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## RN Comprehensive Predictor 2019 with NGN

### **Management of Care**

Priority intervention when discharging a client who had a stroke

- One of the primary roles of nursing is the coordination and management of client care in collaboration with the health care team. The nurse should have a holistic understanding of the client, the client's health care needs, and the health care system.
- The nurse should provide the client with an opportunity to help develop a plan of care and provide them with information regarding the status of their health..
- The nurse's discharge plan should include continued care and references to all needed equipment and services the client may need. These issues should be addressed so the services are in place when the client arrives home.

Professional responsibilities client advocacy

- Professional responsibilities are the obligations that nurses have to their clients. Advocacy refers to the nurse's role in supporting clients by ensuring that they are properly informed, that their rights are respected, and that they are receiving the proper level of care.
- Advocacy is one of the most important roles of the nurse, especially when clients are unable to speak or act for themselves. An advocate ensures that the client has the information they need prior to making decisions about health care.
- Nurses must act as advocates even when they disagree with a client's decisions. The complexity of healthcare systems put the clients in a vulnerable position.

Identifying Electronic databases for research

- It is the nurses responsibility to know federal, state and local laws, and facilities' policies that govern the prescribing, dispensing, and administration of medications.
- If the nurse is going to have the patient look up information for their own research the nurse should suggest the client use nursing drug handbooks, pharmacology textbooks, professional journals, physicians' desk reference, professional websites, and directly from pharmacists.
- The nurse should not encourage the clients to utilize online sources such as health based news articles or health based websites. Instead the client should be directed to more researched based health information with recent evidence based-practice.

### **Safety and Infection Control**

Planning care for a client who is receiving internal radiation therapy

- Internal radiation causes body fluids to be contaminated with radiation, and body wastes should be disposed of appropriately, as directed by the facility.
- Brachytherapy describes internal radiation that is placed close to the target tissue. This is done via placement in a body orifice (vagina) or body cavity (abdomen) or delivered via IV such as with radionuclide iodine, which is absorbed by the thyroid.
- This radiation treatment provides radiation to the tumor and a limited amount to surrounding normal tissues. Most clients remain in a medical facility until brachytherapy is complete. Clients who receive seed implants might go home with the implants.

#### Evaluating client understanding of crutch safety

- The nurse should inform the client to not alter the crutches after fitting and they should follow the prescribed crutch gait.
- The client should support body weight at the hand grips with elbows flexed at 20 to 30 degrees. Hold crutches in one hand and grasp the arm of the chair with the other hand for balance while sitting and rising from a chair.
- The tripod position is the basic crutch stance. The client should place the crutches 6 inches in front of and the side of each foot to provide a wide base of support.

#### Identify complete medication prescriptions

- The nurse should identify if the medication prescription is complete. This includes verifying completeness and clarity.
- Common medication errors include wrong medication or IV fluid, incorrect dose or IV rate, wrong client, route, or time, administration of an allergy-inducing medication, omission of a dose or administration of extra doses, incorrect discontinuation of a medication or IV fluid, inaccurate prescribing, and inadvertently giving medication that has a similar name.
- The nurse should read medication labels and compare them with the MAR 3x: before removing the container, when removing the amount of medication from the container, and in the presence of the client before administering the medication.

### **Health Promotion and Maintenance**

#### Contraindications for oral contraceptives

- Oral contraceptives can include combined oral contraceptives (COC), progestin-only pills, and emergency oral contraceptives.
- COC contraindications include history of thromboembolic disorders, stroke, heart attack, coronary artery disease, cirrhosis or liver tumor, headache with focal neurologic findings, uncontrolled hypertension, diabetes mellitus with vascular involvement, breast or estrogen related cancers, pregnancy, lactating, less than 6 weeks postpartum, or smoking.
- Progestin-only contraception has been contraindicated with bariatric surgery, lupus, severe cirrhosis, liver tumors, and current or past breast cancer. Emergency contraceptives have contraindications involving if the client is pregnant or has undiagnosed abnormal vaginal bleeding.

