



Nelson, Leslie Ann
MRN: 8-753-598, DOB: 3/7/1957, Sex: F
Adm: 6/20/2017, D/C: 6/20/2017

2379231
86

06/20/2017 - OP Visit in HX MCHS EULH ENDOSCOPY (continued)

Progress Notes (continued)

today and has been found to be a suitable candidate for planned procedure:
Consent signed: YES
SEDATION ASSESSMENT
Mallampati class: III
ASA score: II - mild systemic disease
Sedation plan: Sedation by RN
Provider Signatures
Jaime Zigelboim, MD (MRE8897) ESIGNED - 06/20/2017 15:14:24
Source: MCHS MCHSPROVATIONSYS Document Id: MCHSGI-273630MD NOTE0

Electronically Signed by Conversion, Historical Provider Ser on 7/5/2017 10:42 AM

Op Note/Surgical Log

Op Note

Op Note signed by Conversion, Historical Provider Ser at 7/5/2017 10:42 AM

Author: Conversion, Historical Provider Ser	Service: —	Author Type: Physician
Filed: 7/5/2017 10:42 AM	Date of Service: 6/20/2017 3:09 PM	Status: Signed
Editor: Conversion, Historical Provider Ser (Physician)		

NURSE NOTE

MCHS - Eau Claire

Patient Name: Nelson, Leslie
NURSE NOTE
Patient ID: 8753598
Procedure(s): Colonoscopy (6/20/2017 3:09:42 PM)
Exam Date: 6/20/2017
Account #: LH3392915
Exam Date: 6/20/2017
Patient ID: 8753598
Doctor: Zigelboim, Jaime
Patient Name: Leslie Nelson
DOB: 03/07/1957
Gender: Female
ENDO CHECK IN User: MRH3383
Transportation after procedure?: YES
Driver location: Waiting Room
Driver's name: Susan, sister
Driver's relation to the patient?: Family
Driver's Phone Number: 6125903142
Pager Number:
Tracking ID:
HEALTH HISTORY User: MRH3383
Health History Obtainable: YES
Chief Complaint (Purpose for visit): screening
History / Details of Present Illness: see emr
History & Physical Date (MM/DD/YY) / Provider: see emr
Interpreter needed: NO



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2379231
86

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Op Note/Surgical Log (continued)

Cardiovascular?:NO
Ambulatory Infusion Pump:NO
Implanted Medical Device:NO
Pulmonary?:YES
Pulmonary diagnoses:
Comments:post nasal drainage,
GI?:YES
GI diagnoses:
Comments:rectal bleeding on occasion
Diabetes?:NO
Genitourinary/Renal/Endocrine?:NO
Neuro/musculoskeletal?:NO
Cancer:NO
Mental Health?:YES
Mental health diagnoses:Anxiety, Depression
Comments:
Miscellaneous?:NO
Pregnancy status:Post Menopausal
Recent illness, infection or exposure?:NO
Infectious Disease?:NO
Nutritional status?:No issues
Previous surgery?:NO
Patient or family history of problems with anesthesia and sedation (Please set Alert):NO
Tobacco history?:YES
Tobacco use status:Former smoker
Alcohol history?:YES
Type:
Amount:occasionally
Last Consumed:
Recreational drug use?:NO
Patient has a POA?:NO
Anticoagulant:NO
Entire health history obtained from:Patient
PATIENT ASSESSMENT PRE-PROCEDURE User:MRH3383
Patient ID and Procedure verified:YES
Prep taken:YES
Percent of prep taken (%):
Comments:
Prep Details:YES
Prep type:GoLytely
Stool appearance:Clear
NPO:YES
NPO time:Liquid > 2 Hours, Food > 6 Hours, last food 6/19 1100
last drink 6/20 1200
Does the patient have any advance directives:NO
Advance directive information:Information given to patient
Allergy band on:N/A
Caution band on:N/A
Fall Risk?:NO
Baseline Pain:Scale 0-10
Baseline pain level:0
Pain location (if applicable):
Pain type (if applicable):
Pain quality (if applicable):
Onset:
Baseline behavior:Calm
Baseline orientation:Person, Place, Time, Situation
Barrier to care:NO
Skin assessment:Warm, Dry, Pink



