Universal Competencies (Address all)	Required Areas of Care (Address all)
*Health Care Team Collaboration: The nurse should notify the charge nurse of the patient's condition and diagnosis. The infectious disease doctor should be notified of the labs. Respiratory therapy should also be notified of any respiratory changes. As the nurse, it is crucial to monitor and communicate to other health care providers so that the patient can receive appropriate care. *Human Caring: Ms. Mae is very sick; it is important to make sure she feels both physical and emotional safety while under our care. The nurse will need to pay close attention to her body cues and listen to what she may voice regarding pain and other comfort needs. Doing little things like brushing her hair and making sure she is in a comfortable position can mean the world to someone who is stuck in the hospital sick. *Standard Precautions: Ms. Mae is diagnosed with sepsis; it is crucial for to prevent more infections from occurring. Anytime assessments are being done gloves must be worn. Medications should be prepared, scanned, verified, and administered with gloves. When doing dressing changes on her pressure ulcer, asepsis technique should be used to prevent worsening of wound. Allergies should be checked every time it's time for medications too. *Safety & Security: The patient has a very low blood pressure, so she is likely to be dizzy or nauseous meaning she is a fall risk. To prevent her from falling, fall precautions need to be initiated for her. Special colored gown, bed alarm, and 3 side rails need to be	*Assessment & Evaluation of Vital Signs: Assessments and vital signs on Ms. Mae should be done frequently to monitor for all changes. Her pressure ulcer should be assessed every shift for dressing changes and signs of worsening infection. Much of her vitals are out of normal range. She is febrile, hypotensive, and tachypneic while on supplemental oxygen. Right now, the biggest concern to me as her nurse is her respiratory status because she is struggling to oxygenate and her hypotension because it means her organs are not properly perfusing. *Fluid Management Evaluation with Recommendations: From report, Ms. Fae is dehydrated and septic. She has D5 ½ NS running from the ED. For her sepsis, I would recommend changing the D5 ½ NS to either LR or just regular NS because Ms. Fae is most likely hypovolemic due to her diagnosis. She needs to be fluid resuscitated, not only to fix the dehydration, but also help support her blood pressure. Dextrose quickly metabolizes to water and CO2, so when it goes into circulation, it is not active for very long. Septic patients need isotonic crystalloid solutions not hypertonic. *Type of Vascular Access with Recommendations: I recommend starting another large bore peripheral IV on her left arm and would consider the placement of a central venous line. The peripheral IV's would be used for fluid resuscitation and antibiotics. The central line would be useful for admin of vasopressor agents to support her blood pressure and for CVP monitoring. With an IV

raised before leaving her room. It is also important to educate the patient on calling for help when getting out of bed.

Choose Two Priority Assessments and Provide a Rationale for Each Choice

*Neurological Assessment:

*Respiratory Assessment: Ms. Fae is already experiencing labored breathing and tachypnea. She has a diagnosis of pneumonia too so it is crucial to listen to her lungs for wheezing, crackles, or obstructions so the RT and nurse can quickly intervene. We need to also inspect her breathing for any cyanosis or intercoastal retractions to assess the level of respiratory distress. This assessment should be done after every intervention to make sure they are working and to prevent other complications from occurring. This assessment is also important to determine if the patient has developed pulmonary edema or not from the large amounts of fluid she is receiving.

*Abdominal Assessment:

*Cardiac Assessment: A cardiac assessment is essential due to Ms. Mae's hypotension and tachycardia. Her MAP is 59, which means she is not perfusing her organs well at all. This assessment should be done continuously as well. We need to check her capillary refill and skin temperature to ensure her whole body is circulating correctly. Listening to her heart can also help determine if it is pumping effectively to perfuse and guide treatment regarding her hemodynamics.

*Skin Assessment:

access, the nurse needs to make sure they are patent and prevent infections.

*Type of Medications with Recommendations: Since her blood pressure is very low, I recommend giving her a vasopressor, like norepinephrine (Levophed), to support/increase her blood pressure which will also increase perfusion to her organs. For the sepsis, I would recommend starting a broad-spectrum antibiotic, like vancomycin (Zosyn) as well. Possibly giving some sort of electrolyte tablet to help with dehydration and some sort of topical ointment for the pressure ulcer. For pain, a type of IV opioid that does not compromise Ms. Mae's respiratory status too much or over sedate her.

*Oxygen Administration with Recommendations: Her respirations are not improving on NC @ 4L. First, I would switch her to a non-rebreather mask @10L and increase as needed until RT comes. Once RT comes, I would consult with them and the physician about switching her to mechanical vent.

*Special Needs this Patient Might Have on Discharge: Ms. Mae will most likely need physical and occupational therapy. Depending on how long she is hospitalized and septic, she may have issues after recovering from it. She resides in a nursing home, but after discharge she may need to go to a higher care facility. This can all be decided by the healthcare team, along with the case manager to determine the best option for her.

Nursing Management (Choose three areas to address)	
*Wound Management: Wound assessments need to be performed at least once every shift. She has a stage III pressure ulcer, so it involves full thickness skin and possibly subcutaneous tissue. It is crucial that this wound does not progress into infection. Dressing changes need to be done as well to make sure the area stays dry and clean. The nurse must also ensure that Ms. Mae is turned and on wedge pillows every hour to reduce pressure on the wound. *Drain and Specimen Management: *Comfort Management:	*Musculoskeletal Management: *Pain Management: It is essential that we monitor Ms. Mae's pain. Pain can have a direct effect on her vital signs, psychological/ emotional health, and recovery period as it adds stress to her body. Frequent pain assessments should be performed, and medications should be administered on time and as needed to promote comfort and prevent more complications. The physician should be consulted as well regarding what kind of medications should be administered depending on the level of pain and for what kind of pain experienced. *Respiratory Management: Since her respirations are out of normal range, and she is likely to be switched to a higher level of ventilation, it is important to educate her on what is going on. It is also important to tell her to remain calm and coach her breathing so we can get it controlled. Once she is stable enough on room air, I would encourage her to take deep breaths and use an incentive spirometer to prevent lung issues after recovery.