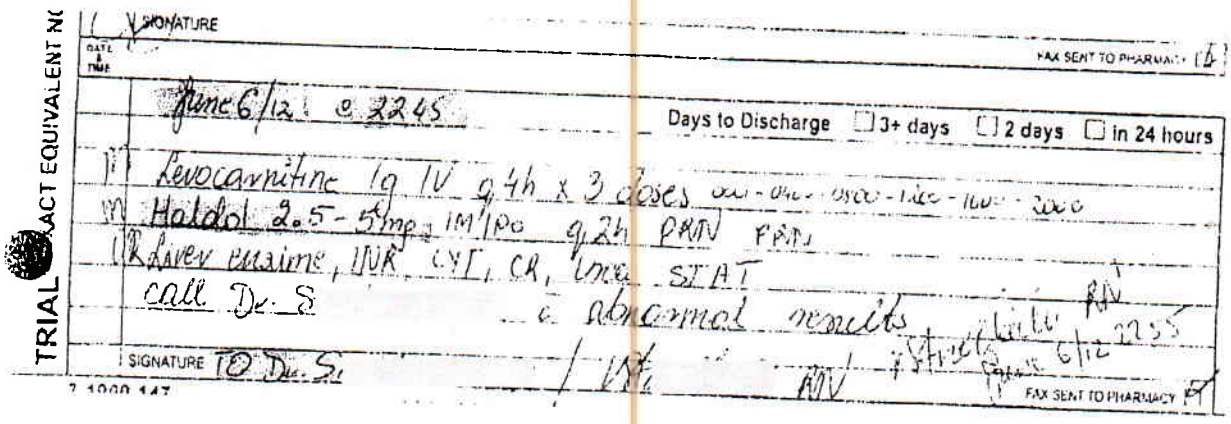
Now at 9:45 he was finally transferred to the fifth floor medical unit and I am enclosing the nurses notes and the order that was faxed to pharmacy for this. As you can clearly see Dr. S. prescribes the Levocarnitine antidote as well as Haldol again. I firmly believe the Haldol was administered and again the nurse in question V.S. should have been questioned. However this was totally ignored by the college. After this, Joshua had a code blue and I was told by Dr. S. later that he had almost swallowed his tongue. They claimed this was due to the placement of the tube however one of the side effects of Haldol is that it hampers your swallowing mechanism. Now after they bring him back from the code he starts to get agitated again and 4 limb restraints are put on him.



Now he is finally sent to ICU. Now the college has said he became agitated only after being sent to ICU. This is a totally false statement. I believe he was given Haldol again as prescribed by Dr. S. at 10:15 and this is what caused the code and the agitation to start again. It is the only explanation for what happened.

RUN DATE: 09/07/12
RUN TIME: 0750
RUN USER: HBUI1

CAMBRIDGE MEMORIAL PCI **LIVE** for HBUI1
PATIENT ASSESSMENT

PAGE 1

Consultation - Physician

Patient: PATEY,JOSHUA ALVIN
Account #: AC001671/12
Admit Date: 06/06/12
Status: DIS INx
Attending:

Age/Sex: 25 M
Unit #: 016955
Location: 5MED
Room/Bed: 577-2

Consultation with:
Reason for Consultation:
BLOOD WORK RESULTS ~~AMMONIA LEVEL INCREASED~~ AND VALPORIC ACID BACK TO NORMAL
BP 154/101 ON RIGHT ARM AND 178/96 ON LEFT PULSE 119, PT CONFUSED, ANSWERIN
"JOSH" TO EVERY QUESTION,
Outcome:
ORDER RECEIVED FOR LEVOCARNITINE 1G IV Q4H X3 DOSES HALDOL 2.5-5MG IM/PO
Q2H PRN, BLOODWORK STAT- CALL DR WITH ABNORMAL RESULTS.

Occurred Date: 06/06/12
Monogram: VXS Initials: VSTRZE1 Name:

Occurred Time: 2245
Nurse Type: RN

	Date	Time	By		Nurse Type	
Occurred:	07/06/12	0056	VXS S	,V	RN	Category
Recorded:	07/06/12	0121	VXS S	,V	RN	Nursing Notes

Abnormal? N **Confidential?** N

PT CAME TO 581-2 AT 2145 FROM MH WITH NURSE AND SECURITY, PT CONFUSED, SHAKY, ON EVERY QUESTION PT ANSWERED "JOSH". BP-154/101 ON R ARM AND 178/96 ON L, PULSE 119, SAT 100% RA RESP 18, TEMP 36.2. PT WENT TO BR , UNSTABLE ON FEET, VOIDED. PT WAS HELPED TO GO TO BED. DR WAS CALLED AT 2245 WITH INCREASED AMONIA LEVEL RESULT, VALPORIC ACID AND PT'S CONDITION. ORDER RECEIVED FOR LEVOCARNITINE 1G IV Q4HR X3DOSES, HALDOL 2.5-5MG PO/IM Q2H PRN AND STAT BLOODWORK- CALL DR WITH ABNORMAL RESULTS. AT 2215 DR CALLED AGAIN AND ORDER NEURO VITALS Q1H, CALL POISON CONTROL, LACTULOSE 30 ML Q6H IF ABLE TO SWALLOW IF NOT TO KEEP HIM NPO,TRANSFER TO ICU IF CONDITION CHANGE. AT 2220 ANOTHER NURSE WENT TO DO VS AND NEUROVITALS, SAT DECREASED TO 94% ON RA RESP 10, PT NOT RESPONDING, CODE BLUE CALLED, ICU CALLED TO LET THEM KNOW THAT PT WILL BE TRANSFER DOWN. PT STARTED BE AGITED, 4 LIMB RESTRAINTS APPLIED, DR S WAS CALLED SHE TALKED TO ER DR WHO RESPOND ON CODE. PT WAS TRANSFERED TO ICU.

Note Type	Description
No Type	NONE

	Date	Time	By		Nurse Type	
Occurred:	06/06/12	2355	ALK G	,A	RN	Category
Recorded:	07/06/12	0203	ALK G	,A	RN	Nursing Notes

Abnormal? N **Confidential?** N

PT RECEIVED FROM MEDICAL FLOOR AT ABOVE TIME IN
LIMB RESTRAINTS AND SHOULDER RESTRAINTS. PT
EXTREEMLY RESISTIVE, SCREAMING, SWEATING AND WRITHING WHILE RESTRAINED.
SECURITY CALLED TO ASSIST. PT PULLED OUT IV AS A RESULT OF HIS STRUGGLING.
NEW IV INSERTED BY ER NURSE AND DR.B CALLED. SEE CODE SHEET FOR MEDS
GIVEN. PT THEN INTUBATED. PT. VOMITED COPIOUS AMOUNTS OF UNDIGESTED FOOD ONCE
ROLLED ONTO SIDE DURING BED EXCHANGE. NG TUBE INSERTED INTO LT NARE. FOLEY
CATHETER ALSO INSERTED WITH GOOD RETURN. PT NOW HAS INFUSION OF PROPOFOL AND
MIDAZOLAM CONTINOUS RUNNING AND PT HAS SETTLED.

Note Type	Description
No Type	NONE

I am positive that he received the Haldol and I am enclosing some information regarding the side effects of Haldol.

taken from the web

> You should check with your doctor immediately if any of these side effects occur when taking haloperidol: (Haldol)
>
> More common
> Difficulty with speaking or swallowing
> inability to move the eyes
> loss of balance control
> mask-like face
> muscle spasms, especially of the neck and back
> restlessness or need to keep moving (severe)
> shuffling walk
> stiffness of the arms and legs
> trembling and shaking of the fingers and hands

twisting movements of the body
weakness of the arms and legs

Less common
Decreased thirst
difficulty in urination
dizziness, lightheadedness, or fainting
hallucinations (seeing or hearing things that are not there)

Joshua had many of the symptoms associated with this and it was totally ignored by the college since conveniently the pharmacy records are missing.

Dr. S. did not speak personally with Poison Control until 12:30 am, more than two hours after prescribing the Haldol. She did not cancel the Haldol order until after this.

Ontario Poison Information Centre

Date of Call: 06/05/2012 04:43:25 Tuesday — Initial SPI: 0049 — Case Number: 2012001-8435842
Date of Exposure: 06/05/2012 03:01:25 Tuesday — Start by: 0049 @CTR: 001/Toronto

=====(Edited:06/07/2012-00:30:36 by 0055/Kirsti Kavanagh(Sarid-30X)=====

00:46 - 06/07/2012 (0055/Kirsti Kavanagh) ICU to PCC->

S/O: Dr.S calling to ask the following questions. Which agent is preferable to use for sedation. Is it all right to use versed? Can and should they give lactulose for hyperammonemia? She has ordered it Q4H. Is this appropriate? Can and should the patient be paralyzed? Is is contraindicated?
How often to give l-carnitine?
M.D. had ordered Dilantin will cancel that order. LFTs are "fine"

A: Info

P: Advised that there are no specific recommendations for sedation but midazolam is acceptable. SPI will speak with On call at but possible role for use of lactulose. Paralytics are not contraindicated, but Dilantin and Haldol are.
Offered direct consult with Dr. St.Onge, M.D. declined and requested that SPI lead information with ICU RN
=====(Edited:06/07/2012-00:50:53 by 0055/Kirsti Kavanagh(Sarid-30X)=====

01:04 - 06/07/2012 (0055/Kirsti Kavanagh)

S/O: paged and spoke with Dr. St. Onge, advised of ICU MDs questions.

A: consult

EXACT EQUIVALENT

DATE & TIME

9 1/2 4 pm.

Days to Discharge ☐ 3+ days ☐ 2 days ☐ in 24 hours

(19) May [illegible] pt if necessary as per protocol

(20) D/C Haldol.

(21) NO Dilantin.

SIGNATURE

FAX SENT TO PHARMACY ☑

7-1900-147 ME C37 Rev 01 2012 Review 02 OD
Included in Kits 1,6,7,11,13,14,24

FAX A COPY TO PHARMACY, THEN PLACE IN PATIENT'S CHART

Again I would say that when a patient is causing so much trouble , yelling and fighting with them that they would naturally give him something for agitation and again it would be the Haldol as prescribed at 10:15 pm by Dr. S.. This is most clearly a cover up by the hospital, doctors and the college.

College decision - Dr. S. page 18

> "Dr. S. (again properly) decided to transfer Mr. Patey to ICU, where shortly thereafter, violent agitation occurred, necessitating extreme levels of sedation. This level of sedation also requited intubation for airway protection. "

Joshua was extremely agitated long before he arrived in ICU. When Josh arrived in the ICU it took 7 - 8 people to hold him down. He was yelling and fighting them off. I believe this could have led to physical harm to his legs and arms. A trauma like this can lead to the development of DVT(Deep Vein Thrombosis). Again this was never considered.

Now I would like to speak to the fact that there is an act called "Consent to Treatment". I complained that I was not notified about my son's condition until they phoned me from the ICU at 12:30 am. You can clearly see by the nurses notes previously, Joshua was unable to speak for himself from the time they woke him in the Mental Health Ward at 8:30 pm until he ended up being restrained in the ICU. This was 4 hours. They are supposed to contact the next of kin when this happens, yet they did not. This is a policy of the college as well as an act of Ontario. It is up to the doctor in charge to do this not the hospital as Dr. S. suggests. She violated this act and the college totally ignored it. If I had been called earlier, I know I could have helped to calm Joshua. He trusted me and listened to me. I can only imagine the unnecessary horror they put him through.

Dr S. - response letter dated February 12/13

> Thank you for providing Ms. Patey's further comments in her letter dated January 16, 2013.
>
> My previous responses and explanations as to the circumstances of the emergency intervention in Mr. Patey's care on the evening of June 6, 2012 were previously explained in my letters of September 20 and October 25, 2012 and January 7, 2013. As was also previously explained, we rely upon our hospital staff to notify family when there is a change in the patient's condition. Indeed, I was not even at the hospital myself when Mr. Patey's condition was first noted to have changed on the evening of June 6, 2012, after my initial assessment. I was immediately involved in stabilizing and treating Mr. Patey upon my return to the hospital that evening and his treatment was my priority. I spoke with Ms. Patey at my first opportunity after assessing and treating her son. If no family had been present at that time, I would have asked staff about whether there were family or friends who were to be notified; however, Ms. Patey was present.

She was in charge of his care from 7:30 that evening regardless of whether she was present at the hospital or not. She should have made sure that I was called asap. I was not called until 12:30 am four hours after the events started. There is no excuse for this. She should know of the "Consent to Treatment Act" by now. Obviously she was there at least by 10:00 pm since she wrote orders at that time.

I have enclosed a copy of the "Health Care Consent Act" for you to review.

> Consent
> No treatment without consent
>
> 4. A health practitioner who proposes a treatment to a person shall ensure that it is not administered unless,
>
> (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
>
> (b) he or she is of the opinion that the person is incapable with respect to the treatment, and another person has given consent in accordance with this Act. 1992, c.31, s.4.

College decision Dr. S. page 21

> "The committee notes that Mr. Patey provided broad consent at the time of admission. This would be presumed to continue unless it was withdrawn (which it was not). It is not necessary or practical to obtain consent for every drug given or minor medical procedure."

When Joshua was admitted to emerge on June 5 he still was lucid and in control of his faculties. However on the evening of June 6 as previously shown and stated by the nurses he became very unstable mentally and this speaks to the "Consent to treatment" act. How was he supposed to withdraw consent when he was like this. Also since he was intubated and sedated he certainly could not give consent. Dr. S. never discussed treatment with me during the whole time she was treating Joshua except for when I first arrived and she told me he was being intubated and restrained due to his erratic behaviour. At this time I had no idea what had gone on and for how long and agreed that he needed to be restrained since I heard him screaming. However this does not give her permission to carry on treating him in the ICU for over 4 days without discussing this with me. She claims that she left it up to the staff to update me. They did so only after I asked questions and only spoke to my questions. She claims if I had asked she would have spoken with me. It is not up to me to ask, it is up to her to initiate this and she should be familiar with this policy of the college and not have to be reminded of it. The college did agree with me on this and only counselled her to communicate more with family. Why do we have these acts if nothing is done when a doctor clearly violates them. Please refer to the informed consent in the "Health Care Consent Act"

> Consent on Incapable Person's Behalf
> Consent
> List of persons who may give or refuse consent
> 20. (1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:
>
> 1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.

2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.

3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.

4. The incapable person's spouse or partner.

5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.

6. A parent of the incapable person who has only a right of access.

CPSO Consent to Treatment Policy

Who to Obtain Consent From

If a patient is capable with respect to a treatment, the physician must obtain consent from the patient directly.

If a patient is incapable with respect to a treatment, the physician must obtain consent from the substitute decision-maker, who will give or refuse consent on the patient's behalf.

College Decision: Dr. S. - page 21

"Furthermore, there is nothing in the medical record to indicate that the use of restraints in this case resulted in harm. Possible harmful effects (e.g. adverse effects from immobility, injury to extremities due to efforts to escape from them) were not possible as Mr. Patey was deeply sedated and already immobile."

"In terms of "chemical restraints" (i.e. sedation), this would have been necessary in an intubated patient, even without a history of agitation. Notably, no muscle relaxants were used; thus total immobility was not present, but this also necessitated the physical (prophylactic) restraints since movement was possible and accidental extubation needed to by guarded against."

Patient Restraints Minimization Act, 2001

Order to restrain a patient

10. (1) Only a physician or a person specified by regulation is authorized to write an order to restrain or confine a patient in a hospital or facility or to use a monitoring device on such a patient. 2001, c. 16, s. 10 (1).

Same

(2) The physician or person writing the order shall comply with this Act, the regulations

made under this Act and any applicable policies of the hospital or facility about restraining patients. 2001, c. 16, s. 10 (2).

I am enclosing this act for you. It clearly states that restraints are only to be ordered by the doctor in charge and are to be closely monitored. Since there is very little in the records regarding this, they were in clear violation of this act. At one point Dr. S. states she has very little recollection of the restraints during Joshua' care in ICU. Well if she did not see them then she did not actually go to his bedside and treat him. Please look at the picture of this enclosed. You can clearly see the wrist restraints.

Response Letter from Dr. S..- Oct 25/12 page 3

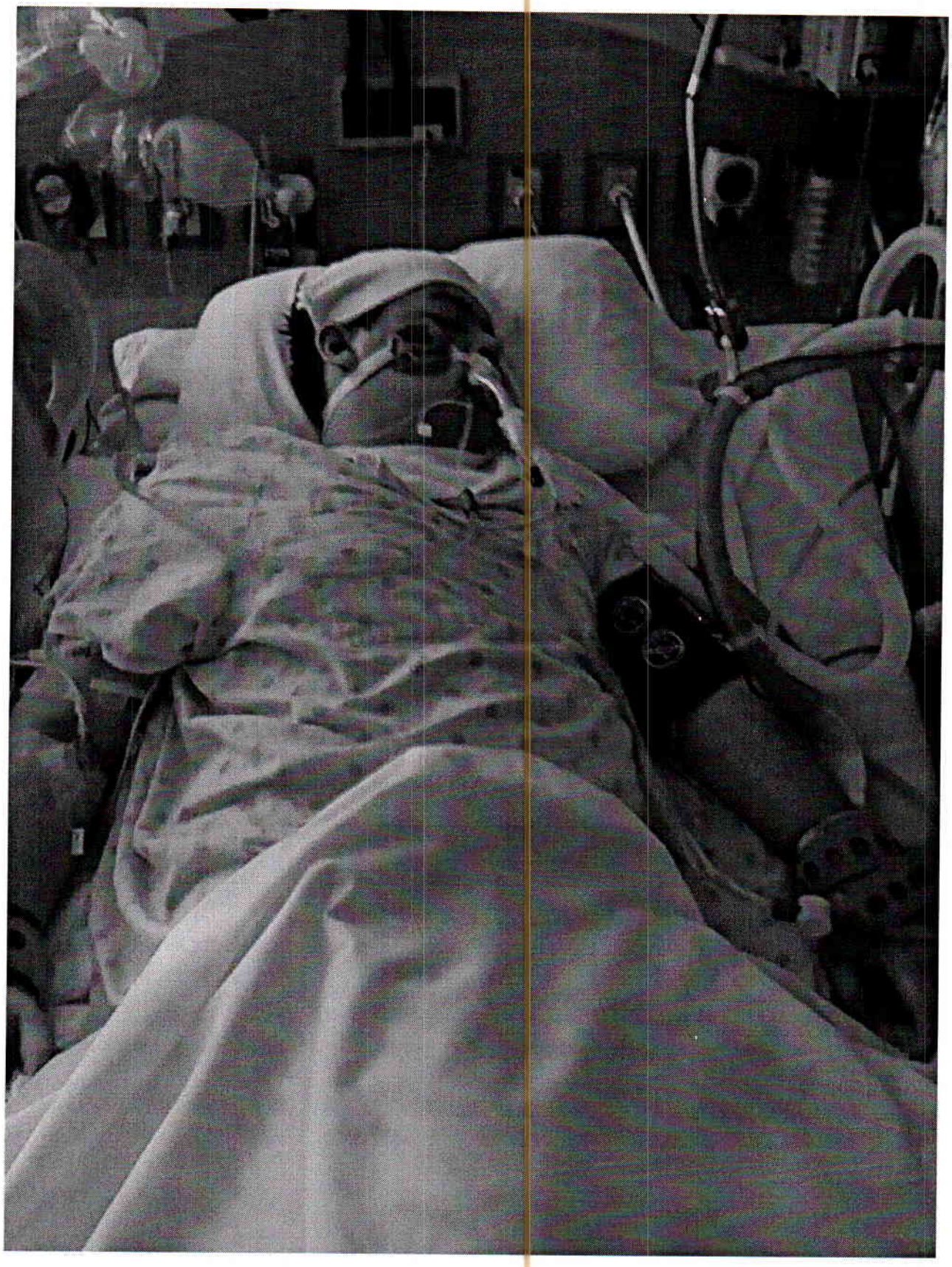
5. **Restraints:** Restraints were used on Mr.Patey as a last resort and in an urgent situation because of the profound nature of his agitation. VIOLATED ACT - LIST NP

As previously explained, I cannot recall being aware of any ongoing use of physical restraint during the four days that he was under sedation. As I was not there on a continuous basis, or when Ms. Patey and other family members were present , I cannot respond to Ms. Patey's reports of the extent to which the physical restraints were used during this time and there is no documentation that corresponds to her report. I am not suggesting that I do not believe Ms. Patey, just that I was not there and do not recall the use of physical restraints, I am unable to resolve any discrepancies arising from her report and what appears in the chart.

While the sedation does act as a chemical restraint, it was also a crucial element of Mr. Patey's treatment for his severe agitation. Delirium

In response to your specific inquiries as to the use of restraints, there are two guidelines and policies in place at CMH regarding the use of restraints which are enclosed. I understand that these policies are under review and that mental health services are working on an updated comprehensive policy. Documentation on the sedation of Mr. Patey, as per my orders, is available in the chart, but documentation on physical restraints does not seem to appear, apart from the reference by nursing as to wrist restraints being briefly used after successful extubation on June 11/12. I acknowledge that as per the policy, a physician is to assess and provide the order for physical restraint within 12 hours of its use. This is difficult to do if I am not made aware of the use of restraints at the time. If physical restraints were used as described by Ms. Patey, I would expect to see documentation as to the indication for the use of physical restraints in the chart. SO WOULD I

She claims restraints were used periodically. This is an outright lie. They were on him from the time he was intubated in ICU, June 7 at midnight, until they extubated him on June 11 in the am. All four limb restraints for the first couple of days and the two wrist restraints for the remaining time. Myself and several visitors have provided statements as to this. Also the college did not bother to ask the nursing staff regarding this and this should have been investigated as this is a very serious matter. Again I say why do we have these acts if nothing is done when they are violated by a doctor.



