LUCENT NCLEX REVIEWS

Fundamentals of Nursing

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Management of Care

- providing and directing nursing care that enhances the care delivery setting to protect clients and health care personnel.

- Advance directives
- Advocacy
- Assignments, Delegation
- Case Management
- Client Rights

PRIORITIZATION

- NCLEX wants to test your ability to set priorities
- Identify the most important patient needs
- Which nursing intervention is most important?
- Which nursing action should be done
- Which response is best?

GUIDELINES FOR PRIORITIZATION

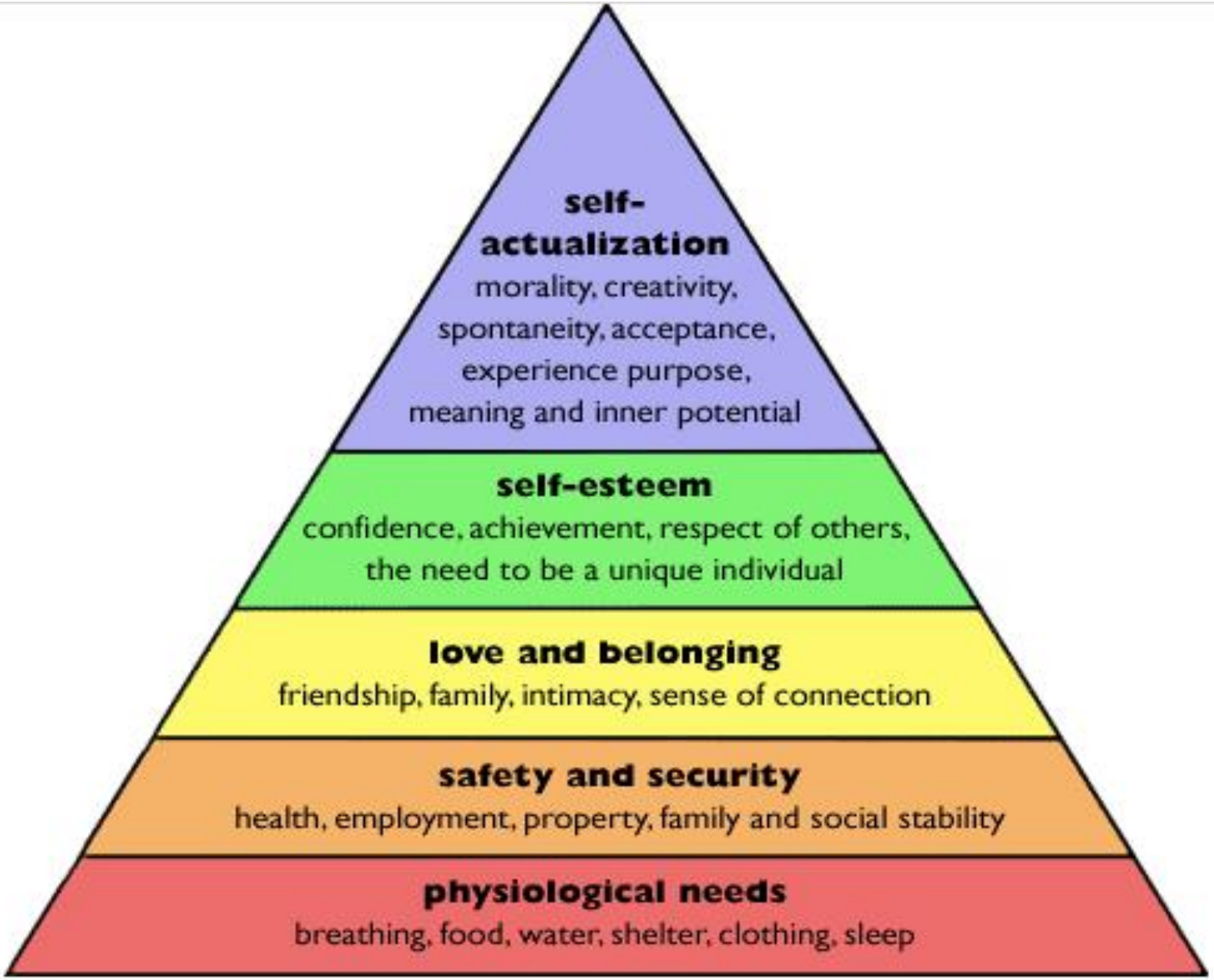
- Safety (Allergic reaction, insulin etc.)
- Timing (Peak & Trough, VS etc.)
- Interdependence of Events (tasks)
  - What will happen if the task is not done in a timely fashion?
  - Check fingerstick before insulin

WHAT SHOULD NURSES DO FIRST

- **High Priority Needs**: Life Threatening Issues
  - Respiratory Distress, Unresponsiveness, Chest Pain
- **Medium Priority Needs**: Urgent events
  - Safety needs, acute pain relief, scheduled medications
- **Low Priority Needs**:
  - Comfort & Hygiene
  - Physical mobility

CRITERIA FOR PRIORITIZATION

- A-B-C-s
- Maslow's Hierarchy of Needs
- Nursing Process
  - Assessment
  - Diagnosis
  - Planning
  - Intervention
  - Evaluation


self-actualization
morality, creativity, spontaneity, acceptance, experience purpose, meaning and inner potential
self-esteem
confidence, achievement, respect of others, the need to be a unique individual
love and belonging
friendship, family, intimacy, sense of connection
safety and security
health, employment, property, family and social stability
physiological needs
breathing, food, water, shelter, clothing, sleep

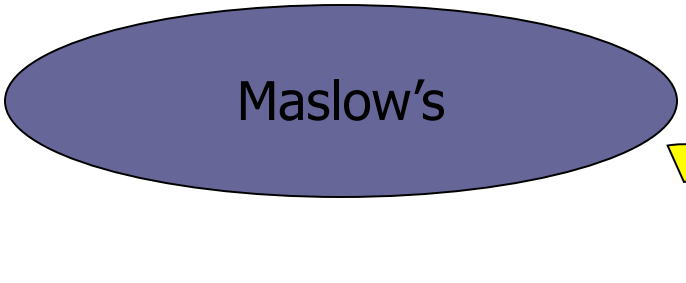
Physiological Needs

- According to Maslow, physiologic needs are the **highest priority** and **must be met first.**

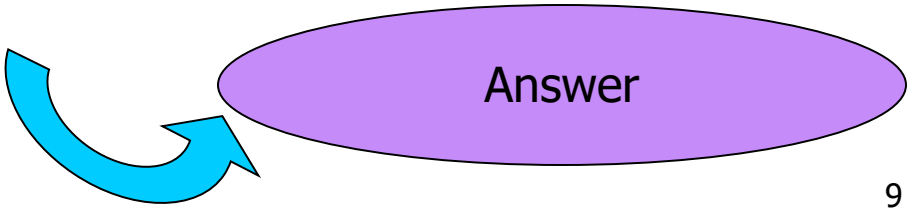
- Physiologic needs are necessary for survival.

Oxygen	Elimination
Fluid	Shelter
Nutrition	Rest
Temperature	Sex

How to Apply Maslow's Needs to Establish Priorities of Care



- First recognize that answer options include both physical and psychosocial needs.
- Next eliminate the psychosocial answer
- Ask yourself "Does this make sense in this case?"
- Finally apply the "ABCs" of care. **A**irway, **B**reathing, **C**irculation



Application of Maslow's Hierarchy

A woman is admitted to the hospital with a ruptured ectopic pregnancy. A laparotomy is scheduled. Which preoperative nursing intervention is most important for the nurse to consider in this patient's plan of care?

1. Fluid Replacement
2. Pain Relief
3. Emotional Support
4. Respiratory Therapy

A patient is admitted with a diagnosis of ruptured abdominal aortic aneurysm. Preoperatively, which goal is MOST important for the nurse to include in the plan of care?

1. Pain relief
2. Fluid replacement
3. Emotional support
4. Aerosol Treatment

A nurse is assigned to the following patients. Which patient should be assessed first at the start of the shift?

