PATIENT CHART

Peggy Nelson Simulation # 1

This simulation is somewhat different than those you may have experienced in the past. While you will be caring for both the patient and the caregiver, the focus of the simulation is the caregiver.

Download these tools and attach to chart:

* The Confusion Assessment Method (CAM)

<https://hign.org/sites/default/files/2020-06/Try_This_General_Assessment_13.pdf>

* Pain Assessment tool: FLACC Scale

<https://www1.health.gov.au/internet/publications/publishing.nsf/Content/triageqrg~triageqrg-pain~triageqrg-FLACC>

SBAR Report Students Will Receive Before Simulation

**Time:** 1900

**Person providing report:** Nurse going off duty

**Situation:** Peggy Nelson is an 83-year-old female widow who lives at alone. She sustained a fracture of her left hip from a fall at home. She had an open reduction internal fixation (ORIF) of her hip yesterday.

**Background:** Bridget Hardy, Peggy’s daughter, is at the bedside. She has been her mother’s caregiver over the past 5 years. She is concerned over the acute changes in her mother’s cognitive status. Patient has a history of mild dementia.

**Assessment**; Mrs. Nelson has been restless and moaning at times. She was trying to get out of bed and appears to be hallucinating. She could not accurately report her pain level and was not able to manage the patient-controlled analgesia (PCA) so we notified Dr. Price and she switched her to oral oxycodone 7.5 mg/acetaminophen 325 mg every 4 hours prn. FLACC scale score was a 6; now a 2 after oral pain meds were given 3 hours ago. Dressing to the left hip has small amount of bloody drainage and is intact. Her urinary catheter was discontinued, and she is voiding without difficulty. She is allowed out of bed with hip precautions, using a walker to toe touch assist to the bedside commode. Physical therapist stopped by to evaluate her today and said they will return to start therapy tomorrow. She will probably be discharged in a few days to a rehabilitation center. At1600 her vitals were BP 146/84, P 86, T 37.4C, RR 16, O2 sat 92%. Neuro check PERRL, alert and oriented X 2 to person and place, confused about time. She has an IV in her right forearm with D5RL running @ 125 ml/hr and her cefazolin was administered at 1600.

**Recommendation:** Continue to assess her cognitive status and monitor for signs/symptoms of delirium. Continue to assess pain using FLACC scale. Remind her to use the incentive spirometer. Please administer the Confusion Assessment Method (CAM) and discuss post-op delirium and pain assessment and treatment plan with her daughter. She is at her mother’s bedside now.

Provider Orders

**Allergies/Sensitivities:** grass, tree pollen, and pet dander

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Post-op Orders1200 | **Activity:** OOB with walker, hip precautions with toe touch assist to the bedside commodeDiscontinue Foley catheterTurn every 2 hours and prnPT and OT consult **Diet:** Soft diet with 1 can nutritional shake daily**Vital signs:** Every 4 hours **Medications:** Discontinue enoxaparin sodium Methylprednisolone 4 mg oral every dayHydroxychloroquine sulfate 200 mg oral twice a dayLevothyroxine sodium 88 mcg every dayLosartan potassium 50 mg every dayCefazolin 1000 mg every 8 hours IVPBPCA morphine sulfate per protocolBegin rivaroxaban 10 mg oral every day X 35 daysFluids: IV D5RL @125 ml/hrIncentive spirometer every 2 hours when awakeIntake and outputMegan Price, MD |
| Post-op Day 11300 | Discontinue PCA and begin oxycodone 7.5 mg/acetaminophen 325 mg every 4 hours for pain greater than 3/10. Megan Price, MD |

Progress Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Post-op Day 1@ 1300 | Stable after left ORIF, left hip dressing intact. Out of bed to chair, nurse reporting signs and symptoms of delirium. PCA discontinued and oral pain meds started. Vital signs every 4 hours. Meghan Price, MD |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Post-op Day 1 @ 1300 | Called provider to report continued delirium, provider discontinued PCA morphine sulfate, oral pain meds ordered. Charles Madden, RN |
| Post-op Day 1@1730 | Patient noted to be moaning, unable to verbalize pain using the 0-10 pain scale.FLACC scale being used, rated at 6.Oxycodone/acetaminophen given for pain @ 1600; patient appears more comfortable now, FLACC scale = 2. Daughter at bedside, concerned about mother’s cognitive changes, patient is moaning and unable to state her pain level. Daughter is distressed about being able to evaluate mother’s pain. Discussed change in pain medication with daughter.Daughter also concerned about her mother’s ability to eventually return home. Requested daughter bring mom’s hearing aid and eye glasses. Charles Madden, RN |