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2379231

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06/20/2017 - OP Visit in HX MCHS EULH ENDOSCOPY (continued)

Op Note/Surgical Log (continued)

Respiratory assessment:Clear
Signs of abuse / neglect:NO
Patient clothing and valuables removed?:YES
Patient items removed:Glasses, Jewelry / Valuables / Piercings
Patient clothing and valuables:
Comments:one earring, clothing
Need for prophylactic antibiotics?:NO
Height (cm):159
Weight (kg):82
Who was assessed and educated:Patient
Education and discharge material reviewed. Patient verbalized understanding:YES
How does patient / family prefer to learn:Discussing, Listening, Reading
Barriers to learning:None
Educational material given:YES
Comment:endoscopy video, post colon instructions
Intake Delay:NO
PROCEDURE BEGIN User:M175827
Patient clothing and valuables removed?:YES
Patient items removed:Glasses, Jewelry / Valuables / Piercings
Patient clothing and valuables:
Comments:one earring, clothing
Abdominal exam:Soft, non-distended, Nontender
IV site patent?:YES
Patient position (Skin integrity maintained, Approved by physician):Supine
Adjuncts used:maxislide
Procedure room delay:NO
RECOVERY QUESTIONS User:M054431
Recovery by Endo Required:YES
Patient positively identified. Transferred by and report received from:Sarah K, RN
Siderails up, wheels locked, bed in lowest position, call bell in reach:YES
Recovery Pain:Scale 0 - 10
Recovery pain level:0
Recovery Pain location (if applicable):
Pain type (if applicable):
Pain quality (if applicable):
Skin assessment:Warm, Dry, Pink
Abdominal exam:Soft, non-distended
IV site patent?:YES
DISCHARGE QUESTIONS User:M054431
Discharge Assessment:YES
Level of Consciousness:Person, Place, Time, Situation
Final Discharge Pain:Scale 0 - 10
Discharge pain level:0
Pain location (if applicable):
Pain type (if applicable):
Pain quality (if applicable):
Oxygen saturation on room air >=92% or equal to pre-sedation state?:YES
Discharge Assessment:YES
Able to take PO fluids?:YES
Swallow, cough, gag reflexes present?:N/A
Final abdominal exam:Soft, non-distended
Passing flatus?:YES
Crepitus:N/A
Discharge Delay:NO
Educational materials provided:YES
Name:Diverticulosis and Diverticulitis (NIH 13-1163), Polyps of the Colon and Rectum (MC 2484)
Comments:Dr Zigelboim's post colonoscopy discharge instructions



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2379231
86

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Op Note/Surgical Log (continued)

All care plan goals met: YES
Discharged to: Home
Patient meets discharge criteria as set by physician and approved by facility?: YES
Able to ambulate independently (or at baseline)? : YES
Transportation after procedure?: YES
Driver location: Waiting Room
Driver's name: Susan, sister
Driver's relation to the patient?: Family
Driver's Phone Number: 6125903142
Pager Number:
Tracking ID:
Discharge instructions?: YES
Discharge instructions given to: Patient, Family member
Verbalizes understanding of discharge instructions?: YES
Patient clothing and valuables returned?: YES
Patient items removed: Glasses, Jewelry / Valuables / Piercings
Patient clothing and valuables:
Comments: one earring, clothing
Patient items returned to: Patient
Discharged under the care of: Family member
Discharged via: Wheelchair
CARE PLAN
CARE PLAN INITIATED - APPLIES TO ALL ADMITTED PATIENTS
DIAGNOSIS Potential for anxiety, barriers to learning, and communication barriers related to knowledge deficit of procedure
OUTCOME Patient and family demonstrate decreased anxiety & understanding of teaching
OUTCOME Able to communicate effectively with patient and family
OUTCOME: Verbalized support of emotional, cultural, and spiritual needs:
OUTCOME Patient will verbalize understanding of procedure and expected physiological and psychological responses
OUTCOME Patient will acknowledge and demonstrate the ability with effective coping mechanisms to manage anxiety / fear
OUTCOME Patient will exhibit reduced physiological manifestations of anxiety / fear
DIAGNOSIS Potential for injury related to procedure, medication administration, physical positioning, skin integrity, electrical and/or radiation therapies
OUTCOME Patient was free from injury from procedure, medication administration, positioning, extraneous objects, physical and electrical hazards
OUTCOME Patient experiences minimal trauma from endoscope
OUTCOME Patient remains stable while sedated
DIAGNOSIS Potential for alteration in comfort related to procedure - pain or discomfort
OUTCOME The patient will experience minimal discomfort related to procedure controlled by administration of moderate sedation and comfort measures
OUTCOME The patient will experience minimal discomfort during his/her stay and with his/her procedure
DIAGNOSIS Potential for alteration in cardiac and respiratory function due to sedation or anesthesia
OUTCOME Patient maintained cardio-pulmonary status according to patient norm (baseline)
OUTCOME Patient will maintain a clear airway with adequate gas exchange
OUTCOME Patient's cardiovascular status will be maintained
OUTCOME Patient's airway remains clear and unobstructed
Oxygen
Time Method Rate Entered By Notes
15:47:48 Oxygen 0 liters/min M175827



