PATIENT CHART

Chart for Mia Jones Simulation #2

*Please download and print the following document and add it to the chart.*

**Discharge instruction sheet**

AAPD Postoperative Instructions for Extractions/Oral Surgery

<https://www.aapd.org/research/oral-health-policies--recommendations/post-operative-instructions-for-extractionsoral-surgery/>

SBAR Report Students Will Receive Before Simulation

**Time:** 1100

**Person providing report:** Recovery room nurse

**Situation:** Mia is a 4½-year-old girl. She had dental extractions and tooth restoration completed at 9 AM.

**Background:** Mia was diagnosed with ECC 6 months ago.

**Assessment:** The surgery went well. There is a small amount of blood on the gauze. Mia keeps trying to spit out the gauze, says it leaves a funny taste in her mouth. We have tried telling her that it is magical cloth and will help her mouth get better. This seems to work for a while, but she does need frequent reminders. Her vitals have been stable. HR 100 and regular, RR 26 and regular, O2 sats 98%, BP 85/45, temp 98.9. She has an IV in her left hand. Fluids are N/S at 50 mL/hr. Lung sounds are clear. Mia was quite drowsy post op but is now alert. Her pain is a 0/10 using the pain faces scale.

**Recommendation:** Continue to assess her pain and check her mouth. Mom and Mia will need discharge teaching.

|  |  |
| --- | --- |
| **Patient Name:** Mia Jones | **MRN:** 8392746 |
| **Room:** 1364 | **Provider Name:** Edward Vance, DDS |
| **DOB:** 05-31-YYYY (reflect age 4.5)  | **Date Admitted:** Today’s date |
| **Age:** 4½ years | **Allergies:** None known |

Provider Orders

**Allergies/Sensitivities:** None known

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 1 | **Activity:** quiet play for the first 48 hrs and then activity as tolerated  |
|  | **Diet:** Clear fluids to soft, nonspicy foods for the first 48 hrs and then diet as tolerated  |
|  | **Vital signs:** every 15 min for the 1st hour, every 30 minutes for next hour and then as required  |
|  | **Medications:** Acetaminophen 200mg by mouth every 4 to 6 hours as needed  |
|  | **Fluids:** IV Normal Saline at 50ml/hr. Decrease when taking fluids well. |
|  | **Discharge**: When taking fluids well and discharge teaching completed. |
|  | Edward Vance, DDS |

Progress Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Today’s date/0900 | OR Note:4.5-year female patient brought by mother for comprehensive dental care under general anesthesia.Reviewed medical history: UnremarkableMedications: None currently takenAllergies: None notedBirth History: No complicationsExtraoral exam: No erythema, no edema or facial asymmetry, No trismus, no pain on palpation, No lymphadenopathy, No drainage Intra Oral exam: Multiple severe early childhood cariesPre-Operative Diagnosis: Early Childhood CariesThroat pack placed. Patient draped in sterile fashion.Treatment was completed as follows:Teeth #C was restored Teeth #B,S received stainless steel crowns.Teeth #E,F: were extracted. Use of local anesthetic 0.50 carpule of Lidocaine HCL, 2% with Epinephrine 1:100,000Prophy and fluoride varnish completed. Restorations checked and verified. Throat pack removed.Treatment Plan: 1 week follow-up in Pediatric Dental ClinicEdward Vance, DDS |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Today’s date/1100 | Recovery Room NotesLung sounds are clear, HR regular.Behavior – Has been tearful, but is easily distracted.Pain – 0/10Oral – Small amount of blood on gauze. Mia keeps trying to spit out the gauze, says it leaves a funny taste in her mouth. We have tried telling her that it is magical cloth and will help her mouth get better. This seems to work for a while, but she does need frequent reminders.Dental restorations intactFluids – IV to left hand. Normal saline infusing well at 50 mL/hrVitals – HR 100 and regular, RR 26 regular and clear, Temp 98.9, BP 85/45, O2 sats 98% N. Motte, RN |

Medication Administration Record

PRN and STAT Medications

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** |
| Day 1 | Acetaminophen  | 200mg  | By mouth | Every 4-6 hours as needed |  |  |
|  |  |  |  |  |  |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| MM | Nancy Motte, RN |  |  |
|  |  |  |  |

Medication Reconciliation Form

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

**Allergies/Sensitivities:** No known allergies

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** | **Last Dose** | **Continue/DC** |
| No daily medications |  |  |  |  |  | [ ]  C [ ]  DC |
|  |  |  |  |  |  | [ ]  C [ ]  DC |
|  |  |  |  |  |  | [ ]  C [ ]  DC |

|  |
| --- |
| Signature RN: Nancy Motte, RN Print Name: Nancy Motte Date: (today’s date)  |

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

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

Scan to pharmacy

Vital Signs Record

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Day**  | **Day**  | **Day** | **Day**  | **Day**  | **Day**  | **Day** |
| **Time:** |  |  |  |  |  |  |  |
| **Temperature:** |  |  |  |  |  |  |  |
| **Heart Rate/Pulse:** |  |  |  |  |  |  |  |
| **Respirations:** |  |  |  |  |  |  |  |
| **Blood Pressure** |  |  |  |  |  |  |  |
| **O2  Saturation:** |  |  |  |  |  |  |  |
| **Weight:** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Nurse Initials:** |  |  |  |  |  |  |  |

Intake & Output Bedside Worksheet (from OR)

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORAL** | **TUBE****FEED** | **IV****Normal Saline** | **IVPB** | **OTHER** | **URINE** | **EMESIS** | **NG** | **Drains****Type:** | **Other** |
| 090010001100 |  | 50ml50ml50ml |  |  | 100ml |  |  |  |  |
| **Total Intake this shift:**  | **Total Output this shift**: |

Lab Data

|  |  |  |
| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 8.0 | 6.0-11.0 K/uL |
| RBC (Red Blood Count) | 4.5  | 4.5-5.9 M/uL |
| HGB (Hemoglobin) | 12.0  | 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)  | 155  | 150-450 K/uL |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 137  | 135-145 mmol/L |
| Potassium | 4.0 | 3.5-5 mmol/L |
| Carbon dioxide | 37 | 35-45 mm hg |
| Calcium | 2.2 | 2-2.6 mmol/L |
| Chloride | 97 | 95-105 mEq/L |
| Glucose | 78 | 65-110 mg/dL |
| Bun | 1.4 | 1.2-3 mmol/L |
| Creatinine | 1.0 | 0.8-1.3 mg/dL |