Nurse Note Sample

ProVation Medical Center
GI Nurse Note
Procedure(s): Colonoscopy

Patient Name: **Martin, Rebecca**
Patient ID: **56564567889**
Exam Date: **7/17/2013**
Account#:

Exam Date: **7/17/2013** Patient ID: **56564567889** Doctor: **Johnson, Matt**

Patient Name: **Rebecca Martin** DOB: **09/21/1944** Gender: **Female**

ALLERGIES AND ALERTS

Alert	Comments	Last Updated By	Last Updated On
Egg Allergy	Patient denies use	Smith, Meghan	7/18/2013 10:06:20 AM
Food Allergy	Patient denies use	Smith, Meghan	7/18/2013 10:06:20 AM
Iodine Allergy	Patient denies use	Smith, Meghan	7/18/2013 10:06:19 AM
Latex Allergy	Patient denies use	Smith, Meghan	7/18/2013 10:06:19 AM
Penicillin	Rash	Smith, Meghan	7/18/2013 10:06:38 AM
ALERT -Diabetic - Yes		Smith, Meghan	7/18/2013 10:06:45 AM
ALERT - Implanted Metal - Hip, Left		Smith, Meghan	7/18/2013 10:06:50 AM

CURRENT MEDICATIONS User: msmith

Medication	Dosage	Route	Frequency	Last Taken
Ibuprofen	400mg	oral	2 times per day as needed	7/13/2013
Prilosec	20	mg	oral	7/16/2013
Fish Oil	2 grams	oral	daily	7/16/2013
Ginseng	100mg	oral	daily	7/16/2013

CHECK-IN User: msmith

Patient ID verified: **YES**
Verified using at least 2: **Date of birth, Full legal name, Verbal**
Verified by: **MS**
Procedure(s) scheduled for: **Colonoscopy**
Indication for procedure: **Screening**
Primary Care Physician: **Dr. Thompson**
Admitted from: **Home**
Admitted via: **Ambulatory**
NPO since: **> 6 hours ago**
Last Fluids Taken: **Midnight**
Last Solids Taken: **8PM - yesterday**
Prep taken: **YES**
Prep type: **Suprep**
Stool Appearance: **Clear, Liquid, Loose**
Transportation after procedure: **YES**
Driver location: **Waiting Room**
Driver's name/Relationship/Phone: **John/husband/ 891-2712**
May we share the results of the procedure with your driver? **YES**
May we contact you tomorrow for a follow-up call? **YES**
Patient Belongings Removed/Reviewed: **YES**
Patient items removed: **Contact lenses, Hearing Aid**
Patient belongings stored: **Stored with patient**
Does the patient have any advance directives: **YES**
Advance directive(s): **Durable power of attorney**
Copy on chart? **YES**

This facility does not honor advanced directives.

Barrier to care: **NO**
Primary language is English: **YES**
Body Mass Index (BMI): **Height (in): 67, Weight (lbs): 223, BMI (%): 34.9**

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HEALTH HISTORY

User: msmith

Medical History

Cardiovascular: **YES**
Cardiovascular diagnoses: **Hypertension**
Implanted cardiac device? **NO**
Comments: **NA**
Pulmonary: **YES**
Pulmonary diagnoses: **Asthma**
Do you have sleep apnea: **YES**
Do you use a C-PAP? **YES**
GI: **YES**
GI diagnoses: **Constipation, Gastric reflux, Hemorrhoids**
Diabetes: **YES**
Treated with: **Diet**

Refer to Vitals Log for Blood Glucose Results

Comments: **NA**
Renal/Endocrine: **NO**
Neuro/musculoskeletal: **YES**
Neuro/musculoskeletal diagnoses: **Headaches, Neck / Back pain**
Psychiatric: **NO**
Cancer: **NO**
Hepatitis: **NO**
Miscellaneous: **NO**
Pregnancy status: **Post Menopausal**
Recent illness or infection: **NO**

Surgical History

Previous non-GI surgery: **YES**
Surgery: **Hip replacement, Tonsillectomy and adenoidectomy**
Previous GI surgery: **YES**
Surgery: **Appendectomy**
History of problems with anesthesia: **NO**
Comments: **NA**

