

### **Quality Improvement Activity: Postoperative Monitoring**

A 33-year-old female was admitted to the postpartum unit two hours postoperatively of a repeat cesarean delivery of one infant. In handoff report, the labor and delivery nurse reported it was an uncomplicated delivery. The patient is G6 P5 L5. The admission assessment of a healthy baby boy was completed without problems. Upon admission assessment of the mother, the postpartum nurse notes the patient is awake and oriented. The patient has a low transverse incision covered with an anti-microbial occlusive foam dressing that is clean, dry, and intact. The nurse also notes a urinary catheter, moderate bleeding on the bed pad, and a firm fundus. Respiratory and cardiac assessment are within defined limits. Before completion of the assessment, the nurse is called to witness a medication in the room down the hall and leaves her patient's room. While walking down the hall, the nurse asked the new unlicensed assistive personnel (UAP) to check the vital signs and apply sequential compression devices to the newly admitted patient. About ten to fifteen minutes later, the UAP had just finished checking the patient's vital signs when the nurse returned to the patient's room to quickly check on the patient and family. The nurse proceeded to leave the floor to get lunch from the cafeteria and take her thirty-minute lunch break. She returned to the patient room where her patient's husband reports that she fell asleep about five minutes before the nurse entered the room. The nurse notices the patient looks paler compared to the initial assessment. The nurse proceeds to quickly assess the patient. She finds the patient is lethargic, pale, and the dressing on the incision and the bed pad are saturated with blood and blood clots. Fundal assessment reveals a boggy fundus and immediately the nurse calls for help and massages the fundus. The primary care giver is notified as the team enters the room. A team member takes the patient's vital signs which shows a heart rate of 128 and a blood pressure of 90/58. Per protocol, IV fluids, supplementary oxygen, and the administration of oxytocin is initiated. It is later found the patient was beginning to experience a postpartum hemorrhage when the UAP checked the patient's vital signs which revealed a blood pressure of 110/62 and a pulse of 112. The patient experienced a postpartum hemorrhage due to ruptured uterine sutures.

### **Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?**

In the scenario, the patient was admitted to the postpartum unit after a repeat, uncomplicated cesarean section. About 45 minutes to an hour after the initial assessment and vital signs were taken by the UAP, the nurse found the patient experiencing a postpartum hemorrhage caused by ruptured uterine sutures. The patient care lacked in that the nurse did not take the initial set of vital signs. If the nurse had checked them herself, she could have quickly recognized they were abnormal and assessed further. Heart rate is the first vital sign to change in a postpartum hemorrhage. The nurse also lacked to follow up with the UAP as soon as the vital signs were checked. The UAP could have also reported the vital signs to the nurse. Postpartum hemorrhages are one of the most common complications after a cesarean delivery.

**What circumstances led to the occurrence?**

The circumstances that led to this occurrence was the nurse not checking the initial set of vital signs, the nurse being interrupted during the postoperative admission assessment, the UAP not reporting the vital signs, and the nurse not following up on vital signs. Vital signs should be one of the first assessments of postoperative patients because they are VITAL. The other nurse that asked for a witness could have also asked another nurse to witness instead of the nurse assessing a postoperative patient. The nurse assessing the patient could have also waited until after the assessment to witness the medication.

**In what way could you measure the frequency of the occurrence? (interview nurses, examining charts, patient surveys, observation, etc.)**

The frequency of postpartum hemorrhages after cesarean sections can be measured by examining charts and counting how many times they have occurred in a month to determine an estimate of how often they occur in a year. Nurses can also be interviewed about how many postpartum hemorrhages after cesarean sections they have cared for in a month. A specialized chart for postpartum hemorrhages after cesarean sections can be used as well over a year's time to figure out how often they happen in a year. Every time a hemorrhage occurs, the primary nurse would document the hemorrhage, what caused it, and if there were any events that led to a delay in care for the hemorrhage.

**What evidence-based ideas do you have for implementing interventions to address the problem?**

The nurse should always check the first set of vital signs on any admission assessment to avoid problems like postpartum hemorrhages. The nurse is more competent to realize the abnormal vital signs and assess the situation further and find the problem quicker to treat it quicker. The nurse that is delegating a task to a UAP should always follow the five rights of delegation (right person, right task, right direction and communication, right supervision and feedback, and right circumstance). In this situation, the nurse delegated the right task to a new UAP and failed to supervise and failed to give the right directions and communication. The nurse also did not delegate under the right circumstance because the patient was being admitted postoperatively. Because the UAP was new, the nurse should have also instructed the UAP to report the vital signs to her. Classes reviewing postoperative care and the five rights of delegation can be held to avoid the occurrence in the scenario. A review for the role of the UAP can be conducted to remind UAP of what needs to be reported to the nurse to also avoid this occurrence. Avoiding distraction and interruptions during admission assessments can be done to avoid missing important assessment information like vital signs.

**How will you measure the efficacy of the interventions?**

Interviewing nurses and UAP can measure the efficacy of the interventions. Nurses can report that UAP are reporting appropriate information like vital signs more frequently. Nurses can also report assessing all necessary components of a postoperative admission assessment. In addition to the nurses' reports of postoperative admission assessments, charts can also be looked at to ensure all admission assessments

are done correctly. UAP can also report that nurses are frequently communicating well and giving clear instructions and direction. Surveys can also be done to evaluate how well communication occurs between nurses and UAP.