

# Scenario 2(TEN-ARDS)

---

## Contents

Med Rec Note ..... 1  
H&P ..... 1  
USAISR Bronchoscopy Proc/Image ..... **Error! Bookmark not defined.**  
Nursing Admission History ..... 7

## Med Rec Note

---

**DOB:** 10 October 1992

**Gender:** Male

**HT:** 70 in

**WT:** 70 kg

**Pregnant:** No

**Lactating:** No

**Allergies:** Septra

**Source:** Other: Medical Records from Austin

### Additional Medications:

Drug Name	Current Taking	Dosing Instructions	Inpatient Plan
Propofol	Yes	Drip	Yes

**Signature:** Blank

**Time/Date:** Blank

## H&P

---

**Name:** TBD

**Clinical Service:** Burn Service 4E  
**Attending on Admit:** (NAME)  
**Trauma:** No  
**Trauma Number:** NA  
**Primary Care Manager:** NA  
**Primary Care Clinic:** NA  
**Attending on Admit:** (NAME)  
**Admission Date:** Today  
**Admission Time:** 0400  
**Discharge last 30 days:** No  
**Acute Burn/Injury:** First Admission  
**Time of Burn:** blank  
**Date of Onset:** T-1  
**Registry Items:** Blank  
**Information Sources:** Other  
**Admission Diagnosis:** TEN  
**Etiology of Burn:** NA  
**Chief Complaint:** TEN

**HPI:** 23 yo man presented to the the emergency room 2 days ago (on the evening of \_\_\_\_\_) after cutting his right hand while butchering a deer. The injury was sutured and he was given Septra as prophylaxis. The following morning he noticed a rash had begun over his entire body. He took his antibiotics that morning. The remainder of the day he was otherwise fine, but the rash continued to worsen. He took the antibiotic again that night thinking the rash would probably go away overnight while he slept. The next morning he began noticing that his eyes were feeling scratchy and his mouth had some discomfort. He stopped taking the antibiotic yesterday morning. For the rest of the day, he thought the discomfort in his eyes and mouth had improved some but noticed some blistering starting to form on his feet and legs. He developed a cough late in the afternoon and tried to go to bed early (around 2000). He woke around 2300 coughing and his eyes and mouth hurt. He called a friend who brought him to the emergency department.

In the ER he was noticed to have a “whole body rash” with some blisters on both legs, back and chest, with some ulcerations in his mouth and red eyes. On presentation, his SpO2 was 89% and it appeared he was developing ARDS. They intubated and sedated him. Given their high index of suspected for TEN they transferred him immediately to the USAISR.

[Version 2: Involved in a motorcycle crash 2 days ago when a car pulled out in front of him and he laid his back down And then collided with a pole.. At the scene he was noted to be confused and bleeding from extensive road rash. He was brought to a hospital in Austin where he underwent thorough evaluation by their trauma service. He was intubated for the evaluation due to his confusion. Injuries included, grade 2 liver laceration, extensive abrasions/soft tissue degloving injuries to the right arm, flank, buttocks, back, and right leg. Also found to have a small R sided SDH and L ICH. He had a seizure on the night of admission and was started on keppra. On the following day, he was noted to have a hole body rash. The keppra was stopped. The rash progressed to involve his oral mucosa and his eyes. He was transferred here overnight and arrived at 0400 this AM.]

**ROS:** Unable to Obtain

**PMH:** None

**Other Medical History:** None

**Immunization History:** Checked

**Last Tetanus Date:** Unknown

**Last Influenza Date:** None

**All others:** Blank

**Blood Transfusion History:** No history

**Past Surgical History:** None

**Other Surgical History:** NA

**Social History**

**Special Duty Status:** Blank

**Command Interest:** none;

**Tobacco Use:** Active; **Type:** Cigarettes; **PPD/Years/Pack Years:** all blank

**Alcohol Use:** Daily; **all others:** blank

**Recreational Drug Use:** Suspected; **all others:** blank

**Employment History:** Works for a butcher shop

**Living Situation:** Lives alone

**Other Social History:** Mother and father live in Dallas, Older sister lives in California

**Family History:** Non-contributory

**Physical Exam**

**Exam Time/Date:** Today at 0400

**Adt dosing wt:** 79

**Temp (F):** 100.6

**Temp (C):** Blank

**HR:** 135

**RR:** 24

**Pulse Ox:** 95%

**BP:** 113/56

**MAP:** 75

**Pain Score:** Blank

**O2 Therapy:** Ventilator

**Flow:** blank

**LPM/FiO2:** Vent

**Exam Date/Time:** Today, 0400

<b>Gen:</b>	Sedated on ventilator.
<b>Head:</b>	Erythematous rash with early blistering throughout.
<b>Mouth:</b>	Multiple ulcerations on the buccal mucosa with some bleeding and sloughing noted. ETT 24 cm at teeth.

<b>ENT:</b>	Rash as noted.
<b>Eyes:</b>	Pupils react sluggishly but symmetrically to light (3mm), eyes red b/l.
<b>Neck:</b>	no jugular vein distention.
<b>Chest:</b>	Confluent rash throughout with some blistering.
<b>Heart:</b>	Tachy, regular rhythm, no murmurs.
<b>Lungs:</b>	Crackles bilaterally. No wheezes. Occasional ronchi R>L.
<b>ABD:</b>	Soft, no apparent tenderness non-distended, + BS.
<b>Back:</b>	Confluent rash with some blistering.
<b>EXTREM:</b>	Confluent rash with some early blistering, R>L. + Nikolsky's sign on R arm. L palm with 4 cm laceration sutured without induration or fluctuate. Palm Erythematous (but same as rest of arm). No disproportionate calor.
<b>Skin:</b>	100% involvement, about 20% open.
<b>Neuro:</b>	GCS E3T; sedated
<b>Rectal:</b>	Deferred.
<b>GU:</b>	Rash involved penis and ulceration at meatus.
<b>VASC:</b>	2+ symmetrical pulses throughout.