Social History

Tobacco history: **NO**
Alcohol history: **YES**
Type: **beer/wine**
Amount: **social**
Quit date: **NA**
Recreational drug use: **NO**
Entire health history obtained from: **H & P, Patient**

PATIENT ASSESSMENT - PREPROCEDURE

User: msmith

Patient ID verified? **YES**
Verified using at least 2: **Date of birth, Full legal name, Verbal**
Person who verified: **MS**
ID bracelet on: **YES**
Consent signed: **YES**
Consent signed by: **Patient**
Witness: **JJ**
H & P completed within 30 days? **YES**
Date H&P was completed: **07/02/2013**
Does the patient currently have pain: **YES**
Baseline pain level: **1**
Pain location: **Hip**
Pain type: **Chronic**
Pain quality: **Aching, Dull**
Pain scale instruction: **1-10**

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Level of Consciousness: **Alert and Oriented x 4**
Respiratory assessment: **Breath sounds clear / equal**
Skin assessment: **Warm, Dry, Pink**
Abdominal exam: **Soft**
IV started: **YES**
Attempts: **1**
IV site: **Right hand**
Size: **18 gauge**
IV solution: **Saline Lock, Normal Saline (NS)**
IV rate: **TKO**
Inserted by: **MS**
Time started: **07/18/2013 10:17**

DISCHARGE User: msmith

Patient transferred by and report received from: **jj**
Siderails up on bed upon receipt of patient? **YES**
Transportation after procedure: **YES**
Driver location: **Waiting Room**
Driver's name/Relationship/Phone: **John/husband/ 891-2712**
May we share the results of the procedure with your driver? **YES**
May we contact you tomorrow for a follow-up call? **YES**
Level of Consciousness: **Alert and Oriented x 4**
Skin assessment: **Warm, Dry, Pink**
Abdominal exam: **Soft**
Does the patient currently have pain? **NO**
Bowel sounds: **Present**
Passing flatus? **YES**

DISCHARGE CRITERIA

Oxygen saturation on room air >=94% or equal to pre-sedation state? **YES**
Able to ambulate independently (or at baseline)? **YES**
Able to take PO fluids? **YES**
IV discontinued: **YES**
IV site assessment: **Dry, intact**
IV removed by: **MS**
Time removed:
Amount IV fluids infused:
Comments:
Patient's valuables returned/reviewed? **YES**
Patient valuables returned to: **Patient**

Patient belongings removed/reviewed in Pre-Procedure

Patient Belongings Removed/Reviewed: **YES**
Patient items removed: **Contact lenses, Hearing Aid**
Patient belongings stored: **Stored with patient**
Patient meets discharge criteria as set by physician and approved by facility? **YES**
Discharge instructions given to: **Patient, Spouse**
Discharged to: **Home**
Discharged via: **Ambulatory**
Discharged under the care of: **Spouse**

CARE PLANS User: jjones

PRE-PROCEDURE

1. Anxiety regarding impending procedure.

Actions: Assess patient for non-verbal clues, listen, clarify questions. Allow use of coping mechanisms. Refer to support system.:
Outcomes: Expresses decreased anxiety and increased understanding of procedure:
Status: **MET**

2. Lack of understanding of procedure and medications.

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Actions: Direct medical questions to MD. Education about procedures/medications.:

Outcomes: Verbalizes understanding of procedures and medications.:

Status: **MET**

PROCEDURE

1. Patient will incur no injury relatead to positioning, use of equipment. Patient is free from injury related to positioning/equipment.:

2. Avoidance of patient infection related to procedures. Standards maintained to prevent infection.:

Status: **MET**

POST-PROCEDURE

1. Alteration in neurological status - sensory disturbances related to sedative agent.

Actions: Assess mental status. Speak directly to the patient at all times. Reorient patient to location frequently.Assess ability to follow commands.:

Outcomes: Alert and aware of environments. Follows commands.:

Status: **MET**

2. Alteration in comfort, related to pain, N/V

Actions: Position or comfort. Offer pain meds as ordered. Evaluated and record intervetions. Provide emotional support.:

Outcomes: Patient verbalizes feelings of comfort or decrease in pain. Patient verbalizes decrease or elimination of nausea.:

Status: **MET**

3. Alteration in cardiovascular status related to sedative agent or procedure.

Actions: Monitor and assess VS and ECG rhythm per policy and procedure. Observe for signs of bleeind PRN. Report and document deviations and interventions.:

Outcomes: Vital signs within Pre-Op limits. Invasive lines functioning. Cardiac rhythm same as Pre-Op.:

Status: **MET**

SURGICAL SAFETY CHECKLIST User: jjones

SIGN IN (Before induction of anesthesia)

Patient has confirmed the following: **Identity, Procedure, Patient unable (Confirmed by facility policy), Consent**

Crash cart and emergency medications check completed? **YES**

Pulse oximeter on patient and functioning? **YES**

Does the patient have a known allergy? **YES**

Is there a difficult airway or aspiration risk? **NO**

Is there risk of >500 mL blood loss (7 ml/kg in children)? **NO**

TIME OUT (Before skin incision or endoscope insertion)

Confirm all team members introduced themselves by name and role? **YES**

Confirm patient's name and procedure? **YES**

Is essential imaging displayed? **YES**

Antibiotic prophylaxis given within the last 60 minutes? **NO**

Off antiplatelets/anticoagulants for appropriate length of time? **YES**

Anticipated Critical Events (Endoscopist): **State critical or nonroutine steps, State how long the case will take, State the anticipated blood loss**

Anticipated Critical Events (Anesthetist): **State any patient-specific concerns**

Anticipated Critical Events (Nurse): **State if endoscope, machine and supplies clean or sterile confirmed, State any patient-specific concerns**

SIGN OUT (Before patient leaves procedure room)

Nurse verbally confirms with team: **Name of procedure, What are the key concerns for recovery and management of this patient?, Specimens identified and labeled (where applicable), Any equipment problems to be addressed**

To Endoscopist, Anesthetist and Nurse: **What are the key concerns for recovery and management of this patient?**

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PROCEDURE NOTES User: msmith

Wed. Jul.17 2013, 10:01:47 (UserID: msmith at PREPROCEDURE station)
(Station notes is a feature that allows stsaff to enter free text and includes a time stamp)

Thu. Jul.17 2013, 10:21:51 (UserID: jjones at PROCEDURE station)
(Station notes can be used in multiple areas)

Thu. Jul.18 2013, 13:04:50 (UserID: msmith at POSTPROCEDURE station)
(Station notes include the user ID and location that the note was entered)

QUALITY REPORTING

Patient Burn	No
Patient Fall	No
Wrong Site, Side, Patient, Procedure, Implant	No
Hospital Admission / Transfer	No
Ordered Prophylactic IV Antibiotic Timing	Patient without preoperative order for prophylactic IV antibiotic

Oxygen

Time	Method	Rate	Entered By	Notes
10:54:40	O2 Discontinued	0 L	jjones	No Notes Taken
10:21:18	Nasal Cannula	2 L	jjones	

Medications

Time	Medication	Dose	Entered By	Notes
10:27:57	Fentanyl IV	50 mcg Total: 100 mcg	jjones	No Notes Taken
10:22:14	Versed IV	2 mg Total: 2 mg	jjones	
10:22:07	Fentanyl IV	50 mcg	jjones	

Aldrete Score

Time	11:45:00	11:35:00	11:25:00	11:08:00	10:56:43
BP	2	2	2	1	2
Heart Rate	2	2	2	2	1
O2 Sat	2	2	1	1	1
Activity	2	2	2	2	1
LOC	2	2	2	1	1
Entered By	msmith	msmith	msmith	msmith	msmith
TotalScore	**10**	**10**	**9**	**7**	**6**
Notes					

