

NurseThink® for Students

# Conceptual Clinical Cases

Clinical-Based for Next Gen Learning  
From Fundamentals to NCLEX®



Over 50 Patient  
Assignments



- Concept-Based
- ✓ Clinical Judgment
- ✓ Next Gen Test Items
- ✓ Prioritization Power
- ✓ Chart Exhibits Throughout
- ✓ Online Quizzing/Video Coaching



**Nurse  
Think**

A NurseTim® Brand

Tim J. Bristol PhD, RN, CNE, ANEF, FAAN

Karin J. Sherrill RN, MSN, CNE, ANEF, FAADN

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Next Gen Clinical Judgment  
From Fundamentals to NCCLEX®

SAMPLE  
Sample only. Not for use.

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INCORPORATED

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# Circulation

## Perfusion / Clotting

Circulation is the movement of blood through the body and is dependent on the strength and function of a healthy heart. Perfusion, although often used interchangeably with circulation, refers to the passage of oxygenated blood through the capillaries to the tissues and cells of the body. In order to have adequate perfusion, both circulation (blood movement) and respiration (the ability to receive oxygen into the blood) are required. Without both of these components, perfusion will be insufficient in meeting the oxygen needs of the body.



Clotting is a normal process within the body for most people. When the process of clotting is not functioning as expected, negative outcomes occur, including tissue necrosis from a blockage of blood flow or hemorrhage from the inability to form clots.

### Next Gen Clinical Judgment:

If a client has poor circulation from a weak heart, what assessment changes can be observed?

- If there are excessive clots in the body, what changes will be seen in the peripheral circulation?
- What assessment differences will there be for a client with decreased perfusion from poor heart function compared to one with excessive clotting?
- How can the nurse determine if there is decreased perfusion to internal organs?
- Which serum labs are impacted by poor circulation or perfusion?



# Go To Clinical Case

While caring for this client, be sure to review the concept maps in chapters 3 and 4.

## Case 1: Impaired Coronary Perfusion and Chest Pain

*Related Concepts: Comfort, Adaptation: Coping & Stress*  
*Threaded Topics: Health Promotion & Teaching, Clinical Calculations, Legal Issues, Communication*

Kandice Sheridan is a 49-year-old female in the emergency department for “achiness” in the elbows that is atypical and worsening over the last three days. She states that the feeling awakens her at night. Ms. Sheridan has felt more short of breath with activity lately and has been under a lot of stress at work. She is planning a trip overseas in a few days and wants to confirm there is nothing significantly wrong before leaving the country.



1. The nurse is beginning an initial assessment. In what priority order should these actions be performed?

Answers: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

1. PQRST pain assessment.
2. Vital signs assessment.
3. Health history and medication use.
4. Place in a hospital gown.
5. Assessment of contributing symptoms.

**Clinical Hint:**  
 P - Provocation/Palliation  
 Q - Quality  
 R - Radiation/Relief  
 S - Severity/Symptoms  
 T - Timing

**Clinical Hint:** Mean Arterial Pressure (MAP) is a calculation that measures the blood perfusion to organs. A MAP < 65 mmHg indicates that there is inadequate perfusion. Ex: 145/88 (107). The MAP is 107.

		Name: Kandice Sheridan Health Care Provider: M. Dixon M.D. Code Status: Full Code	Age: 49 years Allergies: NKDA
<b>NURSING NOTE</b>			
June 1 0730	49-year-old female admitted with atypical pain in the elbows. Afebrile, RR 18, HR 88, BP 145/88 (107), sats 97% on room air (RA). Denies chest pain and shortness of breath at this time. Says her arms feel “heavy” and elbows feel “achy.” Describes achiness as “less than during the night last night.” Denies nausea or other discomforts. Skin moist to touch. History includes iron deficiency anemia, C-sections x 2, and appendectomy. Family history consists of a father with an acute myocardial infarction (AMI) at age 56.		



