Universal Competencies (Address all)	Required Areas of Care (Address all)
*Health Care Team Collaboration: Collaboration of all health care team members is very important when patients are septic because they are not in a good condition at all. During sepsis many areas need to be addressed continuously, therefore collaboration is providing the best care possible. Good communication is the number one priority. Due to the patient's current status, their health can decline at a very rapid rate. Good communication for this patient consists of everyone being informed of the patient's status at all times. Many interventions are being done so every team member needs to be informed on what currently is being done, what already has been done, and what needs to be done if the patient's status changes. The organization of care between different health care members is very important as well. With so many different complications the care needs to be very organized, so nothing is looked over, done wrong, or performed at the wrong time. Some important health care members that need to be involved at all times is the Respiratory Technicians, Wound Care Specialist, Charge nurse, nurse manager, pharmacy, physical therapy, occupational therapy, and the social worker. If the patient is going to be discharged home health nurses are very important in collaboration of care as well. *Human Caring: Best patient center care is the main priority for every single nurse. The patient care that is provided needs to be compassionate and coordinated based on the individual. How patient care is best performed is determined by the patient's preferences, values, and their specific needs. As the nurse, it is your responsibility to carry	*Assessment & Evaluation of Vital Signs: BP – 80/48 – The patient is showing a declining trend. With this declining trend in blood pressure, the patient is at very high risk to go into septic shock if she is not already there. Fluid has been given but we are unsure of how much and how long. If she has already had a proper amount of fluid bolus and the BP is still declining, then she is in septic shock. The reason for a declining BP is the infection is causing the cells that line the vessels to have widespread dilation. The fluid then shifts out into the interstitial space which leads to a decrease in perfusion and adequate fluid balance. HR: 121– patients' body is currently fighting an infection therefore it is having to work extra hard. The HR is increased due to an increased need for blood flow which in return causes the body to need more CO to have adequate perfusion. The patient's body is trying to compensate since there is not enough RBC due to the infection. This compensation is a natural response the body is having which also affects the HR. Temp: 102.5 with an increasing trend due to present infection spreading in the blood. The body's immune response has been stimulated which increases the body temp. The body's temperature rises so it can fight the infection. RR – 39 & labored breathing: The patient is currently hyperventilating due to the amount of oxygen the body has. The patient is on 4L NC however, her VS are declining. When BP continues to decline it means fluid is leaking out of the vessels and shifting into the interstitial spaces. The fluid will then start to pour into the alveoli which prevent gas exchange. Yes, the patient is getting oxygen, but the alveoli could be potentially filled with fluid.

out the ethical principles of beneficence, nonmaleficence, justice, veracity, and fidelity. These are the basis of how all care should be provided and help during ethical decision making. If you follow these ethical principles at all times, then each patient should be satisfied and confident that they were treated with the best care. As nurse integrity is the moral standard, therefore each patient's care is always a priority and should be performed at your best ability.

*Standard Precautions: Standard precautions are practiced by everyone in the health care field and should always be a priority. They minimize the risk of harm not only to patients but to the provider as well. They are determined by system effectiveness and how each individual performs them. There are different levels of safety precautions and that is why proper documentation must be done at all times. Standard precautions consist of protective equipment which may include gloves, impermeable aprons, masks, face shields, and eye protection.
For this patient standard precautions and Droplet precautions are necessary.
The patient has been diagnosed with pneumonia so anyone in the room is at risk. The spread of the infection can be by tiny droplets caused by coughing or sneezing. All healthcare workers should wear a surgical mask while in the room. Make sure gloves are worn when doing invasive procedures or giving meds. Hand washing is mandatory like always as soon as the health care worker enters and leaves the room.

*Safety & Security:

Safety and security are mandatory at all times in the healthcare field. The main goal is to minimize the risk of harm to all providers and patients. There are many different safety goals throughout healthcare therefore, as the nurse

*Fluid Management Evaluation with Recommendations:

30 ml/kg start in 1 hr. and completed by 3 IV of isotonic crystalloids
0.9% NS or Lactated Ringers
The patient is currently on 100ml/hr. which is not enough. However, we do not know when the fluid was started and how much she has already gotten. There is currently a declining trend in her BP which indicates the fluid administration is not working however, we don't know if it has time to work or not. If the vital signs show improvement that means that the fluid administration is working, and the body is being perfused. The lab levels are also a very big indicator of how well the fluid is working. A slow rise may mean that more fluid can be given however, this is why close documentation of the patient's intake and output is important. If the patient is not urinating at least 30ml and hr. this could indicate renal failure. This is why fluid management is important to make sure the body is perfusing, and all the organs are getting the right amount.
Since we don't know how long, or much fluid has been given we do not know if the pt. is in shock yet. If the patient were to have septic shock and the fluid administration did not help the BP, then
passive leg raises for an internal bolus is a good intervention to try and help get fluid back to the heart.

