—	98.2 °F (36.8 °C) -DI (r) TW (t)	98.3 °F (36.8 °C) -DI (r) LF (t)
Temp src	—	Oral -TW	—	Oral -TW	—
Pulse	—	109 -DI (r) TW (t)	—	66 -DI (r) TW (t)	62 -DI (r) LF (t)
Heart Rate Source	—	Monitor -TW	—	Monitor -TW	—
Resp	—	16 -DI (r) TW (t)	—	16 -DI (r) TW (t)	17 -DI (r) LF (t)
BP	—	124/53 -DI (r) TW (t)	—	113/55 -DI (r) TW (t)	154/80 -DI (r) LF (t)
Patient Position	—	Supine -TW	—	Supine -TW	—
Oxygen Therapy					
SpO2	—	93 % -DI (r) TW (t)	—	93 % -DI (r) TW (t)	(!) 89 % -DI (r) LF (t)
O2 Device	—	None (Room air) -TW	None (Room air) -TS	None (Room air) -TW	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -TS	—	—
FACES Pain Rating 1					
FACES Pain Rating	0-No hurt -TS	—	—	—	—

Row Name	06/20/18 1458	06/20/18 14:02:02	06/20/18 1000	06/20/18 0909	06/20/18 0900
Vitals					
Temp	—	98.2 °F (36.8 °C) -DI (r) LF (t)	—	—	—
Pulse	—	61 -DI (r) LF (t)	61 -DG	59 -DG	60 -DG
Resp	—	—	18 -DG	—	17 -DG
BP	—	104/66 -DI (r) LF (t)	122/54 -DG	(!) 122/49 -DG	(!) 122/49 -DG
Oxygen Therapy					
SpO2	—	92 % -DI (r) LF (t)	(!) 88 % -DG	—	(!) 87 % -DG
O2 Device	None (Room air) -MS	—	—	—	—

Row Name	06/20/18 0830	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500
Vitals					
Temp	—	—	98.3 °F (36.8 °C) -HT	—	—
Temp src	—	—	Oral -HT	—	—
Pulse	—	58 -DG	—	59 -EE	57 -EE
Resp	—	18 -DG	—	20 -EE	20 -EE
BP	—	138/62 -DG	—	129/57 -EE	130/50 -EE
Oxygen Therapy					
SpO2	—	(!) 88 % -DG	—	93 % -EE	94 % -EE
O2 Device	—	None (Room air) -DG	—	—	—
Pulse Oximetry Type	—	Continuous -DG	—	—	—
Pain Assessment					
Multiple Pain Sites	No -MS	—	—	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 Simultaneous filing. User may be unaware of other data. -MS	—	2 -DG	—	—

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/20/18 0830	06/20/18 0800	06/20/18 0730	06/20/18 0600	06/20/18 0500
Pain Onset 1	—	—	Gradual -DG	—	—
Pain Location 1	—	—	Back -DG	—	—
Pain Location Orientation 1	—	—	Anterior -DG	—	—
Pain Quality 1	—	—	Aching -DG	—	—
Pain Type 1	—	—	Acute pain -DG	—	—
Aggravating Factors	—	—	Movement -DG	—	—
Alleviating Factors 1	—	—	Medication;Positioning -DG	—	—
Clinical Progression 1	Resolved -MS	—	—	—	—

Row Name	06/20/18 0400	06/20/18 0300	06/20/18 0200	06/20/18 0000	06/19/18 2300
Vitals					
Temp	98 °F (36.7 °C) -JP	—	—	97.5 °F (36.4 °C) -JP	—
Temp src	Oral -JP	—	—	Axillary -JP	—
Pulse	56 -EE	57 -EE	64 -EE	59 -EE	61 -EE
Resp	19 -EE	21 -EE	16 -EE	22 -EE	21 -EE
BP	119/51 -EE	122/58 -EE	(!) 111/47 -EE	—	128/56 -EE
Oxygen Therapy					
SpO2	94 % -EE	97 % -EE	91 % -EE	90 % -EE	97 % -EE

Row Name	06/19/18 2200	06/19/18 2100	06/19/18 2000	06/19/18 1900	06/19/18 1800
Vitals					
Temp	—	—	98.4 °F (36.9 °C) -JP	—	—
Temp src	—	—	Oral -JP	—	—
Pulse	62 -EE	61 -EE	63 -EE	64 -EE	61 -JI
Resp	22 -EE	16 -EE	21 -EE	19 -EE	25 -JI
BP	132/51 -EE	130/60 -EE	135/58 -EE	133/61 -EE	128/56 -JI
Oxygen Therapy					
SpO2	96 % -EE	94 % -EE	94 % -EE	94 % -EE	92 % -JI
O2 Device	—	—	Nasal cannula -EE	—	—
O2 Flow Rate (L/min)	—	—	2 L/min -EE	—	—
Pulse Oximetry Type	—	—	Continuous -EE	—	—
Pain Assessment History					
Previous experiences with pain?	—	—	No -EE	—	—
History of Chronic Pain?	—	—	No -EE	—	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -EE	—	—

Row Name	06/19/18 1700	06/19/18 1644	06/19/18 1600	06/19/18 1500	06/19/18 1430
Vitals					
Temp	—	97.9 °F (36.6 °C) -FT	—	—	—
Temp src	—	Oral -FT	—	—	—
Pulse	59 -JI	—	58 -JI	56 -JI	57 -JI
Resp	21 -JI	—	20 -JI	22 -JI	19 -JI
BP	132/52 -JI	—	134/58 -JI	130/51 -JI	142/60 -JI
Oxygen Therapy					
SpO2	96 % -JI	—	95 % -JI	96 % -JI	96 % -JI
O2 Device	—	—	—	—	Nasal cannula -JI
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -JI
Pulse Oximetry Type	—	—	—	—	Continuous -JI
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	0 -JI	—	—

Row Name	06/19/18 1428	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321
Vitals					
Temp	97.7 °F (36.5 °C) -FT	—	—	—	—
Temp src	Oral -FT	—	—	—	—
Pulse	—	54 -LFA	54 -LFA	53 -LFA	53 -CR
Resp	—	22 -LFA	19 -LFA	21 -LFA	18 -CR
BP	—	123/59 -LFA	128/55 -LFA	(!) 95/46 -LFA	110/53 -CR

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/19/18 1428	06/19/18 1335	06/19/18 1330	06/19/18 1325	06/19/18 1321
Oxygen Therapy					
SpO2	—	100 % -LFA	97 % -LFA	92 % -LFA	93 % -CR
Pain Assessment					
Pain Assessment	—	—	—	—	0-10 -CR
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	—	—	—	0 -CR

Row Name	06/19/18 1114	06/19/18 1031	06/19/18 1000	06/19/18 0900	06/19/18 0808
Vitals					
Pulse	51 -PM	—	50 -JI	51 -JI	55 -JI
Heart Rate Source	Monitor -PM	—	—	—	—
Resp	13 -PM	—	20 -JI	18 -JI	—
BP	123/54 -PM	—	(!) 124/49 -JI	(!) 119/44 -JI	(!) 126/47 -JI
Patient Position	Sitting -PM	—	—	—	—
Oxygen Therapy					
SpO2	98 % -PM	—	92 % -JI	95 % -JI	—
O2 Device	Nasal cannula -PM	None (Room air) -JI	—	—	—
O2 Flow Rate (L/min)	3 L/min -PM	—	—	—	—

Row Name	06/19/18 0800	06/19/18 0700	06/19/18 0600	06/19/18 0500	06/19/18 0400
Vitals					
Temp	98.6 °F (37 °C) -DF	—	—	—	98.2 °F (36.8 °C) -MJ
Temp src	Oral -DF	—	—	—	—
Pulse	56 -JI	63 -JI	52 -RM	53 -RM	55 -RM
Heart Rate Source	—	—	—	Monitor -RM	Monitor -RM
Resp	18 -JI	18 -JI	17 -RM	17 -RM	20 -RM
BP	(!) 126/47 -JI	143/52 -JI	(!) 109/40 -RM	(!) 124/49 -RM	127/55 -RM
Patient Position	—	—	—	Sitting -RM	Supine -RM
Oxygen Therapy					
SpO2	97 % -JI	96 % -JI	94 % -RM	96 % -RM	98 % -RM
O2 Device	Nasal cannula -JI	—	—	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	2 L/min -JI	—	—	—	—
Pulse Oximetry Type	Continuous -JI	—	—	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	—	—	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	—	—	90 -RM	90 -RM
POX Probe Site Changed	—	—	—	No -RM	No -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -JI	—	—	—	—

Row Name	06/19/18 0300	06/19/18 0200	06/19/18 0100	06/19/18 0000	06/18/18 2300
Vitals					
Temp	—	—	—	98.1 °F (36.7 °C) -MJ	—
Pulse	55 -RM	54 -RM	53 -RM	56 -RM	59 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM
Resp	16 -RM	19 -RM	19 -RM	21 -RM	20 -RM
BP	120/59 -RM	113/50 -RM	(!) 109/44 -RM	(!) 123/43 -RM	127/59 -RM
Patient Position	Lying right side -RM	Lying right side -RM	Lying left side -RM	Lying left side -RM	Lying left side -RM
Oxygen Therapy					
SpO2	92 % -RM	93 % -RM	92 % -RM	94 % -RM	97 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	No -RM

Row Name	06/18/18 2200	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800
Vitals					
Temp	—	—	98.4 °F (36.9 °C) -MJ	—	—
Pulse	55 -RM	56 -RM	56 -RM	56 -RM	56 -RM
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	—
Resp	21 -RM	21 -RM	22 -RM	22 -RM	20 -RM

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/18/18 2200	06/18/18 2100	06/18/18 2000	06/18/18 1900	06/18/18 1800
BP	—	—	—	—	132/60 -RM
Patient Position	Supine -RM	—	—	—	—
Oxygen Therapy					
SpO2	99 % -RM	99 % -RM	96 % -RM	(!) 89 % -RM	94 % -RM
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	—
SpO2 Alarm Limit High	100 -RM	100 -RM	100 -RM	100 -RM	—
SpO2 Alarm Limit Low	90 -RM	90 -RM	90 -RM	90 -RM	—
POX Probe Site Changed	No -RM	No -RM	No -RM	No -RM	—
Pain Goal					
Patient's Stated Pain Goal	—	—	0 (No Pain) -RM	—	—
Pain Assessment History					
Previous experiences with pain?	—	No -RM	No -RM	No -RM	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -RM	0 -RM	0 -RM	—

Row Name	06/18/18 1727	06/18/18 1600	06/18/18 1500	06/18/18 1400	06/18/18 1300
Vitals					
Temp	98.1 °F (36.7 °C) -JD	—	—	—	—
Temp src	Oral -JD	—	—	—	—
Pulse	—	52 -JI	54 -JI	58 -JI	57 -JI
Resp	—	20 -JI	18 -JI	19 -JI	15 -JI
BP	—	142/57 -JI	151/56 -JI	134/53 -JI	(!) 130/45 -JI
Oxygen Therapy					
SpO2	—	(!) 87 % -JI	95 % -JI	91 % -JI	93 % -JI
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JI	—	—	—

Row Name	06/18/18 1230	06/18/18 1200	06/18/18 1100	06/18/18 1000	06/18/18 0900
Vitals					
Temp	97.7 °F (36.5 °C) -JD	—	—	—	—
Temp src	Oral -JD	—	—	—	—
Pulse	—	52 -JI	50 -JI	51 -JI	(!) 49 -JI
Resp	—	18 -JI	17 -JI	16 -JI	16 -JI
BP	—	140/56 -JI	(!) 128/46 -JI	131/52 -JI	137/54 -JI
Oxygen Therapy					
SpO2	—	—	97 % -JI	98 % -JI	100 % -JI
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JI	—	—	—

Row Name	06/18/18 0831	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500
Vitals					
Temp	97.8 °F (36.6 °C) -JD	—	—	98.2 °F (36.8 °C) -RM	—
Temp src	Oral -JD	—	—	Axillary -RM	—
Pulse	—	(!) 48 -JI	(!) 46 -JI	(!) 46 -RM	(!) 47 -RM
Heart Rate Source	—	—	—	Monitor -RM	Monitor -RM
Resp	—	17 -JI	17 -JI	13 -RM	18 -RM
BP	—	(!) 123/49 -JI	(!) 115/49 -JI	(!) 126/48 -RM	122/52 -RM
Patient Position	—	—	—	Supine -RM	Lying left side -RM
Oxygen Therapy					
SpO2	—	91 % -JI	95 % -JI	97 % -RM	97 % -RM
O2 Device	—	Nasal cannula -JI	—	Nasal cannula -RM	Nasal cannula -RM
O2 Flow Rate (L/min)	—	5 L/min -JI	—	—	—
Pulse Oximetry Type	—	Continuous -JI	—	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	—	—	—	100 -RM	100 -RM
SpO2 Alarm Limit Low	—	—	—	90 -RM	90 -RM
POX Probe Site Changed	—	—	—	No -RM	No -RM

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/18/18 0831	06/18/18 0800	06/18/18 0700	06/18/18 0600	06/18/18 0500
Height and Weight					
Weight	—	—	—	104.9 kg (231 lb 4.2 oz) -RM	—
Weight Method	—	—	—	Actual -RM	—
Pain Assessment History					
Previous experiences with pain?	—	—	—	No -RM	No -RM
History of Chronic Pain?	—	—	—	No -RM	No -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -JI	—	0 -RM	0 -RM

Row Name	06/18/18 0445	06/18/18 0400	06/18/18 0300	06/18/18 0200	06/18/18 0115
Vitals					
Temp	98.6 °F (37 °C) -RM	—	—	—	—
Temp src	Axillary -RM	—	—	—	—
Pulse	**(!) 47** -RM	**(!) 49** -RM	**(!) 49** -RM	51 -RM	54 -RM
Heart Rate Source	—	Monitor -RM	Monitor -RM	Monitor -RM	—
Resp	18 -RM	19 -RM	18 -RM	19 -RM	20 -RM
BP	120/52 -RM	117/50 -RM	**(!) 109/43** -RM	**(!) 102/39** -RM	—
Patient Position	—	Sitting -RM	Supine -RM	Lying right side -RM	—
Oxygen Therapy					
SpO2	—	97 % -RM	92 % -RM	**(!) 87 %** -RM	—
O2 Device	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -RM	—
O2 Flow Rate (L/min)	—	—	5 L/min -RM	5 L/min -RM	—
Pulse Oximetry Type	Continuous -RM	Continuous -RM	Continuous -RM	Continuous -RM	—
SpO2 Alarm Limit High	—	100 -RM	100 -RM	100 -RM	—
SpO2 Alarm Limit Low	—	90 -RM	90 -RM	90 -RM	—
POX Probe Site Changed	—	No -RM	No -RM	No -RM	—
Pain Assessment History					
Previous experiences with pain?	—	No -RM	No -RM	No -RM	—
History of Chronic Pain?	—	No -RM	No -RM	No -RM	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	—	0 -RM	0 -RM	0 -RM	—

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0000	06/17/18 2300	06/17/18 2225
Vitals					
Temp	—	98.1 °F (36.7 °C) -RM	—	—	98 °F (36.7 °C) -AF
Temp src	—	Oral -RM	—	—	Oral -AF
Pulse	57 -RM	57 -RM	55 -RM	54 -RM	53 -AF
Heart Rate Source	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -RM	Monitor -AF
Resp	21 -RM	20 -RM	20 -RM	17 -RM	18 -AF
BP	123/51 -RM	140/52 -RM	**(!) 115/45** -RM	**(!) 110/41** -RM	**(!) 128/41** -AF
Patient Position	Lying left side -RM	—	Lying left side -RM	Sitting -RM	Sitting -RM
Oxygen Therapy					
SpO2	**(!) 88 %** -RM	—	92 % -RM	90 % -RM	92 % -AF
O2 Device	Nasal cannula -RM	—	Nasal cannula -RM	Nasal cannula -RM	Nasal cannula -AF
O2 Flow Rate (L/min)	—	—	—	—	2 L/min -AF
Pulse Oximetry Type	Continuous -RM	—	Continuous -RM	Continuous -RM	Continuous -RM
SpO2 Alarm Limit High	100 -RM	—	100 -RM	100 -RM	100 -RM
SpO2 Alarm Limit Low	90 -RM	—	90 -RM	90 -RM	90 -RM
POX Probe Site Changed	No -RM	—	Yes -RM	No -RM	No -RM
Height and Weight					
Height	—	—	—	—	67" (1.702 m) -AF
Weight	—	—	—	—	103.4 kg (227 lb 15.3 oz) -AF
Weight Method	—	—	—	—	Actual -AF
BMI (Calculated)	—	—	—	—	35.7 -AF

Flowsheets (all recorded) (continued)

Vitals/Pain (continued)

Row Name	06/18/18 0100	06/18/18 0051	06/18/18 0000	06/17/18 2300	06/17/18 2225
BSA (Calculated - sq m)	—	—	—	—	2.21 sq meters -AF
Pain Assessment History					
Previous experiences with pain?	No -RM	—	No -RM	No -RM	No -RM
History of Chronic Pain?	No -RM	—	No -RM	No -RM	No -RM
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -RM	—	0 -RM	0 -RM	0 -RM

Row Name	06/17/18 2037	06/17/18 1823	06/17/18 1738	06/17/18 1720	06/17/18 1708
Vitals					
Temp	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	98.2 °F (36.8 °C) -BR	97.8 °F (36.6 °C) -BR
Temp src	Oral -BR	Oral -BR	Oral -BR	Oral -BR	Oral -BR
Pulse	57 -BR	51 -BR	55 -BR	55 -BR	55 -BR
Heart Rate Source	Monitor -BR	Monitor -BR	Monitor -BR	—	Monitor -BR
Resp	16 -BR	18 -BR	18 -BR	18 -BR	18 -BR
BP	134/59 -BR	126/55 -BR	132/56 -BR	129/53 -BR	**(!) 115/49** -BR
Patient Position	Sitting -BR	Sitting -BR	Sitting -BR	—	Standing -BR
Oxygen Therapy					
SpO2	100 % -BR	100 % -BR	100 % -BR	—	100 % -BR
O2 Device	—	None (Room air) -BR	None (Room air) -BR	—	None (Room air) -BR
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -BR	0 -BR	—	—	—

Row Name	06/17/18 1706	06/17/18 1538	06/17/18 1537	06/17/18 1535	06/17/18 1504
Vitals					
Temp	—	—	97.8 °F (36.6 °C) -RG	—	—
Pulse	—	—	55 -RG	—	—
Resp	—	—	22 -RG	—	—
BP	—	—	114/51 -RG	—	—
Oxygen Therapy					
O2 Device	—	None (Room air) -RG	—	—	—
Height and Weight					
Weight	—	—	—	95.3 kg (210 lb) -RG	—
Weight Method	—	—	—	Stated -RG	—
Numeric Pain Intensity Scale					
Numeric Pain Intensity Score 1	0 -BR	—	—	—	0 -RG

Row Name	06/17/18 1502	06/17/18 1437
Vitals		
Temp	97.7 °F (36.5 °C) -RG	—
Temp src	Oral -RG	—
Pulse	54 -RG	56 -NS
Heart Rate Source	Monitor -RG	—
Resp	25 -RG	—
BP	112/52 -RG	—
Patient Position	Supine -RG	—
Oxygen Therapy		
SpO2	100 % -RG	98 % -NS
O2 Device	None (Room air) -RG	—
Pulse Oximetry Type	Continuous -RG	—

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
UE	Epic, User	—
SK	Shannon Kelley, RN	02/03/17 -
VT	Victoria Touchstone, RN	02/03/17 -
NS	Naomi Shelton, RN	12/06/13 -
CR	Cheryl A Root, RN	02/03/17 -

Flowsheets (all recorded) (continued)

User Key (continued)

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
CD	Candace N Dean, RN	12/06/13 -
BR	Brian J Rooney, RN	12/06/13 -
PM	Pamela Y Mott, RN	02/03/17 -
KC	Kristy L Cirami	02/03/17 -
KG	Kathryn R Gray, RN	06/18/18 -
EE	Emelin C Edang, RN	12/06/13 - 11/27/18
AM	Alane Morabit, RN	02/03/17 -
RG	Raquel Gil-Trani, RN	04/01/14 -
MD	Mark Daigle, RN	02/02/17 -
BA	Benjamin E Addison, MSW	02/03/17 -
TW	Terrance S Williams, CNA	02/03/17 - 12/26/19
MJ	Monique L Jones, MA	02/02/17 -
JD	Jessican Dobyne, CNA	02/03/17 -
KW	Katlin Wise, RN	12/19/14 -
SJ	Shelby Joji, RCP	02/03/17 -
LT	Luis E Torres Rodriguez	02/03/17 -
RM	Renata Marques-Bryant, RN	02/03/17 -
DF	Demaris Flowers-Taylor, CCP	02/03/17 -
NP	Nirali Patel, RN	02/03/17 -
FT	Felicia Tremble	12/26/17 -
AF	Amy Feltz, RN	02/03/17 -
JI	Janet Ian, RN	02/03/17 -
HT	Hayley Taylor, CNA	01/03/18 -
JP	Jennifer Peake, CNA	02/03/17 -
DG	Dolores Gervase, RN	02/01/17 -
JK	Jeremy Keisler	10/31/17 -
MS	Morgan Stull, RN	07/10/17 - 11/27/18
RD	Rachel Denmark, RN	09/22/17 - 11/27/18
TS	Tenikia Smith, RN	09/07/17 - 11/27/18
LF	Lydia Faggins	10/03/17 -
LFA	Laura Friedman, RN	12/04/17 - 11/27/18
CI	Chingozirim A Igba	06/08/18 -
NI	Nurse Inpatient	—
DM	Donna Marzinske	—
DI	Interface, Doc Flowsheet In	—
DK	Douglas E Krug, MD	05/31/18 - 07/24/18
AH	Andrea C Horsford, PAA	06/12/18 - 06/12/18
CM	Colleen M Meffert, PAA	06/17/18 - 11/09/18

Flowsheet Notes

Significant Event by Jonathan Murray, RN at 6/21/2018 1:51 PM

Author: Jonathan Murray, RN
Filed: 6/21/2018 2:06 PM
Editor: Jonathan Murray, RN (Registered Nurse)
Service: —
Date of Service: 6/21/2018 1:51 PM
Author Type: Registered Nurse
Status: Signed

Attended Discharge Center:

1. Reviewed AVS.
2. Reviewed RX and offered retail pharmacy assistance.
3. Offered f/u appointment assistance.
4. Offered MyChart registration assistance.
5. Education Reinforced - pt verbalized understanding.

Electronically Signed by Jonathan Murray, RN on 6/21/2018 2:06 PM

All Scans

Encounter-Level Documents - 06/17/2018:

Scan on 6/25/2018 8:55 PM (below)

Scan on 6/25/2018 8:55 PM (below)

Scan on 6/23/2018 7:08 PM (below)

Document on 6/21/2018 12:32 PM by Alane Morabit, RN: IP AVS (below)

WELLSTAR.

AFTER VISIT SUMMARY

Eugene G. Maurice Date of birth: 1/2/1949
Upper GI bleed 6/17/2018 - 6/21/2018 WellStar Kennestone Hospital (KH G5N SURGERY)

Instructions

Your medications may have changed today.
See your updated medication list.

Physicians who cared for you during your hospitalization

Provider	Service	Role	Specialty
Samina Fakhr, MD	Internal Medicine	Attending Provider	Hospital Medicine
David L Parks, MD	Otolaryngology/ ENT	Consulting Physician	Otolaryngology
CVM, CARDIOLOGIST	--	Consulting Physician	--

You are allergic to the following

Not on File

Order	Current Status
Lactic Acid	Collected (06/18/18 0053)
Lactic Acid	Collected (06/18/18 0243)
Blood culture	Preliminary result
Blood culture	Preliminary result

What's next

Follow up with Jeffrey L Tharp, MD in 1 week(s) with CBC, CMP	176 Charles Hardy Parkway Unit C Hiram GA 30141 678-945-8200
Follow up with Abdul M Sheikh, MD in 1 week(s)	144 Bill Carruth Parkway Suite 4200 Hiram GA 30141-3749 678-324-4444

Your Next Steps

To Do

☐ Pick up these medications from any pharmacy with your printed prescription
- ferrous sulfate
- furosemide
- oxymetazoline
- pantoprazole
- sotalol

Go

JUN 26 Follow Up Appointment
3:00 PM
Arrive by 2:45 PM
Abdul M Sheikh, MD
WellStar Cardiovascular Medicine Hiram
144 Bill Carruth Parkway STE 4200

HIRAM GA 30141-3749
678-324-4444

You have more future appointments. Please review your full appointment list.

MyChart

View your After Visit Summary and more online at https://mychart.wellstar.org/mychart/.

Eugene G. Maurice (MRN: 561253820) • Printed at 6/21/18 12:32 PM

Page 1 of 5 Epic

What's next (continued)

	Follow up with Patrick C Melder, MD in 1 week(s)	699 Church Street Suite 340 Marietta GA 30060 678-355-1620
	Follow up with Gi Specialist Of Georgia in 2 week(s)	
JUN 26	Follow Up Appointment with Abdul M Sheikh, MD **Tuesday Jun 26, 2018 3:00 PM (Arrive by 2:45 PM)**	WellStar Cardiovascular Medicine Hiram 144 Bill Carruth Parkway Ste 4200 Hiram GA 30141-3749 678-324-4444
AUG 21	Follow Up Appointment with Beau N Dusseault, MD **Tuesday Aug 21, 2018 9:15 AM (Arrive by 9:00 AM)**	WellStar Urology Hiram 144 Bill Carruth Pkwy Suite 2300 Hiram GA 30141-3821 770-428-4475

Medication List

START taking these medications

Medication	Morning	Noon	Evening	Bedtime	As Needed
START **ferrous sulfate** 324 mg (65 mg iron) Tbec Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals Dose: 324 mg Given today?: No Next dose due: With dinner					
START **oxymetazoline** 0.05 % nasal spray Commonly known as: AFRIN 2 sprays by Nasal route 2 (two) times a day as needed (nose bleed) Dose: 2 spray Given today?: No					
START **pantoprazole** 40 MG EC tablet Commonly known as: PROTONIX Take 1 tablet (40 mg total) by mouth 2 (two) times a day before meals Dose: 40 mg Given today?: Yes Next dose due: Before dinner	8:37 am				

CHANGE how you take these medications

Medication	Morning	Noon	Evening	Bedtime	As Needed
CHANGE **furosemide** 20 MG tablet Commonly known as: LASIX Take 1 tablet (20 mg total) by mouth every other day Dose: 20 mg What changed: **when to take this** Given today?: No Next dose due: 6/22/18 Notes to patient: Last dose taken 6/20/18 @ 1:10 pm					
CHANGE **sotalol** 80 MG tablet Commonly known as: BETAPACE Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day Dose: 40 mg What changed: **how much to take** Given today?: Yes Next dose due: 9:00 pm	8:37 am				

CONTINUE taking these medications

Medication List (continued)

CONTINUE taking these medications (continued)

Medication	Morning	Noon	Evening	Bedtime	As Needed
CONTINUE apixaban 5 mg tablet Commonly known as: ELIQUIS Take 1 tablet (5 mg total) by mouth 2 (two) times a day Dose: 5 mg Given today?: Yes Next dose due: 9:00 pm	8:37 am				
CONTINUE atorvastatin 80 MG tablet Commonly known as: LIPITOR Take 1 tablet (80 mg total) by mouth nightly Dose: 80 mg Given today?: No Next dose due: 9:00 pm					
CONTINUE * blood sugar diagnostic strip Commonly known as: glucose blood cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed..					
CONTINUE * blood sugar diagnostic strip True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9					
CONTINUE isosorbide mononitrate 30 MG 24 hr tablet Commonly known as: IMDUR Take 2 tablets (60 mg total) by mouth 2 (two) times a day Dose: 60 mg Given today?: Yes Next dose due: 9:00 pm	8:38 am				
CONTINUE metFORMIN 500 MG tablet Commonly known as: GLUCOPHAGE 2 tablets po in am and 2 in pm For: type 2 diabetes mellitus Given today?: No Next dose due: With dinner					
CONTINUE nitroglycerin 0.4 MG SL tablet Commonly known as: NITROSTAT Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain Dose: 0.4 mg Given today?: No					
CONTINUE VITAMIN B12 ORAL Take 1 tablet by mouth daily Dose: 1 tablet Given today?: No					

Medication List (continued)

CONTINUE taking these medications (continued)

* DUPLICATE WARNING: This list has medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.

STOP taking these medications

STOP

aspirin, buffered 81 mg Tab

STOP

carvedilol 6.25 MG tablet
Commonly known as: COREG

STOP

ramipril 10 MG capsule
Commonly known as: ALTACE

Where to pick up your medications

Pick up these medications from any pharmacy with your printed prescription
ferrous sulfate • furosemide • oxymetazoline • pantoprazole • sotalol

Document on 6/21/2018 12:11 PM by Alane Morabit, RN: IP AVS (below)

WELLSTAR.

AFTER VISIT SUMMARY

Eugene G. Maurice Date of birth: 1/2/1949

Upper GI bleed 6/17/2018 - 6/21/2018 WellStar Kennestone Hospital (KH G5N SURGERY)

Instructions

Your medications may have changed today.
See your updated medication list.

Physicians who cared for you during your hospitalization

Provider	Service	Role	Specialty
Samina Fakhr, MD	Internal Medicine	Attending Provider	Hospital Medicine
David L Parks, MD	Otolaryngology/ ENT	Consulting Physician	Otolaryngology
CVM, CARDIOLOGIST	--	Consulting Physician	--

You are allergic to the following

Not on File

Order	Current Status
Lactic Acid	Collected (06/18/18 0053)
Lactic Acid	Collected (06/18/18 0243)
Blood culture	Preliminary result
Blood culture	Preliminary result

What's next

Follow up with Jeffrey L Tharp, MD in 1 week(s) with CBC, CMP	176 Charles Hardy Parkway Unit C Hiram GA 30141 678-945-8200
Follow up with Abdul M Sheikh, MD in 1 week(s)	144 Bill Carruth Parkway Suite 4200 Hiram GA 30141-3749 678-324-4444

Your Next Steps

To Do

- [ ] Pick up these medications from any pharmacy with your printed prescription
  - ferrous sulfate
  - furosemide
  - oxymetazoline
  - pantoprazole
  - sotalol

Go

JUN 26 Follow Up Appointment
3:00 PM
Arrive by 2:45 PM
Abdul M Sheikh, MD
WellStar Cardiovascular Medicine Hiram
144 Bill Carruth Parkway STE 4200

HIRAM GA 30141-3749
678-324-4444

You have more future appointments. Please review your full appointment list.

MyChart

View your After Visit Summary and more online at https://mychart.wellstar.org/mychart/.