## 2. NurseThink® Prioritization Power!

Evaluate the information within the Nursing Notes from the emergency department and pick the **Top 3 Priority** assessment findings.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**NurseThink**  
HEALTHCARE SYSTEM

Name: Kandice Sheridan  
Health Care Provider: M. D.  
Code Status: Full Code

Age: 49 years  
Allergies: KDA

**HEALTHCARE PROVIDER PRESCRIPTIONS**

June 1 0900	<ol style="list-style-type: none"><li>1. Serology: complete blood cell count (CBC), comprehensive metabolic panel (CMP), prothrombin time, international normalized ratio (INR), partial thromboplastin time (PTT), lipid panel, troponin, myoglobin, creatine kinase-muscle/brain (CK-MB)</li><li>2. 12-lead electrocardiogram (EKG), Chest x-ray ASAP</li><li>3. IV capped line</li><li>4. O<sub>2</sub> at 2 L/NC for sats &lt; 95%</li></ol>
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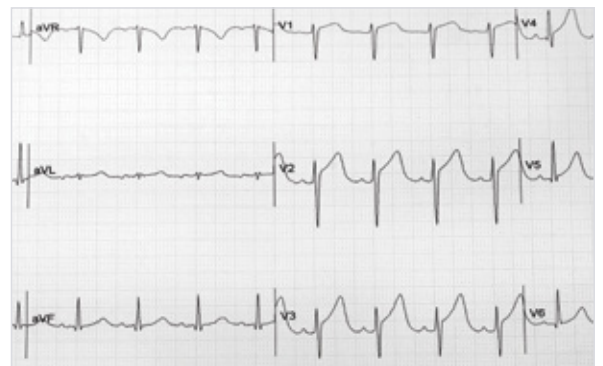
## 3. After reviewing the orders, which action should the nurse take first?

1. Request serum lab draw.
2. Obtain 12-lead EKG.
3. Place IV capped line.
4. Apply O<sub>2</sub> at 2 L/ nasal cannula.

4. In preparation for the IV insertion, the nurse should place a \_\_\_\_\_ gauge capped IV line.

## 5. Which observation(s) should the nurse make in the review of the 12-lead EKG? Select all that apply.

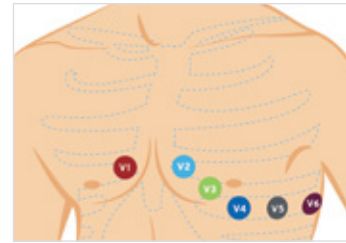
1. The client has tachycardia.
2. There is ST segment elevation in V leads.
3. The client has premature ventricular contractions (PVCs).
4. There is artifact on the tracing.
5. The tracing is normal.





6. After reviewing the EKG, what should be the nurse's next action?

1. Apply continuous EKG monitor.
2. Check to see if the serum lab report is back.
3. Notify the healthcare provider.
4. Apply the ordered oxygen.



LABORATORY REPORT			
Lab	Normal	100%	
WBC	4,000 - 10,000/mm <sup>3</sup>	5.0	
Hemoglobin	12.0 - 17.0 g/dL	11.1	L
Hematocrit	36.0 - 51.0%	39	
RBC	4.2 - 5.4 million/L	4.0	L
Platelets	150,000 - 400,000/L	245,000	
Calcium	9 - 10.5 mg/dL	9	
Chloride	98 - 106 mEq/L	98	
Magnesium	1.2 - 2.4 mEq/L	2.0	
Phosphorus	3.0 - 4.5 mg/dL	3.1	
Potassium	3.5 - 5.0 mEq/L	3.3	L
Sodium	136 - 145 mEq/L	139	
Glucose	70 - 100 mg/dL	110	H
BUN	8 - 20 mg/dL	20	
Creatinine	0.7 - 1.3 mg/dL	1.0	
Creatine Kinase (CPK)	30 - 170 U/L	378	H
CPK-MB	3 - 5%	6%	H
Lactic Dehydrogenase (LDH)	60 - 100 U/L	150	H
Aminotransferase, Aspartate (AST)	0 - 35 U/L	30	
Aminotransferase, Alanine (ALT)	0 - 35 U/L	33	
GGT	9 - 48 U/L	34	
T. Bilirubin	1.2 mg/dL	0.9	
Cholesterol	< 200 mg/dL	254	H
Triglycerides	< 150 mg/dL	298	H
Troponin I	< 0.5ng/mL	0.10	H
Troponin T	< 10 ng/mL	12	H
Myoglobin	< 170 ng/mL	168	
PT	11 - 12.5 seconds	11.5	
INR	0.8 - 1.1	0.8	
aPTT	25 - 35 seconds	32	

**7. NurseThink® Prioritization Power!**



Evaluate the information on the lab report and pick the **Top 3 Priority** lab findings.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**8. THIN Thinking Time!**



Reflect on the events that have occurred since Kandice Sheridan came to the emergency department and apply **THIN Thinking**.

