**Nursing notes**

DATA

PT ADM TO SICU FROM OR S/P R FRONTAL *CRANIOTOMY*. PT AWAKE, ALERT AND ORIENTED, FOLLOWS SIMPLE COMMANDS. PERL PT C/O SL *HEADACHE*- BUT REFUSED ANY *PAIN* MED. FOLEY IN PLACE DRAINING CLEAR YELLOW URINE. LEFT RADIAL A-LINE AND 2 PERIPH IN PLACE. HEAD DRESSING INTACT- SM STAINING NOTED ON LEFT SIDE. PT C/O INTERMITTENT *NAUSEA*- NO *VOMITING*.

ACTION

*ZOFRAN* 2MG IV GIVEN X1. IV OF NS WITH 20MEQ KCL HUNG AT 60CC/HR.

RESPONSE

NEURO STATUS STABLE. *NAUSEA* RESOLVED-TAKING SIPS OF H20 PO.

PLAN

CONTINUE TO MONITOR CLOSELY.

PATIENT QUIET NOC. ALERT AND ORIENTED PERLA. NORMAL STRENGTH NOTED ALL EXTREMITIES. GOOD U/O , FAIR PO'S. DRESSING WITH SOME OLD STAINING DRY AND INTACT. MEDICATED FOR *PAIN* X2. WITH GOOD EFFECT. PLAN TO DC-ALINE AND DISCHARGE TO FLOOR TODAY. CONTINUE TO MONITOR ALL PARAMETERS

DATA

56 YR OLD PT, SEE CHART FOR PMH. PT WITH C/O *HEADACHES*, *LOSS OF MEMORY* -CT SCAN DONE SHOWED R FRONTAL CYSTIC MASS. 7/16 PT WENT TO OR FOR FRONTAL *CRANIOTOMY*- REMOVAL OF SM *TUMOR* (GLIAL) PT ADM TO SICU FOR OVERNIGHT MONITORING. 7/17 PT AWAKE ALERT AND ORIENTED, PERL. MOVES ALL EXTREMITIES WITH NORMAL STRENGTH. LARGE HEAD DRESSING INTACT- SM STAINING NOTED ON LEFT SIDE. PT MEDICATED WITH *TYLENOL #3* FOR *PAIN* WITH GOOD EFFECT. PT TAKING SM AMTS PO'S- TOL WELL, IV OF NS WITH 20MEQ KCL INFUSINGAT 60CC/HR. FOLEY IN PLACE DRAINING CLEAR YELLOW URINE. PT ASSISTED OOB TO CHAIR THIS AM- TOL WELL.

ACTION

TRANSFER TO FLOOR. FOLEY TO BE DC'D. LOCK IV WHEN TOL PO'S.

RESPONSE

STABLE AT PRESENT.

PT. IS A 56 Y/O FEMALE S/P *CRANIOTOMY* ON 7/16 FOR REMOVAL OF BENIGN CYSTIC *LESION*. SURGERY PERFORMED AT BIDMC. STARTED ON *DILANTIN* POST-OP FOR *SEIZURE* PROPHYLAXIS. 2 DAYS PRIOR TO ADMISSION PT. DEVELOPED BILAT. EYE DISCHARGE-- SEEN BY EYE MD AND TREATED WITH SULFATE OPTHALMIC DROPS. ALSO DEVELOPED ORAL SORES AND *RASH* ON CHEST AND RAPIDLY SPREAD TO TRUNK, ARMS, THIGHS, BUTTOCKS, AND FACE WITHIN 24 HRS. UNABLE TO EAT DUE TO MOUTH *PAIN*. + *FEVER*, + *DIARRHEA*, *WEAKNESS*. PRESENTED TO EW ON 8/4 WITH TEMP 104.3 SBP 90'S.GIVEN NS FLUID BOLUS, *TYLENOL* FOR TEMP. SHE PUSTULAR RED *RASH* ON FACE, RED *RASH* NOTED ON TRUNK, UPPER EXTREMITIES AND THIGHS. ALSO BOTH EYES DRAINING GREENISH-YELLOW DRAINAGE. ADMITTED TO CCU ( MICU BORDER) FOR CLOSE OBSERVATION.

PMH

^ CHOL (ON *LIPITOR*) BENIGN R FRONTAL *TUMOR* (CYSTIC) S/P R FRONTAL *CRANIOTOMY* 7/16

SOC. HX

MARRIED, LIVES WITH HUSBAND AND DAUGHTER,SON NKDA

NEURO

LETHARGIC BUT AROUSABLE. FOLLOWS COMMANDS WELL AND MOVES ALL EXTREMITIES. DIFFICULT TO ASSESS PUPILS DUE TO *CONJUNCTIVITIS*, (EYELIDS CRUSTY AND STICKY).

