LOS ANGELES COUNTY COLLEGE OF NURSING AND ALLIED HEALTH
School of Nursing

Nursing 233 L:

Intermediate Medical/Surgical & Psychiatric Nursing

CLINICAL PACKET

Spring 2021

Student Name _____ Admit Date_____ POD#_____
Pt initials _____ Room # _____ Age _____Gender _____ Ethnicity _____ Psych Hold _____

Current Medical Diagnosis:

Resolved Medical Problems:

Chief complaint:

All Secondary Diagnosis:

Current Nursing Assessment

Allergies:_____

Code Status:_____

IV Site:_____

IV Fluids: _____

Ordered Tx _____

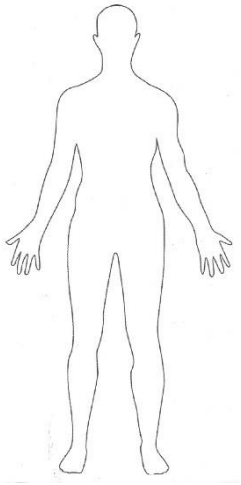
Diet: _____

Activity:_____

Fall Risk/Safety:_____

Skin issues:_____

Attach a Comprehensive Medication Worksheet to this Concept Map



Pathophysiology:

Abnormal Labs & Significance

Diagnostics & Results/ Significance

Priority Nsg Dx #1 (PRS format)	**Priority Nsg Dx #2**(PRS format)	**Potential Complications:**
Goal:	Goal:	
Priority Interventions:	Priority Interventions:	

CLINICAL WORKSHEET

CLINICAL PREPARATION PRIOR TO CLINICAL DAY:

Student Name: _____ Date: _____

Client Initials: _____Admit date: _____Rm#_____Age:_____

Legal Status □ 5150 □ 5250 □ Conservatorship □ Other_____

Primary Language: _____ Culture:_____ Code Status: _____

Discuss brief past medical history (Why is the client here?):

Pathophysiology
Diagnosis/Surgical Procedure/Secondary Diagnosis:

Typical signs and symptoms seen in the disease process: (underline manifestations assessed in your client)

Typical abnormal lab results seen with this disease process:

Potential complications (PCs) associated with this disease process (rank order priority):

Medical Information (from electronic medical records):

Allergies:

Diet:

Activity Level:

Treatments (e.g., dressing change, oxygen therapy):

Admission

Most Current

Vital Signs: T _____BP _____HR _____RR _____02 sat _____ Pain level_____

Height: _____ Weight: _____ Strict I&O □ BRP □

Labs are not limited to those listed below.
All pertinent labs must be included.

Lab Values: Date: Date:

Lab Test	Normal Values	Admission Labs	Current Results	Significance of Findings Specific to Patient
Anion Gap				
Na^+				
K^+				
Cl				
CO2				
Glucose				
Calcium				
Mg^{++}				
Phosphorus				
BUN				
Creatinine				
Alk Phos				
Total Protein				
Albumin				
AST				
ALT				

WBC				
RBC				
HGB				
HCT				
MCV				
MCH				
MCHC				
RDW				
Platelet				
Neutrophil				
Lymphocyte				
Monocyte				
Esionophil				
Basophil				
Pro-Time				
INR				
APTT				
Troponin				
Pre Albumin				
UA:				
Color				
Clarity				
SG				
pH				
Protein				
Ketones				
Uroblinogen				
ABG:				

pO2				
O2 Sat (pulse ox)				
pH				
pCO2				
HCO3				

List other diagnostic tests and result:

List all medications on the Medication Preparation Worksheet.

MEDICATION PREPARATION WORKSHEET*

Client's Name: ____________________________ **ALLERGIES**: ☐ NKDA

* ***Copying from the textbook or electronic source does not constitute satisfactory preparation***

MEDICATION	ACTION	NURSING CONSIDERATIONS
Medication: __________________________ Generic Name: ________________________ Dose/Route/Frequency: Time: Recommended/Usual Dose:	Classification: ________________________ Indication: ____________________________ How does it work? Onset/Peak/Duration: Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ Resp Other: ____________________________________ Labs: _____________________________________ Teaching: Infusion rate: ml/hr ________ gtt/min __________
Medication: __________________________ Generic Name: ________________________ Dose/Route/Frequency: Time: Recommended/Usual Dose:	Classification: ________________________ Indication: ____________________________ How does it work? Onset/Peak/Duration: Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ Resp Other: ____________________________________ Labs: _____________________________________ Teaching: Infusion rate: ml/hr ________ gtt/min __________
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MEDICATION	ACTION	NURSING CONSIDERATIONS
Generic Name: _____ Dose/Route/Frequency: Time: Recommended/Usual Dose:	Indication: _____ How does it work? Onset/Peak/Duration: Adverse Effects:	Other: _____ Labs: _____ Teaching: Infusion rate: ml/hr _____ gtt/min_____
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DAILY ORGANIZATION PLAN*

Clinical Date: **Ward**

Daily Organizational Plan MUST be ready at 0700 each clinical day.

Time	STUDENT ACTIVITY	Time	STUDENT ACTIVITY

Client Initials: **Medical Dx:** **Room/bed #**

PRIORITY NURSING DIAGNOSIS (in PRS Format)	GOALS	INTERVENTIONS
1.		
2.		
3.		

Due the 7th week of each MedSurg Rotation (see schedule for dates)

Clinical Reflection Paper Guidelines

The purpose of this written assignment is to reflect what the student nurse have learned and experienced throughout the clinical rotation. The main focus is to examine the student nurse's thoughts and feelings regarding new experiences that were learned in clinical, those skills that were built upon or enhanced, relationships that may or may not have developed with the nursing staff and perception of the experiences with the patients.

