

Universal Competencies (Address all)	Required Areas of Care (Address all)
<u>*Health Care Team Collaboration:</u> The patient will require a dietician to ensure she is receiving adequate nutrition to support healing and function. An intensivist and infectionist will need to collaborate to treat and prevent advancement of the patient's current infections. Respiratory therapists should be closely involved with patient care to ensure the use of adequate oxygenation methods and respiratory treatment. When the patient is able, OT and PT will be needed to sustain the patient's range of motion and ability to perform ADLs. A wound care specialist will also be beneficial to this patient's care because of her stage III right hip pressure ulcer. The ulcer should be properly cared for to prevent further tissue damage. <u>*Human Caring:</u> The patient should receive CHG bathing every day (or every other day) to reduce the risk of infection of wounds and IV accesses. Frequent bathing and linen changes will also prevent the accumulation of moisture, thus, reducing risk of skin breakdown. Patient care should also include oral care and catheter care. The patient should be repositioned/turned every 2 hours to assist in the prevention of skin breakdown and further tissue deterioration of the known right hip pressure ulcer. Depending on the patient's religious or spiritual beliefs, a priest or pastor may be called to meet the spiritual aspect of human care. As the nurse, even staying a little longer to communicate with the patient may help her feel a little bit better. <u>*Standard Precautions:</u>	<u>*Assessment & Evaluation of Vital Signs:</u> Continuous noninvasive vital sign monitoring and documentation enables the nurse to utilize trended data for timely intervention at the earliest signs of the patient's deterioration. Assessment data provide health care team with a baseline in patient's condition so that changes in the patient's condition may be quickly identified. The patient requires monitoring of all vitals including temperature, heart rate, respirations, O₂ saturation, method of O₂ administration, and blood pressure. Considering the patient's initial presentation of abnormal vital signs, tachypnea, tachycardia, labored breathing and elevated temperature, the nurse should continuously monitor all vitals and periodically assess neurological and respiratory status. <u>*Fluid Management Evaluation with Recommendations:</u> The patient was admitted with the diagnoses of sepsis and dehydration. With septic patients, it is evidence-based practice to begin enteral feeding within 24/48 hours of diagnosis. Tube feeding promotes adequate nutrition and healing for patients who are unable to successfully consume their nutritional requirements. I recommend initiating enteral feeding within 24-hours. To treat dehydration, I recommend continuing D5½NS and perhaps initiating a fluid bolus to help improve blood pressure and perfusion. <u>*Type of Vascular Access with Recommendations:</u> Considering the patient's admitting diagnoses, fluids to treat dehydration and medications to treat

The patient arrived to MICU with a diagnosis of sepsis/pneumonia/ dehydration. Standard precautions would include: 1. Hand hygiene. 2. Use of personal protective equipment (gloves, masks, eyewear) 3. Respiratory hygiene/cough etiquette. 4. Sharps safety 5. Safe injection practices (aseptic technique for parenteral medications). 6. Sterile instruments and devices. 7. Clean and disinfected environmental surfaces. <u>*Safety & Security:</u> Discuss safety measures for the nursing home and patient recommendations: – Get rid of trip hazards like throw rugs and keep floors clutter free. – Brighten the room with extra lighting or brighter light bulbs. – Install grab bars in the bathroom(s) (next to the toilet and inside and outside of your bathtub or shower). – Elderly has a psychological need to express their thoughts and feelings. Providing them therapy with a psychologist may be helpful with the aging process.	infection and control pain will be administered throughout the patient's hospital stay. I recommend evaluating the patient for possible central line insertion. A central line will allow for medications to be administered that cannot be given through a standard IV and provide multiple lines of access (multiple lumens) including a line for blood draws. Also, central lines may remain in place for a longer period than standard IV's. Because our patient will require a long course of treatment, it will be beneficial to have a more long-term intravenous access. Finally, if needed, large volumes of fluid may be administered through a central line. This remains an important consideration regarding fluid resuscitation. <u>*Type of Medications with Recommendations:</u> The patient's primary admitting diagnoses are sepsis, pneumonia, and dehydration, and she has a known stage III right hip pressure ulcer. Medication recommendations for the patient's condition would be Hour-1 bundle - Obtain blood cultures before administering antibiotics, administration of broad spectrum antibiotics, begin rapid administration of 30ml/kg crystalloid for hypotension or a lactate level of 4. Apply vasopressors if hypotension during or after fluid resuscitation to maintain a map of 65 or greater. – Broad spectrum antibiotics within 1 hour is goal – Ceftriaxone – Meropenem – Cefepime – Piperacillin Dehydration- intravenous fluids. We can draw labs again and look at the
Choose Two Priority Assessments and Provide a Rationale for Each Choice <u>*Neurological Assessment:</u> A neurological assessment should be performed at the initial encounter of a patient so that any changes in LOC may be identified quickly. Any change in LOC may signify several conditions. Specific to our patient, it may mean decreased oxygenation and perfusion to the brain related to respiratory distress, or	

confusion related to sepsis (systemic infection).