What's next (continued)

	Follow up with Patrick C Melder, MD in 1 week(s)	699 Church Street Suite 340 Marietta GA 30060 678-355-1620
	Follow up with Gi Specialist Of Georgia in 2 week(s)	
JUN 26	Follow Up Appointment with Abdul M Sheikh, MD **Tuesday Jun 26, 2018 3:00 PM (Arrive by 2:45 PM)**	WellStar Cardiovascular Medicine Hiram 144 Bill Carruth Parkway Ste 4200 Hiram GA 30141-3749 678-324-4444
AUG 21	Follow Up Appointment with Beau N Dusseault, MD **Tuesday Aug 21, 2018 9:15 AM (Arrive by 9:00 AM)**	WellStar Urology Hiram 144 Bill Carruth Pkwy Suite 2300 Hiram GA 30141-3821 770-428-4475

Medication List

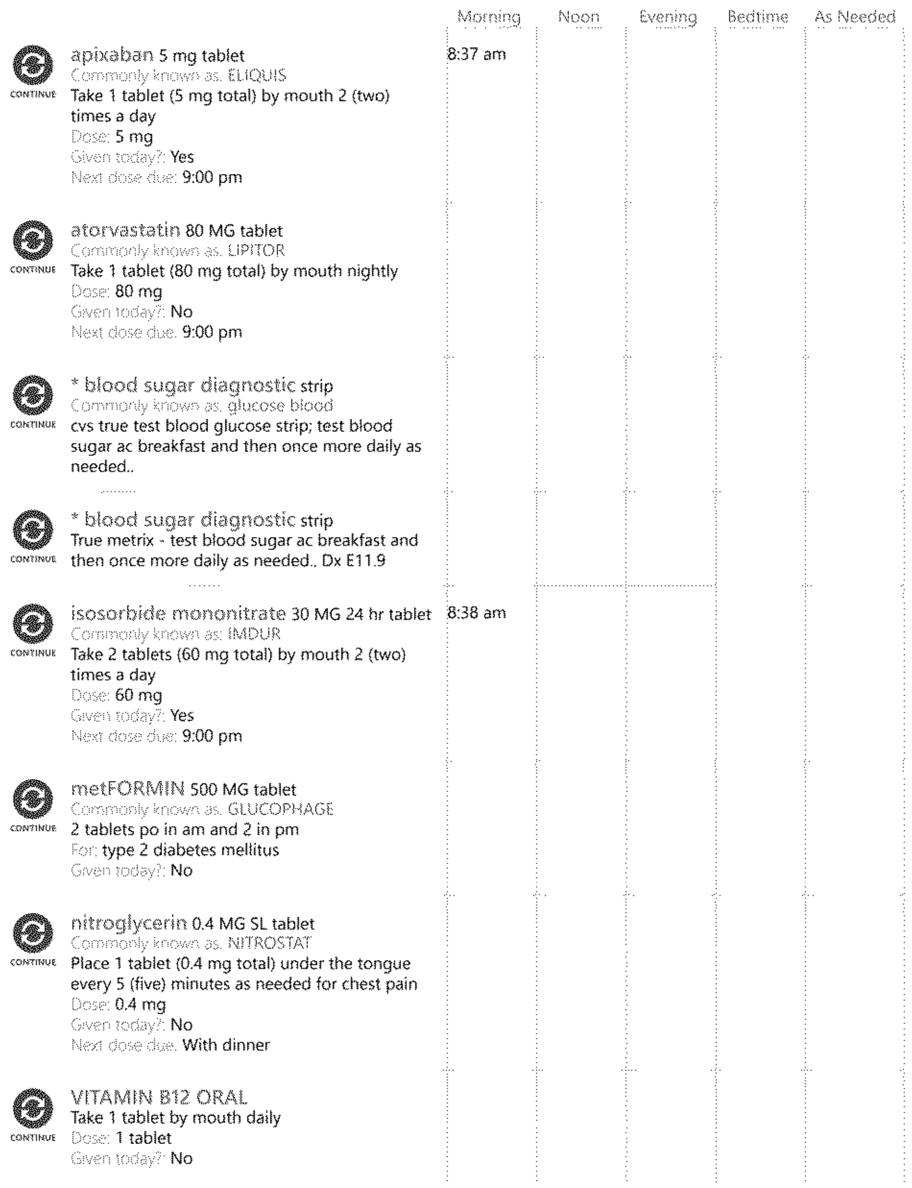
START taking these medications

Medication	Morning	Noon	Evening	Bedtime	As Needed
START **ferrous sulfate** 324 mg (65 mg iron) Tbec Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals Dose: 324 mg Given today?: No Next dose due: With dinner					
START **oxymetazoline** 0.05 % nasal spray Commonly known as: AFRIN 2 sprays by Nasal route 2 (two) times a day as needed (nose bleed) Dose: 2 spray Given today?: No					
START **pantoprazole** 40 MG EC tablet Commonly known as: PROTONIX Take 1 tablet (40 mg total) by mouth 2 (two) times a day before meals Dose: 40 mg Given today?: Yes Next dose due: Before dinner	8:37 am				

CHANGE how you take these medications

Medication	Morning	Noon	Evening	Bedtime	As Needed
CHANGE **furosemide** 20 MG tablet Commonly known as: LASIX Take 1 tablet (20 mg total) by mouth every other day Dose: 20 mg What changed: **when to take this** Given today?: No Next dose due: 6/22/18 Notes to patient: Last dose taken 6/20/18 @ 1:10 pm					
CHANGE **sotalol** 80 MG tablet Commonly known as: BETAPACE Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day Dose: 40 mg What changed: **how much to take** Given today?: Yes Next dose due: 9:00 pm	8:37 am				

CONTINUE taking these medications



Medication List (continued)

CONTINUE taking these medications (continued)

Medication	Morning	Noon	Evening	Bedtime	As Needed
CONTINUE **apixaban** 5 mg tablet Commonly known as: ELIQUIS Take 1 tablet (5 mg total) by mouth 2 (two) times a day Dose: 5 mg Given today?: Yes Next dose due: 9:00 pm	8:37 am				
CONTINUE **atorvastatin** 80 MG tablet Commonly known as: LIPITOR Take 1 tablet (80 mg total) by mouth nightly Dose: 80 mg Given today?: No Next dose due: 9:00 pm					
CONTINUE * **blood sugar diagnostic** strip Commonly known as: glucose blood cvs true test blood glucose strip; test blood sugar ac breakfast and then once more daily as needed..					
CONTINUE * **blood sugar diagnostic** strip True metrix - test blood sugar ac breakfast and then once more daily as needed.. Dx E11.9					
CONTINUE **isosorbide mononitrate** 30 MG 24 hr tablet Commonly known as: IMDUR Take 2 tablets (60 mg total) by mouth 2 (two) times a day Dose: 60 mg Given today?: Yes Next dose due: 9:00 pm	8:38 am				
CONTINUE **metFORMIN** 500 MG tablet Commonly known as: GLUCOPHAGE 2 tablets po in am and 2 in pm For: type 2 diabetes mellitus Given today?: No					
CONTINUE **nitroglycerin** 0.4 MG SL tablet Commonly known as: NITROSTAT Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain Dose: 0.4 mg Given today?: No Next dose due: With dinner					
CONTINUE **VITAMIN B12 ORAL** Take 1 tablet by mouth daily Dose: 1 tablet Given today?: No					

Medication List (continued)

CONTINUE taking these medications (continued)

* **DUPLICATE WARNING: This list has medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.**

STOP taking these medications

STOP

aspirin, buffered 81 mg Tab

STOP

carvedilol 6.25 MG tablet
Commonly known as: COREG

STOP

ramipril 10 MG capsule
Commonly known as: ALTACE

Where to pick up your medications

Pick up these medications from any pharmacy with your printed prescription
ferrous sulfate • furosemide • oxymetazoline • pantoprazole • sotalol

Electronic signature on 6/17/2018 3:43 PM: complete - 1 of 5 e-signatures recorded

Encounter-Level E-Signatures:

CMS IM for Patient Signature (E-Sig) - Received on 6/17/2018

Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FORM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:
Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to KEPRO:
  1-844-455-8708
  KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by KEPRO. This reviewer was hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact KEPRO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the KEPRO and filing an appeal are on page 2**.

To speak with someone at the hospital about this notice, call (770) 793-7100.

Please sign and date here to show you received this notice and understand your rights.

Patient Name

Signature captured with Topaz by Maurice,Eugene G at 6/17/2018 3:42:49 PM

CMS-R-193 (approved 07/10)
WMG Cardiovascular Medicine Hiram
An Important Message from Medicare
About Your Rights

Page 2 of 2

STEPS TO APPEAL YOUR DISCHARGE
- **STEP 1:** You must contact the KEPRO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information: 1-844-455-8708

KEPRO, 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609

- You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
- Ask the hospital if you need help contacting KEPRO.
- The name of this hospital is **WMG Cardiovascular Medicine Hiram 110035**

- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3:** The KEPRO will ask for your opinion. You or your representative need to be available to speak with KEPRO, if requested. You or your representative may give KEPRO a written statement, but you are not required to do so.
- **STEP 4:** The KEPRO will review your medical records and other important information about your case.
- **STEP 5:** KEPRO will notify you of its decision within 1 day after it receives all necessary information.
  - If KEPRO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If KEPRO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after KEPRO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the KEPRO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the KEPRO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
Additional Information: I have received my second notice and understand my appeal rights.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the ime estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, ATTN: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, MD 21244-1850.

WMG Cardiovascular Medicine Hiram
An Important Message from Medicare
About Your Rights

Name: Eugene G Maurice
MRN: 561253820
HAR: 30005374909

Encounter-Level E-Signatures: (continued)

ENCOUNTER

Patient Class:	**OP**		Unit:	**KHUROPROC**
Hospital Service:	**Urology**		Bed:	**Room/bed info not found**
Admitting Provider:			Referring Physician:	**Boren, Kristin M**
Attending Provider:	**Kristin m boren;Michael ***	AD: N	Adm Diagnosis:	**Cancer of prostate with ***
Admission Date:	**8/28/2019**		Admission Time:	**0900**

PATIENT

Name	**Eugene George Maurice**	Sex:	**Male**	DOB:	**1/2/1949 (70 yrs)**
Address:	**61 SHOCKLEY WAY**			Religion:	**Catholic**
City:	**DALLAS GA 30157-8973**			Race:	**White or caucasian**
County:	**PAULDING**				
Email Address:	**Gene.maurice@sgmservice.***				
Primary Care Provider:	**Jeffrey L Tharp, MD**			Primary Phone:	**678-910-2298**

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		**Spouse**	**(678)398-9479**		**678-910-2476**
2. *No Contact Specified*					**678-910-2476**

GUARANTOR

Guarantor:	**MAURICE,EUGENE GEORGE**	DOB:	**1/2/1949**
Address:	**61 SHOCKLEY WAY**	Sex:	**Male**
	DALLAS, GA 30157-8973	Home Phone:	**678-398-9479**
Relation to Patient:	**Self**	Work Phone:	
Guarantor ID:	**123805**	Mobile Phone:	**678-910-2298**

GUARANTOR EMPLOYER

Employer:		Phone:		Status:	**RETIRED**

COVERAGE

PRIMARY INSURANCE

Payor:	**COVENTRY ADVANTRA M***	Plan:	**COVENTRY ADVANTRA /PPO**
Group Number:	**4916004101**	Insurance Type:	**INDEMNITY**
Subscriber Name:	**MAURICE,EUGENE GEOR***	Subscriber DOB:	**01/02/1949**
Coverage	**P O BOX 7156** **LONDON, KY 40742-7156**	Subscriber ID:	**80459609601**
		Pat. Rel. to Subscriber:	**Self**
Phone:	**(866)613-4977**	Co-In: Deductible:	Out of Pocket Max:

SECONDARY INSURANCE

Payor:		Plan:	**N/A**
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage		Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Admission Information

Arrival Date/Time:		Admit Date/Time:	08/28/2019 0900	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Outside Hospital	Admit Category:	
Means of Arrival:		Primary Service:	Urology	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Kennestone Urology Procedure Center
Admit Provider:		Attending Provider:	Kristin M Boren, MD	Referring Provider:	Kristin M Boren, MD

Reason for Visit

Post-op Check

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
09/04/2019 2359	Home Or Self Care	Home	None	WellStar Kennestone Urology Procedure Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
C61 [Principal]	Malignant neoplasm of prostate				
N42.32	Atypical small acinar proliferation of prostate				
E11.9	Type 2 diabetes mellitus without complications				
I10	Essential (primary) hypertension				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			
Z95.1	Presence of aortocoronary bypass graft	Exempt from POA reporting			
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting			
Z79.84	Long term (current) use of oral hypoglycemic drugs	Exempt from POA reporting			
Z79.02	Long term (current) use of antithrombotics/antiplatelets	Exempt from POA reporting			
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting			
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting			

Events

Hospital Outpatient at 8/28/2019 0900

Unit: WellStar Kennestone Urology Procedure Center
Patient class: Outpatient Service: Urology

Discharge at 9/4/2019 2359

Unit: WellStar Kennestone Urology Procedure Center
Patient class: Outpatient Service: Urology

Allergies as of 9/4/2019

Reviewed on 8/28/2019

No Known Allergies

Immunizations as of 9/4/2019

Immunizations last reviewed by Lisa M Stephenson, MA on 7/5/2018 1253

All Scans (continued)

Immunizations (continued) as of 9/4/2019

Annual Influenza

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI700AA

Annual Influenza

Administered on: 9/28/2017 0000 | Site: Left deltoid | Route: Intramuscular
Lot number: UI842AB

Annual Influenza

Administered on: 10/5/2018 0000 | Site: Right deltoid | Route: Intramuscular
Lot number: UJ031AA

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN | Administered on: 9/26/2016 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-399-88
CVX code: 135 | VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur | Lot number: UI700AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Tina M Allen, MA | Administered on: 9/28/2017 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 49281-401-88
CVX code: 135 | VIS date: 09/28/2017
Manufacturer: Sanofi Pasteur | Lot number: UI842AB

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA | Administered on: 10/5/2018 | Dose: 0.5 mL
Site: Right deltoid | Route: Intramuscular | NDC: 49281-403-88
CVX code: 135 | VIS date: 8/7/2015
Product: Fluzone HD | Manufacturer: Sanofi Pasteur | Lot number: UJ031AA
Expiration date: 5/1/2019

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Influenza - Unspecified

Administered on: 9/26/2016 0000 | Site: Left deltoid | Route: Intramuscular
CVX code: 88
Lot number: UI700AA

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA | Administered on: 3/16/2016 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 0005-1971-01
CVX code: 133 | VIS date: 031616
Manufacturer: Wyeth-Ayerst | Lot number: M51193

Pneumococcal Polysaccharide

Administered by: Mary S Wray, MA | Administered on: 10/5/2018 | Dose: 0.5 mL
Site: Left deltoid | Route: Intramuscular | NDC: 0006-4837-01

All Scans (continued)

Immunizations (continued) as of 9/4/2019

CVX code: 33
VIS date: 04/24/2015
Manufacturer: Merck & Co. Inc
Lot number: R012497

Questionnaire

Question	Answer
Have you ever had a serious reaction to any vaccine in the past?	NO
Are you sick today with a moderate to severe illness (e.g. fever)	NO

Pneumococcal Polysaccharide

Administered on: 10/5/2018 0000
Site: Left deltoid
Route: Intramuscular
CVX code: 33
Lot number: R012497

Medical as of 9/4/2019

Past Medical History

Diagnosis	Date	Comments	Source
AKI (acute kidney injury) (HCC) [N17.9]	—	—	Provider
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Cataracts, both eyes [H26.9]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider
Asthma [J45.909]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction (HCC) [I21.9]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

ED Records (continued)

ED Arrival Information (continued)

Chief Complaint

Complaint	Onset	Comment	Last Edited By	Time	Relationship	ED Provider
Post-op Check	8/28/2019		Lisa M Olivarez, RN	8/29/2019 8:33 AM	None	No

ED Disposition

None

H&P - Encounter Notes

H&P by Michael D Bryant, MD at 8/28/2019 8:14 AM

Author: Michael D Bryant, MD
Filed: 8/28/2019 8:14 AM
Editor: Michael D Bryant, MD (Physician)
Service: Urology
Date of Service: 8/28/2019 8:14 AM
Author Type: Physician
Status: Signed

History and Physical

Chief complaint and Indication for procedure
Prostate cancer Active surveillance
History of Present Illness:
Eugene George Maurice is a 70 y.o.male who is seen for prostate ultrasound and core biopsy of the prostate with periprostatic block. The patient is a patient of Dr. Boren
PSA

Lab Results

Component	Value	Date
PSA	7.3 (H)	05/06/2019
PSA	6.7 (H)	02/06/2019
PSA	7.3 (H)	11/09/2018

Past History
Past Medical History:

Diagnosis	Date
• AKI (acute kidney injury) (HCC)	
• CAD (coronary artery disease)	
• Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	1/30/2018
• Cataracts, both eyes	
• Coronary atherosclerosis of native coronary artery	
• Diabetes mellitus (HCC)	
• Essential hypertension, benign	
• Family history of ischemic heart disease	
• Hyperlipidemia	
• Hypertension	
• Infectious viral hepatitis *as teen/cannont recall what type*	
• Obesity	
• Other and unspecified hyperlipidemia	
• Other symptoms involving cardiovascular system	

- PVD (peripheral vascular disease) (HCC)

Past Surgical History:

Procedure	Laterality	Date
• APPENDECTOMY		
• CAROTID ENDARTERECTOMY *x2*		
• COLONOSCOPY *as of 9/2014 has not had this*		
• CORONARY ARTERY BYPASS GRAFT *X6*		1992
• CORONARY STENT PLACEMENT *sheikh*		2014
• EGD *Procedure: GI-EGD (LVL5) W/ BX; Surgeon: Sohail Asfandiyar, MD; Location: KH GI/BRONCH; Service: Gastroenterology; Laterality: N/A;*	N/A	6/19/2018
• shingles		9/2015
• VASCULAR SURGERY *right leg*		

No Known Allergies

(Not in a hospital admission)
Social and Family History

Social History

Substance Use Topics	
• Smoking status:	Former Smoker
Packs/day:	1.00
Years:	25.00
Types:	Cigarettes
Quit date:	4/7/1992
• Smokeless tobacco:	Never Used
• Alcohol use	2.4 oz/week

2 Glasses of wine, 2 Shots of liquor per week
Comment: rarely

Family History

Problem	Relation	Age of Onset
• Coronary artery disease	Mother	
• Other *MI*	Mother	
• Other *MI*	Brother	
• Anemia	Neg Hx	
• Arrhythmia	Neg Hx	
• Asthma	Neg Hx	
• Clotting disorder	Neg Hx	

H&P - Encounter Notes (continued)

H&P by Michael D Bryant, MD at 8/28/2019 8:14 AM (continued)

- Fainting Neg Hx
- Heart attack Neg Hx
- Heart disease Neg Hx
- Heart failure Neg Hx
- Hyperlipidemia Neg Hx
- Hypertension Neg Hx
- Stroke Neg Hx

Pertinent items are noted in the History of Present Illness.
GEN: No acute distress
EYES: EOMI
HEENT: Moist mucus membranes, Sclera non-icteric
CV: Regular rate and rhythm by peripheral pulse
PULM: Easy work of breathing
ABD: Soft, Not tender, Not distended
EXT: No significant lower extremity edema
SKIN: No rashes appreciated
NEURO:No focal deficits

Assessment: Elective Prostate Biopsy 12 cores.

Plan: Prostate ultrasound and biopsy with periprostatic nerve block

The following risks were discussed with patient:
Rectal Bleeding
Blood in Urine
Blood in ejaculatory fluid
Difficulty with urination
Urinary retention
Urinary infection
Severe Sepsis requiring hospitalization

Michael D Bryant, MD
Wellstar Urology
55 Whitcher St.
Marietta, GA 30060
(p) 770-428-4475
(f) 770-426-1499

Electronically Signed by Michael D Bryant, MD on 8/28/2019 8:14 AM

Discharge Instr - Activity - Encounter Notes

Discharge Instr - Activity by Lisa M Olivarez, RN at 8/28/2019 9:03 AM

Author: Lisa M Olivarez, RN | Service: — | Author Type: Registered Nurse
Filed: 8/28/2019 9:03 AM | Date of Service: 8/28/2019 9:03 AM | Status: Written
Editor: Lisa M Olivarez, RN (Registered Nurse)

Discharge Instructions

1. General Anesthesia or Sedation
Do not drive or operate machinery for 24 hours
Do not consume alcohol, tranquilizers, sleeping medication or any other non-prescribed medication for 24 hours.
Do not make any important decisions or sign any important documents in the next 24 hours.
You should have someone with you at home tonight.

2. Activity
You are advised to go directly home from the Urology Associates Surgery Center and rest for a day. Resume light to normal activity tomorrow.
Do not engage in heavy lifting while you see blood in the urine or stool.

3. Fluids and Diet
Begin with clear liquids, bouillon, dry toast, soda crackers. If not nauseated, you may go to a regular diet when you desire.
Greasy or spicy foods are not advised.
Drink plenty of water while you see blood in the urine or stool.
If you are diabetic, please eat before you take your diabetes medication.

4. Medications and Plan
Prescriptions sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications.
You may take non-prescription "headache remedy" type medications that you normally use, if your surgeon permits, preferably one that does not contain aspirin.
You may resume your daily prescription medication when you get home.

Prescriptions
Tylenol as needed for pain or discomfort.
Antibiotic: Cipro this evening.
Patient was provided with updated medication list.

6. Follow up Care
Your physician may call you with biopsy results.

Special Complications to Watch For
You may see blood in your urine or stool for days to weeks.
You may see blood in your ejaculate for up to 6 weeks.
If you have a fever, chills, and are feeling poorly, take your temperature by mouth. Call the office if it is over 101* F.
Please call us if you have large blood clots, difficulty urinating or pain not relieved by Tylenol.

If you have any questions the day of your procedure please call 470-245-9860 to speak with a nurse. For problems or questions after 4:30pm call your urologist at 770-428-4475

If you need immediate attention, go to the emergency room.

Electronically Signed by Lisa M Olivarez, RN on 8/28/2019 9:03 AM

Surgery Report

General Information

Date: 8/28/2019
Time:
Status: Posted
Location: WS Kennestone Urology Procedure at Tower Road
Room:
Service:
Patient class:
Case classification:

Diagnosis Information

No post-op diagnosis codes associated with the log.

Case Tracking Events

Event	Time In
In Facility	0746
In Pre-Procedure	
In Block Room	
Out Block Room	
Pre-Procedure Complete	
Out of Pre-op	
Anesthesia Available	
In Room	
Anesthesia Start	0847
Anesthesia Ready	
Procedure Start	
Procedure End	
Out of Room	
Patient to Floor/ICU	
In Phase I	
Anesthesia Stop	0900
Phase I Criteria Met	
Out of Phase I	
In Phase II	
Phase II Care Complete	
Out of Phase II	
Remove from Status Board	
Anesthesia Follow-up Needed	
Anesthesia Follow-up Complete	
Moderate Sedation Begin	
Moderate Sedation End	

Questionnaire Data

None

PNDS Information

Outcomes - Pre-op

Used?	Description (Code)
Yes	The patient participates in decisions affecting his or her perioperative plan of care. (O23)
Yes	The patient demonstrates knowledge of the expected responses to the operative or invasive procedure. (O31)

Outcomes - Intra-op

Used?	Description (Code)
Yes	The patient is free from signs and symptoms of injury caused by extraneous objects. (O2)
Yes	The patient is free from signs and symptoms of injury related to positioning. (O5)
Yes	The patient is free from signs and symptoms of infection. (O10)

Outcomes - Post-op

Used?	Description (Code)
Yes	The patient is at or returning to normothermia at the conclusion of the immediate postoperative period. (O12)
Yes	The patient's respiratory function is consistent with or improved from baseline levels established preoperatively. (O14)
Yes	The patient demonstrates knowledge of pain management. (O20)
Yes	The patient demonstrates knowledge of wound management. (O22)
Yes	The patient demonstrates and/or reports adequate pain control throughout the perioperative period. (O29)

Surgery Report (continued)

PNDS Information (continued)

Diagnoses

Present?	Description (Code)
Yes	Risk for infection (X28)
Yes	Risk for injury (X29)
Yes	Deficient knowledge (X30)
Yes	Acute pain (X38)
Yes	Anxiety (X4)
Yes	Risk for impaired skin integrity (X51)
Yes	Risk for imbalanced body temperature (X57)
Yes	Ineffective breathing pattern (X7)

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: N/A

Pre-Procedure Verification

H&P note verified?: Yes
Consents verified?: Yes
Site marked?: N/A
Allergies reviewed?: Yes

Verification Date and Time: 8/28/2019 8:49 AM

Nursing - Orders and Results

MAINTAIN IV ACCESS [838765508]

Electronically signed by: **Babur N Kilic, MD on 08/28/19 1357**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Lisa M Olivarez, RN 08/28/19 0829
Authorized by: Babur N Kilic, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]
Communicated by: Lisa M Olivarez, RN
Ordering provider: Babur N Kilic, MD
Ordering mode: Per protocol: cosign required
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM

PATIENT EDUCATION (SPECIFY) [838765511]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0842**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Dawn Coffeen, RN 08/21/19 1118
Authorized by: Michael D Bryant, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]
Order comments: On preparation for the procedure as well as discharge instructions
Communicated by: Dawn Coffeen, RN
Ordering provider: Michael D Bryant, MD
Ordering mode: Per protocol: cosign required
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM

DISCHARGE DIET [838765522]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0904**
Status: **Active**
Ordering user: Michael D Bryant, MD 08/28/19 0904
Authorized by: Michael D Bryant, MD
Frequency: Routine 08/28/19 -
Order comments: Resume previous diet
Ordering provider: Michael D Bryant, MD
Ordering mode: Standard
Quantity: 1

DISCHARGE ACTIVITY [838765523]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0904**
Status: **Active**
Ordering user: Michael D Bryant, MD 08/28/19 0904
Authorized by: Michael D Bryant, MD
Frequency: Routine 08/28/19 -
Order comments: Resume previous activity
Ordering provider: Michael D Bryant, MD
Ordering mode: Standard
Quantity: 1

Nursing - Orders and Results (continued)

DISCHARGE ACTIVITY [838765523] (continued)

DISCHARGE FOLLOW UP [838765524]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0904**
Status: **Active**
Ordering user: Michael D Bryant, MD 08/28/19 0904
Ordering provider: Michael D Bryant, MD
Authorized by: Michael D Bryant, MD
Ordering mode: Standard
Frequency: Routine 08/28/19 -
Quantity: 1
Order comments: .

NURSING COMMUNICATION [838765526]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0904**
Status: **Discontinued**
Ordering user: Michael D Bryant, MD 08/28/19 0904
Ordering provider: Michael D Bryant, MD
Authorized by: Michael D Bryant, MD
Ordering mode: Standard
Quantity: 1
Instance released by: Michael D Bryant, MD (auto-released) 8/28/2019 9:04 AM
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]
Order comments: after patient meets criteria

Code Status - Orders and Results

FULL CODE [838765510]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0842**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Dawn Coffeen, RN
Ordering user: Dawn Coffeen, RN 08/21/19 1118
Ordering provider: Michael D Bryant, MD
Authorized by: Michael D Bryant, MD
Ordering mode: Per protocol: cosign required
Quantity: 1
Code status: Full Code
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]

Questionnaire

Question	Answer
Reason Pending:	Pending scheduled discussion with decision maker
Plan to Address:	Will Reassess

Point of Care Testing - Orders and Results

POCT URINALYSIS DIPSTICK [838765513]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0842**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Dawn Coffeen, RN
Ordering user: Dawn Coffeen, RN 08/21/19 1118
Ordering provider: Michael D Bryant, MD
Authorized by: Michael D Bryant, MD
Ordering mode: Per protocol: cosign required
Quantity: 1
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]

IV - Orders and Results

INSERT PERIPHERAL IV [838765507]

Electronically signed by: **Babur N Kilic, MD on 08/28/19 1357**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Lisa M Olivarez, RN
Ordering user: Lisa M Olivarez, RN 08/28/19 0829
Ordering provider: Babur N Kilic, MD
Authorized by: Babur N Kilic, MD
Ordering mode: Per protocol: cosign required
Quantity: 1
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]

INT [838765509]

Electronically signed by: **Babur N Kilic, MD on 08/28/19 1357**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Lisa M Olivarez, RN
Ordering user: Lisa M Olivarez, RN 08/28/19 0829
Ordering provider: Babur N Kilic, MD

IV - Orders and Results (continued)

INT [838765509] (continued)

Authorized by: Babur N Kilic, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]
Ordering mode: Per protocol: cosign required
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM

Discharge - Orders and Results

DISCHARGE PATIENT [838765525]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0904**
Status: **Completed**
Ordering user: Michael D Bryant, MD 08/28/19 0904
Authorized by: Michael D Bryant, MD
Quantity: 1
Ordering provider: Michael D Bryant, MD
Ordering mode: Standard
Instance released by: Michael D Bryant, MD (auto-released) 8/28/2019 9:04 AM

Imaging - Orders and Results

KUP PROSTATE BIOPSY W NDL [812019629]

Electronically signed by: **Kristin M Boren, MD on 05/09/19 0818**
Status: **Completed**
Ordering user: Kristin M Boren, MD 05/09/19 0818
Authorized by: Kristin M Boren, MD
Ordering mode: Standard
Quantity: 1
Lab status: Final result
Instance released by: Mary Johnston 8/28/2019 7:46 AM
Diagnoses
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]

Questionnaire

Question	Answer
Do you have a joint replacement, pacemaker, or any hardware?	No
Have you ever had MRSA or VRE?	No
Have you had C-Diff with active diarrhea or been on treatment for C-diff in the last 6 months?	No

KUP PROSTATE BIOPSY W NDL [812019629]
Resulted: 08/28/19 0902, Result status: Final result

Order status: Completed
Filed by: Michael D Bryant, MD 08/28/19 0902
Accession number: 31223816
Resulted by: Michael D Bryant, MD
Performed: 08/28/19 0851 - 08/28/19 0857
Result details
Narrative:
OPERATIVE NOTE

Name: Eugene George Maurice
DOB: 1/2/1949
MRN: 561253820
DOS: 8/28/2019

Pre-operative Diagnosis: Active surveillance of known prostate cancer.

Post-operative Diagnosis: Active surveillance of known prostate cancer.

Surgeon: Michael D Bryant, MD

Assistants: None

Anesthesia: IV sedation

Operation:
1. Transrectal ultrasound for guidance of prostate biopsies
2. Transrectal prostate biopsies
3. Periprostatic block for postoperative pain control
(55700, 76942, 64450)

Indications: Eugene George Maurice is a 70 y.o.male who presents for the above procedure due to the above diagnosis. I discussed risks (including specifically bleeding and infection), benefits and alternative treatments with the patient and the patient elected to proceed with the documented plan. All questions were answered.

Imaging - Orders and Results (continued)

Nodule: none on DRE 8/28/2019

Complications: None

EBL: less than 5 mL

IVF: Maintenance

Specimen: 12 cores of prostate tissue labeled by sextant

Findings:
1. Prostate size: 21 cubic centimeters by TRUS
2. Any concerning US findings: no
3. Seminal vesicles: normal

Technique:
The patient confirmed compliance with preoperative enema and antibiotic. The patient was taken to the operative suite. After time out the patient underwent IV sedation per anesthesia. He was then placed in a lateral decubitus position. He was prepped and draped in the standard fashion in the left lateral decubitus position and time out was performed.

Perioperative antibiotics were given prior to the procedure.

The ultrasound probe was then placed in the rectum without difficulty. Subsequently 5 mL of 1% plain lidocaine was infiltrated using a spinal needle and ultrasonic guidance into the junction of the seminal vesicle and prostate gland on each side for intraoperative and post-operative pain control.

Next, sequential transverse (axial) scans were made in small increments beginning at the seminal vesicles and ending at the prostate apex. Sequential longitudinal (sagittal) scans were made in small increments beginning at the right lateral prostate and ending at the left lateral prostate. Excellent anatomical imaging was obtained with peripheral, transitional, and central zones well defined, as well as the seminal vesicles.

Six biopsies were obtained from the lateral part of each lobe at the apex, mid-gland, and base. Six biopsies were additionally taken from the medial part of each lobe spaced evenly from apex to base. Care was taken to avoid the urethra and bladder. Excellent biopsy specimens were obtained. The procedure was tolerated well and the patient transported to recovery in stable condition.

Appropriate patient post procedure education was provided prior to discharge.

Disposition:
1. Follow up with the Wellstar Urology office as previously directed
2. Discharge to home
3. Discharge condition: good
4. Medications: Resume previous medications but stay off of blood thinners until no blood in urine and stool.
5. Diet: resume previous
6. Activity: no strenuous physical activity for the next 48 hours.
Standard post-biopsy instructions given.

Michael D Bryant, MD
Wellstar Urology
(p) 770-428-4475
(f) 770-426-1499

Acknowledged by: Kristin M Boren, MD on 08/28/19 1047

Pathology and Cytology - Orders and Results

SURGICAL PATHOLOGY-KH [838765528]

Electronically signed by: **Interface, Lab In Copath on 08/28/19 1412** Status: **Completed**

Pathology and Cytology - Orders and Results (continued)

SURGICAL PATHOLOGY-KH [838765528] (continued)

Ordering user: Interface, Lab In Copath 08/28/19 1412
Authorized by: Kristin M Boren, MD
Quantity: 1
Instance released by: (auto-released) 8/28/2019 2:12 PM

Ordering provider: Kristin M Boren, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
—	—	08/28/19 1410

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

SURGICAL PATHOLOGY-KH [838765528]

Resulted: 08/29/19 1804, Result status: Final result

Ordering provider: Kristin M Boren, MD 08/28/19 1412
Filed by: Interface, Lab In Copath 08/29/19 1805
Result details
Acknowledged by
Kristin M Boren, MD on 08/30/19 0811
D'Ivory Guerra, MA on 08/30/19 0934

Order status: Completed
Resulting lab: WS KENNESTONE HOSPITAL LAB

Specimen Information

Type	Source	Collected By
—	—	08/28/19 1410

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

Components

Component	Value	Reference Range	Flag	Lab
SURGICAL PATHOLOGY-KH	Patient Name: MAURICE, EUGENE GEORGE Accession #: KS19-14038 Patient #:	—	—	KHLAB

Comment:
2108207510\561253820\1\10 MRN. #: 561253820 Sex: M Location: DOB/Age:
1/2/1949 (Age: 70) Location: Discharged Client: Wellstar Kennestone Hospital
Received: 8/28/2019 Admitting Date: 8/28/2019 Collected: 8/28/2019 Final Report:
8/29/2019 18:04 Order Physician: KRISTIN M BOREN Admit MD: MICHAEL D BRYANT
Other Inst: Not Provided Copy To:
SURGICAL PATHOLOGY-KH REPORT
Final Diagnosis:
PROSTATE BIOPSY X 12: ATYPICAL SMALL ACINAR PROLIFERATION IN 2 OF 12 CORES
1. PROSTATE, LEFT BASE, CORE BIOPSY:
BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.
2. PROSTATE, LEFT MID, CORE BIOPSY:
BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.