Minimum of 1 page and not to exceed 3 pages

The paper should reflect some of the following concepts:

1. What do you do well?

2. In what areas do you feel you need the most improvement?

3. Were there any defining moments when the "light bulb went on" or had a strong moment of insight?

4. Were there stories involving your patients' that you would want to share or had a profound impact on your learning?

5. What (if any) did you learn from your classmates, other nurses or patients?

9. The paper may include questions that you may not have previously asked, seek clarification of things you did not understand or discuss matters of concern to you.

There is no judgment attached to the paper.

Complete this sheet if assigned MedSurg patient was/is discharged

Patient Custom List

Student Name: _____

POCT: _____ ISOLATION: _____ Wt:_____

Name/DOB/Age: _____Admitted on: _____ Room/Bed# _____

Allergies: _____ Code status: _____ Activity level_____

Admitting Diagnosis (es): _____

All Secondary Dx: _____

Organ/Systems:

Neuro_____

CV_____ Pacemaker_____

Respiratory_____ Chest Tube_____

GI_____Diet_____

GU_____Foley_____

MS_____Fall Risk_____

Skin_____Braden_____

Peripheral IV/Shunt/Fistula/Central line_____

Abnormal labs_____

Problems:

Active/inactive: _____

Historical: _____

Care focus: _____

_____

Current procedures: _____

Procedure history: _____

Current Meds with pertinent labs_____

Patient Custom List

PRIORITY PROBLEMS (in PRS Format)	GOALS	INTERVENTIONS
1.		
2.		
3.		

Nursing Dx (based on current assessment): **Student Name: _____**

Additional Notes

Due on the 6th week of each MedSurg rotation

HEALTH ASSESSMENT SUMMARY / NURSING CARE PLAN

Student's Name _____ Date of Assessment_____ Location of Client__
Client's Initials _____ Date of Admission _____ Primary Language_____

Summarize or briefly state what caused the client to come to the hospital (chief complaint) (include age, sex, race)

List all prior health problems including surgeries with approximate dates:

List medications client was taking prior to this hospitalization and client's reason for taking medication (including prescriptions, herbs, over-the-counter).

List significant family health history:

Allergies: No □ Yes □ _____ Ht. _____ Wt.__
Substance Use/Abuse:

Alcohol	No □ Yes □	Type _____	Amount consumed/day _____	Last use: _____
Drugs	No □ Yes □	Type _____	Amount consumed/day in _____	Last use: _____
Smoking	No □ Yes □	Packs per day _____		
Caffeine	No □ Yes □	Cups per day _____		

HEALTH ASSESSMENT SUMMARY / NURSING CARE PLAN

Admitting Diagnosis (discuss briefly):

Current Diagnosis (including pathophysiology):

Summarize what has happened to this client since being admitted to the hospital (include all diagnostic tests):

Other pertinent client information:

a. Predominant stressor: (intra-, inter-, extrapersonal)

b. Variables: (physiological, psychological, spiritual, sociocultural, developmental)

MEDICATIONS

Copying from the textbook or electronic source does not constitute satisfactory preparation

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Medication: ____________________ Generic Name: __________________ Dose/Route/Frequency: Time: Recommended/Usual Dose:	Classification: __________________ Indication: _____________________ How does it work? Onset/Peak/Duration: Adverse Effects:	Assessment: ☐ HR ☐ BP ☐ Resp Other: ___________________________ Labs: ____________________________ Teaching: Infusion rate: ml/hr ________ gtt/min __________
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Cl				
CO2				
Glucose				
Calcium				
Mg^{++}				
Phosphorus				
BUN				
Creatinine				
Alk Phos				
Total Protein				
Albumin				
AST				
ALT				
WBC				
RBC				
HGB				
HCT				
MCV				
MCH				
MCHC				
RDW				
Platelet				
Neutrophil				
Lymphocyte				

Monocyte				
Esionophil				
Basophil				
Pro-Time				
INR				
APTT				
Troponin				
Pre Albumin				
UA:				
Color				
Clarity				
SG				
pH				
Protein				
Ketones				
Uroblinogen				
ABG:				
pO2				
O2 Sat (pulse ox)				
pH				
pCO2				
HCO3				

N233L - ASSESSMENT

Date of Assessment:_____

Vital Signs: BP _____ T _____ P _____ R _____O2Sat _____ Pain Level_____

Neurological: _____

Cardiovascular: _____

Respiratory: _____

Gastrointestinal: _____

Genitourinary: _____

Integumentary: _____

Psychosocial: _____

Musculoskeletal: _____

Other: _____

LIST ALL MEDICAL ORDER: _____

NURSING 233L

List 3-5 nursing diagnoses for your client (PRS format), and collaborative problems.

Rank order the priority of problems identified.

Priority Nursing Diagnoses:

Potential Complications:

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
SUBJECTIVE: **OBJECTIVE:**	**P:** **R:** **S:** **GOAL:**	**INTERVENTIONS:**		***Goal:***

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
SUBJECTIVE: **OBJECTIVE:**	**P:** **R:** **S:** **GOAL:**	**INTERVENTIONS:**		***Goal:***

NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	PLANNING	IMPLEMENTATION	EVALUATION
SUBJECTIVE: **OBJECTIVE:**	**P:** **R:** **S:** **GOAL:**	**INTERVENTIONS:**		***Goal:***

PSYCHIATRIC CLINICAL ORIENTATION

- Olive View students will get instructions on parking and meeting place/time by their instructor prior to the psych orientation.

- Augustus Hawkins Mental Health Center
  1720 East 120th Street
  Los Angeles, CA 90059 [is in Willowbrook]
  (Wilmington and 120th Street) PARK in the older looking parking structure across from Fire Department (not in the new structure). Instructor will give you a parking pass prior to the first day.

    - Instructor will give you a Parking Permit prior to the 1st day of Psych. The student will sign out the parking permit and return to the instructor at the end of the Psych rotation.
    - Instructor will give you an Access Card to wear with your badge. Student will sign out the card and return the Access Card to the instructor at the end of the rotation.
    - Meet at 0645 in front of the Parking Lot, we will all walk in together. After this day, you will meet instructor at 0645 inside the lobby of Augustus Hawkins hospital. If you meet instructor any time after 0645, you will be marked late. At 0645, instructor takes attendance and gives each student the keys [key MUST be given back at end of day].

