Maternity Case 10: Fatime Sanogo (Complex)

Documentation Assignments

1. **Document your initial assessment data for Ms. Sanogo, including vital signs, fundal assessment (consistency, position, location), lochia assessment (amount, color, odor, consistency), and pain (location, quality, severity).**

   Ms. Sanogo's initial vital signs are as follows: Heart rate: 100. Pulse: Present. Blood pressure: 98/50 mmHg. Respiration: 18. Conscious state: Appropriate. SpO2: 97%. Temp: 37 C.

   States pain is a 5/10 located in her "belly". Initial fundal massage indicated uterus did not properly firm up. Bladder scan showed retained urine. Performed straight catheterization and emptied 300 ml urine. Assessment of bed pads showed significant change in output of blood. Weight of bed pads suggested approximately 1270 ml lochia. Time since last change suggested bleeding rate of 1980 ml/hr. Second palpation of fundus indicated uterus was soft and boggy. Perineum assessed: minimal redness, minimal edema and no discharge from tear. Significant amount of blood and lochia noted.

2. **Write the situation-background-assessment-recommendation (SBAR) communications you would use to update the provider on Ms. Sanogo's status after your first encounter with her.**

   Ms. Sanogo is a 23 year old primiparous female in her first hour after vaginal delivery. She has a prolonged second-stage labor. She has a second-degree perineal laceration that has been repaired. The placenta was delivered manually. Bleeding was controlled by fundal massage and infusion of oxytocin that is still running at 20 ml/hr. She was not able to void. Bladder scan showed 300 ml retained in bladder. This RN performed straight catheterization.

3. **Document the medication(s) you administered to Ms. Sanogo and evaluate each drug's effectiveness.**

   2 mg butorphanol tartrate IV for pain: did provide pain relief
   500 ml lactated Ringers IV bolus given over 5 minutes: no change in BP or HR status
   Oxytocin postpartum at 500 ml/hour
   5 mg morphine IV: provided more pain relief

4. **Document the sequence of events during the simulation (i.e., vital signs, assessment findings, blood loss, nursing interventions, and patient response).**

You arrived at the patient.
0:00 You introduced yourself.
0:07 You washed your hands. To maintain patient safety it is important to wash your hands as soon as you enter the room.
0:10 Patient status - Heart rate: 100. Pulse: Present. Blood pressure: 98/50 mmHg. Respiration: 18. Conscious state: Appropriate. SpO2: 97%. Temp: 37 C. EFM: --. Fetal heart rate: --.
0:45 You identified the patient. To maintain patient safety it is important that you quickly identify the patient.
0:56 You asked if the patient was allergic; to anything. (In pain) She replied: “No, I am not allergic to anything”
1:10 Patient status - Heart rate: 102. Pulse: Present. Blood pressure: 100/51 mmHg. Respiration: 19. Conscious state: Appropriate. SpO2: 97%. Temp: 37 C. EFM: --. Fetal heart rate: --.
1:19 You attached the automatic noninvasive blood pressure (NIBP) measurement cuff. This will allow you to reassess the patient continuously.
1:23 You looked for normal breathing. She is breathing at 19 breaths per minute. The chest is moving equally.
1:51 You attached the pulse oximeter; This was indicated by order.
2:03 You checked the radial pulse. The pulse is strong, 105 per minute and regular. It is correct to assess the patient’s vital signs.
2:10 Patient status - Heart rate: 103. Pulse: Present. Blood pressure: 99/50 mmHg. Respiration: 20. Conscious state: Appropriate. SpO2: 97%. Temp: 37 C. EFM: --. Fetal heart rate: --.
2:26 You checked the Temperature; at the mouth. The temperature was 37 C.
2:53 You listened to the lungs of the patient. The breath sounds are clear and equal bilaterally.
3:10 Patient status - Heart rate: 105. Pulse: Present. Blood pressure: 97/49 mmHg. Respiration: 20. Conscious state: Appropriate. SpO2: 96%. Temp: 37 C. EFM: --. Fetal heart rate: --.
3:15 You listened to the heart of the patient. This is reasonable. There were regular heart sounds without murmurs.
3:32 You assessed the patient’s IV. The site had no redness, swelling, infiltration, bleeding, or drainage. The dressing was dry and intact. This is correct. Assessing any IVs the patient has is always important.
3:57 You asked the patient if she had any pain. (In pain) She replied: “Yes! Ahh…”
4:05 You asked: How bad is the pain? (In pain) She replied: “pretty bad; I’d give it a 5.”

4:10 Patient status - Heart rate: 106. Pulse: Present. Blood pressure: 95/50 mmHg. Respiration: 20. Conscious state: Appropriate. SpO2: 96%. Temp: 37 C. EFM: --. Fetal heart rate: --.

4:18 You asked the patient: Where does it hurt? (In pain) She replied: “In my belly”

4:45 You obtained IV access in the antecubital region.

4:55 You flushed the cannula. It is reasonable to flush the cannula here.

5:10 Patient status - Heart rate: 108. Pulse: Present. Blood pressure: 98/51 mmHg. Respiration: 20. Conscious state: Appropriate. SpO2: 96%. Temp: 37 C. EFM: --. Fetal heart rate: --.

5:41 You administered 2 mg of butorphanol tartrate IV. It is important to use the basic rights of medication administration to ensure proper drug therapy. This was indicated by order.

6:02 You assessed the bladder status. The bladder contained 300 mL of urine.

6:10 Patient status - Heart rate: 109. Pulse: Present. Blood pressure: 95/49 mmHg. Respiration: 20. Conscious state: Appropriate. SpO2: 95%. Temp: 37 C. EFM: --. Fetal heart rate: --.

Remember to flush the cannula after drug administration.

