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

FANNIE MAE SCENARIO

Student Name:

Based on the scenario given, use the rubric and this form to complete how/what you would do for each item listed.

CSON Clinical Judgement Model

NCSBN Clinical Judgement	Application of CJM
1. **Recognize Cues** (assessment) – The filtering of information from different sources (i.e., signs, symptoms, health history, environment). **What matters most?**	
2. **Analyze Cues** (analysis) – The linking of recognized cues to the client's clinical presentation and establishing probable client needs, concerns, and problems. **What does it mean?**	
3. **Prioritize Hypotheses** (analysis) – Establishing priorities of care based on the client's health problems (i.e., environmental factors, risk assessment, urgency, signs/symptoms, diagnostic tests, lab values). **Where do I start?**	
4. **Generate Solutions** (planning) – Identifying expected outcomes and related nursing interventions to ensure a client's needs are met. **What can I do?**	
5. **Take Actions** (implementation) – to implement appropriate interventions based on nursing knowledge, priorities of care, and planned outcomes to promote, maintain, or restore a client's health. **What will I do?**	
6. **Evaluate Outcomes** (evaluation) – To evaluate a client's response to nursing interventions and reach a nursing judgment regarding the extent to which outcomes have been met. **Did it help?**	