3. PROSTATE, LEFT APEX, CORE BIOPSY:
ATYPICAL SMALL ACINAR PROLIFERATION (ASAP).
4. PROSTATE, RIGHT BASE, CORE BIOPSY:
BENIGN PROSTATIC TISSUE.
5. PROSTATE, RIGHT MID, CORE BIOPSY:
BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.
6. PROSTATE, RIGHT APEX, CORE BIOPSY:
BEN
IGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.
7. PROSTATE, LEFT LATERAL BASE, CORE BIOPSY:
BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.
8. PROSTATE, LEFT LATERAL MID, CORE BIOPSY:
ATYPICAL SMALL ACINAR PROLIFERATION (ASAP).
9. PROSTATE, LEFT LATERAL APEX, CORE BIOPSY:
BENIGN PROSTATIC TISSUE.
10. PROSTATE, RIGHT LATERAL BASE, CORE BIOPSY:
BENIGN PROSTATIC TISSUE.
11. PROSTATE, RIGHT LATERAL MID, CORE BIOPSY:
BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.
12. PROSTATE, RIGHT LATERAL APEX, CORE BIOPSY:
BENIGN PROSTATIC TISSUE.

Electronically Signed Out By Sara E. Cuadra Acree, M.D.

Pathology and Cytology - Orders and Results (continued)

Sara E. Cuadra Acree, M.D.
SA 8/29/2019
CPT: 1: G0416, OTH-K

Pre-Operative Diagnosis:
Not Provided
Post-Operative Diagnosis:
Not Provide
d
Clinical History:
Hx of prostate cancer
Specimen:
Prostate biopsy x12
Gross Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maurice, Eugene	LB	2 cores, 5 and 12	1A
2. Maurice, Eugene	LM	1 core, 15	2A
3. Maurice, Eugene	LA	1 core, 15	3A
4. Maurice, Eugene	RB	1 core, 13	4A
5. Maurice, Eugene	RM	1 core, 16	5A
6. Maurice, Eugene	RA	1 core, 14	6A
7. Maurice, Eugene	LLB	2 cores, 4 and 11	7A
8. Maurice, Eugene	LLM	1 core, 16	8A
9. Maurice, Eugene	LLA	2 cores, 4 and 10	9A
10. Maurice, Eugene	RLB	1 core, 14	10A
11. Ma urice, Eugene	RLM	1 core, 15	11A
12. Maurice, Eugene	RLA	1 core, 17	12A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The specimens are
inked green. EM/klt 8/28/19

Microscopic Description:
1-12. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis.
SCA/pk 8/29/19

View Image (below)

WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Phone Number: (770) 793-5505
Fax Number: (770) 793-7919

Marla J. Franks, M.D., Laboratory Director

Patient Name:	**MAURICE, EUGENE GEORGE**			Accession #:	**KS19-14038**
Patient #:	2108207510\561253820\1\10	MRN. #:	561253820	Sex:	M
Location:		DOB/Age:	1/2/1949 (Age: 70)		
Location:	Discharged	Client:	Wellstar Kennestone Hospital	Received:	8/28/2019
Admitting Date:	8/28/2019	Collected:	8/28/2019	Final Report:	8/29/2019 18:04
Order Physician:	KRISTIN M BOREN	Admit MD:	MICHAEL D BRYANT	Other Inst:	Not Provided
		Copy To:			

SURGICAL PATHOLOGY-KH REPORT

Final Diagnosis:
PROSTATE BIOPSY X 12: ATYPICAL SMALL ACINAR PROLIFERATION IN 2 OF 12 CORES

1. PROSTATE, LEFT BASE, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.

2. PROSTATE, LEFT MID, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.

3. PROSTATE, LEFT APEX, CORE BIOPSY:
   ATYPICAL SMALL ACINAR PROLIFERATION (ASAP).

4. PROSTATE, RIGHT BASE, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE.

5. PROSTATE, RIGHT MID, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.

6. PROSTATE, RIGHT APEX, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.

7. PROSTATE, LEFT LATERAL BASE, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.

8. PROSTATE, LEFT LATERAL MID, CORE BIOPSY:
   ATYPICAL SMALL ACINAR PROLIFERATION (ASAP).

9. PROSTATE, LEFT LATERAL APEX, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE.

10. PROSTATE, RIGHT LATERAL BASE, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE.

11. PROSTATE, RIGHT LATERAL MID, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE WITH ATROPHY AND INFLAMMATION.

12. PROSTATE, RIGHT LATERAL APEX, CORE BIOPSY:
   BENIGN PROSTATIC TISSUE.

Electronically Signed Out By Sara E. Cuadra Acree, M.D.
Sara E. Cuadra Acree, M.D.

SA 8/29/2019
CPT: 1: G0416, OTH-K

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Phone Number: (770) 793-5505
Fax Number: (770) 793-7919

Marla J. Franks, M.D., Laboratory Director

Pre-Operative Diagnosis:
Not Provided

Post-Operative Diagnosis:
Not Provided

Clinical History:
Hx of prostate cancer

Specimen:
Prostate biopsy x12

Gross Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maurice, Eugene	LB	2 cores, 5 and 12	1A
2. Maurice, Eugene	LM	1 core, 15	2A
3. Maurice, Eugene	LA	1 core, 15	3A
4. Maurice, Eugene	RB	1 core, 13	4A
5. Maurice, Eugene	RM	1 core, 16	5A
6. Maurice, Eugene	RA	1 core, 14	6A
7. Maurice, Eugene	LLB	2 cores, 4 and 11	7A
8. Maurice, Eugene	LLM	1 core, 16	8A
9. Maurice, Eugene	LLA	2 cores, 4 and 10	9A
10. Maurice, Eugene	RLB	1 core, 14	10A
11. Maurice, Eugene	RLM	1 core, 15	11A
12. Maurice, Eugene	RLA	1 core, 17	12A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The specimens are inked green. EM/klt 8/28/19

Microscopic Description:
1-12. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis. SCA/pk 8/29/19

CORE MEASURES - Orders and Results

REASON FOR NO MECHANICAL PROPHYLAXIS [838765512]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0842**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Dawn Coffeen, RN
Ordering user: Dawn Coffeen, RN 08/21/19 1118
Ordering provider: Michael D Bryant, MD

CORE MEASURES - Orders and Results (continued)

REASON FOR NO MECHANICAL PROPHYLAXIS [838765512] (continued)

Authorized by: Michael D Bryant, MD
Quantity: 1
Ordering mode: Per protocol: cosign required
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM

Questionnaire

Question	Answer
If SCDs NOT ordered, indicate reason:	Total Risk Factor Score less than or equal to 1

REASON FOR NO VTE PROPHYLAXIS AT ADMISSION [838765514]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0842**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Dawn Coffeen, RN 08/21/19 1118
Authorized by: Michael D Bryant, MD
Quantity: 1
Communicated by: Dawn Coffeen, RN
Ordering provider: Michael D Bryant, MD
Ordering mode: Per protocol: cosign required
Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 8:30 AM

Questionnaire

Question	Answer
Reason for no pharm VTE prophylaxis at admission?	Patient is at low risk for VTE - No pharm VTE Prophylaxis required

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [838765516]

Electronically signed by: **Interface, Lab In Sunquest on 08/28/19 0834**
Status: **Completed**
Ordering user: Interface, Lab In Sunquest 08/28/19 0834
Authorized by: Michael D Bryant, MD
Quantity: 1
Instance released by: (auto-released) 8/28/2019 8:36 AM
Ordering provider: Michael D Bryant, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
Blood	Blood	08/28/19 0834

POC FINGER STICK GLUCOSE [838765516] (Abnormal)
Resulted: 08/28/19 0836, Result status: Final result

Ordering provider: Michael D Bryant, MD 08/28/19 0834
Filed by: Interface, Lab In Sunquest 08/28/19 0836
External ID: W16448824
Acknowledged by: Michael D Bryant, MD on 08/28/19 0839
Order status: Completed
Resulting lab: WS UROLOGY PROCEDURE CENTER
Result details

Specimen Information

Type	Source	Collected By
Blood	Blood	08/28/19 0834

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	109	70 - 99 mg/dL	H ^	UROPC
POC-OPERATOR'S ID	42526	—	—	UROPC

Diet - Orders and Results

DIET, NPO [838765529]

Electronically signed by: **Babur N Kilic, MD on 08/28/19 1357**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Lisa M Olivarez, RN 08/28/19 0829
Authorized by: Babur N Kilic, MD
Quantity: 1
Communicated by: Lisa M Olivarez, RN
Ordering provider: Babur N Kilic, MD
Ordering mode: Per protocol: cosign required
Diet: NPO

Diet - Orders and Results (continued)

DIET, NPO [838765529] (continued)

Instance released by: Lisa M Olivarez, RN (auto-released) 8/28/2019 11:31 PM
Discontinued by: Automatic Discharge Provider 09/05/19 0445 [Patient Discharge]

Medications - Orders and Results

sodium chloride 0.9 % (NS) flush [812019634]

Electronically signed by: **Babur N Kilic, MD on 08/28/19 1357**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Lisa M Olivarez, RN
Ordering user: Lisa M Olivarez, RN 08/28/19 0829
Ordering provider: Babur N Kilic, MD
Authorized by: Babur N Kilic, MD
Ordering mode: Per protocol: cosign required
PRN reasons: line care
Frequency: Routine Q1 min PRN 08/28/19 0830 - 09/05/19 0440
Released by: Lisa M Olivarez, RN 08/28/19 0830
Discontinued by: Automatic Discharge Provider 09/05/19 0440 [(Patient Discharge - Internal Use Only)]
Acknowledged: Lisa M Olivarez, RN 08/28/19 0830 for Placing Order
Admin instructions: INT Flush
Package: 8290-306547

lactated Ringers infusion [812019635]

Electronically signed by: **Babur N Kilic, MD on 08/28/19 1357**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Lisa M Olivarez, RN
Ordering user: Lisa M Olivarez, RN 08/28/19 0829
Ordering provider: Babur N Kilic, MD
Authorized by: Babur N Kilic, MD
Ordering mode: Per protocol: cosign required
Frequency: Routine Continuous 08/28/19 0900 - 09/05/19 0440
Released by: Lisa M Olivarez, RN 08/28/19 0830
Discontinued by: Automatic Discharge Provider 09/05/19 0440 [(Patient Discharge - Internal Use Only)]
Acknowledged: Lisa M Olivarez, RN 08/28/19 0830 for Placing Order
Package: 0409-7953-09

gentamicin (GARAMYCIN) injection 40 mg/mL [838765505]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0842**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Dawn Coffeen, RN
Ordering user: Dawn Coffeen, RN 08/21/19 1118
Ordering provider: Michael D Bryant, MD
Authorized by: Michael D Bryant, MD
Ordering mode: Per protocol: cosign required
PRN Comment: On call to OR
Frequency: Routine On call to OR 08/28/19 0830 - 1 occurrence
Indications of use: prevention of perioperative infection
Released by: Lisa M Olivarez, RN 08/28/19 0830
Acknowledged: Lisa M Olivarez, RN 08/28/19 0830 for Placing Order

Questionnaire

Question	Answer
Reason for Ordering Antimicrobial:	Preop - Prophylaxis
Expected days of therapy:	1

Package: 63323-010-02

lidocaine (XYLOCAINE) local injection 2 % [838765517]

Electronically signed by: **Michael D Bryant, MD on 08/28/19 0911**
Status: **Completed**
Mode: Ordering in Verbal with readback mode
Communicated by: Lisa M Olivarez, RN
Ordering user: Lisa M Olivarez, RN 08/28/19 0852
Ordering provider: Michael D Bryant, MD
Authorized by: Michael D Bryant, MD
Ordering mode: Verbal with readback
Frequency: Routine Once PRN 08/28/19 0852 - 08/28/19 0852
Package: 0409-4277-02

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
19 - KHLAB	WS KENNESTONE HOSPITAL LAB	Dr. Marla Franks	677 CHURCH ST MARIETTA GA 30060	08/28/18 1256 - Present
527 - UROPC	WS UROLOGY PROCEDURE CENTER	Unknown	300 TOWER RD, STE 150 MARIETTA GA 30060	02/22/17 1825 - 10/28/19 1240

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [812019634]

Ordering Provider: Babur N Kilic, MD
Ordered On: 08/28/19 0830
Dose (Remaining/Total): 3-40 mL (—/—)
Frequency: Every 1 minute PRN
Admin Instructions: INT Flush

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 08/28/19 0830 - 09/05/19 0440
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

lactated Ringers infusion [812019635]

Ordering Provider: Babur N Kilic, MD
Ordered On: 08/28/19 0830
Dose (Remaining/Total): 50 mL/hr (—/—)
Frequency: Continuous

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 08/28/19 0900 - 09/05/19 0440
Route: Intravenous
Rate/Duration: 50 mL/hr / —

Line	Med Link Info	Comment
Peripheral IV 08/28/19 20 G Right Hand	08/28/19 0833 by Lisa M Olivarez, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 08/28/19 0930 Documented: 08/28/19 0939	Stopped	0 mL/hr 0 mL/hr	Intravenous	Performed by: Lisa M Olivarez, RN
Performed 08/28/19 0833 Documented: 08/28/19 0840	New Bag	50 mL/hr 50 mL/hr	Intravenous	Performed by: Lisa M Olivarez, RN

gentamicin (GARAMYCIN) injection 40 mg/mL [838765505]

Ordering Provider: Michael D Bryant, MD
Ordered On: 08/28/19 0830
Dose (Remaining/Total): 5 mg/kg (Adjusted) (0/1)
Frequency: On call to O.R.

Status: Completed (Past End Date/Time)
Starts/Ends: 08/28/19 0830 - 08/28/19 0833
Route: Intravenous
Rate/Duration: — / —

Question	Answer	Comment
Reason for Ordering Antimicrobial::	Preop - Prophylaxis	—
Expected days of therapy::	1	—

Line	Med Link Info	Comment
Peripheral IV 08/28/19 20 G Right Hand	08/28/19 0833 by Lisa M Olivarez, RN	—

Timestamps	Action	Dose	Route	Other Information
Performed 08/28/19 0833 Documented: 08/28/19 0840	Given	400 mg	Intravenous	Performed by: Lisa M Olivarez, RN

lidocaine (XYLOCAINE) local injection 2 % [838765517]

Ordering Provider: Michael D Bryant, MD
Ordered On: 08/28/19 0852

Status: Completed (Past End Date/Time)
Frequency: Once as needed

Timestamps	Action	Dose	Route	Other Information
Performed 08/28/19 0852 Documented: 08/28/19 0852	Given	10 mL	Other	Performed by: Michael D Bryant, MD Documented by: Lisa M Olivarez, RN

Medications (continued)

Patient Education

Education

Title: Acute MI (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

Patient Education (continued)

Education (continued)

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Resolved)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Point: Patient Controlled Analgesia (Resolved)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Point: Epidural Information (Resolved)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Topic: Signs and Symptoms - Acute MI (Resolved)

Point: Recognizing a Heart Attack (MCB) (Resolved)

Description:
Be sure patient reviews video on Coronary Artery Disease

Patient Friendly Description:
Please watch the video and/or read over the documented material and let anyone on your Care Team know if there are any questions by marking below.
If after watching the video and/or reading the material you have questions, please mark below I have question to let the staff know you have additional questions about a topic and they will be in to discuss your questions.

This will inform you of what to expect if you are diagnosed with a Heart Attack.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Educate the patient/family/caregiver on coronary risk factors. Explain the controllable and non-controllable risk factors to Coronary Artery Disease. Review how to control coronary artery disease by altering the controllable risk factors. Some examples include: controlling blood pressure, reducing fat and cholesterol in the diet, stopping smoking, exercising regularly, maintaining ideal body weight, dealing with stress in an appropriate manner, drinking alcohol and coffee in moderation and controlling blood sugar levels (if applicable).

Learner Progress: Not documented in this visit.

Topic: Acute MI (MCB) (Resolved)

Point: Emergency Plan for Heart Attack Symptoms (Resolved)

Description:
Educate the patient/family/caregiver on how to get help immediately if heart attack symptoms occur. The patient should call 911 or the Emergency Medical Service number. Reinforce that the patient should not delay in obtaining help.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Home Activity (Resolved)

Description:
Educate the patient/family/caregiver on home activity guidelines that apply after having had a recent heart attack. Do things in moderation, rest about 30 minutes after eating, pace activities, allow for 7-8 hours of sleep at night, start with short walks 3-5 times a day. Consult with Cardiac Rehab staff, if applicable.

Learner Progress: Not documented in this visit.

Point: Limitations to Activity (Resolved)

Description:
Educate the patient/family/caregiver reagrding the following limitations to activity for 4-6 weeks after discharge. No lifting over 10 pounds (weight of a milk jug), no pushing or pulling motions with the arms (sweeping, vacuuming or raking), no driving (may be changed after talking to the doctor), no bathing in very hot or very cold water.

Learner Progress: Not documented in this visit.

Point: Sexual Activity (Resolved)

Description:
Educate the patient/family/caregiver on the following: Wait 4 weeks before resuming sexual activity. If the patient can climb 2 flights of steps, he/she can assume it is ok to resume sexual activity. Choose a comfortable position. Wait at least 1 hour after a meal. If sex brings on angina, stop and rest. Discuss chest pain during sex with the physician. Some medications can affect sexual desire. If this is the case, talk with the physician.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Resolved)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Resolved)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Title: Diabetes (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Patient Education (continued)

Education (continued)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Introduction to Diabetes (MCB) (Not Started)

Description:
Give patient/family/caregiver written information on diabetes. Explain the definition of the type of diabetes with which the patient was diagnosed, how diabetes works in the body, risk factors, signs and symptoms, and if newly diagnosed, diagnostic criteria. Encourage viewing of diabetes on-demand videos when applicable. Refer to inpatient diabetes educator when applicable.

Patient Friendly Description:
You will receive a booklet entitled Diabetes survival skills. There are also two links to documents about Diabetes for you to read over noted below.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Point: Diabetes Type II management (MCB) (Not Started)

Description:
Patient will watch a video that will discuss information on what to expect if they have Diabetes type II.

Patient Friendly Description:
This will inform you of what to expect if you have Diabetes type II.

Learner Progress: Not documented in this visit.

Point: Diabetic long term complications (MCB) (Not Started)

Description:
Patient will have information from Krames on the long term complications of Diabetes Type II.

Patient Friendly Description:
Some information on the long term complications of Diabetes Type II.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Giving Insulin Injection (Not Started)

Description:
Explain and demonstrate how the injection is given. Allow enough time for the patient/family/caregiver to practice. Have the patient return-demonstrate the technique using normal saline (vial and syringe only unless sterile demonstration pen is also available). Teach the patient how to choose and rotate injection sites. Instruct patient on safe disposal of used needles and syringes.

Learner Progress: Not documented in this visit.

Point: Drawing up Insulin (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before drawing up insulin. Demonstrate and have the patient return-demonstrate drawing up the correct amount of insulin prescribed. If the patient is going to use an insulin pen, demonstrate use and have the patient return-demonstrate. If the patient is going to mix different types of insulin, demonstrate and have the patient return-demonstrate the correct way to draw up and mix the insulin.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Exercise (Not Started)

Description:
Encourage patient/family/caregiver to discuss activity limitations, if any, with physician before starting an exercise routine. Stress the importance of regular exercise and activity to control blood sugar levels and weight. Instruct the patient to carry single carohydrates while exercising in case of hypoglycemic reaction. Explain that both concentrated physical activity (such as walking, swimming, running, cycling, strength training) and being more active through the entire day are equally important to blood sugar control and weight management.

Learner Progress: Not documented in this visit.

Point: Blood Glucose Monitoring (MCB) (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before checking blood glucose. Explain and, if possible to use a complementary glucometer, demonstrate how to check and record blood sugars. Instruct the patient to check blood sugars as frequently as ordered by the physician. Explain that stress or illness will increase blood sugar, making it necesary to check blood sugars more often than usual. Instruct patient on blood glucose target ranges and A1C target range. Discuss care of the meter and supplies, including how to obtain supplies. If using a complementary glucometer, have the patient return-demonstrate checking the blood sugar. Instruct the patient on safe disposal of lancets. Refer to inpatient diabetes educator if applicable.

Patient Friendly Description:
Why is it important to check my blood sugar?

Learner Progress: Not documented in this visit.

Point: Diabetic Foot Care (MCB) (Not Started)

Description:
Explain importance of foot care. Patient should have feet examined by a health care provider at least twice a year. Persons with foot problems should have feet examined at every visit. Explain daily foot care. Review importance of wearing well-fitting shoes and stockings/socks. Reinforce the importance of wearing shoes, even indoors, to prevent injury.

Patient Friendly Description:
This will inform you of why you should check your feet if you have diabetes.

Learner Progress: Not documented in this visit.

Point: Diabetes Identification Jewelry (Not Started)

Description:
Encourage the patient to wear a piece of jewelry that identifies patient as a person with diabetes. This will inform medical personnel that patient has diabetes if unable to communicate.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (Not Started)

Point: Signs and Symptoms of Hypoglycemia (Not Started)

Description:
Define and explain causes of hypoglycemia. Discuss signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Treatment of Hypoglycemia (Not Started)

Description:
Instruct the patient on how to treat low blood sugar using the Rule of 15. Encourage patient to carry a blood sugar treatment at all time.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (Not Started)

Description:
Instruct the patient/family/caregiver to call their health care provider if there are symptoms of hypo- or hyperglycemia or if blood sugars are trending high or low and are not controlled by simple measures.

Learner Progress: Not documented in this visit.

Point: Signs and Symptoms of Hyperglycemia (Not Started)

Description:
Define and explain causes of hyperglycemia. Discuss signs and symptoms (mild, moderate, severe, and ketoacidosis).

Learner Progress: Not documented in this visit.

Point: Prevention of Hyperglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importance of good diabetes management and learning to detect and treat hyperglycemia early before it worsens. Refer to registered dietitian, when applicable, for meal planning assistance.

Learner Progress: Not documented in this visit.

Point: Prevention of Hypoglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importantce of good diabetes management and learning to detect and treat hypoglycemia early before it worsens.

Learner Progress: Not documented in this visit.

Point: WellStar Outpatient Diabetes Education (Not Started)

Description:
Provide information on WellStar Outpatient Diabetes Education when applicable. Information includes a list of classes offered and how to register.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Patient Education (continued)

Education (continued)

Description:
Give the patient/family written information on when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Topic: Diabetic Diet (MCB) (Not Started)

Point: Meal Planning and Portion Sizes (MCB) (Not Started)

Description:
The patient will view documents in Krames talking about meal planning as well learning about serving and portion sizes.

Patient Friendly Description:
This will inform you of ways to stay on track with your diet.

Learner Progress: Not documented in this visit.

Point: Eating well with Diabetes (MCB) (Not Started)

Description:
Patient will watch a video on healthy eating for people with DM.

Patient Friendly Description:
Healthy eating for people with Diabetes.

Learner Progress: Not documented in this visit.

Point: Carbohydrate Counting (MCB) (Not Started)

Description:
Patient will read Krames documents on healthy meals and meal planing for Diabetes.

Patient Friendly Description:
Learn about counting your carbohydrates.

Learner Progress: Not documented in this visit.

Topic: Survival Skills (Not Started)

Point: Review Diagnosis (Not Started)

Description:
Review the diabetes disagnosis, specific to patient's diabetes type.
Diabetes Survival Skills Booklet provided.

Patient Friendly Description:
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Learner Progress: Not documented in this visit.

Point: Nutrition (Not Started)

Description:
Importance of consistent nutrition habits.

Learner Progress: Not documented in this visit.

Point: Appointments (Not Started)

Description:
Importance of follow up appointment with the health care provider who will provide diabetes care after discharge.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Sick Day (Not Started)

Description:
Sick day management

Learner Progress: Not documented in this visit.

Point: Insulin Administration (if applicable) (Not Started)

Description:
Insulin administration and proper use and disposal of needles and syringes. How to schedule outpatient diabetes education. Review self-monitoring of blood glucose and home blood glucose goals.

Learner Progress: Not documented in this visit.

Point: Hyperglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hyperglycemia.

Learner Progress: Not documented in this visit.

Point: Hypoglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hypoglycemia.

Learner Progress: Not documented in this visit.

Point: Glucose Lowering Medications (Not Started)

Description:
When and how to take blood glucose-lowering medications.

Learner Progress: Not documented in this visit.

Topic: Diabetes Zones for Management (Not Started)

Point: Diabetes Zones for Management reviewed (Not Started)

Description:
Diabetes Zones for Management reviewed.

Learner Progress: Not documented in this visit.

Point: Diabetes Zones for Management handout provided (Not Started)

Description:
Diabetes Zones for Management handout provided.

Learner Progress: Not documented in this visit.

Title: WS Cardiac Rehab (Resolved)

Topic: PCI (Resolved)

Point: Books/Educational Material (Resolved)

Description:
Current standardized written information provided specific to diagnosis, recovery, disease progression and prevention.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Exercise (Resolved)

Description:
Information regarding the benefits of exercise provided. Exercise guidelines provided for initial recovery from acute heart event and long term goals of exercise.

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Description:
Medication compliance encouraged. Organization tools discussed and medication information and resources provided.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Written and verbal information provided on modifiable and non-modifiable factors associated with increased risk of heart disease and stroke.

Learner Progress: Not documented in this visit.

Point: Activity guidelines (Resolved)

Description:
Appropriate activity and/or limitations for diagnosis specific recovery provided.

Learner Progress: Not documented in this visit.

Point: Signs/symptoms/activate EMS (Resolved)

Description:
Information provided on the signs and symptoms which commonly occur with a heart attack or stroke. Emphasis placed on appropriate activation of EMS with recognition of signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehab participation/location options (Resolved)

Description:
Cardiac rehabilitation benefits highlighted and participation encouraged.

Learner Progress: Not documented in this visit.

Point: Cardiac Diet/low fat/low sodium (Resolved)

Description:
American Heart Association guidelines provided for a reduced fat and reduced sodium diet.

Learner Progress: Not documented in this visit.

Point: Endocarditis education/card (Resolved)

Description:
Written and verbal instruction provided on endocarditis prevention. Temporary Valve card provided.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Outpatient education classes/Heart Smart/Device Advice/Heart of the Matter (Resolved)

Description:
Description and registration details of outpatient education classes provided. Participation encouraged.

Learner Progress: Not documented in this visit.

Title: Cardiac Arrhythmia (MCB) (Not Started)

Topic: Treatment for Atrial Fibrillation/Atrial Flutter (MCB) (Not Started)

Point: Chemical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how a chemical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a chemical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Electrical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how an electrical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a electrical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Ablation (MCB) (Not Started)

Description:
Provide written education on the catheter ablation procedure and discharge instructions.

Patient Friendly Description:
How an ablation is done, and what to do after the procedure.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (MCB) (Not Started)

Point: Anticoagulation (MCB) (Not Started)

Description:
Provide written education on anticoagulation use including contraindications, side effects, interactions, and medication safety.

Patient Friendly Description:
Information on taking blood thinners safely.

Learner Progress: Not documented in this visit.

Point: Discharge with A Fib/Flutter (MCB) (Not Started)

Description:
Provide written education on treatment options, home care, and follow up care for discharging with atrial fibrillation.

Patient Friendly Description:
Information on treatment options, home care, and when to call your healthcare provider after going home with atrial fibrillation/flutter.

Learner Progress: Not documented in this visit.

Point: Atrial fib/flutter: stroke prevention (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
"Provide written education on risk factors, medication, and prevention of A. Fib.
Hyperlink education materials provided to patient/family/caregiver. "

Patient Friendly Description:
Preventing stroke caused by A. Fib.
Learner Progress: Not documented in this visit.

Topic: What is atrial fibrillation/flutter (MCB) (Not Started)

Point: You have atrial fibrillation (MCB) (Not Started)

Description:
Provide video education on the signs/symptoms of A. Fib, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Fib: causes, symptoms, and treatment.
Learner Progress: Not documented in this visit.

Point: You have Atrial Flutter (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of A. Flutter, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Flutter: causes, symptoms, and treatment
Learner Progress: Not documented in this visit.

Title: MyChart Bedside Teaching completed (Not Started)

Points For This Title

Point: All MCB content reviewed with patient and teachback completed. The patient verbalized understanding. (Not Started)

Description:
Go over all the Eduction for the patient in the Education activity. The Education that was provided to the patient via MCB was included as well as education that was noted within the Eduction activity as Education that was beneifical to the patient during this hospital stay.

Learner Progress: Not documented in this visit.

Title: Cardiac Surgery (Resolved)

Topic: PCI (Resolved)

Additional Points For This Title

Point: ACTIVITY (Resolved)

Learner Progress: Not documented in this visit.

Point: SIGNS AND SYMPTOMS/ACTIVATE EMS (Resolved)

Learner Progress: Not documented in this visit.

Point: BOOKS/EDUCATION MATERIAL (Resolved)

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: CARDIAC REHAB (Resolved)

Learner Progress: Not documented in this visit.

Point: DIET (Resolved)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

Title: Coronary Artery Disease (MCB) (Not Started)

Topic: WS Cardiac Rehabilitation for Arrhythmia (MCB)--This is CAD and AMI Cardiac Rehab Program Information for the Patient (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehabilitation: Emotional Issue (MCB) (Not Started)

Description:
Explain how having heart disease can be stressful. Encourage patient not to ignore feelings of sadness, worry, and depression. Patient should know when to ask for help and/or support.

Patient Friendly Description:
This will explain some emotional feelings related to heart disease.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Heart Healthy Diet- DASH Diet (MCB) (Not Started)

Point: Eating Heart Healthy Food: Using DASH Plan (MCB) (Not Started)

Description:
Review diet information and explain that eating a low salt, low fat and low cholesterol diet with plenty of fruits and vegetables can reduce risk of complications from CAD.

Patient Friendly Description:
This will help you follow a healthy eating plan that can reduce your risk of complications associated with Coronary Artery Disease.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Questions your patient may have for you (MCB) (Not Started)

Point: Questions your patient may have about the AMI (MCB) (Not Started)

Description:
This is information about diet, exercise and medications for patients and it encourages them to ask staff questions.

Patient Friendly Description:
After reading this, you can write down any questions that you have for staff under the Notes section as a reference.
Learner Progress: Not documented in this visit.

Topic: Coronary Artery Disease (MCB) (Not Started)

Point: Recognizing signs and symptoms of Heart Disease (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of CAD, causes, medication(s), risk factors, prevention and treatment.

Patient Friendly Description:
This will explain some of the causes of Coronary Artery Disease.
Learner Progress: Not documented in this visit.

Point: Understanding Coronary Artery Disease (MCB) (Not Started)

Description:
Give patient written information on CAD. Explain the definition of CAD, causes, signs and symptoms.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with Coronary Artery Disease (CAD).

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Risk factors for Heart Disease (MCB) (Not Started)

Point: Tobacco/Smoking Cessation (MCB) (Not Started)

Description:
Give patient written information on Quitting Smoking

Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This will give you some getting started tips to kick the smoking habit.

This will help you plan how to quit the smoking habit.
Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: hydralazine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: nitroglycerin (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose 50 % in water (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: calcium carbonate (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: hydrocodone/acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: aspirin (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: atropine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: phenylephrine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: labetalol HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: metoclopramide HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: cyclopentolate HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: furosemide (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diclofenac sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diphenhydramine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: piperacillin sodium/tazobactam (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: insulin lispro (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: glucagon,human recombinant (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: pantoprazole sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: polyethylene glycol 3350 (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: fentanyl citrate/PF (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: lidocaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: tetracaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: sodium chloride 0.9 % (flush) (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: Congestive Heart Failure (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: Oxygen (Not Started)

Description:
Educate patient/family/caregiver on why oxygen is needed and how it will be delivered (nasal cannula, mask, etc.). Instruct patient/family/caregiver that the patent should not be smoking while on oxygen.

Learner Progress: Not documented in this visit.

Point: Medical Equipment (Not Started)

Description:
Educate patient/family/caregiver on use of medical equipment and provide educational materials.

Learner Progress: Not documented in this visit.

Point: Introduction to Heart Failure (MCB) (Not Started)

Description:
Give patient written information on congestive heart failure. Explain the definition of CHF, causes, signs and symptoms, expected length of stay and criteria for discharge.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with heart failure.

You will be receiving the Congestive Heart Failure red booklet.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Point: Echocardiogram (Not Started)

Description:
Educate patient/family/caregiver on echocardiograms, to include: what the test is, how the test will be performed, and what to expect during the test.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Not Started)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Self Care (MCB) (Not Started)

Point: Eating well with High Blood Pressure (MCB) (Not Started)

Description:
Information provided to patient to explain what their diet should consist of when they have Heart Failure.

Patient Friendly Description:
This will help you make heart healthy eating choices if you have a diagnosis with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure:Being Active (MCB) (Not Started)

Description:
Explain to the patient how to be active with heart failure.

Patient Friendly Description:
This will explain how to safely be active with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Dealing with Sleep problems (MCB) (Not Started)

Description:
Provide tips and ideas to help patient sleep better.

Patient Friendly Description:
This will provide tips on sleeping better with heart faillure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Know your Baselines (MCB) (Not Started)

Description:
Explain to patient how to identify their baseline and recognize changes.

