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Universal Competencies (Address all)	Required Areas of Care (Address all)
*Health Care Team Collaboration: The patient will need an extensive health care team to collaborate including the following specialists: PT/OT to help patient mobilize with their new amputation and facilitate patient rehabilitation Wound Care Specialist to help assess and monitor and facilitate the management of the patient's wound. Surgeon will be needed to assess the amputation and order interventions as necessary Case manager will be needed on this patient's team to ensure that the patient has the proper access to healthcare requirements and needs upon discharge A cardiologist, nephrologist, and endocrinologist will be needed to monitor and help plan management for the patient's CHF, Diabetes 1, and Chronic renal failure. The CNA will also help in helping to monitor patient status and vitals and reporting anything concerning to the Registered Nurse. A spiritual consult will also be needed to help the patient with any spiritual crisis A dietitian/ nutritionist will be needed to monitor patient's nutrition status and help to direct their diet so that their wound may heal properly Psychologist/ therapist will be needed to assess patient's psychiatric status and monitor and discuss with the patient as appropriate due to the patient's risk for ineffective coping and subsequential depression. *Human Caring: Relate and try to communicate therapeutically with my patient. Actively listen to my patient's needs and concerns. Talk with the patient about their feelings including any grief, pain, or feelings of loss. Spend time with patient connecting emotionally and actively listening to their needs and concerns.	*Assessment & Evaluation of Vital Signs: The patient is exhibiting a raised blood pressure of 150/90. To me as the nurse, with the patient's past history of CHF I am concerned about possible fluid overload. Also, this rise in blood pressure could be an indication of an intense pain level the patient is experiencing. The patient's heart rate is 88 beats per minute, while this is not out of range, it is a little high. I would have to monitor this patient's trends in vitals to see if this heart rate is normal for him or elevated possibly due to pain or increased workload of the heart. The patient's respirations are increased at 22 respirations per minute. This is concerning to me as this could likely indicate pain for the patient. This could also indicate that the patient is having increased work of breathing due to possible respiratory distress. The patient's SaO2 is lowered at 91% on room air. This is concerning as this could be an indication of possible respiratory or circulatory impairment. The patient's temperature is concerning to me at 99.2 degrees Fahrenheit, especially due to the patient being diabetic, having a chronically elevated blood glucose, and a recent surgical procedure (amputation), I as the nurse will be worried and continuously monitoring for possible signs of infection within my patient. Infection is probable if proper care is not monitored and managed for this patient especially with the aforementioned risk factors. *Fluid Management Evaluation with Recommendations: I as the nurse would want to decrease the rate at which the maintenance fluid is going or stop it altogether due to the patient exhibiting signs/ symptoms of possible fluid overload in combination with congestive heart failure. I would address this concern with the HCP to determine next course of action for the patient. I would also report concerning lab

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*Standard Precautions:
Wash hands as I walk in the room and glove as necessary, wash hands after degloving. Clean stethoscope and other equipment as needed prior to use on patient. Use aseptic technique, when necessary, especially when administering medications and performing anything invasive or involving wound care. Dispose of gloves and contaminated materials appropriately.

*Safety & Security: verify orders, verify patient using two identifiers, verify patient allergies verbally with the patient. Bed in low position. Patient has one non-skid sock on left foot. Verify 5 med admin rights, use AIDET when conversing with patient. Assess patients need for possessions, potty, and pain. Ensure patient privacy and confidentiality, side rails up x3, patient on a bed alarm, patient's room free of clutter, patient has access to call light within reach.

