PATIENT CHART

Chart for Mary Lou Brady - Simulation #3

SBAR Report Students Will Receive Before Simulation

**Time:** Start of AM shift

**Person providing report:** Nurse ending shift

**Situation:** Mary Lou Brady is a 26-year-old gravida 1, para 1 on the postpartum unit after delivering a viable-term infant boy weighing 7 lbs 2 oz via C-section 48 hours ago.

**Background:** This is Mary Lou’s first child. She had an uncomplicated pregnancy; she did have a slight rise in blood pressure at 28 weeks, but in subsequent visits, her blood pressure stayed at 120-136/80-88. Mary Lou had a stroke 6 years ago while she was in college. She has residual paralysis of the left upper extremity and her left leg. She is right handed. Her C-section was performed after a 10-hour labor that did not progress, even with oxytocin. The fetus presentation was occiput posterior. During the C-section, she received spinal anesthesia. APGAR scores for Mary Lou’s son at birth were 8 and 9. Mary Lou’s blood type is O positive. Screenings for HIV, herpes, syphilis, gonorrhea, chlamydia, hepatitis, and TB skin test were all negative. She is rubella immune.

**Assessment:** Mary Lou has left-side deficits of both her upper and lower extremities. She is able to move her left shoulder, but she is unable to moveher left arm without moving or lifting it with her right arm. She does not have fine motor movements of the fingers on her left hand. Her left leg can bear weight and move, but she often swings the left leg while walking. Prior to the C-section, Mary Lou was able to ambulate without assistance, but since the surgery, she has some concerns about falling in this unfamiliar environment and needs assistance to get out of bed and ambulate to the bathroom. Since she had a low uterine transverse abdominal C-section, her core abdominal muscles are compromised, making her ability to stand up and move a little more difficult. She needs a minute or so after standing to balance herself before she starts walking, and she needs help with bathing and dressing. She is having some post-operative pain and is taking an opioid. Therefore, she is on falls risk precautions. Further skeletal assessment is within expected parameters. Mary Lou is accustomed to living well with her disability.

Vital signs are normal, and she is afebrile. Lungs are clear. She is tolerating a regular diet. The in-dwelling urinary catheter was removed yesterday and she is voiding clear yellow urine. Bowel sounds present and she is passing flatus, but has not had a bowel movement. She is taking docusate sodium, 100 mg PO daily in the morning. Her abdominal incision is open to the air and intact, with no redness, swelling, or drainage. The patient has staples in her incision and complains that they “stab into her” as she moves around and gets up and down.

Pain level is 3 on a scale of 0-10. Mary Lou is taking a combination tablet of oxycodone 5 mg and acetaminophen 325 mg PO every 4 hours, alternating with ibuprofen 600 mg PO every 6 hours and is maintaining comfort on that. Her last dose was 1 oxycodone 5 mg/acetaminophen 325 mg at 6:30 AM. Her last dose of ibuprofen was at 2350 last evening. She is trying to wean herself off of the opioidpain medication because it makes her dizzy when she stands.

Mary Lou’s postpartum assessments have been within normal limits. Her uterus is firm - located approximately 2 cm below the umbilicus. Lochia is rubra transitioning to serosa in small amount with no clots or odor noted. There was about 1 inch serosa on pad when it was changed about 2 hours ago. Her breasts are filling and symmetrical. Nipples have no redness, cracking or breakdown noted. Colostrum present. Patient is wearing a bra. She is comfortably nursing the baby, who latches on well. As a first-time mother, she is a little concerned about providing infant care. Mary Lou and baby seem to be bonding well and the family seems comfortable together.

**Recommendation:** Complete a postpartum assessment and initiate appropriate care as needed. Mary Lou needs assistance lifting the baby from and returning the baby to the bedside crib during these first days following her C-section ~~i~~n the hospital as well as at home. Mary Lou will probably be discharged tomorrow, so a discharge planning assessment needs to be completed this AM. Because of her physical disability, there are many factors that will need to be considered**,** particularly related to safety and infant care management. Mary Lou’s chart contains a home environment checklist and a discharge planning checklist related to care of her baby. Please complete them, and tell Mary Lou to remind her husband to bring in a car seat for discharge to home.

|  |  |
| --- | --- |
| **Patient Name:** Mary Lou Brady | **MRN:** 000-000-000 |
| **Room:** 320 | **Provider Team:** Joseph McGuire, MD; Sara Miller, RN, CRNP |
| **DOB:** 01-05-YYYY (reflect age 26) | **Date Admitted:** xx/xx/xx |
| **Age:** 26 | **Allergies:** no known allergies |

Provider Orders

**Allergies/Sensitivities:** None

|  |  |
| --- | --- |
| **Date/Time:** |  |
|  | **Activity:** Sit upright on side of bed with feet toward floor in 0-6 hours and when fully recovered from anesthesia. Return to supine position if light headed. OOB in 6-12 hours, then ambulate at least 2 times per shift. |
|  | **Labs:** CBC in AM (day after surgery) |
|  | **Vital Signs**: Per recovery room guidelines, then every 1 hour x 4; every 4 hours x 6, then every 8 hours |
|  | **Diet**: Advance as tolerated |
|  | **Call MD** if:   * + temp greater than 100.4 (38.5 C)   + pulse less than 60 or greater than 120   + BP less than 90 or greater than 160 systolic   + if urine output is less than 120 mL in 4 hours |
|  | When patient is tolerating oral intake give oxycodone 5 mg with acetaminophen 325 mg (Percocet 5/325), 1-2 tabs PO q 4 hours PRN for pain. |
|  | Ibuprofen up to 600 mg. PO q 6 hours PRN for fever, pain, discomfort. Alternate with oxycodone/acetaminophen when possible. |
|  | Simethicone 80 mg chewable tablet. Chew and swallow 1 tablet after eating and before bed (not to exceed 4 times daily) PRN for gas pains. |
|  | Docusate Sodium 100 mg PO twice daily. Hold for diarrhea. |
|  | Promethezine 25 mg IV every 3-4 hours, PRN nausea/vomiting |
|  | Lanolin cream: Apply “pea size” amount to nipples for soreness |
|  | Discontinue incision dressing post-operative day #1. |
|  | Abdominal binder |
|  | Joseph McGuire, MD |

Progress Notes

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| --- | --- |
| **Date/Time:** |  |
| Xx/xx/xx  1900 | Mary Lou is a 26-year-old gravida 1, para 1 who gave birth to a 7lb 2oz baby boy via C-section. Prior to the C-section, she was in labor for 10 hours and was given oxytocin but her labor failed to progress. The baby was found to be in the posterior position. She received spinal anesthesia; her incision was a low uterine transverse and secured with staples. Mary Lou is doing well post-operatively. Her baby’s Apgar scores were 8 and 9 and the baby is latching on and breastfeeding well. Good bonding is noted between the mom and baby. Mary Lou’s blood type is O positive. She is GBS negative, Hepatitis B surface antigen negative, Rubella immune and RPR nonreactive. Joseph McGuire, MD |