Joshua was kept chemically restrained by the drug Propofol. The only reason I have been given for keeping him chemically restrained and intubated for over 4 days is that every time they tried to wean him, he became a "little agitated." Propofol is well known for causing agitation and Dr. S. should have known this. I told the nurses several times during his stay that I wanted to be present when they extubated him and this was dismissed. I know if I had been allowed to be present I could have helped to calm him. After all, if you wake up physically restrained, not knowing where you are and surrounded by strangers you would naturally be a "little agitated". This goes for anyone. This is not a good enough excuse for keeping someone dangerously sedated for over 4 days.

On June 11/12 Joshua was extubated at 8:10 AM. At approximately 10:00 am they got him up to go to the commode and he promptly did a face plant and a code blue was called. I was just arriving at this time and heard the code. They managed to get him stabilized again and I was told he probably was "dizzy" due to sedation. This was not investigated further. Even the coroner states that this was most likely caused by a small pulmonary embolism (blood clot). At this time I went in to visit with him and he kept pulling at his oxygen mask. The nurse witnessed this and put the wrist restraints back on. I want to tell you that I watched this and Joshua was not trying to remove the mask. He was pulling it away from his mouth and trying to suck in air. They automatically assumed he was trying to remove it and never questioned him as to why he was doing this. This was clearly an indication of him having trouble breathing.

	Date	Time	By	Nurse Type	
Occurred:	11/06/12	1105	KXS S ,K	RN	Category
Recorded:	11/06/12	1121	KXS S ,K	RN	Nursing Notes

Abnormal? N **Confidential?** N

JUNE 11-PT ATEMPTED TO GET UP TO VOMIT. FEET OVER BEDSIDE. DID NOT VOMIT. PUT BACK TO BED.
THEN AT APPROX 1030 PT STATED HE HAD TO HAVE BM. ASSISTED PT TO GET UP TO USE COMMODE. PT SAT HIMSELF UP AND STOOD BEDSIDE MOVING QUICKLY. A BIT SHAKY WHEN STANDING. TURNED AROUND AND SAT DOWN ON COMMODE. SOME LOOSE STOOL ALREADY IN ATTENDS. WITHIN SECONDS, PT FELL FORWARD WITH FACE PLANTED ON BED. NOT RESPONDING, COLOUR VERY PALE. CODE BLUE CALLED. GOT PT BACK TO BED. PT SWEARING TO LEAVE HIM ALONE. CODE BLUE CANCELLED.

HR WENT UP TO 130'S, SAT DOWN TO 70'S, RR 40'S. APPLIED 50% VM. PT TALKING OCCASIONALLY THEN APPEARED VERY LETHARGIC AND DECREASED LOC. RT PRESENT ALSO, ER PHYSICIAN AND ANESTHESIA. MRP ALSO ARRIVED.

BLOODWORK AND CXRAY DONE. ORDERS RECEIVED. WRIST RESTRAINTS BACK ON AS PT WAS PULLING OFF MASK.

CURRENTLY PT'S RR 29, HR 144, SAT 100% ON 100% NRB, BP 90/53. PT MORE SETTLED NOW AND COLOUR IMPROVED.

PT'S MOTHER IN AT THIS TIME AT BEDSIDE.

Note Type	Description
Problem	Airway Maintenance

Mis Diagnosis - Dr S.

Taken from the following website
http://www.healthline.com/health/aspiration-pneumonia#RiskFactors3
What Are The Symptoms Of Aspiration Pneumonia?
Symptoms of this condition are similar to other types of pneumonia. They include:
chest pain
shortness of breath
wheezing
fatigue
blue discoloration of the skin
cough, possibly with green sputum, blood, pus, or a foul odour
difficulty swallowing
bad breath
excessive sweating
Contact your doctor if you have any of these symptoms. When you do, let your doctor know if you have recently inhaled any food or liquids.
A physical exam may also find additional symptoms, such as:
decreased flow of oxygen
rapid heart rate
crackling sound in the lungs

Dr. S. diagnosed Joshua with aspirated pneumonia. I would agree at first this would be a normal diagnosis as Joshua had some of the symptoms as indicated above and it does happen when patients are intubated.. However, every X-ray taken from June 7 - 11 clearly states that the lungs were "grossly clear". This should have been proof that the symptoms Joshua had were not caused by aspirated pneumonia yet she never even considered another cause. I always believed if one diagnosis proved to be wrong a doctor would naturally look for other reasons for the symptoms. Instead she had tunnel vision and even though the chest x-rays proved her to be wrong she continued to treat him for this.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY,JOSHUA ALVIN	6531424239-ND		M	AC001671/12
ORDERING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S[illegible],		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S[illegible],T	04/11/1986	25	07/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001367673	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. L , Created: 07/06/2012 8:06:48 AM
Report ID: SQ1134651 Transcribed by: , Last Modified: 07/06/2012 8:06:48 AM

Single AP chest. No previous. Heart mediastinum is unremarkable. ETT, tip at the proximal right main bronchus - carinal junction. Repositioning is recommended. Nasogastric tube, tip in the distal esophagus. Repositioning is recommended. Lungs are grossly clear. No large pleural effusions.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
ORDERING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S , T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S , T	04/11/1986	25	07/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001367675	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. L , Created: 07/06/2012 8:07:53 AM
Report ID: SQ1134650 Transcribed by: , Last Modified: 07/06/2012 8:13:08 AM

Portable AP chest. Comparison 07/06/2012 performed at 1:04am. ETT, with the tip 1.3 cm from the carina. Repositioning is recommended. Nasogastric tube in situ, the tip in the distal esophagus. Repositioning is recommended. Heart mediastinum is unchanged. Minor atelectasis left lower lobe. Lungs otherwise clear. No large pleural effusions. Possible small left pleural effusion.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
ORDERING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S , T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S , T	04/11/1986	25	07/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001367745	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. L , Created: 07/06/2012 9:10:52 AM
Report ID: SQ1134724 Transcribed by: , Last Modified: 07/06/2012 9:10:52 AM

Single AP chest. Comparison 07/06/2012. Repositioning of the ETT, tip 2.3 cm the carina. Nasogastric tube in situ, the tip now within the stomach in the left upper quadrant. Lungs are clear. No large pleural effusions. Heart mediastinum is unremarkable.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
ORDERING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S , T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S , T	04/11/1986	25	08/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001367998	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. L , Created: 08/06/2012 7:59:36 AM
Report ID: SQ1135632 Transcribed by: , Last Modified: 08/06/2012 7:59:36 AM

Portable AP chest. Comparison 07/06/2012. Nasogastric tube in situ. ETT, 2-1 cm from the carina.
Atelectatic changes in the left lower lung zone. Lungs otherwise grossly clear. No large pleural effusion.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
ORDERING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S , T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S , T	04/11/1986	25	09/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001368251	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. P , Created: 09/06/2012 12:21:58 PM
Report ID: SQ1136615 Transcribed by: , Last Modified: 09/06/2012 12:21:58 PM

Chest x-ray

Tip of ET tube is at the level of the carina and needs to be withdrawn slightly. Allowing for projection, no change in appearances of the lungs and pleural spaces since imaging dated June 8, 2012.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
ORDERING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S , T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S , T	04/11/1986	25	10/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001368391	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. P , Created: 10/06/2012 12:01:23 PM
Report ID: SQ1136942 Transcribed by: , Last Modified: 10/06/2012 12:01:23 PM

Chest x-ray

Comparisons are made with imaging dated June 9, 2012

Tip of ET tube and NG tubes are satisfactory. Heart size is normal. There is minor new airspace change
seen in the right lung base. No other new lung or pleural pathology is seen.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
ORDERING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S , T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S , T	04/11/1986	25	10/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001368588	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. L , Created: 11/06/2012 8:19:55 AM
Report ID: SQ1137188 Transcribed by: , Last Modified: 11/06/2012 8:19:55 AM

Portable AP chest. Comparison with 10/06/2012 performed at 6:24am. ETT and NG tube in situ. Lungs
are grossly clear. No large pleural effusions seen. Heart mediastinum is unchanged.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
REFERRING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S ,T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S ,T	04/11/1986	25	11/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001368506	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. L , Created: 11/06/2012 8:19:34 AM
Report ID: SQ1137187 Transcribed by: , Last Modified: 11/06/2012 8:19:34 AM

Single AP chest. Comparison 10/06/2012. ETT and NG tube in situ. Lungs are grossly clear. No large pleural effusions seen. Heart mediastinum is unchanged.

CAMBRIDGE MEMORIAL HOSPITAL Diagnostic Imaging Department,
(519) 621-2333 ext.2230 Fax:(519) 740-4904

NAME	HEALTH CARD		SEX	ACCOUNT NUMBER
PATEY, JOSHUA ALVIN	6531424239-ND		M	AC001671/12
REFERRING PHYSICIAN	AGE STATUS	PT. STATUS	LOCATION	MEDICAL RECORD NO.
S ,T		DIS IN	577 2	016955
ATTENDING PHYSICIAN	DATE OF BIRTH	AGE	DATE OF EXAM	RADIOLOGY NO.
S ,T	04/11/1986	25	11/06/2012	00185211

EXAM#	TYPE/EXAM	RESULT
001368710	RAD/PORTABLE CHEST X090	See Chart

ORIGINAL REPORT
Dictating Physician: Dr. L , Created: 11/06/2012 11:25:58 AM
Report ID: SQ1137481 Transcribed by: , Last Modified: 11/06/2012 11:25:58 AM

Portable AP chest. Comparison with 11/06/2011. ETT and NG tube have been removed. Lungs are grossly clear. Heart mediastinum is unchanged.

Josh had many symptoms of a blood clot. Fever, sweating, edema, pink sputum and a high heart rate all the time he was in ICU which rose to over 130 the last two days until his death. Normal heart rate is between 70 - 80. Also paranoia is considered a symptom of this as well.

Pulmonary Embolism - taken from the following website

http://www.webmd.com/lung/tc/pulmonary-embolism-topic-overview
Pulmonary Embolism - Topic Overview
Pulmonary embolism is the sudden blockage of a major blood vessel (artery) in the lung, usually by a blood clot. In most cases, the clots are small and are not deadly, but they can damage the lung. But if the clot is large and stops blood flow to the lung, it can be deadly. Quick treatment could save your life or reduce the risk of future problems.

The most common symptoms are:

Sudden shortness of breath.
Sharp chest pain that is worse when you cough or take a deep breath.
A cough that brings up pink, foamy mucus.
Pulmonary embolism can also cause more general symptoms. For example, you may feel anxious or on edge, sweat a lot, feel lightheaded or faint, or have a fast heart rate or palpitations.

If you have symptoms like these, you need to see a doctor right away, especially if they are sudden and severe.

In most cases, pulmonary embolism is caused by a blood clot in the leg that breaks loose and travels to the lungs. A blood clot in a vein close to the skin is not likely to cause problems. But having blood clots in deep veins (deep vein thrombosis) can lead to pulmonary embolism. More than 300,000 people each year have deep vein thrombosis or a pulmonary embolism.1

Other things can block an artery, such as tumours, air bubbles, amniotic fluid, or fat that is released into the blood vessels when a bone is broken. But these are rare.
Anything that makes you more likely to form blood clots increases your risk of pulmonary embolism. Some people are born with blood that clots too quickly.

Other things that can increase your risk include:

Being inactive for long periods. This can happen when you have to stay in bed after surgery or a serious illness, or when you sit for a long time on a flight or car trip.
Recent surgery that involved the legs, hips, belly, or brain.
Some diseases, such as cancer, heart failure, stroke, or a severe infection.
Pregnancy and childbirth (especially if you had a cesarean section).
Taking birth control pills or hormone therapy.
Smoking.
You are also at higher risk for blood clots if you are an older adult (especially older than 70) or extremely overweight (obese).

It may be hard to diagnose pulmonary embolism, because the symptoms are like those of many other problems, such as a heart attack, a panic attack, or pneumonia.

	Date	Time	By	Nurse Type	Category
Occurred:	11/06/12	0615	JLS S ,J L.	RT	Respiratory Therapy
Recorded:	11/06/12	0624	JLS S ,J L.	RT	

Abnormal? N **Confidential?** N

Pt. suctioned for moderate amt. pink/blood tinged secretions. Sputum sample obtained.

Note Type	Description
No Type	NONE

	Date	Time	By	Nurse Type	Category
Occurred:	10/06/12	2330	JLS S ,J	RT	Respiratory Therapy
Recorded:	11/06/12	0147	JLS S ,J	RT	

Abnormal? N **Confidential?** N

Called to pt. bedside as nurse has suctioned large amt. pink/blood tinged secretions in ETT tube. Suctioned pt. multiple times for pink/ blood tinged secretions. Pt. has just had personal care done by nursing staff and is very agitated. Pt. gagging and vomitted small amt., suctioned via yankauer. Large amt. mucoid secretions also suctioned orally. O/a, air entry is heard bilat, clear b/s t/o post suction. SpO2 91%. O2 increased to 50%. SpO2 increased to 96%. TV now 1000 mls+. PS decreased to 10. Will monitor.

	Date	Time	By	Nurse Type	Category
Occurred:	11/06/12	0725	Y ,Y	RN	Nursing Notes
Recorded:	11/06/12	0726	Y ,Y	RN	

Abnormal? N **Confidential?** N

JUNE 11-LATE ENTRY- PT HAD EPISODE OF LG FROTHY PINK SECRETIONS THROUGH ETT. SPECIMEN OBTAINED.

Note Type	Description
No Type	NONE

Josh was at great risk for developing a blood clot. Some of the medications he was taking regularly can cause blood clots. He was overweight. He could have easily sustained a trauma to his body when they were fighting with him to hold him down and restrain him and I firmly believe this is what happened as he had a injury on his left ankle that they were treating. He was immobilized due to the chemical and physical restraints for over 4 days in ICU which certainly put him at very high risk for this. All patients are at risk for this and they should have known this. Dr. S. and the college maintain that giving Josh the blood thinner Heparin was standard care. No surgical stockings or physio therapy was necessary. I am enclosing an excerpt from a story that the KW record did on my story with a quote form Dr. Lawrie who was the chief of staff at the Cambridge Memorial Hospital at the time of my son's death.

Taken from the KW Record - Sept 8/12 - Story of my son's death

"Lawrie said deep vein thrombosis (DVT), which is a blood clot that forms typically in the big blood vessels in the lower legs up to the abdomen, is a constant consideration at the hospital.

The risk is assessed on every admission and appropriate preventive measures taken, including blood thinners, bed exercises and compression stockings."

Why then did my son not have surgical stockings or physio-therapy?

College Decision: Dr. S. - page 21

"Furthermore, there is nothing in the medical record to indicate that the use of restraints in this case resulted in harm. Possible harmful effects (e.g. adverse effects from immobility, injury to extremities due to efforts to escape from them) were not possible as Mr. Patey was deeply sedated and already immobile."

Joshua had a wound on his left ankle which developed a blister. He also had stiffness in his legs and edema which is swelling. As well he had a rash under his right arm from the restraints. This was evident the whole time. It is clearly documented in the records. I am attaching the pertinent records regarding this so it will be easier for you to see. There are several references to the edema (swelling) and the blister on his ankle and the rash as well as the blood tinged sputum. I have underlined them for you.

I have inserted many ICU records regarding this at the end of this submission.

As well, I have recently learned that Heparin can cause "Heparin-Induced Thrombocytopenia" which means it can cause clots instead of preventing them. I have constantly been led to believe that Heparin is a blood thinner and nobody mentioned the fact that it can cause the exact opposite in some patients.

Taken from the following website

http://emedicine.medscape.com/article/1357846-overview

Heparin-Induced Thrombocytopenia
Background
Heparin-induced thrombocytopenia (HIT) is a complication of heparin therapy. There are two types of HIT. Type 1 HIT presents within the first 2 days after exposure to heparin, and the platelet count normalizes with continued heparin therapy. Type 1 HIT is a nonimmune disorder that results from the direct effect of heparin on platelet activation.[1]

Type 2 HIT is an immune-mediated disorder that typically occurs 4-10 days after exposure to heparin and has life- and limb-threatening thrombotic complications.[1] In general medical practice, the term HIT refers to type 2 HIT.

HIT must be suspected when a patient who is receiving heparin has a decrease in the platelet count, particularly if the fall is over 50% of the baseline count, even if the platelet count nadir remains above 150 x 109/L. Clinically, HIT may manifest as skin lesions at heparin injection sites or by acute systemic reactions (eg, chills, fever, dyspnea, chest pain) after administration of an intravenous bolus of heparin.[2]

Unlike other forms of thrombocytopenia, HIT is generally not marked by bleeding; instead, venous thromboembolism (eg, deep venous thrombosis, pulmonary embolism) is the most common complication. Less often, arterial thrombosis (eg, myocardial infarction) may occur. For that reason, the disorder is sometimes termed heparin-induced thrombocytopenia and thrombosis (HITT).

Diagnosis of HIT is based on the combination of clinical findings, thrombocytopenia characteristics, and laboratory studies of HIT antibodies. See Workup. Treatment of HIT begins with discontinuation of all heparin products

(including heparin flushes of intravenous catheters). The patient should then be started on an alternative anticoagulant. See Treatment and Medication.

Dyspnea: Difficult or laboured breathing; shortness of breath. Dyspnea is a sign of serious disease of the airway, lungs, or heart. The onset of dyspnea should not be ignored; it is reason to seek medical attention.

You can see by the blood work that in fact Josh's platelet count did go down over the course of being treated with Heparin and then back up to normal. See next page

CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd., Cambridge Ont. N1R 3G2
519-621-2333 ext.2210

4A DAILY SUMMARY 5 DAY BACKUP REPORT

LOCATION
Medicine I

PATIENT: PATEY, JOSHUA ALVIN
DATE OF BIRTH: 04/11/86
REG DR: S , T

ACCT #: AC001671/12 LOC: 5MED U #: 016955
AGE/SX: 25/M ROOM: 577 REG: 06/06/12
STATUS: DIS INx BED: 2 DIS: 12/06/12
HC #: 6531424239-ND DISP:

HAEMATOLOGY

CBC

Date / Time	6 JUN 12 2300	7 JUN 12 0105	7 JUN 12 0515	8 JUN 12 1130	Reference	Units
> WBC	7.0	8.9	8.3	8.1	(4.0-10.0)	10^9/L
> RBC	4.43 L	4.19 L	4.17 L	3.48 L	(4.5-5.9)	10^12/L
> Hemoglobin	138	133 L	130 L	110 L	(135-175)	g/L
> Hematocrit	0.41	0.39 L	0.39 L	0.32 L	(0.40-0.54)	L/L
> MCV	92.2	92.2	92.3	92.2	(78-98)	fL
> MCH	31.3	31.7	31.1	31.7	(26.0-33.0)	pg
> MCHC	339	343	337	344	(320-360)	g/L
> RDW	12.3	12.4	12.7	12.4	(11-15)	%
> Platelet Count	180	178	183	116 L	(150-400)	10^9/L
> Neut.	4.9	7.4	6.0	5.8	(2.0-8.0)	10^9/L
> Lymph.	1.6	1.0	1.7	1.5	(1-4.0)	10^9/L
> Mono.	0.4	0.5	0.6	0.8	(0-1.2)	10^9/L
> Eosin.	0.0	0.0	0.0	0.1	(0-0.5)	10^9/L
> Baso.	0.0	0.0	0.0	0.0	(0-0.3)	10^9/L

Date / Time	9 JUN 12 0645	10 JUN 12 0305	11 JUN 12 0630	11 JUN 12 1100	Reference	Units
> WBC	9.8	11.0 H	16.3 H	18.9 H	(4.0-10.0)	10^9/L
> RBC	3.88 L	3.98 L	4.41 L	4.16 L	(4.5-5.9)	10^12/L
> Hemoglobin	123 L	126 L	139	132 L	(135-175)	g/L
> Hematocrit	0.36 L	0.37 L	0.41	0.39 L	(0.40-0.54)	L/L
> MCV	93.7	93.0	93.7	94.1	(78-98)	fL
> MCH	31.6	31.5	31.4	31.8	(26.0-33.0)	pg
> MCHC	337	339	335	338	(320-360)	g/L
> RDW	12.5	12.4	12.8	12.9	(11-15)	%
> Platelet Count	129 L	157	203	199	(150-400)	10^9/L
> Neut.	7.0	7.3	9.5 H	12.0 H	(2.0-8.0)	10^9/L
> Lymph.	1.8	2.0	2.9	3.6	(1-4.0)	10^9/L
> Mono.	0.8	1.1	2.4 #H	2.9 H	(0-1.2)	10^9/L
> Eosin.	0.2	0.5	1.3 #H	0.4 #	(0-0.5)	10^9/L
> Baso.	0.0	0.0	0.2	0.1	(0-0.3)	10^9/L
> Band Neut /l			0.02		(0-0.10)	
> Metamyelocyte/l			0.01 H		(0-0)	
> Myelocytes /l			0.02 H		(0-0)	
> Morphology WBC			(A)			

(A) neutrophilia, monocytosis

College Decision - Dr. S. - page 29

> "Given that immobility for a length of time is a significant risk factor for DVT along with excess weight, it was important that Mr. Patey was on heparin."

