Allowing the family access to the client reduces anxiety and gives both the client and the family some feeling of control. If prognosis is poor, access and involvement allow the family to begin the grieving process. If recovery is expected, contact provides the client and family with a feeling of hope. Supporting the client and family facilitates concrete problem solving, promotes acceptance of the illness and its implications, and helps them begin to establish ways of managing the illness experience.

- Provide information about the current setting to both the client and family; give the family information about available resources (such as pastoral care, social services, temporary housing, meals). Knowing what to expect and how to control the environment to meet basic needs reduces anxiety.

Using NANDA, NIC, and NOC
Chart 6–2 shows links between NANDA nursing diagnoses, NIC, and NOC when caring for the client who is experiencing shock.

Home Care
Home care for the client who has experienced shock is highly individualized, depending on the cause and the illness or injury that caused shock. Therefore, topics for consideration are not included in this section.

Nursing Care Plan
A Client with Septic Shock

Huang Mei Lan is a 43-year-old unmarried female who lives alone in a major West Coast city. Ms. Huang came to America 15 years ago from China and now speaks English well. Her family still lives in China. She worked in a neighborhood sewing shop until 3 years ago, when she was diagnosed with breast cancer. Her treatment included mastectomy of the affected breast and follow-up chemotherapy.

Last month, Ms. Huang experienced a recurrence of cancer in the lymph glands of the affected side. Surgery to remove the glands was performed and chemotherapy started. Ms. Huang has a central line, a urinary catheter, and a surgical incision. She is underweight, weak, and depressed. Although she has multiple physical problems, she never complains or asks for any kind of medication.

ASSESSMENT
Ms. Huang’s primary nurse, Robert O’Brien, enters her room early in the morning to make an initial assessment. He finds Ms. Huang huddled in the middle of the bed, shivering violently. Her vital signs are T 104°F, P 110, R 30, and BP 106/66. Her skin is hot, dry, and flushed with poor turgor. She is alert and oriented, but is restless and appears anxious. Ms. Huang states she is nauseated and suddenly begins vomiting and is incontinent of liquid stool. Laboratory data indicate leukocytosis, respiratory alkalosis, and reduced platelet count. Blood cultures, as well as cultures of Ms. Huang’s sputum, urine, and wound drainage, are conducted. She is diagnosed as having septic shock.

Hetastarch is ordered per intravenous line, and intravenous broad-spectrum antibiotics are begun until the organism and its portal of entry can be determined. Despite treatment, Ms. Huang’s condition worsens. Her blood pressure continues to drop, her skin becomes cool and cyanotic, and she begins to have periods of disorientation. She is transferred to the critical care unit. As she is being prepared for the transfer, she begins to cry and asks, “Am I going to die?”

DIAGNOSES
- **Deficient fluid volume** related to vomiting, diarrhea, high fever, and shift of intravascular volume to interstitial spaces
- **Ineffective breathing pattern** related to rapid respirations and progression of septic shock
- **Ineffective tissue perfusion** related to progression of septic shock with decreased cardiac output, hypotension, and massive vasodilatation

- **Anxiety** related to feelings that illness is worsening and is potentially life threatening, and the transfer to the critical care unit

EXPECTED OUTCOMES
- Maintain adequate circulating blood volume.
- Regain and maintain blood gas parameters within normal limits.
- Regain and maintain stable hemodynamic levels.
- Verbalize increased ability to cope with stressors.

PLANNING AND IMPLEMENTATION
- Monitor neurologic status, including mental status and level of consciousness.
- Monitor cardiovascular status, including arterial blood pressure; rate, rhythm, and quality of pulses; central venous pressure; pulmonary artery pressure; and cardiac output.
- Monitor color and character of skin.
- Monitor results of arterial blood gases, blood counts, clotting times, and platelet counts.
- Monitor respiratory status, including respiratory rate, rhythm, and breath sounds.
- Monitor body temperature every 2 hours.
- Monitor urinary output hourly, reporting any output of less than 30 mL per hour.
- Explain procedures and provide comfort measures (oral care, skin care, turning, positioning).

EVALUATION
Despite intensive nursing and medical care, Ms. Huang’s condition remains critical. The interventions are continued.

Critical Thinking in the Nursing Process
1. Vasopressors may be used in the treatment of septic shock. Explain the rationale for their use.
2. While monitoring Ms. Huang’s arterial blood gases, the nurse notes that her PaO₂ is < 60 mmHg and her PaCO₂ is > 50. What do these findings indicate, and why have they occurred?
3. Ms. Huang has been given large amounts of colloids intravenously. Hemodynamic monitoring indicates a higher than normal CVP and pulmonary artery pressure. What do these findings indicate? What physical assessments would you make to confirm the changes?

See Evaluating Your Response in Appendix C.