**Labs**

WBC	22	Na	137	TP	6.8	Arterial pH	7.33
Hgb	15	K	4.2	Albumin	3.3	Arterial PaCO2	55
HCT	47	CL	108	Tbili	2.1	Arterial PaO2	65
PLTs	210	HCO3	24	Dbili	0.8	Arterial HCo3	22
INR	1.2	Gap	5	Alk Phos	55	Arterial SaO2	93
PT	15	BUN	30	AST	45	Arterial BD/BE	-5
PTT	27	Cr	1.2	ALT	49	Lactate (ABG or Lab)	2.8
		Glu	210				
		iCa	1				
		Mag	2.3				
		Phos	2.3				

**Multi-Drug Resistant Organism Status:**

MDRO Screening Plan: Admitted with exfoliating skin disease, No history of MDRO. Will order MDRO Screening

**Radiology**

CXR: Bilateral infiltrates c/w ARDS, ETT 7 CM from carina.

CT: NA

MRI: NA

Other: NA

ECG: NA

**Assessment and Plan**

**NSI/SI/VIS:** Very Seriously Ill (VSI)

**CHECK Narrative**

**NARRATIVE:**

Probable TEN with 20% open. No evidence of infection of hand wound. Will

- Consult dermatology for biopsy and recommendations
- Start IVIG empirically
- Silverlon per Dr. (NAME) since Silver Nitrate Shortage
- Adjust vent per RT Rec's.

**Tobacco Use:**

Yes

**Tobacco Cessation Counseling:** Practical counseling was not offered to the patient at the time of admission, or unable to determine if tobacco use treatment was provided from medical documentation.

**Tobacco Cessation Medication:** The Patient was not offered a prescription for an FDA-approved tobacco cessation medication, or unable to determine if tobacco use treatment was provided from medical record documentation.

**Prophylaxis**

**GI:** Protonix

**Other:** Blank

**VTE Risk:** VTE High risk

**Contraindications:** None

**VTE Prophylaxis Planned:** Enoxaparin (Lovenox) 30 mg SQ BID (Creatinine clearance > 30 ml/min)

**Active Code Status**

**Initial Resuscitation Status:** Full

**I have personally discussed... was part of this discussion:** NOT CHECKED

**Non-Behavioral Restraint Assessment:** CHECKED

**Indications for Restraints:** Confused;

**Restrain Type(s):** 2P

**Specific Criteria for release from restraint:** Other: no longer intubated

Signatures:

**CHECK Resident**

**SELECT:** I have seen and discussed the patient with my supervising provider listed below and they agree with my assessment & plan.

Sign with anyone's name☺

## Central/Arterial Line Notes

---

Pre-Procedure Time/Date	T 0400
Final Time Out	Yes
Signature	Team member 1
Other	Team member 3
Central Venous Line Insertion	Checked
Arterial Line Placement Checked	
Optimal Site	Yes
Cart Utilized	Yes
Hands Washed	Yes
All meds & Syringes labeled	Yes
Insertion site prepped	Yes
Large Drape	Yes
Cathet Placement Confirmation	No
Operator	Team member 1
Supervisor	NA
Attending	(NAME)
Fellow	Blank
Informed Consent	No
Anesthesia	2% Lidocaine
ASA	IV
Indications	Medication administration and hemodynamic monitoring
Site	R Femoral CVC, L Femoral AL
Chest X-Ray	Blank
Placement Site	Right Femoral
Placed New Line	Yes
Catheter Type	Silver Coated
Number of Providers	1
Guide Wire Removed	Yes
Number of attempts/Sticks	R Femoral Checked – 3 L Femoral Checked – 2
Tip of catheter	Inferior Vena Cava
Mesurement of catheter at skin	20cm
Immediate complications	None
Tip of catheter by KUB	Inferior Vena Cava
No change to standard text	
Placed new line	Yes
Post procedure time/date	T 0500
Comments	Blank

Complications	None

**Signatures:**

CHECK **Resident**

I have seen and discussed the patient with my supervising provider listed below and they agree with my assessment & plan.

**Name of Supervising Staff:** TBA

**Sign:** anyone.

## **Nursing Admission History**

---

**Language spoken:** English

**Language Preferred:** English

**Race:** White

**Date of birth:** 10Oct1992

**Name of Local contact/NOK:** Team member 4

**Relationship:** sister

**Informant/relationship:** sister

**Personal articles:** None

**Admission Ht:** 70 in

**Admission Weight:** 70kg

**BMI:** 22.13

**BSAm2:** 1.870

**Addmission Diagnosis:** TENS

**Chief Complaint:** TENS

**Allergy Information**

**Type:** DRUG

**Name:** Septra

**Onset Date:** t-2 days

**Symptoms:** Skinrashhives

**Severity:** SEVERE

**Medications list:** autopopulated from Med Rec note

**Immunizations Screening Protocol:** blank

**ADL Assessment:** blank

**Nutrition Status**

**Criteria:** 1 Unsure, 2 Blank, Is the patient on TF: no, Referral: yes, specify/plan: unable to eat due to critical illness

**Nutrition referral indicated:** box checked

**Dietary supplements:** blank

**Food intol:** blank

**Spiritual concerns:** blank

**Educational Assessment:** not checked

**Continuity of Care: anticipated d/c: home; ID d/c issues: DME; Assistance making transition,**

**Case Manager: (TBN)**

**SW/dc planning: checked**

**My signature**

**Nursing Assessment (initial)**

**Service: critical care**

**Age: 23, M, White, Ethnicity: unknown**

**Admission dx: TENS**

**Mode of arrival: bed**

**Arrival narrative: Patient arrived via ambulance to BAMC ED, assessed and transported via bed to 4T BICU.**

**Time/Date: 0400**

**Admission ht/wt: autopopulated**

**Full code**

**Isolation Precautions: SP FOR: open wounds**

**Behavioral Health Assessment: unable to assess**

**Social work referral indicated: box checked**

**Pain Assessment:** CPOT; facial expression 1; body movements 1; muscle tension 1 ventilator 0  
vocalization 0: Total score 3