Apparently the college committee needs to read up on Heparin because apparently they are not familiar with the fact that it can do the exact opposite. I wonder just how many people have died by pulmonary embolism after receiving Heparin. The college clearly states that my son was at significant risk for DVT. Apparently Dr. S. was not aware of this "significant risk".

Joshua was most certainly at high risk for developing a blood clot and Dr. S. never considered this even after the code blue he had the morning they extubated him. She continued to assume he had aspirated pneumonia even though she was proven wrong by the chest x-rays. This is clearly medical negligence and incompetence on her part.

Premature Transfer:

College decision: Dr S. - page 23

> "Mr. Patey was stable, he was not intubated and not on isotropes, and he mobilized with assistance, hence it was reasonable to transfer him onto the Medical/Telementry unit."

My son was not anywhere near stable at this time.

On June 12/12 at approximately 12:30 I arrived to be with my son in ICU. The first thing he said to me was "Mom, you have to get me out of here. I will go to another hospital." I asked him why he said this. He said, "They don't want me here. I heard them talking." My response was that they would never say that and he had every right to be there. I was to find out later that this in fact was true and I received an apology from the hospital regarding this. Apparently they needed a bed and they were trying to decide which patient they would move. Since Joshua presented "medically well" and was watching TV they decided it would be him. It did not matter that his heart rate never came down below 130, he still had a fever, he had stomach cramps and diarrhea which could have been C-Diff (as far as anyone knew) and the fact that he was extremely paranoid. However, I did not know the truth about this until after my son died.

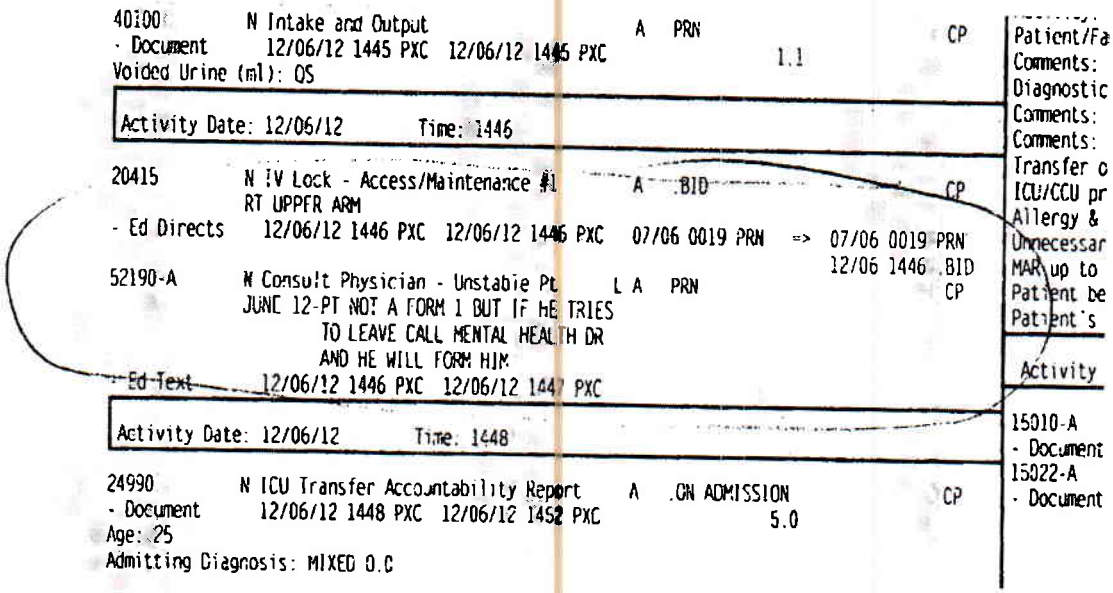
At this time I was concerned about Joshua's paranoia and went out to talk to the doctor who was standing at the desk. I voiced my concern and asked if he could be seen by a psychiatrist. She then called Dr. D. who was the psychiatrist on call and he came to assess Josh. Dr. D. was concerned as well about Joshua's mental status and prescribed medication to calm him.
I have to say I was impressed with Dr D. as he seemed to understand my son in the short time he spent with him.

At about 3:00 a lady came in and started cleaning. She said we were moving as Joshua was

being transferred. This was the first we heard of it. I wondered why they would clean the room before we even left as this is certainly not very sanitary, especially since my son had diarrhea and they did not know why. Then the nurse came in and I confirmed with her that he was being moved. I voiced my concerns as to his very high heart rate and was told not to worry as she was putting on a portable heart monitor. I still did not feel comfortable with this as Josh still had a fever, diarrhea, stomach cramps, high heart rate and was very paranoid.

At 3:30, a porter was called and came in with a wheel chair. The nurse claims Joshua transferred to the wheel chair from the bed with ease but I was present and do not remember it that way. He was very stiff and plunked down in the chair. His legs were stiff and he could not raise them to put his feet on the foot rests. I did this for him. The college maintains that his is from residual sedation, but I believe this to be a symptom of the blood clot.

They took us to the fifth floor medical unit and put Joshua at the very end of the hall, the farthest away from the nursing station in a semi private room with another patient. They did not seem to be worried about his paranoia or that he may have another episode like the one he had 5 days prior. My son was not anywhere near being stable, either physically or mentally when they transferred him. I am inserting a copy of the statement made by the nurse who was looking after Joshua when he arrived on the Medical/Telmentry unit. I am also enclosing one of the last ICU records before transfer.



40100 N Intake and Output A PRN CP
- Document 12/06/12 1445 PXC 12/06/12 1445 PXC 1.1
Voided Urine (ml): QS

Activity Date: 12/06/12 Time: 1446

20415 N IV Lock - Access/Maintenance #1 A BID CP
RT UPPER ARM
- Ed Directs 12/06/12 1446 PXC 12/06/12 1446 PXC 07/06 0019 PRN => 07/06 0019 PRN
12/06 1446 BID

52190-A N Consult Physician - Unstable Pt L A PRN CP
JUNE 12-PT NOT A FORM 1 BUT IF HE TRIES
TO LEAVE CALL MENTAL HEALTH DR
AND HE WILL FORM HIM
- Ed Text 12/06/12 1446 PXC 12/06/12 1447 PXC

Activity Date: 12/06/12 Time: 1448

24990 N ICU Transfer Accountability Report A ON ADMISSION CP
- Document 12/06/12 1448 PXC 12/06/12 1452 PXC 5.0
Age: 25
Admitting Diagnosis: MIXED O.C

Patient/Fa
Comments:
Diagnostic
Comments:
Comments:
Transfer o
ICU/CCU pr
Allergy &
Unnecessar
MAR up to
Patient be
Patient's

Activity

15010-A
- Document
15022-A
- Document

After Ms U... assisted Mr. J.P. to the commode, cleaned him, and settled him into bed, she ensured his telemetry leads were on, took the portable pack and went to the nursing station to check that the telemetry monitor at the station was showing Mr. J.P.'s cardiac rhythm. Ms U told the charge nurse that she was concerned about Mr. J.P. being on the Medicine Unit as she thought he might require one-to-one nursing. Ms U checked the screen for the telemetry unit attached to Mr. J.P. She could tell from the screen that his leads were off, so she ran back to his room. This was also when Mr. J.P.'s mother rang the call bell. Records show that the call bell was activated at 15:36:08 and cleared at 15:36:51, that is, 43 seconds later. This means it took Ms U... 43 seconds to hear the bell, race to the room, walk around the bed to the bell and press it to deactivate it. On any standard, this was a prompt response.

Ms U then reconnected the leads to Mr. J.P.'s chest. He was becoming restless and his mother worried that he was having anxiety. Ms U suggested they give him a little more time to settle. Ms U went to retrieve the chart, which was not yet processed (the ICU orders needed to be transferred into the format required for the Medicine Unit). In the meantime, because of her concerns, Ms U asked the charge nurse to call the internist and the clinical educator to call the ICU. The chart includes an RN "consultation with ICU" "called re patients HR 160 on monitor". The call to the internist did not occur until the code was called: it is documented as "called doctor to update her re code blue being initiated on patient". Around the same time that Ms U requested these phone calls, she heard the second call bell, which was activated at 15:43:17. Ms U returned to the room and cleared the call bell in less than two minutes, by 15:45:12.

Shortly after we arrived in the room, I left to arrange a phone and TV for him and when I returned 10 minutes later I found my son jumping around on the bed trying to pull out his antibiotic IV and hyperventilating. After pushing the call button, not once, but twice the nurse finally arrived. He had dislodged his heart monitor from all of his jumping around. He started turning blue and she left the room. She returned with two other nurses and tried to get oxygen on him. I watched my sons eyes roll back in his head and heard him defecate. Then, and only then, did they push the code blue. I know he was gone before they even arrived to start CPR. The last thing my son said was "Mom, don't let me go"". I will never forget the horror on his face. Joshua died within 30 minutes of being transferred from ICU.
It is obvious to me that Joshua was prematurely moved out of ICU and the most likely reason is the fact that they wanted the bed in ICU.

	Date	Time	By	Nurse Type
Occurred:	12/06/12	1525	CXU U , C	RN
Recorded:	12/06/12	1730	CXU U , C	RN

Category: Nursing Notes

Abnormal? N **Confidential?** N

PT TRANSFERRED FROM ICU VIA W/C. HE ARRIVED TO THE FLOOR WITH A PORTER AND HIS MOM. HIS VITALS SHOW AN ELEVATED TEMP AND RAPID ELEVATED HEART RATE. HE HAD TO GO TO THE WASHROOM QUICKLY AND STARTED URINATING ON HIS GOWN. HE TRANSFERRED TO THE BR WITH HELP AND HAD A LARGE LOOSE CHARCOAL-LIKE BM. I CLEANED HIM AND GOT HIM SETTLED INTO BED. THE TELEMETRY UNIT WAS INITIATED AND SHOWING A HEART RATE OF 158-160. THE ICU WAS NOTIFIED ABOUT THE INCREASED HEART RATE. THE TELEMETRY MONITOR SHOWS HIS LEADS ARE OFF. I FOUND HIM TRYING TO GET OUT OF BED AND HIS MOM WAS TRYING TO GET HIM BACK IN BED. HE WAS RESETTLED AND BREATHING RATE WAS INCREASING RAPIDLY. I WENT TO GET HIM SOME OXYGEN AND WHEN I RETURNED I CALLED FOR HELP AS HE WAS NOT RESPONDING AND TURNING BLUE. A CODE BLUE WAS CALLED AS HE WAS NOT BREATHING AND DETERIORATING VERY RAPIDLY. MOM WAS TAKEN TO THE QUIET ROOM AS THE TEAM WORKED ON THE PT.

Note Type	Description
No Type	NONE

Apparently according to the college it is alright that Dr. S.

- prescribed Haldol on June 6 since I can not prove Josh received it.
- violated the "Consent to Treatment" Act of Ontario
- violated the "Minimal Restraints" Act of Ontario
- lied about not remembering Joshua to be in restraints
- kept Joshua dangerously sedated for over 4 days for no good medical reason
- when it was proven by chest x-rays that josh did not have aspirated pneumonia it was acceptable that she never considered or investigated any other reason for his symptoms
- prematurely moved him from ICU when he was clearly not stable.

This is nothing other than medical negligence on the part of Dr. S. and yet the college does nothing except try to cover up the truth. She gets a slap on the wrist and my son is dead because of her negligence and incompetence.

Finally I would like to point out some interesting facts from the autopsy report.

Left upper limb:

- A 1 cm scar was noted on the anterolateral surface of the left forearm located 5.0 cm proximal to the left wrist.
- A well healed irregular scar of diameter 3.0 cm was noted over the midline dorsal surface of the left forearm ~~midway down the left forearm.~~
- Also to the left dorsal hand were two raised flesh coloured lesions at a level of the wrist, both 0.5 cm in diameter.

Right upper limb:

- A 2.0 cm long vertically oriented linear scar was noted to the right forearm located 5.0 cm above the right wrist on the anterior surface.
- Three well-healed faint circular scars were arranged in an oblique linear pattern ranging from a diameter 0.5 to 1.0 cm over the dorsolateral surface of the proximal right forearm.

Lower limbs:

- A linear black coloured ink pen mark was noted to the left thigh immediately below and just lateral to the left

SIGNS OF THERAPY

- An endotracheal tube was noted originating from the right angle of the mouth.
- Four EKG pads were noted: one over the right deltoid region; one over the right pectoral region; one in the midline halfway between the xiphoid and umbilicus and a fourth at the right costal margin on the anterior surface of the thorax.
- Two intravenous ports were noted; one was noted to the anteromedial surface of the left forearm halfway between the antecubital fossa and the left wrist; a second IV port site was noted along the anteromedial surface of the right proximal upper limb.
- Two pacer pads were noted; one was adherent in the midline of the thorax immediately over the xiphoid process; the second was noted overlying the left anterior superior iliac spine.
- Two bandages were also noted; one over the left antecubital fossa and another overlying an incised wound of the left posterior heel (as described below).
- An irregular patch of bruising with a central needle point site was noted over the left anterior/superior iliac spine and 15 cm from the midline.
- Four pinpoint possible needle prick sites were noted to the right lower quadrant spanning from 6 to 15 cm from the midline and each of diameter of 0.5 cm.
- Immediately lateral to this was a 6.0 cm area of bruising noted to the right flank.
- Bruising was noted to both antecubital fossae bilaterally.

SIGNS OF RECENT INJURY

By Region:

HEAD	None.
NECK	None.
TORSO	An irregular patch of abrasions was noted immediately right lateral of the xiphoid process.
BACK	None.
EXTREMITIES	There was a 3 cm horizontally oriented recent incised wound in the skin

CONTINUED FROM PREVIOUS PAGE

	of the dorsal surface of the left heel.
OTHER	None.

INTERNAL EXAMINATION

BODY CAVITIES

PERICARDIUM & CAVITY	Intact with no significant effusion was noted.
PLEURA & CAVITIES	Intact with no significant effusion was present.
DIAPHRAGM	Several punctate areas of haemorrhage were noted over the anterior surface of the bilateral domes of the diaphragm. The diaphragm was otherwise intact.
PERITONEUM & CAVITY	Intact with no significant fluid collection.
RETROPERITONEUM	Bilateral posterior soft tissue haemorrhages in the fat of the retroperitoneum were noted. There was no associated renal injury.

CARDIOVASCULAR SYSTEM

HEART (WEIGHT)	480 grams.
CORONARY ARTERIES	Appeared widely patent in all major vessels. There was no grossly evident atherosclerotic disease of the coronary arteries.
ATRIA & VENTRICLES	Anatomically normal and in correct orientation relative to one another.
CARDIAC VALVES	The cardiac valves measured in circumference as follows; • Tricuspid valve 13.0 cm. • Pulmonic valve 7.5 cm. • Mitral valve 11.0 cm • Aortic valve 6.0 cm. The cardiac valves were free of evident disease.
MYOCARDIUM	The myocardial thickness was measured as follows; • Right ventricle 0.4 cm. • Left ventricle 1.6 cm. • Interventricular septum 1.8 cm. There was slight circumferential hypertrophy of the left ventricle, but the remainder of the myocardium on sectioning was unremarkable.
AORTA	There were several small punctate haemorrhages noted to the external para aortic soft tissue overlying the ascending aorta in keeping with resuscitative injuries.
INFERIOR VENA CAVA	A thrombus was noted to the right popliteal vein.

CL

Closing

Joshua died from a treatable condition and given that he was at high risk for this and had many of the symptoms. They should have known this.

The college's decision is most certainly in favour of the doctors no matter what the facts are in the records. Apparently, doctors do not even have to follow the college's own rules. When they do not, they are only counselled to "not do this again" like you would a child. They use their medical terminology to twist the truth and try to confuse us into believing they are justified. Dr. N who medically cleared my son should be charged with criminal medical negligence. He set in motion the events that led to my son's death and did this knowingly and willfully. Dr. G and Dr. S most certainly tried to cover for Dr. N and made several incompetent decisions as well. They too, should be charged with medical negligence as well as conspiracy to commit harm to a patient. However, that will never happen since apparently doctors are "above the law". They have a license to kill. Anybody else would be charged. Everyone I have dealt with has tried to cover the truth up from the hospital, to the doctor's, to the coroners and finally the CPSO. Nobody seems to have a conscience and I wonder just how these people sleep at night. They know the truth and I know the truth and nothing will change this. Some day they all will have to answer to a higher power.

When patients are harmed or killed there is very little we can do. I have had a very rude awakening since my son died and I have learned that the very people I trusted to help my son are the ones that are responsible for his death. He was a human being, only 25 years old and like every other Canadian he deserved the best of care. Yet the ones responsible for his death are left to carry on without accountability. I have learned that they cover up for the doctors, that hospitals somehow lose records, and that suing a doctor is next to impossible since our government caps what you can sue for. I have been told by several lawyers that it would cost far more than I could hope to recoup if I was lucky enough to win. That being said, it was never about money as far as I am concerned. If you win a case against them in civil court the moneys you receive would come from the CMPA pot which is largely funded by us, the taxpayers and the doctors would not be held accountable for what they did. This proves nothing and does not serve justice.

I would like to add that if I truly believed my son received the proper care and he still died I would not be here today.

I believe everything happens for a reason. I am positive I have been chosen to fight the corruption in our medical system and I will do this until I am laid to rest next to my son.

Additional Information:

Just last Wednesday I had the pleasure of speaking with a nurse who worked at the Cambridge Hospital for 30 years. She is now retired but was working at the time my son died. I was shocked to learn the following:

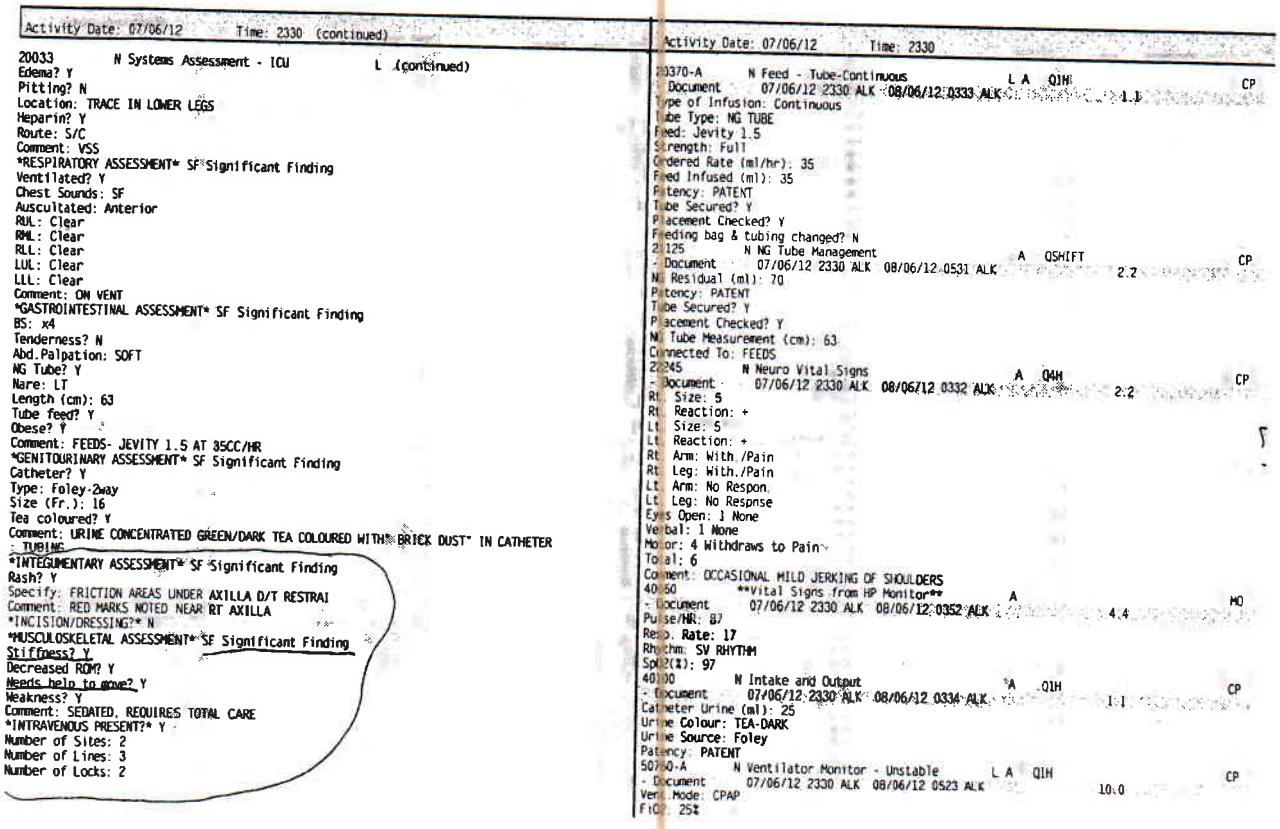
Apparently the nurse, Ms C U, who was lastly in charge of my son at the time of his death was apparently arguing with ICU before Joshua was sent up to her care. She believed he should not have been sent and at the very least had one to one nursing care. She was advocating for my son and apparently was very upset about this. I was also told she was one of the best nurses they had at the CMH.

I now feel very bad about complaining about her but of course I was not aware of this taking place. I complained how she seemed very snooty to us and that she panicked when she did not push the code when my son was turning blue. Although after my complaint she lied about a couple of things, I believe she was just afraid she would be totally blamed for his death. She resigned from the hospital very shortly after this happened. I believe the college should investigate this and question the nurses who where present in the ICU at the time as well as Ms U.

