

Exam Date: **03/20/08**

Patient ID: **499201**

Doctor: **Anderson, John**

Patient Name: **John Smith**

DOB: **09/19/77**

Gender: **Male**

CHECK-IN QUESTIONS

User: edalton

Admitted from: **Home**

Admitted via: **Ambulatory**

Responsible adult to drive home: **Spouse**

Driver location: **Waiting Room**

Driver's name and phone: **Cindy Smith**

Patient ID verified? **YES**

Verified using at least 2: **Date of birth, Full legal name, Verbal**

Person who verified: **E. Dalton**

Consent signed? **YES**

Consent signed by: **Patient**

Witness: **E. Dalton**

Surgical site marked? **YES**

Person who marked site: **E. Dalton**

Witness: **M. Jones**

ID bracelet on? **YES**

Allergy bracelet on? **YES**

H & P completed? **YES**

Pre-op studies available: **N/A**

Site prep completed? **N/A**

Does the patient have any advance directives? **NO**

Patient items removed: **Contact lenses**

Patient clothing and valuables: **Locked in locker**

New piercings that cannot be removed? **NO**

NPO since: **> 6 hours ago**

Void before procedure? **YES**

Patient education completed: **Introduction to staff / environment, Procedure review, Pain management, Crutch training**

ALLERGIES

Substance	Reaction
Penicillin	rash
Latex Allergy	Patient denies allergy
Iodine Allergy	Patient denies allergy
Food Allergy	Patient denies allergy

CURRENT MEDICATIONS

Aspirin use: Patient denies use

NSAID use: Yes (see below)

Anticoagulant use: Patient denies use

Herbal use: Patient denies use

Medication	Dosage	Last Taken
Ibuprofen	400mg 2x per day	>24 hours

HEALTH HISTORY

User: edalton

Medical History

Gender: **Male**

Cardiovascular? **NO**

Pulmonary? **NO**

GI? **NO**

Diabetes? **NO**

Renal/Endocrine? **NO**

Neuro/musculoskeletal? **YES**

Neuro/musculoskeletal diagnoses: **Limited ROM**

Miscellaneous? **NO**

Psychiatric? **NO**
 Pregnancy status: **N/A**
 Recent illness or infection? **NO**
 Usual diet (specify): **Normal dietary habits**

Surgical History

Previous non-GI surgery? **NO**
 Previous GI surgery? **NO**

Social History

Tobacco history? **NO**
 Alcohol history? **NO**
 Recreational drug use? **NO**
 Entire health history obtained from: **Patient**

PATIENT ASSESSMENT

User: edalton

Does the patient currently have pain? **NO**
 Acceptable (goal) pain level: **0**
 Pain scale instruction: **1-10**
 Baseline behavior: **Calm**
 Baseline orientation: **Person, Place, Time, Situation**
 Respiratory assessment: **Breath sounds clear / equal**
 Skin assessment: **Warm, Dry, Pink**
 Patient verbalizes understanding of operative routine? **YES**
 Patient cares for: **Self**
 Patient receives care from: **N/A**
 Knowledge level of patient and family: **Excellent**
 Motivation to learn: **Excellent**
 Barriers to learning: **NONE**
 Family/Escort allowed to visit Post-op? **YES**
 Body Mass Index (BMI): **height(in): 70, weight(lbs): 190, BMI: 27.3**
 Preoperative Nursing Diagnosis:

SPECIAL NEEDS

User: edalton

Need for prophylactic antibiotics? **NO**
 History of problems with anesthesia? **YES**
 Anesthesia reaction: **Prolonged sedation**
 History of difficult IV access? **NO**
 Venous access device? **NO**
 Implanted cardiac device? **NO**
 Removeable dental work? **NO**
 Non-cardiac implants? **NO**
 Prosthetics? **NO**
 Unable to lie flat? **NO**
 Nursing Home patient? **NO**
 Barrier to care? **NO**
 Primary language is English? **YES**
 Patient's race: **White**
 Patient's ethnicity: **Not Hispanic / Latino**

PROCEDURE BEGIN

User: edalton

Operating Room Number

Operating/Procedure room: **OR 1**

Time-Out

TIME-OUT Universal Protocol? **YES**
 Just before starting the procedure, ALL members of the operative team verify CORRECT PATIENT, CORRECT PROCEDURE, and CORRECT SITE? **YES**
 Staff members performing Time-Out: **Surgeon, Assistant, Circulating RN**

Anesthesia Type

Anesthesia type: **General**

Equipment

Equipment utilized? **NO**

X-Ray equipment utilized? **NO**

Patient Positioning

Patient position: **Supine**
Positioning adjuncts used? **YES**
Adjuncts used: **Gel rolls, Well-leg holder**
Skin integrity maintained after positioning? **YES**

Prep

Prep done: **Providine iodine solution**
Prep completed by: **E. Dalton**

Staff

Surgeon: **J. Anderson**
Assistant: **M. Kelly**
Anesthesiologist: **E. Brown**
CRNA: **N/A**
Circulating RN: **E. Dalton**
Scrub RN: **S. Mith**
Other:

PROCEDURE END

User: edalton

Aseptic Technique

Aseptic technique maintained throughout? **YES**

Drains/Dressings/Splintings

Drains used? **NO**
Dressings applied? **YES**
Dressings: **Steri-Strips, 4x4s, TED hose, Tegaderm**
Splints/Immobilizers? **NO**

Pain Pump

Pain pump? **NO**

Surgical Counts

Pre-op/Initial count: **YES**
Sponge count: **Taken**
Needle/Sharp count: **Taken**
Instrument count: **Taken**
First Count: **N/A**
Final Count: **YES**
Sponge count: **Correct**
Needle/Sharp count: **Correct**
Instrument count: **Correct**

Wound Classification

Surgical wound classification:

UNANTICIPATED EVENTS

Unanticipated events?

