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.**

- Opens eyes, but does not follow commands: decreased tissue perfusion, not enough O2 to brain
- Edema: fluids moving into extravascular space
- Large wound/yellow drainage: infection
- HR, BP: indicate hypovolemia
- RR: inadequate tissue perfusion
- T/WBC/procal lab: indicate infection
- Lactate: decreased tissue perfusion, metabolic stress

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

   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.**

- BP/VS- prevent hypotensive crisis
- UO: monitor renal function