*Type of Vascular Access with Recommendations:
In the report it stated that the patient already has vascular access in her right forearm however, the patient's vital signs are still declining. The current vital sign trend indicates the patient could already be in shock or is at a high risk of it happening soon. For a

you should always be up to date on each one. Safety consists of patient privacy and not breaking HIPPA laws, staff communication, use of medications properly, proper use of protocols, and much more. Good security plays hand and hand with safety so that we can minimize the number of complications that can occur as much as possible.

Choose Two Priority Assessments and Provide a Rationale for Each Choice

*Neurological Assessment:
*Respiratory Assessment should always be a priority if sepsis has been confirmed in a patient. Making sure the patient has a secure airway and there is O2 exchange present is very important. The patient's vital signs indicate that the patient is in septic shock or about to go into shock since the BP is not rising. It is a priority to do a resp. assessment because you need to know if they are conscious so you can immediately give a fluid bolus. The patient's RR and 02 are very important however, the obscured levels are due to the fluid shift happening in the body. Once the fluid is given then you can intervene about the patient's other resp. issues. The RR is a reflection of not only the patient's oxygen but also may be caused by perfusion issues as well. If the patient's RR indicates hyperventilation which a natural response when there is an infection and not enough oxygen in the body. The patient's RR is 38 and experiencing labored breathing therefore, supplemental oxygen does need to be supplied as soon as possible along with a continuous pulse ox monitor after fluid has been given. This is only if they have assessed the alveoli are not filled with fluid.
*Abdominal Assessment:
*Cardiac Assessment: When sepsis has been confirmed on a patient a cardiac assessment patient that is in septic shock, a subclavian central venous line access is needed. The patient not only needs fluids they also need access to antibiotics to be given since the patient has pneumonia. The subclavian central line is needed because continuous CVP is very important. The CVP allows the management team to assess if the heart is getting enough fluid for the circulatory system to function properly by supplying all the body organs with adequate perfusion. The target number to achieve is 8-12. If this pressure number is too low, it lets us know that blood is not perfusing and getting to vital organs which leads to organ failure. An essential line is also necessary so vancomycin can be given. If the patient is in septic shock, they could potentially need three different vasopressin's therefore, good patent central access is needed to provide the patient with the best care possible.

However, the main priority is that there is venous access so fluid and medications can be administered as needed.

* Type of Medications with Recommendations:
IV antibiotics to treat pneumonia – i.e. piperacillin/tazobactam and a narrow spectrum because the patient is septic (vancomycin)
Insulin depending on blood glucose level
&
Vasopressors: The vasopressors are administered if fluids do not fix the current BP. They constrict the blood vessels to increase blood pressure. The blood vessels can't handle the infected blood, so they naturally have widespread dilation. Without the constriction of the blood vessels, the body's organs are deprived of oxygen and that is what we are trying to prevent.
Norepinephrine or levafed are the medications of choice and are administered

is always a top priority. The main concern about a septic patient is their BP. When a person is septic their body does everything possible to compensate, however, if immediate intervention is not done then organs start failing. Therefore, the patient's BP is the number one indicator that tells us if the patient is getting enough fluid. The main thing you want to prevent is sepsis is it worsening to shock and organ failure. If the heart is not getting enough fluid returned to it then it is not able to pump correctly to send an adequate amount of oxygenated blood to the body's tissues. Getting the fluid bolus going along with antibiotics is important so the heart will be able to function properly to make sure the body is perfused, and all the organs are getting what they need. *Skin Assessment:	by IV drip. The norepinephrine can be increased or decreased as needed. – vasopressin's – may also be given at the same time but a steady rate. This is because during shock your body naturally depletes vasopressin's. If the body is still not responding to these interventions the third vasopressor, Dobutamine may be added as well. This medication helps increase cardiac output so the body can get adequate perfusion. All three drips will be running at the same time. A sedating medication might be necessary as well. The patient's body is experiencing so much so sedating the patient while care is given helps relax the body so extra energy isn't used. This is last to be cared for, but a type of ointment may be administered also to help cure the pressure ulcer. *Oxygen Administration with Recommendations: After the fluid is given then the administration of oxygen is assessed. The patient is RR is 39 which causes the patient to be in respiratory acidosis. Proper O2 given helps the patient get adequate gas exchange and decreases hypoxia. The type of O2 that is given strictly depends on the patient's current status. Frannie is currently on 4L NC but is still tachycardic. This is due to the demand for blood flow needed to help fight the infection. Because our patient's status is declining NC is not enough oxygen to manage her care. Fi02 is recommended: this is concentrated oxygen for the pt. to inhale which in return helps proper gas exchange at the alveolar