1. A 40-year-old patient with asthma, with a RR 14, HR 92 after receiving xoponex (levalbuterol) treatment.

2. A 60-year-old patient, with a tracheostomy on a ventilator who needs sterile sputum sent to the lab.

3. A 70-year-old patient with pneumonia with a pulse oximetry reading of 89%-91%.

4. An 80-year-old with a stage 3 decubitus ulcer whose dressing has come off because of a moderate amount of serous drainage

A 57-year-old patient was admitted to the hospital with a diagnosis of Hyperglycemic Hyperosmotic Nonketonic Syndrome (HHNKS). Vital signs are T 102.1ºF, P 127, RR 30, and B/P of 112/68. Blood glucose level is 900mg/dL.
Place the following nursing actions in order of priority:

1. Begin insulin drip.
2. Administer an antipyretic medication.
3. Start the ordered IV of 1000mL NS.
4. Assess lung sounds.
5. Check serum potassium level.

A client presents to the emergency department with upper gastrointestinal bleeding and is in moderate distress. In planning care, which nursing action would be the first priority for this client?

1. Thorough investigation of precipitating events
2. Insertion of a nasogastric tube and hematest of emesis
3. Complete abdominal examination
4. Assessment of vital signs

A client returns from surgery after a bowel resection. Which of the nurse's interventions has the highest priority?

1. Administer intravenous fluids
2. Monitor vital signs frequently
3. Maintain the client's NPO status
4. Assess client's pain level

The nurse prioritizes her morning schedule to assess which of the following clients first?

1. A young adult with complaints of severe back pain.
2. An adult admitted to the unit with acute pancreatitis complaining of unrelenting abdominal pain.
3. An older client who complains of foot and ankle pain.
4. A newly admitted client who complains of jaw pain and indigestion.

Leadership Styles

- Authoritarian
  - Directive behaviors
  - Decides alone
  - Focuses on tasks
- Democratic
  - Open communication
  - Team leader
  - Focuses on people
- Laissez-Faire
  - Permissive
  - Abstains from leading
  - Power with staff
- Bureaucratic
  - Insecure
  - Knows the rules
  - Impersonal

DELEGATION

Delegation:

- Transfer of responsibility & authority for the performance of an activity
- RN remains accountable

Guidelines:

- State Nurse Practice Acts
- Clinical situation/ Pt needs
- Job descriptions
- Competencies of employees
- Policies & procedures

SELF DELEGATION

- RIGHT TASK – patient specific
- RIGHT CIRCUMSTANCE – appropriate resources and setting
- RIGHT PERSON – person knows how to do task
- RIGHT DIRECTION / COMMUNICATION – clear directions including limits and expectations.
- RIGHT SUPERVISION /EVALUATION – appropriate monitoring and follow-up

Scope of practice		
RN	**LPN/LVN**	**UAP**
• Clinical assessment • Initial client education • Discharge education • Clinical judgment • Initiating blood transfusion	• Monitoring RN findings • Reinforcing education • Routine procedures (eg, catheterization) • Most medication administrations • Ostomy care • Tube patency & enteral feeding • Specific assessments	• Activities of daily living • Hygiene • Linen change • Routine, stable vital signs • Documentin input/output • Positioning

LPN = licensed practical nurse; **LVN** = licensed vocational nurse; **RN** = registered nurse;
UAP = unlicensed assistive personnel.

Which of these nursing actions for the client with heart failure is appropriate for the nurse to delegate to experienced unlicensed assistive personnel ?

1. Assess for shortness of breath or fatigue after ambulation.
2. Instruct the client about the need to alternate activity and rest.
3. Obtain the client's blood pressure and pulse rate after ambulation.
4. Determine whether the client is ready to increase the activity level.

A unlicensed assistive personnel (UAP) is caring for a client with a nasogastric tube. Which of the following interventions cannot be delegated to the UAP?

1. Repositioning the tube
2. Recording output
3. Documenting the color of drainage
4. Emptying the nasogastric bag.

The client has just experienced a wound dehiscence. He tells the nurse that he felt something "pop" and then began to experience excruciating pain. Sequence the actions the nurse should take in this situation.

1. Notify the MD
2. Lower the client's head.
3. Cover the area with a sterile saline dressing
4. Administer prn antiemetics.

A nurse in the Emergency Room discovers an adult unconscious on the floor in the waiting area. What action should she take first?

1. Call a code.
2. Place the client in a supine position.
3. Use the head tilt method to open the airway.
4. Shake the client gently and shout, “Are you OK?”.

The nurse working in a free clinic often utilized by immigrants is evaluating a client who reports a cough and malaise. The client is hearing impaired, speaks very little English and is currently living in a homeless shelter. The nurse's primary concerns should be the client's:

1. Language barrier
2. Risk for tuberculosis
3. Hearing impairment
4. Lack of health care resources

What is the proper way to check for a pulse for a victim who is 4 years old?

1. Carotid artery
2. Cardiac apex
3. Brachial artery
4. Radial artery

The Automatic External Defibrillator should not be used on which of the following clients?

1. 58 year old male with Cardiovascular disease
2. 72 year old female with a significant history of CVA.
3. 6 year old with asthma
4. 28 year old with a history of a seizure disorder.

Which of the following nursing actions will facilitate medical therapy for a client with COPD?

1. Limiting fluid intake to prevent volume overload and heart failure.
2. Oral and endotracheal suctioning as necessary.
3. Instructing the client in deep breathing and coughing techniques and pursed-lip exhalations.
4. Maintenance of bed rest and activity restrictions to reduce acidosis.

The nurse is teaching a student nurse to insert a nasogastic tube. Which of the following describes the most appropriate method to use to verify tube placement?

1. Insert 5-10 ml of air into the tube and listen for a rush of air in the stomach.
2. Place the end of the tube in a glass of water and assess for bubbling.
3. Aspirate gastric content to check for pH.
4. Obtain an X-ray.

The nurse is supervising a student as she administers a tube feeding. The nurse would intervene if she observed which of the following:

1. The student nurse elevates the head of the bed to 90 degrees.
2. The student nurse aspirates for residuals, measures the residual, checks the pH of the residuals, then discards the residuals.
3. The students nurse assesses for the presence of bowel sounds.
4. The student nurse warms the feeding to room temperature, then begins the feeding.

An endotracheal tube has just been inserted. What action should be performed first?

1. Assess for bilateral breath sounds
2. Call for a chest x-ray
3. Obtain an arterial blood gas
4. Administer prn for pain.

In preparing a client for a left lung thoracentesis, how should the nurse position the client?

1. Left lateral
2. Supine with arms over head
3. Prone without a pillow
4. Sitting forward with arms on bedside stand

The nurse is supervising a student nurse as she cares for a client with a chest tube to water seal drainage via a Pleur-Evac drainage system. Which action below would necessitate an intervention by the nurse?

1. The student nurse measures drainage by emptying the contents of the Drainage Collection Chamber.
2. The student nurse checks to ensure that the drainage tubes are free of kinks.
3. The student nurse checks the water seal chamber for bubbling.
4. The student nurse checks the fluid volume in the suction control chamber.

The nurse finds that the client's Pleur-Evac is cracked and leaking. The client's respiratory rate is 49 and he is complaining of pain and severe "nervousness". Which of the following interventions should be performed first?

1. Administer prn for anxiety/nervousness
2. Administer prn for pain
3. Place the chest tube in a bottle of sterile water.
4. Replace the damaged Pleur-Evac and reattach the chest tube.

A client with a nasogastric tube to suction begins to complain of abdominal discomfort. Which intervention would the nurse implement first?

1. Reposition the nasogastric tube
2. Check the function of the suction equipment
3. Irrigate the nasogastric tube
4. Call the physician

Documentation (FLAT) Factual, Legible, Accurate & Timely

- Clear, concise, accurate, complete & timely
- Guidelines:
  - Correct chart
  - Write Neat & Legibly
  - Check spelling & grammar
  - Clear Factual statements
  - Blue/black ink
  - Standardized abbreviations
  - Sign, Date & Time of entry

Charting DON'Ts

- Do not chart for others
- Do not use labels
- Do not erase
- Do not leave blank spaces
- Do not alter a patient's chart
- Do not mention incident reports

Electronic Medical Records(EMR)

- Never share your password
- Frequent password changes
- Maintain confidentiality
- Check your information prior to press enter
- Access only your own patient's medical record
- Log off after completion
- Date & time are recorded in "real time"

PCP ORDERS

- Telephone orders/Verbal orders (emergencies only)
- Includes a read-back as per Joint Commission
- Be sure to have orders signed
- Follow your hospital policy & procedure!