Lab Data

 (post-op day 1)

|  |  |  |
| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 6.5 | 6.0-11.0 K/uL |
| RBC (Red Blood Count) | 4.33 | 4.5-5.9 M/uL |
| HGB (Hemoglobin) | 11.2 | 12.0-15.6 g/dL (F)13.0-18.0 g/dL (M) |
| HCT (Hematocrit) | 35.0 | 36-46 % (F)40-52 % (M) |
| PLT (Platelets) | 277 | 150-450 K/uL |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 140 | 135-145 mmol/L |
| Potassium | 3.9 | 3.5-5 mmol/L |
| Carbon dioxide | 27 | 35-45 mm hg |
| Calcium | 9.0 | 2-2.6 mmol/L |
| Chloride | 106 | 95-105 mEq/L |
| Glucose | 92 | 65-110 mg/dL |
| Bun | 1.6 | 1.2 -3 mmol/L |
| Creatinine | 0.8 | 0.8-1.3 mg/dL |

|  |  |  |
| --- | --- | --- |
| **Prothrombin Time and INR** (international normalized ratio) | **Result** | **Reference Range** |
| PT | 12.2 | 11-13.5 sec  |
| INR | 1.0 | .9-1.2  |

Medication Administration Record

Scheduled & Routine Drugs

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
| Post-opDay 1 | methylprednisolone | 4 mg | oral | Every day | X/XX/XX | 1800 | *CM* |
|  | hydroxychloroquine sulfate | 200 mg | oral | Twice a day | X/XX/XX | 1800 | *CM* |
|  | levothyroxine sodium  | 88 mcg | oral | Every day | X/XX/XX | 1800 | *CM* |
|  | losartan potassium | 50 mg | oral | Every day | X/XX/XX | 1800 | *CM* |
|  | rivaroxaban | 10 mg | oral | Every day x 35 days | X/XX/XX | 1800 | *CM* |
|  | PCA morphine sulfate | See pain team protocol |

PRN and STAT Medications

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
| Day of Surgery | enoxaparin sodium | 40 mg  | sub cutaneous  | Times one dose |  | 1800 | *CM* |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
| Post-op Day 1 | oxycodone/ acetaminophen  | 7.5 mg / 325 mg  | Oral | Every 4 hours prn for pain > 3/10 | X/XX/XX | 1600 | *CM* |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| CM | Charles Madden, RN |  |  |
| SH | Simone Harrison, RN |  |  |

Medication Reconciliation Form

**Source of medication list (i.e. patient, family member, primary care provider):** daughter Bridget Hardy

**Allergies/Sensitivities:** Grass, pollen and pet dander

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** | **Last Dose** | **Continue/DC** |
| methylprednisolone | 4 mg | oral | every day | Rheumatoid Arthritis | X/XX/XX | [x]  C [ ]  DC |
| hydroxychloroquine sulfate  | 200 mg | oral | twice a day | Rheumatoid arthritis | X/XX/XX | [x]  C [ ]  DC |
| levothyroxine sodium  | 88 mcg | oral | every day | Hypothyroidism | X/XX/XX | [x]  C [ ]  DC |
| losartan potassium  | 50 mg | oral | every day | Hypertension | X/XX/XX | [x]  C [ ]  DC |

|  |
| --- |
| Signature RN: Charles MaddenPrint Name: Charles Madden, RN Date: xx/xx/xxxx |

Reviewed by\_\_\_\_Jasmine Davis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_x/xx/xxxx\_\_\_\_\_\_\_\_\_\_\_

Reviewed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Scan to pharmacy

Vital Signs Record

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date:** | **Post- op Day 1** | **Post-op Day 1** | **Post-op Day 1** | **Post- op Day 1**  | **Post-op****Day 1** |
| **Time:** | 0200 | 0600 | 1000 | 1400 | 1800 |
| **Temperature:** | **36.4** | **36.8** | **37.2** | **37.6** | **37.2** |
| **Heart Rate/Pulse:** | 88 | 94 | 90 | 86 | 88 |
| **Respirations:** | 18 | 16 | 20 | 18 | 16 |
| **Blood Pressure** | 150/78 | 154/88 | 150/78 | 146/84 | 142/84 |
| **O2  Saturation:** | 93 | 91 | 92 | 93 | 93 |
| **Weight:** |  |  |  |  |  |
|  |  |  |  |  |  |
| **Nurse Initials:** | *SH* | *SH* | *CM* | *CM* | *CM* |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORAL****Post-op Day 1 @ 1800** | **PO** | **IV** | **IVPB** | **OTHER** | **URINE****Post-op** **Day 1** | **EMESIS** | **NG** | **Drains****Type:** | **Other** |
|  | 240mL | 1500mL | 50mL |  | 1450mL |  |  |  |  |
| **Total Intake this shift:** 1790mL | **Total Output this shift**:1450mL |