

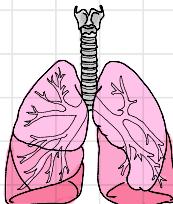
Lecture I: Acid & Bases

As the pH goes, so does my patient, except for K

pH ↑ = irritable, hyper-exitable, borborygmi* (hyperactive bowel sounds) K+ down

pH ↓ = body shuts down, HR/RR down, lethargy, K+ up

* ASK YOURSELF *



Is it the lungs?

If it is NOT caused by the lungs, the answer is METABOLIC



Quick Notes:

There's a difference between s/s of acid base imbalances vs. causes of acid base imbalances

Resp. rate doesn't matter, SaO₂ matters. ↓ = ↓ vent = ↓ pH (acid)

Modifying phrase trumps original noun

Ex. "An odd pt who is now psychotic" (look @ psychotic)

"A vomiting pt who is now dehydrated" (look @ dehydrated)

If the pH and bicarb are in same direction, it's metabolic



[Questions]

When would you want suction at bedside? For a patient with alkalosis bc of their risk for seizures!

When would you want an ambu bag at bedside? For patient with acidosis bc of risk for resp depression!

Vent Alarms

High pressure alarm goes off: working too hard (obstruction)

1. Check for kinks → unkink

2. Water condensation in the tube → empty it

3. Mucus in the airway: turn/cough/deep breathe

(If that doesn't work then suction (last resort))

Low pressure alarm goes off: that was too easy (disconnection)

a. Main tubing: reconnect

b. O₂ sensor tubing (senses fio₂ @ trachea area): reconnect

Translate respiratory alkalosis to ventilating over (settings are too high)

Respiratory acidosis to ventilating under (settings are too low)

Lecture 2: Alcohol/Drugs

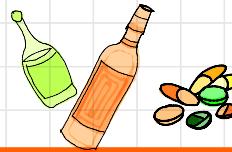
DENIAL is the #1 problem with abuse

Alcoholism

#1 problem psychologically is denial

CONFRONT THEM Point out the difference from what they say and what they do

SET LIMITS & SAY NO "I'm saying no because I'm a good person"



Dependency

abuser gets to keep using
abuser is dependent on spouse to do things for them

Ex. "Call my boss for me"

Co Dependency

Significant other feels **positive self esteem** from supporting the alcoholism

Harder to treat because spouse feels good for helping "I am a wonderful spouse for calling your boss for you"

SET LIMITS & SAY NO

Manipulation

Abuser gets significant other to do things for him/her that's not in the best interest for the significant other

The nature of the act is dangerous or harmful

Manipulation is easier to treat than dependency because there's no positive self esteem issue with manipulation

Wernicke Korsakoff - Psychosis induced by **Vitamin B1**/
Thiamine deficiency
S/s: Amnesia with confabulation (memory loss with making up stories)
Don't confront them or present reality. THEY BELIEVE WHAT THEY ARE SAYING! Redirect them.
To prevent/stop it from getting worse: Take vitamin B1.
They don't have to stop drinking, and it's irreversible.

Aversion Therapy

Antabuse (disulfiram) & **ReVia** (naltrexone)

Makes you hate alcohol and if you drink it you'll get deathly ill

Takes 2 weeks to get into the system

Need 2 weeks to get out of system to safely drink again

AVOID ALL ALCOHOL PRODUCTS

1. Mouthwash
2. Aftershave
3. Perfumes/Cologne
4. Insect repellent
5. Anything that ends in elixir
6. Alcohol based hand sanitizer
7. Unbaked icing (vanilla extract)

**They can have red wine vinegar!

Quick Notes:

With abuse you confront, with loss you support
Neutral: dependency/codependency has 2 pts.
Negative: manipulation has 1 pt.
The most abused drug is laxatives

Uppers (5):



Caffeine, Cocaine, PCP/LSD (hallucinogens), Methamphetamines, Adderal
S/s: (things go up) euphoria, tachycardia, tachypnea, restlessness, irritability, borborygmi/diarrhea, reflexes +3/+4 (spastic), seizure

Downers:



Heroin, Marijuana, Alcohol, Benzos (everything not an upper)
S/s: (things go down) Lethargy, respiratory depression, bradycardia, bradypnea,

* ASK YOURSELF *

Is the drug an **Upper** or **Downer**?

Is the question asking about **overdose** or **withdrawal**?

Withdrawal in upper: everything goes down

Withdrawal in downer: everything goes up

Resp. depression biggest risk in: downer overdose and upper withdrawal

Alcohol Withdraw

Every alcoholic goes through withdrawal

You go into w/d within 24hrs

Not life threatening

Regular diet, semi-private room anywhere on unit, up adlib (go anywhere they want), no restraints

Meds: Antihypertensive pill, Tranquillizer, Vitamin B1

Delirium Tremens

only a small amount get DT

You go into delirium tremens within 72 hrs.

DT's can kill you, DTs are dangerous to self and others

NPO/clear liquids (seizure risk), private room, near nurses station, strict best rest / need bed pans & urinals, must be restrained appropriately: vest or 2 point locked leathers (opposite arm & leg) rotate every 2 hours.

Meds: antihypertensive pill, tranquilizer, bl vitamin



Drug Addiction in Newborns

Always assume **intoxication**, not withdrawal at birth

Baby has to be 24hrs old to go through withdrawal

Withdrawal: difficult to console, exaggerated startle reflex, seizure risk, shrill high pitch cry



Aminoglycosides- A Powerful Class of Antibiotics

* A mean old mycin for a mean old infection *

Used for: Life threatening, resistant, serious, and gram negative infections

All end in mycin, but not all that end in mycin are mean old mycins!

If it has thro, throw it off the list!!

NOT MeanOldMycins: Arithromycin, Zythromycin, and Clarithromycin ~~✓~~

Administration: Administer them q8hr. Route: IM or IV. Don't give PO for infection!

Look out for: Ototoxicity & Nephrotoxicity

-mycin (mice- ears) Monitor for hearing, tinnitus, vertigo/dizziness

The human ear is shaped like the kidney so think ears and kidneys!



Only 2 cases to give orally: sterilize the bowel

1. Hepatic encephalopathy/hepatic coma/liver coma (when ammonia level gets too high & gets to your brain) Kills the E. coli in the gut & lower the ammonia level

2. Pre-op bowel surgery to sterilize the bowel

Oral mycins will kill gram-negative bacteria in your gut (sterilize bowel)

Sargent asks: Who can sterilize my bowel? Neo can! NEOMYCIN and CANOMYCIN!

Lecture 3- Cardiac/Chest Tubes/Infection Precautions

Calcium Channel Blockers Calms the heart

CCB = Cardiac depressant

Uses: CCB's are negative inotropes, negative dromotropes, and negative chromatropes

Weaken, slows down, and depresses the heart **"It's like Valium for your heart"**

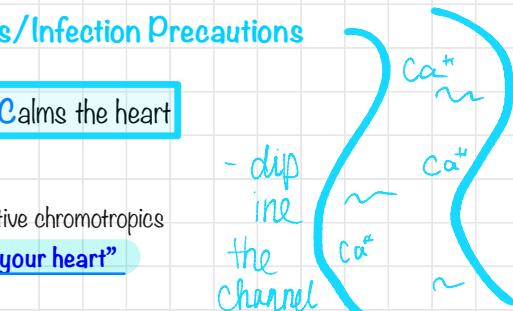
They treat: A, AA, AAA

Anti-hypertensive

Anti-Angina \downarrow O₂ demand

Anti-Atrial-Arrhythmia= it treats everything atrial related, including supra ventricular tachycardia

Side effects: Headache & hypotension



Names of CCB's:

Names ending in "dipine" (You're dipping in the calcium channel)

Others: Verapamil, Cardizem (Continuous IV drip)

Look out for: BP! Monitor BP intermittently. If systolic is below 100, hold.