Although, of course there is nothing in the records regarding this, and it is looked upon as hearsay but it is very important to my son's case and statements from the parties involved should be obtained regarding this matter.

This is clearly just another way to cover up the truth regarding my son's condition (not stable) at the time of transfer from ICU to the Medical/Telemetry unit.

Addition ICU records showing the wound on his left heel and many symptoms of the blood clot such as edema (swelling), pink sputum, high heart rate, pitting, fever, and sweating etc.



Activity Date: 07/06/12 Time: 2330 (continued)

20033 N Systems Assessment - ICU L (continued)
Edema? Y
Pitting? N
Location: TRACE IN LOWER LEGS
Heparin? Y
Route: S/C
Comment: VSS
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
Comment: ON VENT
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: x4
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: LT
Length (cm): 63
Tube feed? Y
Obese? Y
Comment: FEEDS- JEVITY 1.5 AT 35CC/HR
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Tea coloured? Y
Comment: URINE CONCENTRATED GREEN/DARK TEA COLOURED WITH BRICK DUST" IN CATHETER - TUBING
INTEGUMENTARY ASSESSMENT SF Significant Finding
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Comment: RED MARKS NOTED NEAR RT AXILLA
INCISION/DRESSING? N
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Weakness? Y
Comment: SEDATED, REQUIRES TOTAL CARE
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 2

Activity Date: 07/06/12 Time: 2330

20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 07/06/12 2330 ALK 08/06/12 0333 ALK 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 35
Feed Infused (ml): 35
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? N
20125 N NG Tube Management A QSHIFT CP
- Document 07/06/12 2330 ALK 08/06/12 0531 ALK 2.2
NG Residual (ml): 70
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
NG Tube Measurement (cm): 63
Connected To: FEEDS
20245 N Neuro Vital Signs A Q4H CP
- Document 07/06/12 2330 ALK 08/06/12 0332 ALK 2.2
Rt. Size: 5
Rt. Reaction: +
Lt. Size: 5
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: No Respon.
Lt. Leg: No Respnse
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: OCCASIONAL MILD JERKING OF SHOULDERS
40150 **Vital Signs from HP Monitor** A MO
- Document 07/06/12 2330 ALK 08/06/12 0352 ALK 4.4
Pulse/HR: 87
Resp. Rate: 17
Rhythm: SV RHYTHM
Sp02(%): 97
40100 N Intake and Output A Q1H CP
- Document 07/06/12 2330 ALK 08/06/12 0334 ALK 1.1
Catheter Urine (ml): 25
Urine Colour: TEA-DARK
Urine Source: Foley
Patency: PATENT
50760-A N Ventilator Monitor - Unstable L A Q1H CP
- Document 07/06/12 2330 ALK 08/06/12 0523 ALK 10.0
Vent Mode: CPAP
FiO2: 25%

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Directions	Documented Units	From Change

Activity Date: 08/06/12 Time: 0230 (continued)

50760-A N Ventilator Monitor - Unstable L (continued)
PEEP: 6
Triggering? Y
Spont. Rate: 5
Spont. VT: 0
PIP: 16
SPO2(%): 96
ETT? N
Oral: N
Airway Type: Evac
Airway Route: Oral
Size: 8.0
Location @ Teeth (cm): 23
71023 N IV, Normal Saline KCL 20meq/L A Q1H
- Document 08/06/12 0230 KHD 08/06/12 0231 KHD 2.2 CP
Rate (ml/hr): 150
NS w/KCL 20meq/L In (ml): 150
Site: Forearm-R
Condition: IN SITU
Tubing Changed on: 07/06/12
71102 N IV, Versed, Continuous Infusion A Q1H
RN to titrate to lowest effective dose.
- Document 08/06/12 0230 KHD 08/06/12 0231 KHD 3.3 CP
Versed 100
mg/ 100
Rate (ml/hr): 5.0
mg/hr: 5.0
Versed Absorbed (ml): 5.0
Tubing Changed on: 07/06/12
71333 N IV, Propofol 10mg/1ml A Q1H
- Document 08/06/12 0230 KHD 08/06/12 0232 KHD 3.3 CP
kg: 98
Pulse/HR: 90
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 07/06/12

Activity Date: 08/06/12 Time: 0231

40060 **Vital Signs from HP Monitor** A MO
- Document 08/06/12 0231 ALK 08/06/12 0352 ALK 4.4
BP: 139/75

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Sts	Directions	Documented Units	From Change

Activity Date: 08/06/12 Time: 0300

40060 **Vital Signs from HP Monitor** A MO
- Document 08/06/12 0300 ALK 08/06/12 0352 ALK 4.4
Pulse/HR: 91
Resp. Rate: 15
SpO2(%): 97

Activity Date: 08/06/12 Time: 0330

20033 N Systems Assessment - ICU L A Q4H CP
- Document 08/06/12 0330 ALK 08/06/12 0526 ALK 17.2
Temperature: 38.9
Source: ORAL
Pulse/HR: 90
Source: MONITOR
Resp. Rate: 18
FiO2: 25%
O2 Delivery: Vent
SaO2(%): 97
Lt. Cuff BP: 140/80
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT NC No Change
Unable to speak? Y
MAAS Score: 1
Rt. Size: 5
Rt. Reaction: +
Lt. Size: 5
Lt. Reaction: +
Rt. Arm: With /Pain
Rt. Leg: With /Pain
Lt. Arm: No Respon.
Lt. Leg: No Respnse
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: ORAL SECRETIONS
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: Sinus
Edema? Y
Pitting? N
Location: TRACE IN LOWER LEGS
Heparin? Y
Route: S/C
Comment: VSS
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear

Activity Date: 08/06/12 Time: 0330 (continued)

0033 N Systems Assessment - ICU L (continued)
ML: Clear
LL: Clear
UL: Clear
LL: Clear
omment: ON VENT
GASTROINTESTINAL ASSESSMENT* SF Significant Finding
S: x4
enderness? N
bd.Palpation: SOFT
G Tube? Y
are: LT
ength (cm): 63
ube feed? Y
omment: FEEDS- JEVITY 1.5 AT 35CC/HR
GENITOURINARY ASSESSMENT* SF Significant Finding
atheter? Y
ype: Foley-2way
ize (Fr.): 16
oncentrated? Y
omment: URINE CONCENTRATED GREEN/DARK TEA COLOURED WITH" BRICK DUST" IN CATHETER TUBING.
INTEGUMENTARY ASSESSMENT* SF Significant Finding
ash? Y
pecify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
omment: RED MARKS NOTED NEAR RT AXILLA
INCISION/DRESSING?* N
MUSCULOSKELETAL ASSESSMENT* SF Significant Finding
tiffness? Y
ecreased ROM? Y
eeds help to move? Y
eakness? Y
omment: SEDATED, REQUIRES TOTAL CARE
INTRAVENOUS PRESENT?* Y
umber of Sites: 2
umber of Lines: 3
umber of Locks: 2
0370-A N Feed - Tube-Continuous L A Q1H CP
Document 08/06/12 0330 ALK 08/06/12 0527 ALK 1.1
ype of Infusion: Continuous
ube Type: NG TUBE
eed: Jevity 1.5
trength: Full
rdered Rate (ml/hr): 35
eed Infused (ml): 35
atency: PATENT
ube Secured? Y
lacement Checked? Y
eeding bag & tubing changed? N

Activity Date: 08/06/12 Time: 0330

21125 N NG Tube Management A QSHIFT CP
- Document 08/06/12 0330 ALK 08/06/12 0531 ALK 2.2
NG Residual (ml): 35
Tube Secured? Y
Placement Checked? Y
NG Tube Measurement (cm): 63
Connected To: FEEDS
NG Intake/Flush: WATER
NG Intake/Flush Amount (ml): 40
22245 N Neuro Vital Signs A Q4H CP
- Document 08/06/12 0330 ALK 08/06/12 0524 ALK 2.2
Rt. Size: 5
Rt. Reaction: +
Lt. Size: 5
Lt. Reaction: +
Rt. Arm: With /Pain
Rt. Leg: With /Pain
Lt. Arm: No Respon.
Lt. Leg: No Respnse
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: OCCASIONAL MILD JERKING OF SHOULDERS
40060 **Vital Signs from HP Monitor** A MO
Document 08/06/12 0330 ALK 08/06/12 0352 ALK 4.4
Pulse/HR: 87
Resp. Rate: 17
Rhythm: SV RHYTHM
SpO2(%): 97
40100 N Intake and Output A Q1H CP
Document 08/06/12 0330 ALK 08/06/12 0529 ALK 1.1
Catheter Urine (ml): 80
Urine Colour: TEA-DARK
Urine Source: Foley
Patency: PATENT
50760-A N Ventilator Monitor - Unstable L A Q1H CP
Document 08/06/12 0330 ALK 08/06/12 0523 ALK 10.0
Vent.Mode: CPAP
FiO2: 25%
PC: 12
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 25%
VT: 563
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 18
PIP: 17

Activity Date: 08/06/12 Time: 0730 (continued)

20033 N Systems Assessment - ICU L (continued)
Resp. Rate: 19
FiO2: 25%
O2 Delivery: Vent
SaO2(%): 95
Lt. Cuff BP: 144/75
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Decreased LOC? Y
Unable to speak? Y
MAAS Score: 1
Rt. Size: 5
Rt. Reaction: +
Lt. Size: 5
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: No Respon.
Lt. Leg: No Respnse
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: ON VERSED AND PROPOFOL INFUSION. RESPONDS TO PAIN/ SUCTIONING
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: ORAL SECRETIONS
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: Sinus
Pulses absent? N
Edema? Y
Pitting? N
Location: TRACE IN LOWER LEGS
Heparin? Y
Route: S/C
Comment: VSS
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: x4
Tenderness? N

Activity Date: 08/06/12 Time: 0730 (continued)

20033 N Systems Assessment - ICU L (continued)
Abd.Palpation: SOFT
NG Tube? Y
Nare: LT
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Vomiting? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Melena? N
Incontinence? N
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Sediment? Y
Concentrated? Y
Comment: URINE CONCENTRATED GREEN/DARK
INTEGUMENTARY ASSESSMENT SF Significant Finding
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Comment: RED MARKS NOTED NEAR RT AXILLA
INCISION/DRESSING? N
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 2
20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 08/06/12 0730 KXS 08/06/12 0859 KXS 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? N

Activity Date: 08/06/12 Time: 1100 (continued)

40060 **Vital Signs from HP Monitor** (continued)
Perf: 3.1

Activity Date: 08/06/12 Time: 1101

19000-C DIET Assessment, Initial 45 L A CP
- Document 08/06/12 1101 HXR 08/06/12 1101 HXR 45.0

Activity Date: 08/06/12 Time: 1110

20033 N Systems Assessment - ICU L A Q4H CP
- Document 08/06/12 1110 KXS 08/06/12 1113 KXS 17.2
Temperature: 37.8
Source: ORAL
Pulse/HR: 97
Source: MONITOR
Resp. Rate: 21
FiO2: 30%
O2 Delivery: Vent
SaO2(%): 95
Lt. Cuff BP: 143/65
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Decreased LOC? Y
Unresponsive? Y
Unable to speak? Y
MAAS Score: 1
Rt. Size: 5
Rt. Reaction: +
Lt. Size: 5
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: No Respon.
Lt. Leg: No Respnse
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: ORDER TO WEAN IV VERSED AND INITIATE MIDAZOLAM
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: ORAL SECRETIONS
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: Sinus
Pulses absent? N
Edema? Y
Location: TRACE IN LOWER LEGS
Heparin? Y
Route: S/C

Activity Date: 08/06/12 Time: 1110 (continued)

20033 N Systems Assessment - ICU L (continued)
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
Comment: CONTINUES ON CPAP AT THIS TIME
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: x4
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: LT
Length (cm): 63
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? N
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Sediment? Y
Concentrated? Y
Tea coloured? Y
Comment: URINE CONCENTRATED GREEN/DARK
INTEGUMENTARY ASSESSMENT SF Significant Finding
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Comment: RED MARKS NOTED NEAR RT AXILLA
INCISION/DRESSING? N
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y

Activity Date: 08/06/12 Time: 1832 (continued)

50760-A N Ventilator Monitor - Unstable L (continued)
EVAC Drainage Type: Mucopur.
EVAC Drainage Amt: Small
52196-A N Consult Family 10 L A PRN
- Document 08/06/12 1832 KXS 08/06/12 1836 KXS 10.0 CP
Consultation with: family
Reason for Consultation: updates provided through out the day today
: plan of care discused
Outcome: questions answered
71023 N IV, Normal Saline KCL 20meq/L A Q1H
- Document 08/06/12 1832 KXS 08/06/12 1836 KXS 2.2 CP
Rate (ml/hr): 150
NS w/KCL 20meq/L In (ml): 150
Site: Forearm-R
Condition: IN SITU
D/C'd? N
Tubing Changed on: 07/06/12
71102 N IV, Versed, Continuous Infusion A Q1H
RN to titrate to lowest effective dose.
- Document 08/06/12 1832 KXS 08/06/12 1836 KXS 3.3 CP
Versed 100
mg/ 100
Rate (ml/hr): 5.0
mg/hr: 5.0
Versed Absorbed (ml): 5.0
Tubing Changed on: 07/06/12

Activity Date: 08/06/12 Time: 1900

40060 **Vital Signs from HP Monitor** A
- Document 08/06/12 1900 NSP 08/06/12 2149 NSP 4.4 MO
Pulse/HR: 90
Resp. Rate: 24
Rhythm: SINUS RHYTHM
SpO2(%): 95

Activity Date: 08/06/12 Time: 1927

40060 **Vital Signs from HP Monitor** A
- Document 08/06/12 1927 NSP 08/06/12 2149 NSP 4.4 MO
BP: 161/87

Activity Date: 08/06/12 Time: 1930

20033 N Systems Assessment - ICU L A Q4H
- Document 08/06/12 1930 NSP 08/06/12 1947 NSP 17.2 CP
Temperature: 38.4
Source: ORAL
Pulse/HR: 88
Source: MONITOR
Resp. Rate: 25

Activity Date: 08/06/12 Time: 1930 (continued)

20033 N Systems Assessment - ICU L (continued)
FiO2: 30%
O2 Delivery: Vent
SaO2(%): 95
Lt. Cuff BP: 158/87
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Decreased LOC? Y
Unable to speak? Y
MAAS Score: 1
Rt. Size: 4
Rt. Reaction: +
Lt. Size: 4
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: No Respon.
Lt. Leg: No Respnse
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: ORDER TO WEAN IV VERSED. REMAINS SEDATED ON PROPOFOL INFUSION.
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: ORAL SECRETIONS
Comment: Ventilator mouth care provided
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: Sinus
Pulses absent? N
Edema? Y
Pitting? N
Location: FACE & EXTREMITIES
Heparin? Y
Route: S/C
Comment: VSS
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Cough? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
Comment: CONTINUES ON CPAP AT THIS TIME
GASTROINTESTINAL ASSESSMENT SF Significant Finding

Intervention Description | Activity Type | Occurred Date | Occurred Time | Recorded by | Recorded Date | Recorded Time | Recorded by | Comment | Documented Units | Sts | Directions | From Change

Activity Date: 08/06/12 Time: 1930 (continued)

20033 N Systems Assessment - ICU L (continued)
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: FAINT
LLQ: FAINT
Tenderness? N
Abd Palpation: SOFT
NG Tube? Y
Nare: LT
Length (cm): 64
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? N
Comment: Jevity feeds continue, residuals 50-75 /hr
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Comment: URINE OUTPUT QS
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot blister, intact
Comment: RED MARKS NOTED NEAR RT AXILLA
INCISION/DRESSING? N
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
Comment: SEDATED, REQUIRES TOTAL CARE
INTRAVENOUS PRESENT? Y
Number of Sites: 2

Activity Date: 08/06/12 Time: 1930 (continued)

20033 N Systems Assessment - ICU L (continued)
Number of Lines: 3
Number of Locks: 2
20370-A N Feed - Tube-Continuous L A Q1H
- Document 08/06/12 1930 NSP 08/06/12 1950 NSP 1.1 CP
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? N
40100 N Intake and Output A Q1H
- Document 08/06/12 1930 NSP 08/06/12 1948 NSP 1.1 CP
NPO? Y
Catheter Urine (ml): 175
Urine Colour: YELLOW
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H
- Document 08/06/12 1930 NSP 08/06/12 1948 NSP 5.0 CP
Vent.Mode: CPAP
FiO2: 30%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 30%
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 25
Spont. VM: 13.2
Spont. VT: 528
PIP: 17
SPO2(%): 95
ETT? Y
Sputum amount: Small
Sputum Type: Mucopur.
Oral: Y
Sputum Amount: Moderate
Sputum Type: Mucoid
Airway Type: Evac
Airway Route: Oral
Size: 8.0

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 08/06/12 Time: 2330 (continued)

20033 N Systems Assessment - ICU L (continued)
RLL: Clear
LUL: Clear
LLL: Clear
GASTROINTESTINAL ASSESSMENT NC No Change
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Dilute? Y
Comment: URINE OUTPUT OS: GREEN TINGED
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot blister, intact
Comment: RED MARKS NOTED NEAR RT AXILLA. PT IS FEBRILE THIS SHIFT. TYLENOL, ICE : PACKS PRN
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
- Edit Results 08/06/12 2330 NSP 08/06/12 2352 NSP
MUSCULOSKELETAL ASSESSMENT NC No Change []
INTRAVENOUS PRESENT? Y []
Number of Sites: 2 []
Number of Lines: 4 []
Number of Locks: 0 []
20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 08/06/12 2330 NSP 08/06/12 2348 NSP 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Additional H2O (ml): 50
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? N
21125 N NG Tube Management A QSHIFT CP
- Document 08/06/12 2330 NSP 09/06/12 0404 NSP 2.2
NG Residual (ml): 35
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
NG Tube Measurement (cm): 64
Connected To: FEEDS

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 08/06/12 Time: 2330 (continued)

21125 N NG Tube Management (continued)
NG Intake/Flush: WATER/meds
NG Intake/Flush Amount (ml): 60
NG Tube Removed? N
40100 N Intake and Output A Q1H CP
- Document 08/06/12 2330 NSP 08/06/12 2348 NSP 1.1
NPO? Y
Catheter Urine (ml): 285
Urine Colour: YELLOW
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 08/06/12 2330 NSP 08/06/12 2348 NSP 5.0
Vent.Mode: CPAP
FiO2: 30%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 30%
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 20
Spont. VM: 12.7
Spont. VT: 635
PIP: 18
SPO2(%): 96
ETT? N
Oral: N
Airway Type: Evac
Airway Route: Oral
Size: 8.0
71022 N IV. Normal Saline KCL 40meq/L A Q1H CP
- Document 08/06/12 2330 NSP 08/06/12 2349 NSP 2.2
Rate (ml/hr): 150
NS w/KCL 40meq/L In (ml): 150
Site: Forearm-R
Condition: HEALTHY
D/C'd? N
71333 N IV. Propofol 10mg/1ml A Q1H CP
- Document 08/06/12 2330 NSP 08/06/12 2349 NSP 3.3
kg: 98
Pulse/HR: 91
BP: 142/76
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 0630 (continued)

50760 N Ventilator Monitor - Stable L (continued)
Cuff Pressure (cm/H2O): 28
EVAC Lumen patent? Y
EVAC Drainage Type: Mucopur.
EVAC Drainage Amt.: Small
71022 N IV. Normal Saline KCL 40meq/L A Q1H CP
- Document 09/06/12 0630 KXS 09/06/12 0831 KXS 2.2
Rate (ml/hr): 150
NS w/KCL 40meq/L In (ml): 150
Site: Antecub-R
Condition: HEALTHY
D/C'd? N
Tubing Changed on: 07/06/12
71102 N IV. Versed. Continuous Infusion A Q1H CP
RN to titrate to lowest effective dose.
- Document 09/06/12 0630 KXS 09/06/12 0831 KXS 3.3
Versed 100
mg/ 100
Rate (ml/hr): 1.0
mg/hr: 1.0
Versed Absorbed (ml): 2.0
Tubing Changed on: 07/06/12
71333 N IV. Propofol 10mg/1ml A Q1H CP
- Document 09/06/12 0630 KXS 09/06/12 0831 KXS 3.3
kg: 98
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 09/06/12

Activity Date: 09/06/12 Time: 0700

40060 **Vital Signs from HP Monitor** A MD
- Document 09/06/12 0700 KXS 09/06/12 1653 KXS 4.4
Pulse/HR: 93
Resp. Rate: 21
Rhythm: SV RHYTHM
SpO2(%): 93

Activity Date: 09/06/12 Time: 0730

5100 N ICU Standard Care A QSHIFTICU CP
- Document 09/06/12 0730 KXS 09/06/12 0808 KXS 42.0
20033 N Systems Assessment - ICU L A Q4H CP
- Document 09/06/12 0730 KXS 09/06/12 0814 KXS 17.2
Temperature: 37.6
Source: ORAL
Pulse/HR: 88

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 0730 (continued)

