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Age: 66 years Sex: F
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National Simulation Health Service
Patient Admission Details

(Affix Patient Label Here)

URN:

Family Name:

Given Name(s):

Address:

DOB: Sex:

ADMISSION DETAILS

Date of Admission:

Admitting Details: 66 YEAR OLD FEMALE; BIBA; FOUND UNCONSCIOUS ON KITCHEN FLOOR BY HUSBAND. EXPRESSIVE APHASIA AND RIGHT SIDED WEAKNESS NOTED WHEN CONSCIOUNESS REGAINED. CT SCAN – LEFT HEMISPHERE STROKE.

PATIENT PERSONAL DETAILS

Title:	MRS	Surname:	HENDERSON	First Name:	MARGARET
Other Names:	LOUISE	Preferred Name:	MARGIE		
Address:	19 HAROLD STREET			Suburb:	MIDDLETON
Home Phone:	1000 1599	Mobile Phone:	0478 962 383	Work Phone:	-
Religion:	CATHOLIC				
Primary Language:	ENGLISH				
Occupation:	HOUSE WIFE				
Medicare Number:	3890 96501 5	DVA Number:		Pension:	N/A
Private Health Fund:	AHM	Membership Number:	207160848		

MEDICAL HISTORY

Medical Conditions: HTN

Current Medication: COVERSYL 100mg q.d

Allergies: NIL KNOWN

CONTACTS

First Emergency Contact

Name:	JOHN HENDERSON			Relationship to Patient:	HUSBAND
Home Phone:	1000 1599	Mobile Phone:	0478 962 385	Work Phone:	

Second Emergency Contact

Name:	JESSICA COLLINS			Relationship to Patient:	DAUGHTER
Home Phone:	-	Mobile Phone:	0441 756 939	Work Phone:	-

General Practitioner (GP)

Doctor Name:	DR GERALDINE COOKS	Practice:	MIDDLETON MEDICAL PRACTICE
Address:	1807 MIDDLE ROAD	Suburb:	MIDDLETON
Work Phone:	1000 6542	Mobile Phone:	N/A

National Simulation Health Service

FINAL RADIOLOGY REPORT

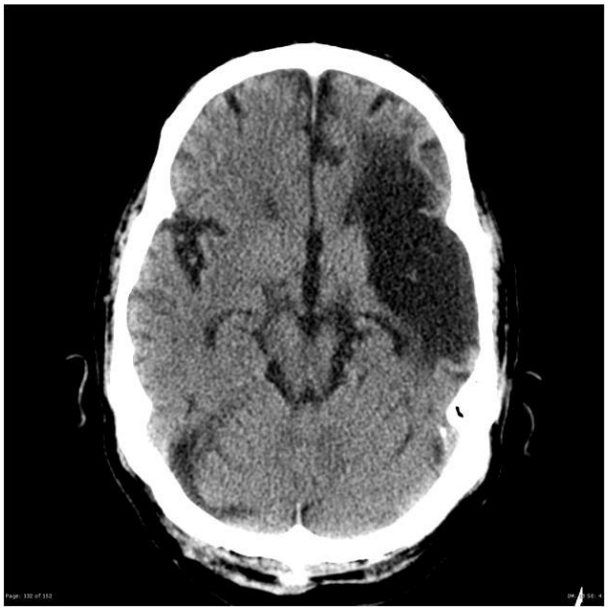
Patient Name: Margaret Henderson **URN:** 24586

Requesting Doctor: Dr S. Myers *(Registrar)*

Clinical History: Pt admitted to NSHS. Found on floor by husband; unconscious. ? stroke

---

EXAMINATION: CT head



TECHNIQUE:
Axial images obtained without contrast.

COMPARISON:
No prior studies available for comparison.

FINDINGS:
Infarction to left middle cerebral artery.
Encephalomalacia and surrounding gliosis.

SCOTT EVANS
Radiologist

-- END OF REPORT --

National Simulation Health Service

PROGRESS NOTES
INPATIENT

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DATE & TIME	*Add signature, printed name, staff category, date and time to all entries.* MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
DD/MM/YY	**EMERGENCY MED TEAM:**
1130hrs	C/O: 66yo F presents with ? stroke. Husband reports finding pt on kitchen floor
	unconscious when he returned home. As per husband, Pt has previously been well with
	nil recent illnesses.
	- Reduced movement on R) side. R) facial droop noted.
	- Nil nausea/vomiting/diarrhoea
	- Nil fevers/chills
	- Nil dysuria or frequency
	- Nil cough or chest pain
	- Pt denies any pain
	- Nil previous hx stroke
	PMHx: HTN on coversyl. Usual BP~150mmHg systolic
	Medications: - Coversyl 100mg b.d
	Allergies: Nil known.
	Social Hx: - Lives with husband. Married for 35years
	- Independent with ADLs
	- Active in church community
	- 2 adult children, 5 grandchildren
	Physical Exam:
	OBS - T: 36.4°C (Tympanic) HR: 58 (Monitored) RR: 20 BP: 195 / 73 SpO2: 97%
	BP in ED remained ~200-230/90-110
	HR 62 - 130/min, intially AF with RVR, then sinus rhythm.
	CVS: 1 + 2 + 0
	Resp: Decreased AE R base with bibasal crackles
	Abdo SNT, bowel sounds present
	Calves SNT, no pitting pedal oedema