#### Priority intervention when assisting a client with smoking cessation

- The nurse should examine risk factors the client may have in attempting to stop smoking. References to clients for educational/community/support resources may be needed. Help clients recognize benefits and overcome barriers to stop smoking.
- The nurse should advocate for changes in the community to benefit the client and the community as a whole.
- The nurse should use behavior-change strategies to help clients identify readiness and acceptable interventions. They should help motivate change by setting realistic timelines and reinforce steps toward change.

#### Assessing developmental milestones ages 1 to 3

- Children between the ages of 1 and 3 should grow about 3 inches per year and gain 4 to 6 pounds per year. The anterior fontanelle should be closed by 18 months of age.
- The child should be in the sensorimotor stage of development; understanding object permanence and should demonstrate memories of events that relate to them. Domestic mimicry is shown in this stage and preoperational thought does not allow them to understand others viewpoints, but does allow them to symbolize objects and people to imitate previously seen activities.
- Children of this age should be in the autonomy vs shame stage of development which shows independence. They will try to do things themselves. Toddlers often use negativism, or negative responses, as they begin to express their independence. Ritualism and maintaining routines provides a sense of comfort for the toddlers and they explore their environment.

#### Screening for Idiopathic Scoliosis

- Scoliosis is a complex deformity of the spine that also affects the ribs. It is characterized by a lateral curvature of the spine and spinal rotation that causes rib asymmetry. Idiopathic or structural scoliosis is the most common form of scoliosis and can be seen in isolation or associated with other conditions.
- Risk factors include genetic tendencies, sex (more common in females), and age (highest incidences from 8 to 15 years of age).
- Screening preadolescence includes observing the child, wearing only underwear, from the back, bending over at the waist with arms hanging down and observing for asymmetry of the ribs and flank. Measure spinal curvature with scoliometer.

#### Teaching about folic acid

- Folic acid is crucial for neurological development and prevention of fetal neural tube defects.
- Folate found naturally in foods is converted to folic acid. Foods high in folate include leafy vegetables, dried peas and beans, seeds, and orange juice. Breads, cereals, and other grains are fortified with folic acid.

- The March of Dimes recommends that clients who wish to become pregnant and clients of childbearing age take 400 mcg of folic acid and clients who become pregnant to take 600 mg of folic acid.

#### Identify the stage of change

- Transtheoretical (TTM) of stages of change (SOC) model theorizes that change occurs over time, and in six distinct stages.
- These stages are precontemplation, contemplation, preparation, action, maintenance, and termination.
- The process explains the individual is unaware of the need to change and then thinks about the need to change. After realizing the need for change the individual will plan to take action and then take action. After taking action, the person will find ways to sustain the behavior until the final stage. Termination occurs when the conscious effort to continue health behavior is no longer needed due to consistency.

#### **Psychosocial Integrity**

##### Action for a client who is experiencing panic level anxiety

- Panic attacks typically last 15 to 30 minutes and present with four or more manifestations. The client might experience behavior changes and/or persistent worries about when the next attack will occur.
- Nurses should provide safety and comfort to the client during the crisis period of these disorders, as clients in severe- to panic-level anxiety are unable to problem solve and focus. These clients should be taken to a quiet, calm environment.
- The nurse should remain with the client during the worst of the anxiety to provide reassurance and perform a suicide safety risk assessment.

##### Manifestations of cocaine exposure during pregnancy

- For newborns who are withdrawing from cocaine, avoid eye contact and use vertical rocking and a pacifier.
- Newborns going through withdrawals will need decreased environmental stimuli and the nurse should use cluster cares to minimize stimulation.
- The nurse should have suction available to reduce the risk for aspiration and ensure infection prevention protocols.

##### Responding to a client who has major depressive disorder

- When speaking with clients with major depressive disorder or schizophrenia the nurse should allow a longer period of time for the client to respond to questions.
- When communicating with the client the nurse should be caring, honest, trusting, empathetic, and non judgemental.
- Therapeutic communication is important when speaking with a client as it helps build and maintain helping relationships with clients, families, and significant others.