6:35 You assisted the patient into lying position.

6:45 You assisted the patient into Trendelenburg position.

7:10 Patient status - Heart rate: 111. Pulse: Present. Blood pressure: 94/49 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 95%. Temp: 37 C. EFM: --. Fetal heart rate: --.

7:10 You performed fundal massage. This was indicated and the correct response to the patient’s condition. The uterus did not firm up properly.

7:31 You performed a straight catheterization. This was reasonable. The bladder was emptied. There was about 300 ml of urine in the bladder.

7:54 You checked for blood, lochia, and fluid on the bed.

8:10 Patient status - Heart rate: 112. Pulse: Present. Blood pressure: 94/49 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 95%. Temp: 37 C. EFM: --. Fetal heart rate: --.

8:13 You changed and weighed the bed pads. The increase in weight of the bed pads suggests that approximately 1270 mL of lochia was on the pads. The time since the last change of the pads suggests a bleeding rate of approximately 1980 mL/hr.

8:51 You palpated the fundus of uterus. This was reasonable. The uterus was soft and boggy.

9:09 You assessed the patient’s perineum. This was reasonable. There was minimal redness, minimal edema, no echimosis, and no discharge from the repair, and it is well approximated. A lot of blood and lochia was seen in the vaginal. She was bleeding at a moderate rate.

9:10 Patient status - Heart rate: 114. Pulse: Present. Blood pressure: 94/50 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 95%. Temp: 37 C. EFM: --. Fetal heart rate: --.

9:38 You phoned the provider in order to discuss the patient.

10:10 Patient status - Heart rate: 115. Pulse: Present. Blood pressure: 95/50 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 95%. Temp: 37 C. EFM: --. Fetal heart rate: --.

11:10 Patient status - Heart rate: 116. Pulse: Present. Blood pressure: 93/49 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 94%. Temp: 37 C. EFM: --. Fetal heart rate: --.

11:27 You gave the patient 100% oxygen from a nonrebreathing mask.

11:33 You turned the oxygen on.

12:06 You started a bolus of 500 mL of lactated Ringer's solution IV, given over 5 minutes. It is important to give IV fluids to bleeding patients.

12:10 Patient status - Heart rate: 115. Pulse: Present. Blood pressure: 92/49 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 96%. Temp: 37 C. EFM: --. Fetal heart rate: --.

13:03 You verified the dose with another nurse. This was reasonable. The dose was correct.

13:10 Patient status - Heart rate: 113. Pulse: Present. Blood pressure: 91/49 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 98%. Temp: 37 C. EFM: --. Fetal heart rate: --.

14:05 You started infusing oxytocin postpartum (mL/hr) at 500 mL/hr. This was indicated by order.

14:10 Patient status - Heart rate: 112. Pulse: Present. Blood pressure: 92/49 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 99%. Temp: 37 C. EFM: --. Fetal heart rate: --.

14:24 You palpated the fundus of uterus. This was reasonable. The uterus was soft and boggy.

14:33 You looked for normal breathing. She is breathing at 21 breaths per minute. The chest is moving equally.

14:59 You phoned the provider in order to discuss the patient.

15:10 Patient status - Heart rate: 111. Pulse: Present. Blood pressure: 94/50 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 99%. Temp: 37 C. EFM: --. Fetal heart rate: --.

16:10 Patient status - Heart rate: 110. Pulse: Present. Blood pressure: 93/49 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 99%. Temp: 37 C. EFM: --. Fetal heart rate: --.

16:33 A 800-mcg dose of misoprostol was given rectally. This was indicated by order.

17:05 You flushed the cannula. It is reasonable to flush the cannula here.

17:10 Patient status - Heart rate: 109. Pulse: Present. Blood pressure: 95/50 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 99%. Temp: 37 C. EFM: --. Fetal heart rate: --.

17:11 You administered 5 mg of morphine IV.

17:23 You flushed the cannula.

17:35 You phoned the provider in order to discuss the patient.

18:10 Patient status - Heart rate: 108. Pulse: Present. Blood pressure: 93/50 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 99%. Temp: 37 C. EFM: --. Fetal heart rate: --.

19:10 Patient status - Heart rate: 108. Pulse: Present. Blood pressure: 93/52 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 99%. Temp: 37 C. EFM: --. Fetal heart rate: --.

19:11 You took a blood sample. This was indicated by order.

19:24 You provided patient education. This is correct. It is important to provide patient educate to improve understanding of the patient's medical condition and methods and means to manage her condition. Effective communication and patient education increases patient motivation to comply.

19:50 You phoned the provider in order to discuss the patient.

20:10 Patient status - Heart rate: 107. Pulse: Present. Blood pressure: 96/55 mmHg. Respiration: 21. Conscious state: Appropriate. SpO2: 99%. Temp: 37 C. EFM: --. Fetal heart rate: --.

20:47 You ended the scenario by returning to the nurse's station. This was reasonable.

5. **Ms. Sanogo is going to be taken back to labor and delivery for a manual examination. Write the transfer note.**

Ms. Sanogo is a 23 year old primiparous female in her first hour after vaginal delivery. She has a prolonged second-stage labor. She has a second-degree perineal laceration that has been repaired. The placenta was delivered manually. Vital signs have been documented above. Bleeding was controlled by fundal massage and infusion of oxytocin that is still running at 20 ml/hr. She was not able to void. Bladder scan showed 300 ml retained in bladder. This RN performed straight catheterization. Assessment of bed pads showed significant change in output of blood. Weight of bed pads suggested approximately 1270 ml lochia. Time since last change suggested bleeding rate of 1980 ml/hr. Second palpation of fundus indicated uterus was soft and boggy. Please further assess and monitor for PP hemorrhage.