Fictional Clinical Record — Jane Doe

Patient: Jane Doe (F) DOB: 01/01/1985 (fictional) MRN: JDOE-0001 (fictional)

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Contents:
- Detailed nursing notes (ED nursing and Inpatient nursing)
- Vitals trending and flowsheet
- Medication administration record (MAR) — fictional
- Progress note (SOAP) and discharge planning summary (fictional)

ED Nurse Triage & Initial Nursing Note

Encounter: ED visit — 2025-09-09 08:40 (fictional)
Triage nurse: RN Emily Carter (fictional)

Chief complaint: Cough and shortness of breath x 10 days.
Triage vitals (08:42): T 100.1°F (oral), HR 92 bpm, BP 126/78 mmHg, RR 20, SpO2 96% on room air.
Triage acuity: ESI level 3 (fictional) — requires diagnostic testing and treatment.

Brief past medical history (reported): Childhood asthma (intermittent); no chronic medications reported. Allergies: NKDA (fictior

Initial nursing assessment (08:50):
- Patient alert, oriented x3, in mild respiratory distress when speaking in long sentences.
- Lung auscultation: coarse breath sounds with faint crackles at right base.
- Skin warm, dry. No cyanosis.
- Patient reports fever at home for first three days (max ~100.4°F), currently afebrile.

Nursing interventions in ED:
- Applied oxygen PRN; not required at triage.
- IV access established, 20G L forearm.
- Tylenol 650 mg PO administered at 09:05 for reported fever earlier at home. (Fictional med administration.)
- Patient positioned upright; encouraged slow diaphragmatic breaths.

ED nurse note signature: EMILY CARTER, RN — Note is fictional and for training only.

Inpatient Nursing Flowsheet & Vital Signs (Fictional)

Unit: Med-Surg Observation Admission: 2025-09-09 11:30 Discharge: 2025-09-11 10:00 (fictional)

Date/Time	Temp	HR	BP	RR	SpO2
2025-09-09 12:00	99.6F	88 bpm	124/78	18 br	96%
2025-09-09 16:00	99.5F	88 bpm	124/78	18 br	96%
2025-09-09 20:00	99.4F	87 bpm	124/78	18 br	96%
2025-09-10 00:00	99.4F	86 bpm	123/78	18 br	96%
2025-09-10 04:00	99.3F	85 bpm	123/78	18 br	96%
2025-09-10 08:00	99.2F	84 bpm	122/78	18 br	96%
2025-09-10 12:00	99.1F	84 bpm	122/78	18 br	96%
2025-09-10 16:00	99.0F	83 bpm	122/78	18 br	96%
2025-09-10 20:00	99.0F	82 bpm	121/78	18 br	96%
2025-09-11 00:00	98.9F	81 bpm	121/78	18 br	96%
2025-09-11 04:00	98.8F	80 bpm	120/77	17 br	96%
2025-09-11 08:00	98.7F	80 bpm	120/77	17 br	97%
2025-09-11 12:00	98.6F	79 bpm	120/77	17 br	97%

Inpatient Nursing Shift Notes (Selected Excerpts)

Shift: 2025-09-09 12:00-20:00 RN: Sarah Nguyen (fictional)
- 12:10: Report received from ED; patient transferred to Med-Surg obs. Ambulatory to bed with assistance. Complains of cough
- 13:00: Vitals: T 100.0F, HR 90, BP 122/76, RR 20, SpO2 96% on RA. Administered first dose of oral antibiotic (fictional — An
- 16:30: Patient resting, cough less frequent. Encouraged incentive spirometry q2h while awake. Education provided on breath

Shift: 2025-09-10 08:00-16:00 RN: Michael Lee (fictional)
- 08:05: Vitals: T 99.2F, HR 85, BP 120/74, RR 18, SpO2 97% RA. Reports improved sleep.
- 10:20: Assisted patient with ambulation to bathroom; tolerated well without oxygen desaturation.
- 14:55: Noted decreased crackles on auscultation; lung sounds improving at right base.