##### Priority intervention for intimate partner violence

- The nurse should assess the client for any current injuries the client may have. If there are any injuries the nurse should prioritize in treating those issues first.
- After assessing the client the nurse should determine the client's understanding of the events. The nurse will use this assessment to determine any subjective data the client has about the event.
- The nurse should then make appropriate referrals, help develop a safety plan and identify triggers of the violence, and use crisis intervention techniques to help resolve family or community situations where violence has been devastating.

#### Identifying characteristics of a therapeutic group

- A group therapy should include goals such as sharing common feelings and concerns, sharing stories and experiences, diminishing feelings of isolation, creating a community of healing and restoration, providing a more cost-effective environment than that of individual therapy.
- The group should those in the same age group of the individual attending the group. Different ages of group therapy will focus on different aspects of the therapy.
- The groups should go through the phases of orientation, working, and termination. Orientation states the purpose and goals of the group. The working phase focuses on problem-solving skills to facilitate behavior change. The termination phase marks the end of the group session.

#### **Basic care and Comfort**

##### Performing post mortem care prior to a family visit

- Nurses are responsible for following federal and state laws regarding requests for organ or tissue donation, obtaining permission for autopsy, ensuring the certification and appropriate documentation of the death, and providing postmortem care.
- The nurse should maintain privacy for the client, remove all tubes, remove all personal belongings to be given to the family, cleanse and align the body supine with a pillow under the head, arms with palms of hand down outside the sheet and blanket, dentures in place, and eyes closed.
- The nurse should apply fresh linens with absorbent pads on the bed and a gown, brush/comb the client's hair, remove excess supplies, equipment, and soiled linens from the room, and dim the lights and minimize noise to provide a calm environment.

##### Priority action for fluid overload

- Fluid overload is an excess of fluid or water, such as with water intoxication. This includes hemodilution, which makes the amount of blood components seem lower.
- The nurse should assess breath sounds and encourage rest. This is a priority because fluid overload can affect the pulmonary function causing crackles.
- The nurse should expect to give diuretics and position the client in semi-Fowler's position, and reposition to prevent tissue breakdown in edematous skin.

##### Caring for a client who is in active labor

- Pain is a subjective and individual experience, and each client's response to the pain of labor is unique. Safety for the mother and fetus must be the first consideration of the nurse when planning pain management measures.
- Help the client maintain the proper position during administration of pharmacological interventions. Assist the client with positioning for comfort during labor and birth, and following pharmacological interventions. Provide client safety prior to and after any pharmacological interventions by placing bed in a low position and placing call light within the client's reach.
- The nurse should try nonpharmacological pain management to reduce anxiety, fear, and tension, which are major contributing factors to pain in labor. These managements include gate-control theory of pain, cognitive strategies, sensory stimulation strategies, and cutaneous stimulation strategies.

Rest and sleep - priority findings to report to the provider

- Getting proper rest and sleep is essential to maintaining good health. Too little sleep leads to an inability to concentrate, poor judgment, moodiness, irritability, and increased risk for accidents.
- Chronic sleep loss can increase risks of obesity, depression, hypertension, diabetes mellitus, heart attack, and stroke.
- The nurse should report any factors interfering with sleep such as physiological disorders, current life events, emotional stress or mental illness, diet, fatigue, sleep environment, medications, or substance use.

Best source of Vitamin C

- Vitamin C (ascorbic acid) aids in tissue building and metabolic reactions (healing, collagen formation, iron absorption, and immune system function).
- Vitamin C is found in citrus fruits such as oranges and tomatoes, as well as, tomatoes, peppers, green leafy vegetables, and strawberries.
- Stress and illness, as well as cigarette smoking, increases the need for vitamin C. Cigarette smokers should increase vitamin C consumption by 35 mg/day due to increased oxidative stress and metabolic turnover.

## **Pharmacological and Parenteral therapies**

Teaching a client about timolol

- Timolol is a beta blocker that is used to treat glaucoma, and decrease intraocular pressure by reducing aqueous humor production.
- The nurse should teach the client this medication can be absorbed systemically and cause bronchoconstriction and hypoglycemia. Use with caution in clients who have asthma, COPD, and diabetes mellitus.
- This medication can potentiate systematic effects of oral beta-blockers and cause bradycardia and hypotension.