- You MUST have a badge on your shoulder – do not leave in your car or you will be marked late if you must retrieve it.

- The following are the items you are NOT to wear [if worn student will be sent home and marked absent]:
    - No tights or leggings, no heavy makeup, no loose long hair, no tight clothing, no long skirts, no short skirts, best to wear dress slacks, no low cut blouses, no jewelry that can be grabbed (necklace, long earrings, bracelets), nothing that will call attention to yourself (super bright colors, t-shirts with any sayings or band names on them), no shoe laces, no long boots, no high heels, no open toed shoes and no fancy bling hairbands or hair ties. No stethoscope needed.
        - *Due to the Covid-19 Pandemic, students may be allowed to wear scrubs. Your instructor will communicate with you regarding the current dress code.*

- The following are items that you CAN wear:
    - Dress very conservative. A light sweater or sweater vest is acceptable as there is no room for us to put heavy jackets in. If you have long hair, keep in a bun. No ponytails as they can be grabbed. You may wear a watch/iwatch. Ok to wear a COLORED lab coat with no markings or stripes (no white lab coats allowed).
    - Ok to take your phone but be sure it is on vibrate and kept in your pocket. Do not reveal your phones while with patients, they may ask you to use it – don't allow this to happen.

- If you bring your lunch box, leave it hidden in your car (use ice packs to keep it cool, use a thermos for hot foods). Olive View instructor will discuss where you can keep it.

- Do not bring books. Items to bring into hospital: 1 small pocket notebook, 1 pen or pencil, a protein bar, or small bag of trail mix or nuts in your pocket as a light snack later. Keep money with you. There is no place to put a backpack. We can drink their water (water bottles have been stolen). You may bring the folders instructor will be giving you.

- The main skill is Therapeutic Communication. No meds given, no hands-on assessments, no ADLs performed, no hands-on skills. Students NOT allowed inside patient's bedrooms; you will be in the dayroom. NEVER be in dayroom alone without another student buddy.

- This first day we will be in orientation all day. Do not be absent as there is no makeup.

- Instructor will walk each group of students to their floors only on the first day, after that, you will walk to your units together without instructor.

SAFETY PRECAUTIONS:

Authorization of an instructor is required for visits to the clinical area during unscheduled clinical hours. For professional and safety reasons, students are not to give out phone numbers or addresses to clients or visitors.

Grounds for failure include but are not limited to:

- Hitting or abusing a client (s)
- Falsifying any client's record
- Sexually provocative behavior (verbal and/or non-verbal) or accepting sexual advances
- Giving out personal phone numbers or addresses
- Visiting the client (s) after hour

CLIENT INTERACTIONS:

- When a client is imminently assaultive or actively assaultive, stay out of the way. Do not choose that patient to care for.

- Call for assistance if you observe an agitated client – do not attempt to manage him/her alone.

- When there is an altercation between a client and a staff member do not become involved - call for assistance.

- If an assaultive client approaches you - move out of the way.

- Interact with clients in the presence of others – do not take a client into a room alone and close the door.

- Be alert when you walk down hallways.

- Avoid touching clients if possible.
- Do not discuss topics on politics, sex, or religion with clients.

PSYCHIATRIC NURSING DOCUMENTATION STANDARDS

The recorded nursing observations should reflect a clear picture of the client's condition on admission and throughout his/her hospital stay as well as nursing interventions. The nursing observations should demonstrate what nursing staff did for the client, how it was done, the frequency with which nursing staff interacted with the client, how the client was behaving, observations of his/her physical condition and how the client responded to nursing staff's interactions. Charting should also include what the client said about him/herself, both verbal and non-verbal and how he/she was able to cooperate with the medical regimen and activities. These observations should be reflected in the care plan established for the individual.

GUIDELINES

Follow the institutional policy established for documentation.

1. Assessment and Progress Notes must be charted about each assigned client each day. Significant behavior, however, should be charted at the time that it occurs.

2. Use the client's own words whenever possible.

3. Use descriptive words and phrases about the client's behavior. Avoid diagnostic terms.

4. Chart objectively what you see and hear, not what you believe, conclude or assume. What or how the client states he/she feels, not what or how you think he/she feels.

5. Never chart another client's name in your client's chart. Refer to the other client as "other male peer" or "other female peer."

CLIENTS WHO ARE AT RISK AND REQUIRE SPECIAL PRECAUTION

THE CLIENT IN RESTRAINTS

It is the responsibility of the Primary Nurse to determine the need for restraints and/or seclusion. It is therefore his/her responsibility to make an entry on the Progress Note regarding the type of "assistive control" necessary. Students should not choose patients in in restraints or seclusion.

THE CLIENT WHO IS SUICIDAL

Chart client behavior and physical whereabouts throughout the charting period. Does the client try to be alone? At what times? Question the client every shift regarding ongoing suicidal ideations and content of hallucination and chart anything the client says. Try to quote these statements exactly if possible. Report these statements to the Charge Nurse and chart that it was reported and to whom. Chart any radical changes in mood or behavior (i.e., if a depressed client suddenly becomes cheerful or more depressed, or if a withdrawn client becomes more active and involved with others). This could be a danger signal and the client needs to be closely observed.

THE CLIENT WHO IS AN ELOPEMENT RISK

Know the client's whereabouts at all times. Chart anything the client says that indicates he wants to leave the hospital. Check with the client throughout the shift regarding continued feelings about leaving.

PSYCHIATRIC CASE PRESENTATION EVALUATION CRITERIA

Purpose: This assignment is designed to help you apply the nursing process to clients with selected psychiatric disorders. This assignment will follow the theory lecture on the assigned disorder.

