Student Name: Sydney Auen
Medical Diagnosis/Disease: UTI

- clean catch urine sample
- urine culture

NCLEX IV *(8)*: Physiological Integrity/Physiological Adaptation

Anatomy and Physiology
Normal Structures
- urinary tract above urethra is normally sterile
- urinary system includes kidneys, ureters, bladder, and urethra (bladder and urethra are lower tract)
- eliminate waste: urea
- keep chemicals: potassium and sodium / water
- urea is produced by breaking down foods containing protein, then carried by blood to kidneys where it is filtered/removed by nephrons

Pathophysiology of Disease
- can be classified as upper or lower according to location
- urinary tract above urethra is normally sterile
- defense mechanisms to avoid UTI's are voiding, complete emptying of bladder, ect. (↑ pH, ↑ urea concentration)
- organism usually originates in perineum → ascending route of urethra
- most organisms that cause infection are gram (-) bacilli (found in GI)
- women ↑ risk → short urethra

NCLEX IV *(7)*: Reduction of Risk

Anticipated Diagnostics
Labs
- dipstick urinalysis (wbc, leukocyte esterase)
- microscopic urinalysis

Additional Diagnostics
- ultrasound
- CT (obstruction or recurring)

NCLEX II *(3)*: Health Promotion and Maintenance

Contributing Risk Factors
- obesity
- aging
- diabetes
- HIV
- renal impairment
- catheters
- constipation
- pregnancy
- poor personal hygiene

Signs and Symptoms
- dysuria
- hesitancy
- incomplete emptying
- incontinence
- nocturia
- urinary frequency
- hematuria
- fever/chills

NCLEX IV *(7)*: Reduction of Risk

Possible Therapeutic Procedures
Non-surgical
- medication regimen
- drug therapy

Surgical
n/a

Prevention of Complications
(What are some potential complications associated with this disease process)
- repeated infections
- permanent kidney damage
- sepsis
- narrowed urethra in males

NCLEX IV *(6)*: Pharmacological and Parenteral Therapies

Anticipated Medication Management
- antibiotics
- analgesics
- prophylactic or suppressive antibiotics

NCLEX IV *(5)*: Basic Care and Comfort

Non-Pharmacologic Care Measures
- patient teaching
- supportive care (positioning, hygiene, change linens)

NCLEX III *(4)*: Psychosocial/Holistic Care Needs

What stressors might a patient with this diagnosis be experiencing?
- pain / discomfort
- $$$
- mental alterations

Client/Family Education

List 3 potential teaching topics/areas
- take all antibiotics as prescribed
- practice appropriate hygiene
- maintain adequate fluid intake

NCLEX I *(1)*: Safe and Effective Care Environment

Multidisciplinary Team Involvement
(Which other disciplines do you expect to share in the care of this patient)
- case management
- urologist
- gerontologist
- endocrinologist

Sydney Aven

Patient Problems (Nursing Diagnoses)

List two potential patient problems you will be addressing as part of your nurse's notes, along with clinical reasoning, goals/expected outcomes, assessments, and priority nursing interventions. The patient problems must be in priority order. Six nursing interventions for each priority problem must be completed.

Problem # 1: Acute pain: Pelvic Area
Clinical Reasoning: burning during urination, facial grimacing, guarding genital area
Goal/EO: ATI will report a pain score of 3/10 on a scale of 0 to 10 during my time of care
Ongoing Assessments:
Assess pain score q4, assess pain goal q4, assess pain characteristics q4, assess for signs of UTI (dysuria, frequency, urgency) q4
NI:
1. Apply a heating pad to the suprapubic area PRN
2. Administer analgesics as ordered
3. Teach to avoid coffee, tea, spices, alcohol, and soda a shift
4. Teach to use distraction techniques (counting, coloring, TV) PRN.
5. Provide rest periods during pain / discomfort.
6. Encourage to change positions q2 PRN