20033 N Systems Assessment - ICU L (continued)
Source: MONITOR
Resp. Rate: 20
FiO2: 30%
O2 Delivery: Vent
SaO2(%): 92
Lt. Cuff BP: 156/79
Rt. Cuff BP: 131/70
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Agitated? Y
Decreased LOC? Y
Unresponsive? Y
Unable to speak? Y
MAAS Score: 0
Rt. Size: 4
Rt. Reaction: +
Lt. Size: 4
Lt. Reaction: +
Rt. Arm: No Respon.
Rt. Leg: No Respnse
Lt. Arm: No Respon.
Lt. Leg: No Respnse
Eyes Open: 1 None
Verbal: 1 None
Motor: 1 None
Total: 3
Comment: MORE RESTLESS TODAY AND DESATING. MIDAZOLAM BOLOUSES GIVEN
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: ORAL SECRETIONS
Comment: THICK COPIOUS ORAL SECRETIONS
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: Sinus
Pulses absent? N
Edema? Y
Location: FACE & EXTREMITIES
Heparin? Y
Route: S/C
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Cough? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL Clear

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 09/06/12 Time: 0330 (continued)

20033 N Systems Assessment - ICU L (continued)
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
GASTROINTESTINAL ASSESSMENT NC No Change
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Comment: URINE OUTPUT QS; GREEN TINGED
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister, intact
Comment: RED MARKS NOTED NEAR RT AXILLA. PT IS FEBRILE THIS SHIFT. TYLENOL, ICE
: PACKS PRN
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
MUSCULOSKELETAL ASSESSMENT NC No Change
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 0
20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 09/06/12 0330 NSP 09/06/12 0407 NSP 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? N
21125 N NG Tube Management A QSHIFT CP
- Document 09/06/12 0330 NSP 09/06/12 0404 NSP 2.2
NG Residual (ml): 40
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
NG Tube Measurement (cm): 64
Connected To: FEEDS

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 09/06/12 Time: 0330

40100 N Intake and Output A Q1H CP
- Document 09/06/12 0330 NSP 09/06/12 0404 NSP 1.1
NPO? Y
Catheter Urine (ml): 250
Urine Colour: YELLOW
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 09/06/12 0330 NSP 09/06/12 0405 NSP 5.0
Vent Mode: CPAP
FiO2: 30%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 30%
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 18
Spont. VM: 9.92
Spont. VT: 551
PIP: 17
SPO2(%): 95
ETT? N
Oral: Y
Sputum Amount: Copious
Sputum Type: Mucoid
Airway Type: Evac
Airway Route: Oral
Size: 8.0
71022 N IV, Normal Saline KCL 40meq/L A Q1H CP
- Document 09/06/12 0330 NSP 09/06/12 0407 NSP 2.2
Rate (ml/hr): 150
NS w/KCL 40meq/L In (ml): 150
Site: Antecub-R
Condition: HEALTHY
D/C'd? N
Tubing Changed on: 07/06/12
71102 N IV, Versed, Continuous Infusion A Q1H CP
RN to titrate to lowest effective dose.
- Document 09/06/12 0330 NSP 09/06/12 0407 NSP 3.3
Versed 100
mg/ 100
Rate (ml/hr): 3.0
mg/hr: 3.0
Versed Absorbed (ml): 3.0

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 09/06/12 Time: 0730 (continued)

20033 N Systems Assessment - ICU L (continued)
LLL: Clear
Comment: SAT DECREASED TODAY. THICKER ORAL SECRETIONS NOTED
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: FAINT
LLQ: FAINT
Tenderness? N
Abd Palpation: SOFT
NG Tube? Y
Nare: LT
Length (cm): 64
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? N
Comment: SMEARING SMALL AMOUNT OF DARK GREEN BM
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Dilute? Y
Comment: URINE REMAINS DILUTE AT THIS TIME
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister, intact
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 09/06/12 Time: 0730 (continued)

20033 N Systems Assessment - ICU L (continued)
Needs help to move? Y
Deformity? N
Weakness? Y
Comment: SEDATED, REQUIRES TOTAL CARE
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 0
20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 09/06/12 0730 KXS 09/06/12 0814 KXS 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? Y
21555 N Activity Level A PRN CP
- Document 09/06/12 0730 KXS 09/06/12 0814 KXS 1.7
Activity Order: Bedrest
Was Patient Out Of Bed? N
40100 N Intake and Output A Q1H CP
- Document 09/06/12 0730 KXS 09/06/12 1209 KXS 1.1
NPO? Y
Catheter Urine (ml): 250
Urine Colour: YELLOW
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 09/06/12 0730 KXS 09/06/12 0816 KXS 5.0
Vent Mode: CPAP
FiO2: 30%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 30%
VT: 512
PC: 12
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 20
Spont. VM: 14.2

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1130 (continued)

71102 N IV. Versed, Continuous Infusion (continued)
Rate (ml/hr): 3.0
mg/hr: 3.0
Tubing Changed on: 07/06/12
71333 N IV. Propofol 10mg/1ml A Q1H CP
- Document 09/06/12 1130 KXS 09/06/12 1217 KXS 3.3
kg: 98
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 09/06/12

Activity Date: 09/06/12 Time: 1156

40060 **Vital Signs from HP Monitor** A MO
- Document 09/06/12 1156 KXS 09/06/12 1653 KXS 4.4
BP: 148/76
BPM: 99

Activity Date: 09/06/12 Time: 1158

20033 N Systems Assessment - ICU L A Q4H CP
- Document 09/06/12 1158 KXS 09/06/12 1208 KXS 17.2
Temperature: 38.2
Source: ORAL
Pulse/HR: 84
Source: MONITOR
Resp. Rate: 20
FiO2: 55%
O2 Delivery: Vent
SaO2(%): 97
Lt. Cuff BP: 156/88
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Agitated? Y
Decreased LOC? Y
Unresponsive? Y
Unable to speak? Y
MAAS Score: 0
Rt. Size: 4
Rt. Reaction: +
Lt. Size: 4
Lt. Reaction: +
Rt. Arm: No Respon.
Rt. Leg: No Respnse
Lt. Arm: No Respon.
Lt. Leg: No Respnse

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1158 (continued)

20033 N Systems Assessment - ICU L (continued)
Eyes Open: 1 None
Verbal: 1 None
Motor: 1 None
Total: 3
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: ORAL SECRETIONS
Comment: THICK COPIOUS ORAL SECRETIONS
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: Sinus
Pulses absent? N
Edema? Y
Pitting? N
Location: FACE & EXTREMITIES
Heparin? Y
Route: S/C
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Cough? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
Comment: DESATING EARLIER, VENT SETTINGS ADJUSTED, DR SIVAKUMARAN ? FLUID OVER : LOAD, IV RATES DECREASED
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: FAINT
LLQ: FAINT
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: LT
Length (cm): 64
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Dehydrated? N
Indigestion? N

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1158 (continued)

20033 N Systems Assessment - ICU L (continued)
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? N
Comment: SMEARING SMALL AMOUNT OF DARK GREEN BM
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Concentrated? Y
Dilute? Y
Tea coloured? Y
Comment: URINE REMAINS DILUTE AT THIS TIME 300-350
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister, intact
Comment: RED MARKS NOTED NEAR RT AXILLA. PT IS FEBRILE THIS SHIFT.
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
Comment: SEDATED. REQUIRES TOTAL CARE
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 0

Activity Date: 09/06/12 Time: 1200

40060 **Vital Signs from HP Monitor** A MO
- Document 09/06/12 1200 KXS 09/06/12 1653 KXS 4.4
Pulse/HR: 87
Resp. Rate: 16
Rhythm: SV RHYTHM
VBP: PVC 0
ST3: 0.2
SpO2(%): 97

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1200 (continued)

40060 **Vital Signs from HP Monitor** (continued)
Perf: 3.9

Activity Date: 09/06/12 Time: 1215

20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 09/06/12 1215 KXS 09/06/12 1215 KXS 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? Y
20915 * Tests - In Hospital A CP
- Ed Text 09/06/12 1215 MNR 09/06/12 1215 MNR
71022 N IV. Normal Saline KCL 40meq/L A Q1H CP
- Document 09/06/12 1215 KXS 09/06/12 1216 KXS 2.2
Rate (ml/hr): 27
NS w/KCL 40meq/L In (ml): 27
Site: Antecub-R
Condition: HEALTHY
D/C'd? N
Tubing Changed on: 07/06/12
71333 N IV. Propofol 10mg/1ml A Q1H CP
- Document 09/06/12 1215 KXS 09/06/12 1217 KXS 3.3
kg: 98
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 09/06/12

Activity Date: 09/06/12 Time: 1230

20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 09/06/12 1230 KXS 09/06/12 1504 KXS 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? Y

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1459 (continued)

20033 N Systems Assessment - ICU L (continued)
LLQ: FAINT
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: LT
Length (cm): 64
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? N
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Sediment? Y
Dilute? Y
Comment: DILUTE COPIOUS URINE >300 CC/HR
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister, intact
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 0

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1500

40060 **Vital Signs from HP Monitor** A MO
- Document 09/06/12 1500 KXS 09/06/12 1653 KXS 4.4
Pulse/HR: 82
Resp. Rate: 13
Rhythm: SINUS RHYTHM
VBP: PVC 0
ST1: 0.0
ST2: 0.2
ST3: 0.2
SpO2(%): 98
Perf: 1.4

Activity Date: 09/06/12 Time: 1530

20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 09/06/12 1530 KXS 09/06/12 1644 KXS 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? Y
40100 N Intake and Output A Q1H CP
- Document 09/06/12 1530 KXS 09/06/12 1645 KXS 1.1
NPO? Y
Catheter Urine (ml): 175
Urine Colour: YELLOW
Urine Source: Foley
Patency: PATENT
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 09/06/12 1530 KXS 09/06/12 1646 KXS 5.0
Vent.Mode: CPAP
FiO2: 40%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 10
PS: 12
Vent. Mode: CPAP
FiO2: 40%
PEEP: 10
PS: 12
Triggering? Y
Spont. Rate: 15
Spont. VM: 10
Spont. VT: 666
SPO2(%): 97

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1856

40060 **Vital Signs from HP Monitor** A MO
- Document 09/06/12 1856 NSP 09/06/12 2358 NSP 4.4
BP: 138/70

Activity Date: 09/06/12 Time: 1900

40060 **Vital Signs from HP Monitor** A MO
- Document 09/06/12 1900 NSP 09/06/12 2358 NSP 4.4
Pulse/HR: 84
Resp. Rate: 12
Rhythm: SINUS RHYTHM
SpO2(%): 97

Activity Date: 09/06/12 Time: 1930

20033 N Systems Assessment - ICU L A Q4H CP
- Document 09/06/12 1930 NSP 09/06/12 2051 NSP 17.2
Temperature: 37.2
Source: ORAL
Pulse/HR: 87
Source: MONITOR
Resp. Rate: 12
FiO2: 40%
O2 Delivery: Vent
SaO2(%): 97
Lt. Cuff BP: 138/70
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Agitated? Y
Decreased LOC? Y
Unresponsive? Y
Unable to speak? Y
MAAS Score: 0
Rt. Size: 4
Rt. Reaction: +
Lt. Size: 4
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: With./Pain
Lt. Leg: With./Pain
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: REMAINS ON PROPOFOL AND VERSED INFUSIONS
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: ORAL SECRETIONS
Comment: THICK COPIOUS ORAL SECRETIONS INCREASED AMT OF CHEST SECRETIONS ALSO

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 09/06/12 Time: 1930 (continued)

20033 N Systems Assessment - ICU L (continued)
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: Sinus
Pulses absent? N
Edema? Y
Pitting? N
Location: FACE & EXTREMITIES
Heparin? Y
Route: S/C
Comment: VSS
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Cough? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
Comment: OCCASIONAL CRACKLES HEARD UPON AUSCULTATION; CLEARS WELL WITH SUCTIONING
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: FAINT
LLQ: FAINT
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: RT
Length (cm): 65
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? N
Last BM (date): 09/06/12
Comment: SMEARING SMALL AMOUNT OF DARK GREEN BM
GENITOURINARY ASSESSMENT SF Significant Finding

Activity Date: 09/06/12 Time: 1930 (continued)

20033 N Systems Assessment - ICU L (continued)
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Dilute? Y
Comment: DILUTE COPIOUS URINE >300 CC/HR; POST LASIX
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister, intact
Comment: RED MARKS NOTED NEAR RT AXILLA. PT IS FEBRILE AT TIMES
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
Comment: SEDATED, REQUIRES TOTAL CARE
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 0
20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 09/06/12 1930 NSP 09/06/12 2057 NSP 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Additional H2O (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
Feeding bag & tubing changed? Y
21125 N NG Tube Management A OSHIFT CP
- Document 09/06/12 1930 NSP 09/06/12 2052 NSP 2.2
NG Residual (ml): 20
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
NG Tube Measurement (cm): 65

Activity Date: 09/06/12 Time: 1930 (continued)

21125 N NG Tube Management (continued)
Connected To: FEEDS
NG Intake/Flush: WATER/meds
NG Intake/Flush Amount (ml): 60
NG Tube Removed? N
40100 N Intake and Output A Q1H CP
- Document 09/06/12 1930 NSP 09/06/12 2053 NSP 1.1
NPO? Y
Catheter Urine (ml): 1580
Urine Colour: CLEAR
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 09/06/12 1930 NSP 09/06/12 2056 NSP 5.0
Vent Mode: CPAP
FiO2: 40%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 10
PS: 12
Vent. Mode: CPAP
FiO2: 40%
PEEP: 10
PS: 12
Triggering? Y
Spont. Rate: 12
Spont. VM: 9.35
Spont. VT: 779
PIP: 23
SPO2(%): 97
ETT? Y
Sputum amount: Large
Sputum Type: Mucoid
Oral: Y
Sputum Amount: Large
Sputum Type: Mucoid
Airway Type: Evac
Airway Route: Oral
Size: 8.0
71022 N IV, Normal Saline KCL 40meq/L A Q1H CP
- Document 09/06/12 1930 NSP 09/06/12 2058 NSP 2.2
Rate (ml/hr): 27
NS w/KCL 40meq/L In (ml): 27
Site: Antecub-R
Condition: HEALTHY
D/C'd? N
Tubing Changed on: 07/06/12

Intervention Description Sts Directions From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 09/06/12 Time: 2200

20456 N Toileting - Incontinent Care A PRN CP
- Document 09/06/12 2200 NSP 10/06/12 0454 NSP 4.4
40060 **Vital Signs from HP Monitor** A MO
- Document 09/06/12 2200 NSP 09/06/12 2358 NSP 4.4
Pulse/HR: 97
Resp. Rate: 16
SpO2(%): 96

Activity Date: 09/06/12 Time: 2230

20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 09/06/12 2230 NSP 09/06/12 2234 NSP 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? N
Feeding bag & tubing changed? N
40100 N Intake and Output A Q1H CP
- Document 09/06/12 2230 NSP 09/06/12 2232 NSP 1.1
NPO? Y
Catheter Urine (ml): 90
Urine Colour: YELLOW
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 09/06/12 2230 NSP 09/06/12 2233 NSP 5.0
Vent Mode: CPAP
FiO2: 40%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 10
PS: 10
Vent. Mode: CPAP
FiO2: 40%
PEEP: 10
PS: 10
Triggering? Y
Spont. Rate: 16
Spont. VM: 11.0
Spont. VT: 687
PIP: 21
SPO2(%): 96
ETT? Y
Sputum amount: Large

Intervention Description Sts Directions From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 09/06/12 Time: 2230 (continued)

50760 N Ventilator Monitor - Stable L (continued)
Sputum Type: Mucoid
Oral: Y
Sputum Amount: Copious
Sputum Type: Mucoid
Airway Type: Evac
Airway Route: Oral
Size: 8.0
Location @ Teeth (cm): 22
EVAC Lumen patent? Y
EVAC Drainage Type: Bld tinged
EVAC Drainage Amt.: Small
71022 N IV, Normal Saline KCL 40meq/L A Q1H CP
- Document 09/06/12 2230 NSP 09/06/12 2234 NSP 2.2
Rate (ml/hr): 27
NS w/KCL 40meq/L In (ml): 27
Site: Antecub-R
Condition: HEALTHY
D/C'd? N
Tubing Changed on: 07/06/12
71102 N IV, Versed, Continuous Infusion A Q1H CP
RN to titrate to lowest effective dose.
- Document 09/06/12 2230 NSP 09/06/12 2234 NSP 3.3
Versed 100
mg/ 100
Rate (ml/hr): 5.0
mg/hr: 5.0
Versed Absorbed (ml): 3.0
Tubing Changed on: 07/06/12
71333 N IV, Propofol 10mg/1ml A Q1H CP
- Document 09/06/12 2230 NSP 09/06/12 2235 NSP 3.3
kg: 98
Pulse/HR: 96
BP: 132/76
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 09/06/12

Activity Date: 09/06/12 Time: 2233

60645-A N Care Plan Update 6 L A OSHIFT CP
- Document 09/06/12 2233 NSP 09/06/12 2233 NSP 6.0
CP Reviewed? Y
CP Revised? Y
Pt/Family Consulted? Y

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 09/06/12 Time: 2256												
40060 **Vital Signs from HP Monitor**										A		MO
- Document		09/06/12	2256	NSP	09/06/12	2358	NSP		4.4			
BP: 119/63												
Activity Date: 09/06/12 Time: 2300												
40060 **Vital Signs from HP Monitor**										A		MO
- Document		09/06/12	2300	NSP	09/06/12	2358	NSP		4.4			
Pulse/HR: 92												
Resp. Rate: 16												
SpO2(%): 98												
Activity Date: 09/06/12 Time: 2325												
20033 N Systems Assessment - ICU										L A Q4H		CP
- Document		09/06/12	2325	NSP	09/06/12	2329	NSP		17.2			
Temperature: 37.6												
Source: ORAL												
Pulse/HR: 85												
Source: MONITOR												
Resp. Rate: 16												
FiO2: 40%												
O2 Delivery: Vent												
SaO2(%): 98												
Lt. Cuff BP: 119/63												
Any Changes from previous assessment? N												
Patient is able to provide self-report of pain? N												
NEUROLOGICAL ASSESSMENT NC No Change												
Unable to speak? Y												
MAAS Score: 0												
Rt. Size: 4												
Rt. Reaction: +												
Lt. Size: 4												
Lt. Reaction: +												
Rt. Arm: With./Pain												
Rt. Leg: With./Pain												
Lt. Arm: With./Pain												
Lt. Leg: With./Pain												
Eyes Open: 1 None												
Verbal: 1 None												
Motor: 4 Withdraws to Pain												
Total: 6												
HEENT NC No Change												
CARDIOVASCULAR ASSESSMENT NC No Change												
Rhythm: Sinus												
Route: S/C												
RESPIRATORY ASSESSMENT SF Significant Finding												
Ventilated? Y												
Oral airway? Y												
Cough? Y												

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 09/06/12 Time: 2325 (continued)												
20033 N Systems Assessment - ICU										L	(continued)	
Chest Sounds: SF												
Auscultated: Ant/Post												
RUL: Clear												
RML: Clear												
RLL: Clear												
LUL: Clear												
LLL: Clear												
Comment: OCCASIONAL CRACKLES HEARD UPON AUSCULTATION: CLEARS WELL WITH SUCTIONING												
GASTROINTESTINAL ASSESSMENT NC No Change												
Last BM (date): 09/06/12												
GENITOURINARY ASSESSMENT NC No Change												
INTEGUMENTARY ASSESSMENT NC No Change												
INCISION/DRESSING? Y												
Incision/Drsg Location: LT HEEL												
Drsg D&I? Y												
Type: Mepore												
MUSCULOSKELETAL ASSESSMENT NC No Change												
INTRAVENOUS PRESENT? Y												
Number of Sites: 2												
Number of Lines: 3												
Number of Locks: 0												
Activity Date: 09/06/12 Time: 2330												
20370-A N Feed - Tube-Continuous										L A Q1H		CP
- Document		09/06/12	2330	NSP	09/06/12	2332	NSP		1.1			
Type of Infusion: Continuous												
Tube Type: NG TUBE												
Feed: Jevity 1.5												
Strength: Full												
Ordered Rate (ml/hr): 60												
Feed Infused (ml): 60												
Additional H2O (ml): 60												
Patency: PATENT												
Tube Secured? Y												
Placement Checked? Y												
Feeding bag & tubing changed? N												
21125 N NG Tube Management										A	QSHIFT	CP
- Document		09/06/12	2330	NSP	09/06/12	2330	NSP		2.2			
NG Residual (ml): 10												
Patency: PATENT												
Tube Secured? Y												
Placement Checked? Y												
NG Tube Measurement (cm): 65												
Connected To: FEEDS												
NG Intake/Flush: WATER/meds												
NG Intake/Flush Amount (ml): 60												
NG Tube Removed? N												

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 10/06/12 Time: 0430												
71102 N IV, Versed, Continuous Infusion										A Q1H		CP
RN to titrate to lowest effective dose.												
- Document		10/06/12	0430	NSP	10/06/12	0456	NSP		3.3			
Versed 100												
mg/ 100												
Rate (ml/hr): 5.0												
mg/hr: 5.0												
Versed Absorbed (ml): 5.0												
Tubing Changed on: 10/06/12												
71333 N IV, Propofol 10mg/1ml										A Q1H		CP
- Document		10/06/12	0430	NSP	10/06/12	0457	NSP		3.3			
kg: 98												
Pulse/HR: 86												
BP: 127/71												
Dose: 1000												
mg/ 100												
Rate (ml/hr): 29.4												
mcg/kg/min: 50.000												
mg/kg/hr: 3.000												
Propofol Absorbed: 29.4												
Tubing Changed on: 10/06/12												
Activity Date: 10/06/12 Time: 0448												
35000 RT Ventilator Monitoring										A		CP
- Document		10/06/12	0448	EXF	10/06/12	0451	EXF		5.0			
Vent.Mode: CPAP												
FiO2: 40%												
PEEP: 10												
PS: 10												
Vent. Mode: CPAP												
FiO2: 40%												
PEEP: 10												
PS: 10												
Triggering? Y												
Spont. Rate: 13												
Spont. VM: 9.24												
Spont. VT: 710												
PIP: 21												
MAP: 13												
Pulse/HR: 87												
BP: 127/71												
SPO2(%): 91												
ETT? Y												
Sputum amount: Moderate												
Sputum Type: Mucoid												
Oral: N												
Humidity: HeatedWire												
Temp: 37.0												
Airway Type: Evac												
Airway Route: Oral												