CV

HR 120'S ST NO VEA. BP 90-120 SYS. PT STATES BASELINE SYS BP 90'S. DENIES CP.

RESP

LUNGS CLEAR. O2 SATS RANGE 88-95% PLACED ON 2L NC FOR O2 SATS 88. OCC. C/O SL. SOB. NO *COUGH*.

GI

+ BOWEL SOUNDS ABD. SOFT NO BM OVERNIGHT. TAKING SMALL SIPS OF WATER WELL.

GU

FOLEY TO GRAVITY. DRAINING CLEAR YELLOW URINE IN GOOD AMTS. SEE FLOWSHEET FOR DATA.

SKIN

HEAD INCISION WELL HEALED. HAIR GROWING IN. FACE HAS PUSTLULE *RASH* NO DRAINAGE YET. RED *RASH* NOTED OVER TRUNK, ARMS, THIGHS. EYES WITH STICKY GREEN-YELLOW DRAINAGE. CLEANED WITH WARM WATER AND ABX. OINT APPLIED. ORAL LESIONS CLEANED GENTLY WITH WARM WATER. *NYSTATIN* LIQ. APPLIED.

CCU NURSING PROGRESS NOTE 7A-7P

Neuro

intact

Resp

Tolerating 2L NC with sats >95%. No resp complaints.

CARDIAC

BP 100's/60's. HR on the rise 110-130's. Conts on D5 1/2 NS at 200cc/hr for hydration. Presently >2L positive this evening. Electrolytes being replaced (K+, K phos, Mg, Ca).

GI

NPO due to *oral ulcers* . No plans for GT placement. Pt has been evaluated for bedside PICC placement for TPN/PPN, however per IV team, pt will most likely require interventional Readiology PICC placement (DL). Team to follow up in am. No stool this shift. +*flatus*.

GU

Foley draining clear yellow urine. Pt is >2L positive at this time.

ID

Tmax 101.4. Given *tylenol* x1. Conts on Iv *oxacillin* q6hrs. Pt also to start IV *solumedrol* BID per dermatology. pt's face appears with more pustules; otherwise red raised *rash* remains the same over trunk, back, buttocks, upper arms. *Diprolene* cream ordered.

ACCESS

2 #20 angios in place. Awaiting central access by Interventional radiology in am. If pt should run into problems this evening, team to place groin line.

S

C/O OF BEING VERY COLD WANTING BLANKETS

O

ID

TEMP MAX 104.8 RECTALLY GIVEN *TYLENOL* 1GM PO X2 HR WHEN *FEBRILE* 120'S *SHAKING* *CHILLS* CONTINUES ON *OXACILLIN* CULTURES STILL PNDING, EYES *EDEMATOUS* ERYTHEMATOUS GREEN-YELLOW EXUDATE GIVEN *POLYSPORIN* OU AS DIRECTED

NEURO

A/O X3 MAE FC STRENGHT NL EQUAL BILATERALLY INCISION RT FRONTAL HEALED C+D

CARDIAC

HR 104-125 ST WITHOUT ECTOPY BP 90/-120/ REPEAT K+ 3.9 AFTER 40 MEQ KCL IV AND 1/2 DOSE OF KPHOSPHATE SKIN W+D PP PRESENT

RESP

O2 SAT 2LNP 95-100% LUNGS CTA

GI

POOR PO INTAKE MOUTH WITH *ULCERATIONS* REFUSING SECOND DOSE OF *NYSTATIN* AND REFUSING *KAOPECTATE*, *BENADRYL* LIDO SOL. ABD SNT BS+4 NO BM

GU

FOLEY U/O > 100CC Q HR BUN AND CR WNL

SKIN

FACE ERYTHEMATOUS *RASH* YELLOW PUSTULES NO D/C NOTED MOUTH ULCERATION THROUGHOUT LIPS CRUSTY, UPPER CHEST AND BACK ERYTHEMATOUS WITH *BLISTERS* NO OPEN AREAS, LOWER TRUNK SCATTERED ERYTHEMATOUS RASH

EXTREMITIES

SCATTERED ERYTHEMATOUS RASH

ACCESS

ONE 20 G PERIPHERIAL LL ARMPAIN GIVEN *MSO4* 2MG IV X2 WITH GOOD EFFECT

A

*STEVEN JOHNSON SYNDROME* SECONDARY TO *DILANTIN* *HYPOKALEMIA* POOR ACCESS

P

MONITOR TEMPS AWAIT CX PRO

P

*OXACILLIN* *TYLENOL* TEMP COOLING BLANKET AS NEEDED MONITOR LYTES REPLETE AS ORDERED IV FLUID AT 200CC QHRIV TO PLACE PICC LINE HAVE IV OBTAIN LABS AT THAT TIME

MICU Nursing Progress Note 7a-7p:

Neuro

Pt alert and oriented x 3. Pt slow to respond at times. Equal strength bilaterally. Moving all extremities with purpose. Pt incontinent of stool x 1. Team notified.

