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Universal Competencies (Address all)	Required Areas of Care (Address all)
***Health Care Team Collaboration:** As the Nurse I would consult many members of the healthcare team: - Infectious Disease MD: I would consult the doctor to provide him/her with updates regarding the patient's status. I would also work with the doctor to formulate a plan of care for this patient (medications, lab tests, course of treatment, results, etc.). - Respiratory Therapist: I would consult the respiratory therapist to receive and provide updates regarding the patient's respiratory status. - Case Manager: I would contact case management and ask them if they are able reach out to the nursing home in order to see if the patient has any home medications. This is important because any medications the patient is taking could interfere/interact with treatment, so no medications should be missed or overlooked. ***Human Caring:** I would demonstrate human caring by: - Continuously assessing pain and staying on top of pain management through both pharmacological and non-pharmacological measures - Visually checking on the patient frequently - allowing the patient enough time to absorb information when providing teaching - communicating information to the patient in a way that they will understand (age-appropriate, language, jargon) - asking the patient what her cultural values, what her religious beliefs are, and if she has any personal preferences so that treatment can be patient-centered - explaining the purpose of any procedures, interactions, interventions to the patient ***Standard Precautions:** I would implement standard precautions by: - introducing myself to the patient - identifying the patient by asking the patient's name & DOB - executing the 7 rights of medication administration before giving a med. - washing/sanitizing my hands when walking into patient room, walking out of patient room, before touching a patient, after touching a patient, before a procedure, after a procedure, and if my hands are soiled. - showing respect to the patient - ensuring the patient's information remains private - wearing the appropriate PPE	*Assessment & Evaluation of Vital Signs: **Temperature:** The most recent temperature is 102.5, which is determined as a marked fever. This high temperature reflects the claim that the patient is septic. I would continue to assess the patient's temperature multiple times a day to see how the patient is responding to treatment. **Respiratory rate:** The patient has a high respiratory rate of 39. This breathing pattern is ineffective and is likely to cause the patient to retain Carbon dioxide. I would assess the respiratory rate frequently to see if the patient as a tool to see if the patient is getting better. Additionally, the patient's respirations are labored. This could be an outcome of pneumonia. The build-up of exudate makes is difficult for the patient to bring air in and out of her lungs. I would continue to assess the patient's breathing pattern in order to help determine if the patient is recovering from pneumonia. **O2 saturation:** I currently do not have a value for the patient's O2 saturation. Yet, this value is still important because it indicates how well the patient's tissues are being perfused. I would retrieve the O2 saturation by using a pulse oximeter. **Heart rate:** The patient has a high heart rate with a value of 121. This value is continuous with dehydration and sepsis. This high heart rate could also be due to pain from the patient's pressure ulcer. I would continue to assess the heart rate to see how the patient is responding to treatment in these areas. I would assess by listening to the apical pulse for 60 seconds and palpating the radial artery. **Blood Pressure:** The patient's blood pressure of 80/48 is worrisome. This value is likely related to her being dehydrated and developing septic shock. Blood pressure is a value that I would assess frequently with a cuff and monitor to see how the patient is doing. *Fluid Management Evaluation with Recommendations: - the patient is receiving Dextrose 5 in ½ NS at 100mL/hr - Dextrose will help bring fluid back into the patient's circulation, stabilizing the blood pressure and correcting dehydration. - The fluid is being administered at this rate to help the patient get more volume in their system gradually. - Recommendation: I would see how the patient's vital signs are while fluids are being administered. If the heart rate and blood pressure continue to worsen, I would definitely contact the doctor and tell him/her that the

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- cleaning medical equipment (ex. Stethoscope) before using it on the patient
- documenting relevant information in a clear, concise, and accurate manner

***Safety & Security:**

I would protect the patient's emotional and physical safety & security by ensuring that:
- all nursing interventions that I carry out are first verified by healthcare provider orders, hospital protocols, and evidence-based nursing practice
- I identify the patient's name, date of birth, and allergies
- the side rails are up
- the bed is locked and in lowest position
- the patient is wearing socks
- there is no clutter on the floor
- the patient has all of her possessions nearby
- the call light is in the patient's hand before I leave the room
- the patient is informed to use her call light if she needs anything
- I round hourly and assess anything I need to
- All 4 P's are assessed and met before exiting the patient's room (possessions, position, potty, pain)

