Alex Young
Fannie Mae 2/1/2023

<table>
<tr><th>Universal Competencies (Address all)</th><th>Required Areas of Care (Address all)</th></tr>
<tr><td>*Health Care Team Collaboration: Work with UAP's/telesitter hub/other nurses to keep an eye on your pt if you get busy in your other icu bed. Work with social services if SNFF placement is needed, and ofc work with pt's MD team and PCP for orders and treatment.
*Human Caring: Basic requirement of being a good nurse, pt mentation may be altered and may say or act silly or hostile. No judgement, treat the pt, and treat them with basic human respect.
*Standard Precautions: Pt is respiratory compromised. Basic protection of washing hands, hand washing teaching, masking, and aseptic technique should be followed for safety.
*Safety & Security: Frequent LOC checks for the pt in order to screen for appropriateness for restraints, sitter, seizure pads etc if LOC changes occur and pt becomes a confused fall risk.</td><td rowspan="3">*Assessment & Evaluation of Vital Signs: 4/4 SIRS results with HR of 121, RR of 39, 102.5 temp, and WBC of 17000. Interventions necessary, inform PCP of pt status.
*Fluid Management Evaluation with Recommendations: Recommend a fluid bolus for the pt due to hypotension and tachycardia, then reassess pt's volume status before resuming continuous fluids.
*Type of Vascular Access with Recommendations: Pt currently has an 18 gauge IV in their right forearm. Recommend ordering a PICC or Central line placed for this pt as continuous fluids and antibiotics can be expected. Possibly blood products.
*Type of Medications with Recommendations: Treat the cause. Antibiotic like ceftriaxone for infection, crystalloid IV medications for dehydration, glucocorticoids for inflammation, glucose control medications, electrolyte medications.
*Oxygen Administration with Recommendations: Continuous o2 to help perfusion, assess needs for high-flow or beyond device. Assess skin and Cardiac output frequently, assess for hypoxemia.
*Special Needs this Patient Might Have on Discharge: Long term antibiotic therapy, long term o2 therapy if ARDS occurs, fall risk/bleed risk from possible thrombocytopenia.</td></tr>
<tr><th>Choose Two Priority Assessments and Provide a Rationale for Each Choice</th></tr>
<tr><td>*Neurological Assessment: Priority for pt safety. Will allow the nurse to understand the pt's current LOC, confusion is a common symptom of sepsis. Understand how severe a fall risk and if there is need for a sitter. Enables the nurse to then assess LOC changes over the course of the shift.
*Respiratory Assessment: At severe risk for ARDS, and RR is very high. Possibly hypercapnic. Need RT on for ABG's. Lowered respiratory function, lowered perfusion functions.
*Abdominal Assessment:
*Cardiac Assessment:
*Skin Assessment:</td></tr>
<tr><th colspan="2">Nursing Management (Choose three areas to address)</th></tr>
<tr><td>*Wound Management: Document pressure</td><td>*Musculoskeletal Management:</td></tr>
</table>

Alex Young
Fannie Mae 2/1/2023

ulcer with pictures and measurements in the chart, rotate positioning to prevent further skin breakdown. Apply pressure injury bandage. *Drain and Specimen Management: *Comfort Management: Assess for pain and give medications. Position changes to help comfort, wound management, and pain management.	*Pain Management: *Respiratory Management: Keep the pt's HOB elevated, o2 on (assessing for skin breakdown), frequent o2 check and auscultation of lungs, observing for S&S of ARDS.