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 assessment findings that require follow up is not being able to follow commands, skin is warm and flushed, trace edema in the bilateral LE and a large wound found on the right arm with yellow drainage. The time that the wound has gone without care and evidence of yellow drainage suggest that it has become infected and may be the cause for the rest of the findings of the patient. He is not following commands, which suggests that that have been some neurological changes. His body has slowly become more permeable, which is why edema was found bilaterally in the LE. His VS show hypotension, tachycardia, tachypnea, which are signs that his body is trying to compensate the low amount of perfusion he is currently experiencing. And his labs show inflammation through the increased WBC and lactate build up which is making him more acidotic.

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 priority assessments the nurse should continue to monitor is the patients perfusion through BP and MAP, peripheral pulses, and UO. These findings help one understand if the body is actively and properly perfusing blood to all organs and tissues. The other assessment that would be priority the patients mental status. After the care he received in the ED his LOC slightly improved. If he begins to deteriorate again and becomes more confused or non responsive it would suggest poor cerebral perfusion which would be something that needs to be immediately addressed.