

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 wife.

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.

• HR: 114 from infection ↓ perfusion
 • BP: 96/52 - ↓ tissue perfusion
 • RR: 24 - tachypnic
 • Temp: 101.5 : infection
 • edema
 • large wound: S/Sx infection
 • WBC: 19.2 infection
 • Lact 2.9↑ POOR O2 perfusion

2. The nurse recognizes that based on the patient's history and diagnosis, he is currently at risk for complications, especially septic shock, Resp. failure, and A.I..

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.

Urine output: indicates perfusion to kidneys

Neuro: indicates if fluid is perfusing to brain.
 ↓ mental status = ↓ perfusion