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 10/06/12 Time: 0448 (continued)												
35000 RT Ventilator Monitoring (continued)												
Size: 8.0												
Location @ Teeth (cm): 22												
Cuff Pressure (cm/H2O): 25												
EVAC Suction Type: I												
EVAC Suction Pressure (mmHg): 125												
EVAC Lumen patent? Y												
EVAC Drainage Type: Bld tinged												
EVAC Drainage Amt.: Small												
Apnea Parameters Reviewed? Y												
Alarms Reviewed? Y												
Ventilator Model: 840 #2												
Comments: See pt notes												
Activity Date: 10/06/12 Time: 0450												
20033 N Systems Assessment - ICU										L A Q4H		CP
- Document		10/06/12	0450	NSP	10/06/12	0452	NSP		17.2			
Temperature: 37.0												
Source: ORAL												
Pulse/HR: 78												
Source: MONITOR												
Resp. Rate: 24												
FiO2: 40%												
O2 Delivery: Vent												
SaO2(%): 98												
Lt. Cuff BP: 132/67												
Any Changes from previous assessment? N												
Patient is able to provide self-report of pain? N												
NEUROLOGICAL ASSESSMENT NC No Change												
Unable to speak? Y												
MAAS Score: 0												
Rt. Size: 4												
Rt. Reaction: +												
Lt. Size: 4												
Lt. Reaction: +												
Rt. Arm: With./Pain												
Rt. Leg: With./Pain												
Lt. Arm: With./Pain												
Lt. Leg: With./Pain												
Eyes Open: 1 None												
Verbal: 1 None												
Motor: 4 Withdraws to Pain												
Total: 6												
HEENT NC No Change												
CARDIOVASCULAR ASSESSMENT NC No Change												
Rhythm: Sinus												
Route: S/C												
RESPIRATORY ASSESSMENT SF Significant Finding												
Ventilated? Y												
Oral airway? Y												

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 10/06/12 Time: 0727												
40060 - Document	**Vital Signs from HP Monitor**	10/06/12	0727	KXS*	10/06/12	0810	KXS*		4.4	A		MO
BP: 130/73												
Activity Date: 10/06/12 Time: 0730												
20033 - Document	N Systems Assessment - ICU	10/06/12	0730	KXS*	10/06/12	0809	KXS*		17.2	L A Q4H		CP
Temperature: 38.1												
Source: ORAL												
Pulse/HR: 115												
Source: MONITOR												
Resp. Rate: 18												
FiO2: 40%												
O2 Delivery: Vent												
SaO2(%): 96												
Lt. Cuff BP: 130/73												
Patient is able to provide self-report of pain? N												
NEUROLOGICAL ASSESSMENT SF Significant Finding												
Decreased LOC? Y												
Unresponsive? N												
Unable to speak? Y												
MAAS Score: 1												
Rt. Size: 2												
Rt. Reaction: 4												
Lt. Size: 2												
Lt. Reaction: 4												
Rt. Arm: With./Pain												
Rt. Leg: With./Pain												
Lt. Arm: With./Pain												
Lt. Leg: With./Pain												
Eyes Open: 1 None												
Verbal: 1 None												
Motor: 4 Withdraws to Pain												
Total: 6												
Comment: REMAINS ON PROPOFOL AND VERSED INFUSIONS.												
HEENT SF Significant Finding												
Drainage/discharge? Y												
Specify: MUCOID ORAL SECRETIONS												
Comment: SUCTIONED ORALLY												
CARDIOVASCULAR ASSESSMENT SF Significant Finding												
Rhythm: ST												
Edema? Y												
Pitting? N												
Location: SLIGHT IN HANDS, FEET												
Heparin? Y												
Route: S/C												
RESPIRATORY ASSESSMENT SF Significant Finding												
Ventilated? Y												
Laboured? N												
Cough? N												

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 10/06/12 Time: 0730 (continued)												
20033	N Systems Assessment - ICU									L	(continued)	
Sputum? Y												
Chest Sounds: SF												
Auscultated: Anterior												
RUL: Clear												
RML: Clear												
RLL: Clear												
LUL: Clear												
LLL: Clear												
Comment: ORAL SECRETIONS SUCTIONED												
GASTROINTESTINAL ASSESSMENT SF Significant Finding												
BS: SF												
RUQ: FAINT												
RLQ: FAINT												
LUQ: FAINT												
LLQ: FAINT												
Abd.Palpation: SOFT												
NG Tube? Y												
Nare: RT												
Length (cm): 65												
Tube feed? Y												
NPO? Y												
Last BM (date): 10/06/12												
GENITOURINARY ASSESSMENT SF Significant Finding												
Catheter? Y												
Type: Foley-2way												
Size (Fr.): 16												
INTEGUMENTARY ASSESSMENT SF Significant Finding												
Wound? Y												
Specify: lt foot(heel) blister.												
INCISION/DRESSING? Y												
Incision/Drsg Location: LT HEEL												
Drsg D&I? Y												
Type: Mepore												
MUSCULOSKELETAL ASSESSMENT SF Significant Finding												
Needs help to move? Y												
Comment: SEDATED, REQUIRES TOTAL CARE												
INTRAVENOUS PRESENT? Y												
Number of Sites: 2												
Number of Lines: 3												
Number of Locks: 1												
20370-A - Document	N Feed - Tube-Continuous	10/06/12	0730	KXS*	10/06/12	0802	KXS*		1.1	L A Q1H		CP
Type of Infusion: Continuous												
Tube Type: NG TUBE												
Feed: Jevity 1.5												
Strength: Full												
Ordered Rate (ml/hr): 60												
Feed Infused (ml): 60												
Patency: PATENT												
Tube Secured? Y												

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 10/06/12 Time: 0850 (continued)												
35000	RT Ventilator Monitoring (continued)											
PIP: 14												
Pulse/HR: 108												
BP: 130/73												
SPO2(%): 96												
ETT? N												
Oral: N												
Humidity: HeatedWire												
Temp: 37.0												
Airway Type: Evac												
Airway Route: Oral												
Size: 8.0												
Location @ Teeth (cm): 22												
Cuff Pressure (cm/H2O): 20												
EVAC Suction Type: I												
EVAC Suction Pressure (mmHg): 125												
EVAC Lumen patent? Y												
EVAC Drainage Type: Bld tinged												
Apnea Parameters Reviewed? Y												
Alarms Reviewed? Y												
Ventilator Model: 840 #2												
Activity Date: 10/06/12 Time: 0900												
40060 - Document	**Vital Signs from HP Monitor**	10/06/12	0900	KXS*	10/06/12	1138	KXS*		4.4	A		MO
Pulse/HR: 113												
Resp. Rate: 20												
SpO2(%): 95												
Activity Date: 10/06/12 Time: 0921												
40060 - Document	**Vital Signs from HP Monitor**	10/06/12	0921	KXS*	10/06/12	1138	KXS*		4.4	A		MO
BP: 152/90												
Activity Date: 10/06/12 Time: 0930												
20370-A - Document	N Feed - Tube-Continuous	10/06/12	0930	KXS*	10/06/12	1105	KXS*		1.1	L A Q1H		CP
Type of Infusion: Continuous												
Tube Type: NG TUBE												
Feed: Jevity 1.5												
Strength: Full												
Ordered Rate (ml/hr): 60												
Feed Infused (ml): 60												
Patency: PATENT												
Tube Secured? Y												
Placement Checked? N												
Feeding bag & tubing changed? N												

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 10/06/12 Time: 0930												
35000 - Document	RT Ventilator Monitoring	10/06/12	0930	AFH	10/06/12	1240	AFH		5.0	A		CP
Vent Mode: CPAP												
FiO2: 40%												
Set Rate: 0												
Set VT: 0												
PC: 0												
PEEP: 5												
PS: 12												
Vent Mode: CPAP												
FiO2: 40%												
PEEP: 5												
PS: 12												
Triggering? Y												
Spont. Rate: 20												
Spont. VM: 6.78												
Spont. VT: 339												
PIP: 19												
Pulse/HR: 108												
BP: 127/83												
SPO2(%): 97												
ETT? N												
Oral: N												
Humidity: HeatedWire												
Temp: 37.0												
Airway Type: Evac												
Airway Route: Oral												
Location @ Teeth (cm): 22												
Cuff Pressure (cm/H2O): 20												
EVAC Suction Type: I												
EVAC Suction Pressure (mmHg): 125												
EVAC Lumen patent? Y												
EVAC Drainage Type: Bld tinged												
EVAC Drainage Amt.: Small												
Apnea Parameters Reviewed? Y												
Alarms Reviewed? Y												
Ventilator Model: 840 #2												
40100 - Document	N Intake and Output	10/06/12	0930	KXS*	10/06/12	1105	KXS*		1.1	A	Q1H	CP
NPO? Y												
Catheter Urine (ml): 25												
Urine Colour: AMBER												
Urine Source: Foley												
Patency: PATENT												
Catheter D/C? N												
50760 - Document	N Ventilator Monitor - Stable	10/06/12	0930	KXS*	10/06/12	1107	KXS*		5.0	L A	Q1H	CP
Vent Mode: CPAP												
FiO2: 40%												
Set Rate: 0												
Set VT: 0												

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1121

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 1121 KXS* 10/06/12 1138 KXS* 4.4
BP: 127/83

Activity Date: 10/06/12 Time: 1130

10092 N Assistance Additional Nsg Staff 10 L A PRN CP
- Document 10/06/12 1130 KXS* 10/06/12 1130 KXS* 10.0
20033 N Systems Assessment - ICU L A Q4H CP
- Document 10/06/12 1130 KXS* 10/06/12 1137 KXS* 17.2
Temperature: 37.7
Source: ORAL
Pulse/HR: 105
Source: MONITOR
Resp. Rate: 16
FiO2: 40%
O2 Delivery: Vent
SaO2(%): 98
Lt. Cuff BP: 127/83
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Decreased LOC? Y
Unresponsive? N
Unable to speak? Y
MAAS Score: 1
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: With./Pain
Lt. Leg: With./Pain
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: REMAINS ON PROPOFOL AND VERSED INFUSIONS. DECREASED VERSED FROM 3 TO 2MG
: PT SETTLED WITH REPOSITIONING.
HEENT SF Significant Finding
Comment: SWABBED WITH CHLORHEXADINE AND SUCTIONED
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: ST
Edema? Y
Pitting? N
Location: SLIGHT IN HANDS, FEET
Heparin? Y
Route: S/C
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Laboured? N
Cough? N
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1130 (continued)

20033 N Systems Assessment - ICU L (continued)
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Clear
Comment: ORAL SECRETIONS SUCTIONED
GASTROINTESTINAL ASSESSMENT NC No Change
Last BM (date): 10/06/12
GENITOURINARY ASSESSMENT NC No Change
INTEGUMENTARY ASSESSMENT SF Significant Finding
Diaphoretic? Y
Comment: SWEATING HEAD AND NECK
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Needs help to move? Y
Comment: REPOSITIONED.
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 1
21125 N NG Tube Management A QSHIFT CP
- Document 10/06/12 1130 KXS* 10/06/12 1534 KXS* 2.2
NG Residual (ml): 10
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
NG Tube Measurement (cm): 65
Connected To: FEEDS
NG Tube Removed? N
71102 N IV. Versed, Continuous Infusion A Q1H CP
RN to titrate to lowest effective dose.
- Document 10/06/12 1130 KXS* 10/06/12 1131 KXS* 3.3
Versed 100
mg/ 100
Rate (ml/hr): 2.0
mg/hr: 2.0
Versed Absorbed (ml): 3.0
Tubing Changed on: 10/06/12
71333 N IV. Propofol 10mg/1ml A Q1H CP
- Document 10/06/12 1130 KXS* 10/06/12 1130 KXS* 3.3
kg: 98
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1730 (continued)

71333 N IV. Propofol 10mg/1ml (continued)
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 10/06/12

Activity Date: 10/06/12 Time: 1800

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 1800 KXS* 10/06/12 1836 KXS* 4.4
Pulse/HR: 104
Resp. Rate: 19
SpO2(%): 96

Activity Date: 10/06/12 Time: 1821

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 1821 KXS* 10/06/12 1836 KXS* 4.4
BP: 108/54

Activity Date: 10/06/12 Time: 1824

35000 RT Ventilator Monitoring A CP
- Document 10/06/12 1824 AFH 10/06/12 1825 AFH 5.0
Vent.Mode: CPAP
FiO2: 35%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 35%
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 19
Spont. VM: 13.6
Spont. VT: 715
PIP: 18
Pulse/HR: 114
BP: 122/66
SPO2(%): 96
ETT? N
Oral: N
Humidity: HeatedWire
Temp: 37.0
Airway Type: Evac
Airway Route: Oral
Size: 8.0

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1824 (continued)

35000 RT Ventilator Monitoring (continued)
Location @ Teeth (cm): 22
Cuff Pressure (cm/H2O): 20
EVAC Suction Type: I
EVAC Suction Pressure (mmHg): 125
EVAC Lumen patent? Y
EVAC Drainage Type: Bld tinged
EVAC Drainage Amt.: Small
Apnea Parameters Reviewed? Y
Alarms Reviewed? Y
Ventilator Model: 840 #2
Comments: See pt notes.

Activity Date: 10/06/12 Time: 1830

20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 10/06/12 1830 KXS* 10/06/12 1833 KXS* 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? N
Feeding bag & tubing changed? N
40100 N Intake and Output A Q1H CP
- Document 10/06/12 1830 KXS* 10/06/12 1833 KXS* 1.1
Catheter Urine (ml): 40
Urine Colour: AMBER
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 10/06/12 1830 KXS* 10/06/12 1834 KXS* 5.0
Vent.Mode: CPAP
FiO2: 35%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 35%
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 19
Spont. VM: 12.7
Spont. VT: 668

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1500 (continued)

40060 **Vital Signs from HP Monitor** (continued)
SpO2(%): 94

Activity Date: 10/06/12 Time: 1521

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 1521 KXS* 10/06/12 1537 KXS* 4.4
BP: 136/84

Activity Date: 10/06/12 Time: 1530

10092 N Assistance Additional Nsg Staff 10 L A PRN CP
- Document 10/06/12 1530 KXS* 10/06/12 1530 KXS* 10.0
20033 N Systems Assessment - ICU L A Q4H CP
- Document 10/06/12 1530 KXS* 10/06/12 1537 KXS* 17.2
Temperature: 37.9
Source: ORAL
Pulse/HR: 109
Source: MONITOR
Resp. Rate: 21
FiO2: 40%
O2 Delivery: Vent
SaO2(%): 92
Lt. Cuff BP: 136/84
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Decreased LOC? Y
Unresponsive? N
Unable to speak? Y
MAAS Score: 1
Rt. Size: 2
Rt. Reaction: +
Lt. Size: 2
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: With./Pain
Lt. Leg: With./Pain
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: VERSED BOLUS TO SETTLE AFTER BM AND REPOSITIONING
HEENT NC No Change
CARDIOVASCULAR ASSESSMENT NC No Change
Rhythm: ST
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Cough? Y
Sputum? Y
Chest Sounds: SF

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1530 (continued)

20033 N Systems Assessment - ICU L (continued)
Auscultated: Anterior
RUL: Coarse Crackles
RML: Coarse Crackles
RLL: Coarse Crackles
LUL: Coarse Crackles
LLL: Coarse Crackles
Comment: COARSE CRACKLES AFTER REPOSITIONING. SUCTIONED BY RN AND RT.
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: FAINT
LLQ: FAINT
Abd Palpation: SOFT
NG Tube? Y
Nare: RT
Length (cm): 50
Tube feed? Y
NPO? Y
Incontinence? Y
Last BM (date): 10/06/12
Comment: LARGE BLACK PASTY WITH LIQUID STOOL (CHARCOAL)
GENITOURINARY ASSESSMENT NC No Change
INTEGUMENTARY ASSESSMENT NC No Change
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
MUSCULOSKELETAL ASSESSMENT NC No Change
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 1
20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 10/06/12 1530 KXS* 10/06/12 1531 KXS* 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? N
Feeding bag & tubing changed? N
21125 N NG Tube Management A QSHIFT CP
- Document 10/06/12 1530 KXS* 10/06/12 1534 KXS* 2.2
NG Residual (ml): 0
Patency: PATENT
Tube Secured? Y

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1830 (continued)

50760 N Ventilator Monitor - Stable L (continued)
PIP: 18
SPO2(%): 97
Airway Type: Evac
Airway Route: Oral
Size: 8.0
71022 N IV, Normal Saline KCL 40meq/L A Q1H CP
- Document 10/06/12 1830 KXS* 10/06/12 1834 KXS* 2.2
Rate (ml/hr): 55
NS w/KCL 40meq/L In (ml): 55
Site: Antecub-R
Condition: HEALTHY
D/C'd? N
Tubing Changed on: 10/06/12
71102 N IV, Versed, Continuous Infusion A Q1H CP
RN to titrate to lowest effective dose.
- Document 10/06/12 1830 KXS* 10/06/12 1835 KXS* 3.3
Versed 100
mg/ 100
Rate (ml/hr): 2.0
mg/hr: 2.0
Versed Absorbed (ml): 2.0
Tubing Changed on: 10/06/12
71333 N IV, Propofol 10mg/1ml A Q1H CP
- Document 10/06/12 1830 KXS* 10/06/12 1835 KXS* 3.3
kg: 98
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 10/06/12

Activity Date: 10/06/12 Time: 1851

10092 N Assistance Additional Nsg Staff 10 L A PRN CP
- Document 10/06/12 1851 KXS* 10/06/12 1851 KXS* 10.0
20195 N Catheter Care A BID CP
- Document 10/06/12 1851 KXS* 10/06/12 1851 KXS* 2.2
20456 N Toileting - Incontinent Care A PRN CP
- Document 10/06/12 1851 KXS* 10/06/12 1851 KXS* 4.4
21452 N Reposition A PRN CP
- Document 10/06/12 1851 KXS* 10/06/12 1851 KXS* 3.3
27075 N Bowel Movement, Assess A QSHIFT CP
- Document 10/06/12 1851 KXS* 10/06/12 1851 KXS* 1.7
Did patient have BM? Y
Incontinence? Y
Amount: Large
Colour: Black
Consistency: Pasty

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 10/06/12 Time: 1851 (continued)

27075 N Bowel Movement, Assess (continued)
Comment: PASTY AND WATERY

Activity Date: 10/06/12 Time: 1857

21624-A N Restraint Management 10 L A Q12SHIFT CP
- Ed Directs 10/06/12 1857 KXS* 10/06/12 1857 KXS*
==> 10/06 1857 Q12SHIFT

Activity Date: 10/06/12 Time: 1900

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 1900 YAD 11/06/12 0004 YAD 4.4
Pulse/HR: 100
SpO2(%): 95

Activity Date: 10/06/12 Time: 1921

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 1921 YAD 11/06/12 0004 YAD 4.4
BP: 111/58

Activity Date: 10/06/12 Time: 1930

5100 N ICU Standard Care A QSHIFTICU CP
- Document 10/06/12 1930 YAD 10/06/12 2233 YAD 42.0
20033 N Systems Assessment - ICU L A Q4H CP
- Document 10/06/12 1930 YAD 10/06/12 2241 YAD 17.2
Temperature: 37.6
Source: ORAL
Pulse/HR: 101
Source: MONITOR
Resp. Rate: 19
FiO2: 35%
O2 Delivery: Vent
SaO2(%): 95
Lt. Cuff BP: 129/61
Rt. Cuff BP: 132/70
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Decreased LOC? Y
Unresponsive? N
Unable to speak? Y
MAAS Score: 1
Rt. Size: 2
Rt. Reaction: +
Lt. Size: 2
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: With./Pain

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 1930 (continued)

20033 N Systems Assessment - ICU L (continued)
Lt. Leg: With./Pain
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: VERSED BOLUS TO SETTLE AFTER BM AND REPOSITIONING.
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: MUCOID ORAL SECRETIONS
Comment: SWABBED WITH CHLORHEXADINE AND SUCTIONED
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: ST
Pacemaker? N
Arterial line? N
PA Catheter? N
CVP Monitoring? N
Pulses absent? N
JVD? N
Edema? Y
Pitting? N
Location: SLIGHT IN HANDS, FEET
Cyanosis? N
Inotropes? N
Nitrates? N
Heparin? Y
Route: S/C
Comment: CARDIAC MONITOR TRACING SR-ST, NO ECTOPY. PPPX4. BP STABLE.
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Laboured? N
Cough? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Decreased Air Entry
Comment: CPAP 35% PEEP 5 PS 12
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS. x4
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: RT
Length (cm): 61
J-Tube? N

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 1930 (continued)

