

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

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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

<ol style="list-style-type: none">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?	<p>Most important is tissue perfusion. Due to her cardiac history and skin breakdown, she already has had incidence of cardiac deficit and infection opportunity. Her extreme age puts her at a higher risk of septicemia and MODS. As Fannie has progressed through the admission, her condition indicates decline. Pt is hypotensive, tachycardic, tachypneic and labored, febrile, and already on oxygen supplementation with no resolve. All signs point to worsening inflammatory response and septicemia. She has no home meds listed at this time. Her immune response is inhibited due to advanced aging. Concerns for added risk of infection with foley catheter. Neuro, cardiac, respiratory, GSC baselines needed to trend patient progress/deficit. Ensure to infuse fluids and watch for hypovolemia or signs and symptoms of DIC is priority to help blood pressure, MAP, HR, RR achieve better baselines. Assess respiratory status clearly to recognize how intervention is affecting current status as pt has labored breathing. Gaining blood cultures and providing broad spectrum antibiotics to patient as soon as possible can help reduce chances of bacterial infection spreading further than if not obtained or instituted. Providing pt with nutritional therapy with close glucose monitoring can support healing of pt condition as indicated. Wound care is indicated for pressure ulcer healing. Goals for the patient include adequate perfusion to all tissues better than at arrival, vital signs to return WNLs, and pt to be afebrile. We would like pt to be able to manage oral antibiotics as needed to continue healing at home and discharge from hospital care. I would like to see pt pressure ulcer decrease in size and to teach pt about how to rotate positions and why this ulcer may have happened. Creating a low stimulation environment for pt is priority to facilitate healing environment. Making sure the head of the bed is raised to low Fowler's position to encourage tissue perfusion without added energy demand. Assessing capillary refill can indicate how much perfusion is happening with peripheral extremities. Evaluation comes with continued monitoring of labs, VS, wound care, and patient affect and response. As the patient is cared for, her WBCs should return to normal range, afebrile presentation, LOC appropriate, HR, RR, BP return to normal ranges. As care progresses, pt will demonstrate independence closer to when she was not septic and altered in immune response. The interventions can help, it all depends on patient progress as care is provided.</p>
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