N202 Unit I

Class Preparation Assignment – Sepsis Case Study

Patient Story

73-year-old man is brought to the emergency department via ambulance after being found unresponsive by his wide.

Assessment: Opens eyes, but does not follow commands. Skin is warm & flushed. Lungs are clear bilaterally. Abdomen is benign with normoactive bowel sounds. Trace edema is noted in the bilateral lower extremities. A large wound is found on the right arm – erythema, moderate amount of yellow drainage (wife states this is from a gardening accident that happened a few days prior).

Vital Signs: HR 114, BP 96/52, RR 24, T 101.5, SpO2 96% on RA

Labs:

WBC	19.2	Na	144	Procal	0.6
Hgb	16	K	4.9	Lactate	2.9
Hct	44	Glu	135		
Plt	249	Cr	1.4		

Questions:

1. **What assessment findings from the information above require follow-up by the nurse? Give rationale for your choices.**

The client's inability to follow commands is an irregular assessment finding likely due to poor oxygenation and vascular circulation throughout his body. His skin being warm and flushed indicates an infection with a WBC (19.2). The bilateral lower-extremity edema could be due to ineffective tissue perfusion, which is why his BP is 96/52 with a compensated heart rate of 114 bpm. Erythema and yellow drainage from the patient's arm, and a fever of 101.5, could be an autoimmune response to the infection. With an RR of 24 and SpO2 of 96%, his body is trying to oxygenate itself to prevent tissue damage, resulting in elevated Procal (0.6), and Lactate (2.9). The patient's Cr (1.4) can indicate kidney injury.

2. **The nurse recognizes that based on the patient's history and diagnosis, he is currently at risk for complications, especially ___Septic shock_____, _____Acute kidney injury_____, and ___Respiratory failure_____.**

   Options:

   Septic shock

Fluid Overload
Respiratory Failure
Hypertensive Crisis
Coronary Vessel Occlusion
Acute Kidney Injury

Story Progression

The patient is transferred to a stepdown unit. The admitting nurse is reviewing orders for cultures and antibiotics. The patient is receiving IV fluids at 150 mL/hr after receiving two 500 mL NS bolus in the emergency department.

Assessment: Awake but confused – complaining of pain in right arm. Voided 500 mL of dark amber urine.

Vital Signs: HR 100, BP 104/88, RR 22, T 101, SpO2 97% on 2L NC

3. **Use an X for the nursing action identifying if that task is indicated, contraindicated, or nonessential.**

Nursing Action:	Indicated	Contraindicated	Nonessential
Start antibiotics prior to initiating other orders		X	
Obtain blood cultures prior to initiating other orders	X		
Change arm dressing every 2 hours			X
Administer pain medication	X		
Measure intake & output every 1 hour	X		
Apply soft restraints to prevent falls		X	

4. **When considering the patient's ongoing fluid responsiveness and organ perfusion, what assessments would be a priority for the nurse to continue to monitor? Provide at least two with rationale.**

The nurse should continue to monitor the client's mental status (confused), BP (104/88), and HR(100). These are all signs of Sepsis, respiratory failure, AKI, and metabolic acidosis. The client's pain level in his arm should be reassessed to keep him comfortable and prevent further agitation. Ongoing monitoring of the

patient's urine characteristics and amount indicates whether the fluids are working.