Universal Competencies (Address all)	Required Areas of Care (Address all)

***Health Care Team Collaboration:** Some of the health care team members that would be included in this case would be the ED nurses who assessed the patient first and are giving report to the MICU nurses, MICU nurses who will be caring for the patient each day, infectious disease doctor who will be caring for the patient due to the pneumonia and sepsis diagnosis, the intensivist who will see the patient due to the patient being in the MICU, respiratory therapists due to the patient's increased respiratory rate and labored breathing, as well as the pneumonia diagnosis, social workers to ensure the patient is taken care of and has arrangements for when the patient is ready to be discharged, and pastoral care for spiritual support if indicated/requested by the patient. ***Human Caring:** Ensuring that the patient is aware of procedures that will be performed, medications that are being administered, and different health care members that will be involved in her plan of care will allow the patient to be involved in her care plan and encourage her to make decisions regarding her care while being admitted. The nurse should listen to the patient's wishes, provide true and honest information regarding her care, and provide her with different resources throughout the time she is admitted. The nurse should also show empathy towards the patient as this could be a very difficult and scary time for her, and her family. ***Standard Precautions:** Standard precautions for this patient include hand hygiene, droplet isolation precautions due to the pneumonia diagnosis, keeping wounds clean and dressed properly to prevent further infections and worsening sepsis, and limiting the number of visitors that come in and out of the room to keep harmful agents at a minimum. I would perform thorough foley care to prevent	*Assessment & Evaluation of Vital Signs: My assessment of the vital signs shows that the patients respiratory rate is increasing, heart rate is increasing, blood pressure is decreasing, and the patient's temperature is increasing. These vital signs are key components of infection/sepsis. The cardiovascular system is experiencing vasodilation and the pulmonary system is showing signs of hypoxemia and hypoperfusion of other organs due to decrease oxygen in the alveoli (increased respiratory rate and labored breathing). The increasing fever is a key sign of infection/sepsis, also shown with the increase of WBCs shown in the lab results. *Fluid Management Evaluation with Recommendations: The patient currently has an 18 gauge IV to the right forearm with D5 1/2 NS at 100 mL/hr. Because the patient is experiencing dehydration and a sepsis infection, I would recommend an isotonic crystalloid solution because this solution does not cause a fluid shift, and it promotes vascular expansion and electrolyte replacement. Fluid resuscitation is indicated for this patient because she is experiencing inadequate tissue perfusion and her current MAP is 59, which is less than the acceptable MAP (>65), as well as her lactic acid levels are very elevated. Electrolyte replacement is also extremely important due to the dehydration that this patient is experiencing. I would monitor strict I&Os for this patient. *Type of Vascular Access with Recommendations: I would recommend that this patient have central venous access due to the need to administer vasoactive agents and multiple medications at a time. I would recommend this to ensure we have central access to this patient to administer the medications she

further infection and risk for worsening sepsis. I would also monitor the patient's IV sites for redness or drainage that may occur. *__**Safety and Security**__ To ensure the patient's safety, I would be sure to obtain a complete and through health history, including and allergies the patient may have, and current medications the patient is on. I would also document in the patient's chart that she is a full code. I would document any changes that occur with the patient, and report any alarming results or changes in the patient's status to the attending physician immediately. I would also obtain the information regarding who will make decisions for the patient in the event that she cannot make decisions for herself. I would do thorough neuro checks on the patient as well to ensure she is still able to make decisions for herself, and is fully comprehending everything that is being provided in her plan of care.	needs to treat the sepsis and in case of emergencies that may arise. *Type of Medications with Recommendations: I would recommend that the patient be given norepinephrine at 2-5 mcg/min and titrate up. I would recommend this medication because it is a first line pressor for sepsis and cardiogenic shock. It increases SVR and blood pressure and protects blood flow to the organs. It also increases CO. I would also recommend the use of vasopressin in this patient, as it is often used in adjunct to norepinephrine. I would use this medication in a dose of 0.01-0.04 units/min. This medication also increases SVR and blood pressure and increases volume, as well as H20 reabsorption in the kidneys, which in turn increases blood pressure. *Oxygen Administration with Recommendations:

Choose Two Priority Assessments and Provide a Rationale for Each Choice	I would recommend that this patient be on oxygen to maintain adequate O2 levels and promote adequate respiratory rates and regular respirations to promote adequate perfusion of the lungs and other organs. I would recommend that this patient be on a high flow nasal cannula or non-rebreather mask depending on the patient's current condition and respiratory assessment. *Special Needs this Patient Might Have on Discharge: Special needs this patient might have upon discharge may include rehabilitation depending on the patient's physical status, the requirement of oxygen delivery following discharge, and follow-up appointments with the patient's PCP and specialists that may be involved throughout her care provided in the MICU. The patient may also require being admitted to a different skilled nursing facility depending on what her recovery consists. The patient will also most likely require emotional support to achieve a full recovery, even outside of the hospital.
*Neurological Assessment: *Respiratory Assessment: I would prioritize Fannie Mae's respiratory assessment because her current respiratory rate is 39 and labored. She is also currently at 4 liters nasal cannula. Increased respirations above 20 per minute, are a key signs of sepsis. Labored breathing can indicate sepsis due to a decrease PaCO2 level. I would prioritize her respiratory assessment because airway and breathing are always the main priority assessments. Because this patient is experiencing an increase in respiratory rate and labored breathing, I would want to make sure she is getting adequate oxygen and intervene as needed. If the patient is not receiving adequate oxygen to the alveoli, hypoperfusion to the other organs can occur, therefore increasing the lactate levels (which we currently see in her labs). I would also review this patient's ABGs. *Abdominal Assessment: *Cardiac Assessment: I would also prioritize a cardiac assessment due to her decreasing blood pressure and increasing heart rate. When the patient arrived to the MICU, her MAP was 59. This indicated that there is a perfusion issue. This cardiac assessment furthermore indicates sepsis in that the patient is experiencing vasodilation causing hypotension and a low MAP. I would prioritize the cardiac assessment, so that I could assess what is causing the decreased blood pressure and increased respiratory rate, and intervene to prevent/stop myocardial depression and stop the vasodilation occurring. The patient also has a history of an MI, which I would take into consideration. *Skin Assessment:	

Nursing Management (Choose three areas to address)	
*Wound Management: *Drain and Specimen Management: *Comfort Management:	*Musculoskeletal Management: The patient's musculoskeletal system should be managed by provided ROM and PROM as tolerated by the patient. Providing these exercises will decrease the risk of muscle tone loss and decrease the risk of loss of function. *Pain Management: Pain management should be provided routinely as ordered in order for the patient to be comfortable and reduce the risk of increasing problems due to pain. Increasing respirations and heart rate often occur due to an increase in pain. These increases could furthermore affect the respiratory and cardiac systems, resulting in advancing issues. *Respiratory Management: Respiratory management is important for the nurse to care for due to the risk for inadequate oxygen consumption and therefore inadequate tissue perfusion. The nurse should perform frequent respiratory assessments, continuous pulse oximetry monitoring, and oxygen therapy as indicated.