

Universal Competencies (Address all)	Required Areas of Care (Address all)
<p><u>*Health Care Team Collaboration:</u>            Infectious disease doctor            Respiratory therapist – Call if the breathing treatment is ordered            Nurse Aides, Nurses at the Nursing Home</p> <p>*At this point in her care I would first try to stabilize her, assess mental status and then try to communicate*</p> <p><u>*Human Caring:</u>  <b>Simple terms</b> – instead of using medical jargon, I would talk to her in a simple way to explain everything that is happening, so she is not confused. I would explain the action, purpose and outcome of what I'm doing. I would ask her if I need to repeat anything or say it in a different way so she can understand better and encourage her to ask questions.</p> <p><b>Communicate</b> – I would take the time to talk to her and ask how she's feeling by asking open ended question and making sure my tone is appropriate. I would make sure my body language is appropriate by maintaining eye contact, being open, directly facing her, close in proximity and having a positive facial expression.            She might just feel alone or start getting depressed after being in the hospital so I'd need to watch for that and provide support because that can also delay healing. If she doesn't speak English, I would find a translator or utilize resources</p> <p><b>Culture/Religious</b> –ask if she has any preferences.  <b>Age</b> – Since she's an elderly patient, she might have trouble hearing so I need to consider that I might need to speak louder. I would also consider how this affects all of her diseases as well = delayed healing</p> <p><b>Personal preferences</b> – she might feel more comfortable if her family was here, so I need to ask If there's anyone she wants me to call. I would also ask if she has her possessions nearby such as a cell phone</p> <p><u>*Standard Precautions:</u>  <b>Hand Hygiene</b> – before and after going in the room, after direct contact with patient, after touching equipment (side rails, iv pole)  <b>Gloves</b> – Applied when doing an intervention such as</p>	<p><u>*Assessment &amp; Evaluation of Vital Signs:</u>            VS have been outside of normal limits and they keep deteriorating. These VS meet the criteria for SEPSIS. The pathogen causing sepsis is from the Pneumonia.</p> <p>Her latest VS:  <b>Respirations</b> – 39 and labored on 4L NC - The patient is breathing harder to try and get more oxygen in the body. However, due to pneumonia the alveoli sacs are obstructed so CO2 is being kept and O2 is not able to get past the capillary wall to be transported throughout the body which will result in hypoxemia. The tissue hypoxia can also be seen with the Lactic acid being at a high 4.0.            I would increase the NC to 6L with consideration to nasal dryness.</p> <p><b>Blood pressure</b> – 80/48 – Since the body is in sepsis, the blood vessels throughout the body are all dilating causing the hypotension. The body is not circulating enough blood which has resulted in the tissues and organs not receiving enough O2. This can also be backed up by the <u>Mean arterial pressure</u> being at 59 right now which is dangerous since below 65 means organs are not receiving oxygen.</p> <p><b>Heart Rate</b> – 121 - since the body is not circulating enough blood the heart is working harder to try and pump more blood. The patient could be at risk for cardiac dysrhythmias b/c of decreased oxygen and electrolyte imbalance due to dehydration</p> <p><b>Temp</b> – 102.5; Infection is getting worse; Wbc Increasing; The body is fighting the pneumonia and pressure ulcer</p> <p><u>*Fluid Management Evaluation with Recommendations:</u>            D5 ½ NS at 100 mL/hr.  <b>D5 ½ NS</b> : This is being used because it's a hypertonic solution and we need to shift fluid back into circulation and expand the vascular system since everything is going into the interstitial space. This is also used to replace electrolytes since she's dehydrated.  <b>Adm at 100 mL/hr</b> -Important b/c we need to quickly support the circulatory system.            -We need to assess renal system and make sure her output is WNL since so much fluid is being</p>

checking the pressure ulcer, if there's contact with secretions/medications. Ex: sputum culture, urine, blood  
**Equipment** – clean everything before it touches the patient stethoscope, pulse ox, temporal thermometer, etc before and after use. I would make sure the IV line have swab caps on them and that the room remains free of clutter.  
**Dispose** – placing needles, syringes, etc into sharps boxes

\*Safety & Security:

**Physical** –She would most likely be disoriented, dizzy, and have blurry vision etc. due to sepsis and dehydration so fall precautions would be implemented.  
Once stable - I would tell her she needs to use the call light if she must get up and always have someone assisting her if she's ambulating. She would also be in a yellow gown and have the correct socks on. If for some reason she continues to get up without calling, a bed alarm might be used, and she might have to be placed near the Nursing's station.

**Emotionally** – I'd introduce myself to the patient and explain every procedure to make sure I don't threaten her emotional well-being. This might need to be done frequently so I would just keep repeating she's in the hospital and being treated.

**Choose Two Priority Assessments and Provide a Rationale for Each Choice**

\*Neurological Assessment:

I would assess Neuro status because with dehydration, sepsis and her history I would imagine it's impaired at this point. If she is unresponsive or in a coma state it could mean the brain isn't getting any oxygen. In addition, if her Neuro status is impaired this could jeopardize her **safety**. For example, she could be pulling out her IV or getting up when she's not supposed to and losing consciousness and falling. Even once she's stabilized from Sepsis, her old age and dehydration status could still cause her to be at risk for confusion. So, with this said, I would constantly do a Neuro assessment and take proper interventions to keep her safe.

\*Respiratory Assessment:

I would assess Respiratory b/c I need to make sure her airway is clear and there's nothing obstructing her breathing. Her RR is high so I need to rule out the possibility she aspirated something which could make

administered.

-If the hypotension does not improve then the patient will go into septic shock

\*Type of Vascular Access with Recommendations:

**18 gauge IV to right forearm** – We need to assess the site frequently and make sure it isn't irritated, which means there's no redness, swelling, drainage, heat, etc.