CV

ST 108-120 no ectopy. HR to 131 with temp. Denies CP. SBP 97-120. K+ 3.9. Pt receiving IVF with to K+ for repletion. Pt to rec KPhos IV w/a for pharmacy. Mg 1.6 repleted with 2gm IV.HCT 27.7 (29.4).

PULM

LS cta. 2.5L NP sats 97%. 93% on Rm air. Pt denies SOB.

GI

Abd soft NT +BS. Pt taking sips of water. Pt denies n/v. Pt had large ob- brown stool.

GU

Foley cath patent draining cyu. +7062 LOS. Goal to maintain positive fluid balance.

ID

T max 101.2 R. +*rigors*. Pt conts on *oxacillin* iv. All cultures pending. Pt rec'd *tylenol* 1gram q4hr.

SKIN

Pt conts with pustulas on face and chest, no drainage. Lips with many scabbed areas. Are yellow and red. Back with *rash* along with abd. Legs essentially clear. Pt c/o doscomfort on back. Warm soaks administred and sauve appiled. Pt to receive domboro soaks to face tonight. Conts on IV *steroids*. *Nystatin* for *oral ulcers* . Pt refusing KBL solution.

Opth

Eyes with minimal yellow discharge. c/o blurred vision secondary to ointment. Steroid gtts a/o. Pt denies *pain* in eyes or double vision.

LINES

2 piv. Pt evaluated for PICC line, plan for placement in am.

DISPO

Full Code

SOCIAL

Husband and son in to visit. Pt living with husband pta and working as an interior decorator.

P

Follow neuro status. follow temp curve. replace electrolytes. po's as tolerated. skin and eye care a/o. provide support.

MICU Nursing Progress Note 7a-7p:

Neuro

Pt alert and oriented x 3. Pt lethargic today, opening eyes to name and answering questions appropriately. Pt conts to be slow to respond to questions. Moving all extremities spontaneously, no deficits noted. Pt denies HA/*dizziness*. Pt log rolling with assistance. ?PT consult.

CV

ST 109-120 ST. Pt had two 10 beat runs and one 9 beat run of SVT s/p PICC line placement. Stable BP, VT nonsustained. Pt denies CP/SOB. EKG and echo obtained. Cyclying enzymes first CK 69. Cardiology consulted, awaiting echo report. Pt to be started on *beta blocker* for treatment of NSVT. ? secondary to severe illness.K+ 3.4 IV. IVF with 20meq KCL at 200cc/hr. S/p NSVT pt rec'd 40meq po and 40 meq IV KCL. K+ 3.9, repeat K+ at 8pm. Mg and Ca repleted. Please follow electrolyte SS.

PULM

LS diminshed bibasilary. Pt encouraged to *cough* and deep breath. Sats 88-91% on Rm air. 94-97%on 2L NC. RR 16-24. Pt denies SOB.

GI

Abd soft NT +BS. Pt having brown liquid stool on bedpan. Pt taking sips of water. *Oral ulcers* very painful with po's.

GU

Foley cath patent draining cyu. Pt is auto diuresing u/o 300-400cc/hr. Goal is to maintian positive fluid status +8740 LOS.

ID

t max 102.2 R. Pt receiving *tylenol* 1gram po. No further culture results. Conts on IV abx.

SKIN

Facial and back pustulas oozing. Domboro soaks to face only. Steroid cream appiled to face, back, chest and trunk. Pt conts on IV *solumedrol*. Skin remains red and *sore*. Skin on lips slothing off. Eyes with decreased *inflammation*. Pt denies blurred or double vision. No *pain* med administred. Goal per Derm is to keep pt's skin moist.

PROPH

Hep sc and protonix.

LINES

1 piv. R antecub PICC line placed at bedside per IV team. CXR revealed cath in r atrium. Cath pulled back and verified per repeat CXR to be mid svc.

DISPO

Full Code

SOCIAL

Involved and supportive family. Pt living at home PTA.

A

Admittted with *Steven's Johnson Syndrome* and *fevers*.

P

labs at 8pm. Replete electrolytes as indicated. Skin care. Follow temp curve *Beta blocker* w/a Provide support.

CCU NURSING PROGRESS NOTE 7A-3P

NEURO

intact. Cooperative.

