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 doesn't follow commands: impaired LOC and mental status can indicate serious disease process (such as septic shock). Skin warm & flushed (early sign of septic shock). Everything about the large wound (wound infection and source of sepsis). HR (114), BP (96/42) signs of septic shock and poor prefusion. Temp: elevated r/t infectious process. RR (24): slightly elevated sign of septic shock, can lead to respiratory alkalosis, then respiratory failure). WBC: elevated r/t infection/sepsis, Cr: elevated suggests potential kidney injury (AKI), lactate: elevated, insufficient oxygenation/hypoperfusion.

   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 Acute Kidney Injury.
   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

2. **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			
Measure intake & output every 1 hour	X		
Apply soft restraints to prevent falls		X	

3. **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.**

   MAP/BP/CO: a map above 65 indicates proper prefusion to organs.

   UO: ensure sufficient CO and function of kidneys, as well as fluid status.