Patient Friendly Description:
This will help you understand what's normal for you and how to watch for changes.

Learner Progress: Not documented in this visit.

Point: Heart Failure : Know your Zones (Not Started)

Description:
Review heart failure zones with patient and educate them on how to know which zone they are in each day.

Learner Progress: Not documented in this visit.

Point: Dealing with Heart Failure: Helping the patient cope (MCB) (Not Started)

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: How to check your Heart Rate and Blood Pressure (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Give patient written information on how to take a pulse. Explain the definition of a pulse, normal range, reason for taking a pulse, where pulses can be found. Demonstrate how to find a pulse. Once found, instruct the patient to count the beats for a full minute. Tell the patient to keep a record of the pulse rate, date and time taken, which site (right/left, wrist/neck) and strength of beats (weak, strong or missing beats).

Patient Friendly Description:
This will explain the importance of understanding your vital signs and show you how to take them.

Learner Progress: Not documented in this visit.

Topic: WellStar Cardiac Rehabilitation (MCB) (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Topic: Review Plan of Care (Not Started)

Point: Review Plan of Care - Day 5 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 1 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 2 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Review Plan of Care - Day 3 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 4 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Heart Failure Medications (MCB) (Not Started)

Description:
Educate patient on the drug type, purpose for medication, and common side effects.

Educate patient on Prescribed Medications

Patient Friendly Description:
This will inform you of medications that you may be taking if you are diagnosed with Heart Failure.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Aspirin (Not Started)

Description:
Give patient written information on Aspirin. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the doctor should be called. Reinforce that this medication should be taken exactly as the doctor has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Topic: Prevention / Discharge (MCB) (Not Started)

Point: Community Resources (Not Started)

Description:
Give written information on available community resources. Refer to Social Services or Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Home Health Care Services (Not Started)

Description:
Give patient written information on Home Health Care Services that have been arranged. Review the role of the home care nurse and when to expect the first visit. Refer to Case Management or Social Services, if needed.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Discharge Medications (Not Started)

Description:
Ensure that there are no barriers to obtain medications prior to discharge. Notify Care Coordination if there are any needs for additional resources prior to discharging the patient.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Topic: Heart Failure Discharge Instructions (Not Started)

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:

1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Resolved)

Point: Encourage Patient to Monitor Own Pain (Resolved)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.
Learner Progress: Not documented in this visit.

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Not Started)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Friendly Description:
In the days and weeks after surgery, you have a higher chance of developing a deep vein thrombosis (DVT).
This is a condition in which a blood clot or thrombus develops in a deep vein.
They are most common in the leg. But, a DVT may develop in an arm, or another deep vein in the body.
A piece of the clot, called an embolus, can separate from the vein and travel to the lungs.
A blood clot in the lungs is called a pulmonary embolus (PE).
This can cut off the flow of blood to the lungs.
It is a medical emergency and may cause death.
Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Antibiotic Education (Not Started)

Description:
If an antibiotic was prescribed, educate patient/family/caregiver on the antibiotics prescribed. Explain how antibiotics work in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed

If a viral diagnosis was made, the patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit.

Learner Progress: Not documented in this visit.

Point: Anticoagulant Therapy (Not Started)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.
2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Non-Steroidal Anti-Inflammatory Drugs (Not Started)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Not Started)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Not Started)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Medication purpose, side effects, schedule, administration (MCB) (Not Started)

Description:
Discussed purpose and possible side effects of medication.

Learner Progress: Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	08/28/19 0913	08/28/19 0903	08/28/19 0900	08/28/19 0827	08/28/19 0826
Vitals					
Pct Wt Change	—	—	—	—	0 % -LO
OTHER					
Weight Change (kg)	—	—	—	—	0 kg -LO
Ideal Body Weight	—	—	—	—	160 lb -LO
Visit Weight	—	—	—	—	216 lb -LO
BMI (Calculated)	—	—	—	—	33.8 -LO
IBW/kg (Calculated) Male	—	—	—	—	66.1 kg -LO
IBW/kg (Calculated) FEMALE	—	—	—	—	61.6 kg -LO
Weight/Scale Event	—	—	—	—	0 -LO
Vitals Sepsis Risk Score	—	—	0 -LO	—	0 -LO
Weight in (lb) to have BMI = 25	—	—	—	—	159.3 -LO
% Weight Change Since Birth	—	—	—	—	0 -LO
Relevant Labs and Vitals					
Temp (in Celsius)	—	—	37.6 -LO	—	36.9 -LO
Adult IBW/VT Calculations					
IBW/kg (Calculated)	—	—	—	—	66.1 -LO
Range Vt 4mL/kg	—	—	—	—	264.4 mL/kg -LO
Low Range Vt 6mL/kg	—	—	—	—	396.6 mL/kg -LO
Adult Moderate Range Vt 8mL/kg	—	—	—	—	528.8 mL/kg -LO
Adult High Range Vt 10mL/kg	—	—	—	—	661 mL/kg -LO
Case Log					
BSA x (CI @3.0)= CO	—	—	—	—	6.45 CO -LO
Aldrete Phase 1					
Aldrete Score	10 -LO	8 -LO	—	10 -LO	—

Flowsheets (all recorded)

Risk for Readmission

Row Name	09/05/19 0235
OTHER	
Risk for Readmission	10 -BP

Flowsheets (all recorded)

Travel Information

Row Name	08/28/19 0826
RETIRED - Travel outside the U.S.	
RETIRED - Has the patient or a household member traveled outside the U.S. in the past 21 days?	No -LO

Flowsheets (all recorded)

Aldrete Score

Row Name	08/28/19 0913	08/28/19 0903	08/28/19 0827
Aldrete			
Activity	2 -LO	2 -LO	2 -LO
Respiration	2 -LO	2 -LO	2 -LO
Circulation	2 -LO	1 -LO	2 -LO
Consciousness	2 -LO	1 -LO	2 -LO
O2 Saturation	2 -LO	2 -LO	2 -LO
Aldrete Score (PAR)	10 -LO	8 -LO	10 -LO

Flowsheets (all recorded)

Vital Signs

Row Name	08/28/19 0928	08/28/19 0915	08/28/19 0912	08/28/19 0905	08/28/19 0900
Vital Signs					
Automatic Restart Vitals Timer	Yes -LO	Yes -LO	Yes -LO	Yes -LO	Yes -LO
Pulse	52 -LO	52 -LO	52 -LO	52 -LO	52 -LO
Heart Rate Source	Monitor -LO	Monitor -LO	Monitor -LO	Monitor -LO	Monitor -LO
Resp	18 -LO	18 -LO	18 -LO	16 -LO	16 -LO
BP	139/65 -LO	122/58 -LO	119/58 -LO	108/56 -LO	125/58 -LO
Calculated MAP	89.67 -LO	79.33 -LO	78.33 -LO	73.33 -LO	80.33 -LO
Temp	—	—	—	—	97.8 °F (36.6 °C) -LO
Temp src	—	—	—	—	Axillary -LO
Oxygen Therapy					
SpO2	95 % -LO	95 % -LO	95 % -LO	94 % -LO	93 % -LO
O2 Device	None (Room air) -LO	None (Room air) -LO	None (Room air) -LO	None (Room air) -LO	None (Room air) -LO
Pulse Oximetry Type	Continuous -LO	Continuous -LO	Continuous -LO	Continuous -LO	Continuous -LO
POX Probe Site Changed	No -LO	No -LO	No -LO	No -LO	No -LO
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	—	—	0 -LO

Row Name	08/28/19 0826
Vital Signs	
Automatic Restart Vitals Timer	Yes -LO
Pulse	52 -LO
Heart Rate Source	Monitor -LO
Resp	18 -LO
BP	**(!) 201/88** -LO
Calculated MAP	125.67 -LO
Temp	98.4 °F (36.9 °C) -LO
Temp src	Oral -LO
Oxygen Therapy	
SpO2	98 % -LO
O2 Device	None (Room air) -LO
Pulse Oximetry Type	Continuous -LO
POX Probe Site Changed	No -LO
Vitals Sepsis Score	
Vitals Sepsis Risk Score	0 -LO

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	08/28/19 0903	08/28/19 0838
[REMOVED] Peripheral IV 08/28/19 20 G Right Hand		
IV Properties	Placement Date: 08/28/19 -LO Placement Time: 0833 -LO Present on arrival to hospital?: No -LO Type of Catheter: Straight -LO Size (Gauge): 20 G -LO Orientation: Right -LO Location: Hand -LO Site Prep: Chlorhexidine ;Alcohol -LO Inserted by: C. Pope RN -LO Insertion attempts: 1 -LO Successful IV Attempt?: Yes -LO Patient Tolerance: Tolerated well -LO IV Access Problem: No -LO Removal Date: 08/28/19 -LO Removal Time: 0936 -LO Catheter Intact on removal?: Yes -LO Removal Reason : Patient discharged -LO	
Site Assessment	Clean;Dry -LO	Clean;Dry -LO
Phlebitis Scale	0 -LO	0 -LO
Infiltration/Extravasation Scale	0 -LO	0 -LO
Line Assessment	Flushes easily;Infusing -LO	Infusing;Flushes easily -LO
Dressing Assesment	Clean;Dry;Intact -LO	Clean;Dry -LO

Flowsheets (all recorded)

Anthropometrics

Row Name	08/28/19 0826
Anthropometrics	
Height	67" (1.702 m) -LO
Weight	98 kg (216 lb) -LO
Weight Method	Stated -LO
Weight Change	0 -LO
BMI (Calculated)	33.8 -LO

Flowsheets (all recorded)

Interpretation

Row Name	08/28/19 0824
Medical Interpretation Services Documentation (All fields are required)	
Is patient using Interpretation Services for this encounter?	No -LO

Flowsheets (all recorded)

Fall Risk

Row Name	08/28/19 0827
Hester Davis Fall Risk Assessment	
Last Known Fall	0 -LO
Mobility	0 -LO
Medications	1 -LO
Mental Status/LOC/Awareness	0 -LO
Toileting Needs	0 -LO
Volume/Electrolyte Status	0 -LO
Communication/Sensory	0 -LO
Behavior	0 -LO
Hester Davis Fall Risk Total	4 -LO
Fall Assessment	
Patient Receiving Sedation	Yes -LO
Fall Risk	Yes -LO
Fall Band Applied	Yes -LO
Yellow socks	Yes -LO

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	08/28/19 0928	08/28/19 0915	08/28/19 0912	08/28/19 0905	08/28/19 0900
Vital sign parameters					
BP	139/65 -LO	122/58 -LO	119/58 -LO	108/56 -LO	125/58 -LO
Pulse	52 -LO	52 -LO	52 -LO	52 -LO	52 -LO
Calculated MAP	89.67 -LO	79.33 -LO	78.33 -LO	73.33 -LO	80.33 -LO
Resp	18 -LO	18 -LO	18 -LO	16 -LO	16 -LO
Temp	—	—	—	—	97.8 °F (36.6 °C) -LO
Vitals Sepsis Risk Score	—	—	—	—	0 -LO
Vital Signs					
Automatic Restart Vitals Timer	Yes -LO	Yes -LO	Yes -LO	Yes -LO	Yes -LO

Row Name	08/28/19 0826
Vital sign parameters	
BP	**(!) 201/88** -LO
Pulse	52 -LO
Calculated MAP	125.67 -LO
Resp	18 -LO
Temp	98.4 °F (36.9 °C) -LO
Vitals Sepsis Risk Score	0 -LO
Vital Signs	
Automatic Restart Vitals Timer	Yes -LO

Flowsheets (all recorded)

Ris Pre Procedure Check list

Row Name	08/28/19 0828
Consent and Procedure	
History and Physical Completed	Yes -LO
Consents Confirmed	Operative;Informed;Anesthesia;Photographs;Facility -LO
Patient ID and Procedure Verified	Yes -LO
Allergy Band Applied	Yes -LO
Do you have any metal in your body?	No -LO
Correct Procedure	Yes -LO
Side/Site Confirmed	N/A -LO
Surgeon/Anesthesia Orders Received	Yes -LO
Surgical Prep Complete	Yes -LO
Date of last liquid	08/27/19 -LO
Time of last liquid	2200 -LO
Date of last solid	08/27/19 -LO
Time of last solid	2200 -LO
Locker Assignment	4 -LO
Pre-Op Teaching Complete	Yes -LO
Lab/Testing Checklist	
Blood Glucose Meter (mg/dl)	109 -LO
MD/Anesthesia Notified of Blood Glucose Result	Yes -LO
Urinalysis Results	Abnormal -LO
Abnormal UA Dip results	Positive protein -LO
Microscopy Complete	No -LO
Pre- op Checklist	
Anti-embolism	n/a -LO
Pre-Op Medications Given and Charted	Yes -LO
Pre-Op Vitals Documented	Yes -LO
Allergies Verified	Yes -LO
Voided Prior to Procedure	Yes -LO
Remove all that apply:	Underwear -LO
Required items available	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -LO
Mode of Transport	Stretcher -LO

Flowsheets (all recorded)

Dischage Information

Row Name	08/28/19 0914
As part of our commitment to quality care, we will be calling you within 7-14 days of your procedure. Please provide us with the following information so we can contact you in a way that is best for you.	
Contact Number	678-910-2298 -LO
Contact Guidelines	Ok to leave a message for me if you get an answering machine -LO
If you have taken sedation medication or have a scheduled procedure with anesthesia you are required to have a responsible adult present to drive you home after your procedure. If your driver needs to step out for a moment we need a cell/contact number	
Driver's Name	Shirley Maurice -LO
Relationship to Patient	Spouse/Significant Other -LO
Cell Phone Number	678-910-2476 -LO

Flowsheets (all recorded)

Assessment

Row Name	08/28/19 0913	08/28/19 0903	08/28/19 0827
Preop Assessment			
Skin Condition/Temp	Intact;Dry;Warm -LO	Dry;Intact -LO	Dry;Intact;Warm -LO
Orient/LOC	WDL;Alert;Awake;Oriented to person;Oriented to place;Oriented to time -LO	Sedated;Sleeping -LO	WDL;Alert;Awake;Oriented to person;Oriented to place;Oriented to time -LO
Psychosocial	Calm -LO	Calm -LO	Calm -LO
Enema by Patient Prior to Admission?	—	—	Yes -LO

Flowsheets (all recorded)

Hand Off

Row Name	08/28/19 0900
Post Sedation Care	
Type of Sedation	MAC -LO
Procedure Tolerated:	Well -LO
Report Given at:	0900 -LO
Transport Method:	Stretcher -LO

Flowsheets (all recorded)

Patient Assessment in OR Room

Row Name	08/28/19 08:48:09	08/28/19 0827
Patient Assessment		
Name Spelling, DOB, Procedure, Consent Verified	Yes -LO	—
Site Verbally Verified	Yes -LO	—
Site marked by physician or proceduralist?	Not applicable -LO	—
Pt Oriented to the OR Suite, Personnel & Roles	Yes -LO	—
Stretcher	Wheels locked;Side rails up x2 -LO	—
Comfort Assessment Complete	Yes -LO	—
Comfort Actions Taken	Warm blankets;Pillow under head;Pillow between knees/feet -LO	—
SCDs Applied	No (see comment) -LO	—
Plan of Care Reviewed by OR Staff	Yes -LO	—
Type of Anesthesia	MAC -LO	—
Prep Assessmnet		
Operative Site Intact	Yes -LO	Yes -LO
Hair Removal	N/A -LO	N/A -LO

Flowsheets (all recorded)

Assessment in OR post procedure

Row Name	08/28/19 08:50:30
Post Procedure Documentation	
Surgical Wound Classification	III -LO
Preoperative Diagnosis	history of prostate cancer -LO
Postoperative Diagnosis	history of prostate cancer -LO
Procedure Performed (Confirmed by MD and Anesthesia)	Yes -LO

Flowsheets (all recorded)

Procedure Documentation

Row Name	08/28/19 08:48:28
Procedure Assessment	
Patient Position	Lateral up right -LO
Warming Device	Off -LO
Electrocautery	
Electrocautery Used?	No -LO
Procedure Interventions	
Xrays Taken?	No -LO
Imaging Displayed?	Yes -LO
Video/Photography?	Yes -LO
Laser Used?	No -LO
Specimen Obtained	
Specimen Obtained?	Yes -LO
Specimen Collection	
Specimen Type	Prostate Biopsy -LO
Side	Right;Bilateral;Left -LO
Site location	prostate gl;and -LO
Prostate Specimen Location	Lat base;Lat mid;Lat apex;Base;Mid;Apex -LO
Specimen Sent to Pathology	Yes -LO
Specimen Discarded per Surgeon	No -LO
Additional Specimens	No -LO
Dressings	
Dressings	N/A -LO

Flowsheets (all recorded)

Intake/Output

Row Name	08/28/19 0939	08/28/19 0902
Intake (mL)		
I.V.	—	300 mL -LO
Urine Assessment		
Urine Color	Yellow/straw -LO	—
Urine Appearance	Clear -LO	—

Flowsheets (all recorded)

Abuse Screen

Row Name	08/28/19 0827
Abuse Screening	
Do you feel safe at home?	Yes -LO
Have you ever thought about hurting yourself?	No -LO

WS Kennestone Urology
Procedure at Tower Road
300 Tower Road
STE 150
MARIETTA GA 30060-9404
Inpatient Record

Maurice, Eugene George
MRN: 561253820, DOB: 1/2/1949, Sex: M
Adm: 8/28/2019, D/C: 9/4/2019

Flowsheets (all recorded)

Vitals/Pain

Row Name	08/28/19 0928	08/28/19 0915	08/28/19 0912	08/28/19 0905	08/28/19 0900
Vitals					
Temp	—	—	—	—	97.8 °F (36.6 °C) -LO
Temp src	—	—	—	—	Axillary -LO
Pulse	52 -LO	52 -LO	52 -LO	52 -LO	52 -LO
Heart Rate Source	Monitor -LO	Monitor -LO	Monitor -LO	Monitor -LO	Monitor -LO
Resp	18 -LO	18 -LO	18 -LO	16 -LO	16 -LO
BP	139/65 -LO	122/58 -LO	119/58 -LO	108/56 -LO	125/58 -LO
Cardiac Rhythm	Normal sinus rhythm -LO	Sinus bradycardia -LO	Sinus bradycardia -LO	Sinus bradycardia -LO	Sinus bradycardia -LO
Pain Assessment					
Currently in Pain	No/denies pain -LO	No/denies pain -LO	No/denies pain -LO	No/denies pain -LO	Faces -LO
FACES Pain Rating	—	—	—	—	0-No hurt -LO
Oxygen Therapy					
SpO2	95 % -LO	95 % -LO	95 % -LO	94 % -LO	93 % -LO
O2 Device	None (Room air) -LO	None (Room air) -LO	None (Room air) -LO	None (Room air) -LO	None (Room air) -LO
Pulse Oximetry Type	Continuous -LO	Continuous -LO	Continuous -LO	Continuous -LO	Continuous -LO
POX Probe Site Changed	No -LO	No -LO	No -LO	No -LO	No -LO

Row Name	08/28/19 0826
Height and Weight	
Height	67" (1.702 m) -LO
Height Method	Stated -LO
Weight	98 kg (216 lb) -LO
Weight Method	Stated -LO
BMI (Calculated)	33.8 -LO
BSA (Calculated - sq m)	2.15 sq meters -LO
Vitals	
Temp	98.4 °F (36.9 °C) -LO
Temp src	Oral -LO
Pulse	52 -LO
Heart Rate Source	Monitor -LO
Resp	18 -LO
BP	**(!) 201/88** -LO
Cardiac Rhythm	Normal sinus rhythm -LO
Pain Assessment	
Currently in Pain	No/denies pain -LO
Oxygen Therapy	
SpO2	98 % -LO
O2 Device	None (Room air) -LO
Pulse Oximetry Type	Continuous -LO
POX Probe Site Changed	No -LO

Flowsheets (all recorded)

Site Preparation

Row Name	08/28/19 08:48:09	08/28/19 0827
Prep Assessmnet		
Operative Site Intact	Yes -LO	Yes -LO
Hair Removal	N/A -LO	N/A -LO

Flowsheets (all recorded)

Advance Directive

Row Name	08/28/19 0826
Advance Directives (For Healthcare)	
Have you reviewed your Advance Directive and is it valid for this stay?	No -LO
Advance Directive	Patient has advance directive, copy not in chart -LO

Flowsheets (all recorded)

Assessment

Row Name	08/28/19 0913	08/28/19 0903	08/28/19 0827
Uro Assessment			
Skin Condition/Temp	Intact;Dry;Warm -LO	Dry;Intact -LO	Dry;Intact;Warm -LO
Orient/LOC	WDL;Alert;Awake;Oriented to person;Oriented to place;Oriented to time -LO	Sedated;Sleeping -LO	WDL;Alert;Awake;Oriented to person;Oriented to place;Oriented to time -LO
Psychosocial	Calm -LO	Calm -LO	Calm -LO

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
LO	Lisa M Olivarez, RN	02/03/17 -
BP	Batch Job Prelude	—

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Document on 8/28/2019 9:04 AM by Lisa M Olivarez, RN: IP After Visit Summary (below)

AFTER VISIT SUMMARY

Eugene G. Maurice MRN: 561253820 8/28/2019 WellStar Kennestone Urology Procedure Center

Instructions

No changes were made to your medications.

Activity instructions

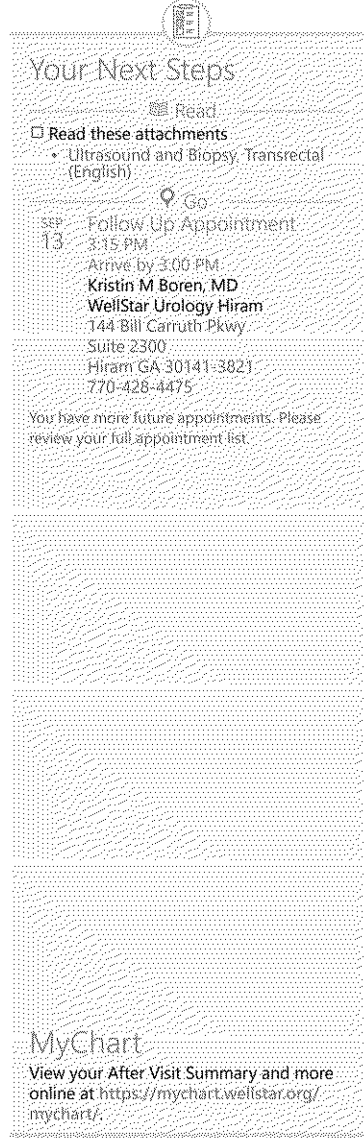
Discharge Instructions

1. General Anesthesia or Sedation
Do not drive or operate machinery for 24 hours
Do not consume alcohol, tranquilizers, sleeping medication or any other non-prescribed medication for 24 hours.
Do not make any important decisions or sign any important documents in the next 24 hours.
You should have someone with you at home tonight.

2. Activity
You are advised to go directly home from the Urology Associates Surgery Center and rest for a day. Resume light to normal activity tomorrow.
Do not engage in heavy lifting while you see blood in the urine or stool.

3. Fluids and Diet
Begin with clear liquids, bouillon, dry toast, soda crackers. If not nauseated, you may go to a regular diet when you desire.
Greasy or spicy foods are not advised.
Drink plenty of water while you see blood in the urine or stool.
If you are diabetic, please eat before you take your diabetes medication.

4. Medications and Plan
Prescriptions sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications.
You may take non-prescription "headache remedy" type medications that you normally use, if your surgeon permits, preferably one that does not contain aspirin.
You may resume your daily prescription medication when you get home.



Your Next Steps

Read

☐ Read these attachments
- Ultrasound and Biopsy, Transrectal (English)

Go

SEP 13 Follow Up Appointment
3:15 PM
Arrive by 3:00 PM
Kristin M Boren, MD
WellStar Urology Hiram
144 Bill Carruth Pkwy
Suite 2300
Hiram GA 30141-3821
770-428-4475

You have more future appointments. Please review your full appointment list.

MyChart

View your After Visit Summary and more online at https://mychart.wellstar.org/mychart/.

Activity instructions (continued)

Prescriptions
Tylenol as needed for pain or discomfort.
Antibiotic: Cipro this evening.
Patient was provided with updated medication list.

6. Follow up Care
Your physician may call you with biopsy results.

Special Complications to Watch For
You may see blood in your urine or stool for days to weeks.
You may see blood in your ejaculate for up to 6 weeks.
If you have a fever, chills, and are feeling poorly, take your temperature by mouth. Call the office if it is over 101* F.
Please call us if you have large blood clots, difficulty urinating or pain not relieved by Tylenol.

If you have any questions the day of your procedure please call 470-245-9860 to speak with a nurse. For problems or questions after 4:30pm call your urologist at 770-428-4475

If you need immediate attention, go to the emergency room.

Other instructions
Discharge Follow-Up

Discharge activity

Discharge diet

What's next

SEP 13 — Follow Up Appointment with Kristin M Boren, MD
Friday Sep 13, 2019 3:15 PM (Arrive by 3:00 PM)
WellStar Urology Hiram
144 Bill Carruth Pkwy
Suite 2300
Hiram GA 30141-3821
770-428-4475

SEP 30 — Nurse Visit
Monday Sep 30, 2019 10:15 AM
WellStar Cobb Northwest Georgia Oncology Hiram
144 BILL CARRUTH PKWY, STE 3100
Hiram GA 30141-3819
678-363-1940

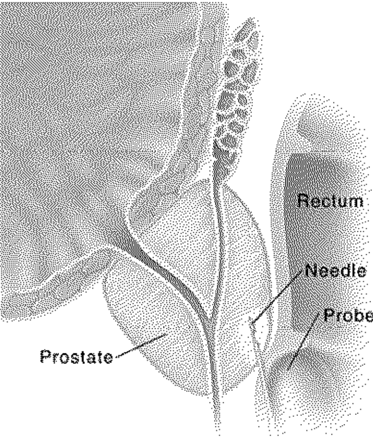
OCT 7 — Follow Up Appointment with Hayley Morton, PA
Monday Oct 7, 2019 10:15 AM
WellStar Cobb Northwest Georgia Oncology Hiram
144 BILL CARRUTH PKWY, STE 3100
Hiram GA 30141-3819
678-363-1940

Medication List

	Morning	Afternoon	Evening	Bedtime	As Needed
aspirin 81 MG tablet, delayed release					
atorvastatin 80 MG tablet Commonly known as: LIPITOR Take 1 tablet (80 mg total) by mouth nightly					
blood sugar diagnostic strip Commonly known as: ONETOUCH VERIO Use to check blood sugar twice daily as directed.					
ciprofloxacin HCl 500 MG tablet Commonly known as: CIPRO					
clopidogrel 75 mg tablet Commonly known as: PLAVIX Take 1 tablet (75 mg total) by mouth daily					
ferrous sulfate 324 mg (65 mg iron) tablet, delayed release Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals					
furosemide 40 MG tablet Commonly known as: LASIX Take 1 tablet (40 mg total) by mouth daily					
gatifloxacin 0.5 % eye drops Commonly known as: ZYMAXID					
isosorbide mononitrate 60 MG tablet, extended release 24 hr Commonly known as: IMDUR Take 1 tablet (60 mg total) by mouth 2 (two) times a day					
metFORMIN 500 MG tablet Commonly known as: GLUCOPHAGE 2 tablet po in am and 1 in pm					
nitroglycerin 0.4 MG SL tablet Commonly known as: NITROSTAT Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain					
prednisoLONE acetate 1 % ophthalmic suspension Commonly known as: PRED FORTE					
ramipril 5 MG capsule Commonly known as: ALTACE Take 1 capsule (5 mg total) by mouth daily					
sotalol 80 MG tablet Commonly known as: BETAPACE Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day					
tamsulosin 0.4 mg 24 hr capsule Commonly known as: FLOMAX Take 1 capsule (0.4 mg total) by mouth nightly					
VITAMIN B12 ORAL					

Ultrasound and Biopsy, Transrectal (English)

Transrectal Ultrasound and Biopsy



A transrectal ultrasound is an imaging test. It uses sound waves to create pictures of a man's prostate gland. Your prostate gland is in front of your rectum. For this test, a special probe (transducer) is placed directly into your rectum. During the test, tissue samples (a biopsy) may also be taken. The test is done by a specially trained technologist called a sonographer.

Getting ready for your test

- You may be asked to clear your bowel before the test. This may be done by injecting liquid into your rectum (an enema). Or it can be done by drinking a special liquid.
- You may be asked not to eat or drink anything after midnight the night before the test.
- Tell your healthcare provider about any medicines, herbs, or supplements you are taking. This includes any over-the-counter medicines such as aspirin or ibuprofen. You might need to stop taking some medicines for a week or so before the test.
- Answer any questions your healthcare provider has about your medical history. This will help tailor the test to your health needs.

During your test

- You may be asked to change into a gown. You will then lie on your side on an exam table, with your knees bent.
- The test is done with a handheld probe. This is a short, slender rod. It has a sterile, disposable cover on it. It is also greased (lubricated) with some gel. It is then gently placed inside your rectum.
- You will feel pressure from the probe. If you feel pain, let your healthcare provider know.
- If a biopsy is needed, you might take medicine before the procedure to make you sleepy. The test is done using a small probe with a very tiny needle on the end. This needle enters your prostate several times and removes tiny samples of tissue. These samples are then sent to a lab to be examined. Any mild pain from the biopsy is usually minor.

After your test

Before leaving, you may need to wait for a short time while the images are reviewed. In most cases, you can go back to your normal routine after the test. If you had a biopsy and took medicine to make you sleepy, you may need to wait until it has worn off before you can go home. You might see some blood in your urine, sperm, or stool for a day or so. This is normal. Your healthcare provider will let you know when your test results are ready.

In some cases, a diagnosis can't be made from the tissue sample that was taken. If this happens, your healthcare provider will talk with you about whether you need another biopsy. Or you may need a different procedure.