**General appearance:** TENS open blisters and rash full body; ill-appearing, disheveled;

**Neuro:** Patient is intubated and mildly sedated on Fentanyl and Precedex drips

**Orientation:** when sedation is turned off, pt can follow simple commands

**Motor:** When not sedated, all extremities bilaterally strong and equal in movement, can move all extremities spontaneously

**Pupils:** Difficult to assess due to significant swelling and burns of eyelids. Pupils seemed equal round and reactive to light directly

**Pupils:** 2 mm, R B

**HEENT:** atraumatic, no drainage noted, swallows without difficulty

**Head:** normocephalic

**Eyes:** periorbital edema; scleral edema

**Ears:** burned nose/throat: nose symmetrical, no discharge

**Oral cavity:** oral mucosa is pink, moist and w/o lesions

**Oral assessment tool:** aspiration risk criteria: yes at risk intubated and sedated

**CV:** tele per protocol parameters: on Heart sounds: s1S2 EKG: ST PR: 0.16 sec

**Ectopy:** none

**Pulses:** cap refill <2 sec R&L all pulses dopplerable ; color NFR, temp : cool , Edema: U

**Pulm:** regular unlabored : chest wall expansion: bilateral and equal BS diminished throughout;

secretions: small amount; **Cont pulse ox; cont ETCO2 O2 therapy: vent; VDR**

**GI:** Last bowel movement: Date: unknown; abdomen: soft non-tender; mildly distended BS: unable to auscultate; pt on VDR making

**Gender:** male; swollen genitalia voiding method: See inv devices flowsheet (indwelling catheter)

**Braden Scale:** Sensory 1; moisture 1; activity: 1 mobility: 1; nutrition; friction and shear 1 total 6:

**Braden:** severe

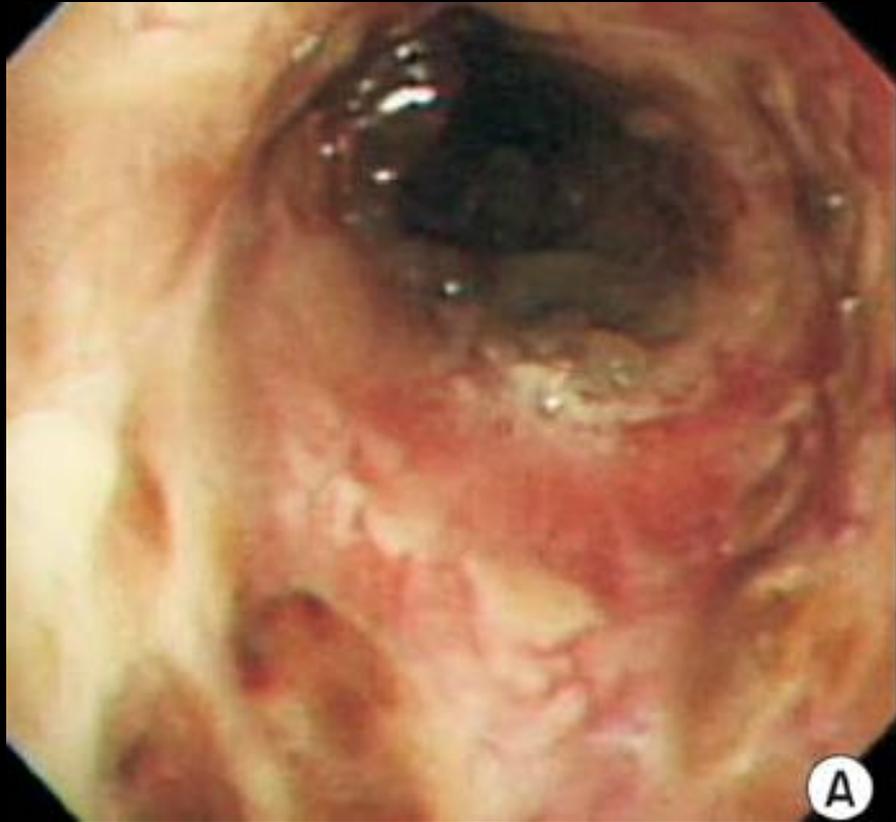
**Skin:** findings: burns over 85% of his body on his face, neck, circumferentially bilateral arms, anterior and posterior torso, small amount of genitalia; buttocks, anterior and posterior thighs; prior skin breakdown: No; PU: Yes Stage II; left cheek small exudate, open wound bed dsg: clean 5% SMS length 2 cm width 1cm; depth 0.5 cm

**Burns:** Deep partial and full thickness burns over body all areas but lower legs and feet odor: absent dsg:  
5% SMS: optional comment: small ulceration noted on right side of faced secondary to umbilical tie