Legal Issues & Ethical Principles

- **Nurse Practice Acts**
  - ✦Each state has their own law
  - ✦Affects the practice of nursing
  - ✦Protects the public from unsafe practitioners
  - ✦Defines the RN/LPN scope of practice

Standards of Practice

- Guidelines defined by the Board of Nursing & described by the NPA
- Describes the nurses responsibilities
- Evaluates quality of care provided
- Developed by professional organization
    - RN (American Nurses Association)
    - LPN (National Federation of LPN)

Principles of Healthcare Ethics

- **Beneficence:** doing/promoting 'good'
  - ✦Is the basis for all healthcare
  - ✦Ex: Helping to alleviate pain
- **Nonmaleficence**: to avoid doing harm; or preventing harm.
  - ✦Ex: Overdosing on pain medication
- **Respect for Autonomy**: independence & the ability to be self-directed.
  - ✦Even if healthcare providers do not agree with a client's decision, they must respect the client's wishes
  - ✦Ex: Terminal Cancer patient
- **Justice**: principle of fairness
  - ✦Treating all clients equally & fairly

Unintentional Torts

- Negligence-Failure to provide the standard of care resulting in injury
- Malpractice
  - Duty
  - Breach
  - Injury/Damages
  - Causation

Common Sources of Negligence

- Medication errors
- Patient falls
- Use of restraints
- Equipment injuries
- Failure to take appropriate nursing actions
- Failure to follow hospital procedure
- Failure to correctly supervise

Intentional Torts

- ASSAULT- Threatening behavior
- BATTERY- Actual contact
- FALSE IMPRISONMENT- restraints
- INVASION OF PRIVACY- video/photos/exposure of patient
- DEFAMATION OF CHARACTER
    - ✦SLANDER- verbal
    - ✦LIBEL- written

HIPAA (1996)
Health Insurance Portability & Accountability Act

- What is confidential health information?
- Individual identifiable health information
- Demographic data:
- Name, Address, Birth date, Social Security #, Billing Information
- (Insurance), email addresses, telephone numbers

- BE CAREFUL USING SOCIAL MEDIA!
- (FB, You Tube Twitter, Blogs)

INFORMED CONSENT

- OBTAINED BY MD/PERSON CONDUCTING THE PROCEDURE
- PHYSICIAN EXPLAINS THE PROCEDURE
- WITNESSED BY RN/LPN
- NOTIFY PHYSICIAN IF PATIENT HAS QUESTIONS OR RESERVATIONS
- DOCUMENT MENTAL STATUS OF PATIENT

REQUIREMENTS

- ALERT AND ORIENTED
- CANNOT BE UNDER INFLUENCE OF ANY DRUGS OR ALCOHOL
- OVER 18
- IF UNDER 18 – EMANCIPATED MINOR OR MARRIED

Which of the following is a true statement about the nurse's role in obtaining informed consent?

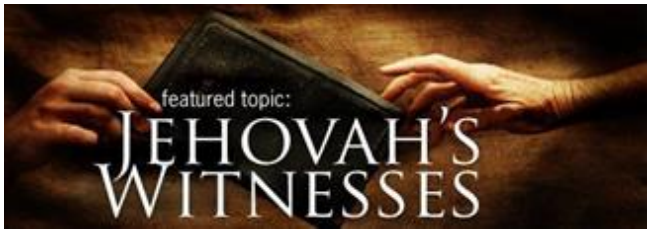
1. The nurse who receives the client in the holding area of the OR is responsible for obtaining informed consent.
2. The nurse assigned to the client 24 hours before the surgery is responsible for obtaining informed consent for the surgical procedure.
3. The circulating nurse is responsible for obtaining informed consent only if an outpatient surgical procedure is performed.
4. The nurse is responsible for ensuring that informed consent has been obtained by the MD prior to the surgical procedure.

When should NSAIDs be discontinued if a client is scheduled for a surgical procedure?

1. 2 weeks preop
2. 48 hours preop
3. 24 hours preop
4. 6 hours preop

Freedom of Religion

- KEEP IN MIND THAT RELIGIOUS FREEDOM IS CRITICAL IN ANY DECISION MAKING
- (ex: Jehovah's witnesses etc.)
- NURSE SHOULD RESPECT PATIENT'S DECISION REGARDLESS OF
- PERSONAL PREFERENCE



INCIDENT REPORTS

- Information should include:
- Patient's name, hospital ID
- Date, time, place of incident
- Physician and family notification
- Any witnesses
- Avoid words: "accidentally, mistakenly or inadvertently"
- NO MENTION OF INCIDENT REPORT IN PATIENT CHART!!

PATIENT ABANDONMENT

WHAT IS…

- ACCEPTING ASSIGNMENT THUS ESTABLISHING NURSE PATIENT RELATIONSHIP
- RN THEN DISCONTINUES RELATIONSHIP WITHOUT NOTICE

WHAT IS NOT…

- REFUSING ASSIGNMENT BEFORE ACCEPTING
- REFUSING TO WORK OVERTIME
- REFUSING ASSIGNMENT BECAUSE YOU ARE TOO MENTALLY OR PHYSICALLY EXHAUSTED TO PROVIDE SAFE CARE

An elderly client is refusing to take his medications as prescribed. The nurse tells the client that if he doesn't take his medication orally, then restraints will be applied and medication will be injected. This nurse can be charged with:

1. Invasion of privacy
2. Negligence
3. Assault
4. Battery

An assault occurs when a person puts another in fear of a harmful or offensive contact.

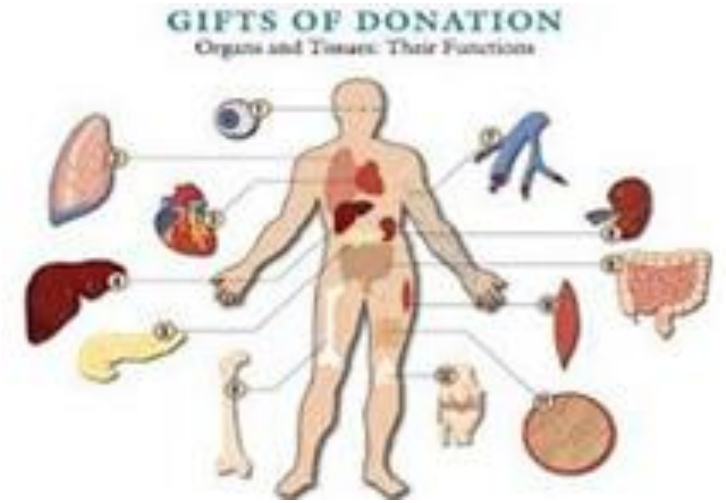
Battery is actual contact.

ADVANCED DIRECTIVES

- LEGAL DOCUMENT
- MADE AND SIGNED BY PATIENT WHEN STILL ALERT, ORIENTED AND OF SOUND MIND
- PROVIDES DIRECTIVES
- EXAMPLES
  - LIVING WILLS
  - HEALTH CARE PROXY
  - DURABLE POWER OF ATTORNEY
  - DNR

ADVANCED DIRECTIVES

- UNIFORM ANATOMICAL GIFT ACT (2006)
- PATIENT HAS RIGHT TO BE A DONOR >18
- MUST OBTAIN FAMILY PERMISSION for A DECEASED FAMILY MEMBER
- IN ORDER OF PRIORITY, NEXT OF KIN ARE
  - SPOUSE
  - ADULT SON OR DAUGHTER
  - PARENT
  - ADULT BROTHER OR SISTER
  - GRANDPARENT
  - LEGAL GUARDIAN



SITUATIONS THAT REQUIRE DISCLOSURE

- CHILD AND ELDER ABUSE
- USE OF NARCOTICS
- VIOLENT CRIME
- DANGEROUS PATIENTS
- COMMUNICABLE DISEASES
- VACCINE RELATED INJURIES
- EQUIPMENT RELATED INJURIES
- INCOMPETENCE OR UNPROFESSIONAL ACTS
- IMPAIRED NURSE

PATIENT SAFETY

- Accident & injury prevention is a major concern for nurses!
- NCLEX: What is a safe environment for your patient or group of patients in the hospital, home and community settings ??
- FACTORS AFFECTING SAFETY:
  - Age
  - Cognitive status
  - Mobility
  - Safety awareness
  - Sensory/ perceptual
  - Communication
  - Environmental FactoRS