20033 N Systems Assessment - ICU L (continued)
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Dehydrated? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? Y
Last BM (date): 10/06/12
Comment: SMALL PASTY STOOL (CHARCOAL)
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Concentrated? Y
Tea coloured? Y
Comment: ADEQUATE HOURLY U/O.
INTEGUMENTARY ASSESSMENT SF Significant Finding
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister.
Comment: SWEATING HEAD AND NECK. FEET ELEVATED ON PILLOW TO RELEAVE HEEL PRESSURE.
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
Comment: DRSG-OPPOSITE D&I.
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
Cast/Splint? N
Comment: PT VENTED AND SEDATED REQUIRES FULL CARE.
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 1
20130-A N Bath - by One Staff L A 0D CP
- Document 10/06/12 1930 YAD 10/06/12 2241 YAD 24.2

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 2307 (continued)

35000 RT Ventilator Monitoring (continued)
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 35%
PEEP: 5
PS: 12
Spont. Rate: 18
Spont. VM: 12.3
Spont. VT: 683
PIP: 19
MAP: 9.4
Pulse/HR: 107
BP: 139/70
SPO2(%): 96
ETT? N
Oral: N
Humidity: HeatedWire
Temp: 36.9
Airway Type: Evac
Airway Route: Oral
Size: 8.0
Location @ Teeth (cm): 22
EVAC Suction Type: I
EVAC Suction Pressure (mmHg): 125
Ventilator Model: 840 #2

Activity Date: 10/06/12 Time: 2321

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 2321 YAD 11/06/12 0004 YAD 4.4
BP: 173/99

Activity Date: 10/06/12 Time: 2330

20033 N Systems Assessment - ICU L A 04H CP
- Document 10/06/12 2330 YAD 11/06/12 0002 YAD 17.2
Temperature: 38.9
Source: ORAL
Pulse/HR: 122
Source: MONITOR
Resp. Rate: 20
FiO2: 35%
O2 Delivery: Vent
SaO2(%): 96
Lt. Cuff BP: 153/81
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 2330 (continued)

20033 N Systems Assessment - ICU L (continued)
Agitated? Y
Decreased LOC? Y
Unresponsive? N
Unable to speak? Y
MAAS Score: 1
Rt. Size: 2
Rt. Reaction: +
Lt. Size: 2
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: With./Pain
Lt. Leg: With./Pain
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: PT ++AGITATED AFTER BEING CHANGED FOR BM AND REPOSITIONED. BOLUS VERSED : GIVEN.
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: MUCOID ORAL SECRETIONS
Comment: SWABBED WITH CHLORHEXADINE AND SUCTIONED
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: ST
Pacemaker? N
Arterial line? N
PA Catheter? N
CVP Monitoring? N
Pulses absent? N
JVD? N
Edema? Y
Pitting? N
Location: SLIGHT IN HANDS, FEET
Cyanosis? N
Inotropes? N
Nitrates? N
Heparin? Y
Route: S/C
Comment: CARDIAC MONITOR TRACING SR-ST, NO ECTOPY. PPPX4. BP STABLE.
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? Y
Oral airway? Y
Laboured? N
Cough? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 2330 (continued)

20033 N Systems Assessment - ICU L (continued)
RLL: Clear
LUL: Clear
LLL: Decreased Air Entry
Comment: CPAP 35% PEEP 5 PS 12. PT SUCTIONED FOR ++ FROTHY PINK SECRETIONS THROUGH
: ETT. MOD ORAL MUCOID SECRETIONS. STAT CHEST X-RAY DONE.
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: x4
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: RT
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Vomiting? Y
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? Y
Last BM (date): 10/06/12
Comment: XLG PASTY-LOOSE STOOL (CHARCOAL). PT HAD SMALL EMESIS. RESIDUALS ARE 50CC
: OF UNDIGESTED FEED ? ASPIRATION.
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Tea coloured? Y
Comment: ADEQUATE HOURLY U/O.
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Diaphoretic? Y
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister.
Comment: SWEATING HEAD AND NECK. FEET ELEVATED ON PILLOW TO RELEAVE HEEL PRESSURE.
: PT FEBRILE PRN TYLENOL ADMINISTERED.
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
Comment: DRSG-OPPOSITE D&I
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 2330 (continued)

20033 N Systems Assessment - ICU L (continued)
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
Cast/Splint? N
Comment: PT VENTED AND SEDATED REQUIRES FULL CARE.
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 3
Number of Locks: 1
20139 N Oral Assess & Care - Ventilator A QSHIFT & PRN CP
- Document 10/06/12 2330 YAD 11/06/12 0714 YAD 15.0
Lips: Moist
Mucus Membranes: Moist
Saliva: Present
Lesions: N
Tongue: Moist
Comprehensive Oral Care done? Y
20370-A N Feed - Tube-Continuous L A Q1H CP
- Document 10/06/12 2330 YAD 11/06/12 0002 YAD 1.1
Type of Infusion: Continuous
Tube Type: NG TUBE
Feed: Jevity 1.5
Strength: Full
Ordered Rate (ml/hr): 60
Feed Infused (ml): 60
Patency: PATENT
Tube Secured? Y
Placement Checked? N
Feeding bag & tubing changed? N
21125 N NG Tube Management A QSHIFT CP
- Document 10/06/12 2330 YAD 11/06/12 0711 YAD 2.2
NG Residual (ml): 50
Drainage Type: Undigested
Patency: PATENT
Tube Secured? Y
Placement Checked? N
NG Tube Measurement (cm): 57
Connected To: FEEDS
NG Tube Removed? N
27075 N Bowel Movement, Assess A QSHIFT CP
- Document 10/06/12 2330 YAD 11/06/12 0714 YAD 1.7
Did patient have BM? Y
Amount: Large
Colour: Black
Consistency: Pasty
Melena? N
Comment: PASTY AND WATERY

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 2330

40100 N Intake and Output A Q1H CP
- Document 10/06/12 2330 YAD 11/06/12 0002 YAD 1.1
NPO? Y
Catheter Urine (ml): 90
Urine Colour: AMBER
Urine Source: Foley
Patency: PATENT
Catheter D/C? N
50760 N Ventilator Monitor - Stable L A Q1H CP
- Document 10/06/12 2330 YAD 11/06/12 0003 YAD 5.0
Vent.Mode: CPAP
FiO2: 35%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 12
Vent. Mode: CPAP
FiO2: 35%
PEEP: 5
PS: 12
Triggering? Y
Spont. Rate: 20
Spont. VM: 14.6
Spont. VT: 730
PIP: 19
SPO2(%): 96
ETT? Y
Sputum amount: Copious
Sputum Type: Frothy
Oral: Y
Sputum Amount: Moderate
Sputum Type: Mucoid
Airway Type: Evac
Airway Route: Oral
Size: 8.0
Location @ Teeth (cm): 22
Cuff Pressure (cm/H2O): 20
EVAC Lumen patent? Y
EVAC Drainage Type: Bld tinged
EVAC Drainage Amt.: Small
68750 N Pain Assessment and Management A QSHIFT & PRN CP
- Document 10/06/12 2330 YAD 11/06/12 0715 YAD 7.0
Patient is able to provide self-report of pain? N
Time: 2330
Are there behaviour indicators of pain? N
Medication Administered: ON PROPOFOL AND VERSED DRIPS; RESTLESS WITH STIMULI. EXTRA
VERSED BOLUS TO HELP SETTLE.

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/06/12 Time: 2330

71021 N IV. Normal Saline (PB) A PRN CP
JUNE 7- IF U/O <60CC IN 2 HOURS THEN
MAYU GIVE 250-500ML NS BOLUS PRN X 3
- Document 10/06/12 2330 YAD 11/06/12 0721 YAD 2.2
NS Absorbed (ml): 50
Bolus? N
Tubing Changed on: 10/06/12
71022 N IV. Normal Saline KCL 40meq/L A Q1H CP
- Document 10/06/12 2330 YAD 11/06/12 0003 YAD 2.2
Rate (ml/hr): 55
NS w/KCL 40meq/L In (ml): 55
Site: Antecub-R
Condition: HEALTHY
D/C'd? N
Tubing Changed on: 10/06/12
71102 N IV. Versed, Continuous Infusion A Q1H CP
RN to titrate to lowest effective dose.
- Document 10/06/12 2330 YAD 11/06/12 0003 YAD 3.3
Versed 100
mg/ 100
Rate (ml/hr): 3.0
mg/hr: 3.0
Versed Absorbed (ml): 2.0
Tubing Changed on: 10/06/12
71333 N IV. Propofol 10mg/1ml A Q1H CP
- Document 10/06/12 2330 YAD 11/06/12 0003 YAD 3.3
kg: 98
Pulse/HR: 122
BP: 153/81
Dose: 1000
mg/ 100
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 10/06/12

Activity Date: 10/06/12 Time: 2335

40060 **Vital Signs from HP Monitor** A MO
- Document 10/06/12 2335 YAD 11/06/12 0004 YAD 4.4
BP: 153/84

Activity Date: 11/06/12 Time: 0000

40060 **Vital Signs from HP Monitor** A MO
- Document 11/06/12 0000 YAD 11/06/12 0722 YAD 4.4
Pulse/HR: 126
SpO2(%): 96

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 11/06/12 Time: 0230												
71333 N IV. Propofol 10mg/1ml										A	QIH	C
- Document		11/06/12	0230	YAD	11/06/12	0303	YAD		3.3			
kg: 98												
Pulse/HR: 136												
BP: 146/96												
Dose: 1000												
mg/ 100												
Rate (ml/hr): 29.4												
mcg/kg/min: 50.000												
mg/kg/hr: 3.000												
Propofol Absorbed: 29.4												
Tubing Changed on: 10/06/12												
Activity Date: 11/06/12 Time: 0234												
20033 N Systems Assessment - ICU										L A	Q4H	CP
- Document		11/06/12	0234	YAD	11/06/12	0242	YAD		17.2			
Temperature: 38.8												
Source: ORAL												
Pulse/HR: 136												
Source: MONITOR												
Resp. Rate: 21												
FiO2: 40%												
O2 Delivery: Vent												
SaO2(%): 97												
Lt. Cuff BP: 146/96												
Patient is able to provide self-report of pain? N												
NEUROLOGICAL ASSESSMENT SF Significant Finding												
Agitated? N												
Decreased LOC? Y												
Unresponsive? N												
Unable to speak? Y												
MAAS Score: 1												
Rt. Size: 2												
Rt. Reaction: +												
Lt. Size: 2												
Lt. Reaction: +												
Rt. Arm: With./Pain												
Rt. Leg: With./Pain												
Lt. Arm: With./Pain												
Lt. Leg: With./Pain												
Eyes Open: 1 None												
Verbal: 1 None												
Motor: 4 Withdraws to Pain												
Total: 6												
Comment: PROPOFOL @ 50MCG/KG/MIN. VERSED @ 3MG/HR.												
HEENT SF Significant Finding												
Drainage/discharge? Y												
Specify: MUCOID ORAL SECRETIONS												
CARDIOVASCULAR ASSESSMENT SF Significant Finding												
Rhythm: ST												

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 11/06/12 Time: 0234 (continued)												
20033 N Systems Assessment - ICU										L	(continued)	
Pacemaker? N												
Arterial line? N												
PA Catheter? N												
CVP Monitoring? N												
Pulses absent? N												
JVD? N												
Edema? Y												
Pitting? N												
Location: SLIGHT IN HANDS, FEET												
Cyanosis? N												
Inotropes? N												
Nitrates? N												
Heparin? Y												
Route: S/C												
Comment: CARDIAC MONITOR TRACING ST 130'S, NO ECTOPY. PPPX4 BP STABLE.												
RESPIRATORY ASSESSMENT SF Significant Finding												
Ventilated? Y												
Oral airway? Y												
Laboured? N												
Chest Sounds: SF												
Auscultated: Anterior												
RUL: Clear												
RML: Clear												
RLL: Clear												
LUL: Clear												
LLL: Decreased Air Entry												
Comment: CPAP 40% PEEP 5 PS 10.												
GASTROINTESTINAL ASSESSMENT SF Significant Finding												
BS: x4												
Tenderness? N												
Abd.Palpation: SOFT												
NG Tube? Y												
Nare: RT												
Length (cm): 67												
J-Tube? N												
G-Tube? N												
Tube feed? Y												
Obese? Y												
NPO? Y												
Nausea? N												
Vomiting? Y												
Dehydrated? N												
Indigestion? N												
Distention? N												
Flatus? N												
Diarrhea? N												
Melena? N												
Incontinence? Y												
Last BM (date): 10/06/12												
Comment: FEEDS TO BE PLACED ON HOLD FOR POSSIBLE EXTUBATION IN AM. RESIDUALS												

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 11/06/12 Time: 0234 (continued)												
20033 N Systems Assessment - ICU										L	(continued)	
: ARE 70CC OF UNDIGESTED FEED. PLACEMENT CONFIRMED THROUGH AUSCULTATION.												
GENITOURINARY ASSESSMENT SF Significant Finding												
Catheter? Y												
Type: Foley-2way												
Size (Fr.): 16												
Dilute? Y												
Comment: ADEQUATE HOURLY U/O.												
INTEGUMENTARY ASSESSMENT SF Significant Finding												
Hot? Y												
Diaphoretic? Y												
Rash? Y												
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI												
Wound? Y												
Specify: lt foot(heel) blister.												
Comment: SWEATING HEAD AND NECK. FEET ELEVATED ON PILLOW TO RELEAVE HEEL PRESSURE.												
: PT FEBRILE PRN TYLENOL ADMINISTERED.												
INCISION/DRESSING?:Y												
Incision/Drsg Location: LT HEEL												
Drsg D&I? Y												
Type: Mepore												
Comment: DRSG-OPPOSITE D&I												
MUSCULOSKELETAL ASSESSMENT SF Significant Finding												
Swelling? Y												
Tenderness? N												
Stiffness? Y												
Decreased ROM? Y												
Needs help to move? Y												
Deformity? N												
Weakness? Y												
Cast/Splint? N												
Comment: PT VENTED AND SEDATED REQUIRES FULL CARE												
INTRAVENOUS PRESENT? Y												
Number of Sites: 2												
Number of Lines: 3												
Number of Locks: 1												
Activity Date: 11/06/12 Time: 0300												
21125 N NG Tube Management										A	QSHIFT	CP
- Document		11/06/12	0300	YAD	11/06/12	0711	YAD		2.2			
NG Residual (ml): 70												
Drainage Type: Undigested												
Patency: PATENT												
Tube Secured? Y												
Placement Checked? N												
NG Tube Measurement (cm): 57												
Connected To: FEEDS												
NG Tube Removed? N												

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change
Activity Date: 11/06/12 Time: 0300												
40060 **Vital Signs from HP Monitor**										A		MO
- Document		11/06/12	0300	YAD	11/06/12	0722	YAD		4.4			
Pulse/HR: 134												
SpO2(%): 97												
Activity Date: 11/06/12 Time: 0321												
40060 **Vital Signs from HP Monitor**										A		MO
- Document		11/06/12	0321	YAD	11/06/12	0722	YAD		4.4			
BP: 102/61												
Activity Date: 11/06/12 Time: 0330												
68750 N Pain Assessment and Management										A	QSHIFT & PRN	CP
- Document		11/06/12	0330	YAD	11/06/12	0715	YAD		7.0			
Patient is able to provide self-report of pain? N												
Time: 0330												
Are there behaviour indicators of pain? N												
Medication Administered: ON PROPOFOL AND VERSED DRIPS. RESTLESS WITH STIMULI. EXTRA VERSED BOLUS TO HELP SETTLE.												
Activity Date: 11/06/12 Time: 0340												
35000 RT Ventilator Monitoring										A		CP
- Document		11/06/12	0340	JLS	11/06/12	0345	JLS		5.0			
Vent Mode: CPAP												
FiO2: 50%												
Set Rate: 0												
Set VT: 0												
PC: 0												
PEEP: 5												
PS: 10												
Vent. Mode: CPAP												
FiO2: 40%												
PEEP: 5												
PS: 10												
Spont. Rate: 25												
Spont. VM: 15.1												
Spont. VT: 604												
PIP: 16												
MAP: 9.8												
Pulse/HR: 135												
BP: 102/61												
SPO2(%): 97												
ETT? N												
Oral: N												
Humidity: HeatedWire												
Temp: 36.9												
Airway Type: Evac												
Airway Route: Oral												
Size: 8.0												

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/06/12 Time: 0730

20033 N Systems Assessment - ICU L A O4H CP
- Document 11/06/12 0730 MXS 11/06/12 0806 MXS 17.2
Temperature: 39.4
Source: ORAL
Pulse/HR: 135
Source: MONITOR
Resp. Rate: 24
FiO2: 40%
O2 Delivery: Vent
SaO2(%): 96
Lt. Cuff BP: 123/67
Patient is able to provide self-report of pain? N
NEUROLOGICAL ASSESSMENT SF Significant Finding
Agitated? N
Decreased LOC? Y
Unresponsive? N
Unable to speak? Y
MAAS Score: 1
Rt. Size: 2
Rt. Reaction: +
Lt. Size: 2
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: With./Pain
Lt. Leg: With./Pain
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6
Comment: PROPOFOL OF @ 745. VERSED OFF @ 0730
HEENT SF Significant Finding
Drainage/discharge? Y
Specify: MUCOID ORAL SECRETIONS
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: ST
Pacemaker? N
Arterial line? N
PA Catheter? N
CVP Monitoring? N
Pulses absent? N
JVD? N
Edema? Y
Pitting? N
Location: SLIGHT IN HANDS, FEET
Cyanosis? N
Inotropes? N
Nitrates? N
Heparin? Y
Route: S/C
RESPIRATORY ASSESSMENT SF Significant Finding

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/06/12 Time: 0730 (continued)

20033 N Systems Assessment - ICU L (continued)
Ventilated? Y
Oral airway? Y
Laboured? N
Cough? Y
Sputum? Y
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Decreased Air Entry
Comment: CPAP 40% PEEP 5 PS 10.
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: ABSENT
LLQ: ABSENT
Tenderness? N
Abd.Palpation: SOFT
NG Tube? Y
Nare: RT
Length (cm): 50
Drainage: Clear
J-Tube? N
G-Tube? N
Tube feed? Y
Obese? Y
NPO? Y
Nausea? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Diarrhea? N
Melena? N
Incontinence? Y
Last BM (date): 10/06/12
Comment: FEEDS TO BE PLACED ON HOLD
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Sediment? Y
Concentrated? Y
Tea coloured? Y
Comment: ADEQUATE HOURLY U/O.
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/06/12 Time: 0730 (continued)

20033 N Systems Assessment - ICU L (continued)
Diaphoretic? Y
Wound? Y
Specify: lt foot(heel) blister.
Comment: SWEATING HEAD AND NECK. FEBRILE 39.4
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg O&I? Y
Type: Mepore
Comment: DRSG-OPPOSITE O&I.
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? Y
Tenderness? N
Stiffness? Y
Decreased ROM? Y
Needs help to move? Y
Deformity? N
Weakness? Y
Cast/Splint? N
Comment: PT VENTED AND SEDATED REQUIRES FULL CARE.
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 1
Number of Locks: 1
- Edit Results 11/06/12 0730 MXS 11/06/12 1105 KXS*
Total: [6]
Comment: CPAP 40% PEEP 5 PS 8 [CPAP 40% PEEP 5 PS 10.]
Swelling? [Y]
Tenderness? [N]
Stiffness? [Y]
Decreased ROM? [Y]
20415 N IV Lock - Access/Maintenance #1 A BID CP
RT UPPER ARM
- Document 11/06/12 0730 MXS 11/06/12 0824 MXS 3.4
Flush: 3ml Normal Saline
Site: Upper Arm
Condition: O & I
20416 N IV Maintenance - Peripheral A QSHIFT CP
- Document 11/06/12 0730 MXS 11/06/12 0824 MXS 0.0
21125 N NG Tube Management A QSHIFT CP
- Document 11/06/12 0730 MXS 11/06/12 0807 MXS 2.2
NG Residual (ml): 50
Patency: PATENT
Tube Secured? Y
Placement Checked? Y
NG Tube Measurement (cm): 50
NG Intake/Flush: WATER
NG Intake/Flush Amount (ml): 130
NG Tube Removed? N

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 11/06/12 Time: 0730

23450 N Cardiac Rhythm/ECG Review A PRN CP
- Document 11/06/12 0730 MXS 11/06/12 0837 MXS 3.3
Rhythm: ST
Rate: 133
Significant Changes? N
34123 N VAP Assessment A QSHIFT CP
- Document 11/06/12 0730 KXS* 11/06/12 1015 KXS* 5.0
Intubation/Ventilation Date: 06/06/12
Today's Date: 11/06/12
# of days Ventilated: 5
Extubation/Ventilation d/c Date: 11/06/12
Time: 0820
HOB Elevated to 30 - 40 degrees? Y
Daily Sedation Vacation? Y
Oral ETT: Y
Nasal ETT: N/A
NG Tube: Nasal
Airway Type: Evac
35000 RT Ventilator Monitoring A CP
- Document 11/06/12 0730 SAH 11/06/12 0851 SAH 5.0
Vent.Mode: CPAP
FiO2: 40%
Set Rate: 0
Set VT: 0
PC: 0
PEEP: 5
PS: 8
Vent. Mode: CPAP
FiO2: 40%
PEEP: 5
PS: 8
I/E Ratio: 1:2.1
Triggering? Y
Spont. Rate: 21
Spont. VM: 14.9
Spont. VT: 709
PIP: 13
MAP: 8
Pulse/HR: 135
BP: 123/67
SPO2(%): 96
ETT? Y
Sputum amount: Scant
Sputum Type: Mucoid
Oral: Y
Sputum Amount: Moderate
Sputum Type: Bld tinged
Humidity: HeatedWire
Temp: 36.5
Airway Type: Evac
Airway Route: Oral