RESP

LS essentially clear; diminished right base only. Sats 96% on room air.

CARDIAC

BP 120-140's most of the day. Dipped to mid 90's after *lopressor* which has since been dc'd. One episode of ?VT with pt turning and rigoring at same time. BP stable. Pt asymptomatic.HR 105-110's up to 130's with *fever* spike.

GI

Minimal po intake. Taking sips of liquid with meds only. Passed small amt soft brown stool x1. +*flatus*. To begin TPN this evening via PICC line. IVF changed to NS @100cc/hr. Will follow QID FS aswell with initiation of TPN.

GU

foley draining ~100cc/hr clear yellow urine.

ID

T max 103 with *rigors* this afternoon. One set bld cx's drawn via PICC line (unable to draw peripherally). Team aware. Pt given 1gm *tylenol*. *Rigors* appear to be subsiding. Pt conts on IV *oxacillin*.

SKIN

Pt conts with red raised *rash* over arms, trunk, back, buttocks, pubic area and upper thighs. Open areas on face and back. Skin care nurse consulted.

the following recommedations have been made

A&D to open areas on face. *Adaptic* and exu-dry dressing to open areas on back. Foam cleanser for baths...no soap, powder or lotions. 1st step mattress ordered. Pt denies *pain* over skin, however states her *oral ulcers* are very *sore*. has been taking *nystatin* and KBL mouthwashes with good effect. No *pain* meds requested this shift.

MICU NSG ADMIT NOTE Mrs. C is a 56yo female rec'd as trans from F5. She had been at BIDMC July 2001 for a craineotomy for a benign *lesion* and sent home on *Dilantin* as prophalaxis 7/19/01. She did well at home until 2days PTA when she developed loss of appetite, eye discharge, *fever*, +*conjunctivitis* and a *rash* rapidly increasing over body, starting with upper body, head, trunk and moving toward thighs. She was S/B her MD and admitted with *Stevens-Johnsons syndrome* . She was initially on F5 however trans toMICU for more freq observations, q1h eye gtts. Tmax on floor=105. AX. She developed GI involvement, placed on TPN. PMH significant for *hypercholesterolemia*, *depression*, ha for 1-1.5yrs prior to craine and C-section.

CURRENT STATUS

NEURO

A+Ox3. Speech clear. MAE ad lib. Unable to assess pupils as pts eyes swollen shut, writer unable to open them wide enough to assess pupil reaction.

CV/Pulm

VS per carevue. Room air with sats 90's. BS clear, diminished bil. 2lumen PICC L brachial patent, dsg D+I.

GI/GU

NPO. On TPN. U/O qs via foley.

ID

Tmax=99.0AX. No change in meds thus far (MD's writing orders at this time).

Integ

Face, back, arms, trunk, hands red, raw with open areas. Thighs, lower legs, feet with *rash* apperance. A+D to face. Eye gtts to eyes. Mouth care given. *Adaptic* to open areas on back, trunk.

Psychosocial

Family in with pt. Emotional support given to pt and fam. Pt sleeping unless awakened for care.

NPN 7PM-7AM:

RESP

RR generally 18-20, non-labored, with sats 92-94% RA. During the evening sat dropping to 88% with no apparent cause pt asymptomatic. 50% FT positioned in front of mouth/nose for some blow-by O2 (did not want to further compromise skin by using strap. Pt later c/o slight difficulty breathing, but felt it was d/t nasal congestion. Gently suctioned nares several times O/N, with NS instillation once (pt asked me not to repeat it). At 3AM, while pt was sleeping, sats suddenly dropped to low 80's. Pt found to be rhochorous, labored, and very difficult to arouse. With 100% FT held to mouth/nose,and vigorous *shaking*, calling her, she eventually awoke. She was able to clear the secretions by clearing throat/swallowing, and returned to baseline MS. Sats back up to 92-94% on RA rest of night. Concern raised over possibility of PE. Pt was to go for CT angio (as well as head CT), but she refused. Will reassess this AM if episodes persist. CXR showed ? LLL consolidation; to be repeated this AM.

C-V

HR as high as 150 ST with *fever*. No VEA. EKG without *ischemic* changes.

ID

Tmax 104.7ax, currently 99.7. Getting *Tylenol* q6 RTC. Started on IV Vanco for +BC from PICC. BCX 2 sent, as well as urine. If 2nd BC from PICC comes back positive, line will need to be D/C'd, and access will be a problem.

F/E

Got 1L NS bolus during the evening. Now getting 2nd of 2L NS at 150cc/hr. Mg repleted.