PATIENT FALLS

- Leading cause of accidents among elderly
- Death is a common complication after a fall

RISK FACTORS:

- Aging
- Visual impairment
- Loss of balance
- Blood pressure changes
- Medications
- Cognitive impairment
- Environmental issues
- Walkers/canes/wheelchairs
- Footwear

FALL ASSESSMENT

- History of fall
- Medications (diuretics, anti- hypertensives, sedatives, antihistamines, narcotics, polypharmacy
- Alteration in mental status
- Unsteady gait/balance
- Weakness
- Urgency/incontinence
- Visual impairment
- Post-op/post sedation
- Ambulation device
- Advanced age over 75

FALL PREVENTION STRATEGIES

- Orient patient to environment and how to call for help
- Upper side rails may be used as a positioning aid
- Equipment within reach
- Assist with ADL
- Bed in lowest position and wheels locked
- Non-skid footwear
- Keep room clutter free
- Document all education on education record
- Consider moving the agitated/confused patients into the hallway for increased observation

- Leave the bathroom light ON during the evening and
- nighttime hours

RESTRAINTS

RESTRAINTS

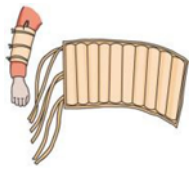
- PHYSICAL
- CHEMICAL
- REQUIRE APPROPRIATE DOCUMENTATION
- USED AS A LAST RESORT ONLY
- RESTRAINTS MAY CONSTITUTE UNLAWFUL IMPRISONMENT

TYPES OF RESTRAINTS

- ◆Waist/ lap belt that cannot be removed by the patient
- ◆Geri- chair with table
- ◆Soft limb restraints
- ◆Soft vest restraints
- ◆Secured and unsecured mittens
- ◆4 side rails
- ◆Freedom splints
- ◆IV arm boards which restrict movement







PRACTICE GUIDELINES

- Provide restraint alternatives
- Physician's order
- Restraints tied to frame of bed with a slip knot
- Assess patient at least every 2 hours!!
- Provide nutrition, hydration, elimination
- Assess skin care/ circulation/ Range Of Motion exercises/ readiness for discharge from restraints
- Appropriate documentation
- Any death in restraints is a state reportable incident!*

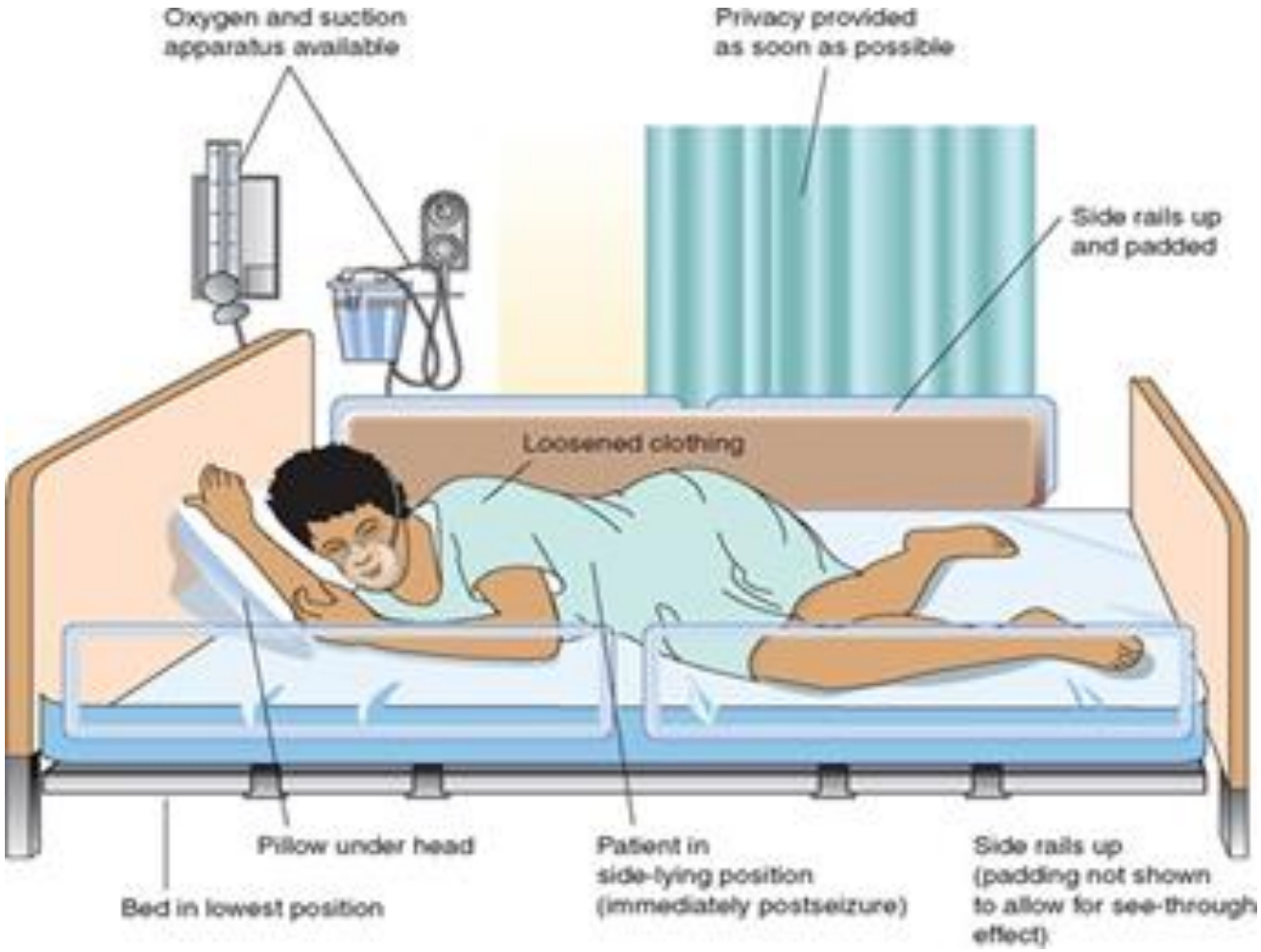
Physical restraints are being used to keep a client from climbing out of bed. Which of the following are true statements re: restraints?

1. Restraints can be ordered prn.
2. The MD order for restraints stands for the remainder of the time the client is in the hospital. No further orders are needed.
3. Skin integrity and neurovascular checks should be performed every 30 minutes while the restraint is in place.
4. Restraints should be removed every four hours as the client is assisted to perform ROM exercises.

A confused client needs to have restraints for seizure or falls. Which of the following can the nurse delegate to the nursing assistive personnel?

1. Applying restraints
2. Obtaining a physician's order to restrain the client
3. Document the events that led to restraining the client Evaluating the effectiveness of the restraints
4. Evaluating the effectiveness of the restraints

SEIZURE PRECAUTIONS



FIRE SAFETY

- Fire evacuation routine
- Location of fire alarms
- Location of extinguishers
- How to use an extinguisher (PASS)
- Location of fire exits

R	RESCUE	Anyone in immediate danger
A	ALARM	Pull the nearest alarm box
C	CONFINE	Close windows, doors, chutes, to confine fire
E	EXTINGUISH	Use appropriate extinguisher or smother the fire

FIRE SAFETY

There are 3 classes of fire extinguishers

- Class A: for paper, wood, upholstery, rags, or other type of trash fire
- Class B: for flammable liquids and gases
- Class C: for electrical fires

TO USE A FIRE EXTIGUISHER, USE THE *PASS* SEQUENCE

- **Pull** the pin
- **Aim** at the base of the fire
- **Squeeze** the levers
- **Sweep** the extinguisher from side to side, covering the area of the fire.

You enter your patient's room and discover a fire. Place your actions in the appropriate order.

Unordered Options **Ordered Response**

A. Contain the fire
B. Remove the patient from the room
C. Activate the alarm
D. Extinguish the flame

The nurse sees smoke coming from the nurse's lounge. Sequence her actions below in the order in which they should be performed.

1. Close the door to the nurses' lounge.
2. Move the patients who are in the rooms closest to the lounge to the other end of the hallway.
3. Ask the ward secretary to call a Code Red (fire).
4. Aim the fire extinguisher at the base of the fire and sweep from side to side.