National Simulation Health Service

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	Neuro exam:
	Cranial nerves: Right sided palsy. Right sided facial droop with weakness of muscles
	of facial expression. Otherwise cranial nerves intact.
	ECG: Atrial fibrillation rate 114/min. L axis deviation.
	Repeat ECG: Sinus rhythm rate 62/min with L axis deviation
	Biphasic p wave. 1st degree AV block.
	Pathology Results:
	Coags normal.
	FBC normal.
	UEC - electrolytes stable. Urea 20.5. Creat 222. eGFR 17
	LFT – normal
	CMP – normal
	Radiology Results
	CT head + perfusion scan + angiogram: Reported: There is a large region of elevated mean
	transit time (MTT), reduced cranial blood flow (CBF) but maintained cranial blood volume (
	CBV) in the left frontal lobe, suggesting large ischaemic penumbra in the territory of the
	superior division in the MCA. This would involve Broca's area and may explain the aphasia.
	Large area of ischaemic penumbra in the left frontal lobe (including Broca's area), in the
	territory of the superior division left MCA.
	CXR: AP projection, however allowing for this, increased CTR. Reasonably clear costophrenic
	angles.
	Assessment:
	1. Acute left MCA territory ischaemic stroke
	- Expressive dysphasia secondary to this
	- R sided facial droop
	- NIHSS score 10-15

National Simulation Health Service

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DATE & TIME	*Add signature, printed name, staff category, date and time to all entries.* MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
	In meantime, 5mg IV hydralazine given for BP control.
	Plan:
	D/W Consultant Dr
	1. Admit under stroke team to stroke ward
	2. NBM until speech pathology review
	3. Continue aspirin
	4. Aim BP <200mmHg
	5. For PO ramipril 5 - 10mg stat now
	6. Neurological obs overnight as per acute stroke protocol
	7. Notify if concerns
	----------(REGISTRAR)--------
DD/MM/YY	**STROKE TEAM WARD ROUND**
1030hrs	Assessment:
	- Ongoing drowsiness. Family report some improvement to speech this morning.
	- HTN was well controlled until recently when pt had to cease medication.
	- Ongoing reduced mobility R) side, improving R) sided facial weakness
	- Ongoing hypertension
	- No other focal neurology
	Impression: L MCA CVA. Facial droop and expressive aphasia. Improving neurology
	Plan:
	1. Amlodipine 5mg mane.
	2. MSTU R/V 2/7.
	3. Daily Chem20.
	4. Carotid USS 2/7.
	5. Continue Asasantin.
	6. Insert NGT and commence feeds. DN review. Continue NBM until Speech Path review.

National Simulation Health Service

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	7. Full MDT Ax
	----------(REG)----------
DD/MM/YY	**NURSING**: 66 yo F admitted to ASU via ED. CT scan confirmed L) MCA CVA.
0800hrs	Swallow screen failed in ED. NBM awaiting SP reviewed. NGT placed and feeds
	scheduled. Pt ++ drowsy with limited responsiveness. R) sided weakness noted to U&LE.
	Referrals made to PT/OT. Obs within normal limits. IV Meds given as charted. -----(RN)-------
	----------
DD/MM/YY	**SOCIAL WORKER:** Noted new admission to ward. Pt asleep however dtr (Jessica) present.
1300hrs	Dtr states pt previously ++ active in church community (attends services 2x weekly &
	involved in knitting groups, volunteering for meals on wheels etc.). Supportive family with
	husband John, 2x children, 5x grandchildren. Dtr particularly concerned re pt's swallow as
	currently NBM and also communication. Encouraged Dtr to speak with NS, SP and/or DN re
	concerns. PLAN: For ongoing support while inpatient on ASU. ---------- (SW) ----------
DD/MM/YY	**SPEECH PATHOLOGY:** Initial Ax. Many thanks for referral of this 66 yo F admitted with L)
1345hrs	MCA infarction. Noted PMHx and SHx. Review of notes – NGT insitu following failed
	swallow screen. Note Obs WNL. Pt reported to be drowsy.
	O/E: Pt LIB. Unable to rouse suitably for Ax of swallow +/- communication. ----------
	Summary/ Impressions: Pt not suitable for oral intake at present due to reduced LOA.
	Recommendations: (1) Continue NBM (2) Regular mouth cares (at least 4-6x daily).
	PLAN: (1) SP to review swallow function +/- communication as able. -------(SP)----------
DD/MM/YY	**NURSING**: Ongoing reduced LOA. Obs WNL. Meds as charted. SP entry noted. Pt to
1930hrs	continue NBM. NGT to remain insitu. DN notified. NGT feeds to continue as per current
	schedule until DN review. ----------(RN)----------
DD/MM/YY	**OCCUPATIONAL THERAPY:** Initial assessment. Referral received with thanks for this 66yo F
0900hrs	admitted post L) MCA infarction. Pt history and current cares noted. Attempted initial
	Ax however pt unable to sustain suitable LOA to participate. PLAN: OT to r/v 1/7 ----- (OT)--

