
Acute Care – Post-Operative Case Study

Introduction

This final case study is based on what you have learned in the course. Please reflect on the following prior to completing this case study:

1. What two general characteristics must your documentation include? Explain how these characteristics apply to your documentation?
2. What are some risks or adverse events that may occur in a post-operative acute care setting?
3. For these risks, what are the essential components of your documentation?
4. Are there inappropriate abbreviations or ambiguous terms?

Scenario

The following is a fictitious scenario in an acute care setting (some details may be missing). Use day/month/year and metric time, and use your name and designation. Begin your documentation when Mrs. Smith arrives on your unit post-op.

Client background information:

- Mrs. Alice Smith – 64 years old
- Dr. D. White – primary physician
- Dr. G. Greene – surgeon
- Family contact – Glenda Matheson, daughter and named agent on personal directive

- Medical diagnoses – hypertension, osteoporosis, osteoarthritis to both hips, Type 2 diabetes, fractured left hip.
- Functional – independent with activities of daily living (ADLs) at home; ambulatory with cane.

What happened?

Mrs. Smith recently fell at home and sustained an introchanteric fracture of the left hip. Client states that there was no loss of consciousness (LOC) during her fall. Because of short staffing and after spending an exhausting ten hours in ER, she is admitted to Unit 4, Room 101 at 0600 and is booked for surgery (left hemiarthroplasty). Her family is upset at the long wait in ER and has threatened to call the Health Minister.

She arrives on your unit via stretcher with 5 pounds of Buck's traction. VS: BP 143/89, T 37.2 C (t) P97, R 18, O2 sats - 96% RA. She was given 2.5 mg Morphine IM at 0430 for pain.

New orders: traction and CTEMPS routines. NPO for OR today at 1000. Foley catheter draining 700 mls of clear amber urine. IV of NS infusing in right hand at 100 ml/hr.

Mrs. Smith's daughter asks the care provider what a "hemiarthroplasty" is. She also asks how long her mother's hospital stay will be.

Mrs. Smith went to the OR at 0930 and returned to the unit at 1430. Her GCS is 14 (there is a flow sheet for GCS). She received morphine 5 mg IV at 1330. Her incision is well approximated and dressing intact with a small amount of sero-sanguinous drainage.

Hemovac intact with 30 mls of sanguineous drainage. CTEMPS stable. VS: 126/84, T 37.1 C (t), P88, R18, SaO2 95%. O2 running at 2 l/minute via nasal prongs. IV of NS in right hand intact and infusing at 150 mls/hr. Foley catheter intact and draining 200 mls of clear amber urine. Oriented. Mrs. Smith has minimal pain now when asked.

Her daughter points to the Hemovac and asks: "What is this contraption?" The care provider assesses and settles the client on return from the recovery unit and answers her daughter's questions and concerns.

Answer Key

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This final case study is based on what you have learned in the course. Please reflect on the following prior to completing this case study:

1. *What two general characteristics must your documentation include? Explain how these characteristics apply to your documentation?*

My documentation must meet both legal and professional standards. Legal means how my documentation would stand in a court of law. Professional means how my documentation would be judged by my employer and regulatory college if applicable, to see if it meets standards of practice, competencies, and how my documentation would compare to a colleague's in a similar setting.

2. *What are some risks or adverse events that may occur in a post-operative acute care setting?*

In a post-operative acute care setting, there are several risks to the client or adverse events that may occur. In this scenario, consider the following:

- An older client has been under the influence of an anesthetic that may contribute to delirium, confusion or a delayed anaphylaxis. After an anesthetic, the client may experience respiratory arrest either from the anesthetic or from analgesics. There is also potential for cardiac arrest, hemorrhage, volemic shock and falls.
- Safety is a major concern when dealing with a client who is recovering from an anesthetic or who has had an analgesic. Are there any safety measures you would implement?
- There is a transfer of care from one unit to another – do you remember the protocol for receiving and transferring a client? SBAR? (Situation, Background, Assessment, Recommendations)
- The family has asked questions about the medical care and surgery and has made a threat of improper treatment. Do you remember how to document an adverse event such as a family threat? Are you able to document direct quotes by the client or family? When you provide education or teaching, how do you document these activities?