CHEMICAL & RADIATION SAFETY

The OSHA Hazard Communication Standard

- Every employee who works with a hazardous chemical has a right to know about the potential hazards
- You should know how to protect yourself against exposure and injury.
- Check container labels and MSDS sheets.

Which actions described below would be appropriate when caring for a client with a radioactive implant?

1. The RN organizes the client's care so that all tasks are done during one visit to the client's room.
2. The RN delegates all tasks related to this client's care to the nurse extern (a senior nursing student) who is working on her team.
3. The RN sits on the side of the bed as she informs the client about lab results that are not "good".
4. The RN wears a lead apron whenever she is in the client's room.

ERGONOMICS

Ergonomics and client positioning:

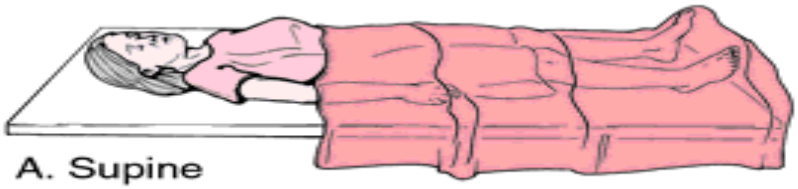
- Lifting and transfer
- Positioning

ERGONOMICS

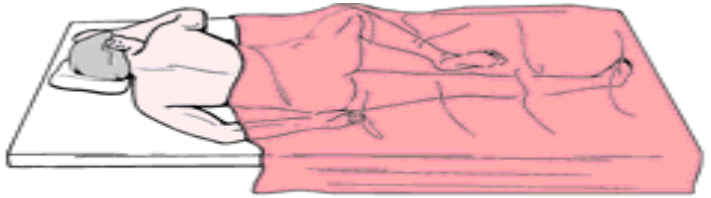
Bed and Client Positions:

- Semi-fowlers position
- Fowlers position
- High-fowlers position
- Supine or dorsal recumbent position
- Prone position
- Lateral or side-lying
- Sims' or semi-prone position
- Trendelenburg position
- Reverse Trendelenburg

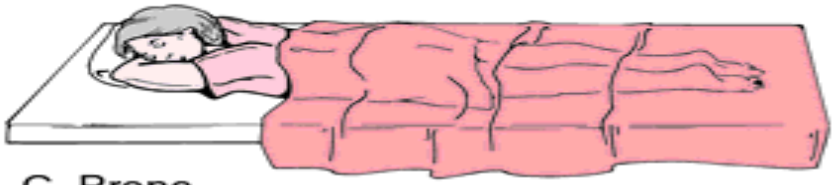
ERGONOMICS



A. Supine



B. Sims' (posterior view)

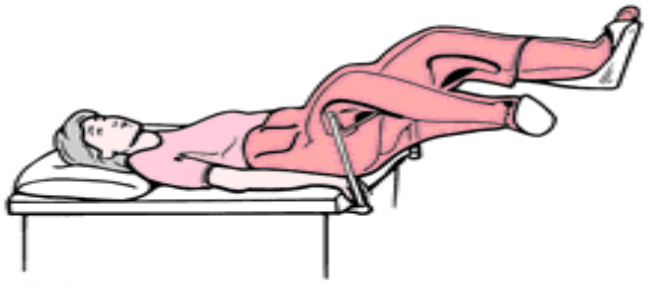


C. Prone

D. Knee-chest

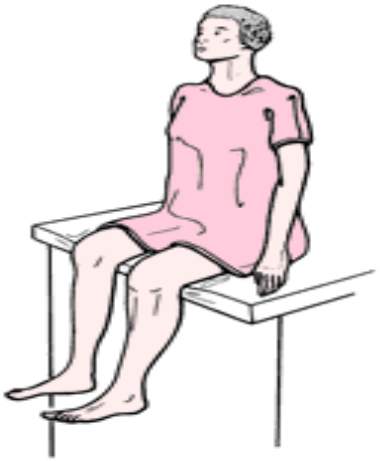
E. Dorsal recumbent

G. Standing



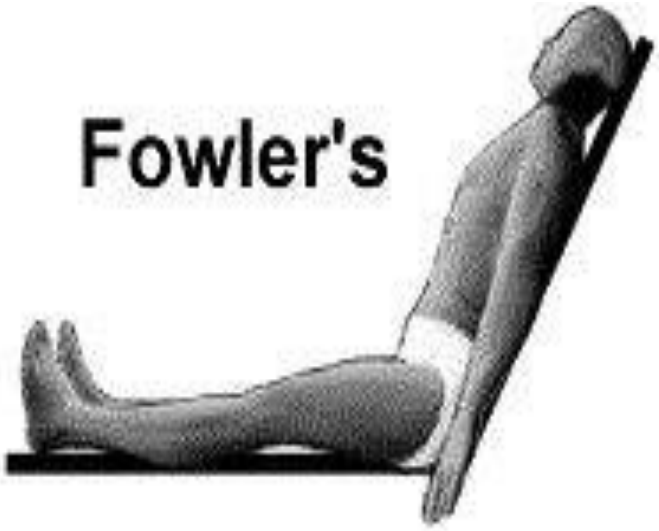
F. Lithotomy

H. Squatting



I. Sitting

ERGONOMICS


Fowler's


Semi-Fowler's

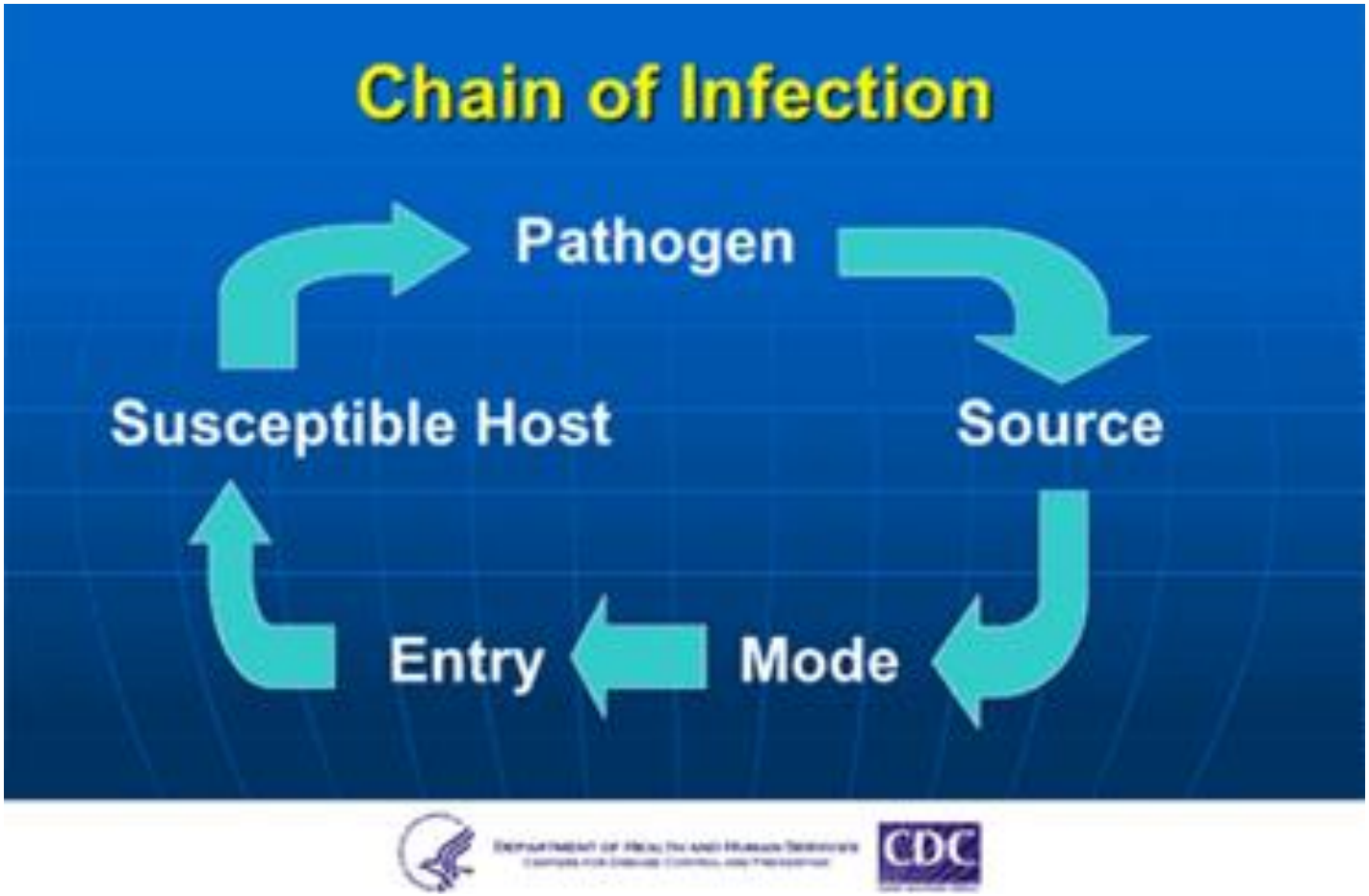

Trendelenberg


Reverse
Trendelenberg

Which of the following would require a nursing intervention?