For drip, if systolic was 98 titrate it down.

above ventricle = atrium



Cardiac Arrhythmias: When it comes to IV push, when you don't know go slow

Normal Sinus Rhythm
evenly spaced



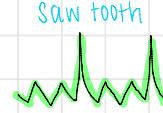
V fib

V-fib \rightarrow D-fib
chaotic + lethal

V tach

Amiodarone
pattern, bizarre

A flutter



Asystole

Epi & Atropine
(In that order if Epi doesn't work)
lethal, flat, GIVE EPI!

SVT

ABCD's'

Adenosine - Push FAST (normal to see Asystole)

Beta blockers - lol Just like CCB's, same treatment, same side effects

Calcium channel blockers - Better for asthmatics

Digoxin/Digitalis (AKA Lanoxin — know this!)

Quick Notes

QRS depolarization- Answer is always ventricular! P wave- Answer is always atrial!

Lack of a P wave- Answer is always ventricular!

Chaotic = fibrillation. Bizarre = tachycardia

Potentially Life Threatening: V-Tach w/ a pulse

Lethal Priority: Kills you in 8 mins or less: \rightarrow Asystole- No pulse V-fib- No pulse

Premature ventricular contraction (PVC)

PVCs are NEVER high priority!



Moderate Priority = A bunch of PVC's (it's like a short run of V-Tach)! If more than 6 PVC's in a minute or row and/or if PVC falls on the T wave of the previous beat

Chest Tubes: reestablishes negative pressure in pleural space

Pneumothorax → chest tube removes air → **REPORT**: \ominus bubbling in 2 locations

Hemothorax → chest tube removes blood → **REPORT**: \ominus drainage

Pneumohemothorax → chest tube removes blood and air

How many chest tubes & where would you place them for postop chest sx?

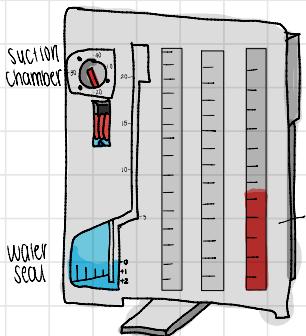
Place apical & basilar on same side of surgery

Apical for Air, Basilar for Blood

Always assume chest sx / trauma is unilateral unless specified as bilateral

Trick Q: Where to put tubes for a post op right Pneumonectomy? NOWHERE because that is the removal of the lung

Troubleshooting



→ knocked down a closed drainage device? set it back up, tell pt to take deep breaths, NOT an emergency

→ water seal breaks? **EMERGENCY**

1. Clamp the water seal
2. Cut it away
3. Submerge in sterilized water
4. Unclamp because we reestablished the water seal.

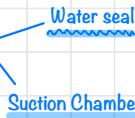
→ chest tube dislodged? COVER IT!

- * first → cover with gloved hand
- * best → cover with vaseline gauze

Best Question: think if you could only do ONE thing out of all the answers, which one would you do? (you have everything at hand)

First Question: you can do everything in the answer choices but think which one you would do first?

→ bubbling? ask yourself where & when



intermittent bubbling is always good

continuous bubbling is always bad (there's a leak! TAPE IT!)

intermittent bubbling is always bad (turn suction higher!)

continuous bubbling is always good

Quick Notes

A straight-cath (in and out foley) is to a foley (continuous drainage) as a thoracentesis (in and out chest tube) is to a chest tube (continuous drainage)

Higher risk for infection- Foley & chest tube

Rules for clamping tubes

Never clamp a tube for longer than 15 secs w/o a Dr order

Use rubber tip double clamps

Congenital Heart Defects

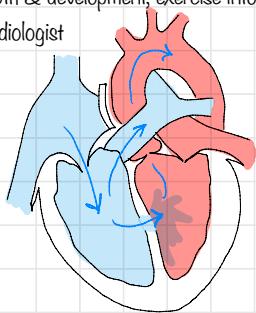
TRouBLE

Starts w/ T, R → L shunt, B for Blue

A trouble defect is right to left shunting, R to L because that's how TRouBLE is spelled, B in trouble means blue (cyanotic), ALL CHD that starts with T is TROUBLE!

The RIGHT side of the heart has deoxygenated blood and needs to go to the lungs... if it bypasses the lungs and goes to the LEFT side of the heart, this deoxygenated blood will get pumped to the body (no use for it because it's not oxygenated!!)

This is BAD! need surgery to live, short life expectancy
delayed growth & development, exercise intolerance, financial difficulties, pediatric cardiologist



~Know TRouBLE~
&
x Tetralogy of Fallot x

Tetralogy of Fallot = VarieD PictureS Of A Ranch

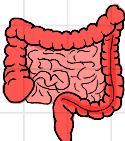
Ventricular Defect
Pulmonary Stenosis
Overriding Aorta
Right Hypertrophy

-QUICK NOTE-

all ↓ defect have murmur
& echocardiogram done

Infectious Disease & Transmission Based Precautions

Contact



Anything enteric

Contact- C diff

Hep A(nus), (vowel for bowel)

Herpes, Staph, RSV

Private room (unless cohort)

PPE - PPE- Gloves, Gown, Disposable supplies/dedicated supplies

Droplet

(sneezing/coughing)



Meningitis, H-flu (causes epiglottis)

Private room (unless cohort)

Lumbar Puncture for cultures

PPE- Gloves, Mask, Pt wears mask when leaving room, Disposable supplies/dedicated supplies (No gown)

Airborne



Measles, Mumps, Rubella, TB, and Varicella.

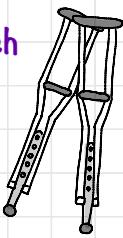
Private room (unless cohort)

Mask, Gloves, Special filter mask (ONLY FOR TB), Pt wear mask when

leaving room, Negative airflow room

PPE Always take off in alphabetical order → Gloves, goggles, gown, mask

Lecture 4: Crutches/Canes/Walkers/Psych



How To Measure Length of Crutches:

2-3 finger widths below the anterior axillary fold to a point lateral to and slightly in front of the foot

*No landmarks on the foot or axilla**

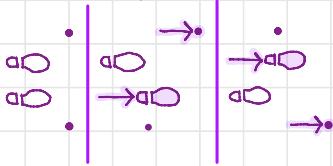
Measure Hand Grip —The angle of elbow flexion is 30 degrees Crutch Gaits

ASK YOURSELF → How many legs are affected? (even for even, odd for odd)

{ 2 legs? Use 2 or 4 point gait
1 leg? Use odd # gait (3) }

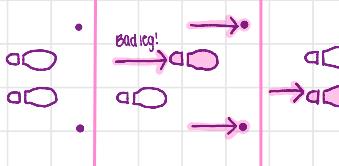
2 point gait

move a crutch and opposite foot together
mild bilateral weakness



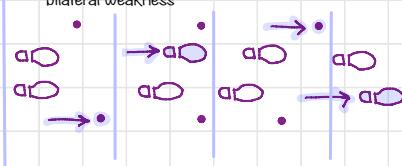
3 point gait

two crutches and bad leg together



4 point gait

Right crutch, left leg, left crutch, right leg, severe bilateral weakness



Swing through: non-weight bearing (amputation) (Amputation with a prosthetic: can bear weight)

STAIRS: Up with the good, down with the bad

Going upstairs, lead with good foot (crutches move with bad legs)

Cane remember COAL - cane opposite affected leg (cane on strong side!)

Walkers - Pick it up, set it down, walk to it

If they must tie something to the walker, tie it to side, not the front of it

No wheels, or tennis balls on walkers**

Psych

ASK YOURSELF

NON-PSYCHOTIC

Has insight (know that they're sick & know it's messing up their life), reality based

ANSWER: good therapeutic communication

"Tell me more about..."