Problem # 2: impaired Urinary Elimination
Clinical Reasoning: frequent urination, urinary urgency, incontinence, incomplete bladder emptying
Goal/EO: ATI will maintain balanced I&O with clear, odor-free urine prior to discharge.
Ongoing Assessments: palpate bladder for distension q4. assess pattern of urination a shift, monitor I&O q8, assess fluid intake q4, monitor urine characteristics q void.
NI:
1. Offer bedpan/urinal/bathroom q2, PRN
2. Administer Levofloxacin as ordered
3. Teach importance of finishing antibiotics completely a shift
4. Encourag preferred fluids q4 PRN
5. Ensure assistive walking devices are at bedside at all times
6. Educate on proper hygiene for toileting on admission

Medication

STUDENT NAME: Sydney Auen
MEDICATION: levofloxacin (Levaquin)
CATEGORY CLASS: fluoroquinolone/antibiotic

Expected Pharmacological Action:
Inhibits DNA enzyme gyrase in susceptible microorganisms, interfering with bacterial cell replication, repair

Therapeutic Use:
Bactericidal

Complications:
Occasional: diarrhea, nausea, abdominal pain, dizziness, dizziness, headache
Rare: flatulence, pain, inflammation, swelling in calves, hands, shoulder, chest pain, difficulty breathing, palpitations, edema, tendon pain

Medication Administration:
IVPB:
-see back of sheet

Contraindications/Precautions:
Contraindications: hypersensitivity to levofloxacin, other fluoroquinolones
Precautions: known or suspected CNS disorders, seizure disorder, renal impairment, bradycardia, rheumatoid arthritis, elderly, severe cerebral arteriosclerosis, ect.

Nursing Interventions:
-monitor serum glucose, renal function, LFT
-monitor daily patterns of BMs
-report hypersensitivity rx
-be alert for superinfection
-monitor for muscle weakness, voice, dystonia in pts with myasthenia gravis, pain, swelling. ect.

Interactions:
Drug: may decrease therapeutic effect of BCG. Antacids,sucralfate, zinc decrease absorption. NSAIDs may increase risk of CNS stimulation seizures. Medications that prolong QT interval may increase risk of arrhythmias. May increase anticoagulation effect of warfarin
Lab: may alter serum glucose

Client Education:
-use of drug: treat bacterial infections
-complete drug therapy completely
-alert medical professional if allergic reaction occurs

Evaluation of Medication Effectiveness:
-monitor for bacterial infection (temperature, WBC, ect.)

Medication

STUDENT NAME: Sydney Auen
MEDICATION: levofloxacin (Levaquin)
CATEGORY CLASS: fluoroquinolone/antibiotic

Compatibility:
-compatible with dexmedetomidine, dobutamine, dopamine, fentanyl, lidocaine, lorazepam, magnesium, morphine
-not compatible with furosemide, heparin, insulin, nitroglycerin, propofol

Amount:
-250 to 750 mg q 24h, 750 mg q 24h for severe or complicated infections

Rate of Administration:
-administer no less than 60 min for 250mg or 500 mg; 90 min for 750mg

Diluent:
-for infusion using single-dose vial, withdraw desired amount
-dilute each 10mL (250 mg) with minimum of 40 mL NS, D5W, providing a concentration of 5 mg/mL

Site, supplies, storage, stability:
-available in single-dose 20 mL (500mg) vials and premixed with D5W, ready to infuse
-diluted vials stable for 72 hrs at room temperature, 14 days if refrigerated

Medication

STUDENT NAME: Sydney Auen
MEDICATION: lorazepam (Ativan)
CATEGORY CLASS: benzodiazepine/antianxiety, sedative-hypnotic, antiemetic, skeletal muscle relaxant, amnesiac, anticonvulsant, and anti tremor

Expected Pharmacological Action:
Enhances action of inhibitory neurotransmitter gamma-aminobutyric acid in CNS, affecting memory, motor, sensory, and cognitive function

Therapeutic Use:
produces anxiolytic, anticonvulsant, sedative, muscle relaxant, antiemetic effects

Complications:
Frequent: drowsiness, dizziness
Rare: weakness, ataxia, headache, hypotension, n/v, confusion, injection site reaction

Medication Administration:
PO:
-give with food
-tablets amy be crushed
-dilute oral solution in water, juice, soda, or semisolid food

