Sristi Pandey

Surgical Case 5: Lloyd Bennett

Documentation Assignments

1. Document your focused postoperative assessment for Lloyd Bennett.

   → Focused postoperative assessment for Llyod Bennett are: assessment of vital signs every 4 hours, assess the wound dressing, and drainage, make sure the patient is on SCD device when in bed, anti-embolism stockings during the day, ankle exercises, and prophylactic anticoagulation to prevent DVTs, auscultate lungs sounds, and heart sounds, assess patient's neurological status, and assess IV site no phlebitis or infiltration.

2. Document Lloyd Bennett's allergies in his chart.

   → Lloyd Bennett experienced acute hemolytic transfusion reaction during administration of packed red blood cells.

3. Document Lloyd Bennett's vital signs during the transfusion reaction.

   → The vital signs during the transfusion reaction were as follows: T 98.6°F, PR 97, RR 20, BP 115/74, and SpO2 94% on room air.

4. Document the priority nursing actions completed during the transfusion reaction.

   → The priority nursing actions completed during the transfusion reaction are as follows: the blood transfusion was stopped immediately, the tubing containing blood was replaced with a new tubing primed with normal saline, vital signs were checked,

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provider was notified, verification of the client ID and blood label was done, the lab was notified, normal saline of 1000 ml at 100ml/hr was administered as per provider's order, and symptoms were treated.

5. Identify and document key nursing diagnoses for Lloyd Bennett.

   → The key nursing diagnoses for Llyod Bennett are: acute respiratory distress and vascular collapse, anxiety related to the transfusion reaction, and Risk of decreased urinary output.

6. Referring to your feedback log, document the nursing care you provided.

   → Firstly, I washed my hands then, identified my patient using two identifiers. I communicated with patient and asked why the patient had presented, assessed the vital signs, checked skin, assessed IV access, auscultated lungs, and heart sounds, assessed the wound dressing, asked about any allergies to medications or food, educated the patient about blood transfusion, checked patient's ID band, type and cross-match with another nurse, asked if patient had any previous reactions to transfusions, verified signed consent, verified the packed red blood cells infusion with a volume of 330 ml and rate of 100 ml/hr with another nurse, administered the blood. The patient complained of back pain and tightness of chest, patient developed transfusion reaction, stopped the blood transfusion immediately, checked vital signs, contacted provider, administered normal saline 1000 ml at 100 ml/hr per order using new tubing, contacted blood bank,

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obtained urine sample, and obtained venous blood sample per order, reassessed vital signs, auscultated lungs and heart sounds, asked about pain, and handed off the patient.

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