HEME

24-25. Clot to BB, and 2U on hold. To be transfused this AM if Hct remains

NEURO

ALERT AND ORIENTED X3. UNABLE TO ASSESS PUPILS DUE TO PREIORBITAL *EDEMA*. TMAX 100.4. RECEIVING *TYLENOL* ATC.

CV

MONITOR SHOWS ST WITHOUT ECTOPY. VSS. AM LABS PENDING. PPX4 STRONG. S1S2 MURMUR NOTED.

RESP

RA SATS 96%. LUNGS CLEAR WITH DIMINISHED BASES. NO *COUGH* NOTED. DENIES ANY C/O SOB.

GI

UNABLE TO TOL PO EXCEPT FOR SMALL SIPS OF COLD WATER D/T *ULCERATIONS* OF ORAL CAVITY. RECEIVING TPN AT 72CC/HR. ABS. S/ND/NT.

GU

FOLEY DRAINING CLEAR YELLOW URINE IN ADEQUATE AMOUNTS.

INTEG

FACE/NECK/EARS/ARMS/TRUNK OF BODY WITH MACULAR *RASH* WITH OPEN AREAS. DRESSING WITH *ADAPTIC* PRN. APPLYING A+D OINTMENT TO FACE AND LIPS. SKIN RN FOLLOWING.

OPTHO

CONTINUES TO HAVE SEVERE PERIORBITAL *EDEMA*. UNABLE TO OPEN EYES. OPTHOMOLAGY FOLLOWING AND WEANING EYE DROPS AS TOLERATED.

ID

RECEIVING VANCO FOR 1/4 + BC. ONE TIME DOSE OF *DIFLUCAN* FOR VAGINAL YEAST *INFECTION*.

SOCIAL

FAMILY VERY INVOLVED. VISITS DAILY. UPDATED ON POC.

PLAN

CONTINUE CURRENT SKIN CARE REGIMIEN. FOLLOW HCT AND WBC. FOLLOW *FEVERS* AND CULTURE Q24 AS NEEDED. STRICT PRECAUTIONS.

RESP

SATS 92-98%. IMPROVED AFTER PT OOB AND AMBIN ROOM. LUNGS WITH DECREASED BS IN BASES. C/O NASAL CONGESTION.

CARD

REMAINS ST 118-130, RATE SENSITIVE TO BODY TEMP. BP 120-140/. NO PERIPHERAL *EDEMA* NOTED. REPLETED WITH KCL AND MAG SO4 IV.

GU

U/O BRISK, IVF INC TO 200CC/HR, BUT UNABLE TO RUN WITH *INSULIN* AT 200CC/HR, DECREASED TO 150CC/HR. TRYING TO KEEP PT 1L (+).

GI

CONTS ON TPN, TAKING PO'S IN SM SIPS. NO BM TODAY.

ENDO

CONTS ON *INSULIN* GTT. CURRENTLY 12U/HR. *INSULIN* TO BE INC IN TPN. BS 200'S.

NEURO

AMB IN ROOM WITH PT. OOB X 2 HOURS AND TOL WELL. TRANS BED TO CHAIR WITH MIN ASSIST.

SKIN

FACE AND BACK LESS RED. CONTS WITH A&D OINTMENT TO AFFECTED AREAS PRN. *ADAPTIC* DSG'S TO BACKAND CHEST. SPOKE WITH SKIN CARE RN, AND BURN VESTS WILL BE IN TOMORROW. VAGINAL AREA CONTS WITH FOUL SMELL AND CLEAR DISCHARGE, ? BACTERIAL VAGINOSIS. AWATING VAG CREAM FROM PHARMACY. OPTHAMOLOGYIN TO EXAMINE PT, EYES CONT TO SLOWLY IMPROVE. DERM ALSO BY TO EVAL PT.

SOCIAL

HUSBAND AND PT'S RABBI IN TO VISIT. PT IN BETTER SPIRITS THIS AFTERNOON AFTER VISITS. HUSBAND UPDATED ON PT'S CONDITION AND PLAN. ? WILL BE CALLED OUT ONCE BS UNDER CONTROL. WILL NEED PRIVATE ROOM FOR REVERSE/BURN PRECAUTIONS. HUSBAND EXPRESSING CONCERNS OVER PT HAVING BEEN IN SEMI-PRIVATE ROOM IN PAST.

PMICU NSG PROGRESS NOTE:

Neuro

no changes, A&O X3, medicated with MS 1mg x2 for general discomfort during night with good effect. Able to move well in bed.

Resp

c/o nasal stuffines and unable to blow nose. lungs clear, sats high to mid 90's.

cardica

ST-BP stable.

GI

TPN, NPO except sips of water and liquid *tylenol*. + *oral ulcers* with some *bleeding*. *Insulin* drip- Blood sugars from 80 to 214 and *insulin* off to 8U hour. Presently at 8U and bs is about 120's. *insulin* now added to TPN as of 8PM.