PSYCHOTIC

Doesn't think they're sick & has no insight

S/S: Delusions, Hallucinations, Illusions

Functional

Acknowledge feelings, present reality, set limits, enforce limit

Dementia

Cannot learn reality, acknowledge feelings and redirect

Delirium

Remove underlying cause, acknowledge feelings and reassure them

Delusion: A false, fixed idea or belief. Thinking, not sensing

Paranoid Delusion- False, fixed belief that people are out to harm you

Grandiose Delusion- False, fixed belief that you are superior

Somatic Delusion- False belief about your body (X-ray vision)

Erotomanic Delusion- False, fixed belief another person (usually famous or powerful) is in love with them.

Jealous Delusion- False, fixed belief that their partner is unfaithful

Persecutory Delusion- False, fixed of being treated in a malicious way

Functional psychotics: Can be married, have a family, job, live alone, pay bills... Schizo, Schizo, Major, Manic

Schizo- Schizophrenia

Schizo- Schizo-affective Disorder

Major- Major Depression

Manic- Bipolar

This pt has the potential to learn reality

1. Acknowledge their feelings "You seem angry" "That must be distressing"

"Tell me how you're feeling"

2. Present reality "I know that ____ is real to you, but I don't see ____"

"I am a nurse & this is a hospital"

3. Set a limit "That topic is off limits in our conversation"

"That topic we talk together we're not going to talk about that" "Stop talking about those aliens/voices"

4. Enforce the limit End the conversation *Don't punish/restrict them*

"I see you're too ill to stay reality based, so our conversation is over"

Abnormal (Abn)- Antisocial, Borderline, Narcissistic

Treat them like a functional. Set limits!

Dementia: Brain damage! Cannot learn reality

1. Acknowledge their feelings "That seems exciting"

"I see that you're happy/sad"

2. Redirect them ***DON'T present reality*** DON'T change the subject***

You can reality orient them (person, place, time)

"Ok, let's sit here and you can tell me about church while we wait for your dead husband"

Hallucination: False, fixed sensory experience

Most common in order- Auditory, Visual, Tactile.

Rare ones -Gustatory (tasting) & Olfactory (smelling)

Illusion: Misinterpretation of reality (sensory experience)

The difference between hallucination & illusion is, with an illusion there's a reference in reality. There's actually something there, but they just misinterpreted it. With a hallucination there's actually NOTHING there

Delirium: Temporary, sudden dramatic secondary loss of reality usually due to a chemical imbalance in the body. (Ex- people high on uppers, withdrawal from downers, drugs like Tegamet, post op pt, occult UTI in elderly, thyroid storm, adrenal crisis, etc)

Remove the underline cause & keep them safe

1. Acknowledge their feelings "That seems exciting" "I see that you're happy" "I see that you're sad"

2. Reassure them "You are safe and that will go away when you get better"

Loose associations: "I like to dance, all people have hands."

My feet are wet"

Flight of Ideas- Thought to thought to thought to thought

Word Salad- Random words

Neologism- Making up imaginary words

Narrow Self-concept- When a functional psychotic refuses to leave their room or change their clothes. (They define who they are based on where they are and what they're wearing. They don't know who they are if they get undressed/ it terrifies them)

Ideas of Reference- Pt thinks everyone is talking about them



Lecture 5: Diabetes

an error in glucose metabolism

Diabetes Insipidus → **DI = high & dry** HIGH urine output, DRY body (polyuria, super thirsty polydipsia, leading to dehydration due to low ADH, low specific gravity, fluid volume deficit)

SIADH: → **too much anti-diuretic = body will hold onto fluids**

Low urine output, oliguria, not thirsty, high specific gravity, fluid volume excess

DM Type 1: Insulin dependent, Ketosis Prone

Tx: Diet, Insulin (most important), Exercise (DIE)

DM Type 2: Non-Insulin Dependent, Non-Ketosis Prone

Tx: Diet (most important), Oral hypoglycemic (pill), Activity (DOA)

Calorie restriction** (ex: 1600 calories / day), 6 small feedings / day (ex: 1600 / 6)

Insulin lowers glucose levels (PEAK is tested more)* *When would you check for hypoglycemia? (Peak question)**

Polyuria, polydipsia, polyphagia

	Regular Insulin (short acting)	NPH (Intermediate acting)	Humalog/Lispro (Rapid acting)	Lantus/Glargine (Long acting)
Onset	1hr	6hr	15 min	
Peak	2hrs	8-10hrs	30 min	
Duration	4hrs	12hrs	3 hours	
When to take	Taken before a meal	Taken after a meal	Give insulin with meals	
Quick Notes	Clear solution, Can be IV dripped	Cloudy, suspension, Never IV		Lantus/Larg = Long, Late @ night, low RISK
	Regular, Run (IV)	NPH: Not so fast, Not IV Nine hours		

Check expiration date - After you open a bottle, the new expiration date is 30 days after that, label it!

Teach pts to refrigerate their insulin at home. Hospitals keep unopened bottles of insulin in the fridge, but they can come out of the fridge once opened.

Eat snack before exercise! (Rapidly metabolized carbs)*** Exercise does the same thing as insulin.

Take insulin even when sick! When diabetics are sick their glucose goes up. They have to take their insulin even when they're not eating. Take sips of water or they might get dehydrated. Stay as active as possible.

Humulin 70/30- percentages mixed of insulin Regular (30%) and NPH (70%) (N is in the numerator)

Mix insulin in the same syringe? Yes. Clear before cloudy is Regular before NPH! R to N for RM!

Inject air into NPH, then Inject air into Regular, draw up regular, then draw up NPH — NRRN

Acute Complications of DM:

Hypoglycemia (Drunk + Shock)

Causes: Too much insulin/meds ***, not enough food, too much exercise

CAN CAUSE BRAIN DAMAGE

S/s: [Drunk] Staggering gait, slurred speech, impaired judgment, delayed reaction times, labile (emotions all over the place)

[Shock] Low BP, tachycardia, tachypnea, pallor, clammy, mottled skin

Tx: GIVE SUGAR & STARCH/PROTEIN

Rapidly metabolized carbs (sugar), juice, soda, candy, 1/2 skim milk, orange juice & crackers, apple juice & turkey

*If unconscious give glucagon IM (at home), D10W / D50W IV (in hospital)

Hyperglycemia in Type1- DKA, Diabetic Ketoacidosis, Coma

Causes: #1 Acute viral upper resp. infection within last 2 weeks *** (too much food, not enough meds or exercise)

D Dehydrated (hot, flushed, dry skin)

K Ketones, Kussmaul, K+

A Acidotic, Acetone breath (fruity breath), Anorexia

Tx: IV fluid fast rate w/ Regular Insulin

Hyperglycemia in Type2- HHNK = Dehydration (More Fatal)

Causes: Dehydration

Tx: IV fluids

Chronic Complications of DM: Poor Tissue Perfusion & Peripheral Neuropathy

*Best test for long term is HbA1C (Glycosated Hemoglobin) Good = 6 & lower, Needs work up / evaluation = 7, Out of control = 8 & up

Lecture 6: Toxic Levels/Dumping Syndrome/Electrolytes

	Therapeutic Range	Toxic Level	Hint
Lithium	0.6-1.2	>2	b-12 shots gets you lit ☺
Digoxin/Lanoxin	1-2	Greater than or equal to 2	dig 1-2 holes -_-
Aminophylline	10-20	Greater than or equal to 20	it has 10-20 letters in the name
Dilantin	10-20	Greater than or equal to 20	same as aminophylline
Bilirubin	<9.9	10-20	9 letters in Bilirubin Hospitalize when you get halfway in the elevated (vl) Toxic lvl greater or = 20

Kernicterus- Bilirubin in the brain. Occurs when bilirubin gets around 20

Opisthotonus- Position baby goes in when they have kernicterus (hyperextension due to irritation of the meninges)

What position should you put them in? On their side

Hiatal Hernia

HIgh Everything

High Stomach, feels like Heartburn, need High fluids, High carbs, High HOB

Going the WRONG WAY on a ONEWAY street

Regurgitation of acid into your esophagus because the upper part of stomach herniates upwards through the diaphragm, 2 chambered stomach

S/S GERD aka heartburn / indigestion when you lay down after eating

Tx: High HOB, High fluids, high carbs, Everything needs to be high, except protein (low)



Dumping Syndrome

Keep it low to go slow

Usually following gastric surgery, The gastric contents dump too quickly into the duodenum.