*Respiratory Assessment: The patient requires 4 liters of O₂ via nasal cannula to maintain adequate oxygenation. The patient presents with tachypnea, labored respirations, and pneumonia. It is important to identify the patient's current respiratory status so that any declination or improvement in condition may be noted and proper interventions (such as moving to non-rebreather at a higher O₂ rate) may be implemented.

*Abdominal Assessment:

*Cardiac Assessment:

*Skin Assessment:

electrolytes (sodium, potassium, chloride, bicarbonate) BUN and creatinine, to evaluate kidney function.

Pneumonia- Antibiotics such as penicillin. Supportive care: oxygen therapy such as a nonrebreather mask and IV Fluids. Given the patient status: Place the patient with proper body alignment for maximum breathing pattern. A sitting position permits maximum lung excursion and chest expansion. Encourage sustained deep breaths by:

- Using demonstration: highlighting slow inhalation, holding end inspiration for a few seconds, and passive exhalation
 - Utilizing incentive spirometer
- These techniques promote deep inspiration, which increases oxygenation and prevents atelectasis.
- Hip pressure ulcer- Wound cleansing, with normal saline and appropriate dressings, is a mainstay of treatment for clean ulcers. For this patient systemic antibiotics would be used such as amoxicillin. Reposition the patient and turning every two hours. The patient has a stage III indicating full-thickness skin loss. Sharp or surgical debridement and mechanical debridement may be considered.

*Oxygen Administration with Recommendations:

The patient's respirations are 39 and labored on 4 liters via nasal cannula. The recommendation would be to put the patient on a nonrebreather mask and increase the O₂. Utilize pulse oximetry to check oxygen saturation and pulse rate. Pulse oximetry is a helpful tool to detect alterations in oxygenation. Teach patient about:

	– pursed-lip breathing – abdominal breathing – performing relaxation techniques – performing relaxation techniques <u>*Special Needs this Patient Might Have on Discharge:</u> • Fannie Mae is an 81-year-old frail woman who has come to us from a nursing home. Given the diagnosis of the patient and circumstances we would need to get a case manager involved, the patient would need a dietician, respiratory therapist, physical, and occupational therapist. They can help assess physical strengths/limitations and the potential for improvement with a program or assistive tools. They can help address issues such as inadequate food and fluid intake. Since the patient is coming from a nursing home and most likely will return to the nursing home. We need to make sure all the teaching is clear, and the patient willingness to learn is assessed. She may need to be sent home with medical equipment. As the nurse, we need to make sure the patient knows how to properly work the equipment. (O2) After talking with the case manager, we would want to assess the patient and see if they understood everything. Provide any demonstrations of medical equipment to the patient.
Nursing Management (Choose three areas to address)	
<u>*Wound Management:</u> The patient is presenting with a fever of 102.5 and her labs indicate infection (WBC of 17). Assessing the characteristics of the patient's right hip stage III pressure wound,	<u>*Musculoskeletal Management:</u> <u>*Pain Management:</u> <u>*Respiratory Management:</u> The patient exhibits respiratory distress as evidenced by tachypnea, labored breathing,

including color and size, and note if there is any drainage present. A proper wound assessment will provide information on the extent of the impaired tissue integrity. Odor may be a result of presence of infection on the site. Serous exudate from a wound is a normal part of inflammation and must be differentiated from pus or purulent discharge, which is present in infection. Given the patient's age wound healing is decreased. Given the status of the patient and the condition we would want to make sure the patient is alert and oriented. Also, to see the willingness to learn and care for herself. Some teaching that would be effective for her care would include meeting nutritional needs such as a high protein. A diet that is high in protein and ascorbic acid protects the skin from breakdown.

***Drain and Specimen Management:**

The patient's lab results show: WBC of 17 which indicates an infection as suggested by the patients admitting diagnoses of sepsis and pneumonia. Her HGB is 9.0, HCT is 42, RBC is 3.0, PT is 15, INR is 2.5, and Lactic Acid is 4.0. The patient is at risk for bleeding out (DIC). An increase in lactate can indicate that the organs are not functioning properly. Low hemoglobin levels usually indicate that the patient has anemia. A low RBC could indicate that the patient is malnourished or signify internal bleeding. A high PT/INR level means the blood is taking longer than normal to clot and may be a sign of bleeding or a clotting disorder. The physician may order for labs to be redrawn to confirm the accuracy of lab results. If wound or sputum cultures are ordered, I will ensure the proper technique is used in specimen retrieval. When labs are redrawn, I will draw tubes in the correct

and the use of 4 liters of O2 via nasal canula. The patient's O2 saturation is unknown at this time, but once identified, the patient's condition may improve by moving to a non-rebreather O2 mask and a higher rate of O2 administration. To teach the patient, the nurse must first acknowledge the patient's physical condition and willingness to learn. If the patient is at a state prepared to receive education, the nurse should discuss the importance of implementing an IS into their daily routine to provide alveolar expansion and removal of the secretions from the bronchial tree, resulting to optimal gas exchange. A demonstration on how to use the IS should be provided.

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order by proper technique and send to the lab in a timely manner. I will teach the patient of the importance of obtaining labs and cultures to identify improvement or declination of condition. Urinalysis and urine cultures will need to be done. Cultures can identify the microorganisms that is causing the infection. Results from cultures and labs help guide the course of treatment.

*Comfort Management: