Universal Competencies (Address all)

*Health Care Team Collaboration:

- Collaborate with wound care nurse.
- Coordinate lab results with charge nurse and HCP especially RBC and Hgb because of the low values the pt might need blood transfusion.
- INR is high pt might have clotting problems. Tell UAPs that pt is at risk for bleeding out.

*Human Caring:

- Ask if patient need spiritual help.
- Ask if patient has as a family member she wants to call.
- Ask patient if she wants warm blanket or watch the television to be comfortable.

*Standard Precautions:

- Introducing self to the patient when entering the room.
- Hand hygiene before taking care or assisting the patient.
- Don gloves when providing care.

*Safety & Security:

- Ask two patient identifiers and do 3 checks (armband, pyxis, and computer in the room)
- Verify allergies.
- 4 Ps (pain, potty, position, and positions).
- Bed alarm, bed low and 2 side rails raised because pt might bleed out if she falls.
- 6 Medication rights before giving meds.

Choose Two Priority Assessments and Provide a Rationale: for Each Choice

*Respiratory Assessment: Pt had labored breathing and a respiration that is higher than normal. The nurse must auscultate lungs and monitor respirations for this is a clue that tells how much effort a patient puts into breathing.

*Cardiac Assessment: Pt is hypotensive and tachycardic. These symptoms can be seen in patients with septic shock. The nurse must assess the heart because it is responsible for good perfusion. By assessing the heart the nurse could coordinate with HCP and find out what medications to give to help the heart.

Required Areas of Care (Address all)

*Assessment & Evaluation of Vital Signs: Her blood pressure is low at 91/59. Her respirations at 38 and temperature of 101.2 are abnormally high. It became worse when patient was moved to MICU. BP went down to 80/48. HR 121, Respirations 39 and labored despite being in 4L NC and temp remains high at 102.5.

*Fluid Management Evaluation with Recommendations: The pt was started on 100 mL/hr of D5 ½ NS. That is not enough fluid resuscitation. Pt should be bolused with 450 mL of NS instead of the D5 ½ NS to help increase that BP quickly.

*Type of Vascular Access with Recommendations: 2 Large bore IVs must be inserted, and 18 gauge is good. This is the site for giving a bolus of NS.

*Type of Medications with Recommendations: Pt must be given antibiotic after the bacteria is cultured to help with sepsis. It is also good to bring up blood transfusion because the Hgb and Hct is low. Medicate pt with pain medication as ordered by HCP because of that ulcer.

*Oxygen Administration with Recommendations: Since, pt is still having labored breathing on 4L of NC, a non-rebreather might be a better option.

*Special Needs this Patient Might Have on Discharge: Educate caregivers on how to clean the wound on the right hip and how to put a dressing on it. Make sure to turn pt every 2 hrs and assist pt when ambulating to the bathroom or just at home to avoid falls. Give family and caregiver support.

Nursing Management (Choose three areas to address)

*Wound Management: The presence of stage III right hip ulcer must be managed to avoid it from getting worse that is why wound care nurse and RN must collaborate.

*Comfort Management: Pt is in pain from the pressure ulcer give pain medication as ordered. Assure pt of presence because she is old and

*Respiratory Management: When the pt arrived, she had labored breathing. If oxygen saturation is maintained using nasal cannula keep using it, however if it doesn't help non-rebreather mask might be used to maintain that oxygen supply. The RN should always communicate with the charge nurse and HCP.