

Universal Competencies (Address all)	Required Areas of Care (Address all)
<p>*<u>Health Care Team Collaboration:</u></p> <p>There are multiple health care team members that should be consulted for this patient's plan of care. Respiratory therapy collaboration should be initiated due to the patient's elevated respiratory rate and labored breathing. The patient may need to be intubated and placed on a mechanical ventilator, which respiratory therapy would oversee carrying out. Wound care should be consulted to evaluate the pressure ulcer the patient has to discuss options of bandages that should be used for healing. Infectious disease provider should be consulted as the patient has sepsis and showing signs of septic shock. An Intensivist may also be consulted for collaboration due to the critical state of the patient and may require more extensive management and interventions to aid in her recovery. A PICC team may also be a collaborating health care team member as the patient is going to be central venous access to initiate IV antibiotics and vasopressor administration.</p> <p>*<u>Human Caring:</u></p> <p>This situation could be terrifying for the patient. She is having high respiration which are labored, and her heart rate is continuing to rise, which could be frightening to the patient. Taking time to explain what is going on with the patient and preparing the patient to things that could happen soon may bring some comfort to the patient. It would also be important to find out information on the patient's immediate family and quickly updating them on the patient's condition may also bring comfort to the patient.</p> <p>*<u>Standard Precautions:</u></p> <p>Making sure to clean the stethoscope before auscultating the patient's heart and lung sounds would demonstrate standard precautions. Cleaning the stethoscope with alcohol for about 15-20 seconds and waiting for the stethoscope to dry before moving forward with the assessment will help reduce microbial contamination to the patient and prevent hospital-acquired infections. Once the assessment is completed the stethoscope should be cleaned again</p>	<p>*<u>Assessment & Evaluation of Vital Signs:</u></p> <p>Assessing the patient's vital signs from arrival to the ED at 0200 to admission to the ICU at 0700, I think patient could be going into septic shock. The patient's blood pressure upon arrival to the ED was 98/62 and decreased to 80/48 despite the patient receiving IV fluids running at 100 mL/hr. The patient's heart rate has also risen from 88 upon ED arrival to 121 on ICU admission which could be due to the low blood pressure and low organ perfusion. The patient's temperature continues to rise which could be because of a confirmed infection the patient has which would be pneumonia. The patient also has an elevated WBC and an elevated Lactic acid level which support the suspicion that this patient has reached septic shock criteria.</p> <p>*<u>Fluid Management Evaluation with Recommendations:</u></p> <p>The patient currently has a right forearm 18-gauge intravenous catheter with D5 ½ NS infusing at 100 mL/hr. Though the scenario does not provide the patient's weight, the patient should be receiving 30 mL/kg/hr of fluid. The blood pressure is not increasing with the IV fluid administration and other interventions may need to be implemented to increase the blood pressure which in turn will increase perfusion and prevent furthering complication in patient's condition such as Multiorgan Dysfunction Syndrome (MODS).</p> <p>*<u>Type of Vascular Access with Recommendations:</u></p> <p>The patient currently only has peripheral access on the right forearm. This patient would benefit from blood cultures and IV antibiotic infusion which should not be given peripherally. The patient would need a central venous access device placed so that cultures can be collected, and IV antibiotics can be infused. The patient's RBC count and Hgb has decreased as well, if patient would need a blood transfusion it would be beneficial to also have a central venous access device</p>

for another 15-20 seconds with alcohol and allowed to air dry.

***Safety & Security:**

It would be important to make sure patient has fall precautions in place. A few things to implement would include at least two siderails up, bed is locked in the lowest position, nonslip socks, and ensuring the patient has her possessions in reach, she does not have to use the restroom, she's in a comfortable position and she is not experiencing any pain. Patient has residual right sided weakness and paresthesia from an old infarction so she would be viewed as a high fall risk and would need precautions established to make sure she does not fall or injury herself through her admission stay. The patient is an 81-year-old frail woman and having a fall could be extremely detrimental for this patient if it were to happen, so taking all necessary precautions to prevent that would take priority.

Choose Two Priority Assessments and Provide a Rationale for Each Choice

***Respiratory Assessment:**

I would want to perform a respiratory assessment quickly after admission due to patient's diagnosis of pneumonia, her elevated respirations and labored breathing. I would want to note the breath sounds heart both anteriorly and posteriorly, proximally, and distally. I would want to document any adventitious sounds such as rhonchi or noting any absent breath sounds. This assessment could help me confirm if the lungs are expanding and moving oxygen through successfully to perfuse the patient's organs.

***Skin Assessment:**

I would want to perform a skin assessment on this patient due to her being admitted with a stage III hip pressure ulcer. I would want to make sure this finding has been documented appropriately and pictures of the wound taken on admission to confirm the patient was admitted with this pressure ulcer. I would also want to assess the pressure ulcer to have a good idea

for infusion. Another reason this patient should receive a central venous access device would be to give a vasopressor which would be needed as the patient's blood pressure is not improving by IV fluid administration.

