

Patient Preparation Worksheet

Time	Meds/Care Priorities	Labs/Glucose
ACHS		Blood Glucose
Q4	Vital Signs	
4/4	CT abd / pelvis w/ contrast	
4/4	CT head w/o contrast	
4/4	4kg, CXR	
4/6	Uho	
4/6	Swallow evaluation	
4/6	Stress Test	

Initials: _____ Room #: 3 Adm. Date 4/5 Post op day# 10-ago

Diagnosis: NSTEMI; Sepsis

Current problem: AMS & generalized weakness

Patient Story: MR. C is a 78y/o male presenting as a transfer with sepsis. Pt has UTI, treated w/ Rocephin prior to arrival. also has concerns for gastric ischemia on CT Scan. A&O x1, but able to move all 4 extremities w/o evidence of focal nerve deficit signifying stroke. 4kg demonstrates a ventricular paced rhythm w/o evidence of starvation, ischemia, or arrhythmia. Troponin elevated at 195. Lactic acid is descending, 3.4 down to 2.0

Allergies: Codonyl, Gabapentin, Simvastatin

PRIORITY Body System to Assess: Cardiac, Respiratory, Neuro

	CV	Resp	Neuro	GI	GU	Skin	VS/Pain	Other
Prior Nursing Assessment	-Chronic a-fib w/ paced rhythm & Rate -CHF - EF 40% -HTN	-Cough/SOB -Rhinchi present	□ A&O x1 -oriented	-Nausea/Vomiting -Abd distention -Hypoactive Bowel sounds	-urinary Retention -UTI	□ WNL	Temp: 98.4°F HR: 72 RR: 27 B/P: 167/92 SpO2: 94%	
Current Nursing Assessment	-Irregular Rhythm (a-fib noted) -Pacemaker -Edema noted on lower extremities -HTN	-Crackles noted bilaterally	□ WNL -A&O x4 -pupils equal round, reactive to light	□ WNL except: -Abd distention	-UTI -Urinary Retention -Possible BPH	□ WNL -Skin warm & dry	Temp: 97.1°F HR: 76 RR: 18 B/P: 137/76 SpO2: 97%	□ NMI - 28.53

Abnormal Relevant Lab Tests	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
WBC (Ref 4.1-11.1)	13.05 ↑	WBC was 33.5 k/wb on admission ~ infection still present
RBC (Ref 4.40-6.0)	4.12 ↓	RBC was normal on admission ~ ↓ O ₂ carrying abilities
H&H (Ref 13.7-17.5; 40.0-52.4%)	8.6 ↓ / 25.6% ↓	H&H were low on admission, & have further decreased
Metabolic Panel Labs		
Lactic acid	2.0 ↑	Lactic acid was 3.4 on admission ~ indicates hypoperfusion
albumin (Ref 3.4-5.0g/dl)	2.3g/dl ↓	albumin was 2.2 on admission
ALT/AST (Ref 10-41; 10-43 u/L)	88 ↑ / 44 ↑	ALT/AST normal on admission
Misc. Labs		
Troponin I (Ref <45ng/L)	3,954 ng/L ↑	indicates cardiac damage
Lab TRENDS Concerning to Nurse?		
RBC trending ↓; H&H trending ↓; albumin trending ↓; ALT/AST - normal on admission, now trending ↑		

Code Status full
 O2 therapy RA - CPAP to sleep
 IV site Peripheral - R - 20g; L - 20g
 IV Maintenance N/A
 IV Drips N/A
 Tubes Foley - 10fr
 Activity as tolerated
 Fall Risk/Safety fall risk
 Diet Soft / bite size & Thin liquids
 Last BM 4/13
 Intake: Last 24 HR - 710ml
 Output: Last 24 HR - 1675ml
 Therapies: RT/OT/PT SLP
 Dressings Tegaderm on peripheral sites

Notes:
 ☐ CF 40% on who

Pharmacology

List each medication you will administer this shift and the PRNs in the last 24 hours.

Medications	Pharm. Class	Mechanism of Action In OWN WORDS	Common Side Effects	Assessments/nursing responsibilities
Aspirin chewable PO - 81mg Q24HR	Platelet aggregation Inhibitors → Salicylates	used to treat pain, reduce fever & inflammation used to treat/prevent angina/MI/stroke	upset stomach heart burn drowsiness easy bleeding/bruising	assess skin for bruising assess for black, tarry stools / vomit like coffee grounds assess for use of other blood thinning medications
Duloxetine DR 20mg PO - Q24HR	SNRIs	works by ↑ the amount of serotonin & norepinephrine help stop the movement of pain signals to brain	nausea constipation insomnia diaphoresis fatigue	train sis of serotonin syndrome may cause weight fluctuation teach to not stop abruptly
Finasteride 5mg PO - Q24HR	5-alpha reductase Inhibitors	used to treat BPH	rash/iters dizziness depression	can cause: - NAFLD - insulin resistance - kidney dysfunction - men/women - baldness
Promethazine 12.5mg IV - Q6H PRN	1st gen. H1 antagonist	antihistamine & antiemetic	sedation confusion dysorientation	do not take with MAOIs monitor cardiac rhythm may cause seizures
Insulin glargine 20units SQ - Q24HR	long acting Insulin	used to control hyperglycemia	hypotension blurred vision chest tightness	check glucose levels prior to administration monitor for sis of hypoglycemia
Insulin lispro 0-units SQ - Q6HR PRN	Rapid acting Insulin	used to control hyperglycemia	hypotension blurred vision chest tightness	check glucose levels prior to administration monitor for sis of hypoglycemia

Pathophysiology

Interpreting clinical data collected, what is the primary/current medical problem? State the pathophysiology of this problem in your own words.

Medical Problem	Pathophysiology of Medical Problem
Sepsis	Sepsis is the body's response to an infection that has moved from the original starting point (UTI) & spread through the blood stream to all parts of the body

Problem Recognition

To prevent a complication based on the primary medical problem, answer each question in the table below.

Question	Most Likely	Worst Possible
Identify the most likely and worst possible complications.	<input checked="" type="checkbox"/> ↑ glucose <input type="checkbox"/> urinary retention (Pt BPH)	<input type="checkbox"/> septic shock <input type="checkbox"/> DIC <input type="checkbox"/> meds
What interventions can prevent them from developing?	<input type="checkbox"/> scheduled insulin drip <input type="checkbox"/> surgical treatment of BPH	<input type="checkbox"/> monitor vs. labs ABGs, I & O, daily weight <input type="checkbox"/> ↑ O ₂ supply, ↓ demand <input type="checkbox"/> nutrition & glycemic control
What clinical data/assessments are needed to identify them early?	<input type="checkbox"/> A&S glucose <input type="checkbox"/> bladder scan; I & O	<input type="checkbox"/> assessments: neuro, cardiac, resp <input type="checkbox"/> clinical data: ↑ lactate, ↓ pO ₂ , ↑/↓ WBC, ↓ platelets, ↑ PTT, ↑ D-dimer
What nursing interventions will the nurse implement if the anticipated complication develops?	<input type="checkbox"/> blood glucose monitoring <input type="checkbox"/> straight cath, Foley	<input type="checkbox"/> prevent/treat infection <input type="checkbox"/> maintain tissue oxygenation <input type="checkbox"/> hemodynamic monitoring <input type="checkbox"/> ambulation/passive ROM <input type="checkbox"/> monitor labs <input type="checkbox"/> CROSBY <input type="checkbox"/> oral care

Putting it All Together to Provide Safe Patient Care

1. Which findings have you collected that are most important and need to be noticed as clinically significant?

Most Important Assessment Findings	Clinical Significance
<input type="checkbox"/> neuro Δ's <input type="checkbox"/> WBC ↑ (33) <input type="checkbox"/> lactic acid ↑ <input type="checkbox"/> ↓ W/O	<input type="checkbox"/> indicates neuro dysfunction <input type="checkbox"/> indicates major infection <input type="checkbox"/> indicates tissue hypoperfusion <input type="checkbox"/> indicates renal damage, fluid retention

Medical Management of Care

2. Identify the rationale for each provider order and its expected outcome.

Provider Order	Rationale	Expected Outcome
<input type="checkbox"/> SLP eval/treat <input type="checkbox"/> CBC w/ differential <input type="checkbox"/> continuous telemetry <input type="checkbox"/> Sepsis parameters	<input type="checkbox"/> aspiration PNA after vomiting <input type="checkbox"/> to monitor treatment of infection <input type="checkbox"/> to monitor cardiac dysrhythmia	<input type="checkbox"/> Pt will not be aspiration risk <input type="checkbox"/> WBC will continue to ↓ <input type="checkbox"/> cardiac dysrhythmia will stay under control

Nursing Management of Care

3. After interpreting clinical data collected, identify the nursing priority goal for your shift and three priority interventions specific for your patient. For each intervention write the rationale and expected outcome.