Preparation: Students will decide, as a group, on one client from the ward who best fits the description of the psychiatric disorder assigned. Each student should spend some time interacting with the client. The presentation should be divided up to assure equal division of labor. There are three (3) areas of investigation necessary to present a thorough case:

The following cognitive skills will be evaluated:

Theory and History:

- Discuss the client's problem. _____
- Describe the client's current behavior. _____
- Describe the reason for hospitalization. _____
- Discuss the past history of psychiatric problems including family history of mental disorder _____

Treatment Team:

- Identify client's goal during hospitalization _____
- Discuss family involvement in the treatment plan _____
- List medications that the client is on, side effects that the client has experienced. has experienced. _____
- What is the cognitive level of the client? _____
- What is the leisure activity of the client prior to hospitalization? _____
- What are the discharge plans for the client? Identify referral sources in the community that maybe of help after D/C, e.g., Medical Case Worker, Social Worker, etc. _____

Nursing Care:

- Formulate a list of all client problems. _____
- Identify the 3-priority nursing diagnoses. _____
- Identify one short-term goal for each nursing diagnosis.
- List two therapeutic interventions appropriate for <u>each</u> of the three-nursing diagnosis. _____

Creativity:

- The group is to prepare a creative way to present the disease process (board game, song, poem, bingo, a skit, poster, etc…) _____

MENTAL HEALTH FIELD ACTIVITY RESOURCES

I. There are 2 Mental Health Court in Los Angeles that students will have patients go to

a) LOS ANGELES SUPERIOR COURT
1945 South Hill Street
Los Angeles, California 90007

OR

b) MENTAL HEALTH COURTROOMS
Hollywood Courthouse
5925Hollywood Blvd
Los Angeles, California 90028

II. Per courthouse regulations, students are no longer allowed to participate in courtroom activities per the court. Each psych instructor will distribute a research module for students to get a better understanding of the mental health court system

The following websites will be utilized for the module:

- http://www.lacourt.org/division/mentalhealth/MH0014.aspx
- http://www.lacourt.org/courthouse/mode/division/mentalhealth

III. Modules will be submitted at a given date during the Psych Rotation. The due date will be determined by the instructor.

Student Name: _____

PSYCHOTIC DISORDER CLINICAL ASSIGNMENT

Watch an assigned film and answer the questions listed below. Submit the assignment to the psych clinical instructor the day the movie is discussed for post-conference in the Psych Rotation.

1. State the title of the film reviewed

2. List three (3) psychiatric features in the movie. Provide a description of each feature.

   a.

   b.

   c.

3. How does the main character in the movie relate to the psychiatric concepts from lecture and/or the textbook (give reference)?

4. In the end, what becomes of the main character's psychiatric disorder? Is he/she cured?

5. What is the overall impression of the film?

***NAMI or SUPPORT GROUP OBSERVATION REPORT**

Student name (print): _____ Date: _____

Name of group: _____ Location: _____

Contact person/facilitator: _____ Phone #: _____

Purpose of group: _____

Your perception about group prior to attending the group:

_____

_____

_____

Your perception of the group after attending the group:

_____

_____

_____

How does the group help group members? _____

_____

_____

_____

The experience helped me understand/appreciate the value of support groups.

Strongly agree *Agree* *Disagree* *Strongly disagree*

Because of my experience, I am more likely to refer clients to a support group.

Strongly agree *Agree* *Disagree* *Strongly disagree*

* http://www.nami.org Find your local NAMI chapter. No more than 2 students are allowed to attend most meetings.
* Due to COVID distancing, if student is unable to participate in either a NAMI meeting or Support Group meeting (such as Alcoholics Anonymous, Overeaters Anonymous, Al-Anon etc…), the psych instructor will provide students with a module to research the NAMI website to get a better understanding of what is provided by the organization. The due date will be determined by the instructor. This page will be completed only if student is able to attend a meeting (live or Zoom).

INTERDISCIPLINARY COLLABORATION

1. Identify discipline.

2. Discuss the function of this discipline.

3. List the types of collaborative activities.

4. Write a short synopsis of your experience collaborating with this discipline.

5. State interactions student witnessed between the discipline and a client.

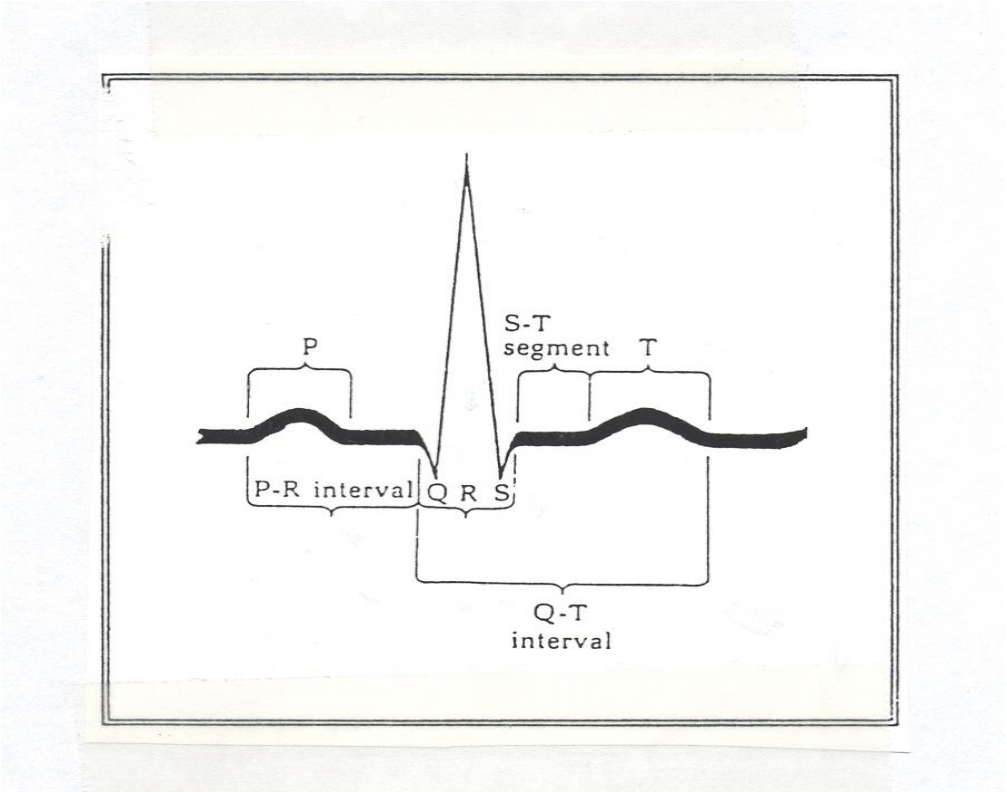
6. State the nursing responsibilities in interdisciplinary collaboration.