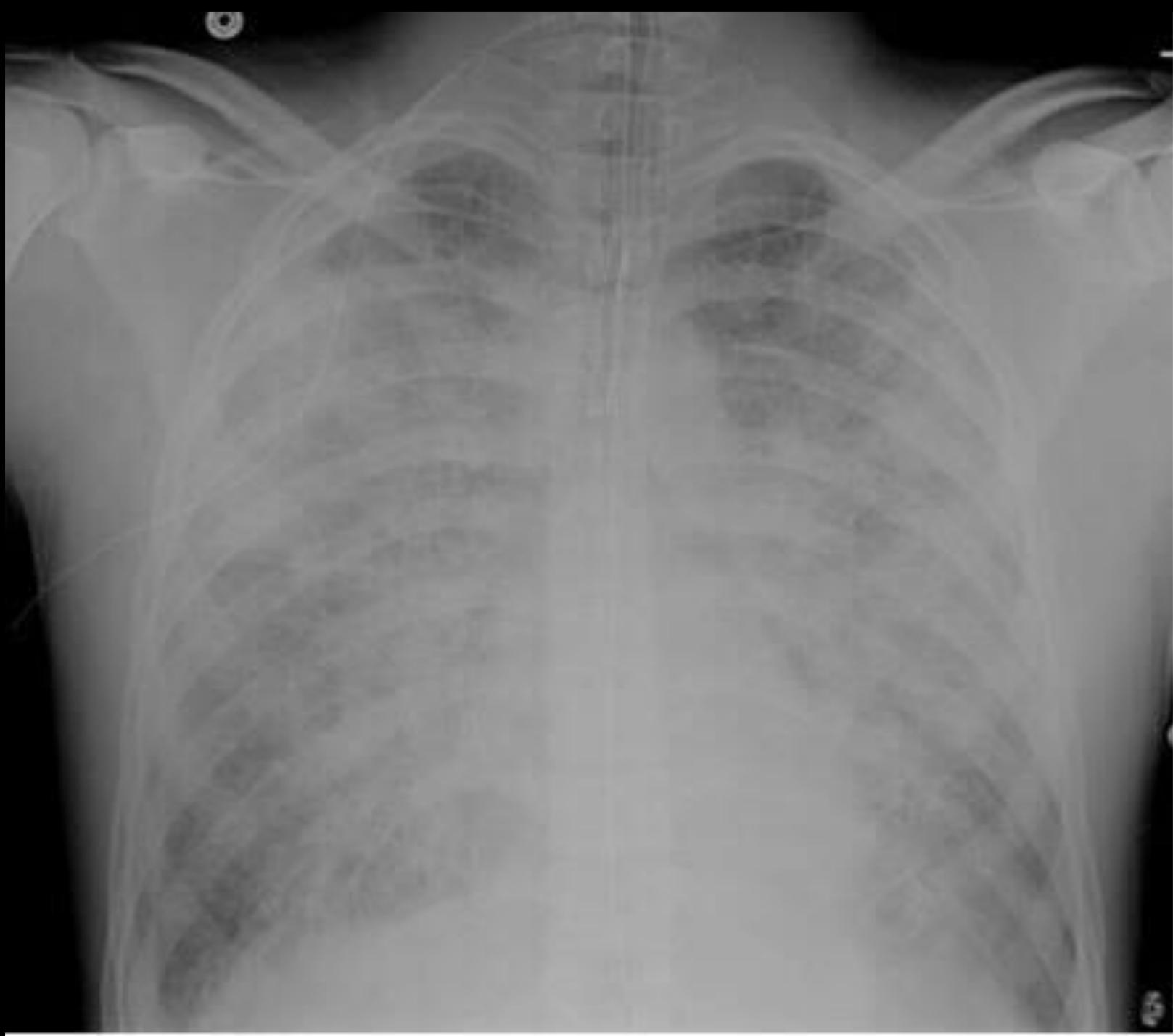
**MS:** muscles equally developed , no abnormal movements

**Falls:** Yes; No;No;No; Patient Risk Level: Low; Low fall risk:SRx3  
I performed the above assessment



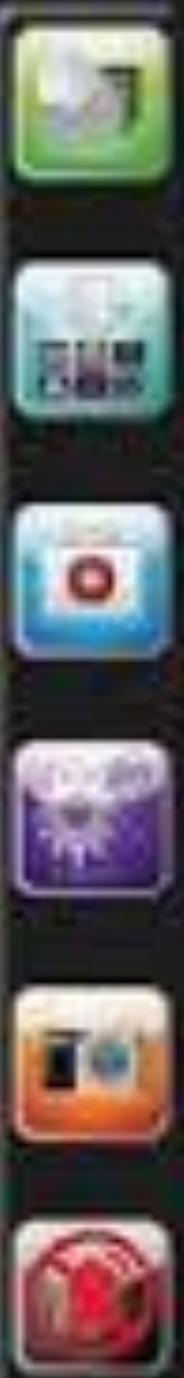








3 CM



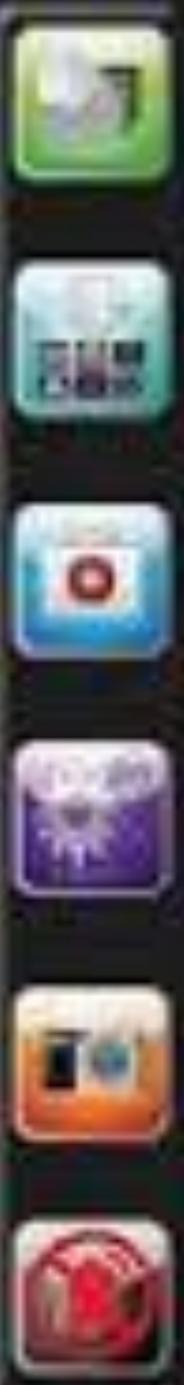
18



9.8  
CO

775  
SVR

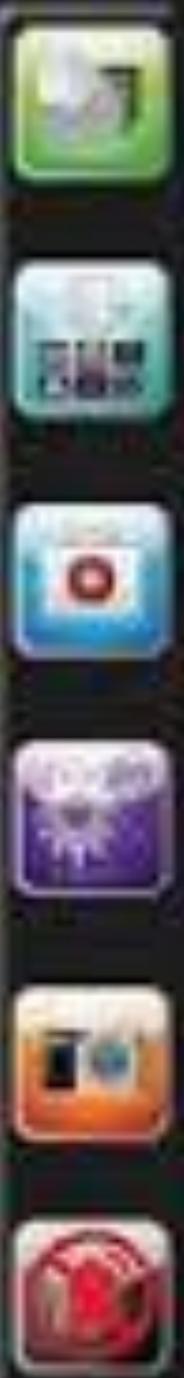
72  
SV



12.7  
CO

680  
SVR

95  
SV



CO

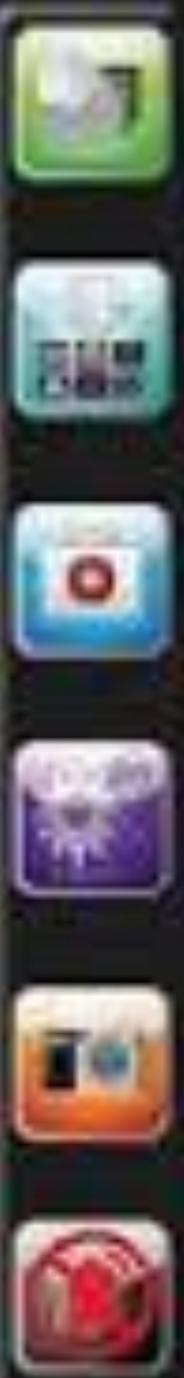
A white circle with a yellow dot in the center, representing a data point for Cardiac Output (CO).

