Universal Competencies (Address all)	Required Areas of Care (Address all)
*Health Care Team Collaboration: There are a group of health care professionals that are on this patient's case. It was important for the ED nurse to give a thorough SBAR communication hand off to the MICU nurse to better prepare the nurse on what to do to care for this patient. The MICU nurse needs to give a thorough summary to the infectious disease doctor and the respiratory therapist to come up with a plan to help better improve this patient's health and to all be on the same page on where the patient is during her hospital stay. *Human Caring: It is important to communicate with the patient on what is happening during her stay and what the health care team is planning on doing for her diagnosis. Even if the patient were to have neurological deficits we would still communicate with her normally. We would also give her proper teaching of what is going on and give her the option to make her own choices. We will maintain the patients comfort and provide adequate care according to her needs. *Standard Precautions: As her nurse I will maintain aseptic technique, such as hand hygiene clean gloves, to prevent further infections or new infections arising especially due to her sepsis diagnosis. I would maintain aseptic technique when administering medications to the patient. *Safety & Security: I would maintain patient confidentiality. Once I enter the room I will check the patient's name and date of birth and allergies is correct. I make sure the patient is under high fall risk precautions due to her right sided weakness. I will use my 7 rights when administering medication safely	*Assessment & Evaluation of Vital Signs: Due to the patient being septic vital signs are crucial to assess. She came on the MICU floor with the septic criteria which includes respirations >20, temp >100.4, WBC >10, etc. and a confirmed infection diagnosis. The patient has tachypnea, tachycardia, and low blood pressure. The lungs are usually the first organ to be affected, therefore having a continuous monitor of her O2 saturation and respiration rate is critical to get an idea of how the patient is perfusing. *Fluid Management Evaluation with Recommendations: Patient is currently on D5 ½ NS at 100 mL/hr. Administering a crytalloid fluids to the patient is critical when they are septic to get her blood pressure back up and help her perfuse properly. This is important to do when a septic patient first arrives to the hospital. *Type of Vascular Access with Recommendations: Patient has a 18g in the right forearm currently. The patient may be required to have a central line put in place to avoid the possibility of blowing the vein to do administering a lot of fluids and decrease the number of times sticking the patient for blood draws. This would also give us another form of IV access. *Type of Medications with Recommendations: Type of medications we may give to this patient would be albumin because it keeps fluid in the vessels and decrease capillary permability. We may give the patient vasopressors to help constrict the vessels and raise the blood pressure.

to the patient. I will use the Red rules when leaving the patients room, such as bed rails up, area is clean, bed is locked and in low position, and call light is in reach.	*Oxygen Administration with Recommendations: Patient is currently on 4L of oxygen per nasal cannula. We will continuously monitor her O2 saturation to see if the patient is receiving adequate oxygen. If the patients O2 saturation starts to decline, then I would give her more oxygen. *Special Needs this Patient Might Have on Discharge: I would make sure this patient has or currently has been using an assistive device to help her be mobile. I would teach the patient about proper use of medications that she will go home with and provide written instructions on to correctly take her medications and when to take them. I would also call her nursing home to address her pressure ulcer and talk about prevention techniques they could use and how to monitor it properly.
Choose Two Priority Assessments and Provide a Rationale for Each Choice	
*Respiratory Assessment: I would choose a respiratory assessment because the patient came in with pneumonia. By assessing lung sounds and respiratory rate it would help monitor if the pneumonia is worsening or getting better. *Skin Assessment: I would choose a skin assessment to asses the patient's skin turgor due to her dehydration. I would also assess her stage III pressure ulcer on her right hip for signs and symptoms of infection.	
Nursing Management (Choose three areas to address)	
*Wound Management: Due to the patient having a stage III pressure ulcer on her right hip I would assess the wound for signs of infection such as purulent drainage, redness, and swelling. As the patient's nurse I would turn the patient every two hours to avoid continuous pressure on that one area.	*Musculoskeletal Management: Due to the patient's history of a CVA causing right sided weakness and paresthesia I would make sure she has non-slick socks, yellow gown, and a bed alarm due to her being a high fall risk. I would assist her and/or make sure she always has assistance when getting out of bed. *Respiratory Management: Due to the patient having pneumonia I would do breathing exercises with them such as incentive spirometer and turn cough deep breath. I would teach the patient that adequate hydration is necessary to improve her health by drinking 3-4 L a day. I would monitor the patient's respirations, O2 saturation to make sure she is still perfusing. If the patient's O2 saturation is declining, then I will increase her oxygen and add humidification if necessary.