Calculating a dose of phenytoin

- Example: a nurse is preparing to administer phenytoin 0.2g PO every 8 hours. The amount available is 100mg/capsule. How many capsules should the nurse administer per dose? 100mg is .1g so the answer is 2.
- A nurse is preparing to administer a liquid dose of 0.25g PO every 8 hours. The amount available is 250 mg/5mL. How many mL should the nurse administer per dose? 250mg is 0.25g. There are 5 mL per 0.25g so the answer is 5mL.
- Nurse is preparing an 8000 unit injection subcutaneous every 12 hours. Available is 10,000units/mL. How many mL should the nurse administer per dose? The nurse should divide 8000 by 10000 units and multiply by the number of mL (1). The answer is 0.8mL.

#### Teaching about adverse effects of Timolol

- Timolol is a beta blocker that is used to treat glaucoma, and decrease intraocular pressure by reducing aqueous humor production.
- Adverse effects the client may experience include stinging discomfort, occasional conjunctivitis, blurred vision, photophobia, dry eyes, and systematic effects of beta blockade on heart and lungs.
- The client should report adverse effects relating to the eye to their provider. Adverse effects with stinging discomfort are transient while systematic effects can cause systemic problems and should also be reported to the provider.

#### Educate client about an intermittent infusion device

- Replacement of the administration set is dependent upon the type of infusion. Administration sets with a continuous infusion of fluids with or without secondary fluids should be changed every 96 hours. Intermittent infusions should be changed every 24 hours.
- Some blood products or medications (propofol) should be changed more frequently, according to facility policy.
- The nurse should teach the client that an intermittent infusion device is set to give a certain amount of medicine and will not exceed the amount that is programmed to relieve anxiety about overdosing on medications given in this manner.

#### Preparing client for insertion of a nontunneled percutaneous central venous catheter access device

- The nurse should educate the client about the procedure and perform hand hygiene before inserting the catheter. The nurse should also confirm the client understands the procedure and instruct them to lie in a comfortable position.
- Central lines are completed in a sterile procedure and must be closely monitored in order to prevent infection.
- When preparing the client for insertion the nurse should obtain the correct catheter size, tubing, prefilled syringes containing 1 to 3 mL of 0.9% saline, infusion pump, clean gloves, and scissors or clippers for hair removal.

#### Medication interactions with warfarin

- Warfarin is a medication that is used if a client has deep vein thrombosis. This medication can prevent venous thrombosis and pulmonary embolism.
- Vitamin K is a medicine used to counteract warfarin. Other medications that should be avoided include medicines that affect bleeding and blood clotting such as heparin, aspirin, and acetaminophen. The medication may also interact with glucocorticoids, sulfonamides, and parenteral cephalosporins which may increase the effects of warfarin.
- The nurse should educate the client on its effects during pregnancy and to avoid breastfeeding while on this medication. They should also avoid foods high in vitamin K which include dark leafy vegetables.

#### Administering headache medications to a client who has a history of peptic ulcer disease

- Clients who smoke, have alcohol use disorder, and previous inability to tolerate NSAIDs should take caution when taking NSAIDs due to increased risk for GI discomfort or bleeding.
- The client should be educated on taking the medication with food or with an 8 oz glass of water or milk and to avoid alcohol while taking NSAIDs. This is to prevent GI upset and the likeliness of developing ulcers.
- Acetaminophen may also be used for headaches, but clients should be instructed not to exceed the recommended daily dose. This medication can be taken with or without food, with a full glass of water.

#### Pudendal block

- Pudendal block is a pain relieving intervention used in the second stage of labor with vaginal births.
- This medication consists of a local anesthetic administered transvaginally into the space in front of the pudendal nerve. This type of block has no maternal or fetal systemic effects, but does provide local anesthesia to the perineum, vulva, and rectal areas during delivery.
- This medication is administered in the late second stage of labor around 10 to 20 minutes before delivery, providing analgesia prior to spontaneous expulsion of the fetus or forceps-assisted or vacuum-assisted birth. It is suitable during the second and third stages of labor and for repair of episiotomy and lacerations.

