

Universal Competencies (Address all)	Required Areas of Care (Address all)
<p><u>*Health Care Team Collaboration:</u> -I would consider all of these for part of the health care team to help in collaboration with patient care, healing, and recovery: PT (for weakness once pt is able), RT (pneumonia, oxygen treatment, breathing tx, etc), Cardiologist (hx of cardiac disease), MICU team (management of septic shock), Wound care team for the stage 3 pressure ulcer. Pharmacy team (consulting and help determining the best medications for tx of infection), Nutritionist (helping determine proper nutrition to help and promote pt healing).</p> <p><u>*Human Caring:</u> -I would make sure that the patient has possessions close by such as glasses, phones, or remote to keep them comfortable as much as possible. I would want them to be aware that their call light is close by them and that I will be available to assist them. It's understandable that being in the hospital can be a very scary thing especially if the patient is alone or cannot talk due to placement of an ETT. Even if that pt has an ETT I would want to speak to the patient and explain to them the care that I am giving as well as giving them the dignity and respect they deserve. It is important to listen to the patient to their complaints and needs in order to give them the proper care that they need. It's important to include the patient in their care and advocate for them for the concerns and fears that they may have.</p> <p><u>*Standard Precautions:</u> -Proper hand hygiene should be done upon entering the patient's room and before delivering any direct care to the patient as well as around handling the lines, drains, and medications going to the patient. Gloves</p>	<p><u>*Assessment & Evaluation of Vital Signs:</u> -The pts current vital signs read: BP – 80/48: This low bp indicates hypoperfusion and is an inflammatory response on the body that cause vasodilation throughout the body. The other issue is the bp could be low due to decreased blood volume throughout the body caused by dehydration. HR – 121: This hr would be increased in the pts body because the body recognizes it's not getting enough blood throughout the body so the heart is working harder to try to pump it through and get the body perfused. Respirations – 39: The increased respirations go along with the increased work on the heart. The heart is basically saying to the lungs they need to work faster to oxygenate all the blood that the heart is pumping through. Labored breathing on 4L NC: This could be a result of the pneumonia infection in the lungs. It is clogging the alveoli within the lungs which makes it harder for the patient to have O2/CO2 exchange throughout the body. Temperature - 102.5: The increased temperature is an inflammatory response in the body in response to the infection. Elevated temperature is an indication of infection as well.</p> <p><u>*Fluid Management Evaluation with Recommendations:</u> -The pt is receiving D51/2 at 100ml/hr. -The patient is more hypotensive than on arrival which indicates either unresponsive to fluid resuscitation or inadequate fluid resuscitation. - Recommend switching fluid to Normal Saline (crystalloid) 30ml/kg -hypotensive and</p>

should be worn when appropriate such as when cleaning the patient's peri area, giving foley care, changing dressing, assessing any open sites, and when coming into contact with any bodily fluids. All medical equipment should be wiped down with an alcohol pad for 15 seconds before it comes into direct contact with the patient. Proper oral care should be given to the patient to prevent any further infections especially if the patient is placed on mechanical ventilation. All hubs in the IV tubing and lines should be cleaned for 15 seconds with an alcohol pad before being assessed for medications or any other reason and should be capped with the orange caps.

*Safety & Security:

-I would address if the patient's bed is on the lowest level, if they have on non-skid socks, if the bed is locked, and if they have their call light and possessions close all to prevent falls and to make sure they have a way to call me if they need immediate assistance.

-I would make sure they have a yellow gown on to indicate their risk for falls and need for assistance.

-I would make sure to use two patient identifiers such as name and DOB upon entering the room.

-I would also make sure that the floor in the room is free from clutter to decrease the chances that the pt might fall or harm themselves.

-I would make sure that the bed is free of anything that might cause pressure sores, and that all of their lines are untangled and are nonrestrictive.

-At least two side rails of the bed should be up to prevent the patient from falling out of bed, but not feeling restrained.

lactate level is at 4 indicating need for fluid resuscitation. This would also be indicated because we know the pt is dehydrated.

*Type of Vascular Access with Recommendations:

-18g intravenous in the right forearm. This site should be monitored closely for signs of infection/infiltration such as redness, tenderness, swelling, itching, etc.