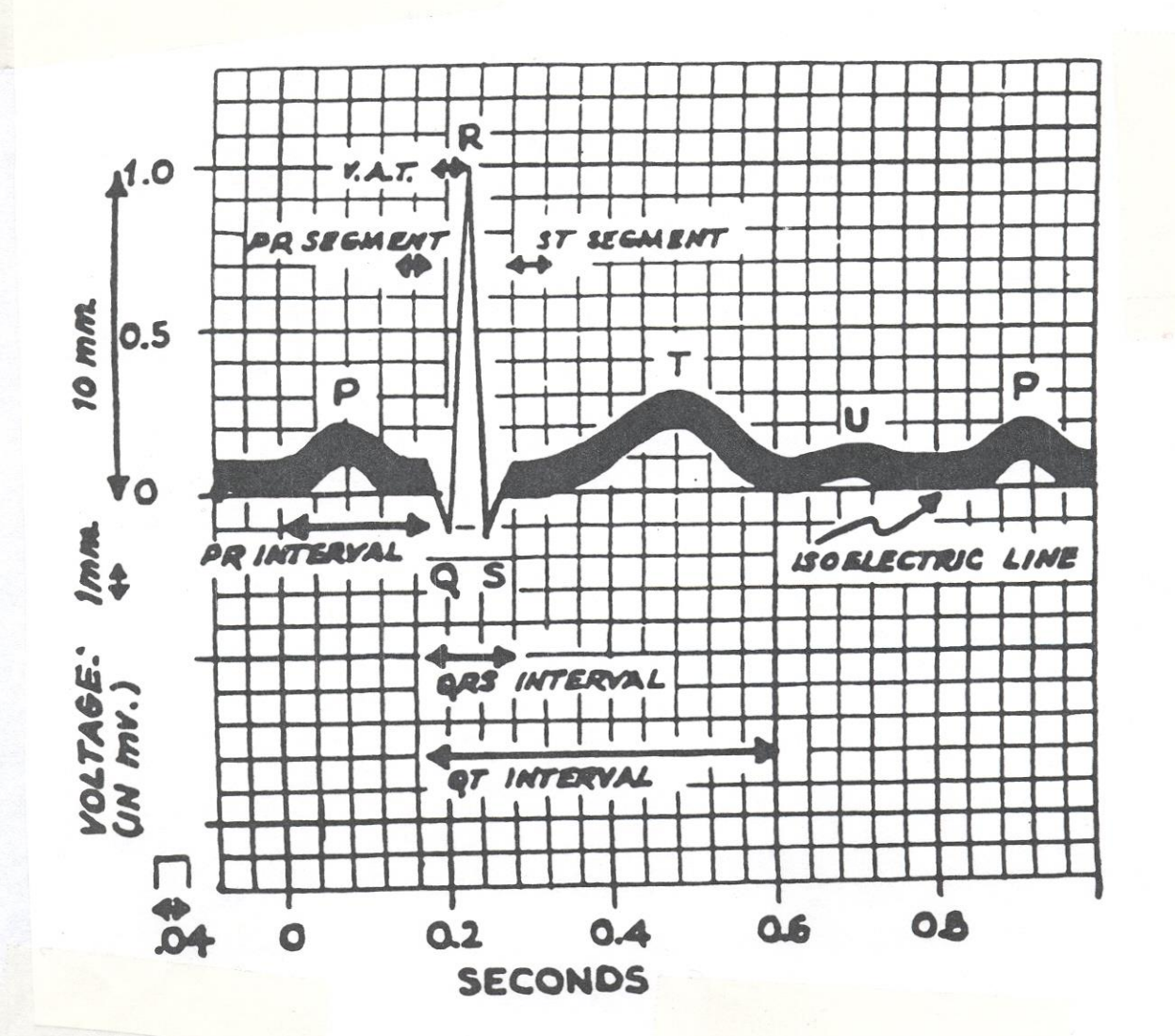
STUDENT NAME (print): _____

DIAGRAM OF ELECTROCARDIOGRAPHIC COMPLEXES, INTERVALS, AND SEGMENTS

Cardiac Cycle: refer to picture/diagram

P wave -	is the depolarization of the atria.
PR Interval -	measures the depolarization time from the sinus more through the bundle of His and into the bundle branches.
QRS Complex -	represents depolarization of the ventricles. Three waves are usually seen: • Q wave is the first negative wave • R wave is the first positive wave • S wave is the first negative wave which follows first positive wave
ST Segment -	may either be isoelectric or slightly elevated.
T Wave -	indicates repolarization or electrical recovery of the ventricles.
U Wave -	occasionally this wave is seen. The exact mechanism of its formation is unknown, but it is sometimes diagnostic. With the appearance of the P wave, the cycle begins again.




R
1.0
V.A.T.
PR SEGMENT
ST SEGMENT
10 mm
0.5
T
P
P
U
0
PR INTERVAL
ISOELECTRIC LINE
Q
S
1mm
QRS INTERVAL
QT INTERVAL
VOLTAGE: (IN mv.)
.04
0
0.2
0.4
0.6
0.8
SECONDS

Method to Calculate Heart Rate:

1. Count the number of cycles in a 6-second strip and multiply by 10. This method can be used when the rhythm is either regular or irregular.

   R wave/6-sec strip x 10 = rate/min

2. Counting boxes between R-waves discussed in clinical conference is accurate only if the rhythm is regular.
   - Count the small boxes between R and R and divide into 1500.

Systematic Assessment of Rhythm Strip

1. **What is the rate?**

   a. To determine the ventricular rate, measure the distance between two consecutive R waves (R-R interval).
   b. To determine the atrial rate, measure the distance between two consecutive P wave (P-P interval).

2. **Is the rhythm regular or irregular**?

   a. To determine if the ventricular rhythm is regular or irregular, measure the distance between two consecutive R-R intervals and compare that distance with the other R-R intervals. If the ventricular rhythm is regular, the R-R intervals will measure the same.
   b. To determine if the atrial rhythm is regular or irregular, measure the distance between two consecutive P-P intervals and compare that distance with the other P-P intervals. If the atrial rhythm is regular, the P-P intervals will measure the same.
   c. Generally, a variation of up to 0.12 seconds (3 small boxes) is acceptable. The slower the heart rate, the more acceptable the variation.

3. **Is there one P wave before each QRS?**

   a. Are P waves present and uniform in appearance?
   b. Is there a P wave before each QRS or are there P waves that are not followed by QRS complexes?
   c. Is the atrial activity occurring so rapidly that there are more atrial beats than QRS complexes?

4. **Is the PR interval within normal limits?**

   a. If the PR interval is less than 0.12 or more than 0.20 second, conduction followed an abnormal pathway, or the impulse was delayed in the area of the AV node.
   b. Is the PR interval of conducted beats constant or does it vary?

5. **Is the QRS narrow or wide?**

    a. What is the duration of the QRS complex?

        1) If it is 0.10 second or less (narrow), it is presumed to be supraventricular in origin.

        2) If it is greater than 0.12 second (wide), it is probably ventricular in origin.

    b. Do the QRS's occur uniformly throughout the strip?

6. **Is theQT interval too long?**

    Normal QT interval is 0.34-0.43 (sec)

7. **Interpret the rhythm** specifying the site where the dysrhythmias originated (sinus), the mechanism (bradycardia), and the ventricular rate. For example, "sinus bradycardia with a ventricular response (rate) of 38 minutes."

8. **How is the rhythm clinically significant**?

ARTERIAL BLOOD GAS INTERPRETATION CASE STUDY

When the client develops an acid-base imbalance, the body attempts to compensate. The body will try to overcome either respiratory or metabolic dysfunction in an attempt to return the pH into the normal range.

A client can be uncompensated, partially compensated, fully compensated, or mixed/combined. When an acid base disorder is either uncompensated or partially compensated, the pH remains outside the normal range. **In fully compensated states, the pH has returned to within the normal range, although the other values may still be abnormal. Combined or mixed means that both the CO2 and the HCO3 cause the imbalance.**

Fully Compensated States

	pH	**$PaCO_2$**	**HCO_3^-**
Respiratory Acidosis	normal, but < 7.40	↑	↑
Respiratory Alkalosis	normal, but > 7.40	↓	↓
Metabolic Acidosis	normal, but < 7.40	↓	↓
Metabolic Alkalosis	normal, but > 7.40	↑	↑

Partially Compensated States

	pH	**$PaCO_2$**	**HCO_3^-**
Respiratory Acidosis	↓	↑	↑
Respiratory Alkalosis	↑	↓	↓
Metabolic Acidosis	↓	↓	↓
Metabolic Alkalosis	↑	↑	↑

Notice that the only difference between partially and fully compensated states is whether or not the pH has returned to within the normal range. In compensated acid-base disorders, the pH will frequently fall either on the low or high side of neutral (7.40). Making note of where the pH falls within the normal range is helpful in determining if the original acid-base disorder was acidosis or alkalosis.

List the normal ranges for the listed components of an Arterial Blood Gas:

pH _____ PaO_2 _____ SaO_2 _____ $PaCO_2$_____ HCO_3^- _____

Case # 1

A client is admitted to the hospital and is scheduled to undergo brain surgery. The client becomes extremely anxious and afraid of the upcoming surgery. The client begins to hyperventilate and becomes dizzy. The client loses consciousness and STAT ABGs reveal: pH 7.61, PaCO2 22, HCO3 25. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case # 2

A client, who underwent abdominal surgery, has a nasogastric tube (NGT) placed. The nurse notes that the NGT has drained 900mL in 2 hours of coffee ground secretions. The client is disoriented to person, place, and time. The physician is contacted and STAT ABGs are drawn. The results are as follows: pH 7.57, PaCO2 37, HCO3 30. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #3

A client is brought to the emergency department after falling and injuring both lower extremities. The client is tachycardic and tachypneic. Following the administration of painkillers, the client reports still being in pain and was now experiencing muscle cramps, tingling, and paresthesia. ABG results are as follow: pH 7.6, PaO_2 120, $PaCO_2$ 31, HCO_3- 25. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #4

Interpret the following ABG's

pH= 7.30
PaO_2 = 92
$PaCO_2$ = 46
HCO_3- = 16

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

pH= 7.47
PaCO2= 48
HCO3=30

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

pH= 7.31
PaO2= 90
PaCO2= 40
HCO3=22

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

pH= 7.46
PaCO2=32
HCO3=23

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #5

A 70-year-old-client is admitted to the hospital for two days of intractable vomiting. The client is lethargic, weak, myalgia dry mucous membranes and the capillary refill is > 4 seconds. The client is diagnosed with gastroenteritis and dehydration. ABG reading is as follows: pH 7.50, PaO_2 85, $PaCO_2$ 40, HCO_3^- 34. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #6

A 54-year-old client with a h/o chronic obstructive pulmonary disease (COPD) is rushed to the emergency department with increasing SOB, pyrexia, and a productive cough with yellow-green sputum. He is unable to complete a sentence, crackles and wheezes can be heard in the lower lobe; he has tachycardia and a bounding pulse. His ABGs are as follows: pH 7.3, PaO_2 60, $PaCO_2$ 68, HCO_3^- 28. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

Case #7

A 9-year-old- client is rushed to the hospital due to vomiting and a decreased level of consciousness. The client displays Kussmaul breathing, is lethargic and irritable in response to stimulation. He appears dehydrated—eyes are sunken and mucous membranes are dry and he has a two week history of polydipsia, polyuria, and weight loss. Initial arterial blood gas result is as follows: pH 7.0, PaO_2 90, $PaCO_2$ 23, HCO_3^- 12. What is your interpretation?

Results	pH	PaO_2	$PaCO_2$	HCO_3^-

N233L Medical-Surgical
Case Study: COPD

"My name is Mrs. Janeway. My husband Jamie Janeway and I have just recently moved to the area. We have an appointment to see Dr. Day next week, but my husband is having shortness of breath and has a fever of 101. He is 70 years old and has a lot of medical problems."

The nurse instructs Mrs. Janeway to bring her husband to the office and bring any medical records in her possession.

During the interview you learn the following information:

SUBJECTIVE ASSESSMENT

- **Past Medical/Surgical History**
  - Heart failure following myocardial infarction at age 68 years
  - COPD (on 2 L home oxygen)
  - Hypertension
  - Appendectomy
- **Family History**
  - Father died of myocardial infarction at age 59 years and had a history of diabetes, hypertension, and smoking.
  - Mother is alive and has a history of atrial fibrillation and heart failure.
  - Healthy siblings
- **Social History**
  - Married, 2 children
  - 40 pack year smoking history (quit after MI in 2019)
  - Worked on a farm
  - No alcohol or illicit drug use
- **Medications / Allergies**
  - NKDA
  - Home oxygen 2L
  - Lisinopril 20 mg twice daily
  - Metoprolol 50 mg twice daily
  - Spironolactone 25 mg daily
  - Furosemide 40 mg daily

- Budenoside/Formoterol (Symbicort) 160mg/4.5mg via dry powdered inhaler (DPI) one puff inhaled twice daily
- Tiotropium Bromide (Spiriva) 18mcg DPI one cap inhaled daily

❖ ***According to his wife they sometimes get confused about what to use when, so the nurse is not sure which medications he takes. Wife states has been on antibiotics 6 at home 6 weeks prior due to "infection."***

❖ **Health Promotion**

- Unable to determine when last pneumococcal vaccine was given
- Patient and wife don't recall "a pneumonia shot"
- Does know he got his "flu shot" last month at a grocery store

❖ **Records Review**

- Mr. Janeway medical file reveals (brought in by wife)
  - Echocardiogram with EF of 25%
  - Spirometry with FEV1 40% predicted that does not change significantly after inhaled bronchodilator

OBJECTIVE ASSESSMENT

❖ **Physical Assessment**

- Vital Signs: BP 128/74; P 98, reg; RR 32; Ht 5ft 6 in; Wt 56kg ; T 38.7°C oral
- Patient is thin. Alert/oriented x 4
- Speaks in 1-2word sentences with difficulty
- Tripoding; unable to sit up
- Audible wheezing, no accessory muscle use
- Clubbing noted to nails
- Chest: diffuse wheezing to all lung fields on auscultation
- Heart: S1/S2, no murmurs, 2+ radial/pedal pulses present bilaterally
- Abdomen soft and rounded. BS x4Q.

Please answer the following questions based on the above information.

1. **Are these findings consistent with a diagnosis of COPD?**

   YES

   NO

2. **Using Gold's criteria what is Mr. Janeway's stage of COPD?**

3. **Given Mr. Janeway's h/o COPD what s/s might the nurse be looking for or ask questions about?**

His wife has noted no change in his alertness or mental status. When you inquire, the wife states that he usually has a cough, worse in the morning, productive of gray sputum, gets short of breath if he walks more than 10 feet, and has episodes of wheezing if he gets sick (e.g. with an upper respiratory infection). He usually can help around the house with light work and fixing things from a seated position.

4. **What diagnostic test would the nurse anticipate the healthcare provider ordering?**

5. **Given Mr. Janeway's COPD identify 3 potential cardiac complications.**

   a.

   b.

   c.

6. **List three potential pulmonary complications of Mr. Janeway's COPD.**

   a.

b.

c.

7. **List three potential non-cardiac and pulmonary complications of Mr. Janeway's COPD.**

a.

b.

c.

8. **Which of the following is the <u>least</u> likely cause of Mr. Mr. Janeway's symptoms?**
   A. COPD exacerbation
   B. Recurrent aspiration
   C. Heart failure
   D. Pneumonia
   E. Asthma exacerbation

The nurse check's his O2 sat and finds that it is 86%
The healthcare orders CXR and results show hyperinflation and RLL pneumonia.

9. **What is Mr. Janeway's primary risk factor for the development of his COPD?**

10. **What risk factors might increase the risk of severe COPD exacerbations?**

11. What clinical factors does Mr. Janeway possess that places him at risk of severe COPD exacerbation?

12. What is Mr. Janeway's strongest social support?

13. As the nurse performing the physical assessment should the healthcare provider treat him as an outpatient or inpatient? Why?

The healthcare provider decides that he is going to hospitalize him.

14. While waiting for EMT transport the healthcare provider instructs the nurse to place him on oxygen by nasal cannula. In addition to the oxygen, the nurse anticipates he will order which of the following?

a. Arformoterol
b. Albuterol
c. Formoterol
d. Budesonide

15. Which of the following are indications for antibiotics in clients with acute exacerbations of COPD? Select all that apply.

a. Dyspnea
b. Increased volume of sputum
c. Change of sputum purulence

d. Presence of comorbidities
e. Need for mechanical ventilation
f. High procalcitonin level
g. Presence of viral infection
h. History of exacerbations

Upon questioning the wife, the nurse finds that Mr. Janeway has had 5 exacerbations in the past year, three of which were treated with antibiotics and oral steroids. Because of this info he gets diagnosed with community acquired pneumonia.