SVR

A white circle with a yellow dot in the center, representing a data point for Systemic Vascular Resistance (SVR).

SV

A white circle with a yellow dot in the center, representing a data point for Stroke Volume (SV).

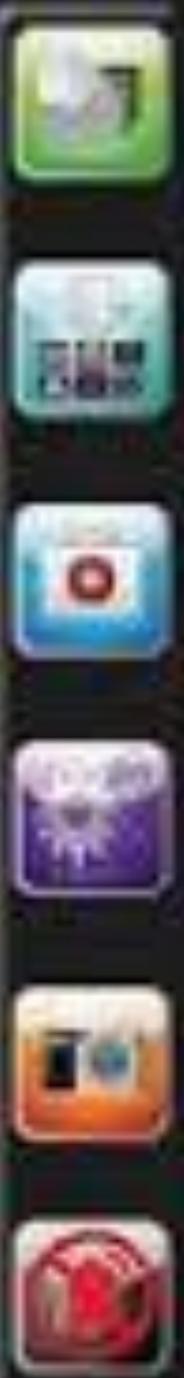


CO

SVR

SV

Three large white circles, each with a small yellow light above it, positioned vertically on the right side of the screen. The labels CO, SVR, and SV are placed to the left of each circle.



CO

A white circle with a yellow dot in the center, representing a data point for Cardiac Output (CO).

SVR

A white circle with a yellow dot in the center, representing a data point for Systemic Vascular Resistance (SVR).

SV

A white circle with a yellow dot in the center, representing a data point for Stroke Volume (SV).

**Cooperative Communication System Scenario 2 (ARDS)**  
**Master Packing List** (Updated 7Jun2016)

Team members

To do:

- Nurse admission history, admit data, nurse assessment initial,

Checklist items:

- Updated Calling cards
- Blank Lab Sheets (printed)
- CXR Images
- KUB Images
- Vent settings flow sheet (printed)
- EV1000 Prints
- UOP Cards
- Subject badges
- Blank SBAR Sheet
- Blank POIP Sheets
- ABG Sheets
- Blood bag attached to A-Line
- Charge nurse checklist
- Hard Chart, Blank Consents, labels (i.e. For labs)
- Extra IV Bag and Medication stickers
- Bag with blood clots/coffee grounds/pink fluid in it
- Sim Lung

<b>Day before</b>	
<b>0800-1200 or after Sim</b>	<ul style="list-style-type: none"> <li>• <b>Sim team: Team Members 1, 2, 3</b> : Set up room</li> </ul>
<b>NLT 1200</b>	<ul style="list-style-type: none"> <li>• <b>Team Member 1/Team Member 2:</b> Enter New patient</li> </ul>
<b>NLT 1600</b>	<ul style="list-style-type: none"> <li>• Enter Notes &amp; Orders</li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Team Member 1:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Med Rec</li> <li><input type="checkbox"/> H&amp;P</li> <li><input type="checkbox"/> Central line/Arterial Line</li> <li><input type="checkbox"/> Enter orders                             <ul style="list-style-type: none"> <li>○ BICU ISR Admission with CK Q6</li> <li>○ Foley to gravity</li> <li>○ Propofol</li> <li>○ Fentanyl</li> <li>○ Insulin Drip</li> <li>○ Wound care orders</li> </ul> </li> </ul> </li> </ul>
	<ul style="list-style-type: none"> <li>• <b>Team Member 2/Team Member 3:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nurse Admission History</li> <li><input type="checkbox"/> Admit Data</li> <li><input type="checkbox"/> Nurse Assessment Initial</li> <li><input type="checkbox"/> Wound Care Procedure Note</li> <li><input type="checkbox"/> Enter NIOs</li> </ul> </li> </ul>
<b>1300-1500</b>	<ul style="list-style-type: none"> <li>• <b>Orientation (All Team Members)</b></li> </ul>
	<ul style="list-style-type: none"> <li>• Test DVE with subject (at appropriate terminals – constitutes terminal checks)</li> </ul>
	<ul style="list-style-type: none"> <li>• Test CCS in DVE with subject</li> </ul>

	<ul style="list-style-type: none"> <li>• Ensure subject consented</li> </ul>
<b>1600</b>	<ul style="list-style-type: none"> <li>• Review Checklist/Huddle and Review Scenario (walk through)</li> </ul>