Moving in the right direction at the wrong rate - SPEEDING TICKET!

S/s: Drunk: Staggering gait, slurred speech, delayed reaction time, emotional lability

Shock: Hypotension, pale cold clammy skin, tachycardia

Acute abdominal distress: Pain, guarding, bordyrgmi, diarrhea, bloating, distention, tenderness

Tx: Low position (HOB flat), Turn to side with head down! Low fluids (1-2hrs before or after meals, not with the meals), Low carbs, If you want the stomach to empty slow, everything is low. Except protein

Electrolytes

Earliest sign of any electrolyte imbalance is paresthesia. (Numbness/Tingling)
All electrolyte imbalances cause paresis. (Muscle weakness)

Do the same as the prefix except for heart rate* and urine output

$\downarrow K^+$ **hypokalemia**: Lethargy, bradypnea, dynamic ileum, constipation, flaccid muscles, hyporeflexia, polyuria, tachycardia

$\uparrow K^+$ **hyperkalemia**: Agitation, irritability, tachypnea, tall p waves, elevated ST waves, diarrhea, borborygmi, spastic muscles, hyperreflexia, oliguria, bradycardia

TREATMENT Never IV push K+! Never give more than 40 of K+ per liter of IV fluid!

Fastest way to lower K+ = **Give D5W with regular insulin** TEMPORARY FIX BUT WORKS FAST
(K+ in blood will kill you, not K+ in cells)

Kayexalate works LATE but it is permanent

Full of sodium, given via enema or orally

Trades sodium for K+ so u shit it out! It results in hypernatremia (dehydration) so give them fluids to correct it

K+

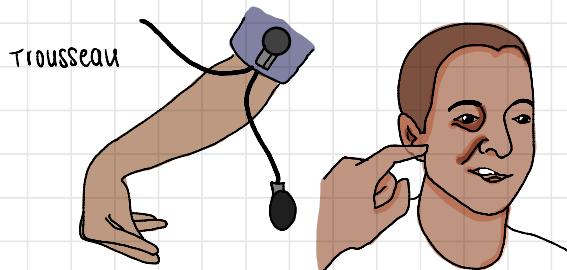
Do the opposite of prefix. Muscles & nerves* (Ca and Mg have same s/s) **Pick Calcium > Magnesium**

$\downarrow Ca (mg)$ Tachycardia, agitation, irritability, tachypnea, diarrhea, borborygmi, spastic muscles,

hypocalcemia hyperreflexia, seizure, chvostek (cheek, face spasm) sign & trousseau sign (BP hand spasm), guy french man* lol

$\uparrow Ca (mg)$ bradycardia, bradypnea, flaccid muscles, hypoactive

hypercalcemia reflexes, lethargy, constipation



Chvostek \rightarrow Stick (stick) you in your cheek

Dehydration Vs. Fluid Overload **The one with the E is dehydration, the one with the O is overload**

$\downarrow Na^+$

hyponatremia

Overload- HypOnatremia, fluid restriction & give Lasix

$\uparrow Na^+$

hypernatremia

Dehydration- HypErnatremia, hot flushed skin give lots of fluids, hot/flushed skin

Na⁺

Lecture 7- Endocrine Glands/Toys/Laminectomy

Know thyroid and adrenal

Hyperthyroidism: Graves Disease

Turn thyroid into metabolism (hyper metabolism), "You're going to run yourself into the grave".

Missy Elliot is a closet Elsa, the cold never bothered her anyway, and she hates the beach

Weight loss, high HR, low BP, irritable/hyper, heat intolerance, cold tolerance, exophthalmos (bulging eyes)



Treatment

Radioactive Iodine

Pt should be isolated for 24 hrs,
They have to be careful with their urine,
flush 3 times
If they spill it you need to call hospital
hazmat team

PTU

Stands for = Puts Thyroid Under
Monitor WBC's, (b/c it's a cancer drug)

Thyroidectomy

Total = lifelong hormone replacement,
risk for hypocalcemia (total = total of
your life you will need tx)

Sub = risk for thyroid storm (sub =
storm)

Thyroid storm/crisis/thyrotoxicosis

Very high temps of 105+, very high BP (stroke category), severe tachycardia, psychotically delirious. VERY BAD! Causes brain damage
Ice pack (First), Cooling blanket (Best), O2 per mask @ 10 L

Do not medicate. They will either come out on their own or die, 2 staff to 1 pt

Post Op Risks:

In the first 12 hrs, top priority is airway

2nd is hemorrhage.

12-48hrs for Total is Tetany r/t hypocalcemia

NEVER PICK INFECTION IN FIRST 72 HRS!

12-48hrs for Subtotal is Storm

Hypothyroidism (Hypo metabolism) \Rightarrow Myxedema

LOW AND SLOW

Obese, flat/boring/dull personality, heat tolerance, cold intolerance, pulse and BP low

Treatment

Thyroid hormone Synthroid (levothyroxine)

CAUTION: Do not sedate these people! They will get into a myxedema coma

NEVER HOLD THYROID HORMONES THE DAY OF SURGERY!

Adrenal Cortex Diseases

All start with A or C

Addison's Disease: Under Secretions of Adrenal Cortex →

S/S: Hyperpigmentation & CANNOT ADAPT TO STRESS

STRESS = SHOCK (glucose and no will go down)

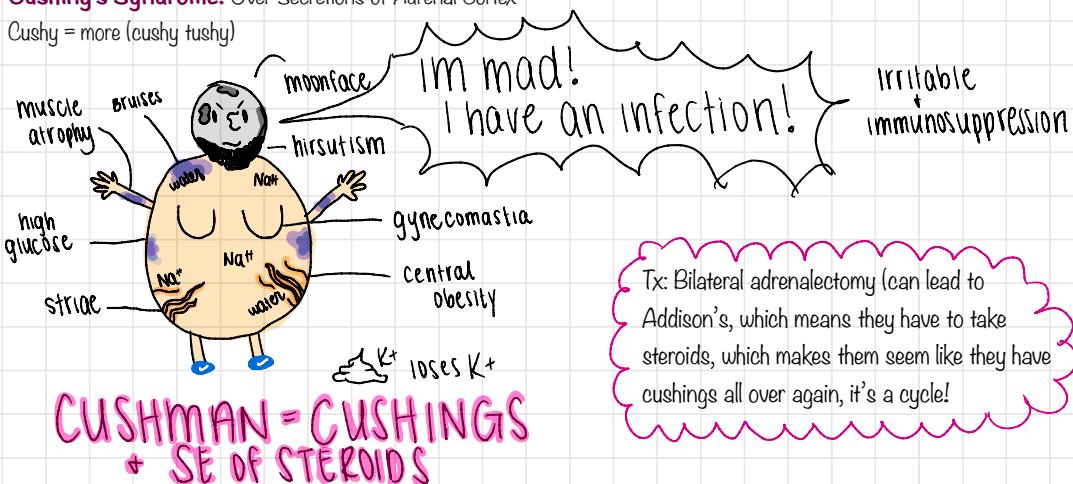
Tx: Steroids (-sones) In Addison's you need to ADD iSONe

HYPERTIGMENTATION

∅ + STRESS

Cushing's Syndrome: Over Secretions of Adrenal Cortex

Cushy = more (cushy tushy)



Tx: Bilateral adrenalectomy (can lead to Addison's, which means they have to take steroids, which makes them seem like they have cushings all over again, it's a cycle!)