Nursing Notes

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| **Date/Time:** |  |
| Xx/xx/xx  1930 | 24**-**hour summary - Mary Lou Brady, post C-section.  All of Mary Lou’s postpartum assessments have been within normal limits. Mary Lou had her indwelling catheter removed today and tolerated the procedure well. Since the catheter was removed, Mary Lou has needed some help ambulating to the bathroom but has been doing well. Mary Lou is able to hold the baby with right armwithout assistance and is comfortable nursing the baby. Her incision dressing was removed today and her incision is midline, with staples present. The incision is clean and dry with no redness, swelling, or drainage. She has been doing well drinking clear liquids and eating some crackers tonight with no nausea. Her uterus is 1 cm below the umbilicus and her lochia is a small amount of rubra. A 20-gauge IV catheter is present in her left forearm and is saline locked. IV site is clean with no redness, swelling, or infiltrate noted. F. Smith, RN |
| Xx/xx/xx  1930 | 24-hour summary  Mary Lou has been doing well over the past 24 hours and is now 48 hours post C-section. She has been getting up and ambulating with assistance x1. Her balance has been unsteady since the surgery. She has been tolerating a regular diet with no nausea, and has been voiding clear yellow urine. She has been passing flatusbut has not had a BM since surgery. Vital signs and postpartum assessments have all been within normal limits and she is breastfeeding well and colostrum is present. No nipple redness, cracking, or breakdown noted. Her uterus is firm and about 2 cm below the umbilicus. Her incision is open to air and intact with no redness, swelling, or drainage. Lochia is rubra and is transitioning to serosa. She had a small amount (1 inch of serosa) on a pad over a 2-hour period with no clots or odor present. Her pain level is 3/10 and she feels like her staples are “stabbing her” when she tries to get up and down. The oxycodone 5 mg/acetaminophen 325 mg (1-2 tabs) PO every 4 hours alternating with Ibuprofen 600 mg PO every 6 hours has been keeping her comfortable. Patient is on fall precautions. Left forearm IV site is clean and intact with no redness, swelling, or infiltrate noted. B. Hayes, RN |

Medication Administration Record

**Allergies:** No known allergies

Scheduled & Routine Drugs

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Dates Given:** | **Time** | **RN Initials** |
|  | Docusate Sodium | 100mg | PO | Twice daily at 0800 and 1400  Hold for diarrhea | Day 1  Day 2  Day 3 | 0800, 1400  0800, 1400  0800, 1400 | *JD*  *JD*  *JD*  *JD*  *BH*  *BH* |

PRN Medications

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Given:** | | | |
|  | Oxycodone/  Acetaminophen  5/325 | Oxycodone 5mg/ Acetaminophen 325mg  1-2 tabs | PO | Q 4 hours PRN for pain | Day 1  1900 *FS*  2300 *FS* | Day 2  0300 *FS*, 0800 *JD*  1300 *JD*  1900 *FS* | Day 3  0600 *BH*  1500 *BH*  2100 *FS* | Day 4  0630 F*S* |
|  | Ibuprofen | Up to 600 mg | PO | Q 6 hours PRN for fever, pain, discomfort | Day 1  2100 *FS* | Day 2  0530 *FS,* 1130 *JD* 1730 *JD*  2350 *BH* | Day 3  0900 *BH*  1700 *BH*  *2350 BH* | Day 4 |
|  | Simethicone | 80 mg | PO | Chew and swallow 1 tablet after eating and before bed (do not exceed 4x/ day) PRN for gas |  |  | Day 3  0900 *BH*  1900 *FS,* | Day 4 |
|  | Promethezine | 25 mg | IV | Q 3-4 hours PRN for Nausea/ Vomiting | Day 1  1900 *FS* |  |  |  |
|  | Lanolin cream | Apply “pea size” amount | Topical | PRN for soreness |  |  |  |  |

Nurse Signatures

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| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| FS | Frances Smith, RN | JD | Judy Daniel, RN |
| BH | Brad Hayes, RN |  |  |

Intravenous Therapy

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| **Date of Order:** | **IV Solution** | **Rate Ordered:** | **Date/Time Hung:** |
|  | Left forearm 20**-**gauge IV is saline locked |  |  |

Vital Signs Record

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Day 1** | **Day 1** | **Day 1** | **Day 2** | **Day 3** | **Day 4** |  |  |
| **Time:** | 0600 | 1400 | 2200 | 0730 | 0730 | 0730 |  |  |
| **Temperature:** | 98.2 | 99.0 | 99.2 | 98.8 | 98.4 | 98.2 |  |  |
| **BP:** | 118/75 | 120/76 | 122/78 | 122/70 | 120/68 | 118/88 |  |  |
| **Pulse:** | 84 | 88 | 84 | 82 | 80 | 78 |  |  |
| **O2 Saturation:** | 98% | 98% | 98% | 99% | 99% | 99% |  |  |
| **Weight:** |  |  |  |  |  |  |  |  |
| **Respirations:** | 18 | 16 | 18 | 20 | 18 | 16 |  |  |
|  |  |  |  |  |  |  |  |  |
| **Nurse Initials:** | *BH* | *BH* | *FS* | *JD* | *BH* | *FS* |  |  |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ORAL  Day 2 | TUBE  FEED | IV | IVPB | OTHER | URINE  Day 2 | Emesis | NG | Drains  Type: | Other |
| 200 ml  250 ml  200 ml  100 ml  180 ml |  |  |  |  | 250 ml  225 ml  205 ml |  |  |  |  |
| Total Intake this shift: 750 mls (12 hr shift) | | | | | Total Output this shift: 680 mls (12 hr shift) | | | | |