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Vitals

Time	BP	HR	RESP	O2 Sat	Entered By
11:44:30	132/88	84	14	97	msmith
11:34:21	132/88	82	12	98	msmith
11:24:13	132/88	82	12	98	msmith
11:07:18	118/76	88	13	94	msmith
10:56:12	126/84	88	13	96	msmith
10:53:46	132/88	88	13	96	jjones
10:48:41	132/88	84	14	97	jjones
10:43:37	132/88	88	13	96	jjones
10:39:10	132/88	88	14	96	jjones
10:33:51	132/88	82	12	98	jjones
10:27:23	118/76	86	14	97	jjones
10:22:57	126/84	82	12	98	jjones
10:20:51	126/84	88	13	96	jjones
10:16:58	118/76	88	13	94	msmith

Notes

No notes entered

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PROCEDURE LOG

Time	Data	Entered By
10:53:17	**Specimen Verification Complete :** YES	jjones
10:53:10	**Endoscope time :** Scope Out	jjones
10:51:06	**Banding :** **Location :** Hemorrhoids,**Number of bands :** 2	jjones
10:46:58	**Dilatation :** **Dilator type :** Balloon,**Dilator size :** 16 Fr	jjones
10:46:46	**Therapeutic Injection :** **Agent :** SPOT,**Location :** Polyp, **Injection Amount :** -	jjones
10:42:08	**Cautery :** **Unit Number :** -,**Coag :** -,**Cut :** -,**Blend :** -, **Pad site :** Left Flank,**Skin condition (pre-cautery) :** Intact, -, **Skin condition (post-cautery) :** -	jjones
10:39:34	**Endoscope time :** Start Withdrawal	jjones
10:38:57	**Endoscope time :** Extent Reached	jjones
10:27:41	**Patient Assessment :** **Sedation Score :** 3 - Responds to commands,**Pain Score: :** 0,**Comments :** -	jjones
10:23:28	**Endoscope time :** Scope In	jjones
10:23:08	**Patient Assessment :** **Sedation Score :** 2 - Cooperative, oriented,**Pain Score: :** 0,**Comments :** NA	jjones
10:21:36	**TIME-OUT / Universal Protocol :** **Just before starting the procedure, ALL members of the procedural team verify CORRECT PATIENT, CORRECT PROCEDURE, and CORRECT SITE? :** YES, **Staff members performing Time-Out :** Physician, CRNA, Circulating RN, -	jjones
10:21:13	**Patient position :** Left Lateral	jjones
10:21:07	**Equipment utilized :** **All equipment available for procedure (patent IV,cardiac monitor,BP Machine/Cuff,Pulse oximeter,Oxygen,Suction apparatus,Ambu bag, crash cart, airway adjuncts,defibrillator,antagonist meds) :** YES	jjones
10:17:48	**Blood Glucose Reading :** 87	msmith
10:17:26	**Cardiac rhythm :** Normal Sinus	msmith
10:17:05	**Temperature (F) :** 99.0	msmith

Specimens Collected

Jar	Sample Type	Procedure	Lab Type	Location	Indication	Entered By
1	Polypectomy	Colonoscopy	Histology	Colon - Sigmoid	Polyp, Hot Snare	jjones
2	Polypectomy	Colonoscopy	Histology	Colon - Rectum	Polyp, Cold Snare	jjones
3	Biopsy	Colonoscopy	Histology	Colon - Transverse	Mass	jjones

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Time Tracking

Time	Event	Entered By
11:47:00	Discharged	msmith
11:01:00	Physican Recovery Visit	msmith
10:54:12	Recovery Start	jjones
10:53:27	Procedure Stop	jjones
10:22:00	Procedure Start	jjones
10:20:27	Into Procedure Room	jjones
10:12:15	PreProcedure Start	msmith
10:06:08	Registration Complete	msmith
09:59:36	Pt Arrival	msmith

IV Fluid

Time	Type	Amount Hung	Entered By	Notes
10:17:22	0.9 % Normal Saline @	250 mL Total: 250 mL	msmith	No Notes Entered

Provider Signatures

Meghan Smith, RN (msmith) **ESIGNED - 07/18/2013 13:14:07**

Jane Jones, RN (jjones) **ESIGNED - 07/18/2013 12:55:17**