Choose Two Priority Assessments and Provide a Rationale for Each Choice

*Respiratory Assessment: Since the patient has pneumonia, the respiratory assessment is a priority. Pneumonia leads to the production of exudate, which interferes with gas exchange. This causes the patient to be at risk for hypoxemia, so blood gases should be monitored. Additionally, the build-up of exudate can cause hypoventilation. Therefore, assessing lung sounds helps provide vital information regarding the patient's condition and plan of care. Respiratory assessment is also important since the patient is on nasal cannula. I would check to make sure that the settings reflect what is ordered. Lastly, the patient is exhibiting tachypnea and labored breathing, so assessing the respiratory system is of great importance. This ineffective breathing pattern can cause the patient to go into acidosis. Continuous assessment provides a baseline and allows the healthcare team to intervene as needed.

*Cardiac Assessment: The cardiac assessment is a priority because it can say a lot about how well the patient could be going into septic shock.

*Type of Vascular Access with Recommendations:
- Right forearm IV 18g
- Recommendation: I would assess the site and watch for any potential complications. I will do this by palpating the site gently and asking the patient if feels tender. I would also feel the temperature of the skin around the IV site for phlebitis/infiltration. Since fluid is being administered, I would make sure there are not kinks in the tubing and that all ports not being used are capped.

*Type of Medications with Recommendations:
- At the moment the patient does not have any ordered medications, but I would anticipate the doctor to order some antibiotics for sepsis and pneumonia, and some mucus and vaccine for the pneumonia.
- Recommendations: before administering any type of antibiotic I would get blood cultures. I would also ask the patient if she has any allergies. In addition, I would investigate to see if the patient is taking any medications at home.

*Oxygen Administration with Recommendations:
- O2 is being administered because the patient has pneumonia. The exudate in her lungs makes it difficult for her to perfuse the alveoli on her own, so Oxygen is being administered to help her.
- Recommendation: I would frequently assess the nasal cannula to make oxygen is being delivered as ordered and appropriately. I would check placement to prevent skin breakdown. I would check for dryness of the mucous membranes. If they are dry, I would consider adding humidification.

*Special Needs this Patient Might Have on Discharge:
- I would reach out to the nursing home and provide them instructions on how to prevent pressure ulcers, especially since the patient has right sided paresthesia and weakness.w
- Since the patient is older, she is at risk for becoming dehydrated again because at her age thirst is diminished. I would send her home with a water bottle that has markings, showing how much fluids she needs to drink per day.

patient's body is handling sepsis. For example, blood pressure and heart rate are important values because they can indicate if the patient is going into septic shock. Blood pressure is also important when retrieving the mean arterial pressure (MAP). The MAP indicates whether or not blood is perfusing to the heart. Although the patient is already dehydrated, deficient fluid volume is a possibility in sepsis so assessing whether or not the patient has sufficient circulatory volume is important.	

Nursing Management (Choose three areas to address)

*<u>Comfort Management</u>: Non Pharmacological - provide a clean and quiet environment - decreasing stimuli - play music that she likes - not putting pressure on the ulcer - HOB at 30 degrees or higher to help the patient breathe, decreasing anxiety Pharmacological - Assess for pain frequently - Administer meds as ordered I would also provide comfort with hygienic measures such as: - oral care - showers - asking the patient if she needs to use the restroom - clean sheets	*<u>Musculoskeletal Management</u>: *<u>Pain Management</u>: - Ask the patient if she is feeling any pain. If so ,I would use the PQRST method. - P: Provoke- what causes it, what Improves the pain, what makes worse? - Q: Quality - ask what the pain feels like (sharp, aching, throbbing, dull, etc.) - R: Radiate – ask the patient if the pain travels or stays in one place - S: Severity – ask the patient to rate her pain using a scale of 0-10 - T: Time – Ask the patient when the pain started, how long it has lasted, and how often. - I would also look for non-verbal ques if the patient is asleep/unconscious by evaluating her vital signs and facial expressions *<u>Respiratory Management</u>: - count respiratory rate - listen to lung sounds - raise head of bed to facilitate breathing - ensure O2 is being administered appropriately and as ordered - suction the patient as needed - interpret blood gas readings and report to the provider anything that is abnormal