RECOVERY QUESTIONS

User: edalton

Patient transferred by and report received from: **E. Dalton**
Siderails up on bed upon receipt of patient? **YES**
Patient orientation: **Person, Place, Time**
Pain level: **1**
Skin assessment: **Warm, Dry, Pink**
Surgical wound classification:
Elevation of extremity: **Right lower**
Ice: **Ice Bag**
Postoperative Nursing Diagnosis:

DISCHARGE QUESTIONS

User: edalton

Level of Consciousness: **Alert, Oriented**
Pain level: **0**
Oxygen saturation on room air $\geq 94\%$ or equal to pre-sedation state? **YES**
Able to ambulate independently (or at baseline)? **YES**

Swallow, cough, gag reflexes present? **YES**
 Voided? **YES**
 Able to take PO fluids? **YES**
 Final Aldrete Score 8-10 based on pre-sedation baseline? **YES**
 Patient meets discharge criteria as set by physician and approved by facility? **YES**
 Driver location: **Waiting Room**
 Driver's name and phone: **Cindy Smith**
 Discharge Instructions given for: Diet: **Resume normal diet as tolerated**
 Limitations: **Do not drive for 24 hours**
 Wound care: **Remove dressing tomorrow morning**
 Pain control: **Take prescription pain medications as ordered**
 Call MD for complications: **Increased or persistent redness around IV or surgical site**
 Follow-up appointment: **Please call your doctor's office for follow-up appointment within 1 week**
 Prescriptions: **Prescriptions are attached to instructions**
 Verbalizes understanding of discharge instructions? **YES**
 Discharge instructions given to: **Spouse**
 Equipment and instructions given: **Crutches**
 Patient items removed: **Contact lenses**
 Patient clothing and valuables: **Locked in locker**
 Patient's valuables returned?
 Discharged to: **Home**
 Discharged under the care of: **Spouse**
 Discharged via: **crutches**

Medications				
Time	Medication	Dose	Entered By	Notes
19:56:03	Ancef	1 g Total: 1 g	edalton	No Notes Taken

Aldrete Score								
Time	Activity	BP	Heart Rate	LOC	O2 Sat	Total Score	Entered By	Notes
20:25:19	2	2	2	2	2	10	edalton	No Notes Taken

Vitals												
Time	BP	HR	RESP	O2 Sat	CO2	O2 Insp	ET	Temp	Tidal Vol	Peak Press	Peep	Entered By
19:56:10	126/84	86	13	97	-	-	-	-	-	-	-	edalton
19:58:37	126/84	88	13	94	-	-	-	-	-	-	-	edalton
19:59:38	132/88	86	14	97	-	-	-	-	-	-	-	edalton
20:00:02	118/76	86	13	97	-	-	-	-	-	-	-	edalton
20:00:21	118/76	88	14	96	-	-	-	-	-	-	-	edalton
20:01:26	126/84	82	12	98	-	-	-	-	-	-	-	edalton
20:04:05	132/88	88	13	94	-	-	-	-	-	-	-	edalton
20:24:59	118/76	88	13	96	-	-	-	-	-	-	-	edalton

Notes
No notes entered

PROCEDURE LOG

Time	Data	Entered By
20:03:00	Cardiac rhythm : Normal Sinus	edalton
20:00:16	Tourniquet applied : DOWN	edalton
19:59:56	Grounding pad? : Pad site : -,Skin condition (pre-cautery) : -,Skin condition (post-cautery) : Intact, -	edalton
19:59:14	Endopearl: 1 Linvatec No Manufacturer Id ACL Fix 928297321 Yes	edalton
19:58:58	Tourniquet applied : UP	edalton
19:58:47	Grounding pad? : Pad site : Left Flank,Skin condition (pre-cautery) : Intact, -,Skin condition (post-cautery) : -	edalton

Time Tracking		
Time	Event	Entered By
20:25:23	Discharged	edalton
20:04:15	Out of PACU	edalton
20:02:00	Into PACU	edalton
20:01:35	Out of Procedure	edalton
20:01:32	Procedure Stop	edalton
19:56:39	Procedure Start	edalton
19:56:29	Into Procedure	edalton
19:52:00	Admit	edalton

IV Fluid				
Time	Type	Amount Hung	Entered By	Notes
19:55:57	Normal Saline	250 cc Total: 250 cc	edalton	No Notes Entered

Provider Signatures

Emily Dalton, RN (edalton) **ESIGNED - 03/20/08 20:39:44**