TOYS

SAFETY: No small toys for kids under 4, No metal/die-cast toys if o2 is in use (sparks), Beware of fomites (teddy)(nonliving object that harbors microorganisms)

0-6 months	Musical mobile, Soft & large
6-9 months	Teach object permanence (looks for the toy when you hide it) Best option is a "cover/uncover toy" (Ex: Jack in the box, peek a boo), Second best: large plastic/wood/metal Worst toy is a musical mobile! NEVER pick answers with the words: build, sort, stack, make, construct, for a child under 9 months
9-12 months	Learning to speak, Speaking toys, Talking books, purposeful activities (build, sort, stack, make, construct)
Toddlers (1-3 years)	Push/pull toy (Ex: stroller, doggie, wagon, etc) Work on gross motor skills: running/jumping, DO NOT choose answers with finger dexterity (Ex: Cut, use pencils, color) *NOT INCLUDING FINGER PAINTING!* Parallel play - play alongside other kids, but not together
Preschoolers	Finger dexterity/work on balance - Tricycles, Tumbling Class/Dance Class, Coloring Cooperative Play = Play together (They like to pretend play (Imaginative thinkers))
School Aged Kids	Create, Collective, & Competitive
Adolescence	Hang out with friends! (unless pt is fresh out of post op (<12 hrs), contagious disease, or immunosuppressed)

Laminectomy Removal of vertebral spinal processes (winged ends of vertebrae)

Relieves nerve root compression! S/S or nerve root compression = 3 P's: Pain, Paresthesia, Paresis

The most important thing to pay attention to is location b/c it will determine prognosis, treatment, symptoms

CERVICAL

Pre op: Airway and Arms

Complications: Pneumonia

THORACIC

Pre op: Cough/Bowels (coughing using abdominal muscles)

Complications: Pneumonia & Paralytic Ileus

LUMBAR

Pre op: Bladder & Legs

Complications: Urinary Retention, legs problems

Post op spinal #1 answer: log roll**

DON'T DANGLE THE PTS LEGS! DON'T SIT FOR LONGER THAN 30 MINS!

THEY MAY WALK, STAND, LAY DOWN W/O RESTRICTION

Discharge teaching:

4 temporary restrictions (6 weeks)

Don't sit for longer than 30 mins

Lie flat & log roll

No driving

Do not lift more than 5 pounds (gallon of milk)

3 permanent restrictions:

Never lift objects by bending with the waist

Cervical lams not allowed to lift ANYTHING over their head

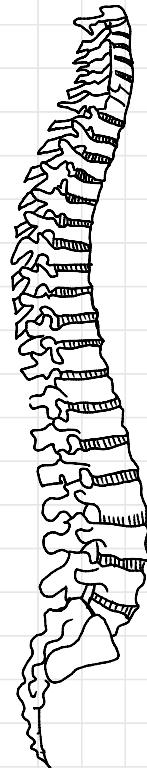
No jerking, horse back riding, 6 flags

Anterior Thoracic: From the front thru the chest to the spine → will have a chest tube

Laminectomy w/fusion: Bone graft from the iliac crest, incisions include one on the hip & one on the spine

Hip incision will have the most pain/bleeding/draining

Both have equal risk for infection! Spine has highest risk of rejection!



A: Abnormal (do nothing)

B: Be concerned (assess/monitor)

C: Critical (do something, can leave bedside)

D: Deadly/Dangerous (ACT NOW, DO NOT leave bedside)

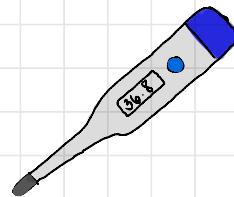
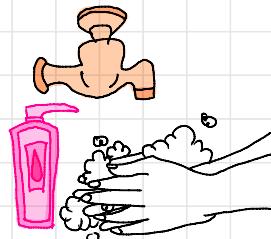
Lecture 8: Lab Values

	Range	A, B, C, or D	Nursing
Serum Creatinine	0.6-1.2	high is A, if due procedure then it is higher priority	
INR	2-3	Anything 4+ is (C)	hold Coumadin, assess for bleeding, prepare to give vit k, call doc
Potassium	3.5-5.3	Low or high is C, 6+ is D	hold K, assess heart, prepare to give Kayexelate or D5 w/regular insulin, call doc
pH	7.35-7.45	Anything in the 6's is a (D)	Are they alive? check vitals & call doc
BUN	8-25	A	Assess for dehydration
Hemoglobin	12-18	If 8-11 it's a B Below 8 is a C	Assess for anemia/bleeding/malnutrition Assess for bleeding, prepare to give blood, call doc
Bicarbonate	22-26	A	No one really cares
CO ₂	35-45	46-59 is a (C) 60+ is a (D) RESP FAILURE	Assess respirations, do pursed lip breathing Assess respirations, prepare for intubation/ventilation, call respiratory therapy then the doctor
PO ₂	78-100	Low 70s it's a (C) 60s and lower is a (D) RESP FAILURE	Assess respiratory, prepare to give O ₂ Give O ₂ , assess respirations, prepare for intubation/ventilation, call respiratory therapy then doctor
O ₂	93-100	<93 it's a (C) Falsely elevated with anemia and dye	Assess respirations, raise head of bed, give O ₂ , unless "best" question then just give O ₂
Hematocrit	36-54	54+ is a (B)	Assess for dehydration
	3x's the hemoglobin		
BNP	<100	100+ (B)	Look for signs of CHF
Sodium	135-145	(B) Unless change in LOC, then it's a (C)	Assess for dehydration or overload
Platelets		<90,000 is a (C) <40,000 is a D	
RBCs	4-6 mil	B	
WBC	5,000-11,000	Less than normal value for WBC, ANC, CD4 are all (C)	Neutropenic Precautions**
ANC	500+		
CD4	200+	Low CD4=AIDS	

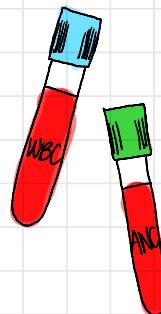
Neutropenic Precautions

- Strict Hand washing
- Shower BID with antimicrobial soap
- Avoid Crowds
- Private Room
- Limit numbers of staff entering room
- Limit Visitors for Healthy Adults
- No fresh flowers or potted plants
- Low Bacteria Diet: No Raw Fruits, Veggies, Salads, No Undercooked meat
- Do not drink water than has been standing longer than 15 minutes
- Vital signs (Especially Temperature) every 4 hours
- Check WBC (ANC) Daily
- Avoid the use of an indwelling catheter
- Do not re-use cups.. must wash between uses
- Use disposable plates, cups, straws, plastic knife, fork, spoon
- Dedicated Items in Room: Stethoscope, BP Cuff, Thermometer, Gloves

ASSESS FOR INFECTION!!!



Ø 15min



Lecture 9 - Psychotropic Drugs

All psych drugs cause hypotension & weight gain

Phenothiazines: 1st Gen / Typical Antipsychotics (All end in zines*)

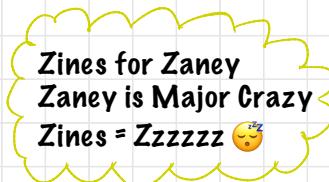
They don't cure psych diseases, only reduce symptoms

Zines for the zaney Zaney is crazy

Small doses are anti-emetics, large doses for psychosis

Major tranquilizers

*DO NOT confuse *zeps for *zines



Side Effects: (Non-toxic) #1 nursing dx is risk for injury

A Anticholinergic (dry mouth)

B Blurred vision

C Constipation

D Drowsiness

EPS- extrapyramidal syndrome (Pill rolling, cogwheel rigidity, shuffling gait)

Fotosensitivity

aGranulocytosis (Low WBC immunosuppressed)

If Pt Displays Side Effect:

Teach pt to keep taking the drug

Inform the Dr

Treat the SE

If Pt Displays Toxic Effects:

Hold the drug & call the Dr immediately

Deconate = after the name of a drug, it is a long acting drug IM form given to non compliant patients

Tricyclic Antidepressants: (NSSRIs)

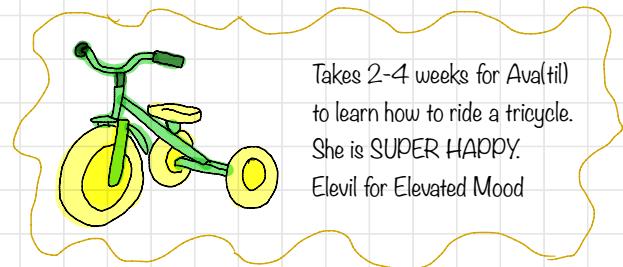
Take for 2-4 weeks before you see effects

Elavil, Tofranil*, Avatil, Desyrel (it rhymes)

Elavil elevates your mood, E for Euphoria

SAME SE, EXCEPT E is for Euphoria (no F or G)

Can take for rest of life



Benzodiazepines: Minor tranquilizers, Anti Anxiety

They always have "zep" in the name

"Zep Zep" Zep works fast! Zzz for sleeping (minor tranquilizer)

Indication: Pre-op to induce anesthesia, Muscle Relaxer, Alcohol Withdrawal, Seizures, Help when pt is fighting the ventilator to calm down (DO NOT take longer than 2-4 weeks)

Side effects: A, B, C, D

*DO NOT confuse *zeps for *zines

MAOI's: Monoamine Oxidase Inhibitors

Beginning of the names all rhyme - Partite, Nardil, Marplan, (Par, Nar, Mar) or PaNaMa

AVOID ALL FOODS CONTAINING TYRAMINE (prevents hypertensive crisis)

Salad BAR Bananas Avocados. Raisins (dried fruit) Yogurt/Dairy EXCEPT for mozzarella and cottage cheese

Organ/preserved/hot dogs/lunch meats (smoked, dried, cured, pickled, etc.)

Alcohol. Chocolate

Don't take OTC meds while on MAOI's

Lithium: Bipolar disorder → Decreases mania! Not for depression

Only psych drug that doesn't mess with neurotransmitters

SE: 3 P's - Peeing, Pooping, Paresthesia - Give & don't call the Dr

Toxic effects: Tremors, metallic taste, severe diarrhea - Hold & call Dr

#1 Intervention while on the med: FLUIDS, ELECTROLYTES, WATCH FOR DEHYDRATION & MONITOR Na

Low sodium = makes lithium toxic / High sodium = lithium won't work

SE: A, B, C, D, & E for Euphoria

Insomnia- Give BEFORE noon, NOT at bedtime

Increased suicide risk when changing doses with young adults



Haldol: Schizophrenic, Typical 1st Gen Antipsychotic

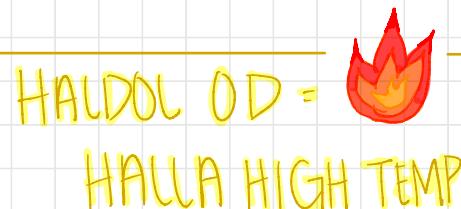
SE: A, B, C, D, E, F, G (destroys marrow) (same SE as -zines)

****NMS Neuroleptic Malignant Syndrome*****

Potentially fatal hyperpyrexia (105-108)! Includes anxiety and tremors

At Risk: Young white men & elderly dudes can get it from overdose (Give elderly half of adult dose)

Take the temp to tell the difference from EPS

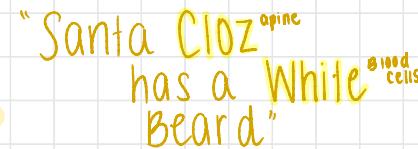


Clozaril/Clozapine: 2nd Gen Atypical Antipsychotic

Used to treat severe schizophrenia, made to replace the *zines and haldol

Does NOT have the side effects (A-F), Has SEVERE agranulocytosis (immunosuppressed)

Monitor WBCs, they can fall very low



Geodon (Ziprasidone)

Black box warning- Prolongs QT interval and can cause sudden cardiac arrest, DON'T give to people with heart conditions.

Zoloft (Sertraline)

SSRI, can cause insomnia but you can give it at bedtime

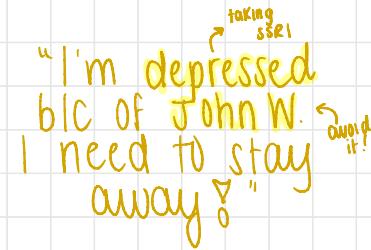
Zoloft interferes with this system increasing toxicity with other drugs

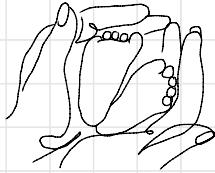
Lower the dose of other drugs! Warfarin/Coumadin must be reduced because you can bleed out

St. John Wort + Zoloft = Serotonin syndrome

Sweating, Apprehension/impending sense of doom, Dizziness, HEADaches

DON'T TAKE St. John Wort





Lecture 10 & 11 - Maternal/Newborn

First day of the LMP + 7 days - 3 months
Average weight gain- 28 lbs plus or minus 3 lbs



1st Trimester

1-12 weeks
1 lb/month, total: 3 lbs
Fundus not palpable
Mother is Priority
If you can palpate the fundus or she gains 10lb, she might have a hydatidiform mole, or not really be in the 1st trimester
You can palpate the fundus at the end of the 1st tri
Visit once a month
Frequent urination

2nd Trimester

13 - 27 weeks
1 lb/week
Fundus at umbilicus or below it
Mother is Priority
At 20-22 weeks the fundus is at the umbilicus
Quickenning (kicking): 16-20 weeks
Visit once a month
Difficulty breathing
Back Pain

3rd Trimester

28 - 40 weeks
1 lb/week
Fundus above umbilicus
Baby is Priority
Ideal weight gain: [Week of gestation] - 9 plus or minus a couple lbs
If more than 3 lbs, you need to assess, something could be wrong
Week 28 come once every 2 weeks until week 3?
Week 36 every week until delivery until week 42.
Frequent urination
Difficulty breathing
Back Pain

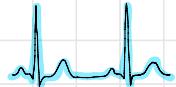
OB Questions

HR begins to beat at 5 weeks, but you can hear it at 8-12 weeks, and when the examiner palpates fetal movement
"First" pick earliest part of range
"Most likely" pick mid part of range
"Should" pick end of range
 When would you first auscultate a fetal heart? - 8 weeks
 When would you most likely auscultate a fetal heart? - 10 weeks
 When should you first auscultate a fetal heart by? - 12 weeks

Signs of Pregnancy:

4 Positive Signs (DEFINITELY PREGNANT)

Fetal skeleton on x-ray, fetal presence on ultrasound, auscultation of FHR, examiner palpates fetal movement



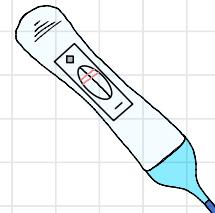
4 Probable/Presumptive "The Maybes":

Positive Prego Test, Chadwick, Goodells, Hagar signs (Alphabetical in that order)

Chadwick: Cervical color change to cyanosis (#4 blue candle, C in Chadwick for Cyanosis)

Goodells: Cervical softening (good when your cervix softens, 2 l's = 2 month)

Hagar: Uterine softening (upside down g for 6 months)



Pt Teaching:

When to visit

Frequent Urination? Minimum Q2hrs void (1st and 3rd)

Difficulty Breathing? Tripod Position (2nd and 3rd)

Back Pain? Pelvic Tilt Exercises (2nd and 3rd)

Hemoglobin will fall, it can fall to 10 & still be normal

Treat morning sickness w/ dry carbs before you get out of bed, not for breakfast

Labor & Birth

Valid sign of labor: Onset of regular progressive contractions

Dilation: Opening of cervix 0-10 cm.