1. The client's family has brought in a blow-dryer just purchased at Wal-Mart for her to use while in the hospital.
2. A nursing student has unplugged the IMED pump as she prepares to clean the device.
3. The client has brought in a two-prong extension cord so that he can move his clock radio closer to his bed.
4. The CNA has used the unit's three-prong extension cord to plug in the intermittent pulsatile compression device for an immobilized client. The cord is running along the left side of the client's bed.
5. The client was transferred to the acute care setting for follow up treatment for chest pain. She has brought a fan with her that she used at the long term care facility.

INFECTION CONTROL



HAND WASHING- Single most important component of an Infection Control Program

Artificial nails or enhancements are prohibited

ASEPSIS

- Medical Asepsis (clean)
- Surgical Asepsis (sterile technique)

STANDARD PRECAUTIONS

Standard Precautions:

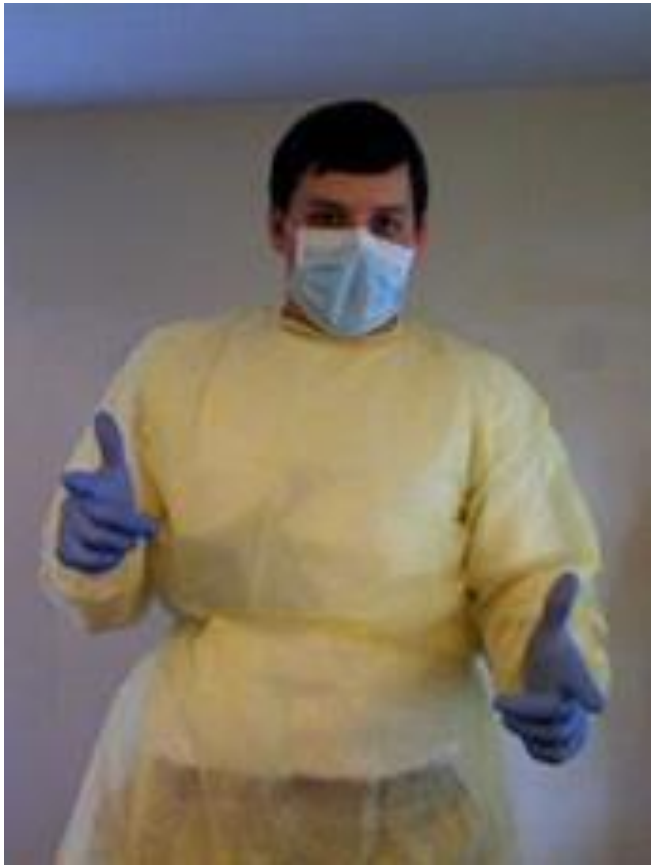
- Assume that each person is potentially infectious and contagious
- Designed for the care of all patients
- Room assignment
- Applies to:
    1. Blood,
    2. All body fluids, secretions and excretions,
    3. (except sweat) whether or not they contain visible blood, non-intact skin, any unfixed human tissue or organ, mucous membranes, contaminated items

STANDARD PRECAUTIONS

- This means PPE should be worn when performing tasks that may be associated with blood and or body fluid.
- Gowns, gloves, mask and goggles or mask with attached face shield are selected and worn based on the type of contamination anticipated.
- Minimize contact with blood and body substances by utilizing safe work practices and protective barriers.

PERSONAL PROTECTIVE EQUIPMENTS

- To protect yourself from exposure, you must wear Personal Protective Equipment (PPE)
- Gloves (vinyl & latex)
- Gowns(fluid proof, fluid resistant
- Protective eyewear
- Mask (surgical, non-surgical, respirator)
- All PPE should be removed IMMEDIATELY and disposed of according to Hospital policy.



NCLEX DONNING SEQUENCE: PPE

FOLLOW THE EXACT ORDER

1. GOWN
2. MASK OR RESPIRATOR
3. GOGGLES OR FACE SHIELD
4. GLOVES.

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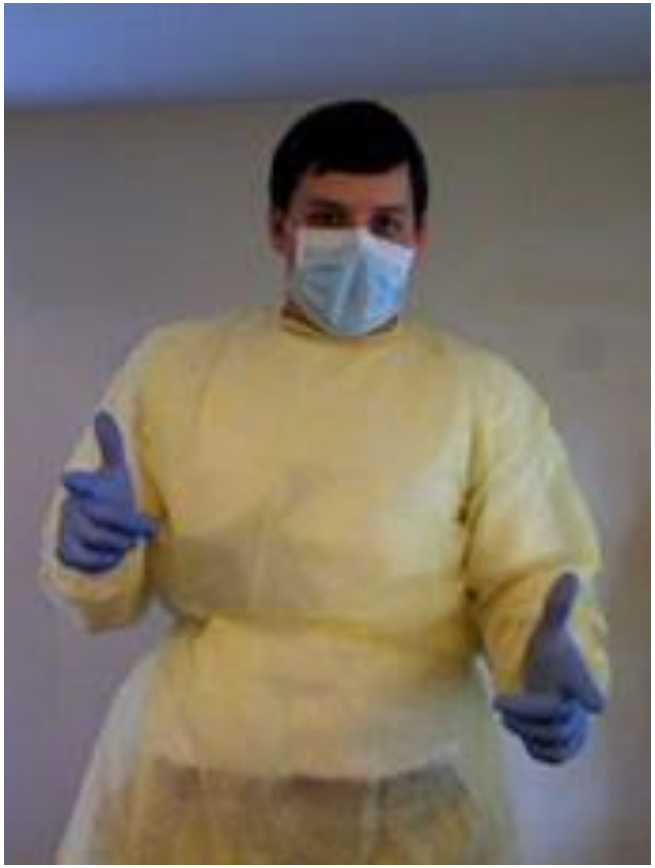
1. GLOVES
2. GOOGLES OR FACE SHIELD
3. GOWN
4. MASK OR RESPIRATOR



A nurse is using personal protective equipment (PPE) before entering the room of a patient who is being treated for an intestinal infection with diarrhea and vomiting. The nurse most likely needs to use which combination of PPE?

1. Gown, gloves, and mask
2. Gown, gloves, and goggles (or glasses)
3. Shoe covers, gown, and gloves
4. Gloves, gown, mask, goggles

INFECTION CONTROL

DROPLET Precautions

Wear a surgical mask when within 3 FEET of a client

- COUGHING
- SNEEZING
- TALKING
- SINGING
- DO NOT REMAIN SUSPENDED IN AIR
- SURGICAL MASK FOR PATIENT WHEN THE PATIENT NEEDS TO LEAVE THE ROOM

DISEASES SPREAD BY DROPLETS

1. MYCOPLASMA PNEUMONIA
2. ADENOVIRUS
3. MUMPS
4. INFLUENZA (FLU)
5. RUBELLA
6. ADENOVIRUS
7. DIPHTHERIA
8. EPIGLOTITTIS
9. MENINGITIS
10. SCARLET FEVER
11. STREPTOCOCCAL PHARYNGITIS
12. PNEUMONIA
13. PERTUSSIS
14. PNEUMONIA

Which of the following describes the proper way to maintain droplet precautions during client transport?

1. A client on droplet precautions would never be allowed to leave his room.
2. The nurse transporting the client should wear a gown, glove, mask. The client is covered with a sheet.
3. The client is required to wear a non-rebreathing mask during transport.
4. The client should wear a mask during transport.

