

Fannie Mae Patient Care Scenario

You are the nurse working in the medical intensive care unit (MICU) and you take the following report at 0500 from the emergency department (ED) nurse: We have a patient for you; Fannie Mae is an 81-year-old frail woman who has come to us from a nursing home at 0200. Her primary admitting diagnoses are sepsis, pneumonia, and dehydration, and she has a known stage III right hip pressure ulcer. Her past medical history includes cerebrovascular accident with residual right-sided weakness and paresthesia, a myocardial infarction, and peripheral vascular disease. She is a full code. Her vital signs on arrival were: blood pressure 98/62, heart rate 88 bpm and regular, respirations 38 and labored, and a temperature of 100.4 F (38 C). She is on oxygen at 4 liters per nasal cannula, she has an 18-gauge intravenous to the right forearm with D5 ½ NS at 100 mL/hr. We just inserted a 16 French Foley catheter. Her current vital signs are: blood pressure 91/59, heart rate 92, respirations 38, and temperature of 101.2 F. There are no home medications listed, the infectious disease doctor has been notified, and the respiratory therapist is with the patient. The patient is just leaving the ED and should arrive shortly.

0700 Fannie Mae arrives to MICU. You connect her to the cardiac monitor and her vital signs are: blood pressure 80/48, heart rate 121, respirations 39 and labored on 4 liters per nasal cannula and temperature 102.5 F. Lab results are as follows:

Lab:	Nursing Home:	ED:	MICU
WBC	13	15	17
HGB	10	10.1	9.0
HCT	38	40	42
RBC	4	3.9	3.0
PT	12	13	15
INR	1.8	1.9	2.5
Lactic Acid	2.1	3.8	4.0

Universal Competencies (Address all)	Required Areas of Care (Address all)
<p><u>*Health Care Team Collaboration:</u></p> <p>Case management Primary Nurse UAP RT Physician</p> <p><u>*Human Caring:</u></p> <p>Provide patient with emotional support, make sure everything that is being done to the patient is explained as this can be scary and may cause anxiety</p> <p><u>*Standard Precautions:</u></p> <p>Hand hygiene, gloves, PPE, recommendation of masks, limit visitors</p> <p><u>*Safety & Security:</u></p> <p>Bed alarms 3 rails up Bed in the lowest position Call light with in reach Personal items with in reach Assess the need for toileting Pain management</p>	<p><u>*Assessment & Evaluation of Vital Signs:</u> HR: 121 RR: 39 and labored on 4L NC BP: 80/48 Temp: 102 F</p> <p><u>*Fluid Management Evaluation with Recommendations:</u></p> <p>Patient is dehydrated, my recommendation to assist with this would be to use the Fluid Resuscitation using the formula 30ml/kg/Hr</p> <p>This may also help with the patient's blood pressure</p> <p><u>*Type of Vascular Access with Recommendations:</u></p> <p>Needs a second line inserted or possibly a PICC line</p> <p><u>*Type of Medications with Recommendations:</u></p> <p>If patient is not responsive to fluid resuscitation, meaning hemodynamic stabilization has not been obtained, a vasopressor such as Norepinephrine should be considered.</p>
<p>Choose Two Priority Assessments and Provide a Rationale for Each Choice</p>	<p>Patient has a temp of 102, an antipyretic such as acetaminophen is my recommendation to assist with this</p>
<p><u>*Neurological Assessment:</u></p> <p>This should be obtained in order to get a baseline, as sepsis progresses patient may experience AMS</p> <p><u>*Respiratory Assessment:</u></p> <p>Patients RR is 39 and labored even on 4L NC, (Unsure of O2 since it was not provided, or go ahead and obtain this information)</p> <p><u>*Abdominal Assessment:</u></p> <p><u>*Cardiac Assessment:</u></p> <p>Patient is tachycardic and hypotensive, also has a history of MI</p>	<p>Patient should be placed on a broad-spectrum antibiotic until culture results are received to start treating the sepsis</p> <p><u>*Oxygen Administration with Recommendations:</u></p> <p>Patient is currently on 4L non rebreather, I feel as though ABG's should be obtained as well as she should be placed on a non rebreather at 10L and assess response</p> <p><u>*Special Needs this Patient Might Have on</u></p>

<p><u>*Skin Assessment:</u></p> <p>Patient has a stage 3 ulcer to the right hip. This needs to be monitored to prevent further progression and infection</p>	<p><u>Discharge:</u></p> <p>Home health services especially since patient has an extensive history and has a stage 3 pressure ulcer</p>
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Nursing Management (Choose three areas to address)

<p><u>*Wound Management:</u> Irrigation Monitor and prevent infection Maintain clean and dry dressing</p> <p><u>*Drain and Specimen Management:</u></p> <p><u>*Comfort Management:</u> Pain assessment Keep weight off of pressure ulcer Facilitate breathing</p>	<p><u>*Musculoskeletal Management:</u></p> <p><u>*Pain Management:</u></p> <p><u>*Respiratory Management:</u> Collaborate with RT, If patient is unresponsive to nonrebreather and progresses intubation should be considered to help the patient to breath while they heal and also promotes rest</p>
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