

Universal Competencies (Address all)	Required Areas of Care (Address all)
<p><u>*Health Care Team Collaboration:</u></p> <ul style="list-style-type: none"> <li>• Nurses- ED, MICU, Charge nurse</li> <li>• Infectious disease physician</li> <li>• Wound care specialist</li> <li>• Cardiologist</li> <li>• Lab</li> <li>• Radiology</li> <li>• Case Management</li> <li>• Respiratory Therapist</li> </ul> <p><u>*Human Caring:</u></p> <ul style="list-style-type: none"> <li>• Demonstrate active listening and therapeutic communication</li> <li>• Include her religious or cultural preferences into care</li> <li>• Involve family members into care, if the patient allows</li> <li>• Provide a calm and quiet environment</li> <li>• Protect the patient's privacy and dignity</li> </ul> <p><u>*Standard Precautions:</u></p> <ul style="list-style-type: none"> <li>• Apply gloves when indicated</li> <li>• Perform hand hygiene when entering and leaving the room and as needed</li> <li>• Clean stethoscope before and after use</li> <li>• Maintain asepsis</li> <li>• If patient has a productive cough, wear a mask</li> <li>• Assess all IV lines, IV fluids, and drains</li> </ul> <p><u>*Safety &amp; Security:</u></p> <ul style="list-style-type: none"> <li>• Follow all HIPAA rules</li> <li>• Ensure both side rails up</li> <li>• Bed in the lowest position and locked</li> <li>• Ensure patient is wearing non-slip socks</li> <li>• Place call light and possessions in reach. Teach patient how to operate call light and not to get up without help.</li> </ul>	<p><u>*Assessment &amp; Evaluation of Vital Signs:</u></p> <ul style="list-style-type: none"> <li>• B/P is low</li> <li>• MAP of 59 is low</li> <li>• Respiratory rate is high</li> <li>• Heart rate is slightly elevated</li> <li>• Temperature is elevated</li> <li>• Need to assess the patient's pain level and oxygen saturation</li> <li>• The following vitals indicate that the patient is experiencing poor perfusion and respiratory distress</li> </ul> <p><u>*Fluid Management Evaluation with Recommendations:</u></p> <ul style="list-style-type: none"> <li>• The patient is hypovolemic as evidence by fever, low blood pressure, and high heart rate</li> <li>• Recommendation: Aggressive IVF infusion of NS at 30mL/kg completed within 3 hours</li> <li>• Monitor electrolytes and fluid status</li> </ul> <p><u>*Type of Vascular Access with Recommendations:</u></p> <ul style="list-style-type: none"> <li>• Patient currently has a large bore IV to the right forearm. I would insert another large bore IV (18g) to the opposite forearm for rapid fluid administration and other medication the patient may need.</li> <li>• Monitor sites for patency, infiltration, and skin reactions</li> </ul> <p><u>*Type of Medications with Recommendations:</u></p> <ul style="list-style-type: none"> <li>• Early administration of antibiotics is important for the patient's outcome. Piperacillin/tazobactam or cefepime may be used to treat pneumonia.</li> <li>• *Obtain blood and sputum culture before administration of antibiotics.</li> <li>• If B/P does not rise, administer a</li> </ul>

<ul style="list-style-type: none"> <li>• Ensure floor is clean and clear and provide adequate lighting to prevent falls.</li> <li>• Verify patient using 2 identifiers and assess for allergies</li> <li>• Assess 4 P's hourly (pain, position, possessions, and if she needs to go to the bathroom)</li> <li>• Ensure BVM at bedside and suction/oxygen are working properly</li> <li>• Turn patient every 2 hours and elevate right hip to prevent pressure ulcer from worsening</li> <li>• Apply SCDs (patient has a hx of PVD)</li> </ul>	<p>vasopressor (norepinephrine or epinephrine)</p> <ul style="list-style-type: none"> <li>• Albumin may be needed to maintain blood volume</li> <li>• If patient requires intubation, she will need a sedative medication (propofol)</li> <li>• Patient will also need Enoxaparin to prevent thrombus formation (Hx of MI and PVD)</li> </ul> <p><u>*Oxygen Administration with Recommendations:</u></p> <ul style="list-style-type: none"> <li>• Patient is currently receiving oxygen via NC 4L/min, but she still has an increased work of breathing.</li> <li>• Patient should be placed on non-rebreather mask and prepare for intubation if her respiratory status does not improve quickly.</li> <li>• If patient requires intubation, she will need a high FIO2 and PEEP</li> <li>• Continue to monitor her O2 saturation, respiratory rate, and oral mucosa.</li> </ul> <p><u>*Special Needs this Patient Might Have on Discharge:</u></p> <ul style="list-style-type: none"> <li>• Follow-up wound care</li> <li>• Case management to ensure patient has means to obtain all medications, oxygen therapy, and an assistive mobile device or physical therapy (for her right sided weakness)</li> <li>• Education on post sepsis syndrome</li> </ul>
<p><b>Choose <b>Two</b> Priority Assessments and Provide a Rationale for Each Choice</b></p>	
<p><u>*Neurological Assessment:</u></p> <p><u>*Respiratory Assessment:</u> The patient is displaying signs of respiratory distress with a respiratory rate of 39 labored breaths per minute with supplemental oxygen. She also has a diagnosis of pneumonia.</p> <p><u>*Abdominal Assessment:</u></p> <p><u>*Cardiac Assessment:</u> The patient is also displaying a high heart rate and a low blood pressure with a low MAP. She is experiencing poor perfusing.</p> <p><u>*Skin Assessment:</u></p>	
<p><b>Nursing Management (Choose <b>three</b> areas to address)</b></p>	
<p><u>*Wound Management:</u> Ensure patient's wound is dry and clean. Clean wound with normal saline as needed and per protocol to prevent infection. Cover the ulcer with the appropriate dressing and maintain cleanliness of the dressing. Prevent episodes of incontinence with hourly rounding to help the patient to the bathroom. Turn patient at</p>	<p><u>*Musculoskeletal Management:</u></p> <p><u>*Pain Management:</u> Assess the patient's pain level hourly. Ask the patient to rate her pain level on a scale of 0-10 and describe the pain. Then, I will respond appropriately. If the patient's is experiencing pain, I will provide the patient with ordered pain medication or request an additional medication. I will also</p>

least every 2 hours and elevate the right hip to prevent further damage. Ensure patient is obtaining adequate nutrition and fluids, which is required for healing.

\*Drain and Specimen Management:

\*Comfort Management:

implement non-pharmacological interventions based on the patient's wishes. Some examples: calm and quiet environment, music therapy, or distraction therapy.

\***Respiratory Management:** Educate the patient about the importance of preventing atelectasis by TCDB hourly and how to use an incentive spirometer. Raise HOB to decrease respiratory effort. Assess patient's O2 saturation and respirations. If the patient is not intubated, titrate oxygen based on respiratory distress and recommend intubation. If the patient is intubated, assess ventilator functions and how the lungs are responding. Monitor for barotrauma and ABG changes. Assess the patient for increased secretions and suction as needed. Provide oral hygiene every 4 hours to prevent VAP.