Contraindications/Precautions:
Contraindications: hypersensitivity to lorazepam, other benzodiazepines. acute narrow-angle glaucoma, severe respiratory depression
Precautions: neonates, renal/hepatic impairment, compromised pulmonary function, depression, concomitant use of CNS depressants, pt at high risk for suicidal ideation and behavior, hx of drug abuse/misuse, drug-seeking behavior, dependancy

Nursing Interventions:
-monitor BP, RR, HR
-screen for suicidal ideation and behavior, new onset/worsening of depression, anxiety, or mood disorder
-screen for drug abuse and misuse

Interactions:
Drug: valproic acid may increase concentration/effects. alcohol, other CNS depressants, may cause CNS depressants
Herbal: herbs with sedative properties may increase CNS depressants

Client Education:
-use of med: to treat anxiety and seizures, and to ease anxiety before surgery
-avoid tasks that require alertness until response is established
-no alcohol or CNS depressants

Evaluation of Medication Effectiveness:
monitor for calm facial expression, decreased restlessness, insomnia, decrease in seizure-related symptoms

Module Report

Tutorial: Real Life RN Medical Surgical 4.0

Module: Urinary Tract Infection

Individual Name: **Sydney Auen**

Institution: **Margaret H Rollins SON at Beebe Medical Center**

Program Type: **Diploma**

Standard Use Time and Score

	Date/Time	Time Use	Score
Urinary Tract Infection	2/27/2023 4:33:04 PM	1 hr 27 min	Strong

Reasoning Scenario Details
Urinary Tract Infection - Use on 2/27/2023 3:34:08 PM

Reasoning Scenario Performance Related to Outcomes:

*See Score Explanation and Interpretation below for additional details.

Body Function	Strong	Satisfactory	Needs Improvement
Cardiac Output and Tissue Perfusion	100%		
Cognition and Sensation	100%		
Immunity	100%		
Integument	100%		
Mobility	100%		
Oxygenation	100%		
Regulation and Metabolism	100%		

NCLEX RN	Strong	Satisfactory	Needs Improvement
RN Management of Care	100%		
RN Safety and Infection Control	100%		
RN Psychosocial Integrity	100%		
RN Pharmacological and Parenteral Therapies	100%		

RN Physiological Adaptation	100%		

QSEN	Strong	Satisfactory	Needs Improvement
Safety	100%		
Patient-Centered Care	100%		
Evidence Based Practice	100%		
Teamwork and Collaboration	100%		

Decision Log:

Scenario	Question Fill In the Blank Essay (Not Scored)
Question	What additional information would assist Nurse Craig in preparing to care for Mrs. Jordan? List 5 additional pieces of information that should have been included in the report.
Selected Option	Nurse Craig would benefit from receiving information about Mrs. Jordan such as, 1) her most recent vital signs, 2) characteristics of her urine output (amount, color, odor..), 3) details on probable discharge in the next day (discharge orders or plans), 4) her normal level of activity (assistive devices, history of falls..), and 5) the type and amount of fluid bolus that was administered in the ED. This information will better help Nurse Craig in caring for Mrs. Jordan.
Rationale	1. Levofloxacin (Levaquin) – How much was given and when is the next dose? 2. Agitation – The client's baseline level of orientation. Is this agitation new or getting worse? How do you know she is tired? Did she tell you that or is she sleeping on and off? 3. Probable discharge in next 24 hr – Is there a discharge order or plan? 4. Output – Amount, color and characteristic of urine.5. IV – The type and amount of IV solution given since arrival in the emergency department. The type and rate of IV solution that is currently infusing. Location of IV site and size of catheter.6. Vital signs – Range of vital signs, including O2 saturation. Current vital signs. 7. Blood glucose – Results of blood glucose and time obtained. 8. Social status – Any significant others that are with her. Individuals who should be contacted about hospitalization. 9. Medical history – Pre-existing conditions, allergies, and home medications and adherence. 10. Other – Normal level of activity, history of falls, and diet at home.

Optimal Decision	
Scenario	Nurse Craig just entered Mrs. Jordan's room to do his assessment.
Question	Nurse Craig is assessing Mrs. Jordan. Which of the following actions should the nurse take next?
Selected Option	Apply oxygen per nasal cannula at 2 L/min.
Rationale	According to the airway, breathing, and circulation (ABC) priority-setting framework, this is the first intervention the nurse should take to address the client's difficulty breathing.