16. Why was Mr. Janeway diagnosed with community acquired pneumonia?

17. Which antibiotic regimen does the nurse anticipate will be ordered for this hospitalization?

a. Sulfamethoxazole 800mg/trimethoprim 160mg PO every 12 hours
b. Amoxicillin 875mg/clavulanate 125mg PO every 12 hours
c. Ceftriaxone 1gm IVPB plus azithromycin 500mg PO every 24 hours
d. Piperacillin/tazobactam 2.25gms IVPB every 8 hours, levofloxacin 500mg PO every 24 hours and vancomycin 1gm IVPB every 12 hours

Hospital Course (3 day admission)

During hospitalization, Mr. Janeway receives the following treatment:

- ***Nebulized albuterol 5mg/ipratropium 0.5mg every 6 hours as needed***
- ***Prednisone 60 mg PO daily by mouth daily for 2 weeks***
- ***Ceftriaxone 1gm IVPB plus Azithromycin 500mg PO daily***
- ***Oxygen to maintain PO2 > 60 mmHg***

18. What is the purpose of the Prednisone?

19. What is the purpose of nebulized albuterol in the treatment of Mr. Janeway?

Preparing for discharge

- ***In completing the medication reconciliation forms, the nurse notes that Mr. Janeway had a complex medication regiment at time of admission***
- ***It is clear, during discussions with him, that he is having difficulty complying with his medication regimen***

20. What medications would the nurse identify in the medication reconciliation form(s)?

21. What medications should not be included as part of the medication reconciliation?

22. What can the nurse do to simplify Mr. Janeway's medication compliance?

AMBULATORY CARE ROTATION

Directions for the Ambulatory Care Rotation in the Outpatient Building/Clinic Tower and Comprehensive Health Centers.

A. Clinical Rotation

1. 8 days of ambulatory care

There will be some variation on the starting times (and possibly ending times) for certain clinics which will be discussed with you at the beginning of the rotation.

B. Forms That Must Be Completed

1. Twenty (20) informal teachings in the ambulatory care setting by the end of week 4.

2. Weekly activities due at the end of each week (4 in total).

3. One Cultural Assessment Interview (some groups will do it in MedSurg).

4. One Formal Teaching project to be scheduled by instructor by week 4.

5. Evaluation of outpatient clinic experience due at the end of the experience.
   - Evaluations for each clinic to be completed.

C. Under the direction and guidance of an instructor from the College of Nursing and the Outpatient Nurse Manager(s) or designee, the nursing student will:

1. Implement infection control and safety measures per ambulatory health care provider policy and procedure.

2. Participate in screening procedures of the assigned clinic.

3. Utilize all components of the nursing process to implement standards of care that promote health or prevent health care problems.

5. Promote a positive work environment for all ambulatory health care staff members.

6. Prioritize client, client family and/or community education based on the needs identified by the client(s).

7. Devise and implement client and/or client family education which demonstrate sensitivity to ethnic and cultural diversity.

8. Provide care and education (answer questions/concerns)

AMBULATORY CARE / MEDSURG ROTATION
CULTURAL ASSESSMENT INTERVIEW
GUIDELINES

For Ambulatory Care or MedSurg, the following assignment will be required as one of the requisites to satisfactorily pass the rotation:

1. This assignment will only be done one time this semester while in either Ambulatory Care or MedSurg. It cannot be completed while in the Psych rotation as is not appropriate to discuss culture with mentally ill patients.

2. Permission is required from client. Client needs to be from a culture different from your own.

3. Begin the discussion with a brief analysis of the client's country of origin (where is it, how big is it, what is population, what other languages spoken, what is it mostly known for etc…).

4. You will need to ask the client about his/her culture in relation to the following: cultural religion, communication, diet/nutrition, overall description of client's family (authority figure, social role, gender hierarchy), client's health risk, and other information that you find pertinent.

5. Based on the findings from the Cultural Assessment interview, the student will write a formal paper in the role course (see Semester Schedule for due date).

AMBULATORY CARE ROTATION

FORMAL TEACHING PROJECT

Student(s): _____ Clinic: _____

Student(s): _____ Clinic: _____

A. Learning Objectives (State what Clinic the teaching is for and state the Learning Objectives prior to presenting the project)

1.

2.

3.

B. Teaching Strategies and Visual Aids Used (Submit original to instructor and have copies for your audience…if applicable)

C. State how you would know if your teaching is effective.

D. If teaching were ineffective, what could you do differently to make it effective?

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
1.						
2.						
3.						
4.						
5.						

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
6.						
7.						
8.						
9.						
10.						

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
11.						
12.						
13.						
14.						
15.						

AMBULATORY CARE ROTATION - INFORMAL TEACHING

Student:_____ Date: _____

	Client Initials	Clinic Name	Reason for Client's Visit	Teaching Performed	Was Teaching Effective? (yes or no)	Discuss Client's Response to Teaching
16.						
17.						
18.						
19.						
20.						

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____
(Week #1)

Time Reported In: (**Day #1)** _____ Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____ Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____

(Week #2)

Time Reported In: (**Day #1)** _____ Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____ Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____

(Week #3)

Time Reported In: (**Day #1)** _____ Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____ Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____

AMBULATORY CARE ROTATION

WEEKLY ACTIVITIES

Student Name: _____ Date(s): _____

(Week #4)

Time Reported In: (**Day #1)** _____Clinic Assigned: _____

I participated in the following activities on Day #1:

DAY #1: Time Reported Off: _____

Signature of Responsible Person: _____

Time Reported In: **(Day #2)** _____Clinic Assigned: _____

I participated in the following activities on Day #2:

DAY #2: Time Reported Off: _____

Signature of Responsible Person: _____

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N233L: MED/SURG Orientation Packet Spring 2021

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