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2377231
86

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Op Note/Surgical Log (continued)

15:04:54 Oxygen 2 liters/min M175827

No Notes Taken

Medications

Time Medication Dose Entered By Notes

15:25:20 Midazolam IV 1 mg

Total: 5 mg M175827

15:25:20 Fentanyl IV 25 mcg

Total: 100 mcg M175827

15:20:11 Midazolam IV 1 mg M175827

15:20:10 Fentanyl IV 25 mcg M175827

15:15:00 Midazolam IV 1 mg M175827

15:15:00 Fentanyl IV 25 mcg M175827

15:12:58 Fentanyl IV 25 mcg M175827

15:12:56 Midazolam IV 2 mg M175827

No Notes Taken

Aldrete Score

Time Motor Resp BP LOC O2 Entered By Total Score Notes

15:47:53 2 2 2 1 2 M175827 9

15:04:58 2 2 2 2 1 M175827 9

No Notes Taken

Vitals

Time BP HR RESP O2 Sat CO2 Entered By

16:17:05 129/90 78 16 97 - M054431

16:01:55 119/82 75 16 96 - M054431

16:00:58 129/68 79 16 93 - M054431

15:50:58 110/77 75 11 94 - M175827

15:46:43 123/72 78 12 97 - M175827

15:40:53 114/71 77 11 98 - M175827

15:35:48 106/79 75 12 98 - M175827

15:30:58 100/64 73 10 97 - M175827

15:25:58 112/70 75 12 98 - M175827

15:21:18 117/76 72 13 98 - M175827

15:21:18 117/76 72 13 98 - M175827

15:20:03 115/75 73 14 98 - M175827

15:16:13 138/104 74 10 97 - M175827

15:14:43 132/81 75 12 96 - M175827

15:14:43 132/81 75 12 96 - M175827

14:14:43 130/85 78 18 97 - MRH3383

No Notes Taken

PROCEDURE LOG

Time Data Entered By

16:17:50 IV Fluids Infused (mL) : 50 M054431

16:17:45 IV discontinued : IV site assessment : Dry, intact, Catheter

Intact : YES, Comments : - M054431

16:17:20 PPRS : PPRS Motor Activity : 2=Active motion, voluntary or on

command-2, PPRS Respiration : 2=Coughs on command or cries-2, PPRS Systolic

Blood Pressure : 2= +/- 20 mm Hg of preanesthetic level-2, PPRS Consciousness

: 2=Fully awake or easily aroused when called-2, PPRS O2 Saturation :

2=Saturation > = 92% or > preoperative reading without supplemental O2-2, PPRS

Total : 10 M054431

16:02:13 Pre-existing IV? : Type : Peripheral IV, IV site : Right hand, -

Size : 20 gauge, Comments : - M054431

16:01:11 PPRS : PPRS Motor Activity : 2=Active motion, voluntary or on

command-2, PPRS Respiration : 2=Coughs on command or cries-2, PPRS Systolic

Blood Pressure : 2= +/- 20 mm Hg of preanesthetic level-2, PPRS Consciousness

: 2=Fully awake or easily aroused when called-2, PPRS O2 Saturation :

2=Saturation > = 92% or > preoperative reading without supplemental O2-2, PPRS

Total : 10 M054431

15:50:00 RASS : RASS : -2 Light sedation - briefly awakens with eye contact

to voice (less than 10 seconds) M175827



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86

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Op Note/Surgical Log (continued)