Optimal Decision	
Scenario	Nurse Craig finds Mrs. Jordan restless and having increased difficulty breathing.
Question	Nurse Craig observes that Mrs. Jordan is restless and having increased difficulty breathing. Which of the following assessments is appropriate for Mrs. Jordan's needs at this time?
Selected Option	Rapid focused assessment
Rationale	The client is experiencing an acute episode of dyspnea. A rapid focused assessment will allow the nurse to determine the underlying cause of the dyspnea and to intervene quickly. Therefore, this is the correct assessment at this time.

Optimal Decision	
Scenario	Nurse Craig completes a rapid focused assessment.
Question	Based on the findings from the rapid focused assessment, which of the following actions should Nurse Craig perform first?
Selected Option	Increase oxygen to 4 L/min.
Rationale	The client is demonstrating clinical manifestations of heart failure and hypoxemia. Using the priority-setting framework of ABCs, increasing the rate of oxygen administration is the priority action because this promotes improved oxygenation.

Optimal Decision	
Scenario	Nurse Craig has received a bag of medications from Mrs. Jordan's home.
Question	Nurse Craig has received a bag of medications from Mrs. Jordan's home. He reviews each of the medications. Which of the following is the best action for Nurse Craig to take at this time?
Selected Option	Request medication reconciliation with pharmacy.
Rationale	The client's preadmission medications should be compared to the current medications prescribed by the provider upon admission.

Optimal Decision	
Scenario	Nurse Craig is discussing Mrs. Jordan's medications with the pharmacist.
Question	Nurse Craig has reviewed Mrs. Jordan's medications received from her home. Nurse Craig labels the medication bag and locks the medications in a cabinet. Based on events so far, which of the following best describes Mrs. Jordan's priority underlying medical condition?
Selected Option	Cardiac
Rationale	Based on the client's home medications and the events that have occurred, the client's cardiac condition is the priority at this time. Digoxin (Lanoxin), furosemide (Lasix), potassium chloride, and isosorbide (Imdur) are medications prescribed for heart failure. The client is experiencing shortness of breath and difficulty breathing related to fluid overload.

Optimal Decision	
Scenario	Mrs. Jordan is demonstrating exacerbation of heart failure.
Question	Mrs. Jordan has experienced increased respiratory distress during the past 2 hr. Since admission, she has received 2,550 mL IV and 100 mL orally. Her urinary output since admission to the medical-surgical unit has been 100 mL. Which of the following clinical manifestations indicates exacerbation of heart failure and should be reported to the provider? (Select all that apply.)
Selected Ordering	Dependant pitting edema Crackles in the lungs
Rationale	Pitting edema is a clinical manifestation of heart failure. Weak peripheral pulses is a clinical manifestation of heart failure. Dark amber urine is typically seen in a client who has fluid volume deficit. Therefore, this finding does not indicate heart failure.Neck vein distension is a typical clinical manifestation for a client who has heart failure. Crackles in the lungs is a clinical manifestation of heart failure.

Optimal Decision	
Scenario	The provider just explained to Mrs. Jordan that she is not a candidate for surgery and needs to be placed in Buck's traction. Mrs. Jordan is tearful and has a frightened look on face.
Question	The provider has just informed Mrs. Jordan that due to her cardiac condition she is not a candidate for surgery. Mrs. Jordan is tearful and has a frightened look on her face. Which of the following is an appropriate statement by Nurse Craig?
Selected Option	"Tell me about the concerns you have."
Rationale	This is a therapeutic statement by the nurse to the client.

Optimal Decision	
Scenario	Mrs. Jordan is in Buck's traction and needs a bed bath.
Question	Nurse Debbie is preparing to provide a bed bath for Mrs. Jordan, who is in Buck's traction. Which of the following is the appropriate action for Nurse Debbie to take?
Selected Option	Leave the traction in place.
Rationale	Buck's traction is to remain in place to keep the extremity immobilized to decrease muscle spasms until surgery is performed on the fractured hip.

