Universal Competencies (Address all)	Required Areas of Care (Address all)
*Health Care Team Collaboration: The following are team members that can be included in Fannie Mae's care: -HCP (Rationale- manage patient care) -Primary care nurse (Rationale- provide direct patient care and carry out doctor's orders) -Respiratory therapist (Rationale- Can recommend and care for patient's oxygenation status, intubate if required, and help manage lung function) -Infectious disease doctor (Rationale- can help manage sepsis) -Dietician (Rationale- Can help plan nutritional needs for the patient since she is dehydrated and need to preserve organ function if MODS develops) -Pharmacy (Rationale- Ensures medications are available) -Wound care team (Rationale- To care for the stage III pressure ulcer) -Case manager (Rationale- Ensure patient is receiving the appropriate level of care and manage services and plans needed during and after hospital stay) *Human Caring: To help build a trusting relationship with the patient it is important to do the following: -Introduce myself and address the patient by name (Rationale- shows respect and can decrease patient anxiety and increase patient compliance) -Explain and teach about patient condition and procedures (ex. sepsis, pneumonia & wound care) (Rationale- can decrease patient anxiety and increase patient compliance) - Include Ms. Mae in her POC (Rationale: can decrease patient anxiety and increase patient compliance) -Speak in a respectful manner (Rationale – shows respect and can decrease patient anxiety and increase patient compliance) -Address and listen to all the patient's needs and concerns (Rationale- builds trust and	*Assessment & Evaluation of Vital Signs: -Blood pressure 80/48 (indicates low MAP of 59 and decreased perfusion to organs.) -Heart rate 121 (Compensating for low blood pressure) -Respirations 39 and labored on 4 liters per nasal cannula (Due to the pneumonia and sepsis and trying to compensate for the decreased oxygenation and perfusion) -Temperature 102.5 F (due to the infection) -There is not an oxygen saturation stated so I would have to apply a pulse ox. -Vital signs indicate that the patient is becoming at risk for MODS due to decreased perfusion. *Fluid Management Evaluation with Recommendations: The patient was started on D5 ½ NS at 100 mL/hr in the ED. From her first set of vital signs to the most current, her blood pressure has continued to decrease indicating decreased perfusion. Her lactate level also has reached a level of 4.0. I would recommend to the HCP to increase her fluid rate based off the 1-hour sepsis bundle (30 mL/kg of fluid for hypotension or lactate level of 4 or greater). It will help increase blood pressure, help decrease her heart rate, and improve cardiac output which will improve tissue perfusion. Then, we can treat the cause of her sepsis. *Type of Vascular Access with Recommendations: The patient has an 18-gauge intravenous to the right forearm with D5 ½ NS at 100 mL/hr. I would recommend to the HCP about having a PICC or central venous line placed to measure vascular resistance and perfusion effectiveness to ensure treatment is working

rapport)
-Address and implement behaviors that respect her ethical, cultural, religious, and personal beliefs (If unknown, I will ask) (Rationale- Builds trust and rapport)

*Standard Precautions:
-Wash hands entering and leaving the patient's room and PRN (before and after procedures) (Rationale – prevents transfer of microorganisms)
-Clean stethoscope, thermometer, pulse ox, skin and IV hub before medication administration, and other equipment used for patient care before use (Rationale – prevents transfer of microorganisms)
-Wear gloves during procedures (patient wound care to stage III pressure ulcer) and preparing medications (Rationale – prevents transfer of microorganisms)
-Initiate droplet precautions due to patient's pneumonia (Rationale – prevents transfer of microorganisms)

*Safety & Security:
-Identify patient with 2 identifiers and check allergies (Rationale: prevents providing the wrong care plan for the wrong patient and allergic reactions)
-Side rails up, bed is in low position, non-skid socks due to patient's right-sided weakness and paresthesia (Rationale- prevents falls)
-7 rights of medication administration (Rationale- prevents medication errors)
-Verify nursing interventions and medications against HCP orders (Rationale- prevents harm and medication errors)
-Ensure privacy during care (bed baths) (Rationale- prevents emotional harm)
-Do ongoing assessments (Rationale- Monitor for worsening conditions to prompt early intervention)
-Patient information remains confidential

and organs are being perfused. I would also recommend a PICC or central venous line so medications like norepinephrine, vasopressin, dopamine, and epinephrine can be administered if indicated.