-Would also recommend getting a site such as a central line due to the different types of fluids/medications the pt is going to need. It will give us better access to the pt, as well as more sites to run different things through. It would cut down on the number of times the pt would need to be stuck with a needle. This site would need to be monitored closely to prevent infection by doing sterile dressing changes per hospital policy, using proper aseptic technique when handling the lines, and proper assessments of the dressing/site.

*Type of Medications with Recommendations:

-Would recommend a broad-spectrum antibiotic such as Zosyn until blood cultures return with targeted medication to treat the infection.

-Would recommend a vasopressor such as Norepinephrine if hypotension persists/is unresponsive to fluid resuscitation.

-Might consider insulin therapy if glucose is elevated due to the increase stress and inflammatory response caused on the body by sepsis/shock.

*Oxygen Administration with Recommendations:

- 4L NC, I recommended consulting RT and the MICU physician for a non-rebreather or mechanical ventilation to prevent the

<p>Choose Two Priority Assessments and Provide a Rationale for Each Choice</p>	<p>patient's lungs from tiring out. -Pts respirations are already at 39 with labored breathing which shows the pt is at risk for tiring out and might need help to take some of the work load off by mechanical ventilation</p> <p><u>*Special Needs this Patient Might Have on Discharge:</u> -I would bring up to the healthcare team to consider having PT a part of the patient's care plan in the nursing home to make sure she is moving around as much as possible. -We might consider social services/case management to help with getting any supplies the pt might have to go home with such as oxygen, a walker, etc.. -Might get help from case management to consider if we need to set up transportation for the pt to be able to make all of the follow up appointments. -We might need wound care set up for home care if the pressure ulcer has not resolved during the hospital stay.</p>
<p><u>*Neurological Assessment:</u> <u>*Respiratory Assessment:</u> I would do a respiratory assessment to assess the patient's lung function with a diagnosis of sepsis/pneumonia. I would want to see if she is needing help keeping her alveoli open or help to take the workload off her increased work of breathing. I would want to assess her O2 saturation as well. I would want to assess the lung sounds to see where I hear diminished or abnormal lung sounds, compared to where I hear normal lung sounds. <u>*Abdominal Assessment:</u> <u>*Cardiac Assessment:</u> <u>*Skin Assessment:</u> The pt is already known to be dehydrated and presented with a known stage III right hip pressure ulcer. This would be an area of concern for me due to the advanced stage of the skin ulcer and the increased risk for loss of skin integrity due to dehydration, infection, age of the pt, and her hx of peripheral vascular disease. This is also an increased risk for infection and will need to be monitored/assessed closely.</p>	<p align="center">Nursing Management (Choose three areas to address)</p>
<p><u>*Wound Management:</u> The patient presented to the emergency department with a stage 3 pressure ulcer. This is a huge site for increased risk of infection. It is extremely important to do proper wound care and management of the wound. The wound/dressing should be kept dry and clean and free from signs of infection such as redness, tenderness, and purulent drainage. This is also indicative that she is at increased risk for wounds, so the pt should be on the skin care protocol. The pt should be turned every 2 hours and be given proper, frequent skin assessments. The other focus for the</p>	<p><u>*Musculoskeletal Management:</u> <u>*Pain Management:</u> <u>*Respiratory Management:</u> The patient's respirations are greatly elevated at 39 with labored breathing on 4L NC. I am concerned that the pt will get tired out and will need help breathing and keeping the alveoli in her lungs open by means of mechanical ventilation. Due to the pneumonia infection her lungs are an area of concern due to the alveoli getting clogged up and not able to deliver proper gas exchange, the other concern is that the alveoli will collapse if they are not kept open.</p>

current pressure ulcer is to prevent further advancement and to promote healing.

*Drain and Specimen Management: We want to make sure to keep a close eye on the foley inserted as well as the IV site or central line if one is decided to be put in. We want to identify all the risks for the patient to get an infection and make sure we are taking all precautions to prevent it. This would include proper peri care as well as foley care, proper hand hygiene, frequent assessments of all drain/foley sites, and proper aseptic technique when handling all these areas.

*Comfort Management: