NR224 Final Exam

Nursing Process

- Assessment-
  - Gathering data - Biographical/subjective/objective data, hx, GA: hygiene, facial expression, alert, allergies/pain, Vital Signs, Head to Toe Assess
  - How do we know if we have enough data? After going through entire checklist. 1min Head-Toe = ABCs
- Diagnosis
  - Clustering data/finding patterns Nursing dx, identify a health-related problem/something that can develop
  - Diagnostic label (NANDA) related to etiology as evidenced by assessment data i.e.: Impaired O2 exchange related to an etiology, evidence by.. S
- Planning
  - Prioritize, set up goals and outcomes, and plan what needs to occur
  Stay away from risks for.
- Implementation
  - Putting the interventions into action. Doing.
- Evaluation
  - Were goals met? How do you know? Does the client agree? Do items need to be modified? Can the plan of care or parts of the plan of care be discontinued? Mo dified?

Question

- By the end of the 2nd postop day, a client has not achieved satisfactory pain relief. Based on this evaluation, which of the following actions should the nurse take, according to the nursing process?
  - A. Reassess the client to determine the reasons for inadequate pain relief - Incorrect bc need to know why the pain is still there => Pain could an indicater Something be
  - B. Wait to see whether the pain lessens in the next 24 hours
  - C. Change the plan of care to provide different pain relief interventions
  - D. Teach the client about the plan of care for managing pain

Infection Control

Infection Inhabits → Infection is present, no S/S yet. Contagious → S/S present

- Stages of Infection - Incubation, Prodromal, Illness, Convalesce -> Recovery
- Types of isolation and the diseases
- Standard precautions
  - PPE on: gown, mask, goggles, gloves
  - PPE off: gloves, goggles, gown, mask
- Medical vs. surgical asepsis - Sterile
- Healthcare acquired infections

Clean gloves

HAI: Iatrogenic - Procedure associated infection
Exogenous - microorganism outside of the individual - food poisoning
Endogenous - Pt's normal flora becomes altered => abdnormal growth.

Standard (hand hygiene), Contact (gown & gloves), Airborne (n95, + Gown, gloves, goggles)
C. Diff, wounds, MERSA
- measles, varicella, TB

Question

- A nurse is reviewing hand hygiene techniques with a group of assistive personnel. Which of the following instructions should the nurse include in this discussion? (Select All That Apply)
  - A. Apply 3 to 5 mL of liquid soap to dry hands (wet)
  - B. Wash the hands with soap and water for at least 20 seconds
  - C. Rinse the hands with hot water
  - D. Use a clean paper towel to turn off hand faucets
  - E. Allow the hands to air dry after washing

Vital Signs

Temp: 97°F - 99°F (36.1C 98.6 37.2C), BP: 120/80, HR: 60-100 bpm, RR: 12-16, SPO2: 95% - 100%

- Vital sign ranges
  - What are the terms when they are not in range? Temp: exercise, age, hormone level, circadian rhythm, enviroment
  - What are the rationales, clinical judgements, and interventions if not in range? -> Hot or cold to drink
- Assessments to complete with each vital sign HR: last smoke?
- How to perform the skill

O2 stats: nail polish, cold hands, edema/swelling
BP: measure @ level of heart, size of cuff, where IV sites are, AV fistula/mastectomy/traumc

Question

- A nurse is explaining to a group of nursing students the various factors that can affect a client's heart rate. List 5 factors that can cause tachycardia and 5 factors that can cause bradycardia. Tachycardia - dehydration, pain, Infection, medication, exercise/activity, fever, position changes, Respiratory: anemia, hypoxia, anxiety, stress, hypovolemia

Bradycardia - Decrease oxygen, immobility, ↓↓ cardiac output, long term athletes (body is trained from frequent exercise)
hypothermia, change in positions, hypothyroidism.

Skin Integrity and Wound Care

- Risk Factors for Pressure Ulcer Development -> sensory issues, impaired mobility, alterations in LOC, friction, shear, moisture, nutrition (low albumin Prote
- Friction and shear: F-rubbing or resistance that the body meets (moving to surface to surface) Chronic diseases, age, &
- Skin assessment and assessment tools ?? Shear - Force exerted on the skin while the skin remains stationary & the bony structures move. Culture.
- Healing process
  - primary and secondary intention
  - •We side the pt up in bed & they slide back down into the groove.
- Stages of pressure injuries
- Assessing a wound
  - Tissue types Eschar - black necrotic tissue
    Slough - brown, yellow, white stringy moist
  - Drainage types
  - Measurements L x W x Depth
- Wound skill

Suspected deep tissue Injury
Purple bruise, touch is soft & boggy

Serous - clear -> Serosanguinous: clear & watery - little bit of blood.
Sanguinous - bloody
Purulent - pus, green, brown

1: redness, intact skin, warmth, nonblanchable
2: breakdown in skin, open wound bed, fluid fil blister
3: Full thickness skin loss, subq fat, edges, tunnelin
4: bone, tendon, muscle seen, eschar, slough, tur undermining

Primary: Surgical wound, suture is well approximated, closed, heals quickly, low risk of an infection
Secondary: wound edges are not approximated, Left open to heal from ground up; contaminated wound, pressure ulcer, burns longer to heal, greater risk of infection, bigger Scar

Unstagable: too much slough, eshar ha debrided before Staging.