GU

foley with u/o over 200-300 in some hours. approx 1 liter + for yesterday. miconizole cream for vagianl *infection* startd. + dischagre and foul odor.

skin

dsg changes done after skin cleansed with sterile water. approx 2 hours to complete skin care.Pt requires high level of nursing care due to skin sluffing. and meticulous precautions to prevent *infection*. Unable to do anything for herself. Steroid taper, nooo new lesions. labs pending for this morining. spirits remain good. Family supportive.

Plan

support pt and family, skin care and precautions. cleanse gently with warm sterile water. follow blood sugars. OOB today to chair and ambulate in room with assistance. Once off *insulin* drip pt may be transferred to floor but she does require a high amount of nursing time.

REVIEW OF SYSTEMS

NEURO

ALERT AND ORIENTED X3. MOST COOPERATIVE WITH CARE.

RESP

SATS 93-95% ON RA. BS CLEAR DIMINISHED AT THE BASES. RESP MID TEENS. CONTINUES ON NS AT 150CC/HR TO ACCOUNT FOR INSENSIBLE LOSSES. POS 320 SO FAR THIS SHIFT.CARDIAC. REMAINS TACHY 118-130. SBP 120-130.

GI

TOLERATING SIPS OF H20. RECEIVING MOUTH CARE AS ORDERED. CONTINUES ON TPN.

GU

FOLEY PATENT DRAINING CLEAR YELLOW URINE 110-400CC/HR.

ENDO

ON 6U/HR WITH 50U REG *INSULIN* IN TPN BS 94-128. TPN WRITTEN FOR TODAY TO CONTAIN 100U REG *INSULIN*.

SKIN

SKIN CARE CONTINUES WITH A AND D OINTMENT TO FACE UPPER CHEST AND UPPER BACK. ALSO *ADAPTIC* TOCHEST AND BACK. SOFTSORB VEST ALSO ARRIVED TODAY. VIVIAN SEIDE SKIN CARE SPECIALIST UP TO ASSIST WITH APPLICATION OF VEST. PATIENT TO TRIAL THIS TO SEE IF SHE LIKES IT OR NOT. *ADAPTIC* DOES NOT NEED TOBE USED UNDER THE VEST.

DISPO

REMAINS IN UNIT DUE TO BS ISSUES AND DUE TO NURSING CARE REQUIRED TO DO SKIN CARE.

PAIN

PATIENT OFFERED *PAIN* MED FOR GENERALIZED *PAIN* FROM SKIN LESIONS THIS AM. SHE REFUSED. FELT THE *PAIN* WAS NOT THAT SEVERE ENOUGH TO TAKE IT.

PMICU NSG PROGRESS NOTE: continues to progress with improved mobility and ability to open eyes. face and trunk cleansed with sterile water. A&D applied and vest reapplied. skin improved over lasst night. No s/s *infection*, afebrile. tyenol q 6 hours for *pain* with effect. MS 2 mg X1 given for discomfort at bedtime and pt slept well. no resp or cardicac decompensation despite ST one teens to . tolerating sips po well of water only. large amount of greenish foul smelling drainage from peri area. Cleasned x2 with some effect. Anti fungal cream inserted vaginally. foley patent and drainig fair to large amts of urine.Pt continues on IV *insulin*, 100 untis *Insulin* now in tpn and pt stable on 3 U IV *insulin* and blood sugars under 150 and above 110. *prednisone* taper.

Plan

continue meticulous skin care and precautions, follow cultures, temps, assist with rom and adl. OOB after skin care. follow vaginal *infection* and reeval after 3 days of treatment. Yesterday wasday # 2. Monitor blood sugars and decrease *insulin* when able.

NEURO

TMAX 100.6. A+OX3. PERRLA. MAE. OOB TO CHAIR. DENIES ANY C/O.

CV

REMAINS TACHY. HCT 24. RECHECK FROM 1730 PENDING. PPX4. S1S2. *INSULIN* GTT D/C'D THIS AM. SUGARS STABLE.

RESP

RA SATS 96%. LUNGS CLEAR. NO *COUGH*.

GI

TOL PO WELL. ABS. ABD S/ND/NT.

GU

DRAINING CLEAR YELLOW URINE IN ADEQUATE AMOUNTS.

INTEG

SKIN ON TORSO, FACE, HANDS, NECK AND BACK WITH BREAKDOWN/ *RASH*. APPLYING A+D OINTMENT APPLIED. SKIN RN FOLLOWING.

SOCIAL

HUSBAND AT BEDSIDE. QUESTIONS ANSWERED.

