

<b>Universal Competencies (Address all)</b>	<b>Required Areas of Care (Address all)</b>
<p><b>*<u>Health Care Team Collaboration:</u></b></p> <ul style="list-style-type: none"> <li>• An infectious disease doctor for her diagnosis of sepsis and worsening condition.</li> <li>• A Radiologist to obtain x-rays to monitor pneumonia.</li> <li>• A wound care specialist to aid with healing for her stage III hip pressure ulcer.</li> <li>• Lab tech to process cultures and specimens</li> <li>• Case management to collaborate care between the MICU and her nursing home</li> <li>• Adult protective services (APS) for possible signs of neglect due to admitting diagnoses</li> <li>• A cardiologist due to her medical history of peripheral vascular disease, MI, along with her current spike in HR and drop in blood pressure</li> <li>• A neurologist due to her history of a CVA accompanied with residual right sided weakness and paresthesia</li> </ul> <p><b>*<u>Human Caring:</u></b></p> <ul style="list-style-type: none"> <li>• Do not let gender or age affect overall care</li> <li>• Encourage the patient while having a positive attitude when providing care</li> <li>• Care for the patient as if this was my own grandmother.</li> <li>• Provide holistic care</li> <li>• Promote patient independence as much as possible</li> </ul> <p><b>*<u>Standard Precautions:</u></b></p> <ul style="list-style-type: none"> <li>• Take steps to prevent contamination/risks of other infections by:</li> <li>• Wash hands before, prn, and after patient contact</li> <li>• Clean stethoscope, pulse ox, and any other equipment before and after patient use</li> <li>• Wear gloves following handwashing when providing care</li> </ul>	<p><b>*<u>Assessment &amp; Evaluation of Vital Signs:</u></b> Monitoring vital signs frequently will indicate if Fannie's condition is worsening and allow for immediate intervention. Her current VS are already worrisome and that is why they need to be monitored often.</p> <p><b>*<u>Fluid Management Evaluation with Recommendations:</u></b> Since Fannie has been diagnosed with sepsis, we need to initiate fluid administration of NS or LR (crystalloid) for her hypotension. Her lactic acid was 4mmol/L, so this is another reason why she needs fluids promptly. We will also need to monitor responsiveness by assessing VS, cap refill, skin temperature, and urine output to see if we need to intervene with a vasopressor.</p> <p><b>*<u>Type of Vascular Access with Recommendations:</u></b> My recommendation for vascular access would be 2 large bore IVs for Fannie. She is going to be having fluids and antibiotics running, and we might have to do a blood transfusion if needed.</p> <p><b>*<u>Type of Medications with Recommendations:</u></b> My recommendations for medications for Fannie include antibiotics for sepsis, pneumonia and pressure ulcer, fluids for dehydration and sepsis, blood products, bronchodilator if needed, norepinephrine (vasopressor) if patient is unresponsive to fluid replacement, and a beta-blocker to help decrease HR.</p> <p><b>*<u>Oxygen Administration with Recommendations:</u></b> I believe Fannie needs a more effective oxygen delivery device. She not only has sepsis, but she also has pneumonia, so her need for oxygen is at a higher demand. Her current respirations are</p>

<ul style="list-style-type: none"><li>• Follow policy and procedures for proper disposal of contaminated materials</li></ul> <p><u>*Safety &amp; Security:</u></p> <ul style="list-style-type: none"><li>• Verify nursing interventions against HCP's orders, standing protocols, and evidence-based nursing practice</li><li>• Identify the patient using 2 identifiers and allergies (use arm band to verify name, DOB, and allergies)</li><li>• Protect patient from physical harm by use of side rails, bed is in low position and locked prior to leaving room, do hourly rounding with 4 P's, and assess mobility level before patient position is altered.</li><li>• Protect patient from psychological harm by using AIDET, pronouncing patient name correctly, communicate in a trusting and respectful way, provide privacy when needed, provide accurate information to patient when needed, and keep all patient information confidential</li><li>• Protect the patient and others from both psychological and emotional harm by providing clear, accurate, and relevant teaching</li></ul>	<p>39 and labored on 4 liters per nasal canula. She still seems to have trouble breathing which is why I think she needs a venturi mask or a high flow NC.</p> <p><u>*Special Needs this Patient Might Have on Discharge:</u> Fannie may need follow up appointments with wound care to ensure proper healing of her pressure ulcer. In the event she is discharged with oxygen make sure nursing home is aware of proper amount, administration, and frequency. I will make sure nursing home is aware of signs of post sepsis syndrome and what to do if Fannie begins to experience any physical, psychological, or emotional issues.</p>
<p><b>Choose Two Priority Assessments and Provide a Rationale for Each Choice</b></p>	
<p><u>*Neurological Assessment:</u></p> <p><u>*Respiratory Assessment:</u> I would do a respiratory assessment because Fannie has a respiration rate of 39 and breathing is labored on 4 liters per nasal cannula. I would obtain her respiratory rate again along with her O2 sat, since her hgb is less than normal to detect any deterioration of physiological function. I would also assess for any purse-lipped breathing, pallor, cyanosis of the lips or fingertips, that would indicate hypoxia. I would assess the position of the trachea and assess her cough. Next, I would inspect the</p>	

<p>size, shape, and symmetry of the chest, and look for any scars, wounds, drains, or dressings. Fannie also has labored breathing so I would listen to her breath sounds for 1 full breath in each location anteriorly, laterally, and posteriorly for any abnormal, absent, or diminished breath sounds.</p> <p><u>*Abdominal Assessment:</u></p> <p><b>*Cardiac Assessment:</b> Since Fannie has a MAP score of 59, she is having trouble with perfusion, and therefore I will do a cardiac assessment. I would inspect the chest to look for any scars, bruising, or abnormalities, such as pacemaker implants, wires, etc. I would also listen to each of the 4 locations for at least 2 complete cycles to see if I am hearing anything irregular going on with any of the valves. According to Fannie's current vital signs she has a HR of 121 bpm, so I would auscultate her apical pulse to compare for a more accurate reading.</p> <p><u>*Skin Assessment:</u></p>	
<p><b>Nursing Management (Choose three areas to address)</b></p>	
<p><u>*Wound Management:</u></p> <ul style="list-style-type: none"> <li>• If patient is prescribed an antibiotic, make sure it is taken appropriately</li> <li>• Teach patient the reason for the antibiotic and to finish the entire course of treatment</li> <li>• Keep the wound dressed, moist, and free of infection- teach patient these techniques as well</li> </ul> <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></p> <ul style="list-style-type: none"> <li>• Teach patient nonpharmacological ways to relieve pain</li> <li>• Use appropriate pain medication based off patient's rating</li> <li>• Give patient medication prior to wound debridement</li> </ul> <p><u>*Respiratory Management:</u></p> <ul style="list-style-type: none"> <li>• Make sure patient's O2 delivery device is appropriate based off patient's need</li> <li>• Teach patient why O2 delivery device is needed and make sure they keep it on</li> <li>• Teach patient ways to conserve respiratory function to reduce labored breathing</li> </ul>