15:48:02 Cardiac rhythm : Normal Sinus Rhythm M175827
15:46:57 IV Fluids Infused (mL) : 400 M175827
15:45:08 RASS : RASS : -2 Light sedation - briefly awakens with eye contact to voice (less than 10 seconds) M175827
15:42:50 Implants - YES : Implant : Endoloop,-, Lot : 68V, Comments : sterile lot V6823 M175827
15:40:55 Implants - YES : Implant : Endoloop,-, Lot : 59V, Comments : sterile lot V5918 M175827
15:40:00 RASS : RASS : -2 Light sedation - briefly awakens with eye contact to voice (less than 10 seconds) M175827
15:37:20 Cautery : Unit Number : 285450, Coag : 18, Cut : 200, Blend : -, Pad site : Right Thigh,-, Skin condition (pre-cautery) : Intact,-, Skin condition (post-cautery) : Intact,-, Comments : - M175827
15:35:51 Abdominal Compressions : YES M175827
15:35:47 RASS : RASS : -2 Light sedation - briefly awakens with eye contact to voice (less than 10 seconds) M175827
15:30:00 RASS : RASS : -3 Moderate sedation - movement or eye opening to voice (but no eye contact) M175827
15:25:00 RASS : RASS : -1 Drowsy - not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (greater than or equal to 10 seconds) M175827
15:20:35 RASS : RASS : -1 Drowsy - not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (greater than or equal to 10 seconds) M175827
15:16:00 Notes: second pause M175827
15:15:53 RASS : RASS : -1 Drowsy - not fully alert, but has sustained awakening (eye-opening/eye contact) to voice (greater than or equal to 10 seconds) M175827
15:11:24 TIME-OUT / Universal Protocol : ALL members of the procedural team verify CORRECT PATIENT, PROCEDURE, CONSENT, SIDE-SITE-POSITION, DOCUMENTATION SYSTEMS, SAFETY PRECAUTIONS, EQUIPMENT CHECKED AND AVAILABLE, INSTRUMENTATION, SUPPLIES, SPECIAL REQUIREMENTS : YES, Staff members performing Time-Out : Physician, Sedation RN, Technician,-, Additional verification : Patient safety precautions started,- M175827
15:11:12 PAUSE: Immediately prior to the administration of sedation/anesthetic, a quick look was performed to assess the vital signs and oxygen saturation : YES M175827
15:10:00 RASS : RASS : 0 - Alert and calm M175827
15:05:36 Pre-existing IV? : Type : Peripheral IV,-, IV site : Right hand,-, Size : -, Comments : patent, infusing M175827
15:04:50 Cardiac rhythm : Normal Sinus Rhythm M175827
15:03:54 Cardiac rhythm : Normal Sinus Rhythm M175827
14:49:30 Notes: apical pulse regular, lungs clear MRH3383
14:46:13 IV started : Attempts : 1, IV site : Right hand,-, Size : 20 gauge, Comments : with lidocaine, no problems MRH3383
14:14:50 Temperature : Baseline Temperature (C) : 36.3, Temp reading location : Core MRH3383
Specimens Collected
Jar Sample Type Procedure Lab Type Location Indication Entered By
1 Polypectomy Colonoscopy Histology Colon - Transverse , proximal Polyp M175827
2 Polypectomy Colonoscopy Histology Colon - Sigmoid 2 polyps M175827
Time Tracking
Time Event Entered By
16:26:49 Discharged M054431
16:00:35 Bedded (Recovery) M054431
15:45:31 LOWER Scope Out M175827
15:24:40 Extent Reached M175827
15:17:06 LOWER Scope In M175827
15:11:06 MD in Room M175827



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2379231
86

06/20/2017 - OP Visit in HX MCHS EULH ENDOSCOPY (continued)

Op Note/Surgical Log (continued)

