

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.

-WBC is high which indicates infection, potassium is high which can lead to cardiac dysrhythmias, blood pressure is low, respiratory rate is high, and temp is high which can also indicate infection. His arm has a wound that has yellow drainage which also points to infection and his level of consciousness is decreased by not being able to follow commands but can open eyes. Procal is high which indicates inflammation or infection, and lactate is elevated, which can be an indication of sepsis.

2. The nurse recognizes that based on the patient's history and diagnosis, he is currently at risk for complications, especially __septic shock_____, __fluid overload_____, 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

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.

-Continue to monitor the patient’s intake and output continuously to ensure proper hydration and avoid fluid overload.

-Continue to monitor the patient’s level of consciousness because changes in LOC can be significant signs to a change in the patient’s status. Decreased LOC can be a sign of deterioration and increased LOC can be a sign of the patient getting better.