- Assessing and monitoring pain is an area that lawyers examine to see if the standard of care has been breached. Be sure to use your employer's pain scale.
- Be sure to include the emotional status of your client, as this is part of the assessment, not just physical signs and symptoms. Research has shown that this is one area of client care that is often neglected and not documented.

3. *For these risks, what are the essential components of your documentation?*

- Think of the nursing diagnosis and process: Assessment, planning, implementation and evaluation. Assessment data – have you provided enough significant details that accurately describe the client's condition? You must also document what you did or implemented and show what the outcomes or results were of your care and interventions. Remember: care that is not documented is care that was not done according to the legal system.
- In post-operative care, the following are documented: drains, IVs, dressings, traction, vital signs, fluid balances, level of consciousness (LOC), Foley catheter, analgesics/pain control, nausea, orientation of client and emotional status. This client data may be entered in the progress notes or it may be on a post-op form.

4. Are there inappropriate abbreviations or ambiguous terms?

LOC can mean both level of consciousness or loss of consciousness.

Document the return of Mrs. Smith to the post-op unit. You are the care provider assigned.

- Use day/month/year and metric time.
- Use your name and designation.

Setting: post-operative care

Essential Elements: older person has been under anesthesia – delirium; cardiac arrest; hemorrhaging; color, temperature, edema, movement, pulses, sensation (CTEMPS); family concerns – no matter how minimal; teaching; safety equipment in place.

Risks: do not address short staffing, family is upset and has threatened action, what is RA, came from post-operative recovery with what type of physician's orders?

Client information:

- Mrs. Smith – 74 years old
- Dr. David Black – primary physician
- Family contact – Glenda Matheson, daughter
- Medical diagnoses – hypertension, osteoporosis, osteoarthritis to both hips, Type 2 diabetes, fractured left hip.
- Functional – independent with activities of daily living (ADLs) at home. Uses a cane for mobility.

Scenario and background information: Mrs. Smith recently fell at home and sustained an introchanteric fracture of the left hip. No loss of consciousness (LOC) during her fall. Because of short staffing and after spending an exhausting ten hours in the emergency department (ER), she is admitted to Unit 4, Room 101 at 0600 for surgery (left hemiarthroplasty). Her family is upset at the long wait in ER and had threatened to call the Health Minister.

CTEMPS – color, temperature, edema, movement, pulses, sensation (of the affected limb)

My documentation should resemble the following example:

09/06/2014-----0600-----Client transferred to Unit 4, Room 101 from ER via stretcher with 5 pounds of Buck's Traction. SBAR report received from S. Jones, RN as per hospital policy. Client received 4 mg Morphine IM at 0430 in ER for pain. VS: BP 143/89, T 37.2 C (t), P97, R 18, SaO2 96% on room air. New orders received from Dr. Greene. Continue with traction and CTEMPS routines. NPO for OR today at 1000. Foley catheter draining 700 mls of clear amber urine. IV of NS infusing into right radial vein at 100 ml/hr. ----C. Williams, LPN

09/06/2014-----0900-----To OR via stretcher with consent and health record.----- C. Williams, LPN

09/06/2014-----1430-----Returned to unit. SBAR report received from M. Brown, RN as per hospital policy. New orders received from Dr. Greene. Had morphine 4 mg IV at 1330 in post anesthesia care unit for pain. Incision well approximated and intact - small amount of sero-sanguinous drainage. Hemovac intact with 30 mls of sanguineous drainage. CTEMPS to right and left leg completed, VS: 126/84, P88, R18, SaO2 95% (see post-op checklist). O2 at 2 litres/minute via nasal prongs. IV of Normal Saline infusing at 150 mls/hr in right radial vein – client instructed for infiltration and client repeated back signs and

symptoms of infiltration. Foley catheter inside and draining 200 mls of clear amber urine. No complaints of nausea. Awake and resting in bed. Able to recall name, time and place. Pain assessment is 5/10 as per hospital protocol and will call if pain increases. Daughter, Glenda asks about the Hemovac: "What is this contraption?" Daughter instructed that Hemovac is to remove extra fluid and blood as the healing process begins immediately after surgery. Both side rails up and call light placed within easy reach. Will continue to monitor VS, nausea and pain. ----- C. Williams, LPN