	level. However, a close assessment of this is necessary because the patient is at high risk of atelectasis, fluid feeling up in the lungs causing it to collapse. If a high amount of Fi02 is given and the fluids are filled with lungs, then the oxygen is pointless because it is not being perfused properly as it should in the alveoli. So, The PEEP level during Fi02 administration will need to be increased as well. This gives positive pressure to the alveoli to prevent collapsing so the gas exchange can happen PEEP – to prevent atelectasis During 02 admin – the HBG levels are a good indicator to see how well the tissues are being oxygenated *<u>Special Needs this Patient Might Have on Discharge</u>: Depending on how long the patient was sepsis depends on the care the patient will need upon discharge. Sepsis is a very serious condition that takes a huge toll on the body. Therefore, the patient needs to be aware that it could be a long while until they feel like themselves again. They need to be taught that this is not abnormal and is call post sepsis syndrome. Some special needs the patient might need consist of special counseling. Depending on how long the patient was hypoxic and there was bad perfusion they are at high risk of gangrene. The patient needs to be taught to assess all their peripheral extremities well and report if any changes occur. Special needs for pain medication might be necessary. It is normal for the patient to have prolonged muscle and joint pains. Due to an increase in pain the patient may need help with daily activities. The patient needs to take care of all their necessary needs. The need for a good family/friend source is needed as well. Due to

	the amount of trauma, the body went through the patient may have low self-esteem so good positive resources may be needed as well. The last main special need a patient might need is proper oxygen support. Depending on how long the patient was deprived of adequate oxygen their lungs will need a while to recover. The patient needs to have a proper oxygen supply on hand and certain respiratory medications to support the airway needs. It is also important to access their pressure ulcer and make sure they understand the importance of good wound care and the parts of the body that are at risk of getting pressure sores.
Nursing Management (Choose three areas to address)	
*Wound Management: *Drain and Specimen Management: *Comfort Management:	*Musculoskeletal Management: *Pain Management: *Respiratory Management:

Wound management: This area is important because the patient has a stage 3 pressure ulcer. Due to the patient being septic and not very mobile proper intervention of the wound is important. This biggest priority for this is to prevent it from getting worse and making sure the best care possible is given. The patient's immune system is shocked, so they are at a high risk of acquiring another infection easily. Proper documentation of the wound is important, so the care team is up to date on interventions that have been done. If tunneling is present proper care of the depth of the injury is important. Making sure the wound stays clean and dry to promote healing. The importance of good nutrition is also necessary to help the wound heal. Wound care is a very good source for making sure the proper dressings are applied and what kind of damage may be done.
The patient is at high risk for pressure ulcers due to her age and poor circulation from sepsis, and paresthesia from the CVA. The facilities protocol should be strictly followed; therefore q 24 assessment is mandatory, turning q2-4 hours to prevent other pressure ulcers, proper tools like a heel block, and pain management is required at all times.

Respiratory management for Fanny Mae needs to be addressed at all times. Tissue perfusion needs to be restored and continued to be monitored. During sepsis and sepsis shock the patient is having an abnormal inflammatory response throughout their whole body which leads to fluid building up in the alveoli which leads to atelectasis. Therefore, once oxygenation is assessed, management of the respiratory status is very important to prevent any type of resp. failure or

trauma to the lungs. After the patient is stable and on supplemental oxygen, the patient may be very weak so sedation may be necessary. If there is current sedation then the patient's respiratory rate needs to be monitored closely to prevent respiratory depression. Respiratory management is very important since good oxygenation and perfusion is the best cure for all types of complications.

The third area to be continually addressed is the patient's comfort. The patient is elderly, so she is at a high risk of many different complications. If the patient's comfort is good and she is not in distress it is much easier to communicate, care for all her needs and helps active participation of the patient when dealing with complications. When a patient's comfort is not continually addressed then it is very common for more complications to arise and health status decline. Since the patient is septic and possibly has septic shock it is very important to keep the family/friends involved in the planning of care and making sure they are at the bedside if wanted. Good outside support always is comfort support when a patient's health is declining.