- T - \_\_\_\_\_
- H - \_\_\_\_\_
- I - \_\_\_\_\_
- N - \_\_\_\_\_

**T** - Top Priority  
**H** - Happen Quick  
 Identify Risk to Safety  
**N** - Nursing Process

Scan to access the  
 10-Minute-Mentor →  
 on THIN Thinking.



[NurseThink.com/THINThinking](http://NurseThink.com/THINThinking)

**9. The nurse gathers the lab report and begins to prepare an SBAR conversation for the HCP. Complete each section of the communication form.**

- S - \_\_\_\_\_
- B - \_\_\_\_\_
- A - \_\_\_\_\_
- R - \_\_\_\_\_

**Clinical Hint:**

- S - Situation
- B - Background
- A - Assessment
- R - Recommendation

**10. The nurse obtains several STAT verbal prescriptions from the HCP for a client experiencing an acute myocardial infarction. In what order should the nurse complete these actions?**

**Answers:** \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

1. Nitroglycerin (NTG) 0.4 mg SL x 3 PRN for pain.
2. Consult Dr. Nemus, Cardiologist.
3. Obtain blood pressure and heart rate.
4. Read back the verbal orders.
5. Morphine 2-4 mg IV PRN for pain unrelieved by NTG.

**Clinical Hint: Remember MONA?**

- M - Morphine
- O - Oxygen
- N - Nitroglycerin
- A - Aspirin

**11. After administering 4 mg of morphine sulfate IV for chest pain, the nurse discovers that the consent for an emergent coronary angiogram was not signed. The assessment shows that the client is alert, oriented and pain-free. What should the nurse do next?**

1. Obtain a signature before the morphine peaks in the bloodstream.
2. Notify the cardiologist and cancel the procedure.
3. Determine if a power of attorney is available.
4. Ask the client's teenage son, who is at the bedside, to sign the consent.

12. The nurse teaches the client about expectations of the emergent coronary angiogram and reviews what the cardiologist told her about the possibility of open-heart surgery if the stent placement is unsuccessful. The client begins to cry saying that her father died after open-heart surgery. How should the nurse respond?

1. "I'm sure you are frightened, this is a scary thing to go through."
2. "Do you want me to get the cardiologist back in here to answer your questions?"
3. "It's okay, your cardiologist is excellent; he's one of the best."
4. "Would you like it if I called the chaplain?"

## Hand-Off Report

Kandice Sheridan is a 49-year-old returning from the cardiac cath lab after an anterior ST-Elevation Myocardial Infarction (STEMI). The cardiologist was able to place a stent in her proximal left anterior descending (LAD) artery. She also has a 40% lesion in her circumflex and a 30% lesion in her right coronary artery (RCA) which do not require intervention at this time. She has a sheath in her right femoral artery. There is no bleeding at the groin site, and her pedal pulses are 3-4+ bilaterally. Her skin is warm to touch. Her vital signs are stable. The nurses review the prescriptions together.

**Nurse Think HEALTHCARE SYSTEM**

Name: Kandice Sheridan  
 Age: 49 years  
 Health Provider: [Redacted]  
 Allergies: NKDA  
 Code: [Redacted]

### HEALTH CARE PROVIDER PRESCRIPTIONS

June 1 1545	<p>on arrival to patient care unit, assess puncture site, vital signs, and color, warmth, movement, and sensation of the affected limb.</p> <p>every 15 min x 2</p> <ul style="list-style-type: none"> <li>▶ every 30 min x 2</li> <li>▶ every 1 hr x 2 then with routine vital signs as ordered and PRN</li> </ul>
	O <sub>2</sub> at 2 L/NC continuously
	Heparin infusion at 1,000 units/hr until 2100. Draw activated clotting time (ACT) at 2200 and discontinue sheath if ACT <180 seconds.
	Complete bedrest x 6 hrs. post hemostasis with affected limb straight. May be out of bed tomorrow at 0400 if no hematoma or bleeding. If bleeding occurs from the puncture site, apply direct pressure for 10 minutes or until bleeding stops.