<b>Morning Sequence:</b>	
0600	
<ul style="list-style-type: none"> <li>○ <b>Team Member 1:</b> <ul style="list-style-type: none"> <li>□ Turn on vent;</li> <li>□ Write vent settings on white board and record on vent flow sheet (vent check note?)</li> <li>□ Ensure Vent Flow Sheet on Ventilator.</li> <li>□ Update POIP Board</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>○ <b>Team Member 3:</b> <ul style="list-style-type: none"> <li>□ Enter Flow Sheets/Acknowledge orders/NIOs</li> <li>□ Make room hot.</li> <li>□ UOP Cards on Urimeter</li> <li>□ BP Cuff is flat</li> <li>□ Turn on/set IV Pumps</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>○ <b>Team Member 2/Team Member 4:</b> Log into mobile DVE computers as back-ups</li> </ul>	
<ul style="list-style-type: none"> <li>○ <b>CSD Team:</b> Check cameras and Clocks</li> </ul>	
<ul style="list-style-type: none"> <li>○ <b>Engineer:</b> Enters morning labs into CCS if running.</li> </ul>	
<b>0630 – Huddle:</b>	
<ul style="list-style-type: none"> <li>○ review pre-flight Checklist</li> </ul>	
<ul style="list-style-type: none"> <li>○ Check pumps/equipment in room</li> </ul>	
0645 – Start Handoffs, give badges, and log into DVE computers with their users ( <b>Team Member 4, Team Member 2</b> )	
<ul style="list-style-type: none"> <li>○ Resident –<b>Team Member 2</b> does CAC login &amp; DVE set Up whilst <b>Team Member 1</b> does Handoff</li> </ul>	
<ul style="list-style-type: none"> <li>○ Bedside Nurse – <b>Team Member 4</b> does CAC login &amp; DVE set Up whilst <b>Team Member 3</b> does Handoff</li> </ul>	
<ul style="list-style-type: none"> <li>○ Attending - <b>Team Member 2</b> sets up DVE</li> </ul>	
Charge Nurse – <b>Team Member 3</b>	
RT – <b>Team Member 1</b>	
0700 – Simulation starts (Team Member 1 in sim room/Team Member 2 outside sim room as comma with Engineer, in DVE to support, Team Member 4 as runner.	
0700-Rounds	
<ul style="list-style-type: none"> <li>• Resident Pre-Rounds</li> <li>• Nursing care</li> <li>• Attending pre-rounds or other</li> </ul>	
~0800- Rounds	
0900- Family member calls	
Post rounds – Rounds plans implemented, patient declines, decisions made.	

### Goals and Concepts

- Lungs are clearly a problem and this will be the focus of the day.
- Team should ask why? TEN lungs vs. infection.
  - Cultures and antibiotics should be ordered
  - A Bronchoscopy should be completed (simulated – time will be assessed by when Bronchoscope in in the room and all team members performing procedure are at the bedside – procedure will not be performed/set-up).)
- Team should manage ARDS – low VT ventilation, increased sedation, paralysis, consideration of prone positioning, finally the ECMO team should be consulted.
- At some point soon after rounds, blood is noted from NG output (either during placement, residual check, suction, or the patient will vomit with suctioning which will prompt gastric suctioning).

- When Residuals are checked, they are high and are noted to have bright red blood in them (300 mL, bright red blood with some clots).
- If a gastric lavage is completed it does not clear after 500 mL; if a second 500 mL attempted it gets very light red, but no active bleeding). Should be started on high dose PPI (bonus plus drip) and consult GI.
- As ventilator pressures go up/sats go down, UOP goes down and is not responsive to fluid challenges. AKI develops.
- Assessment of perfusion (serial lactates and/or svo2) and lactate starts going up.

### **Outcomes**

End state (Primary decision) is decision for decision to start ECMO or not.

Other key outcomes:

- Time to complete pre-rounds by resident
- Time for oncoming nurse to say he/she feel's "comfortable" (i.e. feels like he/she knows what is going on with the patient and starts documenting their assessment)
- Time to order cultures and start antibiotics
- Time to starting paralysis
- Time to prone positioning if attempted (should be)
- Time to perform Bronchoscopy
- Time to consult GI
- Time to order & start PPI drip
- Maintain low tidal volume ventilation

Other items to note:

- How does the team communicate about changes to plans (i.e. Related to possible GI bleed) messaging vs.... What?

### Room Set-up

- Bedside silver tray – for monitor
- Hospital bed
- New room set up
  - Bedside tables with new admission supplies
  - RT table and back table
- 2 IV pumps stands (one in room, one available)
- Kangaroo Pump (available, not in room)
- Fill out white board
- Wet down bottles
- Ventilator settings flow sheet attached to the ventilator
- Chux
- Blood bag attached to arterial line for blood draws
- New paper insulin protocol
- NGT attached with Blood/Coffee Ground Emesis (hibiclens plus coffee) 200mL
- Ties available
- Hard chart/consents/labels in room
- Laptop with Essentris Available

### Patient / Miscellaneous

- 3G Mannequin
  - Triple lumen CVC in right femoral vein
  - Abdominal distention BP cuff deflated
  - Arterial catheter in left femoral artery with blood bag attached
  - 8.0 ETT at 24cm at the lip with bite block in place – tied to the face
  - Foley catheter hooked up to IV tube for output
  - Urimeter with additional urine to input over time with cards displaying urine output
  - Bandages over everything including feet (simulates silverlon since no Silver Nitrate available).
  - Arm band with patient name
  - Allergy Band
  - Falls Band
  - HOB up 30 degrees
- Ventilator with flow sheets– PAC 50% PEEP 5 PIP 24 RR 18 MAPS 22
- Room Hot
- Simulated medications/blood products (all boxed and outside with sim team)
  - Enoxaparin syringe
  - Protonix IV push or piggyback
  - Albuterol & atrovent (saline neb) – get from RT
  - Fentanyl drip
  - Ketamine drip
  - Propofol drip
  - Nimbex drip
  - Antibiotics (imipenem, vancomycin, amikacin) drips
  - Protonix bolus plus drip
  - LR bags x 2
  - Albumin
  - PRBCs x1
  - Vasopressin drip
  - Levophed drip
  - IVIG drip
  - Enteral feeding
- Extension tubing/primary tubing for all drips x 4-6 sets
- Foley/reservoir bag for medications to drain
- Stethoscope

## Physician Handoff

24 yo man with probable TEN. Started 2 days ago probably from Septra. He works as a taxidermist or a butcher or something. Anyway, he cut left his hand while doing something with a deer 2 nights ago. We went to an ER in Austin where the sutured his hand and gave him Septra for prophylaxis. The day before yesterday, he woke up with a rash over his entire body. He kept taking the Septra, the rash continued to worsen, and yesterday morning he woke up with involvement of his eyes and mouth. He apparently stopped taking the antibiotics then – this history is all by report from the outside hospital. Last night he woke up about 11 with a cough and eye and mouth pain, called a friend, and went to an ER in Austin. The ED thought he had TENs. Because he was hypoxic they (SpO2 was 89%) they intubated him and sent him here.

No PMH, surgeries, allergies, etc.