AIRBORNE

1. SMALL PARTICLES
2. WIDELY SPREAD
3. SPECIAL AIR HANDLING AND VENTILATION REQUIRED
4. VISITORS REPORT TO NURSES' STATION
5. DOOR CLOSED Negative Airflow Room
6. SINGLE ROOM
7. PATIENT IN ROOM
8. N95 MASK ON HCP
9. SURGICAL MASK ON PATIENT
10. EXAMPLES: Measles, Chickenpox (varicella), Disseminated varicella zoster, Tuberculosis

Which of the following clients would be placed on airborne precautions?

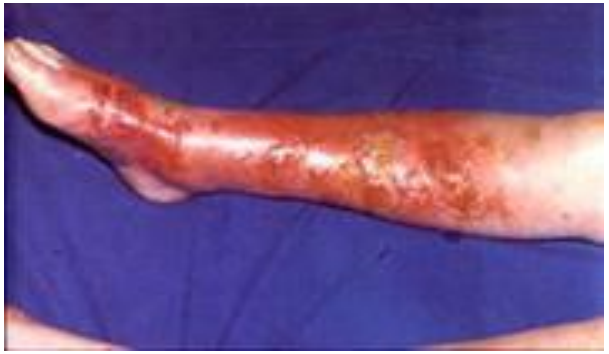
1. 7 year old who is neutropenic.
2. 22 year old who is HIV+.
3. 18 year old with varicella (Chickenpox).
4. 35 year old with MRSA.

CONTACT PRECAUTIONS

1. SURFACE TO SURFACE TRANSFER via VECTOR
2. GLOVES
3. GOWN
4. WASH HANDS
5. MASK
6. LINEN DISPOSAL
7. EXAMPLES:
8. VRSA, MRSA, C DIFF, RSV, HERPES, SCABIES

MRSA

1. **HOSPITAL ACQUIRED**
   - ➢COMPROMISED IMMUNE SYSTEM
2. **COMMUNITY ACQUIRED**
   - ➢WRESTLERS
   - ➢GYMNASTS
   - ➢CONTACT SPORTS



TREATMENT FOR MRSA

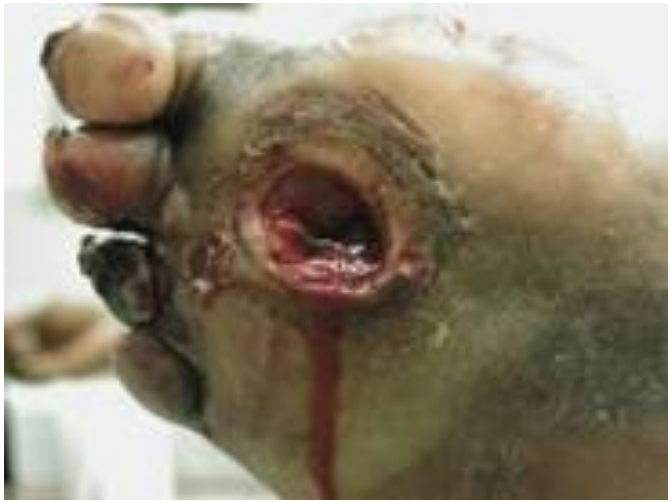
KEY IS TO DECOLONIZE

1. ANTIBIOTIC
2. HIBICLENS (CHLORHEXIDINE) BODY WASH HEAD TO TOE BID FOR 7 DAYS
3. MUPIROCIN NASALLY BID FOR 7 DAYS
4. Culture After Treatment

VRE

CONTACT PRECAUTIONS –DEDICATED

1. STETHOSCOPE
2. THERMOMETER
3. GLUCOMETER
4. BP CUFF, EKG WIRES



STERILIZE BED RAILS, FAUCET HANDLES – ANYTHING THAT COMES INTO CONTACT WITH PATIENT

MRSA & VRE

1. 2 NEGATIVE CULTURES (MRSA)
2. 3 NEGATIVE CULTURES (VRE)

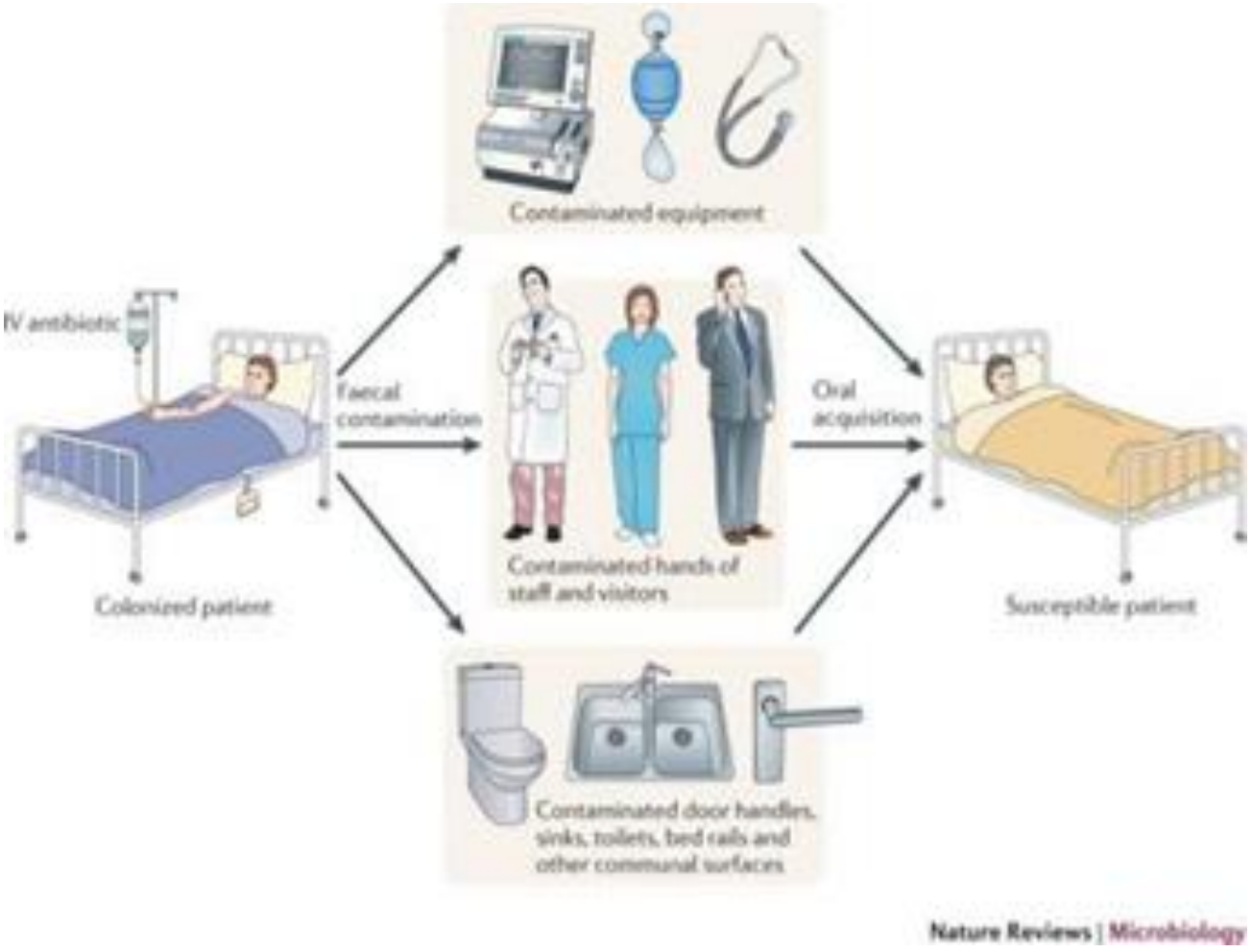
CLIENTS WITH:

1. VRE CAN COHORT
2. MRSA CANNOT COHORT

CLOSTRIDIUM DIFFICILE

- MOST COMMON FORM OF DIARRHEA CAUSED BY ANTIBIOTICS
- MOST COMMON OFFENDING AGENT IS AUGMENTIN
- WATERY, EXTREMELY FOUL SMELLING STOOL CONTAINING BLOOD AND MUCUS
- STOOL SAMPLE FOR O&P AND CULTURE