PLAN

FOLLOW SUGAR. CONTINUE SKIN CARE REGIMINE.

PT/RSD

S

no new c/o

O

Pt seen to address goals set at initial evaluation and re-evaluation documented previously in chart

Rx

Pt instructed in supine therapeutic exercises for bilateral lower extremities times ten each. Pt too fatigued to get out of bed for further rx as she was up in chair this afternoon.

Vital Signs

HR 120-127 with exercise

A

Pt will benefit from continued physical therapy services to prevent deconditioning. Pt should ambulate with assist 1-2 times per day and perform sitting/supine exercises as tolerated during the day.

P

F/U 8/20Time Frame: 5:30-6:00pm

pt's face, trunk and chest continue to improve w/daily cleansing and application of a&d ointment.oral *ulcerations* *bleeding* intermittently w/mouth care although pt states she is getting some relief from a&d ointment. she continues to c/o a *sore* throat and is taking sips of water only tonoc. less vaginal discharge noted tonoc. she requested and received *mso4* ivp x1 for c/o discomfort w/good effect.

respiratory

on room air w/sats >94%. lung exam essentially cta.

cardiac

100-120's, st w/o ectopy. less tacycardic as the noc has progressed.

gu

foley intact draining clear urine w/uo >100cc/hr. receiving maintainence fluid.

gi

abd soft w/+bs. denies *pain* n/v. taking only sips of water d/t *sore* throat.

neuro

a&o x3; able to cooperate w/care. she has been geeting oob to chair daily.

endo

doing well off of an *insulin* qtt. fs range 165 to 145. she received *insulin* twice per slidingscale parameters.

access

line patent and intact.

dispo

pt is medically stable for transfer to the floor but continues to require much nursing time.

REIVEW OF SYSTEMS

NEURO

ALERT AND ORIENTED X3. VERY COOPERATIVE WITH CARE.

RESP

ON RA SATS IN THE MID 90'S. RESP 18-20. NO C/O SOB. BS CLEAR.

CARDIAC

HR ONE TEENS TO ONE TWENTIES. SBP 120-130. IV FLUIDS INCREASED TO NS AT 200CC/HR X2L AS PATIENT WAS SLIHGTLY NEG YESTERDAY. GOAL IS TO KKEP PATIENT 1 LITER POS QD DUE TO PATIENT'S INSENSIBLELOSSES.

GI

TAKING SIPS H20, GINGERALE, AND SMALL AMOUNTS OF ITALIAN ICE. ABD SOFT WITH POS BS. CONTINUES ONTPN.

GU

UO VIA FOLEY CATH 100-240CC/HR.

ENDO

BS 150-170 TX WITH SS *INSULIN*.

SKIN

SKIN CONTINUES TO IMPROVE. FACE APPEARS MUCH IMPROVED FROM 2 DAYS AGO. CONTINUES WITH AGGRESSIVE SKIN CARE.

MOBILITY

OOB TO CHAIR X5 HOURS TODAY.

PAIN

PATIENT FEELS OVERALL MUCH IMPROVED. ABLE TO TALK BETTER, MOVE BETTER AND TAKE SIPS W/O AS MUCH *PAIN*. PATIENT ALSO APPEARS MUCH MORE COMFORTABLE WITH SKIN CARE THEN SHE DID A COUPLE DAYS AGO. SHE IS NO LONGER WINCING WHEN EYE CARE AND OUTH CARE DONE.

DISPO

MEDICALLY CLEARED TO GO TO FLOOR. DOES REQUIRE MANY NURSING CARE HOURS. WILL REMAIN IN THE MICU OVER THE WEEKEND. ? TRANSFER TO FLOOR ON MONDAY.

SOCIAL

PATIENT'S SISTER IN TO VISIT MOST OF THE DAY.

pt had an uneventful noc; she received 25mg ivp *benadryl* x2 w/excellent effect, sleeping about 6hrs overnoc.

respiratory

lungs cta w/ra sats >93%. denies c/o sob.

cardiac

hr 110's, st w/o ectopy. sbp range 120-150's overnoc.

neuro

a&o x3, able to cooperate w/care.

gu

to put out large amts of urine but completed yesterday ~1 liter positive. however, she is again negative for today and may require more aggressive fluid hydration.

gi

pt had a small, loose bm last evening. abd is soft, nontender w/+bs. she continues to c/o a moderate amt of throat discomfort. mouth care provided overnoc.

endocrine

fs frequency reduced to qid and ranged 144-120 overnoc. she did not receive any *insulin* per sliding scale parameters.

skin

skin care provided to face, chest, and trunk. pt c/o feeling "*itchy*" and received *benadryl* x2 w/good effect. vest was not reapplied per the pt's request, but aquaphor was placed over affected areas after a&d was applied to the skin. pericare provided although there continues to be large amtsof foul smelling vaginal discharge d/t her yeast *infection*.