He lives alone. He has parents that live in Dallas that he's apparently estranged from and his sister Sena (210-8232292) lives somewhere in California.

N: He's sedated on Propofol, fentanyl. He got a BUNCH of benzos during transport (10mg versed, 200mcg fentanyl)

C: No issues a little tachycardia (130s, 110s/50s)

P: Biggest issue. PAC PIP 24 PEEP 5 FiO2 50% APG 7.33/55/65/93%, seems like he's developing ARDS.

G: No issues. Needs an NGT. Not sure if we should start feeding.

R: No issues. Elytes OK.

E: Blood sugars a little high. I started him on an insulin drip.

H: No issues.

ID: No fever (100.6), WBC is high 22, but not surprised with the TEN/ARDS, not on antibiotics (we didn't talk about them, probably something to discuss on rounds)

Wounds: He got showered, we took pictures, and we put him in silverlon based on rec's from Dr. Driscoll because this is apparently a national shortage of silver nitrate.. Plan to re-look tomorrow. (100% involvement, 20% open)

T/L/D: He has a foley, ETT, R femoral CVC and L femoral AL both put in since he got here.

### Labs

WBC	22	Na	137	TP	6.8	Arterial pH	7.33
Hgb	15	K	4.2	Albumin	3.3	Arterial PaCO2	55
HCT	47	CL	108	Tbili	2.1	Arterial PaO2	65
PLTs	210	HCO3	24	Dbili	0.8	Arterial HCo3	22
INR	1.2	Gap	5	Alk Phos	55	Arterial SaO2	93
PT	15	BUN	30	AST	45	Arterial BD/BE	-5
PTT	27	Cr	1.2	ALT	49	Lactate (ABG or Lab)	2.8
		Glu	210	Mag	2.3		
		iCa	1	Phos	2.3		

## SBAR Report Nursing

<p><b>SITUATION:</b>  <b>Admit/Burn Date:</b> Admitted this morning at 0400  TBSA: TENS full body</p>	<p><b>Doctor:</b> (NAME)</p>
<p><b>BACKGROUND:</b>  <b>History:</b> 24 yo man with probable TEN. Started 2 days ago probably from Septra. He works as a taxidermist or a butcher or something. Anyway, he cut his right hand while doing something with a deer 2 nights ago. We went to an ER in Austin where the sutured his hand and gave him Septra for prophylaxis. The day before yesterday, he woke up with a rash over his entire body. He kept taking the Septra, the rash continued to worsen, and yesterday morning he woke up with involvement of his eyes and mouth. He apparently stopped taking the antibiotics then – this history is all by report from the outside hospital. Last night he woke up about 11 with a cough and eye and mouth pain, called a friend, and went to an ER in Austin. The ED thought he had TENs. Because he was hypoxic they intubated him and sent him here. EMS reports that they gave him lots of benzos so I've kept him on lower sedation—and he's still snoring. He was filthy when we took him to the shower, teeth look terrible. Maybe he's been on drugs, meth? Don't know if he'll need CIWA, banana bag?? No PMH, surgeries, allergies, etc.  Social: He lives alone. He has parents that live in Dallas that he's apparently estranged from and his sister Nicole (XXX-XXXX) lives somewhere in California.</p>	<p><b>Code Status:</b> Full   <b>Allergies:</b> Septra</p>
<p><b>ASSESSMENT:</b>  <b>Neuro/Pain:</b> He's a GCS of 3T, He's sedated on propofol  <b>Respiratory:</b> He has crackles bil, He's on the vent—on FiO2 of 50%, Sats have been 92-95%  <b>Cardiac:</b> HR has been 130s, BP 110s/50s, MAPs have been in the 60's  <b>GI:</b> Absent BS, no NG yet, I think he will need that  <b>GU:</b> UOP has been 50's  <b>Skin/Wounds:</b> We took him to the shower, dressed him in silverlon—Driscoll said that there's some nationwide shortage of silver nitrate so we can't use that. Driscoll wants the dressings down tomorrow.  <b>Accu Checks/Labs:</b> Accu check was 210—he's on an insulin drip now at 7u/hour WBC is high 22, Last ABG pH was 7.33, PaCO2 55, PaO2 65, bicarb 22, SaO2 93, BD/BE -5, Lactate 2.8  <b>Lines:</b> He has a foley, ETT, L femoral a line and R femoral CVC both put in since he got here  <b>Infx:</b> T max: 100.6 not on antibiotics</p>	
<p><b>RECOMMENDATIONS:</b>  <b>Goals:</b> Burn surgeon will look at wounds tomorrow  <b>Tests/Treatments:</b> none</p>	

<b>WBC</b>	<b>22</b>	Na	137	TP	6.8			<b>Arterial pH</b>	<b>7.33</b>
Hgb	15	K	4.2	Albumin	3.3	<b>Glu</b>	<b>210</b>	<b>Arterial PaCO2</b>	<b>55</b>
HCT	47	CL	108	Tbili	2.1	iCa	1	<b>Arterial PaO2</b>	<b>65</b>
PLTs	210	HCO3	24	Dbili	0.8	Mag	2.3	<b>Arterial HCo3</b>	<b>22</b>
INR	1.2	Gap	5	Alk Phos	55	Phos	2.3	<b>Arterial SaO2</b>	<b>93</b>
PT	15	BUN	30	AST	45			<b>Arterial BD/BE</b>	<b>-5</b>
PTT	27	Cr	1.2	ALT	49			<b>Lactate (ABG or Lab)</b>	<b>2.8</b>

## RT Handoff

Name: TBD			
Hospital Day: 1			
Admission Dx: TENS			
RT orders: CONT Ventilator: PAC			
<b>RT Meds: ??</b>			
<b>70 inches , IBW 73kg</b>			
Breath sounds/Secretions: crackles b/l			
<b>Vent Parameters/Trends</b>			
<b>Hour</b>	0400	0500	0600
<b>Mode</b>	PAC		PAC
<b>FiO2</b>	0.5		0.7
<b>PEEP (demand PEEP)</b>	5		10
<b>PIP</b>	28		30
<b>RR Set</b>	18		26
<b>MAP</b>	22	24	
<b>VT</b>	585	525	