#### Indications for increasing the rate of oxytocin infusion

- Oxytocin is used to induce labor and initiate uterine contractions. This medication can be given via IV or nipple stimulation to trigger the release of endogenous oxytocin.
- While the client is receiving oxytocin the nurse should monitor maternal blood pressure, pulse, and respirations every 30 to 60 minutes and with every change in dose.
- Increase oxytocin until desired contraction pattern is obtained and then maintain the dose if there is contraction frequency every 2 to 3 minutes, contraction duration of 80 to 90 seconds, contraction intensity of 40 to 90 mm Hg on IUPC or strong to palpation, uterine resting tone of 10 to 15 mm Hg on IUPC, cervical dilation of 1cm/hr or reassuring FHR between 110 to 160/min.

## **Reduction of Risk Potential**

Planning to position a client following total hip arthroplasty

- The nurse should avoid positions that cause flexion of the hip.
- Place the client supine with the head slightly elevated and the affected leg in a neutral position. Place a pillow or abduction device between the legs when turning to the unaffected side.
- The client should not be turned to the operative side, which could cause hip dislocation, unless prescribed by agency policy or the provider.

Caring for a child who has neutropenia

- The nurse should provide emotional support to the child and family and encourage peer contact if appropriate. Assess pain using an age-appropriate pain scale. Use pharmacological and nonpharmacological interventions to provide around-the-clock pain management.
- The client should be placed in a negative pressure room that allows for adequate air flow to reduce airborne pathogens and restrict visitors and health personnel who have active illnesses.
- The nurse should encourage adequate protein and caloric intake and administer antibiotics if a source of bacteria is identified through blood, stool, urine, and nasopharyngeal cultures.

Nursing interventions for Hypocalcemia

- Hypocalcemia occurs when the total blood calcium is less than 9.0.
- The nurse should administer oral or IV calcium supplements. Vitamin D supplements enhance the absorption of calcium.
- Seizure and fall precautions should be implemented.
- The nurse should encourage foods high in calcium, including dairy products, canned salmon, sardines, fresh oysters, and dark leafy green vegetables.

## **Physiological adaptations**

Expected finding of elevated pulmonary artery wedge pressure

- A pulmonary artery wedge is used to diagnose severe left ventricular failure and mitral stenosis.
- Heart failure generally results in increased central venous pressure, increased pulmonary wedge pressure, increased pulmonary artery pressure, and decreased cardiac output.
- If a nurse has a client with pulmonary edema they will need to monitor the hemodynamic status which includes pulmonary wedge pressure and cardiac output.

Hyperemesis Gravidarum

- The nurse should expect excessive vomiting for prolonged periods, dehydration with possible electrolyte imbalance, weight loss, increased pulse rate, decreased blood pressure, poor skin turgor, and dry mucous membranes.
- This disease causes excessive nausea and vomiting that is prolonged past 16 weeks of gestation or that is excessive and causes weight loss, dehydration, nutritional deficiencies, electrolyte imbalance, and ketonuria.
- This disease is a risk to the fetus for intrauterine growth restriction, small for gestational age, or preterm birth if the condition persists.

#### Identifying manifestations of Fat Emboli

- Fat embolisms occur mostly in adults aged 70 to 80 and males between 20 and 40. Most commonly following hip fracture or within 72 hours of pelvic fracture or surgery.
- Early manifestations of fat embolism include dyspnea, increased respiratory rate, decreased oxygen saturation, headache, decreased mental acuity related to low arterial oxygen level, respiratory distress, tachycardia, confusion, and chest pain.
- Late manifestations include cutaneous petechiae on the neck, chest, upper arms, and abdomen. This is a discriminating finding of pulmonary embolism.

#### Interventions for a client who is experiencing hypotension

- For a pregnant patient who is experiencing hypotension the client may feel lightheadedness or faintness. This can reduce blood supply to the fetus.
- The nurse should teach the client to lie in a side-lying or semi-sitting position with the knees slightly flexed.
- The nurse should encourage the patient to maintain adequate hydration to battle hypotension.