National Simulation Health Service

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DATE & TIME	*Add signature, printed name, staff category, date and time to all entries.* MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
DD/MM/YY	**NURSING**: Pt remains stable. Obs WNL and meds given as charted. Ongoing reduced LOA.
1200hrs	NGT feeds continuing as per current schedule with nil concerns. Pt visited by family and
	appears settled at time of entry. ----------(RN)----------
DD/MM/YY	**SPEECH PATHOLOGY:** Review of notes - Obs stable and chest OK. NGT insitu. D/W NS – pt
1530hrs	remains drowsy++ and not suitable for swallow review +/- communication Ax. ----------
	Recommendations: (1) Continue NBM (2) Regular mouth cares (at least 4-6 x daily).
	PLAN: (1) NS to contact SP when increased LOA suitable for Ax ----------(SP)----------
DD/MM/YY	**NURSING**: Pt more alert today. Slumps to right side SUIB. Needing assistance to SUIB and
	placement of pillows for support. Awaiting PT Ax. Noted NGT dislodged
0930hrs	over night. Contacted SP – will r/v prior to re-insertion of NGT. Obs WNL. Meds as charted.
	----------(RN)----------

Progress notes on following page –not to be inserted into patient file until **after Day 3** of simulation clinic.

To be inserted prior to Day 4 of sim clinic.

National Simulation Health Service

PROGRESS NOTES
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DD/MM/YY	SPEECH PATHOLOGY. SWALLOW REVIEW---
09:00	Notes reviewed. Patient seen previously in by students and commenced on oral intake.
	Discussed with nursing staff and reviewed file – pt reportedly tolerating recommended
	fluids and diet. No signs of aspiration reported. Note meds being crushed currently. Review
	of notes – chest clear. Pt on RA. Afebrile.
	REC's: 1. Continue with previous fluids and diet. 2. Assistance as required with oral intake
	3. Continue to monitor for signs and/or symptoms of aspiration i.e. coughing during oral
	Intake, chest deterioration, increased temperature 4. Continue with regular mouthcares
	If any concerns, please contact SP
	PLAN: SP to review 2/7 ----------(SP, Pager #456)---

National Simulation Health Service

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DATE & TIME	*Add signature, printed name, staff category, date and time to all entries.* MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
DD/MM/YY	SPEECH PATHOLOGY. REVIEW----------
11:00	Notes reviewed. Patient tolerating current diet and fluids. Nil chest concerns. Note
	discussions in MDT meeting – pt likely for rehabilitation.
	O/E: pt SUIB. Alert and cooperative. SpO2 98% on RA. Afebrile.
	Communication: reliable personal and concrete Y/N ATOR. pt consistently following single
	stage commands, breakdown with two stage commands although patient attempting them.
	Following conversation with me when short, direct phrases used. Able to say full name
	today, name of husband and names of children. Some difficulty with grandchildren.
	Pt able to repeat single words and short phrases accurately. Increased processing time
	required. Expressive language limited. Mainly single words with occasional short phrases.
	Some automatic phrases. Semantic paraphasias noted with confrontation naming task and
	In conversational speech. Support of communication partner in clarifying intended meaning
	assisted overall communication exchange. Pt motivated to communicate ATOR.
	Swallow Ax: trialled with thin fluids, and slice of bread.
	Adequate control of liquid bolus in oral cavity with no anterior spillage. Slow but adequate
	mastication of bread. Noted pt to use tongue to move solid residue from right side of mouth
	to left to assist with posterior movement of bolus. Trigger and laryngeal excursion appeared
	adequate. Nil signs of penetration or aspiration noted. Clearing swallows noted with solid
	bolus – appeared to be effective. Pt reported nil residue in throat following clearing
	swallows.
	Imp: pt suitable for upgrade to thin fluids and soft diet. Communication is functional with
	support of communication partner in hospital environment. Pt keen for therapy targeting
	speech and language. Will aim to commence basic therapy on ward while awaiting rehab. Pt
	would also benefit from pharyngeal strengthening exercises to assist swallow.
	REC's: thin fluids and a soft diet when sitting upright and fully alert. Monitor for signs/
	Symptoms of aspiration i.e. coughing/throat clearing during oral intake, chest deterioration,

	Continue with regular mouthcares. If any concerns, please contact SP.
	Use short phrases when communicating with pt. Use Yes/No and forced choice questions
	where able. Confirm intended meaning with pt by repeating information and requesting
	clarification through Yes/No response.
	Plan: SP to commence language and swallowing therapy with pt----------
	----------(SP, Pager #456)----------