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| **Fluid Measurements:** |
| 1 ml = 1 cc |
| 1 ounce = 30 cc |
| 8 ounces = 240 cc |
| 1 cup = 8 ounces = 240 cc |
| 4 cups = 32 ounces = 1 quart or liter = 1000 cc |

Lab Data

**POST-OP Day #1**

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| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 6.6 | 3.6-11.0 K/uL |
| RBC (Red Blood Count) | 4.8 | 4.5-5.9 M/uL |
| HGB (Hemoglobin) | 12.1 | 12.0-15.6 g/dL (F)  13.0-18.0 g/dL (M) |
| HCT (Hematocrit) | 37 | 36-46 % (F)  40-52 % (M) |
| PLT (Platelets) | 250 | 150-450 K/uL |

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| **Home and Safety Assessment Tool for New Mothers and Babies** | |
| **Home Environment** | **Response** |
| 1. Safety in the home (how is the home set up?)   Location of kitchen, sitting area, bathrooms, and bedrooms |  |
| 1. If no bathroom on main floor, how will mother manage? |  |
| 1. Are there stairs? Are the stairs an issue of concern? |  |
| 1. What types of additional support may be needed? |  |
| 1. Does the mother have concerns related to caring for baby? |  |
| 1. Are there sufficient resources for mother and baby at home? |  |
| 1. Are there others available to help/ provide support? |  |
| 1. Are any assistive devices or modification to the home needed? |  |

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| **Discharge Teaching Checklist - Care of the Newborn** | | |
| **Newborn Care:** | **Discussed with mother/ Date/Initials** | **Mother able to “teach back”**  **Date/Initials** |
| 1. Back to sleep - all babies should sleep on their back |  |  |
| 1. Allow time for newborns when awake to lay on their belly |  |  |
| 1. Remove any blankets or stuffed animals from crib |  |  |
| 1. Review Feeding and Burping |  |  |
| * 1. Breastfeeding      1. Wash your breasts with water daily for cleanliness.      2. Air dry nipples after each feeding.      3. If nipples are sore, apply a few drops of breast milk after a feeding and let air dry.      4. If breasts are engorged, apply warm packs and express milk.      5. Wear well-fitting bra for support |  |  |
| * 1. Non-Breastfeeding      1. Wear a well-fitting bra for support.      2. Use ice packs to relieve discomfort from engorgement.      3. Avoid handling your breasts and do not express milk.      4. Non-breastfeeding engorgement will subside in 24-36 hours. |  |  |
| **When To Call Your Baby’s Doctor** | **Discussed with mother/ Date/Initials** | **Mother able to “teach back”**  **Date/Initials** |
| * Has a sharp, high cry for no reason or is unusually fussy. |  |  |
| * Feels hot or has a dry mouth. |  |  |
| * Doesn’t eat in his/her usual way. |  |  |
| * Breathes in a different way (slower, faster, and noisier). |  |  |
| * Acts like s/he has a cold. |  |  |
| * Fever, especially when accompanied by signs of illness. |  |  |
| * Vomiting (not just spitting up) especially if it is green or projectile. |  |  |
| * Refusal of food several times in a row. |  |  |
| * Excessive crying. |  |  |
| * Listlessness. |  |  |
| * Loose, runny stools if there is mucus, blood, or a foul odor. |  |  |
| * Unusual rash. |  |  |