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 11/06/12 Time: 0730 (continued)

71333 N IV. Propofol 10mg/1ml (continued)
Rate (ml/hr): 29.4
mcg/kg/min: 50.000
mg/kg/hr: 3.000
Propofol Absorbed: 29.4
Tubing Changed on: 10/06/12

Activity Date: 11/06/12 Time: 0751

21624-A N Restraint Management 10 L A .Q12SHIFT CP
- Document 11/06/12 0751 MXS 11/06/12 0752 MXS 10.0
Standards Of Care Have Been Met? Y
Level of Restraint: Level 3
Reason for Restraint: Injury to self
Alternatives Considered: Y
Specify: SEDATION
Physician Order? N
Patient/SDM Informed Consent? N
Abrasions? N
Bruises? N
Skin tears? N
Ulcerations? N
Restraint Type: Limb Holder
Time of Application: 1930
Patient Response: ALREADY RESTRAINED TO PROTECT ETT
Alert? N
Oriented? N

Activity Date: 11/06/12 Time: 0752

5100 N ICU Standard Care A QSHIFTICU CP
- Document 11/06/12 0752 MXS 11/06/12 0752 MXS 42.0

Activity Date: 11/06/12 Time: 0800

21452 N Reposition A PRN CP
- Document 11/06/12 0800 MXS 11/06/12 0932 MXS 3.3
27075 N Bowel Movement, Assess A QSHIFT CP
- Document 11/06/12 0800 MXS 11/06/12 0931 MXS 1.7
Did patient have BM? Y
Incontinence? Y
Amount: Large
Colour: Black
Consistency: Pasty
Melena? N
Measured? N
40060 **Vital Signs from HP Monitor** A MO
- Document 11/06/12 0800 KXS* 11/06/12 1342 KXS* 4.4
Pulse/HR: 129
Resp. Rate: 15
SaO2(%): 97

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 11/06/12 Time: 0800

52190 N Consult Physician - Stable Pt L A PRN CP
- Document 11/06/12 0800 MXS 11/06/12 0919 MXS 2.1
Consultation with: DR SIVAKUMARIN
Reason for Consultation:
QUESTIONING D/C VENT/FEVER
Outcome: VENT D/C'D LESS FLUID ORDERED NG TUBE ORDERED OUT
BW ORDERED FOR FEVER

Activity Date: 11/06/12 Time: 0810

21125 N NG Tube Management A QSHIFT CP
- Document 11/06/12 0810 MXS 11/06/12 0819 MXS 2.2
NG Tube Measurement (cm): 50
NG Tube Removed? Y

Activity Date: 11/06/12 Time: 0813

40060 **Vital Signs from HP Monitor** A MO
- Document 11/06/12 0813 KXS* 11/06/12 1342 KXS* 4.4
BP: 132/65

Activity Date: 11/06/12 Time: 0817

22245 N Neuro Vital Signs A Q4H>SYS ASSESS CP
- Document 11/06/12 0817 MXS 11/06/12 0817 MXS 2.2
Rt. Size: 2
Rt. Reaction: +
Lt. Size: 2
Lt. Reaction: +
Rt. Arm: With./Pain
Rt. Leg: With./Pain
Lt. Arm: With./Pain
Lt. Leg: With./Pain
Eyes Open: 1 None
Verbal: 1 None
Motor: 4 Withdraws to Pain
Total: 6

Activity Date: 11/06/12 Time: 0821

40060 **Vital Signs from HP Monitor** A MO
- Document 11/06/12 0821 KXS* 11/06/12 1342 KXS* 4.4
BP: 129/78

Activity Date: 11/06/12 Time: 0823

20130-A N Bath - by One Staff L A QD CP
- Document 11/06/12 0823 MXS 11/06/12 0823 MXS 24.2

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 11/06/12 Time: 1130

20033 N Systems Assessment - ICU L A Q4H CP
- Document 11/06/12 1130 MXS 11/06/12 1158 MXS 17.2
Temperature: 38.5
Source: ORAL
Pulse/HR: 146
Source: MONITOR
Resp. Rate: 34
O2 Delivery: VM
SaO2(%): 99
Lt. Cuff BP: 91/48
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? Y
Pain? Denies Pain @ Rest/Movemt
NEUROLOGICAL ASSESSMENT SF Significant Finding
Headache? N
Confused? Y
Agitated? Y
Blackouts? Y
Fainting? Y
Seizures? N
Numbness? N
Tingling? N
Facial Droop? N
Paralysis? N
Decreased LOC? Y
Unresponsive? N
Vague? N
Inapprop. speech? Y
Neuro Blocked? N
Unable to speak? N
MAAS Score: 1
Rt. Size: 2
Rt. Reaction: +
Lt. Size: 2
Lt. Reaction: +
Rt. Arm: Sev. Weak.
Rt. Leg: Sev. Weak.
Lt. Arm: Sev. Weak.
Lt. Leg: Sev. Weak.
Eyes Open: 4 Spontaneously
Verbal: 3 Inappropriate
Motor: 6 Obeys Commands
Total: 13
HEENT SF Significant Finding
Bleeding gums? N
Dry mucosa? Y
Mth/lip colour abnormal? Y
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: ST
Pacemaker? N
Arterial line? N

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 11/06/12 Time: 1130 (continued)

20033 N Systems Assessment - ICU L (continued)
PA Catheter? N
CVP Monitoring? N
Pulses absent? N
JVD? N
Edema? Y
Pitting? N
Location: SLIGHT IN HANDS, FEET
Chest Pain? N
Palpitations? N
Cyanosis? N
Nitrates? N
Heparin? Y
Route: S/C
Comment: PT BP DROPPED TO 91/48
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? N
Shallow? N
Stridor? N
Cyanosis? Y
Accessory muscle use? N
Assym. Chest Movement? N
Laboured? Y
Cough? N
Sputum? N
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Decreased Air Entry
Comment: PT SAT DROPPED TO 70S WHEN UP TO COMMODE CODE CALLED
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: ABSENT
LLQ: ABSENT
Tenderness? N
Abd Palpation: SOFT
NG Tube? N
Length (cm): 50
Drainage: Clear
Obese? Y
NPO? Y
Nausea? N
Vomiting? N
Indigestion? N
Flatus? N
Diarrhea? Y

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From	Change

Activity Date: 11/06/12 Time: 1130 (continued)

20033 N Systems Assessment - ICU L (continued)
Melena? N
Incontinence? Y
Last BM (date): 11/06/12
Comment: HAD HALF POPSICLE AND ICE CHIPS
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Sediment? Y
Concentrated? Y
Dilute? Y
Tea coloured? Y
Comment: OUTPUT HAS DROPPD TO OML/H IN PAST HOUR
INTEGUMENTARY ASSESSMENT SF Significant Finding
Hot? Y
Pale? Y
Cyanosis? Y
Jaundiced? N
Flushed? N
Diaphoretic? N
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Wound? Y
Specify: lt foot(heel) blister.
Comment: SWEATING HEAD AND NECK. FEBRILE 38.5
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
Comment: DRSG-OPPOSITE D&I
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Needs help to move? Y
Deformity? N
Weakness? Y
Cast/Splint? N
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 1
Number of Locks: 1
- Edit Results 11/06/12 1130 MXS 11/06/12 1341 KXS*
FiO2: 50% []
Total: [13]
Comment: PT HAD PERIOD DECREASED LOC. PASSED OUT WHILE ON COMMODE. FLUMAZENIL []
: GIVEN. MORE ALERT BUT NOT ORIENTED. []
Comment: PT BP DROPPED TO 91/48; IV RATE INCREASED [PT BP DROPPED TO 91/48]
Shallow? Y [N]
Comment: PT SAT DROPPED TO 70S WHEN UP TO COMMODE CODE CALLED. PT RECOVERING AND
[PT SAT DROPPED TO 70S WHEN UP TO COMMODE CODE CALLED]
: RR DOWN FROM HIGH 40'S. SAT IMPROVING ON 100% NRB []
Sediment? [Y]

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From	Change

Activity Date: 11/06/12 Time: 1130 (continued)

20033 N Systems Assessment - ICU L (continued)
Concentrated? [Y]
Dilute? [Y]
Tea coloured? [Y]
Comment: OUTPUT HAS DROPPED TO OML/H IN PAST HOUR:
[OUTPUT HAS DROPPD TO OML/H IN PAST HOUR]
: NS IV BOLUS FOR LOW U/O []
Comment: NEW DRSG APPLIED. BLISTER OOZING SEROUS FLUID. [DRSG-OPPOSITE D&I.]
Comment: PT VERY WEAK BUT ABLE TO ASSIST TO REPOSITION. []
- Edit Results 11/06/12 1130 MXS 11/06/12 1426 KXS*
Length (cm): [50]
Drainage: [Clear]
40060 **Vital Signs from HP Monitor** A MD
- Document 11/06/12 1130 KXS* 11/06/12 1342 KXS* 4.4
Pulse/HR: 147
Resp. Rate: 38
SpO2(%): 98
40100 N Intake and Output A QIH CP
- Document 11/06/12 1130 KXS* 11/06/12 1335 KXS* 1.1
Catheter Urine (ml): 0
Urine Source: Foley
Patency: PATENT
Catheter D/C? N

Activity Date: 11/06/12 Time: 1141

40060 **Vital Signs from HP Monitor** A MD
- Document 11/06/12 1141 KXS* 11/06/12 1342 KXS* 4.4
BP: 91/48

Activity Date: 11/06/12 Time: 1145

19120-0 DIET Monitoring: 30 L A CP
- Document 11/06/12 1145 HXR 11/06/12 1145 HXR 30.0

Activity Date: 11/06/12 Time: 1200

20456 N Toileting - Incontinent Care A PRN CP
- Document 11/06/12 1200 KXS* 11/06/12 1334 KXS* 4.4
21452 N Reposition A PRN CP
- Document 11/06/12 1200 MXS 11/06/12 1215 MXS 3.3
21454 N Reposition - with Skin Care A PRN CP
- Document 11/06/12 1200 MXS 11/06/12 1215 MXS 5.5
40060 **Vital Signs from HP Monitor** A MD
- Document 11/06/12 1200 KXS* 11/06/12 1342 KXS* 4.4
Pulse/HR: 146
Resp. Rate: 23
SpO2(%): 92

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From	Change

Activity Date: 11/06/12 Time: 1456 (continued)

20033 N Systems Assessment - ICU L (continued)
FiO2: 2L
O2 Delivery: NP
SaO2(%): 96
Lt. Cuff BP: 111/41
Any Changes from previous assessment? Y
Patient is able to provide self-report of pain? Y
Pain? Denies Pain @ Rest/Movemt
NEUROLOGICAL ASSESSMENT SF Significant Finding
Headache? N
Confused? Y
Agitated? Y
Blackouts? N
Seizures? N
Numbness? N
Tingling? N
Facial Droop? N
Paralysis? N
Decreased LOC? N
Unresponsive? N
Vague? N
Dizzy? N
Inapprop. speech? Y
Neuro Blocked? N
Unable to speak? N
MAAS Score: 1
Rt. Size: 2
Rt. Reaction: +
Lt. Size: 2
Lt. Reaction: +
Rt. Arm: Sev. Weak.
Rt. Leg: Sev. Weak.
Lt. Arm: Sev. Weak.
Lt. Leg: Sev. Weak.
Eyes Open: 4 Spontaneously
Verbal: 3 Inappropriate
Motor: 6 Obeys Commands
Total: 6
HEENT SF Significant Finding
Vertigo? N
Tinnitus? N
Hoarse? N
Bleeding gums? N
Dry mucosa? Y
Mth/lip colour abnormal? N
Drainage/discharge? N
CARDIOVASCULAR ASSESSMENT SF Significant Finding
Rhythm: ST
Pacemaker? N
Arterial line? N
PA Catheter? N

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From	Change

Activity Date: 11/06/12 Time: 1456 (continued)

20033 N Systems Assessment - ICU L (continued)
CVP Monitoring? N
Pulses absent? N
JVD? N
Edema? Y
Pitting? N
Location: SLIGHT IN HANDS, FEET
Chest Pain? N
Palpitations? N
Cyanosis? N
Tingling? N
Calf tenderness? N
Inotropes? N
Nitrates? N
Heparin? Y
Route: S/C
RESPIRATORY ASSESSMENT SF Significant Finding
Ventilated? N
Tracheostomy? N
Oral airway? N
Chest tube? N
Cheyne Stokes? N
Kussmaul's? N
Irreg. RR? N
Apneic? N
Grunting? N
Raspy? N
Shallow? N
Stridor? N
Cyanosis? N
Accessory muscle use? N
Assym. Chest Movement? N
Laboured? Y
Cough? N
Sputum? N
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Decreased Air Entry
Comment: PT COMFORT. AND SATS ARE 96%. NO SOB
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: OCC.
LLQ: OCC.
Tenderness? N
Abd.Palpation: SOFT

Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

Activity Date: 11/06/12 Time: 1456 (continued)

20033 N Systems Assessment - ICU L (continued)
NG Tube? N
Tube feed? N
Obese? Y
NPO? N
Nausea? N
Vomiting? N
Dehydrated? Y
Indigestion? N
Distention? N
Flatus? N
Ascites? N
Diarrhea? Y
Melena? N
Incontinence? Y
Ostomy? N
Last BM (date): 11/06/12
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Swelling? N
Bruising? N
Flank pain? N
Bladder spasms? N
Distention? N
Retention? N
Dysuria? N
Nocturia? N
Urgency? N
Incontinence? N
Dribbling? N
Burning? N
Foul odour? N
Sediment? N
Discharge? N
Cloudy? N
Concentrated? N
Dilute? N
Hematuria? N
Cherry red? N
Tea coloured? Y
INTEGUMENTARY ASSESSMENT SF Significant Finding
Cold? N
Cool? N
Hot? N
Pale? N
Cyanosis? N
Jaundiced? N
Flushed? N
Diaphoretic? N

Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

Activity Date: 11/06/12 Time: 1456 (continued)

20033 N Systems Assessment - ICU L (continued)
Flaking? N
Pruritis? N
Poor turgor? N
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Burns? N
Wound? Y
Specify: lt foot(heel) blister.
Comment: TEMP DOWN TO 37.4
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
Drain(s)? N
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? N
Tenderness? N
Stiffness? N
Muscle atrophy? N
Decreased ROM? N
Needs help to move? Y
Deformity? N
Weakness? Y
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 1
Number of Locks: 1
- Edit Results 11/06/12 1456 MXS 11/06/12 1713 KXS*
FiO2: 4L [2L]
Total: [6]
- Edit Results 11/06/12 1456 MXS 11/06/12 1740 KXS*
Agitated? [Y]
MAAS Score: 4 [1]
Total: 13 []
Comment: PERIODS OF AGGITATION, SWEARING, BUT CALMS EASILY WITH EXPLANATIONS, []
: REORIENTATION []
Laboured? [Y]
Comment: TOLERATING DRINKS, PUDDING []

Activity Date: 11/06/12 Time: 1500

40060 **Vital Signs from HP Monitor** A MO
- Document 11/06/12 1500 KXS* 11/06/12 1718 KXS* 4.4
Pulse/HR: 134
Resp. Rate: 19
SpO2(%): 90

Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

Activity Date: 11/06/12 Time: 2040 (continued)

20033 N Systems Assessment - ICU L (continued)
Ventilated? N
Tracheostomy? N
Oral airway? N
Chest tube? N
Cheyne Stokes? N
Kussmaul's? N
Irreg. RR? N
Apneic? N
Grunting? N
Raspy? N
Shallow? N
Stridor? N
Cyanosis? N
Accessory muscle use? N
Assym. Chest Movement? N
Cough? N
Sputum? N
Chest Sounds: SF
Auscultated: Anterior
RUL: Clear
RML: Clear
RLL: Clear
LUL: Clear
LLL: Decreased Air Entry
Comment: pt on 3l np, sats 95%
GASTROINTESTINAL ASSESSMENT SF Significant Finding
BS: SF
RUQ: FAINT
RLQ: FAINT
LUQ: OCC
LLQ: OCC
Tenderness? N
Abd Palpation: SOFT
NG Tube? N
J-Tube? N
G-Tube? N
Obese? Y
NPO? N
Nausea? N
Vomiting? N
Dehydrated? N
Indigestion? N
Distention? N
Flatus? N
Ascites? N
Diarrhea? N
Melena? N
Incontinence? Y
Ostomy? N
Last BM (date): 11/06/12

Intervention Description | Sts | Directions | From
Activity Type | Occurred Date Time | by | Recorded Date Time | by | Comment | Documented Units | Change

Activity Date: 11/06/12 Time: 2040 (continued)

20033 N Systems Assessment - ICU L (continued)
GENITOURINARY ASSESSMENT SF Significant Finding
Catheter? Y
Type: Foley-2way
Size (Fr.): 16
Swelling? N
Bruising? N
Flank pain? N
Bladder spasms? N
Retention? N
Dysuria? N
Nocturia? N
Urgency? N
Incontinence? N
Dribbling? N
Burning? N
Foul odour? N
Sediment? N
Discharge? N
Cloudy? N
Concentrated? N
Dilute? N
Hematuria? N
Cherry red? N
Tea coloured? Y
Comment: out put qs 50 cc/hr
INTEGUMENTARY ASSESSMENT SF Significant Finding
Cold? N
Cool? N
Hot? N
Pale? N
Cyanosis? N
Jaundiced? N
Flushed? N
Diaphoretic? N
Flaking? N
Pruritis? N
Poor turgor? N
Rash? Y
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Burns? N
Wound? Y
Specify: lt foot(heel) blister.
Comment: pt febrile this assessment
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
Drain(s)? N
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? N

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 12/06/12 Time: 0030 (continued)

20033 N Systems Assessment - TCU L (continued)
Specify: FRICTION AREAS UNDER AXILLA D/T RESTRAI
Burns? N
Wound? Y
Specify: lt foot(heel) blister.
INCISION/DRESSING? Y
Incision/Drsg Location: LT HEEL
Drsg D&I? Y
Type: Mepore
Drain(s)? N
MUSCULOSKELETAL ASSESSMENT SF Significant Finding
Swelling? N
Tenderness? N
Stiffness? N
Muscle atrophy? N
Decreased ROM? N
Needs help to move? Y
Deformity? N
Weakness? Y
Cast/Splint? N
INTRAVENOUS PRESENT? Y
Number of Sites: 2
Number of Lines: 1
Number of Locks: 1

40100 N Intake and Output A Q1H CP
- Document 12/06/12 0030 KXS 12/06/12 0046 KXS 1.1
NPO? N
Catheter Urine (ml): 75
Urine Colour: AMBER
Urine Source: Foley
Patency: PATENT
Catheter D/C? N

71022 N IV, Normal Saline KCL 40meq/L A Q1H CP
- Document 12/06/12 0030 KXS 12/06/12 0046 KXS 2.2
Rate (ml/hr): 150
NS w/KCL 40meq/L In (ml): 150
Site: Antecub-R
Condition: D & I
D/C'd? N
Tubing Changed on: 10/06/12

Activity Date: 12/06/12 Time: 0130

40100 N Intake and Output A Q1H CP
- Document 12/06/12 0130 KXS 12/06/12 0250 KXS 1.1
NPO? N
Oral Intake (ml): 500
Catheter Urine (ml): 60
Urine Colour: AMBER
Urine Source: Foley
Patency: PATENT

Intervention Description	Sts	Directions	From
Activity Type / Occurred Date Time by / Recorded Date Time by / Comment / Documented Units / Change			

Activity Date: 12/06/12 Time: 0130

71022 N IV, Normal Saline KCL 40meq/L A Q1H CP
- Document 12/06/12 0130 KXS 12/06/12 0258 KXS 2.2
Rate (ml/hr): 150
NS w/KCL 40meq/L In (ml): 150
Site: Antecub-R
Condition: D & I
D/C'd? N
Tubing Changed on: 10/06/12

Activity Date: 12/06/12 Time: 0230

40100 N Intake and Output A Q1H CP
- Document 12/06/12 0230 KXS 12/06/12 0250 KXS 1.1
NPO? N
Catheter Urine (ml): 50
Urine Colour: AMBER
Urine Source: Foley
Patency: PATENT
Catheter D/C? N

71022 N IV, Normal Saline KCL 40meq/L A Q1H CP
- Document 12/06/12 0230 KXS 12/06/12 0258 KXS 2.2
Rate (ml/hr): 150
NS w/KCL 40meq/L In (ml): 150
Site: Antecub-R
Condition: D & I
D/C'd? N
Tubing Changed on: 10/06/12

Activity Date: 12/06/12 Time: 0251

90000 N Orientate/Re-orientate A PRN CP
- Document 12/06/12 0251 KXS 12/06/12 0251 KXS ...
90390-A N Emotional Support 10 L A PRN CP
- Document 12/06/12 0251 KXS 12/06/12 0256 KXS 8.3 10.0
Provided To: Patient
Initiated By: RN
Presenting Problem: Unaware at times of events that lead him to be hospitalized
Content: reminded of reason why he is the hospital
: patient forgetful and often feels he is here because he was in a plane
: crash
: discussed events that have in fact occured over the last few days
Outcome: Josh is easily redirected
: able to rationalize and reorientate Josh

Activity Date: 12/06/12 Time: 0257

20130-A N Bath - by One Staff L A OD CP
- Document 12/06/12 0257 KXS 12/06/12 0257 KXS 24.2