Call your healthcare provider if you have:

- Very bloody urine or stool
- A fever lasting 24 to 48 hours
- Any other symptoms that your healthcare provider asks you to report, based on your health

Date Last Reviewed: 5/1/2017

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Scan on 8/28/2019 8:02 AM by Mary Johnston: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

ENCOUNTER

Patient Class:	**OP**		Unit:	**KHUROPROC**
Hospital Service:	**Urology**		Bed:	**Room/bed info not found**
Admitting Provider:			Referring Physician:	**Boren, Kristin M**
Attending Provider:	**Kristin m boren;Nikolas ***	AD: N	Adm Diagnosis:	**Cancer of prostate with ***
Admission Date:	**1/28/2020**		Admission Time:	**0743**

PATIENT

Name	**Eugene George Maurice**	Sex:	**Male**	DOB:	**1/2/1949 (71 yrs)**
Address:	**61 SHOCKLEY WAY**			Religion:	**Catholic**
City:	**DALLAS GA 30157-8973**			Race:	**White or caucasian**
County:	**PAULDING**				
Email Address:	**Gene.maurice@sgmservice.***				
Primary Care Provider:	**Jeffrey L Tharp, MD**			Primary Phone:	**678-910-2298**

EMERGENCY CONTACT

Contact Name	Legal Guardian?	Relationship to Patient	Home Phone	Work Phone	Mobile Phone
1. Maurice,Shirley		**Spouse**	**(678)398-9479**		**678-910-2476**
2. *No Contact Specified*					**678-910-2476**

GUARANTOR

Guarantor:	**MAURICE,EUGENE GEORGE**	DOB:	**1/2/1949**
Address:	**61 SHOCKLEY WAY**	Sex:	**Male**
	DALLAS, GA 30157-8973	Home Phone:	**678-398-9479**
Relation to Patient:	**Self**	Work Phone:	
Guarantor ID:	**123805**	Mobile Phone:	**678-910-2298**

GUARANTOR EMPLOYER

Employer:		Phone:		Status:	**RETIRED**

COVERAGE

PRIMARY INSURANCE

Payor:	**AETNA MEDICARE**	Plan:	**AETNA /MDCR ADV PPO H5521**
Group Number:	**000003-GA**	Insurance Type:	**INDEMNITY**
Subscriber Name:	**MAURICE,EUGENE GEOR***	Subscriber DOB:	**01/02/1949**
Coverage	**P O BOX 981106** **EL PASO, TX 79998-1106**	Subscriber ID:	**101048133500**
		Pat. Rel. to Subscriber:	**Self**
Phone:	**(800)624-0756**	Co-In: Deductible:	Out of Pocket Max:

SECONDARY INSURANCE

Payor:		Plan:	**N/A**
Group Number:		Insurance Type:	
Subscriber Name:		Subscriber DOB:	
Coverage		Subscriber ID:	
		Pat. Rel. to Subscriber:	
Phone:			

Admission Information

Arrival Date/Time:		Admit Date/Time:	01/28/2020 0743	IP Adm. Date/Time:	
Admission Type:	Elective	Point of Origin:	Outside Hospital	Admit Category:	
Means of Arrival:		Primary Service:	Urology	Secondary Service:	N/A
Transfer Source:		Service Area:	WS SERVICE AREA	Unit:	WellStar Kennestone Urology Procedure Center
Admit Provider:		Attending Provider:	Kristin M Boren, MD	Referring Provider:	Kristin M Boren, MD

Reason for Visit

Post-op Check

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
02/04/2020 2359	Home Or Self Care	None	None	WellStar Kennestone Urology Procedure Center

Final Diagnoses (ICD-10-CM)

Code	Description	POA	CC	HAC	Affects DRG
C61 [Principal]	Malignant neoplasm of prostate				
N42.32	Atypical small acinar proliferation of prostate				
I10	Essential (primary) hypertension				
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris				
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene				
E66.9	Obesity, unspecified				
Z68.33	Body mass index (bmi) 33.0-33.9, adult	Exempt from POA reporting			
E78.5	Hyperlipidemia, unspecified				
I48.0	Paroxysmal atrial fibrillation				
Z87.891	Personal history of nicotine dependence	Exempt from POA reporting			
Z86.19	Personal history of other infectious and parasitic diseases	Exempt from POA reporting			
Z79.899	Other long term (current) drug therapy	Exempt from POA reporting			
Z79.82	Long term (current) use of aspirin	Exempt from POA reporting			
Z79.02	Long term (current) use of antithrombotics/antiplatelets	Exempt from POA reporting			
Z95.1	Presence of aortocoronary bypass graft	Exempt from POA reporting			
Z95.5	Presence of coronary angioplasty implant and graft	Exempt from POA reporting			
Z79.84	Long term (current) use of oral hypoglycemic drugs	Exempt from POA reporting			

Events

Hospital Outpatient at 1/28/2020 0743

Unit: WellStar Kennestone Urology Procedure Center
Patient class: Outpatient Service: Urology

Discharge at 2/4/2020 2359

Unit: WellStar Kennestone Urology Procedure Center

All Scans (continued)

Events (continued)

Patient class: Outpatient   Service: Urology

Allergies as of 2/4/2020

Reviewed on 1/28/2020

No Known Allergies

Immunizations as of 2/4/2020

Immunizations last reviewed by Lisa M Stephenson, MA on 7/5/2018 1253

Annual Influenza

Administered on: 9/26/2016 0000   Site: Left deltoid   Route: Intramuscular
Lot number: UI700AA

Annual Influenza

Administered on: 9/28/2017 0000   Site: Left deltoid   Route: Intramuscular
Lot number: UI842AB

Annual Influenza

Administered on: 10/5/2018 0000   Site: Right deltoid   Route: Intramuscular
Lot number: UJ031AA

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Jade Westover, LPN   Administered on: 9/26/2016   Dose: 0.5 mL
Site: Left deltoid   Route: Intramuscular   NDC: 49281-399-88
CVX code: 135   VIS date: 8/7/2015
Manufacturer: Sanofi Pasteur   Lot number: UI700AA

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Tina M Allen, MA   Administered on: 9/28/2017   Dose: 0.5 mL
Site: Left deltoid   Route: Intramuscular   NDC: 49281-401-88
CVX code: 135   VIS date: 09/28/2017
Manufacturer: Sanofi Pasteur   Lot number: UI842AB

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA   Administered on: 10/5/2018   Dose: 0.5 mL
Site: Right deltoid   Route: Intramuscular   NDC: 49281-403-88
CVX code: 135   VIS date: 8/7/2015
Product: Fluzone HD   Manufacturer: Sanofi Pasteur   Lot number: UJ031AA
Expiration date: 5/1/2019

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

INFLUENZA HD, 65 YEARS AND ABOVE

Administered by: Mary S Wray, MA   Administered on: 10/30/2019   Dose: 0.5 mL
Site: Left deltoid   Route: Intramuscular   NDC: 49281-405-88
CVX code: 135   VIS date: 8/15/2019
Product: FLUZONE HIGH-DOSE 2019-20 (PF)   Manufacturer: Sanofi Pasteur   Lot number: UJ285AA

All Scans (continued)

Immunizations (continued) as of 2/4/2020

Questionnaire

Question	Answer
Have you ever had a serious reaction to eggs?	NO
Have you ever had Guillain Barre Syndrome?	No

Influenza - Unspecified

Administered on: 9/26/2016 0000
Site: Left deltoid
Route: Intramuscular
CVX code: 88
Lot number: UI700AA

Pneumococcal Conjugate 13-Valent

Administered by: Mary S Wray, MA
Site: Left deltoid
CVX code: 133
Manufacturer: Wyeth-Ayerst
Administered on: 3/16/2016
Route: Intramuscular
VIS date: 031616
Lot number: M51193
Dose: 0.5 mL
NDC: 0005-1971-01

Pneumococcal Polysaccharide

Administered by: Mary S Wray, MA
Site: Left deltoid
CVX code: 33
Manufacturer: Merck & Co. Inc
Administered on: 10/5/2018
Route: Intramuscular
VIS date: 04/24/2015
Lot number: R012497
Dose: 0.5 mL
NDC: 0006-4837-01

Questionnaire

Question	Answer
Have you ever had a serious reaction to any vaccine in the past?	NO
Are you sick today with a moderate to severe illness (e.g. fever)	NO

Pneumococcal Polysaccharide

Administered on: 10/5/2018 0000
Site: Left deltoid
Route: Intramuscular
CVX code: 33
Lot number: R012497

Medical as of 2/4/2020

Past Medical History

Diagnosis	Date	Comments	Source
AKI (acute kidney injury) (HCC) [N17.9]	—	—	Provider
CAD (coronary artery disease) [I25.10]	—	—	Provider
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]	1/30/2018	—	Provider
Cataracts, both eyes [H26.9]	—	—	Provider
Coronary atherosclerosis of native coronary artery [I25.10]	—	—	Provider
Diabetes mellitus (HCC) [E11.9]	—	—	Provider
Essential hypertension, benign [I10]	—	—	Provider
Family history of ischemic heart disease [Z82.49]	—	—	Provider
Hyperlipidemia [E78.5]	—	—	Provider
Hypertension [I10]	—	—	Provider
Infectious viral hepatitis [B15.9]	—	as teen/cannont recall what type	Provider
Obesity [E66.9]	—	—	Provider
Other and unspecified hyperlipidemia [E78.5]	—	—	Provider
Other symptoms involving cardiovascular system [R09.89]	—	—	Provider
PVD (peripheral vascular disease) (HCC) [I73.9]	—	—	Provider

Pertinent Negatives

Diagnosis	Date Noted	Comments	Source
Abnormal ECG [R94.31]	04/07/2014	—	Provider
Aneurysm (HCC) [I72.9]	04/07/2014	—	Provider
Arrhythmia [I49.9]	04/07/2014	—	Provider

All Scans (continued)

Medical as of 2/4/2020 (continued)

Asthma [J45.909]	04/07/2014	—	Provider
Clotting disorder (HCC) [D68.9]	04/07/2014	—	Provider
Congenital heart disease [Q24.9]	04/07/2014	—	Provider
Deep vein thrombosis (HCC) [I82.409]	04/07/2014	—	Provider
Heart failure (HCC) [I50.9]	04/07/2014	—	Provider
Heart murmur [R01.1]	04/07/2014	—	Provider
Mitral valve prolapse [I34.1]	04/07/2014	—	Provider
Myocardial infarction (HCC) [I21.9]	04/07/2014	—	Provider
Pulmonary embolism (HCC) [I26.99]	04/07/2014	—	Provider
Sleep apnea [G47.30]	04/07/2014	—	Provider
Stroke (HCC) [I63.9]	04/07/2014	—	Provider
Valvular disease [I38]	04/07/2014	—	Provider

ED Records

ED Arrival Information

Patient not seen in ED

Chief Complaint

Complaint	Onset	Comment	Last Edited By	Time	Relationship	ED Provider
Post-op Check	1/28/2020		Chrissie Pope, RN	1/29/2020 1:36 PM	None	No

ED Disposition

None

H&P - Encounter Notes

H&P by Nikolas P Symbas, MD at 1/28/2020 8:57 AM

Author: Nikolas P Symbas, MD
Filed: 1/28/2020 8:58 AM
Editor: Nikolas P Symbas, MD (Physician)
Service: Urology
Date of Service: 1/28/2020 8:57 AM
Author Type: Physician
Status: Signed

History and Physical

Chief complaint: Prostate cancer

History of Present Illness:
Eugene George Maurice is a 71 y.o.male who is seen for Prostate biopsy.

Had active surveillance biopsy 8/2019
Gland 21 cc
ASAP 2/12 cores
Now here after repeat MRI 12/11/19
PI-RADS category 5 lesion in the anterior central gland, just slightly larger than on the prior.
Volume 30cc

History:
Negative biopsy 2016
-MRI fusion bx 1/16/18 (volume 31 gm)
-GL 3+3, 1/13 cores (LT ACZP4), 10%
did have urinary retention and needed catheterization after second biopsy

Past History

Past Medical History:

Diagnosis	Date
• AKI (acute kidney injury) (HCC)	
• CAD (coronary artery disease)	
• Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	1/30/2018
• Cataracts, both eyes	
• Coronary atherosclerosis of native coronary artery	
• Diabetes mellitus (HCC)	
• Essential hypertension, benign	
• Family history of ischemic heart disease	
• Hyperlipidemia	
• Hypertension	
• Infectious viral hepatitis *as teen/cannont recall what type*	
• Obesity	
• Other and unspecified hyperlipidemia	
• Other symptoms involving cardiovascular system	
• PVD (peripheral vascular disease) (HCC)	

Past Surgical History:

Procedure	Laterality	Date
• APPENDECTOMY		
• CAROTID ENDARTERECTOMY *x2*		
• COLONOSCOPY *as of 9/2014 has not had this*		
• CORONARY ARTERY BYPASS GRAFT *X6*		1992
• CORONARY STENT PLACEMENT *sheikh*		2014
• EGD *Procedure: GI-EGD (LVL5) W/ BX; Surgeon: Sohail Asfandiyar, MD; Location: KH GI/BRONCH; Service: Gastroenterology; Laterality: N/A;*	N/A	6/19/2018
• shingles		9/2015
• VASCULAR SURGERY *right leg*		

No Known Allergies
(Not in a hospital admission)

Social and Family History

Social History

Tobacco Use	
• Smoking status:	Former Smoker
Packs/day:	1.00
Years:	25.00
Pack years:	25.00
Types:	Cigarettes
Last attempt to quit:	4/7/1992
Years since quitting:	27.8
• Smokeless tobacco:	Never Used
Substance Use Topics	
• Alcohol use:	Yes
Alcohol/week:	4.0 standard drinks

H&P - Encounter Notes (continued)

H&P by Nikolas P Symbas, MD at 1/28/2020 8:57 AM (continued)

Types: 2 Glasses of wine, 2 Shots of liquor per week
Comment: rarely

Family History

Problem	Relation	Age of Onset
• Coronary artery disease	Mother	
• Other *MI*	Mother	
• Other *MI*	Brother	
• Anemia	Neg Hx	
• Arrhythmia	Neg Hx	
• Asthma	Neg Hx	
• Clotting disorder	Neg Hx	
• Fainting	Neg Hx	
• Heart attack	Neg Hx	
• Heart disease	Neg Hx	
• Heart failure	Neg Hx	
• Hyperlipidemia	Neg Hx	
• Hypertension	Neg Hx	
• Stroke	Neg Hx	

A comprehensive review of systems was negative.

GEN: No acute distress
EYES: EOMI
HEENT: Moist mucus membranes, Sclera non-icteric
CV: Regular rate and rhythm by peripheral pulse
PULM: Easy work of breathing
ABD: Soft, Not tender, Not distended
EXT: No significant lower extremity edema
SKIN: No rashes appreciated
NEURO:No focal deficits

Assessment: Prostate cancer

Plan: MRI fusion biopsy

Nikolas P Symbas, MD
Wellstar Urology
55 Whitcher St.
Marietta, GA 30060
(p) 770-428-4475
(f) 770-426-1499

Electronically Signed by Nikolas P Symbas, MD on 1/28/2020 8:58 AM

Discharge Instr - Activity - Encounter Notes

Discharge Instr - Activity by Lisa M Olivarez, RN at 1/28/2020 9:25 AM

Author: Lisa M Olivarez, RN　Service: —　Author Type: Registered Nurse
Filed: 1/28/2020 9:25 AM　Date of Service: 1/28/2020 9:25 AM　Status: Written
Editor: Lisa M Olivarez, RN (Registered Nurse)

Discharge Instr - Activity - Encounter Notes (continued)

Discharge Instr - Activity by Lisa M Olivarez, RN at 1/28/2020 9:25 AM (continued)

Discharge Instructions

1. General Anesthesia or Sedation
Do not drive or operate machinery for 24 hours
Do not consume alcohol, tranquilizers, sleeping medication or any other non-prescribed medication for 24 hours.
Do not make any important decisions or sign any important documents in the next 24 hours.
You should have someone with you at home tonight.

2. Activity
You are advised to go directly home from the Urology Associates Surgery Center and rest for a day. Resume light to normal activity tomorrow.
Do not engage in heavy lifting while you see blood in the urine or stool.

3. Fluids and Diet
Begin with clear liquids, bouillon, dry toast, soda crackers. If not nauseated, you may go to a regular diet when you desire.
Greasy or spicy foods are not advised.
Drink plenty of water while you see blood in the urine or stool.
If you are diabetic, please eat before you take your diabetes medication.

4. Medications and Plan
Prescriptions sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications.
You may take non-prescription "headache remedy" type medications that you normally use, if your surgeon permits, preferably one that does not contain aspirin.
You may resume your daily prescription medication when you get home.

Prescriptions
Tylenol as needed for pain or discomfort.
Antibiotic: Cipro this evening.
Patient was provided with updated medication list.

6. Follow up Care
Your physician may call you with biopsy results.

Special Complications to Watch For
You may see blood in your urine or stool for days to weeks.
You may see blood in your ejaculate for up to 6 weeks.
If you have a fever, chills, and are feeling poorly, take your temperature by mouth. Call the office if it is over 101* F.
Please call us if you have large blood clots, difficulty urinating or pain not relieved by Tylenol.

If you have any questions the day of your procedure please call 470-245-9860 to speak with a nurse.
For problems or questions after 4:30pm call your urologist at 770-428-4475

If you need immediate attention, go to the emergency room.

Electronically Signed by Lisa M Olivarez, RN on 1/28/2020 9:25 AM

Surgery Report

General Information

Date: 1/28/2020
Time:
Status: Completed
Location: WS Kennestone Urology Procedure at Tower Road
Room:
Service:
Patient class:
Case classification:

Diagnosis Information

No post-op diagnosis codes associated with the log.

Case Tracking Events

Event	Time In
In Facility	0743
In Pre-Procedure	
In Block Room	
Out Block Room	
Pre-Procedure Complete	
Out of Pre-op	
Anesthesia Available	
In Room	
Anesthesia Start	0906
Anesthesia Ready	
Procedure Start	
Procedure End	
Out of Room	
Patient to Floor/ICU	
In Phase I	
Anesthesia Stop	0922
Phase I Criteria Met	
Out of Phase I	
In Phase II	
Phase II Care Complete	
Out of Phase II	
Remove from Status Board	
Anesthesia Follow-up Needed	
Anesthesia Follow-up Complete	
Moderate Sedation Begin	
Moderate Sedation End	

Questionnaire Data

None

PNDS Information

Outcomes - Pre-op

Used?	Description (Code)
Yes	The patient participates in decisions affecting his or her perioperative plan of care. (O23)
Yes	The patient demonstrates knowledge of the expected responses to the operative or invasive procedure. (O31)

Outcomes - Intra-op

Used?	Description (Code)
Yes	The patient is free from signs and symptoms of injury caused by extraneous objects. (O2)
Yes	The patient is free from signs and symptoms of injury related to positioning. (O5)
Yes	The patient is free from signs and symptoms of infection. (O10)

Outcomes - Post-op

Used?	Description (Code)
Yes	The patient is at or returning to normothermia at the conclusion of the immediate postoperative period. (O12)
Yes	The patient's respiratory function is consistent with or improved from baseline levels established preoperatively. (O14)
Yes	The patient demonstrates knowledge of pain management. (O20)
Yes	The patient demonstrates knowledge of wound management. (O22)
Yes	The patient demonstrates and/or reports adequate pain control throughout the perioperative period. (O29)

Surgery Report (continued)

PNDS Information (continued)

Diagnoses

Present?	Description (Code)
Yes	Risk for infection (X28)
Yes	Risk for injury (X29)
Yes	Deficient knowledge (X30)
Yes	Acute pain (X38)
Yes	Anxiety (X4)
Yes	Risk for impaired skin integrity (X51)
Yes	Risk for imbalanced body temperature (X57)
Yes	Ineffective breathing pattern (X7)

Timeouts

Pre-Procedure Timeout

Right Patient, Right Site, Right Procedure

Correct patient?: Yes
Correct site?: Yes
Correct procedure?: Yes
Correct laterality?: N/A

Pre-Procedure Verification

H&P note verified?: Yes
Consents verified?: Yes
Site marked?: N/A
Allergies reviewed?: Yes

Verification Date and Time: 1/28/2020 9:08 AM

Anesthesia Encounters

Anesthesia Encounter - Episode ID 44151006

Anesthesia Summary - Maurice, Eugene George [561253820] Male 71 y.o.

Current as of 01/28/20 0900

Height: 67" (1.702 m) (01/28/20)
Weight: 97.1 kg (214 lb) (01/28/20)
BMI: 33.5 (01/28/20)
NPO Status: 2200
Allergies: No Known Allergies

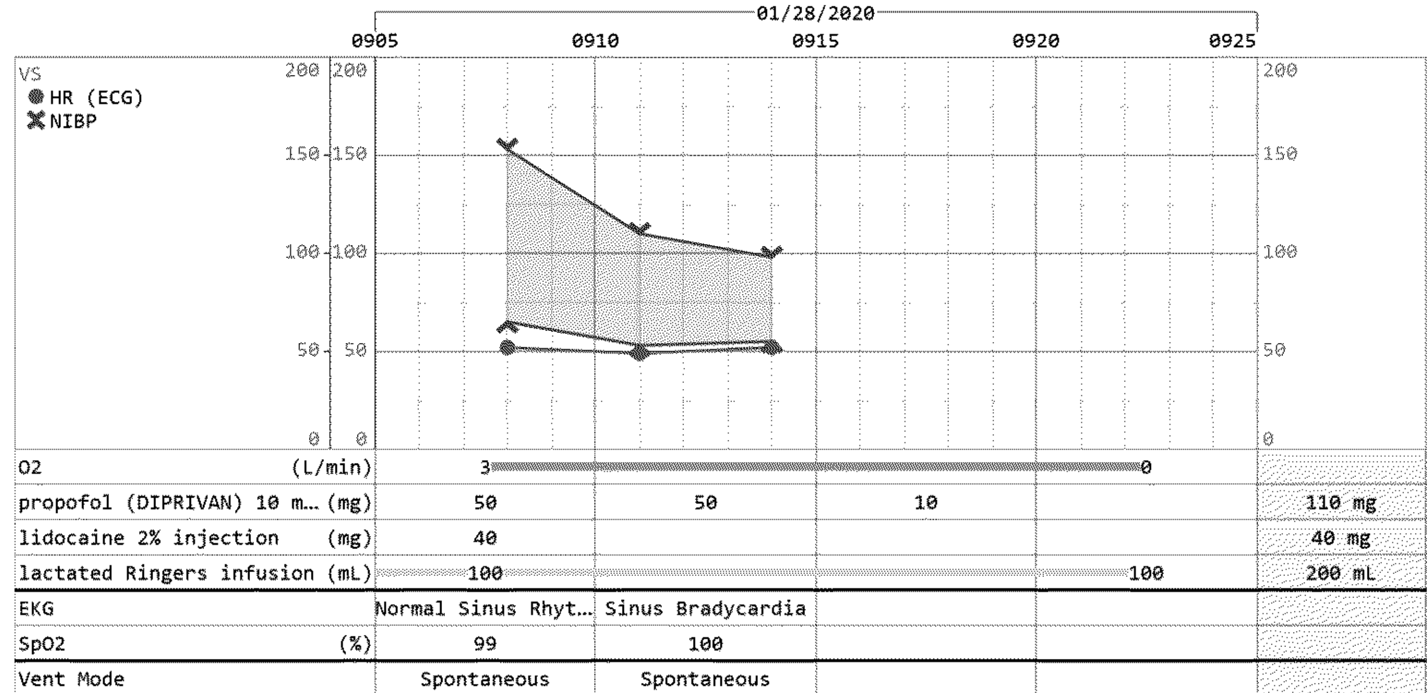
Procedure Summary

Date: 01/28/20
Anesthesia Start: 0906
Procedure: KUP PROSTATE BIOPSY W NDL

Scheduled Providers: Nikolas P Symbas, MD; Robert G Lawhead, MD
Anesthesia Type: MAC

Room / Location: WellStar Kennestone Urology Procedure Center
Anesthesia Stop: 0922
Diagnosis:
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)
Elevated PSA
Responsible Provider: Robert G Lawhead, MD
ASA Status: 3

Anesthesia Encounter - Episode ID 44151006 (continued)



	0905	0910	0915	0920	Total
O2 (L/min)	3			0	
propofol (DIPRIVAN) 10 m… (mg)	50	50	10		110 mg
lidocaine 2% injection (mg)	40				40 mg
lactated Ringers infusion (mL)	100			100	200 mL
EKG	Normal Sinus Rhyt…	Sinus Bradycardia			
SpO2 (%)	99	100			
Vent Mode	Spontaneous	Spontaneous			

Staff

01/28/20

Name	Role	Begin	End
Robert G Lawhead, MD	ANMD	0906	0922

Events

Date	Time	Event
1/28/2020	0900	Signed/Cosigned and Ready for Procedure
	0906	Anesthesia Start
	0922	Handoff to Receiving Nurse I completed my handoff to the receiving nurse during which we: 1. Identified the patient 2. Identified the responsible providers 3. Discussed the surgical procedure and course 4. Reviewed the pertinent medical history and allergies 5. Reviewed intra-op anesthesia management (airway, medications and I&O) 6. Reviewed nerve block expectations (when applicable) 7. Set expectations for post-procedure period and reviewed post-op orders 8. Allowed opportunity for questions and acknowledgement of understanding
	0922	Anesthesia Stop

Anesthesia Medical History

Other symptoms involving cardiovascular system	Coronary atherosclerosis of native coronary artery
Family history of ischemic heart disease	Other and unspecified hyperlipidemia
Essential hypertension, benign	PVD (peripheral vascular disease) (HCC)
Obesity	Hypertension
Hyperlipidemia	CAD (coronary artery disease)
Infectious viral hepatitis	Diabetes mellitus (HCC)
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	AKI (acute kidney injury) (HCC)
Cataracts, both eyes	Gout

Substance History

Smoking Status: Former Smoker - 25 pack years
Quit Smoking: 04/07/92
Smokeless Tobacco Status: Never Used

Anesthesia Encounter - Episode ID 44151006 (continued)

Substance History (continued)

Alcohol use: Yes; 4.0 standard drinks per week
Drug use: No

Surgical History

APPENDECTOMY	CORONARY ARTERY BYPASS GRAFT
CAROTID ENDARTERECTOMY	CORONARY STENT PLACEMENT
COLONOSCOPY	shingles
EGD	VASCULAR SURGERY

Facility Administered Medications

Taken on 01/28/20

gentamicin (GARAMYCIN) injection 40 mg/mL	lidocaine (XYLOCAINE) local injection 2 %
lactated Ringers infusion	lidocaine (XYLOCAINE) local injection 2 %
propofol (DIPRIVAN) injection 10 mg/mL	

Prescription Medications

Within last 14 days from 01/28/20

	Last Taken	Last Updated
aspirin 81 MG EC tablet	Taking	01/28/20 0822
atorvastatin (LIPITOR) 80 MG tablet	1/27/2020	01/28/20 0822
ciprofloxacin HCl (CIPRO) 500 MG tablet	Taking	01/28/20 0822
clopidogrel (PLAVIX) 75 mg tablet	Taking	01/28/20 0822
cyanocobalamin, vitamin B-12, (VITAMIN B12 ORAL)	1/27/2020	01/28/20 0822
diclofenac (VOLTAREN) 1 % Gel	As needed	01/28/20 0822
ferrous sulfate 324 mg (65 mg iron) TbEC	1/27/2020	01/28/20 0822
furosemide (LASIX) 40 MG tablet	1/27/2020	01/28/20 0822
isosorbide mononitrate (IMDUR) 60 MG tablet, extended release 24 hr	1/27/2020	01/28/20 0822
nitroglycerin (NITROSTAT) 0.4 MG SL tablet	Not Taking	01/28/20 0822
ramipril (ALTACE) 5 MG capsule	Taking	01/28/20 0822
sotalol (BETAPACE) 80 MG tablet	Taking	01/28/20 0822
blood sugar diagnostic (ONETOUCH VERIO) strip	Taking	01/28/20 0822
~~metFORMIN (GLUCOPHAGE) 500 MG tablet (Discontinued)~~	~~Taking~~	~~11/15/19 1400~~
metFORMIN (GLUCOPHAGE) 500 MG tablet	1/27/2020	01/28/20 0822
~~sotalol (BETAPACE) 80 MG tablet (Discontinued)~~	~~Taking~~	~~01/17/20 0831~~
tamsulosin (FLOMAX) 0.4 mg 24 hr capsule		

Preprocedure Vitals

Current as of 01/28/20 0900

BP: 153/65
Resp: 16
Temp: 98.4 °F (36.9 °C)
Height: 67" (1.702 m) (01/28/20)
BMI: **33.5**
Last edited 01/28/20 0831 by SC

Pulse: 48
SpO2: 97

Weight: 97.1 kg (214 lb) (01/28/20)
IBW: 66.1 kg (145 lb 12.2 oz)

Blood Orders

Ordered in last 14 days - Current as of 04/09/20 0954

No blood orders found

Hematology Labs (Last 90 days)

	03/17 0914
HGB	13.3 ▾
HCT	--
Plt	--

Electrolyte Labs (Last 90 days)

Anesthesia Encounter - Episode ID 44151006 (continued)

Electrolyte Labs (continued) (Last 90 days)

	03/17 0914
K+	5.2 ^
Na+	--
Cl-	--
HCO3	--

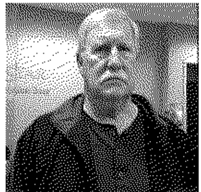
Procedure Notes

No procedure notes have been written.

Preprocedure Note

Last edited 01/28/20 0900 by Robert G Lawhead, MD
Date of Service 01/28/20 0859
Status: Signed

Anesthesia Pre-op Evaluation



Patient Name: Eugene George Maurice **MRN:** 561253820
Date of Birth: 1/2/1949 **Age:** 71 yrs **Sex:** Male
Height: 1.702 m (5' 7") **Weight:** 97.1 kg (214 lb) **BMI:** Body mass index is 33.52 kg/m².

Pre-Assessment Information

No Known Allergies

Past Medical History:

Diagnosis	Date
• AKI (acute kidney injury) (HCC)	
• CAD (coronary artery disease)	
• Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)	1/30/2018
• Cataracts, both eyes	
• Coronary atherosclerosis of native coronary artery	
• Diabetes mellitus (HCC)	
• Essential hypertension, benign	
• Family history of ischemic heart disease	
• Hyperlipidemia	
• Hypertension	
• Infectious viral hepatitis *as teen/cannont recall what type*	
• Obesity	

- Other and unspecified hyperlipidemia
- Other symptoms involving cardiovascular system
- PVD (peripheral vascular disease) (HCC)

Past Surgical History:

Procedure	Laterality	Date
• APPENDECTOMY		
• CAROTID ENDARTERECTOMY *x2*		
• COLONOSCOPY *as of 9/2014 has not had this*		
• CORONARY ARTERY BYPASS GRAFT *X6*		1992
• CORONARY STENT PLACEMENT *sheikh*		2014
• EGD *Procedure: GI-EGD (LVL5) W/ BX; Surgeon: Sohail Asfandiyar, MD; Location: KH GI/BRONCH; Service: Gastroenterology; Laterality: N/A;*	N/A	6/19/2018
• shingles		9/2015
• VASCULAR SURGERY *right leg*		

Tobacco Use

- Smoking status: Former Smoker
  - Packs/day: 1.00
  - Years: 25.00
  - Pack years: 25.00
  - Types: Cigarettes
  - Last attempt to quit: 4/7/1992
  - Years since quitting: 27.8
- Smokeless tobacco: Never Used

Substance and Sexual Activity

- Alcohol use: Yes
  - Alcohol/week: 4.0 standard drinks
  - Types: 2 Glasses of wine, 2 Shots of liquor per week
  - *Comment: rarely*
- Drug use: No
- Sexual activity: Yes
  - Partners: Female
  - Birth control/protection: None

Documented NPO status:
Date of last liquid: 01/28/20
Time of last liquid: 0630
Date of last solid: 01/28/20

Time of last solid: 2200

Review of Systems

Relevant Problems

CARDIOVASCULAR

(+) Angina pectoris (HCC)
(+) Atrial flutter (HCC)
(+) Controlled type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, without long-term current use of insulin (HCC)
(+) Coronary artery disease of native artery of native heart with stable angina pectoris (HCC)
(+) Essential hypertension
(+) Localized edema
(+) PAF (paroxysmal atrial fibrillation) (HCC)

ENDOCRINE

(+) Controlled type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, without long-term current use of insulin (HCC)

GI/HEPATIC

(+) Obesity

Physical Exam

Patient's patient summary and labs reviewed.

Mental Status: normal exam

Airway:
Mallampati: II
Neck ROM: full
TM distance: >3 FB

Dental: normal exam

Patient is aware of the dental risk(s) associated with airway management.

Cardiovascular: normal exam
Rhythm: regular
Rate: normal

Pulmonary: normal exam
Respiratory Effort: normal
Breath sounds clear to auscultation.

Anesthesia Plan

ASA: 3
Anesthetic Plan: MAC

Airway Management: supplemental O2
Premedication Plan: none
Induction: Intravenous

Anesthetic plan and risks discussed with: Patient.

Electronically signed by Robert G Lawhead, MD at 1/28/2020 9:00 AM

All Postprocedure Notes

Last edited 01/28/20 0950 by Robert G Lawhead, MD
Date of Service 01/28/20 0950
Status: Signed

Patient Name: Eugene George Maurice

Procedure Summary

Date: 01/28/20 Room / Location: WellStar Kennestone Urology

Procedure Center

Anesthesia Start: 0906
Anesthesia Stop: 0922
Procedure: KUP PROSTATE BIOPSY W NDL
Diagnosis:
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC)
Elevated PSA
Scheduled Providers: Nikolas P Symbas, MD; Robert G Lawhead, MD
Responsible Provider: Robert G Lawhead, MD
Anesthesia Type: MAC
ASA Status: 3

Final Anesthesia Type: MAC

Vitals	Value	Taken Time
BP	159/66	1/28/2020 9:49 AM
Temp	36.7 °C (98.1 °F)	1/28/2020 9:23 AM
Pulse	49	1/28/2020 9:49 AM
Resp	16	1/28/2020 9:49 AM
SpO2	99 %	1/28/2020 9:49 AM

Patient location: PACU
Post vital signs: post-procedure vital signs reviewed and stable
Level of consciousness: awake, alert and oriented
Post-anesthesia pain:
Pain Status: adequate analgesia

Airway patency: patent
Respiratory: spontaneous ventilation
Cardiovascular: blood pressure at baseline and stable
Hydration: euvolemic
Nausea and vomiting: no signs of nausea and vomiting
Anesthetic complications: No

Electronically signed by Robert G Lawhead, MD at 1/28/2020 9:50 AM

Attestation Information

Staff Name	Date	Time	Type
Robert G Lawhead, MD	01/28/20	0848	Pre-Induction Assessment
Robert G Lawhead, MD	01/28/20	0848	Anesthesia Present

Medications

Medication	Rate/Dose/Volume	Action	Date Time	Administering User	Audit
propofol (DIPRIVAN) 10 mg/mL injection (mg)	50 mg	Given	01/28/20 0908	Robert G Lawhead, MD	
	50 mg	Given	0911	Robert G Lawhead, MD	

Anesthesia Encounter - Episode ID 44151006 (continued)

Medications (continued)

Medication	Rate/Dose/Volume	Action	Date Time	Administering User	Audit
	10 mg	Given	0915	Robert G Lawhead, MD	
lidocaine 2% injection (mg)	40 mg	Given	01/28/20 0908	Robert G Lawhead, MD	
lactated Ringers infusion (mL)	100 mL	Anesthesia Volume Adjustment	01/28/20 0908	Robert G Lawhead, MD	
Dosing weight: 97.1 kg	100 mL	Stopped	0922	Robert G Lawhead, MD	

Signoff Status

None

Flowsheets (all recorded)

Agents

Row Name	01/28/20 0922	01/28/20 0907
Agents		
O2	0 L/min -RL	3 L/min -RL

Flowsheets (all recorded)

Anesthesia Checklist

Row Name	01/28/20 0847
Anesthesia Checklist	
Monitors In Use	Anesthesia apparatus checked;Pulse oximeter;O2 analyzer;Gas humidifier;Capnometer;Infusion pump;PC/E stethescope;Ventilator;Fluids warmer;Nerve stimulator -RL
NIBP Site	Arm L -RL
Cardiac	EKG -RL
Leads	3 -RL

Flowsheets (all recorded)

Agents

Row Name	01/28/20 0922	01/28/20 0907
Agents		
O2	0 L/min -RL	3 L/min -RL

Flowsheets (all recorded)

Graph Vitals

Row Name	01/28/20 0914	01/28/20 0911	01/28/20 0908
BP/Pulse			
HR (ECG)	52 -RL	(!) 49 -RL	52 -RL
NIBP	98/55 -RL	110/53 -RL	153/65 -RL

Flowsheets (all recorded)

EKG/Respiratory

Row Name	01/28/20 0911	01/28/20 0909
EKG/Resp		
EKG	Sinus Bradycardia -RL	Normal Sinus Rhythm -RL
SpO2	100 % -RL	99 % -RL

Flowsheets (all recorded)

Vent Settings

Row Name	01/28/20 0910	01/28/20 0907
Respiratory		
Vent Mode	Spontaneous -RL	Spontaneous -RL

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
RL	Robert G Lawhead, MD	01/22/20 - 01/28/20

Flowsheet Notes

No notes of this type exist for this encounter.