Optimal Decision	
Scenario	Nurse Stephanie has inspected Mrs. Jordan's back for skin breakdown.
Question	Image|RN_AMS_UTI_22_stem_800px.png|Mrs. Jordan is at risk for skin breakdown due to her age, her cardiac condition and her mobility that is restricted due to the placement of Buck's traction. Nurse Stephanie assesses the client for skin breakdown. Based on the photograph, Nurse Stephanie should classify the skin breakdown as which of the following?
Selected Option	Stage 2
Rationale	In stage 2, there is partial thickness skin loss involving the dermis with a shallow pink ulcer that has a red pink bed without sloughing. It also can appear as an intact blister.

Optimal Decision	
Scenario	Nurse Debbie is planning care for Mrs. Jordan
Question	Which of the following should Nurse Debbie include in the plan of care for Mrs. Jordan, who has a fractured hip and is in Buck's traction?
Selected Option	Monitor Mrs. Jordan's ability to move her toes on the affected leg.
Rationale	The nurse should monitor the client's ability to move her toes on the affected extremity to assess for circulatory compromise.

Optimal Decision	
Scenario	Mrs. Jordan tells Nurse Debbie that she is short of breath. Mrs. Jordan's SaO2 saturation is 85%. Nurse Debbie increased the oxygen flow rate to 6 L/min.
Question	Mrs. Jordan reports that she is short of breath. Her SaO2 is 85%, and the oxygen flow rate has been increased to 6 L/min. Nurse Debbie reassesses the client. Which of the following clinical findings is an early indicator of shock?
Selected Option	Restlessness
Rationale	Restlessness is due to decreased cerebral perfusion and can be a clinical finding in the early stages of shock.

Optimal Decision	
Scenario	Nurse Debbie completes an assessment of Mrs. Jordan.
Question	Nurse Debbie assessed Mrs. Jordan and determined that Mrs. Jordan is at risk for shock. Which of the following types of shock is Mrs. Jordan at risk for?
Selected Option	Distributive shock
Rationale	The client is becoming septic. Sepsis is a widespread infection that triggers a whole-body inflammatory response. It leads to distributive shock when infectious micro-organisms are present in the blood.

Optimal Decision	
Scenario	Nurse Debbie has received the laboratory reports.
Question	Nurse Debbie is reviewing the laboratory report. Which of the following arterial blood gases (ABGs) indicate that Mrs. Jordan is experiencing metabolic acidosis?
Selected Option	pH 7.28, PaCO2 35, HCO3 20
Rationale	The client is at risk for metabolic acidosis. In the presence of metabolic acidosis, the pH is less than 7.35, the HCO3 is less than 22, and the PaCO2 is within the expected reference range.

Score Explanation and Interpretation
Individual Performance Profile

REASONING SCENARIO INFORMATION

Reasoning Scenario Information provides the date, time and amount of time use, along with the score earned for each attempt. The percentage of students earning a Scenario Performance of Strong, Satisfactory, or Needs Improvement is provided. In addition, the Scenario Performance for each student is provided, along with date, time, and time use for each attempt. This information is also provided for the Optimal Decision Mode if it has been enabled.

If a detrimental decision is made during a Real Life scenario, the scenario will diverge from the optimal path and potentially end prematurely, in which case an indicator will appear on the score report.

REASONING SCENARIO PERFORMANCE SCORES

Strong	Exhibits optimal reasoning that results in positive outcomes in the care of clients and resolution of problems.
Satisfactory	Exhibits reasoning that results in mildly helpful or neutral outcomes in the care of clients and resolution of problems.
Needs Improvement	Exhibits reasoning that results in harmful or detrimental outcomes in the care of clients and resolution of problems.

REASONING SCENARIO PERFORMANCE RELATED TO NURSING COMPETENCY OUTCOMES

A performance indicator is provided for each outcome listed within the nursing competency outcome categories. Percentages are based on the number of questions answered correctly out of the total number of questions that were assigned to the given outcome. Outcomes have varying numbers of questions assigned to them. Also, due to divergent paths within the branching simulation, the outcomes encountered and the number of questions for each outcome can vary. The above factors cause limitations related to comparing scores across students or groups of students.