REVIEW OF SYSTEMS

NEURO

REMAINS ALERT AND ORIENTED X3.

RESP

BS REMAIN CLEAR. RESP 18-20. SATS 94-96% ON RA.

CARDIAC

REMAINS TACHY IN THE 120'S. CONTINUING TO RECEIVE NS AT 150CC/HR. 1L NS BOLUS GIVEN. HR AFTER BOLUS 110-120. WAS TO RECEIVE 2U PRBC FOR HCT 24.8 [ PATIENT HAS *ANEMIA* OF CHRONIC NATURE. HER HCT HAS BEEN AROUND 25 THE PAST FEW DAY} NURSE SPOKE TO PATIENT ABOUT REASON FOR BLOOD TRANSFUSION. SHE FELT SHE ONLY WANTED PRBC IF IT WAS AN EMERGENCY SITUATION. DR H ALSO SPOKE TO THE PATIENTAND SHE AGAIN REFUSED. PATIENT UNCOMFORTABLE ON THE MONITOR. LEADS KEEP POPPING OFF DUE TO A AND D ON SKIN. AFFECT HER ABILITY TO MOVE AROUND. DR H NOTIFIED AND ORDER WRITTEN THAT MONITOR COULDBE DC'D WHICH IT WAS.

GI

TAKING SIPS H2O, GINGERALE, AND ITALIAN ICE. ABD SOFT DISTENDED WITH POS BS.

GU

CONTINUE TO PUT OUT LARGE AMOUNTS OF URINE. IS APPROXIMATELY 1 L POS TODAY.

SKIN

SKIN CONTINUES TO IMPROVE. CONTINUES WITH METICULOUS SKIN CARE. SKIN LESS *ITCHY* TODAY.

DISPO

TO ? VICU IN AM.

SOCIAL

PATIENT WITH MULT PHONE CALLS TODAY. SON AND DAUGHTER IN LAW IN TO VISIT. HUSBAND TO BE IN LATER THIS EVENING.

pt accidentally pulled out the hubs connected to her picc line last evening. iv therapy subsequently pulled the line out and placed a #20 angio in her left hand. she will need to go back to ir today to have the picc line reinserted under flouro. otherwise, she had an uneventful noc; she received *benadryl* w/good effect and was able to sleep for most of the noc.

respiratory

lungs cta w/sats >94% on room air. no c/o sob.

cardiac

hr 120's, st. sbp 120's. she remains off of telemetry.

neuro

a&o x3, pleasant and cooperative w/care.

gi

abd soft, nontender w/+bs. she had a small, loose bm last evening. tpn on hold d/t lack of central access. she is taking sips of water overnoc but claims that her *sore* throat has improved w/use of the kbl solution.

gu

continues to autodiurese @200cc/hr w/a negative tfb despite ivf repletion. ?need for more aggressive replacement considering insensible loss of fluid.

endocrine

fs 106-116 off of tpn overnoc. she did not require any *insulin* per sliding scale parameters.

skin

skin care to face, chest, and trunk with a&d ointment provided. she continues to c/o purities and received *benadryl* w/excellent effect. vaginal yeast *infection* has also improved w/less discharge.

dispo

anticipate transfer to medicine later today.

D

PT ALERT AND ORIENTD. PLEASANT AND TALKATIVE. O2 SATS 96% ON RA. LUNGS CTA. C/O DRY *COUGH* AND CAN HAVE COOL MIST NEBS AS NEEDED. ABD SOFT AND NONTENDER. C/O *SORENESS* TO BACK OF THROAT BUT HAS BEEN TAKING SIPS OF H2O. STILL AWAITING NEW PICC LINE PLACEMENT UNDER FLUORO THUS TPN ON HOLD. STEROID INDUCED *HYPERGLYCEMIA* WHICH IS NOW BETTER CONTROLLED. BS AT 1200=118 NOT REQUIRING TX. SM AMT OF LIQ BROWN STOOL GUIAC NEG. UO ADEQUATE VIA FOLEY CATH. MAINTENANCE IV CHANGED TO D5 1/2 NS AT 150CC'S/HR. SKIN HAS IMPRVOED AND DERM CONTINUES TO FOLLOW PT. THEY STATE THAT SHE CAN NOW SHOWER USING BASIS SOAP. AND A&D UNG CAHNGED TO HYDRATED *PETROLATUM*. CONITNUE WITH BURN PRECAUTIONS AND MEDICAL TX.