15:00:47 Patient Roomed M175827
14:51:13 In-Take Complete MRH3383
14:07:33 In-Take Start MRH3383
14:07:32 Endo Check In MRH3383
IV Fluid
Time Type Amount Infused Entered By
14:45:11 D5 0.9 NS 1000 ml
Total: 1000 ml MRH3383
No Notes Entered
Provider Signatures
Sarah Kaiser, (M175827) ESIGNED - 06/20/2017 15:53:29
Barb Schwengler, RN (MRH3383) ESIGNED - 06/20/2017 14:51:46
Brenda Handy, (M054431) ESIGNED - 06/20/2017 16:27:25
Source: MCHS MCHSPROVATIONSYS Document Id: MCHSGI-273631NURSE NOTED

Electronically Signed by Conversion, Historical Provider Set on 7/5/2017 10:42 AM

Procedures

Procedures signed by Zigelboim, Jaime, M.D. at 7/10/2017 12:50 PM

Author: Zigelboim, Jaime, M.D.	Service: —	Author Type: Physician
Filed: 8/15/2017 8:10 PM	Date of Service: 6/20/2017 3:09 PM	Status: Addendum
Editor: Zigelboim, Jaime, M.D. (Physician)		
Related Notes: Original Note by Zigelboim, Jaime, M.D. (Physician) filed at 7/11/2017 7:14 AM		

Colonoscopy

MCHS - Eau Claire

GI
Patient Name: Leslie Nelson
Procedure Date: 6/20/2017 3:09 PM
MRN: 8753598
Date of Birth: 3/7/1957
Age: 60
Gender: Female
Procedure: Colonoscopy
Providers: Jaime Zigelboim, MD, Gregory Dorfus, MD (Ordering Provider)
Pre-op Diagnoses: Screening for colorectal malignant neoplasm, This is the patient's first colonoscopy, Incidental - Rectal bleeding
Post-op Diagnoses:
- One 2 mm polyp in the proximal transverse colon, removed with a cold biopsy forceps. Resected and retrieved.
- Two 13 to 18 mm polyps in the distal sigmoid colon. Resected and retrieved.
- Diverticulosis in the sigmoid colon.
- The examination was otherwise normal on direct and retroflexion views.
Recommendation:
- High fiber diet for the rest of the patient's life.
- Await pathology results.
- Repeat colonoscopy in 3 years.



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86

06/20/2017 - OP Visit in HX MCHS EULH ENDOSCOPY (continued)

Op Note/Surgical Log (continued)

Findings:

A 2 mm polyp was found in the proximal transverse colon. The polyp was sessile. The polyp was removed with a cold biopsy forceps. Resection and retrieval were complete.

Two pedunculated polyps were found in the distal sigmoid colon. The polyps were 13 to 18 mm in size. An endoloop was maneuvered over the polyp stalks and closed at the mucosal attachment prior to removal in order to prevent bleeding. These polyps were then removed with a hot snare. Resection and retrieval were complete.

Diverticula were found in the sigmoid colon.

The exam was otherwise without abnormality on direct and retroflexion views.

Medicines:

Fentanyl IV 100 mcgs, Midazolam IV 5 mgs

Complications: No immediate complications.

Procedure Details: Pre-Anesthesia Assessment:

- Sedation was administered by an endoscopy nurse. The sedation level attained was moderate.

The patient was seen, evaluated, and history reviewed. Airway and heart and lung exams were performed and were satisfactory for planned sedation care.

The risks, benefits and alternatives for the procedure and sedation were discussed and informed consent was obtained. A procedural pause was conducted in the presence of assisting personnel to verify the correct patient identity and procedure to be performed. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously.

The Colonoscope PCF H-190 was introduced under direct vision through the anus and advanced to the cecum, identified by appendiceal orifice and ileocecal valve. The colonoscopy was somewhat difficult. Successful completion of the procedure was aided by changing the patient to a supine position. The patient tolerated the procedure well. The quality of the bowel preparation was excellent. The ileocecal valve, appendiceal orifice, and rectum were photographed. The entire colon was examined.

Jaime Zigelboim, MD

6/20/2017 3:51:47 PM

This report has been signed electronically.

Number of Addenda: 0

Note Initiated On: 6/20/2017 3:09 PM

Total Procedure Duration Time 0 hours 28 minutes 32 seconds

Scope In: 3:17:06 PM

Scope Out: 3:45:38 PM

Source: MCHS MCHSPROVATIONSYS Document Id: 47088470297533513150

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Electronically Signed by Zigelboim, Jaime, M.D. on 7/10/2017 12:50 PM
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