NCLEX® CLIENT NEED CATEGORIES

Management of Care	Providing integrated, cost-effective care to clients by coordinating, supervising, and/or collaborating with members of the multi-disciplinary health care team.
Safety and Infection Control	Incorporating preventative safety measures in the provision of client care that provides for the health and well-being of clients, significant others, and members of the health care team.
Health Promotion and Maintenance	Providing and directing nursing care that encourages prevention and early detection of illness, as well as the promotion of health.
Psychosocial Integrity	Promoting mental, emotional, and social well-being of clients and significant others through the provision of nursing care.
Basic Care and Comfort	Promoting comfort while helping clients perform activities of daily living.
Pharmacological and Parenteral Therapies	Providing and directing administration of medication, including parenteral therapy.
Reduction of Risk Potential	Providing nursing care that decreases the risk of clients developing health-related complications.
Physiological Adaptation	Providing and directing nursing care for clients experiencing physical illness.

Score Explanation and Interpretation
Individual Performance Profile

QUALITY AND SAFETY EDUCATION FOR NURSES (QSEN)

Safety	The minimization of risk factors that could cause injury or harm while promoting quality care and maintaining a secure environment for clients, self, and others.
Patient-Centered Care	The provision of caring and compassionate, culturally sensitive care that is based on a client's physiological, psychological, sociological, spiritual, and cultural needs, preferences, and values.
Evidence Based Practice	The use of current knowledge from research and other credible sources, upon which clinical judgment and client care are based.
Informatics	The use of information technology as a communication and information gathering tool that supports clinical decision making and scientifically based nursing practice.
Quality Improvement	Care related and organizational processes that involve the development and implementation of a plan to improve health care services and better meet the needs of clients.
Teamwork and Collaboration	The delivery of client care in partnership with multidisciplinary members of the health care team, to achieve continuity of care and positive client outcomes.

BODY FUNCTION

Cardiac Output and Tissue Perfusion	The anatomical structures (heart, blood vessels, and blood) and body functions that support adequate cardiac output and perfusion of body tissues.
Cognition and Sensation	The anatomical structures (brain, central and peripheral nervous systems, eyes and ears) and body functions that support perception, interpretation, and response to internal and external stimuli.
Excretion	The anatomical structures (kidney, ureters, and bladder) and body functions that support filtration and excretion of liquid wastes, regulate fluid and electrolyte and acid-base balance.
Immunity	The anatomic structures (spleen, thymus, bone marrow, and lymphatic system) and body functions related to inflammation, immunity, and cell growth.
Ingestion, Digestion, Absorption, and Elimination	The anatomical structures (mouth, esophagus, stomach, gall bladder, liver, small and large bowel, and rectum) and body functions that support ingestion, digestion, and absorption of food and elimination of solid wastes from the body.
Integument	The anatomical structures (skin, hair, and nails) and body functions related to protecting the inner organs from the external environment and injury.
Mobility	The anatomical structures (bones, joints, and muscles) and body functions that support the body and provide its movement.
Oxygenation	The anatomical structures (nose, pharynx, larynx, trachea, and lungs) and body functions that support adequate oxygenation of tissues and removal of carbon dioxide.
Regulation and Metabolism	The anatomical structures (pituitary, thyroid, parathyroid, pancreas, and adrenal glands) and body functions that regulate the body's internal environment.
Reproduction	The anatomical structures (breasts, ovaries, fallopian tubes, uterus, vagina, vulva, testicles, prostate, scrotum, and penis) and body functions that support reproductive functions.

DECISION LOG

Information related to each question answered in a scenario attempt is listed in the report. A brief description of the scenario, question, selected option and rationale for that option are provided for each question answered. The words "Optimal Decision" appear next to the question when the most optimal option was selected.

The rationale for each selected option may be used to guide remediation. A variety of learning resources may be used in the review process, including related ATI Review Modules.

If a detrimental decision that could result in grave harm to the client is made during a Real Life scenario, the scenario ends immediately and an indicator that a detrimental decision has been made appears in the score report. A detrimental decision indicates the need to remediate the related topic area to prevent detrimental outcomes in the future.

