

Universal Competencies (Address all)	Required Areas of Care (Address all)
<p><u>*Health Care Team Collaboration:</u> I will collaborate with the infectious disease doctor, the paramedics if possible, the ED nurse, the respiratory therapist, the wound care specialist, and the social worker.</p> <p><u>*Human Caring:</u> I will involve family and keep them informed and bring them to bedside if it is an option. I will ask the patient if she has any religious preferences and if she has a pastor/chaplain that she would like for us to call for her. I would ask her about any advance directives that she may have. I would ask if she has any personal items from home that she wants at the bedside to make her feel comfortable and alleviate stress.</p> <p><u>*Standard Precautions:</u> I would change position every two hours for pressure ulcer relief. I would ensure that the bed is all the way down. If the patient's situation worsens and there is a possibility of shock then I would pull the bed rails up as a precaution and I would use hand restraints. I would wash hands upon entering and leaving the room. I would use gloves when changing dressing on wound. I would tell patient to call for assistance if she needs to get up.</p> <p><u>*Safety & Security:</u> I would scan the patient's armband and ensure I have the right patient. I would ensure that I scan all medications and ensure seven medication rights. I would be sure to check for allergies. If possible, I would move her close to nurses' station due to possibility of confusion. I would conduct frequent neuro assessments.</p>	<p><u>*Assessment & Evaluation of Vital Signs:</u> Neurological, respiratory, and skin assessment will need to be conducted. There were three sets of vital signs taken; blood pressure continued to decrease and the last blood pressure showed a MAP of 58.6. I recommend aggressive fluid administration. In sepsis, lactate is the new vital sign. The patient's lactic acid is 4.0 which indicates tissue hypoxia. The patient is likely going into septic shock. I recommend monitoring of CVP along with urine output.</p> <p><u>*Fluid Management Evaluation with Recommendations:</u> Aggressive fluid administration of IVF at 30 mg/kg will need to be started if not already. Fluids should be started by one hour and finish within three hours. Fluids to be infused will be crystalloid (NS or LR). I recommend passive leg raise to see if blood pressure increases. If blood pressure does not raise then it could be an indication of septic shock. Urine output should be >0.5mL/kg per hour. If kidneys are not being perfused then we will see a drop in urine output. Patient is at risk for bleeding because of decreased clotting which is evident by the increase in PT and INR levels. It is recommended that Heparin or LMWH be given to the patient.</p> <p><u>*Type of Vascular Access with Recommendations:</u> The patient has an 18 gauge. I recommend that the patient have at least two large gauge IV access.</p> <p><u>*Type of Medications with Recommendations:</u> Patient has an increase in WBC's. I recommend obtaining a blood culture from the patient and then give the patient a broad-spectrum antibiotic until culture is returned. Once culture is returned, give the patient a narrow spectrum antibiotic. It is likely that the patient will be prescribed Zosyn+ Vancomycin. If patient has persistent hypotension after adequate fluid</p>
Choose Two Priority Assessments and Provide a Rationale for Each Choice	
<p><u>*Neurological Assessment:</u> <u>*Respiratory Assessment:</u> Fanny Mae is receiving 4 liters of oxygen per nasal cannula and her respirations are still at 39</p>	

<p>breaths per minute and are labored. It is important to continuously assess respiratory system because Ms. Mae seems to be declining quickly. Her lactic levels are consistent with septic shock which can progress into MODS very quickly. Patient may need to be ventilated as well as sedated. If patient is ventilated, they will need a higher concentration of oxygen; FIO2 possibly 70-100%. An analgesia will need to be given to control pain so that patient can relax and rest. Hemoglobin level will need to be monitored since oxygen binds to hemoglobin. If patient goes into ARDS then they may be placed in a prone position to allow for collapsed alveoli to re-expand. This will improve oxygenation and allow for decrease in FIO2 and PEEP setting on ventilator.</p> <p><u>*Abdominal Assessment:</u></p> <p><u>*Cardiac Assessment:</u> The patient's CVP will need to be monitored. A normal CVP is between 0-8 mmHg however, the target CVP is 8-12 mmHg due to the amount of fluids the patient is receiving. An adequate CVP will let us know if the patient has enough fluid volume to support their system. Ms. Mae has history of cardiac disease so it is important to monitor her.</p> <p><u>*Skin Assessment:</u></p>	<p>resuscitation, a vasopressor or inotrope may be added.</p> <p><u>*Oxygen Administration with Recommendations:</u> Patient is already receiving supplemental oxygen and is not responding well. I would recommend that the patient be ventilated.</p> <p><u>*Special Needs this Patient Might Have on Discharge:</u> The patient will need wound care for the hip pressure ulcer. Nurse will talk to case manager about if patient is being discharged back to the nursing home or if she is being discharged to a family member. Wound care and signs and symptoms of infection will need to be explained to family member if she is not going back to the nursing home. Patient will need to be informed of the importance of taking antibiotics in its entirety.</p>
<p>Nursing Management (Choose three areas to address)</p>	
<p><u>*Wound Management:</u> It is important to address the pressure ulcer that Ms. Mae has. The wound will be cared for in the hospital but it is important to work with the hospital social worker to ensure that wound care will continue to be provided at the nursing home or an appointment set for Ms. Mae to receive wound care at her HCP's office. Proper management and care of the wound is important to prevent further infection.</p> <p><u>*Drain and Specimen Management:</u></p> <p><u>*Comfort Management:</u></p>	<p><u>*Musculoskeletal Management:</u></p> <p><u>*Pain Management:</u> Ms. Mae is older and will need pain management especially before and after wound care management. Ms. Mae will need to be informed of side effects of pain medication. Information on non-pharmacological pain management should also be addressed with Ms. Mae.</p> <p><u>*Respiratory Management:</u> Ms. Mae has a pneumonia and will likely be prescribed medication for the pneumonia when she is released. It is important to teach her how to use the medication and teach her how to cough and deep breath to prevent pneumonia. It</p>

	is important to find out if the nursing home has a respiratory therapist on-site to assist Ms. Mae with breathing exercises.
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