## Family Member Script (Questions/Answers/Cue's)

**\*\*Bold denotes KEY Messages to convey.**

- Hi, my name's **TBD**.....
- **Yes, he is my young brother by 8 years.**
- **What's going on? (Act shocked, stunned).**
- **Is he going to be OK?**
- **Do I need to come now, or not yet?**
- I live in Oakland California. I'm a nurse – in a skilled nursing facility.
- Last time I saw him was like 2 years ago? He had dropped out of school.
- He is estranged from our parents – me too. They are both alcoholics. I left home like 10 years ago. I don't think he'd want you to contact them.
- I know he drinks a lot.... Not sure how much.
- Yes, he used to do drugs – meth, heroin. I think he's cleaned up from that though.
- He graduated high school.
- He's not a taxidermist or a butcher. I don't think he works at all right now.

Hour	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
<b>Vital Signs</b>												
Weight (kg)	70											
HR	135	129	134	130	136	130	134	137	130	134	139	132
MAP	75	64	63	58	63	62	60	58	59	63	61	58
SBP	113	108	102	96	102	105	99	97	98	100	98	95
DBP	56	42	43	39	44	40	41	38	39	45	42	40
RR	24	32	35	30	30	33	31					
CVP												
Temp	100.6	100.8	102.7	102.4	102.2	102.3	102.2	102.1	102.3	102.5	102.1	102
SpO2	95	92	93	92	92	91	90	88	85	80	78	65
FiO2	0.7	0.9	0.9	1	1	1	1	1	1	1	1	1
CO					9.792		12.73					
SV					72		95					
SVV					18%		10%					
SVR					775		680					
RASS	-4	-4	-3	-3	-3							
FSGlucose	160	143	152	177	162	183	166	150				
<b>Inputs</b>												
LR	125	125	125	125	125	125						
Albumin	250				250							
vasopressin					2.4	2.4						
Levo												
Promote												
Insulin		6	6	7	7	7						
Propofol	3	3	3	1	1	0						
Ketamine												
Fentanyl	5	5	5	5	10	10						
IVIIG							IVIIG					
Ins	383	139	139	138	395.4	144.4	0	0	0	0	0	0
<b>Outputs</b>												
UOP/Foley	0	50	54	35	20	10	10	5	10	4	0	
CRRT UF												
Residuals												
Stool												
Outs	0	50	54	35	20	10	10	5	10	4	0	0
Net Ins/Outs	383	89	85	103	375.4	134.4	-10	-5	-10	-4	0	0
<b>Labs</b>	<b>4:00</b>	<b>5:00</b>	<b>6:00</b>	<b>7:00</b>	<b>8:00</b>	<b>9:00</b>	<b>10:00</b>	<b>11:00</b>	<b>12:00</b>	<b>13:00</b>	<b>14:00</b>	<b>15:00</b>
WBC	22							23				
Hgb	15							13				
HCT	47							39				
PLTs	210							189				
INR	1.2							1.2				
PT	15							14.5				
PTT	27							26.1				
Na	137							135				
K	4.2							4.7				
CL	108							103				
HCO3	24							20				
Gap	5							12				
BUN	30							45				
Cr	1.2							1.4				
Glu	210							155				
Mag	2.3							1.9				
Phos	2.3							3.2				
TP	6.8											
Albumin	3.3											
Tbili	2.1											
Dbili	0.8											
Alk Phos	55											
AST	45											
ALT	49											
HCG												
EtOH												
CK												
Troponin												
T&S												
A1C												
Arterial pH	7.33		7.29	7.27				7.25				
Arterial PaCO2	55		52	56				65				
Arterial PaO2	65		66	55				50				

Arterial HCO3	22		19	19					17			
Arterial SaO2	93		92	90					87			
Arterial BD/BE	-5		-7	-7					-9			
iCa	1								0.89			
Lactate (ABG or Lab)	2.8		3	3.2					4			
Venous pH	7.2											
PvO2	30											
PvCO2	79											
Venous blood gass SvO2	60											

Invasive Devices	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
------------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

PIV	Norm											
Foley	Norm											
Arterial Line	Norm											
Central Line	Norm											
NG Tube	Assessed											
ETT	Assessed											
Dialysis/Pheresis Cath												

Ventilator	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

Mode	PAC		PAC	PAC					VDR?			
FiO2	0.5		0.7	1					1			
PEEP (Demand PEEP)	5		10	10					5			
PIP	28		30	30					35			
RR-Set	18		26	28					15			
Hz												
MAP	22	24		26					24			
OsPEEP									5			
VT	585	525		483								
P-High												
P-Low												
TH												
TL												

Physical Exam	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
---------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

Pupils	R 3-4mm sluggish L 3-4mm sluggish											
GCS	M1 E1 V1T 3T											
Lungs	Crackles b/l											
Heart	Normal											
Abdomen	S/NT/ND											
Abdominal sounds	Absent											
Pulses	Normal											

Family/Social interaction	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
---------------------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

Sister calls					☐0830							
--------------	--	--	--	--	-------	--	--	--	--	--	--	--

Activity Checks	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
-----------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

Sim Team	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
----------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

UOP Card Updated	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Check eyes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Check FSBG and Adjust Drip	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vital Signs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
I/Os	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Treatments	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medications	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Nurse Due-Outs	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
----------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

Nursing Assessment Note					☐					☐		
Shift Note					☐							

Resident Due Outs	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
-------------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

Resident DPN							☐					
Bronchoscopy/Note							☐					
Paralysis							☐					
Cultures/Antibiotics							☐					

RT Due-Outs	4:00	5:00	6:00	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00
-------------	------	------	------	------	------	------	-------	-------	-------	-------	-------	-------

				Vent Commo		Neb!		Vent Commo		Vent Commo		Vent Commo
--	--	--	--	------------	--	------	--	------------	--	------------	--	------------





