

Peggy Nelson's Chart - (caregiver - Bridget Hardy)

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 this am .

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.) FLACC scale score was a 6. 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. At 1600 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 Orders 1200	<p>Activity: OOB with walker, hip precautions with toe touch assist to the bedside commode Discontinue Foley catheter Turn every 2 hours and prn PT and OT consult</p> <p>Diet: Soft diet with 1 can nutritional shake daily</p> <p>Vital signs: Every 4 hours</p> <p>Medications: Discontinue enoxaparin sodium</p> <p>Methylprednisolone 4 mg oral every day Hydroxychloroquine sulfate 200 mg oral twice a day Levothyroxine sodium 88 mcg every day Losartan potassium 50 mg every day Cefazolin 1000 mg every 8 hours IVPB PCA morphine sulfate per protocol Begin rivaroxaban 10 mg oral every day X 35 days</p> <p>Fluids: IV D5RL @125 ml/hr Incentive spirometer every 2 hours when awake Intake and output</p> <p style="text-align: right;">Megan Price, MD</p>

Progress Notes

Date/ Time:	
Post-op Day 1 @ 0730	Stable after left ORIF, left hip dressing intact. Out of bed to chair, nurse reporting signs and symptoms of delirium. <p style="text-align: right;">Meghan Price, MD</p>

Nursing Notes

Date/ Time:	
Post-op Day 1 @ 0800	Patient noted to be moaning, unable to verbalize pain using the 0-10 pain scale. FLACC scale being used, rated at 6. <p style="text-align: right;">Charles Madden, RN</p>

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-op Day 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	subcutaneous	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		

Vital Signs Record

Date:	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:	<i>SH</i>	<i>SH</i>	<i>CM</i>	<i>CM</i>	<i>CM</i>

Intake & Output Bedside Worksheet

INTAKE					OUTPUT				
ORAL Post-op Day 1 @ 1800	PO	IV	IVPB	OTHE R	URINE Post-op Day 1	EMESI S	NG	Drain s Type:	Other
	240mL	1500mL	50mL		1450mL				
Total Intake this shift: 1790mL					Total Output this shift: 1450mL				