Shift: 2025-09-10 20:00-04:00 RN: Priya Sharma (fictional)
- 21:10: Overnight patient complains of persistent cough interrupting sleep. Administered cough suppressant (dextromethorpha
- 02:30: Vitals stable. Provided oral care and suctioned minimal oral secretions.

Shift: 2025-09-11 04:00-10:00 RN: Alex Johnson (fict.) — Discharge day
- 06:45: Vitals: T 98.6F, HR 76, BP 118/72, RR 16, SpO2 98% RA. Patient ambulatory and independent with ADLs.
- 08:30: Reviewed discharge instructions with patient: finish antibiotic course, use albuterol inhaler PRN, follow up with PCP in

Nursing documentation signature lines omitted — all names and details fictional and for training only.

Medication Administration Record (MAR) — Selected Entries (Fictional)

Medication: Amoxicillin-clavulanate 875/125 mg PO q12h — Order placed 2025-09-09 12:45
- 13:15 2025-09-09 GIVEN — RN Sarah Nguyen
- 01:15 2025-09-10 GIVEN — RN Michael Lee
- 13:20 2025-09-10 GIVEN — RN Michael Lee
- 01:20 2025-09-11 GIVEN — RN Priya Sharma

Medication: Dextromethorphan 30 mg PO PRN q6h for cough — Order 2025-09-09
- 21:20 2025-09-10 GIVEN — RN Priya Sharma (patient reported reduced cough and improved sleep)

Medication: Albuterol HFA 90 mcg 2 puffs PRN for wheeze/shortness of breath — Patient given a demonstration and inhaler provided.

Non-pharmacologic interventions recorded: Incentive spirometry q2h while awake; chest physiotherapy education; oral hydration encouraged

Note: This MAR is fictional and created for simulation/training only. Do not use for actual medical administration.

Nursing Narrative: Focused Assessments & Discharge Planning

Focused respiratory assessment (selected entries):
- 2025-09-09 12:30: Breath sounds: crackles RLL greater than L. No wheeze. Patient able to speak full sentences.
- 2025-09-09 18:00: Continued cough; oxygenation adequate on RA. Incentive spirometry education provided and documented
- 2025-09-10 08:10: Reduced adventitious breath sounds; incentive spirometry used with moderate effort.
- 2025-09-11 06:50: Lungs clear to auscultation bilaterally, minimal residual basilar crackles on the right.

Discharge teaching (documented):
- Finish full antibiotic course as prescribed. (Education provided verbally and with printed instructions.)
- Use albuterol inhaler PRN for wheeze; demonstrate return demonstration of inhaler technique — patient performed correctly.
- When to seek care: worsening shortness of breath, persistent high fevers >101.5°F, hemoptysis, chest pain, or lightheadedne
- Activity: resume light activity; avoid heavy exertion until symptoms resolve.
- Follow-up: Primary care in 3–5 days; pulmonology if cough persists beyond 4 weeks.

Discharge disposition: Home in stable condition with family support. Transport: self-car.

Nurse signature: ALEX JOHNSON, RN — Fictional note for simulation purposes.

Progress Note (SOAP) & Discharge Summary (Fictional)

S: Patient reports decreased cough and improved breathing. Denies fever today. Able to sleep with minimal cough interruption

O: Vitals this morning: T 98.6F, HR 76 bpm, BP 118/72, RR 16, SpO2 98% on RA. Lungs: minimal bibasilar crackles on right; r

A: 1) Community-acquired pneumonia — improving on oral antibiotics. 2) Intermittent asthma — history; no current exacerbatio

P: Discharge home with instructions to finish antibiotic, use albuterol PRN, follow-up with PCP in 3–5 days, return for worsenin

Discharge summary (brief): Patient admitted for observation and treatment of focal right lower lobe pneumonia. Received initia

Attending physician: Dr. B. Example, MD — Fictional.

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