Encounter-Level E-Signatures:

No documentation.

Nursing - Orders and Results

MAINTAIN IV ACCESS [870656967]

Electronically signed by: **Robert G Lawhead, MD on 01/28/20 1030**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 01/28/20 0818
Authorized by: Robert G Lawhead, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 02/05/20 0418 [Patient Discharge]
Communicated by: Sharon H Crider, RN
Ordering provider: Robert G Lawhead, MD
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM

PATIENT EDUCATION (SPECIFY) [870656970]

Electronically signed by: **Nikolas P Symbas, MD on 01/28/20 0904**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Chrissie Pope, RN 01/22/20 1411
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 02/05/20 0419 [Patient Discharge]
Order comments: On preparation for the procedure as well as discharge instructions
Communicated by: Chrissie Pope, RN
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM

Code Status - Orders and Results

FULL CODE [870656969]

Electronically signed by: **Nikolas P Symbas, MD on 01/28/20 0904**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Chrissie Pope, RN 01/22/20 1411
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM
Communicated by: Chrissie Pope, RN
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Per protocol: cosign required
Code status: Full Code
Discontinued by: Automatic Discharge Provider 02/05/20 0419 [Patient Discharge]

Questionnaire

Question	Answer
Status:	Code Discussion Completed
Legally recognized decision maker	Patient/Self

Point of Care Testing - Orders and Results

POC URINE DIPSTICK [870656973]

Electronically signed by: **Nikolas P Symbas, MD on 01/28/20 0904**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Chrissie Pope, RN 01/22/20 1412
Communicated by: Chrissie Pope, RN
Ordering provider: Nikolas P Symbas, MD

Point of Care Testing - Orders and Results (continued)

POC URINE DIPSTICK [870656973] (continued)

Authorized by: Nikolas P Symbas, MD
Quantity: 1
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM

Ordering mode: Per protocol: cosign required
Lab status: Final result

Specimen Information

Type	Source	Collected By
Urine	—	OLIVAREZ, LISA M 01/28/20 0836

POC URINE DIPSTICK [870656973] (Abnormal) — Resulted: 01/28/20 0836, Result status: Final result

Ordering provider: Nikolas P Symbas, MD 01/28/20 0818
Filed by: Lisa M Olivarez, RN 01/28/20 0837
Result details
Acknowledged by
Claire E Tichy, NP on 01/28/20 0856
Nikolas P Symbas, MD on 01/28/20 0904

Order status: Completed
Resulting lab: WS UROLOGY PROCEDURE CENTER

Specimen Information

Type	Source	Collected By
Urine	—	OLIVAREZ, LISA M 01/28/20 0836

Components

Component	Value	Reference Range	Flag	Lab
Color	Yellow	Yellow, Colorless	—	UROPC
Clarity	Clear	Clear	—	UROPC
Glucose Urine	Negative	Negative, 1000 (2+), Color Interference mg/dl	—	UROPC
Bilirubin	Negative	Negative	—	UROPC
Ketones	Negative	Negative, 5 (trace), Color Interference mg/dl	—	UROPC
Specific Gravity	1.025	1.000 - 1.023	A !	UROPC
Blood	Trace	Negative, Color Interference Ery/µL	A !	UROPC
PH	7.0	5.0 - 7.5	—	UROPC
Protein	Negative	Negative, Color Interference mg/dl	—	UROPC
Urobilinogen	Normal (0.2-1)	Normal (0.2-1), Color Interference mg/dL	—	UROPC
Nitrite	Negative	Negative, Color Interference	—	UROPC
Leukocyte Est	Negative	Negative, Trace, Color Interference Leu/µL	—	UROPC
Employee ID	23942	—	—	UROPC

IV - Orders and Results

INSERT PERIPHERAL IV [870656966]

Electronically signed by: **Robert G Lawhead, MD on 01/28/20 1030** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 01/28/20 0818
Authorized by: Robert G Lawhead, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 02/05/20 0418 [Patient Discharge]

Communicated by: Sharon H Crider, RN
Ordering provider: Robert G Lawhead, MD
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM

INT [870656968]

Electronically signed by: **Robert G Lawhead, MD on 01/28/20 1030** — Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 01/28/20 0818

Communicated by: Sharon H Crider, RN
Ordering provider: Robert G Lawhead, MD

IV - Orders and Results (continued)

INT [870656968] (continued)

Authorized by: Robert G Lawhead, MD
Quantity: 1
Discontinued by: Automatic Discharge Provider 02/05/20 0418 [Patient Discharge]
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM

Discharge - Orders and Results

DISCHARGE PATIENT [870656980]

Electronically signed by: **Nikolas P Symbas, MD on 01/28/20 0921**
Status: **Completed**
Ordering user: Nikolas P Symbas, MD 01/28/20 0921
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Standard
Instance released by: Nikolas P Symbas, MD (auto-released) 1/28/2020 9:21 AM

Imaging - Orders and Results

KUP PROSTATE BIOPSY W NDL [869494536]

Electronically signed by: **Kristin M Boren, MD on 12/13/19 1526**
Status: **Completed**
Ordering user: Kristin M Boren, MD 12/13/19 1526
Ordering mode: Standard
Quantity: 1
Instance released by: Chastity Payton 1/28/2020 7:43 AM
Authorized by: Kristin M Boren, MD
Lab status: Final result
Diagnoses
Cancer of prostate with low recurrence risk (stage T1-2a and Gleason < 7 and PSA < 10) (HCC) [C61]
Elevated PSA [R97.20]

Questionnaire

Question	Answer
Do you have a joint replacement, pacemaker, or any hardware?	No
Have you ever had MRSA or VRE?	No
Have you had C-Diff with active diarrhea or been on treatment for C-diff in the last 6 months?	No

Scheduling instructions
MRI fusion-PI-RADS category 5 lesion in the anterior central gland, just slightly larger than on the prior.

KUP PROSTATE BIOPSY W NDL [869494536]

Resulted: 01/28/20 0921, Result status: Final result

Order status: Completed
Filed by: Nikolas P Symbas, MD 01/28/20 0922
Accession number: 32229584
Resulted by: Nikolas P Symbas, MD
Performed: 01/28/20 0911 - 01/28/20 0919
Result details
Narrative:
OPERATIVE NOTE

Name: Eugene George Maurice
DOB: 1/2/1949
MRN: 561253820
DOS: 1/28/2020

Pre-operative Diagnosis: Active surveillance of known prostate cancer.

Post-operative Diagnosis: Same.

Surgeon: Nikolas P Symbas, MD

Assistants: None

Anesthesia: IV sedation

Operation:
1. Transrectal ultrasound for guidance of prostate biopsies
2. Transrectal prostate biopsies (with MRI fusion)
3. Periprostatic block for postoperative pain control
   (55700, 76942, 64450)

Indications: Eugene George Maurice is a 71 y.o.male who presents for the above procedure due to the above diagnosis. I discussed risks (including specifically bleeding and infection), benefits and alternative treatments

Imaging - Orders and Results (continued)

with the patient and the patient elected to proceed with the documented plan. All questions were answered.

Nodule: No on DRE 1/28/2020

Complications: None

EBL: less than 5 mL

IVF: Maintenance

Specimen: 12 cores of prostate tissue labeled by sextant, additional biopsies of MRI lesions labelled as:
1. ANT MCZ P5

Findings:
1. Prostate size: 30 cubic centimeters by MRI
2. One lesion(s)/ROI(s) on MRI. Described as PIRADS 5.

Technique:
The patient confirmed compliance with preoperative enema and antibiotic. The patient was taken to the operative suite. After time out the patient underwent IV sedation per anesthesia. He was then placed in a lateral decubitus position. He was prepped and draped in the standard fashion in the left lateral decubitus position and time out was performed.

Perioperative antibiotics were given prior to the procedure.

The ultrasound probe (Phillips machine) was then placed in the rectum without difficulty. Subsequently 5 mL of 1% plain lidocaine was infiltrated using a spinal needle and ultrasonic guidance into the junction of the seminal vesicle and prostate gland on each side for intraoperative and post operative pain control.

The MR fusion was performed with the Phillips Invivo UroNav machine. After co-registering, the above mentioned lesions were targeted and mpMRI fusion directed samples of these lesions were taken and the needle paths were recorded in the software.

Next, sequential transverse (axial) scans were made in small increments beginning at the seminal vesicles and ending at the prostate apex. Sequential longitudinal (sagittal) scans were made in small increments beginning at the right lateral prostate and ending at the left lateral prostate. Excellent anatomical imaging was obtained with peripheral, transitional, and central zones well defined, as well as the seminal vesicles.

Several biopsies were taken from the target lesion.

Six biopsies were obtained from the lateral part of each lobe at the apex, mid-gland, and base. Six biopsies were additionally taken from the medial part of each lobe spaced evenly from apex to base. Care was taken to avoid the urethra and bladder. Excellent biopsy specimens were obtained. The procedure was tolerated well and the patient transported to recovery in stable condition.

Appropriate patient post procedure education was provided prior to discharge.

Disposition:
1. Follow up with the Wellstar Urology office as previously directed
2. Discharge to home
3. Discharge condition: good
4. Medications: Resume previous medications but stay off of blood thinners until no blood in urine and stool.
5. Diet: resume previous
6. Activity: no strenuous physical activity for the next 48 hours.
Standard post-biopsy instructions given.

Nikolas P Symbas, MD
Wellstar Urology
(p) 770-428-4475
(f) 770-426-1499

Imaging - Orders and Results (continued)

Acknowledged by: Kristin M Boren, MD on 01/28/20 0940

Pathology and Cytology - Orders and Results

SURGICAL PATHOLOGY-KH [870656983]

Electronically signed by: **Interface, Lab In Copath on 01/28/20 1335**
Status: **Completed**
Ordering user: Interface, Lab In Copath 01/28/20 1335
Ordering provider: Kristin M Boren, MD
Authorized by: Kristin M Boren, MD
Ordering mode: Standard
Quantity: 1
Lab status: Edited Result - FINAL
Instance released by: (auto-released) 1/28/2020 1:36 PM

Specimen Information

Type	Source	Collected By
—	—	01/28/20 1334

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

SURGICAL PATHOLOGY-KH [870656983]
Resulted: 01/30/20 0845, Result status: Edited Result - FINAL

Ordering provider: Kristin M Boren, MD 01/28/20 1335
Order status: Completed
Filed by: Interface, Lab In Copath 04/07/20 0806
Resulting lab: WS KENNESTONE HOSPITAL LAB
Result details
Acknowledged by: Kristin M Boren, MD on 04/07/20 0814

Specimen Information

Type	Source	Collected By
—	—	01/28/20 1334

Comment: PROSTATE BIOPSY, 1ST SPECIMEN&NO CHARGE&NO CHARGE&NO CHARGE&NO CHARGE

Components

Component	Value	Reference Range	Flag	Lab
SURGICAL PATHOLOGY-KH	Patient Name: MAURICE, EUGENE GEORGE Accession #: KS20-1574 Patient #:	—	—	KHLAB

Comment:
2116236477\561253820\1\11 MRN. #: 561253820 Sex: M Location: DOB/Age:
1/2/1949 (Age: 71) Location: Discharged Client: Wellstar Kennestone Hospital
Received: 1/28/2020 Admitting Date: 1/28/2020 Collected: 1/28/2020 Final Report:
1/30/2020 08:45 Order Physician: KRISTIN BOREN Admit MD: NIKOLAS SYMBAS Other
Inst: Not Provided Copy To:
SURGICAL PATHOLOGY-KH REPORT
Final Diagnosis:
PROSTATE BIOPSY X 13: 1 WITH DEFINITIVE ADENOCARCINOMA
1. PROSTATE, LEFT BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
2. PROSTATE, LEFT MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

3. PROSTATE, LEFT APEX, CORE BIOPSY:
- ATYPICAL SMALL ACINAR PROLIFERATION, SUSPICIOUS FOR ADENOCARCINOMA.
4. PROSTATE, RIGHT BASE, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
5. PROSTATE, RIGHT MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
6. PROSTATE, RIGHT APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
7. PROSTATE, LEFT LATERAL BASE, CORE BIOPSY:
- BE
NIGN PROSTATIC TISSUE.
8. PROSTATE, LEFT LATERAL MID, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.
9. PROSTATE, LEFT LATERAL APEX, CORE BIOPSY:
- BENIGN PROSTATIC TISSUE.

Pathology and Cytology - Orders and Results (continued)

10. PROSTATE, RIGHT LATERAL BASE, CORE BIOPSY:
 - BENIGN PROSTATIC TISSUE.
11. PROSTATE, RIGHT LATERAL MID, CORE BIOPSY:
 - BENIGN PROSTATIC TISSUE.
12. PROSTATE, RIGHT LATERAL APEX, CORE BIOPSY:
 - BENIGN PROSTATIC TISSUE.
13. PROSTATE, ANTMCZP5, CORE BIOPSY:
 - PROSTATIC ADENOCARCINOMA, GLEASON SCORE 7 (3+4), GRADE GROUP 3, OCCUPYING APPROXIMATELY 20% OF TOTAL CORE LENGTH.

Pathologist's Comment:
Specimen #13 was reviewed by Dr. Jakowski who concurs with the diagnosis.
Decipher testing will be performed on block 13A.
PIN4 multiplex immunohistochemical stains (CK5, CK14, p63 and P504S) are performed on blocks 1A, 3A, 10A, and 13A. In specimen #13, lack of staining of basal cells surrounding the glands of interest and overexpression of p504S support the diagnosis of prostatic
adenocarcinoma. In specimen #3, rare atypical
glands lacking full diagnostic criteria for adenocarcinoma are noted lacking basal cell expression, supporting the diagnosis. In all others, demonstration of staining of basal cells surrounding the glands of interest and lack of overexpression of p504s support the final diagnosis. Appropriate internal and/or external positive and negative controls have been reviewed and exhibit the expected reactivity.

Electronically Signed Out By Joseph P. Bergeron, MD
Joseph P. Bergeron, MD
JPB 1/30/2020
CPT: 1: G0416, OTH-K, 88344
10: 88344
13: 88344, MT
3: 88344

Pre-Operative Diagnosis:
Not Provided
Post-Operative Diagnosis:
Not Provided
Clinical History:
HX of Prostate Cancer - v10.46; DECIPHER
Specimen:
Prostate biopsy x13
Gr
oss Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maurice, Eugene	LB	19	1A
2. Maurice, Eugene	LM	14	2A
3. Maurice, Eugene	LA	15, 2	3A
4. Maurice, Eugene	RB	17	4A
5. Maurice, Eugene	RM	15	5A
6. Maurice, Eugene	RA	14	6A
7. Maurice, Eugene	LLB	16	7A
8. Maurice, Eugene	LLM	16	8A
9. Maurice, Eugene	LLA	16	9A
10. Maurice, Eugene	RLB	18	10A
11. Maurice, Eugene	RLM	15	11A
12. Maurice, Eugene	RLA	13	12A
13. Maurice, Eug ene	ANTMCZP5	20, 21, 19, 17	13A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The specimens are
inked black. JJ/pk 1/28/20

Microscopic Description:
1-13. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis.
JPB/gpr 1/29/20

Procedures/Addenda:
ADDENDUM
Addendum Comment:
Decipher Biopsy Test is performed (block 13A) at GenomeDX Biosciences Inc. 10355 Science Center Dr Suite 240, San Diego, CA 92121 by Bashar Dabbas, M.D. as follows. Please see separate report for additional information.

Pathology and Cytology - Orders and Results (continued)

Your Decipher Result - Genomic Low Risk
Decipher Score: 0.33
Risk at RP - Percent Likelihood
High Grade Disease (primary Gleason grade 4 or 5) 16.4%
5- Year Metastasis 1.9%
10-Year Prostate Cancer Specific Mortality 2.8%
These results
were reported by GenomeDX Biosciences on 2/18/20, and the report
was received by WellStar Pathology on 3/26/20.
JPB/gpr 3/26/20
ANAC
Procedure Signed Out: 4/7/2020 08:05
Electronically Signed By Joseph P. Bergeron, MD

View Image (below)

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Phone Number: (770) 793-5505
Fax Number: (470) 793-7919

Marla J. Franks, M.D., Laboratory Director

Patient Name:	**MAURICE, EUGENE GEORGE**			Accession #:	**KS20-1574**
Patient #:	2116236477\561253820\1\11	MRN. #:	561253820	Sex:	M
Location:		DOB/Age:	1/2/1949 (Age: 71)		
Location:	Discharged	Client:	Wellstar Kennestone Hospital	Received:	1/28/2020
Admitting Date:	1/28/2020	Collected:	1/28/2020	Final Report:	1/30/2020 08:45
Order Physician:	KRISTIN BOREN	Admit MD:	NIKOLAS SYMBAS	Other Inst:	Not Provided
		Copy To:			

SURGICAL PATHOLOGY-KH REPORT

Final Diagnosis:
PROSTATE BIOPSY X 13: 1 WITH DEFINITIVE ADENOCARCINOMA

1. PROSTATE, LEFT BASE, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

2. PROSTATE, LEFT MID, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

3. PROSTATE, LEFT APEX, CORE BIOPSY:
   - ATYPICAL SMALL ACINAR PROLIFERATION, SUSPICIOUS FOR ADENOCARCINOMA.

4. PROSTATE, RIGHT BASE, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

5. PROSTATE, RIGHT MID, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

6. PROSTATE, RIGHT APEX, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

7. PROSTATE, LEFT LATERAL BASE, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

8. PROSTATE, LEFT LATERAL MID, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

9. PROSTATE, LEFT LATERAL APEX, CORE BIOPSY:
   - BENIGN PROSTATIC TISSUE.

10. PROSTATE, RIGHT LATERAL BASE, CORE BIOPSY:
    - BENIGN PROSTATIC TISSUE.

11. PROSTATE, RIGHT LATERAL MID, CORE BIOPSY:
    - BENIGN PROSTATIC TISSUE.

12. PROSTATE, RIGHT LATERAL APEX, CORE BIOPSY:
    - BENIGN PROSTATIC TISSUE.

13. PROSTATE, ANTMCZP5, CORE BIOPSY:
    - PROSTATIC ADENOCARCINOMA, GLEASON SCORE 7 (3+4), GRADE GROUP 3, OCCUPYING APPROXIMATELY 20% OF TOTAL CORE LENGTH.

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Phone Number: (770) 793-5505
Fax Number: (470) 793-7919 Marla J. Franks, M.D., Laboratory Director

Pathologist's Comment:
Specimen #13 was reviewed by Dr. Jakowski who concurs with the diagnosis.

Decipher testing will be performed on block 13A.

PIN4 multiplex immunohistochemical stains (CK5, CK14, p63 and P504S) are performed on blocks 1A, 3A, 10A, and 13A. In specimen #13, lack of staining of basal cells surrounding the glands of interest and overexpression of p504S support the diagnosis of prostatic adenocarcinoma. In specimen #3, rare atypical glands lacking full diagnostic criteria for adenocarcinoma are noted lacking basal cell expression, supporting the diagnosis. In all others, demonstration of staining of basal cells surrounding the glands of interest and lack of overexpression of p504s support the final diagnosis. Appropriate internal and/or external positive and negative controls have been reviewed and exhibit the expected reactivity.

Electronically Signed Out By Joseph P. Bergeron, MD
Joseph P. Bergeron, MD

JPB 1/30/2020
CPT: 1: G0416, OTH-K, 88344
10: 88344
13: 88344, MT
3: 88344

Pre-Operative Diagnosis:
Not Provided

Post-Operative Diagnosis:
Not Provided

Clinical History:
HX of Prostate Cancer - v10.46; DECIPHER

Specimen:
Prostate biopsy x13

Gross Description:

Specimen	Labeled	Core(s) length (mm)	Cassette
1. Maurice, Eugene	LB	19	1A
2. Maurice, Eugene	LM	14	2A
3. Maurice, Eugene	LA	15, 2	3A
4. Maurice, Eugene	RB	17	4A
5. Maurice, Eugene	RM	15	5A
6. Maurice, Eugene	RA	14	6A
7. Maurice, Eugene	LLB	16	7A
8. Maurice, Eugene	LLM	16	8A
9. Maurice, Eugene	LLA	16	9A
10. Maurice, Eugene	RLB	18	10A
11. Maurice, Eugene	RLM	15	11A
12. Maurice, Eugene	RLA	13	12A
13. Maurice, Eugene	ANTMCZP5	20, 21, 19, 17	13A

All specimens received in formalin and consist of tan cylinders approximately 0.1 cm diameter. The specimens are

Pathology and Cytology - Orders and Results (continued)

WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060

Phone Number: (770) 793-5505
Fax Number: (470) 793-7919

Marla J. Franks, M.D., Laboratory Director

inked black. JJ/pk 1/28/20

Microscopic Description:
1-13. Microscopic examination of the material identified as above has been performed and the histologic findings incorporated into the final diagnosis. JPB/gpr 1/29/20

Procedures/Addenda:

ADDENDUM

Addendum Comment:
Decipher Biopsy Test is performed (block 13A) at GenomeDX Biosciences Inc. 10355 Science Center Dr Suite 240, San Diego, CA 92121 by Bashar Dabbas, M.D. as follows. Please see separate report for additional information.

Your Decipher Result - Genomic Low Risk
Decipher Score: 0.33

Risk at RP - Percent Likelihood	
High Grade Disease (primary Gleason grade 4 or 5)	16.4%
5- Year Metastasis	1.9%
10-Year Prostate Cancer Specific Mortality	2.8%

These results were reported by GenomeDX Biosciences on 2/18/20, and the report was received by WellStar Pathology on 3/26/20.

JPB/gpr 3/26/20

ANAC

Procedure Signed Out: 4/7/2020 08:05

Electronically Signed By Joseph P. Bergeron, MD

CORE MEASURES - Orders and Results

REASON FOR NO MECHANICAL PROPHYLAXIS [870656971]

Electronically signed by: **Nikolas P Symbas, MD on 01/28/20 0904** Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Chrissie Pope, RN
Ordering user: Chrissie Pope, RN 01/22/20 1411
Ordering provider: Nikolas P Symbas, MD

CORE MEASURES - Orders and Results (continued)

REASON FOR NO MECHANICAL PROPHYLAXIS [870656971] (continued)

Authorized by: Nikolas P Symbas, MD
Quantity: 1
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM

Questionnaire

Question	Answer
If SCDs NOT ordered, indicate reason:	Total Risk Factor Score less than or equal to 1

REASON FOR NO VTE PROPHYLAXIS AT ADMISSION [870656972]

Electronically signed by: **Nikolas P Symbas, MD on 01/28/20 0904**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Chrissie Pope, RN 01/22/20 1411
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Communicated by: Chrissie Pope, RN
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Per protocol: cosign required
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 8:18 AM

Questionnaire

Question	Answer
Reason for no pharm VTE prophylaxis at admission?	Patient is at low risk for VTE - No pharm VTE Prophylaxis required

Point of Care Testing-Docked Device - Orders and Results

POC FINGER STICK GLUCOSE [870656975]

Electronically signed by: **Interface, Lab In Sunquest on 01/28/20 0823**
Status: **Completed**
Ordering user: Interface, Lab In Sunquest 01/28/20 0823
Authorized by: Nikolas P Symbas, MD
Quantity: 1
Instance released by: (auto-released) 1/28/2020 8:29 AM
Ordering provider: Nikolas P Symbas, MD
Ordering mode: Standard
Lab status: Final result

Specimen Information

Type	Source	Collected By
Blood	Blood	01/28/20 0823

POC FINGER STICK GLUCOSE [870656975] (Abnormal)
Resulted: 01/28/20 0829, Result status: Final result

Ordering provider: Nikolas P Symbas, MD 01/28/20 0823
Filed by: Interface, Lab In Sunquest 01/28/20 0830
External ID: T16955027
Acknowledged by
Claire E Tichy, NP on 01/28/20 0856
Nikolas P Symbas, MD on 01/28/20 0904
Order status: Completed
Resulting lab: WS UROLOGY PROCEDURE CENTER
Result details

Specimen Information

Type	Source	Collected By
Blood	Blood	01/28/20 0823

Components

Component	Value	Reference Range	Flag	Lab
GLUCOSE, BEDSIDE	107	70 - 99 mg/dL	H ^	UROPC
POC-OPERATOR'S ID	23942	—	—	UROPC

Diet - Orders and Results

DIET, NPO [870656984]

Electronically signed by: **Robert G Lawhead, MD on 01/28/20 1030**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Ordering user: Sharon H Crider, RN 01/28/20 0818
Communicated by: Sharon H Crider, RN
Ordering provider: Robert G Lawhead, MD

Diet - Orders and Results (continued)

DIET, NPO [870656984] (continued)

Authorized by: Robert G Lawhead, MD
Quantity: 1
Instance released by: Sharon H Crider, RN (auto-released) 1/28/2020 11:31 PM
Ordering mode: Per protocol: cosign required
Diet: NPO
Discontinued by: Automatic Discharge Provider 02/05/20 0419 [Patient Discharge]

Medications - Orders and Results

sodium chloride 0.9 % (NS) flush [869494541]

Electronically signed by: **Robert G Lawhead, MD on 01/28/20 1030**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Sharon H Crider, RN
Ordering user: Sharon H Crider, RN 01/28/20 0818
Ordering provider: Robert G Lawhead, MD
Authorized by: Robert G Lawhead, MD
Ordering mode: Per protocol: cosign required
PRN reasons: line care
Frequency: Routine Q1 min PRN 01/28/20 0818 - 02/05/20 0413
Released by: Sharon H Crider, RN 01/28/20 0818
Discontinued by: Automatic Discharge Provider 02/05/20 0413 [(Patient Discharge - Internal Use Only)]
Acknowledged: Sharon H Crider, RN 01/28/20 0818 for Placing Order
Admin instructions: INT Flush
Package: 8881-579300

lactated Ringers infusion [869494542]

Electronically signed by: **Robert G Lawhead, MD on 01/28/20 1030**
Status: **Discontinued**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Sharon H Crider, RN
Ordering user: Sharon H Crider, RN 01/28/20 0818
Ordering provider: Robert G Lawhead, MD
Authorized by: Robert G Lawhead, MD
Ordering mode: Per protocol: cosign required
Frequency: Routine Continuous 01/28/20 0900 - 02/05/20 0413
Released by: Sharon H Crider, RN 01/28/20 0818
Discontinued by: Automatic Discharge Provider 02/05/20 0413 [(Patient Discharge - Internal Use Only)]
Acknowledged: Sharon H Crider, RN 01/28/20 0818 for Placing Order
Package: 0409-7953-09

gentamicin (GARAMYCIN) injection 40 mg/mL [870656963]

Electronically signed by: **Nikolas P Symbas, MD on 01/28/20 0904**
Status: **Completed**
Mode: Ordering in Per protocol: cosign required mode
Communicated by: Chrissie Pope, RN
Ordering user: Chrissie Pope, RN 01/22/20 1411
Ordering provider: Nikolas P Symbas, MD
Authorized by: Nikolas P Symbas, MD
Ordering mode: Per protocol: cosign required
PRN Comment: On call to OR
Frequency: Routine On call to OR 01/28/20 0818 - 1 occurrence
Released by: Sharon H Crider, RN 01/28/20 0818
Acknowledged: Sharon H Crider, RN 01/28/20 0818 for Placing Order

Questionnaire

Question	Answer
Reason for Ordering Antimicrobial:	Preop - Prophylaxis
Expected days of therapy:	1

Package: 63323-010-02

lidocaine (XYLOCAINE) local injection 2 % [870656978]

Electronically signed by: **Robert G Lawhead, MD on 01/28/20 1030**
Status: **Completed**
Mode: Ordering in Verbal with readback mode
Communicated by: Ramona McNeil, RN
Ordering user: Ramona McNeil, RN 01/28/20 0912
Ordering provider: Robert G Lawhead, MD
Authorized by: Robert G Lawhead, MD
Ordering mode: Verbal with readback
Frequency: Routine Once PRN 01/28/20 0912 - 01/28/20 0912
Package: 0409-4277-02

Testing Performed By

Lab - Abbreviation	Name	Director	Address	Valid Date Range
19 - KHLAB	WS KENNESTONE HOSPITAL LAB	Dr. Marla Franks	677 CHURCH ST MARIETTA GA 30060	08/28/18 1256 - Present
527 - UROPC	WS UROLOGY PROCEDURE CENTER	Nikolas P Symbas, MD	300 TOWER RD, STE 150 MARIETTA GA 30060	10/28/19 1240 - Present

Medications

All Meds and Administrations

sodium chloride 0.9 % (NS) flush [869494541]

Ordering Provider: Robert G Lawhead, MD
Ordered On: 01/28/20 0818
Dose (Remaining/Total): 3-40 mL (—/—)
Frequency: Every 1 minute PRN
Admin Instructions: INT Flush

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/28/20 0818 - 02/05/20 0413
Route: Intravenous
Rate/Duration: — / —

(No admins scheduled or recorded for this medication)

lactated Ringers infusion [869494542]

Ordering Provider: Robert G Lawhead, MD
Ordered On: 01/28/20 0818
Dose (Remaining/Total): 50 mL/hr (—/—)
Frequency: Continuous

Status: Discontinued (Past End Date/Time), Reason: (Patient Discharge - Internal Use Only)
Starts/Ends: 01/28/20 0900 - 02/05/20 0413
Route: Intravenous
Rate/Duration: 50 mL/hr / —

Line	Med Link Info	Comment
Peripheral IV 01/28/20 22 G Right Wrist	01/28/20 0830 by Sharon H Crider, RN	—

Timestamps	Action	Dose / Rate	Route	Other Information
Performed 01/28/20 0922 Documented: 01/28/20 0922	Stopped	— 0 mL/hr	Intravenous	Performed by: Robert G Lawhead, MD
Performed 01/28/20 0908 Documented: 01/28/20 0908	Anesthesia Volume Adjustment	—	Intravenous	Performed by: Robert G Lawhead, MD
Performed 01/28/20 0830 Documented: 01/28/20 0830	New Bag	50 mL/hr 50 mL/hr	Intravenous	Performed by: Sharon H Crider, RN

gentamicin (GARAMYCIN) injection 40 mg/mL [870656963]

Ordering Provider: Nikolas P Symbas, MD
Ordered On: 01/28/20 0818
Dose (Remaining/Total): 5 mg/kg (Adjusted) (0/1)
Frequency: On call to O.R.

Status: Completed (Past End Date/Time)
Starts/Ends: 01/28/20 0818 - 01/28/20 0830
Route: Intravenous
Rate/Duration: — / —

Question	Answer	Comment
Reason for Ordering Antimicrobial::	Preop - Prophylaxis	—
Expected days of therapy::	1	—

Line	Med Link Info	Comment
Peripheral IV 01/28/20 22 G Right Wrist	01/28/20 0830 by Sharon H Crider, RN	—

Timestamps	Action	Dose	Route	Other Information
Performed 01/28/20 0830 Documented: 01/28/20 0830	Given	390 mg	Intravenous	Performed by: Sharon H Crider, RN

lidocaine (XYLOCAINE) local injection 2 % [870656978]

Ordering Provider: Robert G Lawhead, MD
Ordered On: 01/28/20 0912

Status: Completed (Past End Date/Time)
Frequency: Once as needed

Timestamps	Action	Dose	Route / Site	Other Information

Medications (continued)

All Meds and Administrations (continued)

Performed 01/28/20 0912 Given Documented: 01/28/20 0912	10 mL	Other Other	Performed by: Robert G Lawhead, MD Documented by: Ramona McNeil, RN Comments: prostate gland

Patient Education

Education

Title: Acute MI (MCB) (Resolved)

Topic: Psycho/Social/Spiritual Support (Resolved)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Resolved)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Resolved)

Point: When to Call the Doctor (Resolved)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Resolved)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Resolved)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.
Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Resolved)

Point: General Self Care (Resolved)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Resolved)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.
Learner Progress: Not documented in this visit.