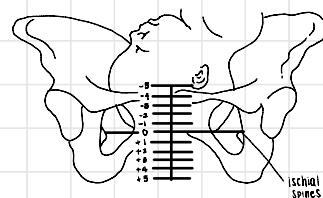
Effacement: Thinning of the cervix. From thick to 100%

Station

Relationship between the fetal presenting part & the ischial spines

Negative station: Presenting part is above the tight squeeze (-1, -2) BAD

Positive stations: Presenting part is below the tight squeeze (+1, +2) GOOD



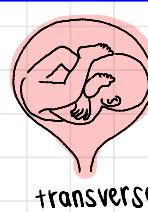
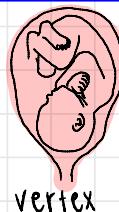
LIE

Relationship between the spine of mom & spine of baby

Vertex lie (longitudinal): Compatible for natural birth -

Mom's spine and baby's spine are parallel (Good)

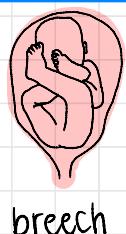
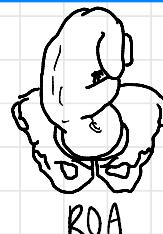
Transverse lie (shoulder presentation): Trouble



Presentation

Part of baby that enters the birth canal first

Most common is: ROA or LOA



4 Stages of Labor ↴ {*Phase IS NOT Stage*}

Stage One: purpose of uterine contractions in 1st stage: **dilate & efface the cervix**

Phase 1 (Latent) 0-4 cm, frequency 5 - 30 mins apart, lasts 15-30secs, intensity mild

Phase 2 (Active) 5-7 cm, frequency 3-5 mins apart, lasts 30-60 secs, intensity moderate

Phase 3 (Transition) 8-10 cm, frequency 2-3 mins, lasts 60-90 secs, intensity strong st

Stage Two: Delivery of the baby

Deliver head

Suction the mouth then nose

Check for nuchal (around the neck) cord

Deliver shoulders then body

Baby must have ID band on before leaving the delivery area

Stage Three: Delivery of the placenta

Make sure it's all there

Check for a 3 vessel cord- 2 arteries 1 vein- AVA

Stage Four: Recovery

Contract the uterus to stop bleeding

Postpartum technically begins 2 hours after the placenta comes out

4 things you do 4 times (q 15 min) an hour in the 4th stage:

Vital Signs: Looking for S/S of shock (BP down, HR go up, cold and clammy)

Fundus check: If boggy=massage, if displaced= void / catheterize

Pads: Check pad saturation. If bleeding excessively she will saturate a whole pad (100%) in 15 mins or less, if 98% saturated it's okay. She should not soak a pad in one hour or less due to risk of hemorrhage.

Roll her over: check for bleeding underneath her

Uterine tetany/Uterine hyperstimulation

Constrictions lasting longer than 90 seconds & closer than every 2 mins **STOP PITOCIN**

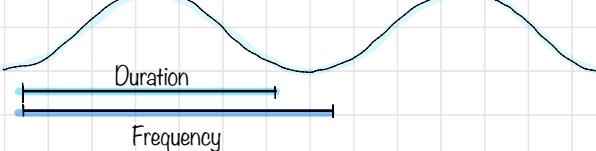
How to time contractions:

Frequency: The beginning of one to the beginning of the next

Duration: Beginning to end of one contraction

Intensity: How strong they are & subjective (Palpate w/ 1 hand over the fundus w/ the pads of the fingers)

Uterine Contractions



Complications:

Pain management: Do not administer pain med to a woman if the baby is likely to be born when the med peaks

Painful back labor: OP (occiput posterior) IS OH PAIN

Position THEN Push: Knee chest(FaceDownAssUp), then push (take fist & push into sacrum)

Prolapsed Cord: BAD - Cord is presenting part

PUSH THEN POSITION (push the head back in then position knee chest)

Interventions for all other complications of birth: LION

If Pitocin is running stop the Pitocin first! & then do LION*****

L *eft side* I *ncrease* IV O₂ N *otify*

Post Partum Assessment = BUBBLE 4-8 hrs

B *reasts* U *terus* B *owel* B *ladder* L *ochia* E *xtremity check* E *pisotomy*

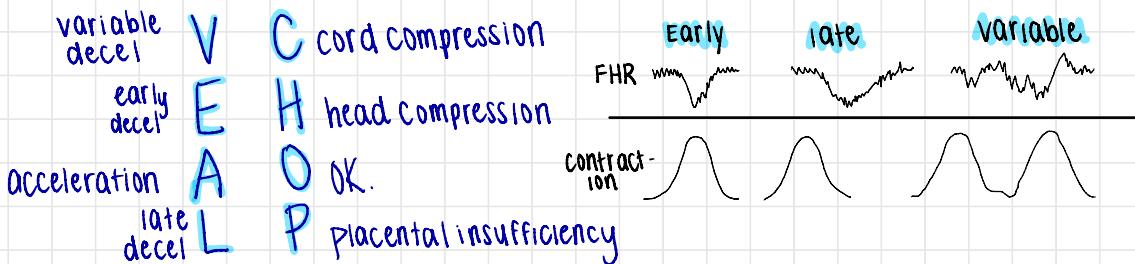
Uterine Fundus: If boggy, massage, If displaced, catheterize.

Fundal height = Day postpartum (ex-4 hotspot below) Make sure it's midline!

Lochia: Rubra (Red), Serosa (Rosa = Rosey = Pinkish), Alba (White)

Extremity Check: look for thrombophlebitis via bilateral calf measurements

Fetal Monitoring Patterns = VEAL CHOP



Low fetal HR- under 110 STOP PIT & LION

High fetal HR- over 160, normal, document take mom's temp

Low baseline variability- stays the same, does not fluctuate, BAD, LION

High baseline variability- always changing, good, document

Late decels- baby's heart slows after contraction, BAD, LION

Early decels- baby's heart slows before or at contraction, good

Variable decels- very bad, prolapsed cord, put mom in push then position

Any position that starts with L, do LION, except variable (push position)

V's = Variable = VERY BAD

Check fetal heart rate — always a good choice on test

Variations in the Newborn:

Caput Succedaneum- Crosses Sutures and Caput Symmetrical **CS**

Cephalohematoma- doesn't cross & asymmetrical

Pathological Jaundice- normal

Physiological Jaundice- 24hrs after birth

OB Meds:

Tocolytics: Stops labor

Terbutaline - (causes maternal tachy)

Mg Sulfate- (causes hypermagnesemia) making uterine contractions, HR, BP, reflexes, respiratory rate, and LOC go down)

As long as the respirations are above 12, it's ok. If under titrate down 2+ reflexes is good, 1+ is bad

Oxytoxics: Stimulate & strengthen labor

Pitocin- Causes uterine hyper stimulation (longer than 90, closer than q 2

mins)

Methergine- Causes high BP

Fetal Lung Maturing Meds:

Betamethasone (steroid)- Mom gets it, given IM, given before the baby is born

Servanta (surfactant)- Given to the neonate, given trans-tracheal (blown into the trachea), given after the baby is born

The only antipsychotic pregnant women can get is Haldol

INSULIN

Humulin 70/30- percentages mixed of insulin

Regular (30%) and NPH (70%) (N is in the numerator)

Mix insulin in the same syringe? Yes. Clear before cloudy is Regular before NPH! R to N for RN!

