

→ **Management of care**

- ◆ Establishing priorities: Multiple sclerosis: priority action for a client during an initial visit
 - Discuss coping mechanisms and sources of support for patients with multiple sclerosis.
 - Initiate methods to prevent urinary tract infection such as encouraging fluid intake, establishing a voiding schedule and assisting with intermittent bladder catheterization.
 - Promote and monitor cognitive changes

→ **Safety and Infection Control**

- ◆ Accident/Error/Injury prevention: Spinal Cord Injury: Care of clients who has halo device
 - Maintaining airway patency is the top priority as respirations can be affected.
 - Tissue perfusion can be affected due to neurogenic shock causing peripheral vasodilation leading to venous pooling
 - Assessing hydration status is necessary as the patient may be NPO
- ◆ Handling hazardous and infection material: Cancer treatment: Caring for a client who is receiving brachytherapy
 - The nurse should limit the visitors to stay in the room for 30 mins, and maintain 6 ft.
 - The lead container should be left in the client's room, tongs should always be available.
 - In most cases, linens and dressing should be left in the clients room.

→ **Basic Care and Comfort**

- ◆ Elimination: Disorders of the eye: priority action for eye irrigation
 - The nurse should ask the patient about the chemical that was exposed to the eye.
 - The nurse should irrigate the eye with normal, saline or Ringer lactate solution.
 - Flushing the eye will remove harmful chemicals in the conjunctiva and cornea.
- ◆ Mobility/Immobility:
 - Pressure ulcers, wounds, management: Implementing preventive strategies
 - The nurse should encourage a diet high in protein such as meat, fish, eggs, dairy, beans, and nuts.
 - Using risk assessment tools such as Braden and Norton scales helps monitor the risk for skin breakdown.
 - Bony prominences should not be massaged.
 - Stroke: caring for a client who has left-sided hemiplegia

- If a patient has one-sided neglect, the nurse should teach them about protecting the affected extremity.
- The nurse should support the patient when they start to lean towards the affected side.
- Frequent position is necessary for those with hemiplegia.
- ◆ Nutrition and Oral hydration: Heart failure and pulmonary edema: dietary teaching about sodium restrictions
 - Patients with pulmonary edema will have fluid and sodium restrictions.
 - Nurses should provide patients with low sodium food choices.
 - Nurses should notify the provider for a weight gain of more than 5lb in 1 week.

→ **Pharmacological and parenteral therapies**

- ◆ Adverse effects/contraindication/side effects/interactions: electrolyte imbalance: manifestations of hypokalemia
 - Weakness and reduced deep tendon reflexes are present in hypokalemia.
 - Hypoactive bowel sounds, abdominal distention, and paralytic ileus can occur in hypokalemia.
 - Altered mental status, anxiety, and lethargy can occur in patients with hypokalemia.
- ◆ Blood and blood products: preparing to administer a blood transfusion
 - The nurse should initiate IV access with an 18- or 20-gauge needle prior to obtaining the blood products.
 - Two RNs should verify the products by noting the hospital identification number and the number on the client's identification band.
 - The nurse should prime the tubing with .9% normal saline only.

→ **Reduction of risk potential**

- ◆ System specific assessment: Hemodialysis and peritoneal dialysis: Monitoring patency of an arteriovenous graft
 - Assessment of the patency of the arteriovenous fistula include monitoring for the presence of a bruit, palpable thrill, distal pulses, and circulation.
 - Avoid IM injections, venipunctures, and BP measurements in the affected arm.
 - Hemodialysis occurs 3x per week for 3-5H sessions.
- ◆ Therapeutic procedures:
 - Amputation: Postoperative interventions to prevent complications
 - Encourage patients to maintain good footcare and to seek medical attention for non-healing wounds.
 - Position affects the extremity in a dependent position to promote circulation.
 - Warmth of the residual limb can indicate infection.

- Postoperative nursing care: priority assessment following a coronary artery bypass grafting
 - The client should remain NPO until the return of gag reflex and peristalsis after operation.
 - Encourage the use of an incentive spirometer at least every 1-2H when awake to prevent atelectasis.
 - The nurse should outline drainage spots with a pen and noting the date and time.
- Sensory perception: performing ear irrigation
 - The patient should sit upright with a towel on the shoulder.
 - The nurse should pull the ear upward and backwards and insert the syringe in the ear canal.
 - Warm water should be used and flushed gently to prevent ear damage.

→ Physiological adaptation

◆ Alterations in body system:

- Airway management: evaluating client understanding of tracheostomy care
 - Tracheostomy ties should be replaced if they are soiled, and new ties should be secured before removing the soiled ones.
 - Non-Disposable tracheostomy tubes should be changed every 6-8 weeks.
 - Oral care should be initiated every 2H.
- Diagnostic and therapeutic procedures for female reproductive disorders: discharge instructions for syphilis
 - A venereal disease research laboratory (VDRL) used the oldest diagnostic test for syphilis.
 - False positives can occur due to infection, pregnancy, cancers, or autoimmune disorders.
 - If the test is reactive, it needs to be confirmed used in the fluorescent treponemal antibody absorbed (FTA-ABS) or Microhemagglutination assess antibody to T.pallidum

◆ Illness management: respiratory management and mechanical ventilation

- Mechanical ventilation can be delivered through a tube or tracheostomy.
- Mechanical ventilation provides positive pressure to deliver air into lungs keeping the alveoli open.
- Mechanical ventilation enhances lung expansion and decreases the work of breathing.

◆ Medical emergencies

● Emergency nursing principles and management: priority action for abdominal trauma

- The nurse should assess respirations by auscultating breath sounds and observing for chest expansion and respiratory effort.

- The nurse should assess the abdomen by inspection, auscultation, percussion, and palpation.
 - The nurse should provide direct pressure to prevent bleeding.
- Hemodynamic shock: priority intervention for hypovolemic shock
 - The nurse should then assess for circulation by assessing for heart rate, blood pressure, and peripheral pulses.
 - The nurse should obtain IV access to prevent hypovolemia.
 - The nurse should administer oxygen.
- Intravenous therapy: priority action for central venous access device
 - Nurses should flush intermittent catheters with normal saline every 8-12H.
 - IV sites should be changed every 72H or according to facility policy.
 - Do not allow fluids to hang for more than 24H
- ◆ Unexpected response to therapies: hemodialysis and peritoneal dialysis: assessment of an arteriovenous fistula
 - An arteriovenous fistula should be assessed for the presence of bruit, palpable thrill, distal pulses, and circulation.
 - The nurse should apply light pressure if bleeding occurs.
 - A palpable thrill and audible bruit indicate vascular flow.