***Type of Medications with Recommendations:**

With the continual decline in patient's blood pressure even with fluid administration, I would recommend this patient receive vasopressors to increase the systolic blood pressure and increase the MAP. The patient's MAP is currently 32 which means the patient's organs are not receiving adequate perfusion to her vital organs. One vasopressor I would recommend for this patient would be Norepinephrine. This medication is going to cause vasoconstriction of the vessels and increase the systemic vascular resistance and blood pressure. Another vasopressor that could be used would be Dopamine. Dopamine will cause vasoconstriction to the vessels and increase the strength of heart contractility which will increase systemic vascular resistance and blood pressure. Both medications can only be given through a central venous access device further encouraging the need for this patient to have one established prior to the administration of these vasopressors.

***Oxygen Administration with Recommendations:**

The patient is currently receiving 4L with nasal cannula, but it does not state how much the patient is saturation in the scenario. Since the patient's respirations have elevated, she is experiencing labored breathing, and the nasal cannula is reaching the max amount of oxygen on nasal cannula method of administration, the patient may need to be placed on a different form of oxygen administration. The patient's most recent respirations were 39 and labored which means this patient could be close to experiencing exhaustion and going into respiratory arrest. It may be beneficial to consider mechanical ventilation to allow the lungs to rest and recover while the patient receives IV antibiotics, and the pneumonia infections resolves. Intubating the patient would be

<p>of baseline and be able to identify if the patient is healing well or if the pressure ulcer is becoming worse through the patient's stay. This patient is frail which makes me feel that this patient has a high risk for developing another ulcer during her admission stay. I would want to assess any other potential areas of concern and make sure to provide support to those areas.</p>	<p>the best method to correct the increased breathing and increase the perfusion to the patient's organs which will decrease the patient developing MODS.</p> <p><u>*Special Needs this Patient Might Have on Discharge:</u></p> <p>The patient may need to be discharged to an inpatient rehab facility to regain strength and mobility depending on how long her treatment and recovery takes.</p> <p>The patient may need to be discharged with wound care orders to continue to receive care on her pressure ulcer.</p> <p>The patient may need to practice TCDB exercises to keep her lungs inflated upon discharge.</p> <p>The patient may need to continue a high protein diet to ensure successful wound healing upon discharge.</p> <p>The patient may need to be educated on avoiding activities that could increase her chances of bleeding as her PT was prolonged from her recent lab results indicating it may take a little longer for her blood to clot.</p>
---	--

Nursing Management (Choose three areas to address)

<p><u>*Wound Management:</u></p> <ul style="list-style-type: none"> • Keeping the wound dry and clean <p>It's important that the bandage covering the wound be always kept dry to prevent infection from developing. Standard precautions should also be implemented such as handwashing before and after providing wound care and wearing clean gloves during the dressing changes.</p> <ul style="list-style-type: none"> • Adequate nutrition for healing <p>The patient should be receiving a diet high in protein to aid in healing of the wound. This nutrition should be received enterally if patient is able to take food by mouth, if</p>	<p><u>*Respiratory Management:</u></p> <ul style="list-style-type: none"> • Mechanical ventilation care <p>The patient should be intubated and supported by mechanical ventilation due to RR elevation and pneumonia infection. Care should be taken to prevent complications from intubation. These interventions include elevating the HOB 30-45 degrees, routine oral care with chlorohexidine, and strict hand washing and wearing gloves while providing care.</p> <ul style="list-style-type: none"> • Adequate oxygenation support <p>Providing oxygen to maintain organ perfusion and allowing the lungs to heal from infection</p>
---	---

patient is intubated then a NG tube may need to be used to provide adequate nutrition.

- Good circulation and perfusion to tissues

The tissue around the wound should be receiving good blood circulation to aid in successful wound healing. Supporting good oxygenation will ensure the tissue surrounding the wound is well perfused as well. Pillows under the hips and knees should be limited or avoided altogether to ensure vessels are not being compressed and compromising circulation to and from the area.

***Comfort Management:**

- Maintain skin integrity

Patient will be on bedrest during her treatment and recovery period, and it is important to ensure good skin management is provided to the patient. The skin is already compromised with the stage III hip pressure ulcer the patient currently has. Strict turning of the patient every 1-2 hours will help to achieve this goal or using a waffle mattress to help reduce pressure on bony prominences. The patient can participate as well by shifting her weight to the best of her ability during each commercial break on tv or another simple reminder to alert patient to shift her weight.

- Good body alignment

The patient should have good body alignment while resting in bed, especially if patient is on a mechanical ventilator and not able to move herself. Her head should be elevated 30-40 degrees and her head midline. Her spine should be straight and her extremities resting in a comfortable position.

- Treat/Control pain if needed

If patient is experiencing any discomfort from her pressure ulcer or discomfort during respirations from infection, that should be addressed and treated to help aid in relaxation and healing. If the patient is nonverbal and unable to verbalize pain, other

are top priorities for this patient's care. Using settings that give the patient PEEP support will help keep the alveoli open during exhalation which is important with a pneumonia infection.

- Incentive Spirometer/TCDB

It will be important to educate the patient on using an incentive spirometer during her recovery process to keep her lungs open and well inflated. Prolonged bedrest and mechanical ventilation can place the patient at risk for atelectasis and complicate her recovery process. The patient should also be educated on preventing further infections such as avoiding crowded areas during peak community viral times such as the flu and good hand hygiene especially before eating meals.

<p>options to utilize would be assessing for grimacing, changes in vital signs, or FLACC scale.</p>	
---	--