

<p>Universal Competencies (Address all)</p>	<p>Required Areas of Care (Address all)</p>
<p><u>*Health Care Team Collaboration:</u> Respiratory therapist, Physical therapy, Nutrition/dietary, wound care, infectious disease/PCP, Social work</p> <p><u>*Human Caring:</u> I want to make sure that the patient feels cared for by considering and displaying appropriate interaction. I will take into consideration her age, religion, culture, and personal preferences when taking care of her.</p> <p><u>*Standard Precautions:</u> I will wash hands before and after any contact with the patient or if my hands are contaminated. I will maintain appropriate aseptic technique and use sterile technique when necessary. I will wear gloves when maintaining either technique. I will also protect myself and my patient from any microbial contamination by cleaning all surfaces and instruments when used.</p> <p><u>*Safety & Security:</u> I will verify nursing interventions with healthcare orders, evidence-based nursing practice, and standard protocols. I will make sure that the patient has 3 side rails up, no clutter around the floor, call light within reach, and non-slip socks are on. The bed is in the lowest position. I also will make sure that the patient understands to call before getting out of bed without assistance. I will also do the 7 rights of medication administration each time I administer a medication.</p>	<p><u>*Assessment & Evaluation of Vital Signs:</u> The patient's current vital signs and the trend of her past VS all indicate septic shock. She has a blood pressure of 80/48= hypotension, RR of 39=tachypneic, HR of 121=tachycardic, and a fever of 102.5. She is not responsive to the 4L of O2 because she is still SOB. Her lab work also indicates septic shock in the early stages because her lactic level is 4. A lactic acid level greater than 4 is indicative of septic shock. Septic shock criteria include: severe sepsis with persistent signs of end organ damage, hypotension, and a lactate >4. She meets all of the criteria.</p> <p><u>*Fluid Management Evaluation with Recommendations:</u> She has a 16 French foley in place, but no output was listed on the scenario. I would check to see if she has any output at all. I would also like to get a CMP to see what her electrolytes are like. With her current state, I would give her 30mL/kg of a crystalloid- 0.9% NS and position her with her legs passively raised. I know that she is on a maintenance fluid of D5 1/2 NS at 100 mL/hr. After getting the shock under control, I would continue with the maintenance fluid. In order to know how her fluid balance is doing I will assess daily weights, monitor her I/O making sure that she is voiding at least 30mL/hr and doing a frequent skin assessment; to evaluate for any edema, worsening signs of shock, MODS, or further dehydration.</p> <p><u>*Type of Vascular Access with Recommendations:</u> I recommend that she gets a CVAD in place, but due to the current situation I would start another peripheral IV site with an 18-gauge on the left forearm. She currently has an 18-gauge on the right forearm. The CVAD is a recommendation</p>
<p>Choose Two Priority Assessments and Provide a Rationale for Each Choice</p>	
<p><u>*Neurological Assessment:</u></p>	

I would do a neurological assessment to see if she has any of the following: anxiety, restless, confusion, or decreased LOC. If she has a decreased LOC that is a good indicator that she is in the hypodynamic phase (late) of septic shock. I would also like to assess her neurological status to see if she is having worsening hypoxemia or for seizures.

***Respiratory Assessment:**

I want to assess her respiratory status as one of the main assessments that I will perform. Respiratory status is a good indicator of whether or not the patient is deteriorating. From all of her current vital signs, she is displaying signs of septic shock. I want to establish an airway by giving her 6L of O₂ and then changing to a high-flow. I want to prevent further hypoxemia and neurological deterioration. I also want to monitor her for fluid retention or atelectasis by listening to her lung sounds either for an absence of sound or for crackles that are worse. After she is stabilized, I will continually assess her respiratory status because she has pneumonia. I want to get ABG's as well as another chest-x ray.

***Abdominal Assessment:**

I would do an abdominal assessment to see if she is retaining anything. I would also monitor her BM output.

***Cardiac Assessment:**

I would also choose to do cardiac as my other primary assessment. Hypotension is another indicator of septic shock. Her current blood pressure is 80/48. Her MAP is 59 and her pulse pressure is 32. She is not adequately perfusing to her other organs and can quickly go into organ failure. If the fluids do not correct her hypotension, then I would give her norepinephrine. With this medication I would do continually peripheral assessments. I would also like to put her on a cardiac monitor to see if she is having any dysrhythmias.

because she will be needing constant lab draws.

***Type of Medications with**

Recommendations:

Earlier I stated that I would give her 30mL/kg of 0.9%NS to treat the hypotension. If with further evaluation her MAP is not increased, then I would give norepinephrine. I also would like to recommend a broad-spectrum antibiotic to treat the infection as well as the pneumonia. I would continue with the maintenance dose of fluids after the shock is corrected. I also would suggest putting the patient on a calcium supplement and a multivitamin to enhance overall wellness. For her respiratory status I would also recommend a corticosteroid or bronchodilator to help promote adequate breathing.

***Oxygen Administration with**

Recommendations:

She is already on 4L of O₂ via a nasal canula and is not responding. I want to put her on high-flow, but until we can get a high-flow machine, I will give her the maximum amount of O₂ via a nasal canula (6L) or get a non-rebreather. In the future, I want to put her on a CPAP to help open up the alveoli when she becomes more stable. I also recommend getting another chest x-ray to see if any respiratory compromise has occurred. I would also obtain an ABG.

***Special Needs this Patient Might Have on Discharge:**

This patient has a history of right sided weakness. She also is older and does not seem to be taking care of herself as appropriately as she should. If she was able to go to an assisted living facility, I would recommend that, but if not then I would suggest that she get home health services. I think that she would benefit from physical therapy as well as consulting with a dietician to maintain adequate nutrition. I don't know

<p><u>*Skin Assessment:</u> I want to assess her skin for any further breakdown. She currently has a stage III pressure ulcer on her right hip r/t the right sided weakness and paresthesia. I will turn her every 2 hours and make sure her skin is clean and dry. When I am assessing her for shock I want to monitor to see if she has any petechiae or bruising because her clotting factor will be decreasing. I also want to see if she is retaining any fluid and will check to see if she has pitting edema. If she is retaining fluid, it is an indicator of kidney dysfunction.</p>	<p>if she has any assistive walking devices, but if she doesn't then I recommend getting a walker to help with her mobility and to increase her safety.</p>
Nursing Management (Choose three areas to address)	
<p><u>*Wound Management:</u> I don't want the patient's pressure ulcer to get worse. I want to reposition her every two hours as well as making sure the wound is clean and dry by implementing whatever orders the wound care recommends. I also will make sure the patient bathes daily and that she is eating a diet with enough calories and protein to assure wound healing.</p> <p><u>*Drain and Specimen Management:</u></p> <p><u>*Comfort Management:</u></p>	<p><u>*Musculoskeletal Management:</u> I want the patient to prevent the risk of further injury and will assist/ have her be assisted when she is ambulating. I will also recommend that the doctor put her on a calcium/vitamin D supplement to promote bone health. I want her to be repositioned every 2 hours to make sure she is comfortable. I also want physical therapy to work with her to help her become stronger with her right sided weakness and paresthesia.</p> <p><u>*Pain Management:</u></p> <p><u>*Respiratory Management:</u> I want to make sure that the patient is getting adequate and appropriate respiratory care. I want to monitor her ABG's, respiratory status, and vital signs. I will monitor her O2 saturation and her ability to tolerate whatever supplemental machine she is on: CPAP, high-flow, or NC. I want to make sure that she uses an incentive spirometer as well and repositions and hydrates adequately to assist with drainage of fluid and decreasing WOB.</p>