Topic: Pain Management (Resolved)

Point: Pain Medication Actions & Side Effects (Resolved)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Patient Education (continued)

Education (continued)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".
Learner Progress: Not documented in this visit.

Point: Non-Pharmacological Comfort Measures (Resolved)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Point: Patient Controlled Analgesia (Resolved)

Description:
Give the patient written information on Patient Controlled Analgesia. Explain how the pump works. Demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the PCA button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Point: Epidural Information (Resolved)

Description:
Give the patient written information on Epidural Analgesia. Explain why an epidural is used, how the epidural is placed and how the medication is given. If the epidural is PCA, demonstrate pushing the button to give pain medicine to the patient. Caution the patient and other family/visitors that only the patient should press the button for pain relief to decrease the chance of getting too much pain medicine.

Learner Progress: Not documented in this visit.

Topic: Signs and Symptoms - Acute MI (Resolved)

Point: Recognizing a Heart Attack (MCB) (Resolved)

Description:
Be sure patient reviews video on Coronary Artery Disease

Patient Friendly Description:
Please watch the video and/or read over the documented material and let anyone on your Care Team know if there are any questions by marking below.
If after watching the video and/or reading the material you have questions, please mark below I have question to let the staff know you have additional questions about a topic and they will be in to discuss your questions.

This will inform you of what to expect if you are diagnosed with a Heart Attack.
Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Educate the patient/family/caregiver on coronary risk factors. Explain the controllable and non-controllable risk factors to Coronary Artery Disease. Review how to control coronary artery disease by altering the controllable risk factors. Some examples include: controlling blood pressure, reducing fat and cholesterol in the diet, stopping smoking, exercising regularly, maintaining ideal body weight, dealing with stress in an appropriate manner, drinking alcohol and coffee in moderation and controlling blood sugar levels (if applicable).

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Topic: Acute MI (MCB) (Resolved)

Point: Emergency Plan for Heart Attack Symptoms (Resolved)

Description:
Educate the patient/family/caregiver on how to get help immediately if heart attack symptoms occur. The patient should call 911 or the Emergency Medical Service number. Reinforce that the patient should not delay in obtaining help.

Learner Progress: Not documented in this visit.

Point: Home Activity (Resolved)

Description:
Educate the patient/family/caregiver on home activity guidelines that apply after having had a recent heart attack. Do things in moderation, rest about 30 minutes after eating, pace activities, allow for 7-8 hours of sleep at night, start with short walks 3-5 times a day. Consult with Cardiac Rehab staff, if applicable.

Learner Progress: Not documented in this visit.

Point: Limitations to Activity (Resolved)

Description:
Educate the patient/family/caregiver reagrding the following limitations to activity for 4-6 weeks after discharge. No lifting over 10 pounds (weight of a milk jug), no pushing or pulling motions with the arms (sweeping, vacuuming or raking), no driving (may be changed after talking to the doctor), no bathing in very hot or very cold water.

Learner Progress: Not documented in this visit.

Point: Sexual Activity (Resolved)

Description:
Educate the patient/family/caregiver on the following: Wait 4 weeks before resuming sexual activity. If the patient can climb 2 flights of steps, he/she can assume it is ok to resume sexual activity. Choose a comfortable position. Wait at least 1 hour after a meal. If sex brings on angina, stop and rest. Discuss chest pain during sex with the physician. Some medications can affect sexual desire. If this is the case, talk with the physician.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Resolved)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Resolved)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Title: Diabetes (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Patient Education (continued)

Education (continued)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Introduction to Diabetes (MCB) (Not Started)

Description:
Give patient/family/caregiver written information on diabetes. Explain the definition of the type of diabetes with which the patient was diagnosed, how diabetes works in the body, risk factors, signs and symptoms, and if newly diagnosed, diagnostic criteria. Encourage viewing of diabetes on-demand videos when applicable. Refer to inpatient diabetes educator when applicable.

Patient Friendly Description:
You will receive a booklet entitled Diabetes survival skills. There are also two links to documents about Diabetes for you to read over noted below.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Point: Diabetes Type II management (MCB) (Not Started)

Description:
Patient will watch a video that will discuss information on what to expect if they have Diabetes type II.

Patient Friendly Description:
This will inform you of what to expect if you have Diabetes type II.

Learner Progress: Not documented in this visit.

Point: Diabetic long term complications (MCB) (Not Started)

Description:
Patient will have information from Krames on the long term complications of Diabetes Type II.

Patient Friendly Description:
Some information on the long term complications of Diabetes Type II.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Giving Insulin Injection (Not Started)

Description:
Explain and demonstrate how the injection is given. Allow enough time for the patient/family/caregiver to practice. Have the patient return-demonstrate the technique using normal saline (vial and syringe only unless sterile demonstration pen is also available). Teach the patient how to choose and rotate injection sites. Instruct patient on safe disposal of used needles and syringes.

Learner Progress: Not documented in this visit.

Point: Drawing up Insulin (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before drawing up insulin. Demonstrate and have the patient return-demonstrate drawing up the correct amount of insulin prescribed. If the patient is going to use an insulin pen, demonstrate use and have the patient return-demonstrate. If the patient is going to mix different types of insulin, demonstrate and have the patient return-demonstrate the correct way to draw up and mix the insulin.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Exercise (Not Started)

Description:
Encourage patient/family/caregiver to discuss activity limitations, if any, with physician before starting an exercise routine. Stress the importance of regular exercise and activity to control blood sugar levels and weight. Instruct the patient to carry single carohydrates while exercising in case of hypoglycemic reaction. Explain that both concentrated physical activity (such as walking, swimming, running, cycling, strength training) and being more active through the entire day are equally important to blood sugar control and weight management.

Learner Progress: Not documented in this visit.

Point: Blood Glucose Monitoring (MCB) (Not Started)

Description:
Instruct patient/family/caregiver to wash hands before checking blood glucose. Explain and, if possible to use a complementary glucometer, demonstrate how to check and record blood sugars. Instruct the patient to check blood sugars as frequently as ordered by the physician. Explain that stress or illness will increase blood sugar, making it necesary to check blood sugars more often than usual. Instruct patient on blood glucose target ranges and A1C target range. Discuss care of the meter and supplies, including how to obtain supplies. If using a complementary glucometer, have the patient return-demonstrate checking the blood sugar. Instruct the patient on safe disposal of lancets. Refer to inpatient diabetes educator if applicable.

Patient Friendly Description:
Why is it important to check my blood sugar?

Learner Progress: Not documented in this visit.

Point: Diabetic Foot Care (MCB) (Not Started)

Description:
Explain importance of foot care. Patient should have feet examined by a health care provider at least twice a year. Persons with foot problems should have feet examined at every visit. Explain daily foot care. Review importance of wearing well-fitting shoes and stockings/socks. Reinforce the importance of wearing shoes, even indoors, to prevent injury.

Patient Friendly Description:
This will inform you of why you should check your feet if you have diabetes.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Diabetes Identification Jewelry (Not Started)

Description:
Encourage the patient to wear a piece of jewelry that identifies patient as a person with diabetes. This will inform medical personnel that patient has diabetes if unable to communicate.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (Not Started)

Point: Signs and Symptoms of Hypoglycemia (Not Started)

Description:
Define and explain causes of hypoglycemia. Discuss signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Treatment of Hypoglycemia (Not Started)

Description:
Instruct the patient on how to treat low blood sugar using the Rule of 15. Encourage patient to carry a blood sugar treatment at all time.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (Not Started)

Description:
Instruct the patient/family/caregiver to call their health care provider if there are symptoms of hypo- or hyperglycemia or if blood sugars are trending high or low and are not controlled by simple measures.

Learner Progress: Not documented in this visit.

Point: Signs and Symptoms of Hyperglycemia (Not Started)

Description:
Define and explain causes of hyperglycemia. Discuss signs and symptoms (mild, moderate, severe, and ketoacidosis).

Learner Progress: Not documented in this visit.

Point: Prevention of Hyperglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importance of good diabetes management and learning to detect and treat hyperglycemia early before it worsens. Refer to registered dietitian, when applicable, for meal planning assistance.

Learner Progress: Not documented in this visit.

Point: Prevention of Hypoglycemia (Not Started)

Description:
Encourage patient/family/caregiver to follow healthcare providers' instructions for diet, activity and medications. Explain the importantce of good diabetes management and learning to detect and treat hypoglycemia early before it worsens.

Learner Progress: Not documented in this visit.

Point: WellStar Outpatient Diabetes Education (Not Started)

Patient Education (continued)

Education (continued)

Description:
Provide information on WellStar Outpatient Diabetes Education when applicable. Information includes a list of classes offered and how to register.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Topic: Diabetic Diet (MCB) (Not Started)

Point: Meal Planning and Portion Sizes (MCB) (Not Started)

Description:
The patient will view documents in Krames talking about meal planning as well learning about serving and portion sizes.

Patient Friendly Description:
This will inform you of ways to stay on track with your diet.

Learner Progress: Not documented in this visit.

Point: Eating well with Diabetes (MCB) (Not Started)

Description:
Patient will watch a video on healthy eating for people with DM.

Patient Friendly Description:
Healthy eating for people with Diabetes.

Learner Progress: Not documented in this visit.

Point: Carbohydrate Counting (MCB) (Not Started)

Description:
Patient will read Krames documents on healthy meals and meal planing for Diabetes.

Patient Friendly Description:
Learn about counting your carbohydrates.

Learner Progress: Not documented in this visit.

Topic: Survival Skills (Not Started)

Point: Review Diagnosis (Not Started)

Description:
Review the diabetes disagnosis, specific to patient's diabetes type.
Diabetes Survival Skills Booklet provided.

Patient Friendly Description:
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Learner Progress: Not documented in this visit.

Point: Nutrition (Not Started)

Description:
Importance of consistent nutrition habits.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Appointments (Not Started)

Description:
Importance of follow up appointment with the health care provider who will provide diabetes care after discharge.

Learner Progress: Not documented in this visit.

Point: Sick Day (Not Started)

Description:
Sick day management

Learner Progress: Not documented in this visit.

Point: Insulin Administration (if applicable) (Not Started)

Description:
Insulin administration and proper use and disposal of needles and syringes. How to schedule outpatient diabetes education. Review self-monitoring of blood glucose and home blood glucose goals.

Learner Progress: Not documented in this visit.

Point: Hyperglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hyperglycemia.

Learner Progress: Not documented in this visit.

Point: Hypoglycemia (Not Started)

Description:
Definition, recognition, treatment and prevention of hypoglycemia.

Learner Progress: Not documented in this visit.

Point: Glucose Lowering Medications (Not Started)

Description:
When and how to take blood glucose-lowering medications.

Learner Progress: Not documented in this visit.

Topic: Diabetes Zones for Management (Not Started)

Point: Diabetes Zones for Management reviewed (Not Started)

Description:
Diabetes Zones for Management reviewed.

Learner Progress: Not documented in this visit.

Point: Diabetes Zones for Management handout provided (Not Started)

Description:
Diabetes Zones for Management handout provided.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Title: WS Cardiac Rehab (Resolved)

Topic: PCI (Resolved)

Point: Books/Educational Material (Resolved)

Description:
Current standardized written information provided specific to diagnosis, recovery, disease progression and prevention.

Learner Progress: Not documented in this visit.

Point: Exercise (Resolved)

Description:
Information regarding the benefits of exercise provided. Exercise guidelines provided for initial recovery from acute heart event and long term goals of exercise.

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Description:
Medication compliance encouraged. Organization tools discussed and medication information and resources provided.

Learner Progress: Not documented in this visit.

Point: Risk Factors (Resolved)

Description:
Written and verbal information provided on modifiable and non-modifiable factors associated with increased risk of heart disease and stroke.

Learner Progress: Not documented in this visit.

Point: Activity guidelines (Resolved)

Description:
Appropriate activity and/or limitations for diagnosis specific recovery provided.

Learner Progress: Not documented in this visit.

Point: Signs/symptoms/activate EMS (Resolved)

Description:
Information provided on the signs and symptoms which commonly occur with a heart attack or stroke. Emphasis placed on appropriate activation of EMS with recognition of signs and symptoms.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehab participation/location options (Resolved)

Description:
Cardiac rehabilitation benefits highlighted and participation encouraged.

Learner Progress: Not documented in this visit.

Point: Cardiac Diet/low fat/low sodium (Resolved)

Description:
American Heart Association guidelines provided for a reduced fat and reduced sodium diet.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Endocarditis education/card (Resolved)

Description:
Written and verbal instruction provided on endocarditis prevention. Temporary Valve card provided.

Learner Progress: Not documented in this visit.

Point: Outpatient education classes/Heart Smart/Device Advice/Heart of the Matter (Resolved)

Description:
Description and registration details of outpatient education classes provided. Participation encouraged.

Learner Progress: Not documented in this visit.

Title: Cardiac Arrhythmia (MCB) (Not Started)

Topic: Treatment for Atrial Fibrillation/Atrial Flutter (MCB) (Not Started)

Point: Chemical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how a chemical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a chemical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Electrical cardioversion (MCB) (Not Started)

Description:
Provide written education on why and how an electrical cardioversion is done. As well as accociated risks.

Patient Friendly Description:
Why and how a electrical cardioversion is done and associated risks.

Learner Progress: Not documented in this visit.

Point: Ablation (MCB) (Not Started)

Description:
Provide written education on the catheter ablation procedure and discharge instructions.

Patient Friendly Description:
How an ablation is done, and what to do after the procedure.

Learner Progress: Not documented in this visit.

Topic: Prevention/Discharge (MCB) (Not Started)

Point: Anticoagulation (MCB) (Not Started)

Description:
Provide written education on anticoagulation use including contraindications, side effects, interactions, and medication safety.

Patient Friendly Description:
Information on taking blood thinners safely.

Learner Progress: Not documented in this visit.

Point: Discharge with A Fib/Flutter (MCB) (Not Started)

Description:
Provide written education on treatment options, home care, and follow up care for discharging with atrial fibrillation.

Patient Education (continued)

Education (continued)

Patient Friendly Description:
Information on treatment options, home care, and when to call your healthcare provider after going home with atrial fibrillation/flutter.

Learner Progress: Not documented in this visit.

Point: Atrial fib/flutter: stroke prevention (MCB) (Not Started)

Description:
"Provide written education on risk factors, medication, and prevention of A. Fib.
Hyperlink education materials provided to patient/family/caregiver. "

Patient Friendly Description:
Preventing stroke caused by A. Fib.

Learner Progress: Not documented in this visit.

Topic: What is atrial fibrillation/flutter (MCB) (Not Started)

Point: You have atrial fibrillation (MCB) (Not Started)

Description:
Provide video education on the signs/symptoms of A. Fib, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Fib: causes, symptoms, and treatment.

Learner Progress: Not documented in this visit.

Point: You have Atrial Flutter (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of A. Flutter, causes, medication(s), risk factors, prevention, and treatment.

Patient Friendly Description:
What to expect if you are diagnosed with A. Flutter: causes, symptoms, and treatment

Learner Progress: Not documented in this visit.

Title: MyChart Bedside Teaching completed (Not Started)

Points For This Title

Point: All MCB content reviewed with patient and teachback completed. The patient verbalized understanding. (Not Started)

Description:
Go over all the Eduction for the patient in the Education activity. The Education that was provided to the patient via MCB was included as well as education that was noted within the Eduction activity as Education that was beneifical to the patient during this hospital stay.

Learner Progress: Not documented in this visit.

Title: Cardiac Surgery (Resolved)

Topic: PCI (Resolved)

Additional Points For This Title

Point: ACTIVITY (Resolved)

Learner Progress: Not documented in this visit.

Point: SIGNS AND SYMPTOMS/ACTIVATE EMS (Resolved)

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: BOOKS/EDUCATION MATERIAL (Resolved)

Learner Progress: Not documented in this visit.

Point: CARDIAC REHAB (Resolved)

Learner Progress: Not documented in this visit.

Point: DIET (Resolved)

Learner Progress: Not documented in this visit.

Point: EXERCISE (Resolved)

Learner Progress: Not documented in this visit.

Point: Medications (Resolved)

Learner Progress: Not documented in this visit.

Point: POST OP CARE (Resolved)

Learner Progress: Not documented in this visit.

Point: RISK FACTORS (Resolved)

Learner Progress: Not documented in this visit.

Title: Coronary Artery Disease (MCB) (Not Started)

Topic: WS Cardiac Rehabilitation for Arrhythmia (MCB)--This is CAD and AMI Cardiac Rehab Program Information for the Patient (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Point: Cardiac Rehabilitation: Emotional Issue (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Explain how having heart disease can be stressful. Encourage patient not to ignore feelings of sadness, worry, and depression. Patient should know when to ask for help and/or support.

Patient Friendly Description:
This will explain some emotional feelings related to heart disease.
Learner Progress: Not documented in this visit.

Topic: Heart Healthy Diet- DASH Diet (MCB) (Not Started)

Point: Eating Heart Healthy Food: Using DASH Plan (MCB) (Not Started)

Description:
Review diet information and explain that eating a low salt, low fat and low cholesterol diet with plenty of fruits and vegetables can reduce risk of complications from CAD.

Patient Friendly Description:
This will help you follow a healthy eating plan that can reduce your risk of complications associated with Coronary Artery Disease.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Questions your patient may have for you (MCB) (Not Started)

Point: Questions your patient may have about the AMI (MCB) (Not Started)

Description:
This is information about diet, exercise and medications for patients and it encourages them to ask staff questions.

Patient Friendly Description:
After reading this, you can write down any questions that you have for staff under the Notes section as a reference.
Learner Progress: Not documented in this visit.

Topic: Coronary Artery Disease (MCB) (Not Started)

Point: Recognizing signs and symptoms of Heart Disease (MCB) (Not Started)

Description:
Provide written education on the signs/symptoms of CAD, causes, medication(s), risk factors, prevention and treatment.

Patient Friendly Description:
This will explain some of the causes of Coronary Artery Disease.
Learner Progress: Not documented in this visit.

Point: Understanding Coronary Artery Disease (MCB) (Not Started)

Description:
Give patient written information on CAD. Explain the definition of CAD, causes, signs and symptoms.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with Coronary Artery Disease (CAD).

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.
Learner Progress: Not documented in this visit.

Topic: Risk factors for Heart Disease (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Point: Tobacco/Smoking Cessation (MCB) (Not Started)

Description:
Give patient written information on Quitting Smoking

Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Patient Friendly Description:
This will give you some getting started tips to kick the smoking habit.

This will help you plan how to quit the smoking habit.

Learner Progress: Not documented in this visit.

Title: First-Dose Education (Not Started)

Points For This Title

Point: hydralazine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: iohexol (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: nitroglycerin (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: Ringer's solution,lactated (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: dextrose 50 % in water (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: calcium carbonate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: morphine sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: hydrocodone/acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: aspirin (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: acetaminophen (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: atropine sulfate (Resolved)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: phenylephrine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: labetalol HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: metoclopramide HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: cyclopentolate HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: furosemide (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diclofenac sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gentamicin sulfate (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: diphenhydramine HCl (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: 0.9 % sodium chloride (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: piperacillin sodium/tazobactam (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: insulin lispro (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: glucagon,human recombinant (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: gadobenate dimeglumine (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: pantoprazole sodium (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: polyethylene glycol 3350 (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: perflutren lipid microspheres (Not Started)

Patient Education (continued)

Education (continued)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: fentanyl citrate/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: lidocaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: ondansetron HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: tetracaine HCl/PF (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Point: sodium chloride 0.9 % (flush) (Not Started)

Description:
Instruct learners on name and purpose of medications and possible side effects. If appropriate, include food/drug interactions, reporting of efficacy, and symptoms to report.

Learner Progress: Not documented in this visit.

Title: Congestive Heart Failure (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Patient Education (continued)

Education (continued)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Treatments/Procedures (MCB) (Not Started)

Point: Oxygen (Not Started)

Description:
Educate patient/family/caregiver on why oxygen is needed and how it will be delivered (nasal cannula, mask, etc.). Instruct patient/family/caregiver that the patent should not be smoking while on oxygen.

Learner Progress: Not documented in this visit.

Point: Medical Equipment (Not Started)

Description:
Educate patient/family/caregiver on use of medical equipment and provide educational materials.

Learner Progress: Not documented in this visit.

Point: Introduction to Heart Failure (MCB) (Not Started)

Description:
Give patient written information on congestive heart failure. Explain the definition of CHF, causes, signs and symptoms, expected length of stay and criteria for discharge.

Patient Friendly Description:
This will inform you of what to expect if you are diagnosed with heart failure.

You will be receiving the Congestive Heart Failure red booklet.

Please watch video/read over the material and let anyone on your Care Team know if there are any questions by marking below.

If you understand all material, mark I understand below.

Learner Progress: Not documented in this visit.

Point: Echocardiogram (Not Started)

Description:
Educate patient/family/caregiver on echocardiograms, to include: what the test is, how the test will be performed, and what to expect during the test.

Learner Progress: Not documented in this visit.

Topic: Pain Management (Not Started)

Point: Pain Medication Actions & Side Effects (Not Started)

Description:
Provide medication specific handouts when available.

Learner Progress: Not documented in this visit.

Point: Pain Rating Scale (Not Started)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Non-Pharmacological Comfort Measures (Not Started)

Description:
Explain there are other ways of controlling pain than medication. The following are suggestions: position change, aromatherapy, deep slow breathing, distraction, quiet environment, imagery, heat therapy and/or cold therapy, laughter, massage, music, physical therapy, and touch therapy.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: Eating well with High Blood Pressure (MCB) (Not Started)

Description:
Information provided to patient to explain what their diet should consist of when they have Heart Failure.

Patient Friendly Description:
This will help you make heart healthy eating choices if you have a diagnosis with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure:Being Active (MCB) (Not Started)

Description:
Explain to the patient how to be active with heart failure.

Patient Friendly Description:
This will explain how to safely be active with heart failure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Dealing with Sleep problems (MCB) (Not Started)

Description:
Provide tips and ideas to help patient sleep better.

Patient Friendly Description:
This will provide tips on sleeping better with heart faillure.

Learner Progress: Not documented in this visit.

Point: Heart Failure: Know your Baselines (MCB) (Not Started)

Description:
Explain to patient how to identify their baseline and recognize changes.

Patient Friendly Description:
This will help you understand what's normal for you and how to watch for changes.

Learner Progress: Not documented in this visit.

Point: Heart Failure : Know your Zones (Not Started)

Description:
Review heart failure zones with patient and educate them on how to know which zone they are in each day.

Learner Progress: Not documented in this visit.

Point: Dealing with Heart Failure: Helping the patient cope (MCB) (Not Started)

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Patient Education (continued)

Education (continued)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: How to check your Heart Rate and Blood Pressure (MCB) (Not Started)

Description:
Give patient written information on how to take a pulse. Explain the definition of a pulse, normal range, reason for taking a pulse, where pulses can be found. Demonstrate how to find a pulse. Once found, instruct the patient to count the beats for a full minute. Tell the patient to keep a record of the pulse rate, date and time taken, which site (right/left, wrist/neck) and strength of beats (weak, strong or missing beats).

Patient Friendly Description:
This will explain the importance of understanding your vital signs and show you how to take them.

Learner Progress: Not documented in this visit.

Topic: WellStar Cardiac Rehabilitation (MCB) (Not Started)

Point: Exercise for a Healthier Heart (MCB) (Not Started)

Description:
Explain how exercising regularly offers many health rewards. Provide exercise tips to beginning a new exercise routine; Set Small goals and aim for 150 minutes a week.

Patient Friendly Description:
This provides healthy heart tips on why exercise is important.

Learner Progress: Not documented in this visit.

Point: WellStar Cardiac Rehabilitation Program (MCB) (Not Started)

Description:
At WellStar, our cardiac rehab patients are individually assessed to review medical history, evaluate risk factors, analyze functional abilities and set goals. Ongoing assessments are conducted to ensure patients are making progress toward their goals, educational needs are being met, and any problems or concerns are being addressed with the referring physician.

Patient Friendly Description:
This will help you better understand Cardiac Rehabilitation. At WellStar, our cardiac rehab programs provide education, supervised exercise, lifestyle modification and emotional support to help patients increase physical fitness, reduce cardiac symptoms and improve health and wellbeing.

Learner Progress: Not documented in this visit.

Topic: Review Plan of Care (Not Started)

Point: Review Plan of Care - Day 5 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 1 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 2 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 3 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Point: Review Plan of Care - Day 4 (Not Started)

Description:
Review plan of care including provider roles, health history, IV and medications, labs and tests, and discharge planning. Take extra time to reiterate to patient that he/she may ask questions at any time and should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Heart Failure Medications (MCB) (Not Started)

Description:
Educate patient on the drug type, purpose for medication, and common side effects.

Educate patient on Prescribed Medications

Patient Friendly Description:
This will inform you of medications that you may be taking if you are diagnosed with Heart Failure.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Aspirin (Not Started)

Patient Education (continued)

Education (continued)

Description:
Give patient written information on Aspirin. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the doctor should be called. Reinforce that this medication should be taken exactly as the doctor has prescribed.

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Topic: Prevention / Discharge (MCB) (Not Started)

Point: Community Resources (Not Started)

Description:
Give written information on available community resources. Refer to Social Services or Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Home Health Care Services (Not Started)

Patient Education (continued)

Education (continued)

Description:
Give patient written information on Home Health Care Services that have been arranged. Review the role of the home care nurse and when to expect the first visit. Refer to Case Management or Social Services, if needed.

Learner Progress: Not documented in this visit.

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Influenza Vaccine (Not Started)

Description:
Educate the patient/family/caregiver on obatining a yearly influenza vaccine.

Learner Progress: Not documented in this visit.

Point: Discharge Medications (Not Started)

Description:
Ensure that there are no barriers to obtain medications prior to discharge. Notify Care Coordination if there are any needs for additional resources prior to discharging the patient.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:
1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Learner Progress: Not documented in this visit.

Point: Smoking Cessation (Not Started)

Patient Education (continued)

Education (continued)

Description:
Educate the patient/family/caregiver on smoking cessation and smoking cessation programs offered in the community. Explain effects smoking and second hand smoke have on the body. Encourage the patient to ask people that smoke around him/her to smoke outside or in another room. Refer patient to Cardiopulmonary Rehabilitation, if applicable.

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Topic: Heart Failure Discharge Instructions (Not Started)

Point: Follow-up Appointments (Not Started)

Description:
Give the patient/family written information on their next appointment and when to make follow-up appointments. Reinforce importance of making and keeping the appointments. If appointments were made during the visit, give the patient a written reminder of the time and location.

Learner Progress: Not documented in this visit.

Point: Daily Weights (MCB) (Not Started)

Description:
Give written information about daily weights. Instruct the patient to weigh on the same scale every day at the same time, wearing the same amount of clothing. Explain why it is important to check weight. Inform the patient that gaining weight from fluid build up may be an early sign that heart failure is getting worse. The patient should call a care provider if there is a weight gain of more than 2-3 pounds in one day or 4-5 pounds in five days.

Patient Friendly Description:
Information on the importance of Daily weights.

Learner Progress: Not documented in this visit.

Point: When to Call the Doctor (MCB) (Not Started)

Description:
Provide written documentation instructing the patient to call the doctor if the patient has:
1. Ankles and legs that become more swollen.
2. Shoes and socks that get tight suddenly.
3. Shortness of breath that does not go away with rest.
4. Weight gain of 2 - 3 pounds in one day.
5. Weight gain of 4 - 5 pounds in one week.
6. No energy for normal activities.
7. Dizziness or weakness.
8. Yellowish or blue green vision.
9. Heartbeat changes (feels like a butterfly in the chest).
10. Chest pain.
11. Blurred vision.
12. Passing out.
13. Cough that does not go away.

Patient Friendly Description:
Heart Failure symptoms to know and when to call your healthcare provider.
Lifestyle changes to help you feel and live better with Heart Failure.

Learner Progress: Not documented in this visit.

Point: Review Discharge Plan (Not Started)

Description:
Review the discharge plan with patient and primary care giver including: diet, activity, medications, and special precautions. Refer to Case Management, if needed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Diet Instructions for CHF Prevention (Not Started)

Description:
Review diet information and explain that eating a low fat and low cholesterol diet with plenty of fruits and vegetables can reduce their chance of suffering a future heart attack.

Learner Progress: Not documented in this visit.

Title: General Patient Education (MCB) (Not Started)

Topic: Psycho/Social/Spiritual Support (Not Started)

Point: Coping Mechanisms (Resolved)

Description:
Help patient identify healthy coping mechanisms. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Support Systems (Resolved)

Description:
Help patient identify available support systems. Refer to Social Service, Case Management, or Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Spiritual/Emotional Needs (Resolved)

Description:
Offer resources to meet spiritual/emotional needs. Refer to Spiritual Care, if needed.

Learner Progress: Not documented in this visit.

Point: Stress Management and Support Systems (Not Started)

Description:
Explain the importance of stress management and support systems in diabetes management. Refer to WellStar diabetes support groups, social services, case management or spiritual care, if needed.

Learner Progress: Not documented in this visit.

Point: Anxiety Reduction (Not Started)

Description:
Explain the definition of anxiety, signs and symptoms, and examples of ways to reduce anxiety. Inform patient that Spiritual Care and Social Services are available.

Learner Progress: Not documented in this visit.

Topic: Pain Management (MCB) (Resolved)

Point: Encourage Patient to Monitor Own Pain (Resolved)

Description:
Provide patient with information on the Pain Rating Scale. Explain the rating scale of 0 to 10.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Discuss Significance of VAS Scores (Resolved)

Description:
Refer to rating score of 0-10.

Learner Progress: Not documented in this visit.

Point: Discuss the Use of Pain Control Measures Before Pain Becomes Severe (MCB) (Resolved)

Description:
Take time to reiterate to patient that he/she should always let staff know if he/she is having difficulty breathing, pain or any discomfort at any time before pain becomes severe.

Patient Friendly Description:
Please inform staff that if you are having any difficulty breathing, pain or any discomfort at any time before the pain gets severe.

Please read over the items and let anyone on your Care Team know there are any questions about the material by marking below that "I HAVE QUESTIONS".

If once you have received the items and understand the material you can mark this as "I understand".

Learner Progress: Not documented in this visit.

Topic: Prevention (MCB) (Not Started)

Point: When to Call the Doctor (Not Started)

Description:
Educate patient/family/caregiver on when to call the doctor.

Learner Progress: Not documented in this visit.

Point: Protect Others from Infection (Not Started)

Description:
Educate patient/family/caregiver on respiratory hygiene and cough etiquette. To protect from further infection and to protect others from getting an infection, patient should cover nose and mouth with tissues when coughing. Encourage patient to place used tissues in a plastic bag that will not allow secretions to soak through. Patient should always wash his/her hands after using or handling used tissues.

Learner Progress: Not documented in this visit.

Point: Protect Yourself from Further Infection (MCB) (Not Started)

Description:
Educate patient/family/caregiver that because patient is in a weakened condition he/she needs to avoid others who are sick as to not acquire another illness. Family/caregiver should wear gloves, gown and face shield/eye protection.

Patient Friendly Description:
Information on Flu.
Information on Pneumonia and Pneumococcal Vaccination.

Learner Progress: Not documented in this visit.

Point: Falls education, precautions, prevention at home and in the hospital (MCB) (Not Started)

Description:
Patient was given information on preventing falls both while in the hospital and when they are at home.

Patient Friendly Description:
Things to help you prevent falls while you are in the hospital and when you are home.

Learner Progress: Not documented in this visit.

Patient Education (continued)

Education (continued)

Point: Prevention Deep Vein Thrombosis after surgery (MCB) (Not Started)

Description:
Educate patient/family/caregiver to prevent DVT and PE after Suergery

Patient Friendly Description:
In the days and weeks after surgery, you have a higher chance of developing a deep vein thrombosis (DVT).
This is a condition in which a blood clot or thrombus develops in a deep vein.
They are most common in the leg. But, a DVT may develop in an arm, or another deep vein in the body.
A piece of the clot, called an embolus, can separate from the vein and travel to the lungs.
A blood clot in the lungs is called a pulmonary embolus (PE).
This can cut off the flow of blood to the lungs.
It is a medical emergency and may cause death.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Self Care (MCB) (Not Started)

Point: General Self Care (Not Started)

Description:
Instruct patient on self care needs. These may include: hygiene, how to take a blood pressure, how to change a dressing, etc.

Learner Progress: Not documented in this visit.

Point: Demonstrate Handwashing (MCB) (Not Started)

Description:
Educate patient/family/caregiver on how to perform proper hand hygiene. Explain that hand washing is the single most important step in preventing the spread of germs. Have the patient/family/caregiver demonstrate proper hand washing technique using soap, water, friction, clean nails under running water, and dry hands on clean towel without touching dirty surfaces.

Patient Friendly Description:
This will explain the importance of washing and cleansing your hands to prevent infection.

Learner Progress: Not documented in this visit.