Choose Two Priority Assessments and Provide a Rationale for Each Choice

*Neurological Assessment:
*Respiratory Assessment:
I would like to perform a respiratory assessment on this patient due to the reported incidence of coarse crackles in the patient's lungs. As a patient with a history of renal failure and CHF, I am worried about fluid overload and any excess fluid potentially backing up into the patient's lungs. I also want to assess respiratory due to the patient showing a SaO2 sat of 91% on room air.
*Abdominal Assessment:
*Cardiac Assessment: I would like to perform a cardiac assessment on this patient due to their previous history of congestive heart failure. I would also like to perform this assessment due to the patient showing low RBC's, Hct, and Hgb levels. I want to particularly pay attention for good patient findings to the HCP concerning the need for the patient to possibly undergo dialysis soon.

*Type of Vascular Access with Recommendations:
The patient has a Right AV fistula for dialysis and the sight displays good access for dialysis as a bruit and thrill are both assessed in the sight. The patient has A left peripheral IV access sight with a connected maintenance fluid of NS at 150 mL/hr. I would recommend that maintenance fluids be stopped and the patient possibly INT'd due to possible fluid overload and the presence of lung crackles.
I would also carefully watch the patient's lab values especially the Hgb as it is at a level of 8 and by protocol, blood transfusions occur if the patient displays a Hgb level of 7 or below.

*Type of Medications with Recommendations:
The patient has prescribed sliding scale insulin with glucose checks every 4 hours. The patient, however, is displaying consistently increased blood glucose levels. I would continue to monitor my patient and attempt to keep his blood glucose in check so as to prevent future complications such as infection. I would also communicate with the charge nurse about my patient's consistently high blood glucose despite insulin intervention and communicate these same findings to the HCP as a concern of mine.
I would also make recommendations that the patient receive appropriate pain medication management due to the patient's recent surgery, current vital signs, and previous severe pain levels.

*Oxygen Administration with Recommendations:
Due to this patient displaying signs of respiratory distress with a lowered SaO2 on room air and course crackle sounds in the lungs, I would

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circulation, and capillary refill. I also want to assess my patient's cardiac status due to their high serum potassium as this may cause cardiac dysthymias. I would also contact the HCP with my cardiac assessment findings and the patient's current serum potassium level. *Skin Assessment:	increase the head of the bed for my patient and start them on a nasal cannula going at 2L of O2 per minute. I would take these actions to decrease my patient's work of breathing. I would then continue to monitor this patient and assess further. *Special Needs this Patient Might Have on Discharge: The patient will need psychological and emotional support in dealing with their newfound condition. This is evidenced by the patient not wanting look at the operation sight which could be a likely indicator of ineffective coping related to grief. The patient will also need rehabilitative support in learning how to manage themselves in their new "normal." Rehab will be needed to work with the patient to relearn skills such as walking with a possible new assistive device and how to properly promote their independent lifestyle by focusing on completing activities of their daily living. The patient may also need home health intervention as the patient has voiced concern about possible difficulty taking care of themselves when they get home.
Nursing Management (Choose three areas to address)	
*Wound Management: *Drain and Specimen Management: *Comfort Management:	*Musculoskeletal Management: *Pain Management: *Respiratory Management:

I want to closely monitor the sight of amputation and dressing for signs of infection or hemorrhage. Though the patient's sight is reported to be clean and dry, I would need to assess for myself first thing coming onto my shift what the sight looks like and assess it appropriately so that I may monitor it appropriately for any changes throughout my shift. I would also have to monitor the patient's nutritional status as good nutrition is essential for this patient's wound healing properly. One of my number one priorities for this patient is pain management. The patient has displayed previous severe pain in the PACU and the patient's most current vital signs such as heart rate, blood pressure, and SaO2 could indicate severe pain in the patient as well. Managing the patient's pain will promote comfort and healing within my patient not only psychologically, but physically as well. I would also want to manage my patient's respiratory

effort as increased work of breathing and distress could easily make my patient more in pain and anxious. I would want to decrease my patient's work of breathing by raising the head of the bed and starting them on a nasal cannula. This will also help the patient's CHF by increasing the supply of O2. The presence of crackles in the patient's lungs also is an indicator to help support the patient's respiratory effort.