-Since she has paresthesia on the right side she might not feel that the numbness or tingling is coming from the IV site so we need to clearly explain what the IV site might feel like if something is wrong.

-If for some reason this IV needs to be discontinued we need to quickly put an IV in the left arm to continue rapid fluid administration.

\*Type of Medications with Recommendations:

-I would obtain a culture first before administering any medication so there's no interference to identify the organism

**Sepsis Meds:** Pt. will most likely receive a Broad Spectrum first and then when we get the culture back is when we would administer the narrow spectrum antibiotic.

Narrow spectrum = Vancomycin

Broad-Spectrum = Piperacillin/Tazobactam or Cefepime, Levofloxacin, Ceftriaxone, Cefazolin and Meropenem could all be used because it treats skin, respiratory and/or pneumonia.

**Pneumonia Meds:**

I would obtain a sputum culture first and most likely a chest X-ray would be ordered before administering medication

-A variety of medications could be used to treat her pneumonia such as Penicillin, Cephalosporins, Macrolides, Expectorant, Antitussives or Decongestants. With each medication I would be aware of the Nursing considerations if there are any and teach her what signs to report.

-Pneumococcal vaccine – can receive q 5 years

\*Oxygen Administration with Recommendations:  
**Nasal Canula (humidified)**

it harder to breathe or if the RR is strictly b/c of pneumonia/sepsis. In addition, she has pneumonia so a respiratory assessment is a good way to determine if she's getting worse or better.

**Color** - if there's cyanosis in the lips or oral mucosa I know this would mean hypoxia.

I would check her fingertips and toes for capillary refill to make sure they're getting O2.

**Intercostal Retractions** - I suspect I'll see this b/c I know she's having difficulty breathing.

**Lung sounds** - I expect to hear crackles b/c of the pneumonia

**Incentive Spirometer**

\*Special Needs this Patient Might Have on Discharge:  
 Since she lives in a Nursing home, I would tell the Nurses/Caregivers these recommendations.

**Diet** - Fluid and High protein - The elderly are known to be malnourished and dehydrated which can delay their healing and increase the chance of future infections. They need a proper diet to minimize complications.

**Reminders** - To frequently change positions, assess skin, hand hygiene, avoid sick people, brushing teeth (to avoid gingivitis) and future appointments (CXR in 6-8 Weeks to make sure the pneumonia disappeared).

I would hope that the Nursing home caretakers would help with the reminders, but I would even tell her to write on a sticky note and put on her mirror that she needs to check her skin and body throughout the day.

**Vaccine** - I would tell her the importance of a flu shot every year to prevent infection since she's at high risk.

**Wound care** - If there's special instructions or equipment we used, we should let the nursing home know what it is or have the patient bring extra supplies when discharged so they are aware of what to use.

**Nursing Management (Choose three areas to address)**

\*3 Management:

\*Drain and Specimen Management:

**-Hand hygiene, Gloves, Mask**

**-Sputum Culture** - for pneumonia - to determine whether it's a bacteria or virus. I would also document the color, viscosity, odor, amount, time and date.

**-Urine output** - Since she's dehydrated and getting fluid, her urine output needs to be watched closely to make sure her kidneys are working. Generally, If her output is less than 30 mL/hr it means the it's not getting blood to kidneys and there could be something wrong with the heart

**Foley Catheter drainage** - Other than urine, I would be watching if there was anything abnormal such as blood or particles. I would make sure the site stays clean watching for redness, swelling, drainage, pus, or pain.

\*Respiratory Management:

**-Auscultate lung sounds** - I would expect to hear diminished crackles or coarse crackles

**-Assess** rate, depth, chest movement, and cough frequently.

**-Incentive spirometer** - use 10x q 1-2 hrs - this is to help the patient pop open alveoli sacs and get mucus out

**-Deep Breathing Exercise**

**-Chest percussion** - helps loosen up mucus on the side of the lungs

**-Nasal cannula** - Since she has this on at all times, I would make sure there's no sign of skin breakdown around ears, make sure it's placed the right way (pointing down); make sure it's humidified

**-HOB** at least 30 degrees - to prevent aspiration, to facilitate better breathing

**-Suction** - prn

**-ABG's** - monitor to observe the severity of pneumonia/sepsis

\*Wound Management:

**Keep patient off of the pressure ulcer** – use pillows, turn patient frequently q 2 hours

**Assessment** – Stage 3 I would expect to see full loss of skin tissue, some subcutaneous tissue and the wound may be rolled away. I could see slough and eschar.

**Diet** – Pt. Needs extra protein, might consult nutritionist. If patient is unable to eat TPN could be started.

**Transport** – if we need to move the patient or change linens, we need to be considerate of the site making sure it's not harmed

**Cleaning** – Ask the wound care specialist if there's any special instructions, but when I clean I would use normal saline and water unless advised not to.

**Document** - Stage, size, location, exudate, pain scale, photograph would be taken.

**Braden Scale** – the scale can be used to monitor if her pressure ulcer is getting better/worse. It can also be used to identify her risk of developing other pressure sores. Due to limited information given, I can't properly give her a score, but I would say she's very high risk.

Elderly patients have less moisture, more thinning of the epidermis and less elastic skin causing them to be at risk.

Her nutrition is unknown but elderly people are known to be malnourished putting them at risk to heal less quickly

Her sensory impairment information is not given, but if she's dehydrated and in sepsis her mental status is most likely disoriented aka completely limited

**Other sites** – Check for breakdown in bony prominences and do a skin assessment frequently, especially on right side

**-Oral care** – not brushing teeth could result in bacteria buildup. It's possible I might need to do this on bed.