EX_RealLife_Ind

ATI Virtual Clinical Questions and Reflection:

1) Identify two members of the healthcare team collaborating in the care of this patient:
   a. Angela (RN charge)
   b. Ashley (Assistive personnel)
2) What were some steps the nursing team demonstrated that promoted patient safety?
   a. contacted pharmacy for medication reconciliation
   b. reading back orders to confirm with provider
   c. stayed with patient while she was short of breath
3) Do you feel the nurse and medical team utilized therapeutic communication techniques when interacting with individuals, families, and health team members of all cultural backgrounds?
   a. If **yes**, describe:
      charge nurse, primary nurse, and provider worked together to make sure patient is getting the best, up-to-date care
   b. If **no**, describe:
      _____

Reflection

1) Go back to your Preconference Template:
   a. Indicate (circle, star, highlight, etc.) the components of your preconference template that you saw applied to the care of this patient.
2) Review your Nursing Process Form: Did you select a correct priority nursing problem?
   a. If **yes,** write it here: _____
   b. If **no,** write what you now understand the priority nursing problem to be:
      decreased cardiac output
3) Review your Patient Problem Form: Did you see many of your anticipated nursing assessments and interventions used?
   a. Were there interventions you included that *were not* used in the scenario that could help this patient?
      i. If **yes,** describe:
         encourage to change positions, teach importance of complying with medication order
      ii. If **no,** describe:
         _____
4) After completing the scenario, what is your patient at risk for developing?
   a. CHF and shock → death
   b. Why? not taking cardiac medications appropriately, ↑ SOB, ↓ orientation

5) What was your biggest "take-away" from participating in the care of this patient? How did this impact your nursing practice?

My biggest "take-away" from this simulation is to not focus on one specific problem but to look at all of them together. The patient came in for eurosepsis and they didnt pay enough attention to her past medical history of chronic heart failure. There were no medications ordered for her chronic heart failure and this may have made the clinical manifestations worse then if she was taking those medications as well. The nurse also was able to discover this by taking the time to go over the medications that were brought in. Attention to detail is very important!

SOAP Note Based on Priority Problems

Priority Patient Problem #1: Decreased cardiac output

Subjective: *This section explains the client symptoms. Include a narrative of the patient's complaints/concerns and/or information obtained from secondary sources.* 1,000 mL lactated Ringer's IV at 30 mL/hr	**History Present Illness (HPI):** 78 Female urosepsis **PMH:** CHF, diabetes **Allergies:** nka **Current Medications:** glyburide 2.5 mg PO daily w/ breakfast levofloxacin 250 mg IV bolus q 12 hr acetaminophen 325 mg PO q 4 hr PRN fever > 37.7°C lorazepam 2 mg PO q 6 hr PRN agitation and restlessness
Objective: *This section is your clinical observations. Include pertinent vital signs, pertinent labs and diagnostics related to the priority problem.*	**Vital Signs:** (Admission) T 37.4°C, P 96, R 24, BP 136/76, O_2 sat 91% RA **Labs:** Hgb - 11.3 WBC - 13,000 albumin - 3.2 | ABG pH 7.28 CO_2 35 CO_3 20 | UA - slightly amber - cloudy - 1.039 spec. gravity - 2 protein Hct - 33% BUN - 21 Cholesterol - 225 **Diagnostics:** X-ray: hilar and pulmonary vasculature is dilated consistent with long-standing mild COPD. Heart size is enlarged consistent with hypertrophy of LV.
Assessment: *Focused assessments on your priority problem.*	- lungs clear - labored breathing, 32 RR and shallow - 38.3°C - 85% on 4L NC - stated "I don't feel so good" "it is so cold" - scant amount of cloudy urine in foley bag
Plan ***Based on priority problem only** *Include what your plan is for the client. What treatments or medications are needed? You can include procedures, consults, labs/diagnostics, etc. What nursing interventions are being performed?*	**Plan:** - Digoxin 0.25 mg PO now - Digoxin 0.25 mg PO daily - furosemide 20 mg IV bolus now - furosemide 20 mg IV bolus if < 500mL urinary output in next 6 hr. - albuterol 0.5% sodium in 3 mL 0.9% Sodium Chloride via nebulizer q 6 hr. - continue IVF NS 150 mL/hr - maintain O_2 6L (titrate PRN) - UA - push high IV antibiotics **Teaching & Resources:** - teach signs and symptom of UTI and sepsis - teach importance of following medicine regimen - may need home health for altered orientation - case management for discharge plans