#### Staging a Pressure Ulcer

- Stage one skin is intact with an area of persistent, nonblanchable redness that can feel warmer or cooler than the adjacent skin.
- Stage 2 involves the epidermis and the dermis. The wound bed is viable with a reddish-pinkish bed without slough, eschar, granulation tissue, or adipose tissue.
- Stage 3 exhibits visible adipose tissue with possible granulation tissue. No muscle, tendons, ligaments, cartilage, or bones are exposed.
- Stage 4 presents with skin and tissue loss with cartilage, bone, fascia, muscle, ligaments, or tendon exposed in the wound or easily palpable.
- The last stage is Unstageable which has no determination of stag due to eschar or slough obscuring the wound bed. The depth of the injury is unknown unless slough and eschar removed, at which time the wound is restaged.

### **Clinical Judgment**

#### Analyzing Assessment Findings for a child who has arm pain

- The nurse should expect the assessment to show pain, crepitus, deformity, edema, ecchymosis, warmth or redness, or decreased use of the affected area.

- Children are prone to different types of breaks than adults. The nurse may see plastic deformation, buckle, greenstick, transverse, oblique, spiral, physeal, stress, complete, incomplete, closed or simple, open or compound, complicated fracture, or commuted break.
- The nurse should confirm the break with an x-ray of the affected limb to determine the positioning of the bone, immobilize the affected area to prevent further injury, and provide emotional support to the patient.

#### Anticipating potential provider prescriptions for a client who has arm pain

- The nurse should anticipate analgesics for pain. Opioid analgesics are the most commonly prescribed medications used for pain management for breaks for children
- A splint should be expected to be ordered by the physician, to immobilize the limb to prevent further pain or injury.
- The nurse should perform a neurological assessment on the affected limb to determine if there are any other potential complications that may occur while attempting to treat the injury.

#### Determining potential complications for a child who has arm pain

- With fractures one complication the child may experience is compartment syndrome. This complication presents with moderate to severe pain and if left untreated it may cause paralysis or infection.
- Renal calculi may occur with non-weight-bearing injuries. The nurse should ensure adequate nutrition and hydration.
- Embolism may also occur with breaks that occur in fractures where fat breaks away from the bone of the injured area and enters the bloodstream.

#### Identify findings requiring follow-up for a child who has arm pain

- The nurse should note that if the break requires any surgical intervention or formal casting they should follow up with an orthopedic.
- If a client needs a Halo-device or traction care they may need inpatient care and further assessments by nurses and doctors specializing in orthopedics.
- The nurse should educate the client on the necessary steps to take prior to discharge and what to do if a follow up appointment is necessary.

#### Priority actions for a child who has a fracture

- The nurse should provide emergency care at the time of the injury and maintain ABCs as the priority intervention. The nurse should also monitor the vitals and neurological status. The nurse should also provide pain medications as prescribed by the physician.
- The nurse should position the client in a sitting position for injuries to the shoulder and upper arm and remove jewelry or objects that can cause constriction on the affected extremity.
- If a pelvic fracture is suspected, monitor urine for blood and for development of hypovolemic shock.

- The nurse should elevate the affected limb and provide ice packs (do not exceed cold therapy for over 20 minutes).

#### Substance use and addictive disorders: identifying manifestations

- Opioid is used to create a rush of euphoria and relief of pain. The effects of intoxication can include slurred speech, impaired memory, pupillary changes, decreased respirations and level of consciousness, psychological changes, or impaired judgment,
- Alcohol is used to relax, decrease social anxiety, and reduce stress. The effects of intoxication include slurred speech, nystagmus, memory impairment, altered judgment, decreased motor skills, decreased level of consciousness, respiratory arrest, peripheral collapse, and death.
- Sedatives/hypnotics/anxiolytics are used to help decrease anxiety and for sedation. Effects of toxicity include increased drowsiness and sedation, agitation, slurred speech, uncoordinated motor activity, nystagmus, disorientation, nausea, vomiting, respiratory depression, and decreased level of consciousness.
- Cannabis is commonly used for euphoria, sedation, hallucinations, decrease of nausea and vomiting secondary to chemotherapy, and management of chronic pain. Signs and symptoms of intoxication include respiratory issues, occurrences of paranoia, increased appetite, dry mouth, and tachycardia, impaired motor skills, and sedation.