Nursing Priority	Maintain perfusion	
Goal/Outcome	Organs will maintain adequate oxygenation	
Priority Intervention(s)	Rationale	Expected Outcome
1. monitor indications for fluid resuscitation 2. monitor I&O & daily weight 3. monitor labs	1. if BP begins to ↓ we could see progression to septic shock 2. assess organ function 3. assessment of organ function	1. BP will stay in normal range, skin warm, cap refill 2-3s 2. I&O will be adequate 3. lab values will continue to improve

4. What interventions/nursing responsibilities could be delegated?

Nursing Tasks/Interventions	Appropriate Delegation to Whom?	Rationale for Delegation
<ul style="list-style-type: none"> □ Bathing / Hygiene / linen changes □ Positioning □ I & O □ ADL's □ Reinforces teaching (not initial!) 	<ul style="list-style-type: none"> □ UAP □ UAP □ UAP □ UAP □ UAP □ LVN 	<ul style="list-style-type: none"> □ Time management skill to ensure pts. are safely cared for

5. To provide compassionate holistic care for this patient, answer the following questions.

What is the patient likely experiencing/feeling right now in this situation?	fear, panic, anxiety
What can you do to engage yourself with this patient's experience, and show that they matter to you as a person?	treat patient with respect & empathy.

6. Identify the psychosocial/holistic care priority specifically for your patient based on the findings you noticed as most important. List appropriate interventions, rationale, and expected outcomes.

Psychosocial/Holistic Care Priority	Optimal Comfort & Wellbeing	
Priority Intervention(s)	Rationale	Expected Outcome
<ul style="list-style-type: none"> □ Oral Care □ TCNB □ Bathing / Hygiene 	<ul style="list-style-type: none"> □ Oral care is necessary to maintain oral hygiene □ TCNB will help break up secretions & also help offload pressure to skin □ Personal hygiene will help keep the pt. clean & will also help them feel better 	<ul style="list-style-type: none"> □ Mucous membranes will be moist, intact & clean □ Lungs will be clear & pt. will have skin intact □ Pt. will feel more comfortable

EDUCATION PRIORITIES/DISCHARGE PLANNING

7. Identify three priority educational topics that need to be included in a teaching plan to prevent complications and prepare this patient for discharge.

Teaching About Illness Care	Rationale	How are you going to teach?
1. Lab values/meanings	1. Teach pt & family so they can help prevent recurrence	1. Routine labwork; monitor BP at home; teach sig of infection
2. Medications	2. What they're for & their side effects	2. Safe use of meds, what to report, what to avoid
3. Maintain a normal BMI/diet	3. To help control HTN	3. Teach exercises that are within pt. capabilities, give resources

EVALUATION

8. After implementing the plan of care, interpret clinical data at the end of your shift to determine if your patient's condition has improved, has not changed, or has declined. (NCSBN: Step 6 Evaluate outcomes)

Most Important Data	Improved	No Change	Declined
↓ LUC	✓		
↑ WBC	✓		
↑ Troponin		✓	
↓ RBC			✓
↓ UB	✓		
↓ albumin			✓
↑ Lactate	✓		

9. Has the patient's *overall* status improved, declined, or remained unchanged during your shift? If the patient has not improved, what other interventions must be considered by the nurse? (NCSBN: Step 6 Evaluate outcomes)

Overall Status	Additional Interventions to Implement	Expected Outcome
Improved-stable	<ul style="list-style-type: none"> □ continue antibiotic therapy □ continue to monitor Labs & treat as needed □ continue care plans 	<ul style="list-style-type: none"> □ WBCs will continue to ↓ □ Lab values will move towards normal

END OF SHIFT: Professional Communication-SBAR to Primary NURSE

Situation
<ul style="list-style-type: none"> • Name/age MR. C - 78 y/o male presenting as a transfer w/ sepsis • Brief summary of primary problem Pt. has UTI, treated w/ Rocephin prior to arrival, AMS • Day of admission/post-op #
Background
<ul style="list-style-type: none"> • Primary problem/diagnosis UROSEPSIS, possible aspiration pneumonia, NSTUMI • Most important past medical history Chronic a-fib, Pacemaker, HTN, AAA, DM, BPH • Most important background data WBC Count 33, Lactic acid 3.4 down to 2.0, Troponin 195
Assessment
<p>Most important clinical data:</p> <ul style="list-style-type: none"> • Vital signs • Assessment • Diagnostics/lab values - ↑ WBC - 13.05; ↓ RBC, ↓ H&H <p>Trend of most important clinical data (stable-increasing/decreasing)</p> <ul style="list-style-type: none"> • How have you advanced the plan of care? • Patient response • Current status (stable/unstable/worsening) Stable
Recommendation
<ul style="list-style-type: none"> • Suggestions to advance plan of care

POST-CLINICAL REFLECTION

To strengthen your clinical judgment skills, reflect on your knowledge and the decisions made caring for this patient by answering the reflection questions below.

Reflection Question	Nurse Reflection
What feelings did you experience in clinical? Why?	
What did you already know and do well as you provided patient care?	
What areas do you need to develop/improve?	
What did you learn today?	
How will you apply what was learned to improve patient care?	