

<p><b>Universal Competencies (Address all)</b></p>	<p><b>Required Areas of Care (Address all)</b></p>
<p><u>*Health Care Team Collaboration:</u>                      -Respiratory Therapy to help ensure that the patient is ventilating properly and has adequate oxygenation for perfusion                      -Wound care to create a care plan for the stage III pressure ulcer, and teaching on preventing recurrence                      -Unlicensed assistive personnel, to assist the nurse with turning the patient every two hours and providing assistance with ADLs                      -Physical/Occupational therapy consult, when possible, to get the patient moving and help patient move to the best of her ability with the residual effects of a prior CVA                      -Infectious Disease doctor, for sepsis                      -Nutrition, to collaborate with the health care team and come up with a feeding plan that is best for the patient                      -Cardiology consult may be necessary for low blood pressure, and hx of MI and PVD. The patient's MAP is only 59.</p> <p><u>*Human Caring:</u>                      Go meet the patient and establish a relationship with the patient. Let her know what her current plan of care is and ask if she has any concerns that you can address. Spend time with the patient and acknowledge any fears or concerns she may have. If applicable communicate with the family and keep them updated. Check back on the patient frequently to make sure she is comfortable and see if you can help with anything.</p> <p><u>*Standard Precautions:</u>                      Good Hand Hygiene when entering the room, throughout the interaction, and when leaving the room. Follow strict aseptic technique when administering medications, providing wound care, and clean equipment before and after use. Patient will be on droplet precautions for</p>	<p><u>*Assessment &amp; Evaluation of Vital Signs:</u> The vital signs concern me as the blood pressure continues to drop, the patient's MAP is only 59. A MAP of 59 is not adequate to perfuse the organs properly, so I'm concerned this patient has progressed to septic shock. Septic shock is even more of a concern because her lactic acid is 4, I would like to know her urine output. Measures should be taken to lower temperature both pharmacologic and nonpharmacologic interventions. Respiratory effort is also concerning because the patient is breathing at 39 breaths per minute, she may fatigue. Heart rate of 121, is probably due to the body trying to compensate for hypoperfusion.</p> <p><u>*Fluid Management Evaluation with Recommendations:</u>                      The patient should be put on a crystalloid fluid bolus at 30 mL/kg. This would also help with the patient's dehydration.</p> <p><u>*Type of Vascular Access with Recommendations:</u>                      I would advocate for a central line to administer antibiotics because antibiotics can easily irritate veins, if not two large gauge IVs. You can also draw blood from central lines which would minimize sticks.                      I would also like an arterial line to monitor the patient's pressures more accurately.</p> <p><u>*Type of Medications with Recommendations:</u>                      The patient would get a broad-spectrum antibiotic like ceftriaxone, or meropenem, for sepsis and pneumonia. The patient would also be receiving IV crystalloids to rehydrate the patient. I would anticipate the addition of pressors because the patient's map is low, and we need to increase the blood pressure to perfuse organs adequately. The patient</p>

<p>pneumonia.</p> <p><u>*Safety &amp; Security:</u> Bed should be in the lowest position, with wheels locked. Bed rails x3, call light within reach. Make sure to address the 4 p's when leaving the room: Pain, potty, position, and possessions. Patient should be wearing a yellow gown, yellow grip socks, and signs should be posted to call before getting up. Make sure the room is clean, and frequently checking on the patient.</p>	<p>may receive a nebulizer to help with breathing and oxygenation.</p> <p><u>*Oxygen Administration with Recommendations:</u> I would switch the patient to high flow nasal cannula, to see if that improves oxygenation. I would look at her ABGs, and work of breathing, if there is no improvement, I may advocate towards intubation to allow the patient to rest.</p> <p><u>*Special Needs this Patient Might Have on Discharge:</u> The patient would need wound care outside of the hospital to continue to heal the pressure ulcer and prevent infection. I would like to make sure that the nursing home is aware of her plan of care. That the patient needs to be turned at least every two hours and be getting up to ambulate as much as possible. The patient needs a high caloric diet and be provided with fluids throughout the day.</p>
<p><b>Choose Two Priority Assessments and Provide a Rationale for Each Choice</b></p>	
<p><u>*Neurological Assessment:</u> -Always reassessing this when you walk into a patient's room.</p> <p><u>*Respiratory Assessment:</u> I would perform frequent respiratory assessments because the patient respirations are 39 and labored, and she is on 4L of oxygen. The patient has also been diagnosed with pneumonia, so I would want to listen to her lungs. I would continually reassess this to check the patients work of breathing and to see how well they are oxygenating.</p> <p><u>*Abdominal Assessment:</u></p> <p><u>*Cardiac Assessment:</u> A cardiac Assessment would also be a priority the patient's MAP is only 59, which is not adequate to be properly perfusing organs, I would also want to know the patient's cap refill to check circulation</p> <p><u>*Skin Assessment:</u> -A skin assessment would be next on my list after priority assessments...as the patient has a stage III pressure ulcer. Keeping this area as clean as possible and promoting healing to prevent further infections for a patient that is already septic.</p>	

**Nursing Management (Choose three areas to address)**

**\*Wound Management:** The patient has a stage III pressure ulcer; the patient needs to be turned properly to promote healing and prevent another pressure ulcer. I would teach the patient that she needs to be turned every two hours and if she is not able to on her own, she should remind staff that she needs to be turned. The pressure ulcer should be dressed properly, pads on heels, and sacrum, and elbows may help to prevent further pressure ulcers.

**\*Drain and Specimen Management:**

**\*Comfort Management:**  
The patient should be in a comfortable position with pillows, patient's care should be clustered to allow time for her to rest. Lights in the room should be dim, and the room should be kept at a comfortable temperature for the patient. Can teach the patient relaxation techniques to promote relaxation and better sleep.

**\*Musculoskeletal Management:**

**\*Pain Management:**

**\*Respiratory Management:** The patient HOB should be at least 30 degrees to allow better lung expansion and lower the risk of aspiration. Teach the patient how to use the IS, and TCDB. Teach the patient about the importance of adequate fluid intake and provide the patient with fluids. Frequently assess the patient's oxygenation status, breathing effort, and lung sounds.