CRE Form

Vitals:

Fever-acetaminophen, apply cold compress to the forehead

BP: Considering fluids are not working we need to administer a vasopressor next (norepinephrine) and place some SCD's on her legs to help with clotting as well

Tachypnea: talking calm to the patient, listen to breathing with stethoscope, measure oxygen level with pulse ox, dim the lights a little, CVT

blood tests to measure acid levels

Respiratory rate: we need to get a wound, blood, and urine sample because our patient has an infection. We will need to ask about ordering a broad-spectrum antibiotic in the meantime.

We also need to get an O2 stat because there is not one listed in the report

Patients glucose was not taken so we need a blood surgar as well

*Fluid Management Evaluation with Recommendations:

Aggressive administration of NS or LR at 30mL/kg over 1-3 hours, and albumin, and we need to get her weight because her weight is not listed. The large amount of fluids will open up those vessels

*Type of Vascular Access with Recommendations:

Considering the patient did not respond well to fluids a central venous catheter should be placed (subclavian vein) so the patient can receive fluids, antibiotics, and vasopressors

*Type of Medications with Recommendations:

She stated that she was not on any medications but if a family member comes in, we need to double check just make sure

She needs a vasopressor (norepinephrine)(vasoconstriction) because she is not responding well to the fluids that were given

Need to administer IV phytonadione because her INR is too high and continuously check labs

Early administration of Antibiotics- Zosyn vancomycin to help with the infection but we need a culture first and ask about allergies, ask if she has any kidney problems, ask about hearing issues because it can make it worse

*Oxygen Administration with Recommendations: patient needs to be switched to a venturi mask 8-10mL/min because the nasal canula is not enough for her at this point

*Special Needs this Patient Might Have on Discharge:

Encourage plenty of fluids and incentive spirometer for deep breathing

Need to discuss being up to date on vaccinations such as the flu shot and pneumovax

Need to discuss avoiding people who are sick and wash hands

Talk with a case worker to frequently check on this patient to make sure she is taking her antibiotics or any medication the doctor prescribes

Discuss resources considering the patient became ill from lack of care and resources

Use a soft toothbrush

Oral hygiene

Talk about follow-up appointment

Talk to patient about the signs and symptoms of sepsis and to contact PCP

Patient may need counseling because post-sepsis may cause problems

*Health Care Team Collaboration: set up team meetings daily and make sure we are doing our part in preventing infections, sterile fields, delegate roles to the right team member, get everyone on the same page, set up the same goals for our patients. MAKE A PLAN and stick to it

*Human Caring: spiritual feeling, cultural preferences, family being in the room, making sure she is comfortable

*Standard Precautions: call light, bed alarm, side rails are up and bed is locked, allergies, maintain sterile field when spiking IV bags or medication to prevent infection

*Safety & Security: fall risk because of age and dehydration, making sure possessions are nearby and the area is free of clutter, checking allergies
*Neurological Assessment: to monitor the progression of my patient's illness
*Respiratory Assessment: to monitor her breathing problems, if her respiratory rate has changed, she is already showing signs of trouble breathing so we need to continuously check for increased respiratory effort, and it can provide us information with other organ systems
*Wound Management: patient needs more protein in diet, turning frequently to prevent another ulcer, eternal nutrition to help fight infections and healing, checking and cleaning the wound, check daily for changes, control bleeding, and change dressing
*Respiratory Management: keeping the head of bed greater than 30 degree to prevent aspiration and turn frequently, good fluid intake through IV, cough and deep breath techniques, maintain airway patency, monitor color and consistency of sputum, supplemental oxygen, and checking O2 stats frequently.
Comfort Management: provide pain medication when needed, turn frequently to also prevent another ulcer, suctioning, adequate hydration, semi-fowlers position, and promote lots of fluids, check fever consistently, ask patient if she would like the tv on or off, blankets, and or lights on or off