*Type of Medications with Recommendations:
Treat the primary cause of sepsis and manage symptoms. Treat the sepsis and pneumonia depending on what type of infection it is (ex. bacterial or viral). Antibiotics like broad spectrum (levofloxacin, piperacillin/tazobactam, ceftriaxone, meropenem, cefepime) or narrow spectrum (vancomycin) can be given to treat the infection if it is bacteria related. Glucocorticoids like dexamethasone or prednisone can be given to treat inflammation caused by sepsis. Insulin may be needed temporarily for elevated blood glucose levels caused by the glucocorticoids. Anticoagulants can be given to help breakdown blood clots that are formed during the body's natural response of sepsis (inflammation). If fluid resuscitation is ineffective, norepinephrine can be given, and if that does not work, follow-up with vasopressin. Dopamine, and phenylephrine, and epinephrine can also be given to help correct fluid balance and hypotension.

*Oxygen Administration with Recommendations:
The patient is on 4L NC. Because the patient's respirations are 39, I would recommend a higher level of oxygen delivery to help decrease labored breathing and ensure adequate oxygenation. High flow O2, cpap/bipap, or possible mechanical ventilation can be used.

*Special Needs this Patient Might Have on Discharge:
Depending on the severity of damage from decreased perfusion, this patient may need supplementary oxygen (due to lung or even heart damage if it causes a decreased cardiac

(Rationale- prevents emotional harm and ensures trust and rapport)	output), dialysis (due to kidney damage), or even jejunostomy tube (due to GI damage).
Choose Two Priority Assessments and Provide a Rationale for Each Choice	
*Neurological Assessment: *Respiratory Assessment: I will do a respiratory assessment due to the patient's pneumonia, labored respirations with a rate of 39 on 4L NC, and a decreased MAP of 59 which indicates decreased organ perfusion. I need to ensure adequate oxygenation, so I can apply appropriate nursing interventions and assess for the need of mechanical ventilation to avoid further organ damage due to decreased oxygenation and perfusion. *Abdominal Assessment: *Cardiac Assessment: I will do a cardiac assessment based on the patient's history of a cerebrovascular accident, myocardial infarction, and peripheral vascular disease. It is also important I do this assessment because of her low blood pressure of 80/48, MAP of 59, and heart rate of 121. Due to the body's response of sepsis, excessive clotting can occur. It is important to check for pulses in her extremities to ensure pulses are present and not being blocked by a possible blood clot. *Skin Assessment:	
Nursing Management (Choose three areas to address)	
*Wound Management: I would address wound care due to her stage III right hip pressure ulcer. Because this can be a source for infection, it is important to keep the ulcer clean. It is also important to turn the patient if not contraindicated to help stop new	*Musculoskeletal Management: *Pain Management: *Respiratory Management: I would address the patient's respiratory status due to her labored respirations with a rate of 39 on 4 liters per NC. Due to her decreased blood

pressure ulcers from forming. I would teach the patient why the ulcer needs to be cleaned (to avoid infection) and explain the procedure of cleaning it. *Drain and Specimen Management: *Comfort Management: I would address the patient's comfort status to help reduce anxiety, increase patient compliance, and reduce pain if present. Providing comfort can help the patient rest so she can heal. I can make sure the patient is comfortable in bed, fever is not causing chills or other discomfort, turn the patient in bed if not contraindicated, talk to the patient especially if she seems anxious (to calm anxiety and avoid emotional harm), and remove unnecessary blankets or pillows. I would teach the patient the importance of comfort (allows healing by decreasing stress hormones that are triggered by discomfort).	pressure, it is important to give the patient adequate oxygenation to help perfusion. I could raise the HOB if not contraindicated and increase O2 per orders. I would teach the patient her respirations are so high due to the increased need of oxygen because her organs are not getting enough blood flow (low BP) so not enough oxygen is reaching the organs.