Topic: Medications (MCB) (Not Started)

Point: Antibiotic Education (Not Started)

Description:
If an antibiotic was prescribed, educate patient/family/caregiver on the antibiotics prescribed. Explain how antibiotics work in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed

If a viral diagnosis was made, the patient/family was educated on their viral diagnosis and the reason for no antibiotic this visit.

Learner Progress: Not documented in this visit.

Point: Anticoagulant Therapy (Not Started)

Description:
1-Educate patient/family/caregiver on anticoagulant being prescribed and provide educational materials.

Patient Education (continued)

Education (continued)

2-Explain action of medication, reason for taking, and importance of adherence to correct medication dose and schedule,
3-Explain potential for adverse drug reactions, signs of allergic reaction, potential for drug-drug and drug-food interactions, and when physician should be called.
4-Reinforce that the medication should be taken exactly as the physician has prescribed.
5-Explain importance of maintaining follow-up appointments and adhering to laboratory testing as prescribed by physician.
6-Explain that the dose of the anticoagulant being prescribed may change depending on the results of the laboratory testing.

Learner Progress: Not documented in this visit.

Point: Insulin (MCB) (Not Started)

Description:
Educate patient/family/caregiver on the insulin prescribed. Explain how insulin works in the body. Explain the action of insulin, reason for taking, side effects, signs of allergic reaction and when physician should be called. Reinforce that insulin should be taken exactly as the physician has prescribed. Explain the proper storage of insulin, that extreme temperatures can damage insulin and never take insulin that has expired. Explain that the patient's primary care physician may change the dosage depending on the results of blood glucose tests and/or A1C level.

Patient Friendly Description:
This will inform you of why you are prescribed insulin if you have Diabetes Type II.

Learner Progress: Not documented in this visit.

Point: Hypoglycemic Agents (Not Started)

Description:
Educate patient/family/caregiver on the oral and/or injectable hypoglycemic(s) prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, as well as when the physician should be called. Reinforce that this medication(s) should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Non-Steroidal Anti-Inflammatory Drugs (Not Started)

Description:
Educate patient/family/caregiver on the NSAID prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Psychotropic Medications (Not Started)

Description:
Educate patient/family/caregiver on the Psychotropic medication prescribed. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: ACE Inhibitors (Not Started)

Description:
Educate patient/family/caregiver on the ACE Inhibitor prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Angiotensin II Receptor Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Angiotensin II Receptor Blockers prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Patient Education (continued)

Education (continued)

Learner Progress: Not documented in this visit.

Point: Beta Blockers (Not Started)

Description:
Educate patient/family/caregiver on the Beta Blocker prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Digoxin (Not Started)

Description:
Educate patient/family/caregiver on Digoxin and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed. The physician will order a blood test to monitor the concentration of the drug in the patient's blood. The dose of this medication may be changed according to the results of this test.

Learner Progress: Not documented in this visit.

Point: Diuretics (Not Started)

Description:
Educate patient/family/caregiver on the Diuretic prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Inotropes (Not Started)

Description:
Educate patient/family/caregiver on the Inotropes prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Vasodilators (Not Started)

Description:
Educate patient/family/caregiver on the Vasodilator prescribed and provide educational materials. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Antibiotics (Not Started)

Description:
Educate patient/family/caregiver on the Antibiotics prescribed. Explain how antibiotics works in the body. Explain the action of medication, reason for taking, side effects, signs of allergic reaction, and when the physician should be called. Reinforce that this medication should be taken exactly as the physician has prescribed.

Learner Progress: Not documented in this visit.

Point: Medication purpose, side effects, schedule, administration (MCB) (Not Started)

Description:
Discussed purpose and possible side effects of medication.

Patient Education (continued)

Education (continued)

Learner Progress:	Not documented in this visit.

All Flowsheets

Flowsheets (all recorded)

Custom Formula Data

Row Name	01/28/20 0957	01/28/20 0925	01/28/20 0923	01/28/20 0831
OTHER				
BSA (Calculated - sq m)	—	—	—	2.14 sq meters -SC
Weight Change (kg)	—	—	—	0 kg -SC
Ideal Body Weight	—	—	—	160 lb -SC
Visit Weight	—	—	—	214 lb -SC
BMI (Calculated)	—	—	—	33.5 -SC
IBW/kg (Calculated) Male	—	—	—	66.1 kg -SC
IBW/kg (Calculated) FEMALE	—	—	—	61.6 kg -SC
Weight/Scale Event	—	—	—	0 -SC
Vitals Sepsis Risk Score	—	—	0 -LO	0 -SC
Weight in (lb) to have BMI = 25	—	—	—	159.3 -SC
% Weight Change Since Birth	—	—	—	0 -SC
Relevant Labs and Vitals				
Temp (in Celsius)	—	—	37.7 -LO	36.9 -SC
Adult IBW/VT Calculations				
IBW/kg (Calculated)	—	—	—	66.1 -SC
Range Vt 4mL/kg	—	—	—	264.4 mL/kg -SC
Low Range Vt 6mL/kg	—	—	—	396.6 mL/kg -SC
Adult Moderate Range Vt 8mL/kg	—	—	—	528.8 mL/kg -SC
Adult High Range Vt 10mL/kg	—	—	—	661 mL/kg -SC
Case Log				
BSA x (CI @3.0)= CO	—	—	—	6.42 CO -SC
Aldrete Phase 1				
Aldrete Score	10 -SC	7 -LO	—	—

Flowsheets (all recorded)

Risk for Readmission

Row Name	02/05/20 0213
OTHER	
Risk for Readmission	8 -UE

Flowsheets (all recorded)

Aldrete Score

Row Name	01/28/20 0957	01/28/20 0925	01/28/20 0825
Aldrete			
Activity	2 -SC	2 -LO	2 -SC
Respiration	2 -SC	2 -LO	2 -SC
Circulation	2 -SC	1 -LO	—
Consciousness	2 -SC	1 -LO	2 -SC
O2 Saturation	2 -SC	1 -LO	2 -SC
Aldrete Score (PAR)	10 -SC	7 -LO	—

Flowsheets (all recorded)

Intake/Output

Row Name	01/29/20 1336	01/28/20 0957	01/28/20 0949	01/28/20 0929	01/28/20 0926
Intake (mL)					
P.O.	—	300 mL -SC	—	—	—
I.V.	—	400 mL -SC	—	—	—
Simple Vitals					
Pulse	—	—	(!) 49 -SC	50 -LO	52 -LO
Resp	—	—	16 -SC	16 -LO	16 -LO
Urine Output					
Urine Color	Pink -CP	—	—	—	—

Row Name	01/28/20 0925	01/28/20 0923	01/28/20 0922	01/28/20 0922	01/28/20 0915
Intake (mL)					
I.V.	200 mL -LO	—	—	—	—
lactated Ringers infusion	Start: 01/28/20 0900				
Rate	—	—	—	0 mL/hr -RL	—
Volume (mL)	—	—	100 mL -RL	—	—
Simple Vitals					
Pulse	—	52 -LO	—	—	—
Resp	—	16 -LO	—	—	—
propofol					
propofol Bolus Dose (mg)	—	—	—	—	10 mg -RL
propofol Concentration	—	—	—	—	10 mg/mL -RL

Row Name	01/28/20 0911	01/28/20 0908	01/28/20 0908	01/28/20 0831	01/28/20 0830
Weights					
Weight	—	—	—	97.1 kg (214 lb) -SC	—
Weight Method	—	—	—	Stated -SC	—
BSA (Calculated - sq m)	—	—	—	2.14 sq meters -SC	—
lactated Ringers infusion	Start: 01/28/20 0900				
Rate	—	—	—	—	50 mL/hr -SC
Volume (mL)	—	100 mL -RL	—	—	—
Simple Vitals					
Pulse	—	—	—	(!) 48 -SC	—
Resp	—	—	—	16 -SC	—
propofol					
propofol Bolus Dose (mg)	50 mg -RL	—	50 mg -RL	—	—
propofol Concentration	10 mg/mL -RL	—	10 mg/mL -RL	—	—

Flowsheets (all recorded)

Vital Signs

Row Name	01/28/20 0949	01/28/20 0929	01/28/20 0926	01/28/20 0923	01/28/20 0831
Vital Signs					
Automatic Restart Vitals Timer	Yes -SC	Yes -LO	Yes -LO	Yes -LO	Yes -SC
Pulse	**(!) 49** -SC	50 -LO	52 -LO	52 -LO	**(!) 48** -SC
Heart Rate Source	—	Monitor -LO	Monitor -LO	Monitor -LO	Monitor -SC
Resp	16 -SC	16 -LO	16 -LO	16 -LO	16 -SC
BP	159/66 -SC	113/56 -LO	106/52 -LO	109/54 -LO	153/65 -SC
Calculated MAP	97 -SC	75 -LO	70 -LO	72.33 -LO	94.33 -SC
Temp	—	—	—	98.1 °F (36.7 °C) -LO	98.4 °F (36.9 °C) -SC
Temp src	—	—	—	Axillary -LO	Oral -SC
Oxygen Therapy					
SpO2	99 % -SC	100 % -LO	100 % -LO	100 % -LO	97 % -SC
O2 Device	None (Room air) -SC	Nasal cannula -LO	Nasal cannula -LO	Nasal cannula -LO	None (Room air) -SC
O2 Flow Rate (L/min)	—	2 L/min -LO	2 L/min -LO	2 L/min -LO	—
Pulse Oximetry Type	Continuous -SC	Continuous -LO	Continuous -LO	Continuous -LO	Continuous -SC
POX Probe Site Changed	No -SC	No -LO	No -LO	No -LO	No -SC
Vitals Sepsis Score					
Vitals Sepsis Risk Score	—	—	—	0 -LO	0 -SC

Flowsheets (all recorded)

OR Lines/Drains/Airways

Row Name	01/28/20 0925	01/28/20 0829
[REMOVED] Peripheral IV 01/28/20 22 G Right Wrist		
IV Properties	Placement Date: 01/28/20 -SC Placement Time: 0829 -SC Present on arrival to hospital?: No -SC Type of Catheter: Straight -SC Size (Gauge): 22 G -SC Orientation: Right -SC Location: Wrist -SC Site Prep: Chlorhexidine -SC Local Anesthetic: None -SC Inserted by: L Olivarez RN -SC Insertion attempts: 1 -SC Successful IV Attempt?: Yes -SC Patient Tolerance: Tolerated well -SC IV Access Problem: No -SC Removal Date: 01/28/20 -SC Removal Time: 0957 -SC Catheter Intact on removal?: Yes -SC Remaining intact at discharge?: No -SC	
Site Assessment	Clean;Dry -LO	Clean;Dry -SC
Phlebitis Scale	0 -LO	0 -SC
Infiltration/Extravasation Scale	0 -LO	0 -SC
Line Assessment	Flushes easily;Infusing -LO	Blood return with no resistance -SC
Dressing Assesment	Clean;Dry;Intact -LO	Clean;Dry;Intact -SC

Flowsheets (all recorded)

Anthropometrics

Row Name	01/28/20 0831
Anthropometrics	
Height	67" (1.702 m) -SC
Weight	97.1 kg (214 lb) -SC
Weight Method	Stated -SC
Weight Change	0 -SC
BMI (Calculated)	33.5 -SC

Flowsheets (all recorded)

Post Op Telephone Call

Row Name	01/29/20 1336
Post-Op	
Do you feel comfortable?	Yes -CP
Are you taking your Medication?	N/A -CP
Is your pain medication working?	N/A -CP
Do you have a fever over 101 F?	No -CP
Are you having any difficulty urinating?	No -CP
Urine Color	Pink -CP
Any nausea or vomiting?	No -CP
Which areas of service were you satisfied with?	Scheduling;Check-In;Pre-Op;Clinical Staff;Physician;Check-Out;Anesthesia Provider -CP

Flowsheets (all recorded)

Fall Risk

Row Name	01/28/20 0823
Hester Davis Fall Risk Assessment	
Last Known Fall	0 -SC
Mobility	0 -SC
Medications	0 -SC
Mental Status/LOC/Awareness	0 -SC
Toileting Needs	0 -SC
Volume/Electrolyte Status	0 -SC
Communication/Sensory	0 -SC
Behavior	0 -SC
Hester Davis Fall Risk Total	3 -SC
Fall Assessment	
Patient Receiving Sedation	Yes -SC
Fall Risk	Yes -SC
Fall Band Applied	Yes -SC
Yellow socks	Yes -SC

Flowsheets (all recorded)

ED Sepsis Screen

Row Name	01/28/20 0949	01/28/20 0929	01/28/20 0926	01/28/20 0923	01/28/20 0831
Vital sign parameters					
BP	159/66 -SC	113/56 -LO	106/52 -LO	109/54 -LO	153/65 -SC
Pulse	**(!) 49** -SC	50 -LO	52 -LO	52 -LO	**(!) 48** -SC
Calculated MAP	97 -SC	75 -LO	70 -LO	72.33 -LO	94.33 -SC
Resp	16 -SC	16 -LO	16 -LO	16 -LO	16 -SC
Temp	—	—	—	98.1 °F (36.7 °C) -LO	98.4 °F (36.9 °C) -SC
Vitals Sepsis Risk Score	—	—	—	0 -LO	0 -SC
Vital Signs					
Automatic Restart Vitals Timer	Yes -SC	Yes -LO	Yes -LO	Yes -LO	Yes -SC

Flowsheets (all recorded)

Ris Pre Procedure Check list

Row Name	01/28/20 0823
Consent and Procedure	
History and Physical Completed	Yes -SC
Consents Confirmed	Operative;Informed;Anesthesia;Facility -SC
Patient ID and Procedure Verified	Yes -SC
Allergy Band Applied	No -SC
Do you have any metal in your body?	No -SC
Correct Procedure	Yes -SC
Side/Site Confirmed	N/A -SC
Surgeon/Anesthesia Orders Received	Yes -SC
Surgical Prep Complete	Yes -SC
Date of last liquid	01/28/20 -SC
Time of last liquid	0630 -SC
Date of last solid	01/28/20 -SC
Time of last solid	2200 -SC
Locker Assignment	3 -SC
Pre-Op Teaching Complete	Yes -SC
Lab/Testing Checklist	
Blood Glucose Meter (mg/dl)	107 -SC
MD/Anesthesia Notified of Blood Glucose Result	Yes -SC
Urinalysis Results	Abnormal -SC
Abnormal UA Dip results	Blood trace -SC
Microscopy Complete	No -SC
Pre Procedure Testing In Chart	Urinalysis;Glucose Test -SC
Pre- op Checklist	
Anti-embolism	n/a -SC
Pre-Op Medications Given and Charted	Yes -SC
Pre-Op Vitals Documented	Yes -SC
Allergies Verified	Yes -SC
Voided Prior to Procedure	Yes -SC
Remove all that apply:	Underwear -SC
Required items available	Required test results, blood/antibiotics/irrigation fluids, implants, devices and special needs/equipment are available -SC
Mode of Transport	Stretcher -SC

Flowsheets (all recorded)

Dischage Information

Row Name	01/28/20 0929	01/28/20 0800
As part of our commitment to quality care, we will be calling you within 7-14 days of your procedure. Please provide us with the following information so we can contact you in a way that is best for you.		
Contact Number	678-910-2298 -LO	6789102298 -SC
Contact Guidelines	Ok to leave a message for me if you get an answering machine -LO	Ok to leave a message for me if you get an answering machine -SC
If you have taken sedation medication or have a scheduled procedure with anesthesia you are required to have a responsible adult present to drive you home after your procedure. If your driver needs to step out for a moment we need a cell/contact number		
Driver's Name	Shirley Maurice -LO	Shirley -SC
Relationship to Patient	Spouse/Significant Other -LO	Spouse/Significant Other -SC
Cell Phone Number	678-910-2476 -LO	—

Flowsheets (all recorded)

Assessment

Row Name	01/28/20 0925	01/28/20 0822
Preop Assessment		
Skin Condition/Temp	Dry;Intact;Warm -LO	Dry;Intact;Warm -SC
Orient/LOC	WDL;Sleeping;Sedated -LO	Alert;Oriented to person;Awake;Oriented to place;Oriented to time -SC
Psychosocial	Calm -LO	Calm -SC
Enema by Patient Prior to Admission?	—	Yes -SC

Flowsheets (all recorded)

Hand Off

Row Name	01/28/20 0923
Post Sedation Care	
Type of Sedation	MAC -LO
Procedure Tolerated:	Well -LO
Report Given at:	0923 -LO
Transport Method:	Stretcher -LO

Flowsheets (all recorded)

Patient Assessment in OR Room

Row Name	01/28/20 09:08:26	01/28/20 0823
Patient Assessment		
Name Spelling, DOB, Procedure, Consent Verified	Yes -RM	—
Site Verbally Verified	Yes -RM	—
Site marked by physician or proceduralist?	Not applicable -RM	—
Pt Oriented to the OR Suite, Personnel & Roles	Yes -RM	—
Stretcher	Side rails up x2;Wheels locked -RM	—
Comfort Assessment Complete	Yes -RM	—
Comfort Actions Taken	Warm blankets;Pillow between knees/feet;Pillow under head -RM	—
SCDs Applied	No (see comment) -RM	—
Plan of Care Reviewed by OR Staff	Yes -RM	—
Type of Anesthesia	MAC -RM	—
Prep Assessmnet		
Operative Site Intact	Yes -RM	Yes -SC
Hair Removal	N/A -RM	N/A -SC

Flowsheets (all recorded)

Assessment in OR post procedure

Row Name	01/28/20 09:12:53
Post Procedure Documentation	
Surgical Wound Classification	III -RM
Preoperative Diagnosis	prostate cancer -RM
Postoperative Diagnosis	prostate cancer -RM
Procedure Performed (Confirmed by MD and Anesthesia)	Yes -RM

Flowsheets (all recorded)

Procedure Documentation

Row Name	01/28/20 09:09:06
Procedure Assessment	
Patient Position	Lateral up right -RM
Warming Device	On;Low -RM
Electrocautery	
Electrocautery Used?	No -RM
Procedure Interventions	
Xrays Taken?	No -RM
Imaging Displayed?	Yes -RM
Video/Photography?	No -RM
Laser Used?	No -RM
Specimen Obtained	
Specimen Obtained?	Yes -RM
Specimen Collection	
Specimen Type	Prostate Biopsy -RM
Side	Bilateral -RM
Site location	prostate gland-13 core -RM
Prostate Specimen Location	Lat base;Apex;Lat mid;Lat apex;Base;Mid -RM
Specimen Sent to Pathology	Yes -RM
Specimen Discarded per Surgeon	No -RM
Additional Specimens	Yes -RM
Specimen Collection	
Specimen Type	Prostate Biopsy -RM
Site location	#1ANTMCZP5 -RM
Prostate Specimen Location	Mid -RM
Specimen Sent to Pathology	Yes -RM
Specimen Discarded per Surgeon	No -RM
Additional Specimens	No -RM
Dressings	
Dressings	N/A -RM

Flowsheets (all recorded)

Intake/Output

Row Name	01/29/20 1336	01/28/20 0957	01/28/20 0925
Intake (mL)			
P.O.	—	300 mL -SC	—
I.V.	—	400 mL -SC	200 mL -LO
Urine Assessment			
Urine Color	Pink -CP	—	—

Flowsheets (all recorded)

Abuse Screen

Row Name	01/28/20 0823
Abuse Screening	
Do you feel safe at home?	Yes -SC
Have you ever thought about hurting yourself?	No -SC

Flowsheets (all recorded)

Vitals/Pain

Row Name	01/28/20 0949	01/28/20 0929	01/28/20 0926	01/28/20 0923	01/28/20 0831
Height and Weight					
Height	—	—	—	—	67" (1.702 m) -SC
Height Method	—	—	—	—	Stated -SC
Weight	—	—	—	—	97.1 kg (214 lb) -SC
Weight Method	—	—	—	—	Stated -SC
BMI (Calculated)	—	—	—	—	33.5 -SC
BSA (Calculated - sq m)	—	—	—	—	2.14 sq meters -SC
Vitals					
Temp	—	—	—	98.1 °F (36.7 °C) -LO	98.4 °F (36.9 °C) -SC
Temp src	—	—	—	Axillary -LO	Oral -SC
Pulse	(!) 49 -SC	50 -LO	52 -LO	52 -LO	(!) 48 -SC
Heart Rate Source	—	Monitor -LO	Monitor -LO	Monitor -LO	Monitor -SC
Resp	16 -SC	16 -LO	16 -LO	16 -LO	16 -SC
BP	159/66 -SC	113/56 -LO	106/52 -LO	109/54 -LO	153/65 -SC
Cardiac Rhythm	Normal sinus rhythm -SC	Sinus bradycardia -LO	Sinus bradycardia -LO	Sinus bradycardia -LO	Normal sinus rhythm -SC
Pain Assessment					
Currently in Pain	No/denies pain -SC	Faces -LO	Faces -LO	Faces -LO	—
FACES Pain Rating	—	0-No hurt -LO	0-No hurt -LO	—	—
Oxygen Therapy					
SpO2	99 % -SC	100 % -LO	100 % -LO	100 % -LO	97 % -SC
O2 Device	None (Room air) -SC	Nasal cannula -LO	Nasal cannula -LO	Nasal cannula -LO	None (Room air) -SC
O2 Flow Rate (L/min)	—	2 L/min -LO	2 L/min -LO	2 L/min -LO	—
Pulse Oximetry Type	Continuous -SC	Continuous -LO	Continuous -LO	Continuous -LO	Continuous -SC
POX Probe Site Changed	No -SC	No -LO	No -LO	No -LO	No -SC

Flowsheets (all recorded)

Site Preparation

Row Name	01/28/20 09:08:26	01/28/20 0823
Prep Assessmnet		
Operative Site Intact	Yes -RM	Yes -SC
Hair Removal	N/A -RM	N/A -SC

Flowsheets (all recorded)

Assessment

Row Name	01/28/20 0925	01/28/20 0822
Uro Assessment		
Skin Condition/Temp	Dry;Intact;Warm -LO	Dry;Intact;Warm -SC
Orient/LOC	WDL;Sleeping;Sedated -LO	Alert;Oriented to person;Awake;Oriented to place;Oriented to time -SC
Psychosocial	Calm -LO	Calm -SC

Flowsheets (all recorded)

Call Complete

Row Name	01/29/20 1335
Completion of Post-op Call	
Post-op Call Complete	Yes -CP

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Effective Dates
UE	Epic, User	—
LO	Lisa M Olivarez, RN	02/03/17 -
CP	Chrissie Pope, RN	02/03/17 -
SC	Sharon H Crider, RN	02/03/17 -
RM	Ramona McNeil, RN	02/03/17 -
RL	Robert G Lawhead, MD	01/22/20 - 01/28/20

Flowsheet Notes

No notes of this type exist for this encounter.

All Scans

Document on 1/28/2020 9:26 AM by Lisa M Olivarez, RN: IP After Visit Summary (below)

AFTER VISIT SUMMARY

Eugene G. Maurice MRN: 561253820 1/28/2020 WellStar Kennestone Urology Procedure Center

Instructions

No changes were made to your medications.

Activity instructions

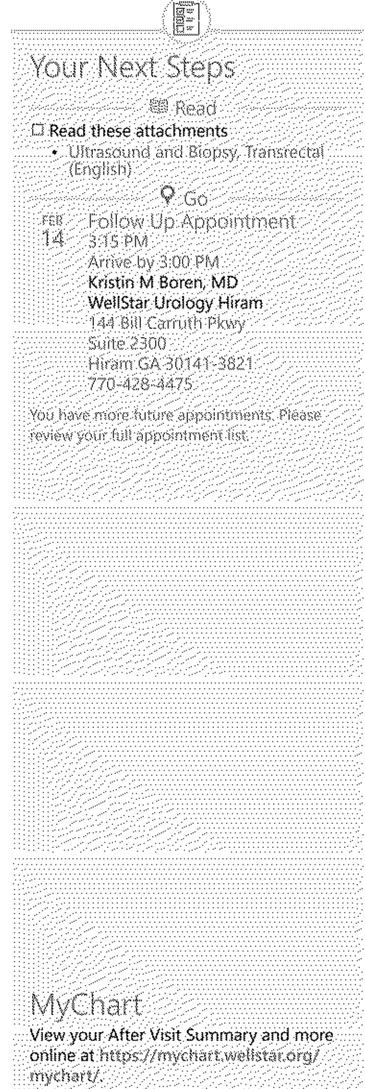
Discharge Instructions

1. General Anesthesia or Sedation
Do not drive or operate machinery for 24 hours
Do not consume alcohol, tranquilizers, sleeping medication or any other non-prescribed medication for 24 hours.
Do not make any important decisions or sign any important documents in the next 24 hours.
You should have someone with you at home tonight.

2. Activity
You are advised to go directly home from the Urology Associates Surgery Center and rest for a day. Resume light to normal activity tomorrow.
Do not engage in heavy lifting while you see blood in the urine or stool.

3. Fluids and Diet
Begin with clear liquids, bouillon, dry toast, soda crackers. If not nauseated, you may go to a regular diet when you desire.
Greasy or spicy foods are not advised.
Drink plenty of water while you see blood in the urine or stool.
If you are diabetic, please eat before you take your diabetes medication.

4. Medications and Plan
Prescriptions sent with you. Use as directed. When taking pain medications, you may experience dizziness or drowsiness. Do not drink alcohol or drive when you are taking these medications.
You may take non-prescription "headache remedy" type medications that you normally use, if your surgeon permits, preferably one that does not contain aspirin.



Your Next Steps

Read

☐ Read these attachments
- Ultrasound and Biopsy, Transrectal (English)

Go

FEB 14 — Follow Up Appointment
3:15 PM
Arrive by 3:00 PM
Kristin M Boren, MD
WellStar Urology Hiram
144 Bill Carruth Pkwy
Suite 2300
Hiram GA 30141-3821
770-428-4475

You have more future appointments. Please review your full appointment list.

MyChart

View your After Visit Summary and more online at https://mychart.wellstar.org/mychart/.

Activity instructions (continued)

You may resume your daily prescription medication when you get home.

Prescriptions
Tylenol as needed for pain or discomfort.
Antibiotic: Cipro this evening.
Patient was provided with updated medication list.

6. Follow up Care
Your physician may call you with biopsy results.

Special Complications to Watch For
You may see blood in your urine or stool for days to weeks.
You may see blood in your ejaculate for up to 6 weeks.
If you have a fever, chills, and are feeling poorly, take your temperature by mouth. Call the office if it is over 101* F.
Please call us if you have large blood clots, difficulty urinating or pain not relieved by Tylenol.

If you have any questions the day of your procedure please call 470-245-9860 to speak with a nurse. For problems or questions after 4:30pm call your urologist at 770-428-4475

If you need immediate attention, go to the emergency room.

What's next

Follow up with Jeffrey L Tharp, MD
176 Charles Hardy Parkway
Unit C
Hiram GA 30141
678-945-8200

FEB 14 — Follow Up Appointment with Kristin M Boren, MD
Friday Feb 14, 2020 3:15 PM (Arrive by 3:00 PM)
WellStar Urology Hiram
144 Bill Carruth Pkwy
Suite 2300
Hiram GA 30141-3821
770-428-4475

MAR 16 — Established Patient with Susan E Ashworth, NP
Monday Mar 16, 2020 8:00 AM (Arrive by 7:45 AM)
WellStar East Paulding Primary Care Center
176 Charles Hardy Parkway Unit C
Hiram GA 30141-1836
678-945-8200

MAY 21 — Follow Up Appointment with Abdul M Sheikh, MD
Thursday May 21, 2020 9:00 AM (Arrive by 8:45 AM)
WellStar Cardiovascular Medicine Hiram
144 Bill Carruth Parkway STE 4200
HIRAM GA 30141-3749
678-324-4444

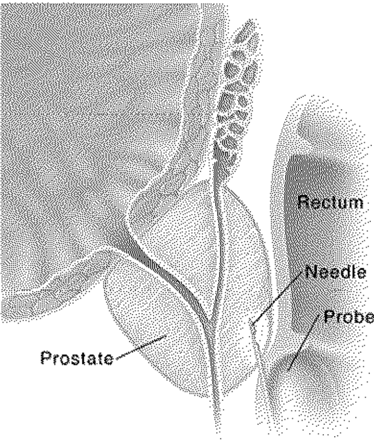
Medication List

	Morning	Afternoon	Evening	Bedtime	As Needed
aspirin 81 MG tablet, delayed release					
atorvastatin 80 MG tablet Commonly known as: LIPITOR Take 1 tablet (80 mg total) by mouth nightly					
blood sugar diagnostic strip Commonly known as: OneTouch Verio Use to check blood sugar twice daily as directed.					
ciprofloxacin HCl 500 MG tablet Commonly known as: CIPRO					
clopidogreL 75 mg tablet Commonly known as: PLAVIX Take 1 tablet (75 mg total) by mouth daily					
diclofenac 1 % Gel Commonly known as: VOLTAREN Apply 2 g topically 4 (four) times a day					
ferrous sulfate 324 mg (65 mg iron) tablet, delayed release Take 1 tablet (324 mg total) by mouth 2 (two) times a day with meals					
furosemide 40 MG tablet Commonly known as: LASIX Take 1 tablet (40 mg total) by mouth daily					
isosorbide mononitrate 60 MG tablet, extended release 24 hr Commonly known as: IMDUR Take 1 tablet (60 mg total) by mouth 2 (two) times a day					
metFORMIN 500 MG tablet Commonly known as: GLUCOPHAGE TAKE TWO TABLETS BY MOUTH EVERY MORNING AND TAKE ONE TABLET BY MOUTH EVERY EVENING					
nitroglycerin 0.4 MG SL tablet Commonly known as: Nitrostat Place 1 tablet (0.4 mg total) under the tongue every 5 (five) minutes as needed for chest pain					
ramipril 5 MG capsule Commonly known as: Altace Take 1 capsule (5 mg total) by mouth daily					
sotalol 80 MG tablet Commonly known as: Betapace Take 0.5 tablets (40 mg total) by mouth 2 (two) times a day					
VITAMIN B12 ORAL					

Attached Information

Ultrasound and Biopsy, Transrectal (English)

Transrectal Ultrasound and Biopsy



A transrectal ultrasound (TRUS) is an imaging test. It uses sound waves and a computer to create pictures of a man's prostate gland. It doesn't use X-rays.

Your prostate gland is in front of your rectum. For this test, a special probe (called a transducer) is put into your rectum to see the prostate. During this test, tissue samples (called a biopsy) may be taken. TRUS is done by a specially trained technologist called a sonographer. It takes 15 to 30 minutes. It might take longer if a biopsy is done.

Getting ready for your test

- You may be asked to clear your bowel before the test. This may be done by putting liquid into your rectum (an enema). Or you may be asked to drink a special liquid to clean out your colon and rectum.
- You may be asked not to eat or drink anything after midnight the night before the test.
- Tell your healthcare provider about any medicines, vitamins, herbs, or supplements you take. This includes any over-the-counter medicines such as aspirin or ibuprofen. You might need to stop taking some medicines, such as blood thinners, for a week or so before the test.
- Answer any questions your healthcare provider has about your health history. This will help tailor the test to your health needs.

During your test

- You will be asked to change into a hospital gown. You'll then lie on your side on an exam table, with your knees bent toward your chest.
- The test is done with a hand-held probe. This is a short, slender rod about the size of your finger. It has a sterile, disposable cover on it. It's greased (lubricated) with some gel. It's gently put inside your rectum.
- You'll feel pressure from the probe. If it hurts, let your healthcare provider know.
- Sound waves are sent into the probe and through the wall of your rectum. They bounce off your prostate, and the computer uses them to form an image of the gland and nearby tissues. (It works much like sonar on a ship.)
- If a biopsy is needed, you might be given medicine before the ultrasound to make you sleepy. This is done using a small probe with a very tiny needle on the end. This needle very quickly goes into your prostate many times and takes out tiny pieces (samples) of tissue. These samples are then sent to a lab to be tested. Any pain from the biopsy is usually mild.

After your test

Before leaving, you may need to wait for a short time while the images are reviewed. In most cases, you can go back to your normal routine after the test. If you had a biopsy and took medicine to make you sleepy, you may need to wait until it has worn off before you can go home. You might see some blood in your urine, sperm, or stool for a day or so. This is normal. You may be asked to take antibiotics before and after TRUS if a biopsy is done. This is to help prevent infection.

Your healthcare provider will let you know when your test results are ready.

In some cases, a diagnosis can't be made from the tissue sample that was taken. If this happens, your healthcare provider will talk with you about if you need another biopsy. Or you may need a different procedure.

When to call your healthcare provider

Call your healthcare provider if you have:

- Very bloody urine or stool
- A fever lasting 24 to 48 hours
- Pain that's not getting better or that gets worse
- Any other symptoms that your provider asks you to report, based on your health

Be sure you know what other problems you should watch for. Also know how to get help any time, including after office hours, on weekends, and on holidays.

StayWell last reviewed this educational content on 7/1/2019

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Scan on 1/28/2020 7:53 AM by Mary Johnston: Perceptive Content Scan (below)

Encounter-Level E-Signatures:

No documentation.

END OF REPORT