C-DIFF: METHOD OF TRANSMISSION



C-DIFF: TREATMENT

- NO COHORTS UNLESS SHARING SAME ORGANISM
- TREATMENT:
  - Oral metronidazole (Flagyl) or oral vancomycin.
  - Lactobacillus such as that found in yogurt helps re-establish normal gastrointestinal flora.
  - NO CONSTIPATING AGENTS (NO LOMOTIL or IMMODIUM)
    - ✓Places patient at risk for toxic megacolon
  - HYDRATION

NEUTROPENIC PRECAUTIONS (REVERSE ISOLATION)

- To protect the patient who is at increased risk for infection against contact with potential pathogens
- Conditions:
  - Agranulocytosis
  - Burns, extensive non infected
  - Immunosuppressive therapy
  - Lymphomas / Leukemia
- Patient Care: single room with + air pressure, no raw fruits & veggies, no visits from ill or infected individuals

BIOLOGICAL WARFARE AGENTS

- A warfare agent is a biological or chemical substance that can cause mass casualty destruction or fatalities

- Anthrax:
  - Transmitted by direct contact with the bacteria and its spores, and can be contracted through the GI Tract, abrasion of skin and inhalation thru the lungs
  - Treatment: Cipro, doxycycline or penicillin

- Smallpox:
  - Transmitted in air droplets and by handling contaminated materials. Very contagious. Vaccine is available

- Botulism:
  - Serious paralytic illness caused by a nerve toxin produced by Clostridium botulinum. Infected person can die in 24 hrs
  - Spread thru the air or food, but not from person to person
  - Treatment: induce vomiting, enema, penicilin

Which client described below would be at highest risk of developing Anthrax?

1. A postal worker with impetigo opens an envelope with the Bacillus anthracis toxin inside.
2. A postman with COPD delivers a box that has the Bacillus anthracis toxin inside.
3. A public high school lunch lady serves food that has been contaminated with the Bacillus anthracis.
4. A mother hugs her child after learning that the child has Anthrax.

DISASTER NURSING (MASS CASUALTY EVENT

- The local medical resources are
- overwhelmed
- Victims exceed resources
- Disasters : Natural or Acts of terrorism
- Care begins at the event
- Role of the Nurse
  - Disaster preparedness
  - Disaster response
  - Disaster recovery

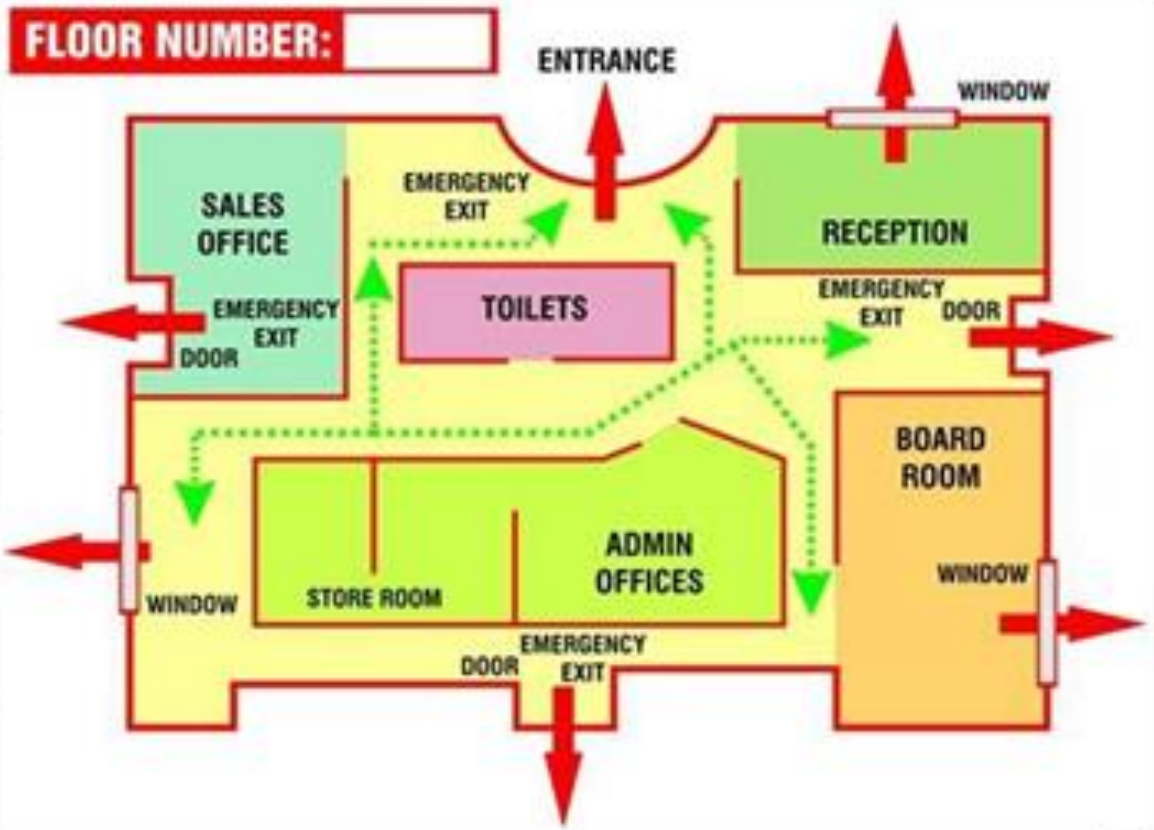
DISASTER TRIAGE

- Limited supply of equipment & personnel
- Setting: Hurricane, Flood, Terror Attack
- START System (EMS)
  - Separate the walking wounded
  - Green Tagged
  - Non- Walking Victims
  - Assess:
    - Respiration/ Circulation/ Mental Status

EMERGENCY EVACUATION PLAN

IN CASE OF FIRE

1. REPORT TO:
   EXT No:
   or
   CELL No:
2. EVACUATE TO EMERGENCY EXIT'S IMMEDIATELY
3. DO NOT USE ELEVATORS
4. FOLLOW EVACUATION PROCEDURES
5. PROCEED TO YOUR ASSEMBLY POINT



A tornado has touched down 1 mile from the hospital and a tornado warning has been issued with sirens. The nursing staff caring for the 36 patients on the second floor medical-surgical unit should move the patients to

1. The evacuation center across the street.
2. The hall, closing room doors and windows.
3. Their rooms, padding the windows with bed linens.
4. The basement in wheelchairs using the elevators

POISONS

- Any substance that impairs health or destroys life when ingested, inhaled or absorbed by the body
  - Toddlers, preschoolers, and young school age children must be protected from accidental poisoning
  - Poision control center phone number should be visible in homes with children
- Interventions
  - Remove substance from mouth, eye or body immediately
  - Identify the type and amount of substance
  - Call the poison control center before attempting to intervene
  - If the victim vomits or vomiting is induced save the vomitus and deliver it to the poison control center
  - Call an ambulance if instructed to take the victim to the ER
  - Vomiting is never induced after ingestion of lye, house hold cleaners, grease or petroleum products
  - VOMITING IS NEVER INDUCED IN AN UNCONSCIUOS VICTIM

Which of the following is recommended in a case of expected poisoning?

1. Rush victim to the nearest Emergency Department.
2. Induce vomiting, then call the Poison Control Center.
3. Save all vomitus and deliver to the Poison Control Center.
4. Induce vomiting immediately if a household cleaner is the expected poison.

TEST YOUR MATH SKILLS

A patient is to receive a 250 mL unit of packed red blood cells to infuse over two hours. The blood administration set has a drip factor of 10gtt/ml. What is the flow rate in drops per minute?

A heparin drip is being administered at a rate of 18 ml/hour. The bag of fluid has 25,000 units of heparin in 500 ml of saline. How many units of heparin is the client receiving per hour?

- 900 units per hour (this mixture gives you 50 units of heparin in 1 ml. 50 units x 18 ml/hour = ____ units/hour

The 1000ml IV solution is to infuse over an 8 hour time period. Calculate drops per minute if a minidrip (60 gtts/ml) is being used.

1. 50 gtts/minute
2. 75 gtts/minute
3. 100 gtts/minute
4. 125 gtts/minute

The MD has prescribed heparin sodium 1000 units per hour by continuous IV infusion. The pharmacy prepares the medication and delivers an IV bag with 10,000 units per 100 ml. The nurse sets the infusion pump at how many ml per hr to deliver the prescribed dose?

1. 10 ml/hr
2. 15 ml/hr
3. 20 ml/hr
4. 25 ml/hr

END