Medications

Amiodarone hydrochloride (benzofuran derivative/antiarrhythmics) tablet 200 mg p.o/daily. Patient is taking it for A. fib. Key nursing assessment prior to: check patient's implantable cardiac device if present at the start of and during therapy. Because drug may affect pacing or defibrillating thresholds.

Atorvastatin Lipitor (HMG-CoA reductase inhibitor/ antihyperlipidemic) tablet 40 mg p.o/ daily. Patient is taking it to reduce risk of acute cardiovascular events. Key nursing assessment prior to: Perform liver function tests before and thereafter therapy.

Furosemide Lasix (Loop diuretic) tablets 40 mg p.o/ daily. Patient is taking it to reduce edema as he has congestive heart failure. Key nursing: obtain pt's weight before and periodically.

Vancomycin Vancocin (Antibiotic) 540ml IVPB/ daily. Patient is taking it for UTI. Key nursing: monitor for serum level in blood.

Lab Values/Diagnostics

Cal 8.7 <

AST 146>

ALT 61 >

PT 41.4 >

INR 4.3>

RBC 3.58<

Hgb 11.0<

HCT 34.9<

Urine culture: Escherichia Coli ESBL

Blood culture: Staphylococcus methicillin resistant

CT scan of head: negative

Demographic Data

Date of Admission: 09/12/21
Admission Diagnosis/Chief Complaint: septic shock UTI
Age: 67
Gender: Male
Race/Ethnicity: White Caucasian
Allergies: no known allergies
Code Status: full
Height in cm: 1.3 m
Weight in kg: 123 Kg
Psychosocial Developmental Stage: normal
Cognitive Developmental Stage: normal
Braden Score: 12
Morse Fall Score: 55
Infection Control Precautions: contact isolation

Admission History

On 9/12/21 a 67 y/o white, divorced male was brought to the ER department of Carle from nursing home with alteration of mental status 2 days earlier. The confusion in his head has been going on for days, characterized by inattention, agitation, and pt became unresponsive. Pt was intubated in the ICU then admitted to cardiology department. Pt is on O2 2L nasal canula and has been given Lasix and Vancomycin. Pt is on cardiac diet. A urine sample was collected for analysis and a CT scan of head was done. Pt is alert and oriented x4.

Medical History

Previous Medical History: CHF, SLEEP APNEA, ASTHMA, TOTAL O2 DEPENDENT, A. FIB, URINARY RETENTION, DIABETES MELLITUS, OBESETY, CAD, HYPERLIPIDEMIA.

Prior Hospitalizations: 7/9/21 CHF, ISCHEMIC CARDIOMYOPATHY, 3/6/21 GI HEMMORHAGE

Previous Surgical History: removal of gallbladder, retinal detachment surgery, right eye surgery, coronary artery bypass graft, colonoscopy.

Social History: tobacco use

Pathophysiology

Disease process: UTI is an infection involving any part of urinary system, including urethra, bladder, ureters, and kidneys. Escherichia coli is the most commonly cause of lower UTI. The bacteria become pathogen when entered to the lower urinary tract, colonize the urethra and cause infections. If not treated, infections can travel to the upper urinary tract and cause urosepsis, bacterial invasion of bloodstream. This is more common in older adults with long-term indwelling urinary catheterization (Capriotti, 2020). In septic UTI, patients can become agitated, confused, dizzy, Pts can also have behavior changes. In severe cases, septic UTI can cause more damages to the body organs (Swearinger & Wright, 2019).

S/S of disease: pain or burning on urination (dysuria), full smelling urine, urgency, and hematuria occasionally (Capriotti, 2020).
Method of Diagnosis: urinalysis and urine culture, blood test, blood culture.
Treatment of disease: antibiotic is the appropriate treatment for UTI.

Active Orders

Vancomycin: is relevant because it is an antibiotic efficacy to treat infections.

Physical Exam/Assessment

General: patient is well developed and appears amused, alert and oriented x4, speaks normally and follow commands, no sign of distress.

Integument: skin color is pink, moisture, warm to touch. Skin is damaged, pt has rashes, bruises on arms and legs, wound on left leg, stage 1 decubitus ulcers and pressure at sacral areas. He is on q2 turn.

HEENT: head and neck symmetrical, normal cephalic. Ears are symmetrical and free of discharges, no auditory impaired. Eyes are symmetrical, vision impaired, wears glasses for reading and mobility. Nose septum midline, no bleeding. Patient has natural teeth, no dentures.

Cardiovascular: peripheral pulses are 2+ more diminished through bilateral, capillary refill weak. Edema inspected and palpated in both lower extremities.

Respiratory: shortness of breath, uses accessory muscles, patient is on 2L oxygen nasal canula.

Genitourinary: urine is yellow, clear. Patient has a urethral indwelling catheter for extended time. Quantity of urine 270ml.

Musculoskeletal: patient has edema on both lower extremities. Passive ROM lower extremities. Weak strength both upper and lower extremities bilateral. ADLs limited to self- feeding and teeth brushing. Pt is obese and at fall risk, Hoyer lift dependent.

Neurological: patient is awake in bed, tired. Patient speaks clearly without any sign of altered mental status. He opens eyes spontaneously. Patient's strength is weak on both legs and arms, can only make slow movements.

Most recent VS (include date/time and highlight if abnormal): BP: 165/91, T: 97.6 F, O2: 95 % with nasal canula, HR: 90, R: 18 on 9/22/21 at 0415.

Pain and pain scale used: 5/10 on scale of 0-10

Nursing Diagnosis 1	Nursing Diagnosis 2	nnNursing
Nursing Diagnosis 1 **Impaired gas exchange related to altered O2 supply secondary to sleep apnea as evidenced by shortness of breath.**	Nursing Diagnosis 2 **Risk for septic infections related to UTI as evidenced by blood culture: Staphylococcus methicillin resistant.**	**Nursing Diagnosis 3** **Impaired skin integrity related to an inadequate tissue perfusion as evidenced by stage 1 decubitus ulcers and wound on the leg.**
Rationale **This diagnosis was chosen because client exhibits signs of respiratory distress such as SOB. Pt is on O2 dependent.**	**Rationale** **This diagnosis was chosen because of the proximity of sacral wounds to perineum and patient has UTI which can become septic. Fecal contamination is possible.**	**Rationale** **This diagnosis was chosen because the client's skin is damaged with rashes, wounds, and decubitus ulcers.**
Interventions **Intervention 1: assess the pt's VS and characteristics of respiration at least every 4 hours** **Intervention 2: keep HOB elevated and monitor O2 supply to increase O2 level and achieve an SpO2 within normal range**	**Interventions** **Intervention 1: provide thorough perineal hygiene after each episode of fecal incontinence or toilet use.** **Intervention 2: administer antibiotics as prescribed.**	**Interventions** **Intervention 1: frequent repositioning every 2 hours.** **Intervention 2: provide frequent skin care to minimize contact with moisture and excretions.**
Evaluation of Interventions **Patient achieved adequate oxygenation as evidenced by O2 saturation and absence of SOB.**	**Evaluation of Interventions** **Patient is checked frequently, and perineal area thorough cleaned by healthcare providers and fecal contamination is minimized. Patient tolerated treatment of antibiotics.**	**Evaluation of Interventions** **Patient is frequently repositioned and wound care is done regularly to maintain skin integrity.**

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