Inject air into NPH, then inject air into Regular, draw up regular, then draw up NPH — NRRN

Heparin

given IV or SQ, works immediately, cannot be given for more than

3 weeks (except for Lovenox)

Antidote: protamine sulfate,

Lab: PTT (count on your fingers "heparin" you're only left with 3 fingers)

can be given to pregnant women

Coumadin

given only PO, takes a few days to a week to work, can take forever, antidote: vitamin K, lab: PT/INR (count on your fingers "Coumadin" you're only left with 2 fingers), cannot be given to pregnant women

PYSCH Nurse/PT Relationships

Know what phase of the relationship you are in

Gift giving: Do not give/accept gifts from patients

Don't give advice- "What do you think I should do"

Don't guarantee anything- "If you talk to me I can help you/don't cry you'll feel better"

Best answer is the one that keeps them talking (open ended), it's never wrong to get a patient to talk in any instance

Concreteness- Don't use slang because psych patients take things literally. Don't ask them what their neologisms are

Empathy- acknowledge feeling, always be empathetic. Never choose answers like this "don't feel..." "don't worry", Read the feeling in the q.

Recognize an empathy question: always have quote in the question and in the answers.

Put yourself in the clients shoes

Ask yourself "If I said those words and meant them, how would I be feeling?"

Choose the answer that reflects that feeling, NOT their words. Empathy ignores what is said and responds to what they feel.

INJECTION

IM: 21 gauge/1inch 1 in IM looks like 1

Subcutaneous: 25gauge 5/8ths S in SQ looks like 5

K⁺ WASTING vs SPARING

Any diuretic ending in X X's out K⁺ (wastes) + Diuril

All others are sparing

MUSCLE RELAXANTS

Fatigue/Drowsiness/Muscle weakness

Teach not to drink/drive/operate heavy machinery when taking these

Baclofen and Flexeril are most tested**

When you're on your Baclofen you are your Back Loafin'

PIAGET'S THEORY

Present oriented (0-2 y/o): PRESENT, teach verbally while you do it, pre-teach parents

Pre-operational (3-6 y/o): Pre school for pre teaching, fantasy oriented pick answer with "the morning/day of" or "two hours before" teach what you are going to do (future tense) through play, they are very imaginative!

Concrete operational (7-11 y/o): "concrete 7-11's" rule oriented, teach days ahead, teach what you're going to do + teach skills with age appropriate reading and demonstration

Formal Operational (12+ y/o): can abstract, adult medsurg question, teach like an adult, can manage their own care

Lecture 12 - Prioritization/Delegation/MGMT

Question Format

Age, gender, dx, and modifying phrase, i.e.: "10 yr old male w/ **hypospadias** who's throwing up bile & emesis."

Irrelevant are age and gender

Dx & modifying phrase is important, but **modifying phrase is always more important**

Prioritization

Acute > Chronic

1st 12 hrs POST OP

unstable > stable

Stable Pts

The word "stable" Chronic illness Local or regional Anesthesia Unchanged assessment

Post op greater than 12hrs Lab abnormalities of an A or B level

Phrases "ready for discharge", "to be discharged", or "admitted longer than 24hrs ago"

Experiencing the typical expected s/s of the disease with which they were diagnosed

Unstable Pts

The word "unstable" Acute illness General Anesthesia Changing/changed assessment

Post op less than 12hrs Lab abnormalities of C or D

Phrases "not ready for discharge", "newly admitted", "newly diagnosed", or "admitted less than 24 hrs ago"

Experiencing unexpected s/s of the disease with which they're diagnosed

Always Unstable Regardless of Whether It's Expected or Not (4):

Hemorrhage (there's a difference between bleeding)

High fevers (105+)

Hypoglycemia

Pulselessness or breathlessness **Unless it was unwitnessed, then they're dead already and not a priority**

Black Tags in an Unwitnessed Accident: **LOW PRIORITY!**

Pulselessness, Breathlessness, Fixed and dilated pupils (even if they're still breathing)

Still STUCK? → TIE BREAKER

The more vital the organ, the higher the priority (organ in modifying phrase, not dx)

#1 Brain



#2 Lungs



#3 Heart



- 4. Liver
- 5. Kidney
- 6. Pancreas

DELEGATION

Do not delegate what you can EAT

Evaluate
Assess
Teach

LPN - DO NOT DELEGATE

Starting/Hanging/Mixing anything IV, NO IVP meds (they can only maintain and doc flow)

They can't administer blood or mess with central lines (including flushing or changing central line dressings unless that's the only option they can do)

They cannot plan or create the care, BUT they can implement

They can't perform/develop teaching, BUT they can reinforce it

They can't care for unstable patients

They can't do the first of anything, RN must do the first of anything

New is for you!

They can't do admission/discharge/transfer/first assessment after a change

UAP/Aid

WHAT YOU CAN DELEGATE; Topical OTC barrier creams, Vital signs, accucheck, enemas, ADLs (not the first one and only on stable patients)

BESIDES THAT, they cannot chart about the pt (can only chart what they did), give meds, assess, treat, nor delegate to the family of the pt safety responsibilities (i.e.: taking off restraints for a family member in the room)

With sitters/care givers, they can only do what you teach them to do and you must make sure you document that you taught them

Staff Management

How do you handle inappropriate behavior amongst staff?

There are always four answers: "Tell supervisor," "Confront them and take over immediately," "Approach them later and talk to them about it," and "Ignore the behavior"

Never ignore inappropriate behavior. That is never the answer!

ASK YOURSELF

Is pt in immediate harm? →

Yes? Confront and intervene immediately.

No? Approach them later.

Is what they are doing illegal? → Yes? Always tell supervisor

How To Guess:

Use knowledge first, then common sense, then educated guess

Psych questions: Best answer is “the nurse will examine their own feelings about...” to prevent countertransference. Another is “Establish a trusting relationship”.

Nutrition questions: Pick chicken (unless it's fried), if chicken's not there pick fish (not shellfish). Also never pick casseroles for children. Never mix meds in children's food. For toddlers choose finger foods. Preschoolers leave them alone, one meal a day is okay.

Pharmacology questions: Memorize side effects of drugs. If you know what a drug does but you don't know the side effects, pick a side effect in the same body system where the drug is working (i.e: GI drug pick diarrhea or a CNS drug pick drowsiness etc...). If you don't know what the drug is, look to see if it's PO pick a GI side effect (works about 50/50). Never tell a child medicine is candy.

OB questions: check fetal heart rate.

Med Surg questions: LOC over airway on assessments, but the first thing you do should be establish airway

Pediatric Growth and Development questions-

3 Rules based on the principle: Always give the child more time, don't rush their growth and development

Rule 1: When in doubt call it normal

Rule 2: When in doubt pick the older age (if there is 2 ages it could be, pick the older age)

Rule 3: When in doubt pick the easier task (roll over is easier than sitting up)

Rule out generalized absolutes if you're guessing (all, never, everyone, etc...)

If two answers say the same thing, neither of them is right

If two answers are opposite, one of them is probably right

The “Umbrella Strategy”: look for an answer that covers all the others without saying it does (i.e: use safety and good body mechanics when transferring a patient from bed to wheelchair)

If the question gives you four right answers and the question is asking for prioritization, use the rules above, however if they give you one patient in the question and it asks “which needs is highest priority” don't use it! Do the worst consequence game. Choose the answer with the most severe consequence.

When you're stuck between two answers, re-read the question

The Sesame Street Rule: (use as a last resort) Right answers tend to be different than the others because it is the only one which is right so the other “wrong” answers have something in common

Don't be tempted to answer a question based on your ignorance instead of your knowledge. Pull the “thing” you don't know out of the question and answer it with the things you know. Boards will give you things you never heard of to measure your common sense

If something really seems right, it probably is. **DON'T go against your gut answer unless you can prove why the other is superior**

Conflicts on the job: never say “you” Always say “I”

Headache good thing to check on SATA!

NEVER PICK INFECTION IN FIRST 72 HRS of anything!

DO NOT have these 3 Expectations because they cause negativity:

Rule #1: Don't expect 75 questions, prepare to get all 265 questions. “I'm still in the game”.

Rule #2: Don't expect to know everything.

Rule #3: Don't expect everything to go right.

GOOD

LUCK!