13. The client returns from a cardiac catheterization procedure with a right groin sheath in place. What should the nurse include in the priority assessment of this client? Select all that apply.

1. Blood pressure.
2. Temperature.
3. Right groin assessment.
4. Lung sounds.
5. Cardiac monitor.

**Clinical Hint:** After a procedure that involved the large vessels of the groin, the distal pulse assessment should include the popliteal, dorsalis pedis, and posterior tibialis arteries.

14. A client has 25,000 units of heparin in 500 mL NS infusing at 1,000 unit per hour via a 20 gauge IV in the left hand. At what rate should the pump be set?

1. 10 mL/hr.
2. 20 mL/hr.
3. 25 mL/hr.
4. 50 mL/hr.



Nursing
Flow Sheets
Provider
Labs & Diagnostics
MAR
Laborative Care
Other

Name: Kandice Sheridan  
Health Care Provider: M. Dixon M.D.  
Code Status: Full Code

Age: 49 y  
Allergies: N

Vital Signs SIGN P BOARD

Time	BP (MAP)	HR	RR	Sats
1545	105/70 (79)	93	19	97% 2 L/NC
1601	105/70 (76)	97	20	98% 2 L/NC
1622	100/59	108	20	98% 2 L/NC

15. The nurse obtains the first three sets of vital signs. What should the nurse do next?

1. Have the unlicensed assistive personal complete the remaining set of vital signs.
2. Assess for bleeding at the sheath site.
3. Re-evaluate the vital signs in 15 minutes.
4. Notify the health care provider of the client's status.

The client is dehydrated and vital signs are stabilized after the intravenous fluid is administered. The sheaths are pulled at 2245 without complications.

16. While administering the ordered medications, Kandice asks why each of these medications are needed. Describe how the nurse should instruct her for each of these medications.

1. Clopidogrel 75 mg daily, by mouth. \_\_\_\_\_
2. Aspirin 81 mg daily, by mouth. \_\_\_\_\_
3. Metoprolol 50 mg daily, by mouth. \_\_\_\_\_
4. Atorvastatin 80 mg daily, by mouth. \_\_\_\_\_

17. **Kandice asks what she can do to help decrease the risk for having another heart attack in the future. What should the nurse instruct? Select all that apply.**

1. Eat a diet low in cholesterol and saturated fats.
2. Minimize carbohydrate intake.
3. Walk 30 minutes 5 days a week.
4. Increase dietary intake of fruit.
5. Monitor serum lipid levels.

18. **As the nurse enters Kandice’s room on the morning of discharge, she finds her crying. When asked what is wrong, she states, "I'm so afraid I'll pass my bad genes to my children, and they'll have heart disease also." How should the nurse respond?**

1. "I don't think that will be an issue since your spouse has a good heart."
2. "I'm sure you are afraid for them, maybe they'll be luckier than you."
3. "They can make some lifestyle changes now, so their chances of heart disease are low."
4. "With proper medication, they will have less chances of heart disease."

**19. NurseThink® Prioritization Power!**



Evaluate the care of this client and pick the **3** Priority discharge needs.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

20. **Kandice returns to the clinic two weeks later appearing withdrawn and sad. The nurse asks how things are going and she states, "It's such an adjustment, I don't know if I can do it." What suggestions should the nurse make to the client?**

1. Request an antidepressant from the cardiologist.
2. Participate in a cardiac support group.
3. Encourage her spouse to be more supportive.
4. Suggest she takes more time off of work.

**Clinical Hint:** Heart disease demands a lifetime of compliance with lifestyle change. Providing community support and resources for the client after discharge will improve the chances of long-term success.

Because heart disease is often familial it is important for the nurse to address concern for the blood relatives of the client. Prevention education is critical to slowing the cycle of disease and illness.

**Next Gen Clinical Judgment:** List all possible symptoms that can indicate impaired circulatory event. Consider the cues of each body system when it is experiencing a decrease in perfusion.

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## Go To Clinical Case

While caring for this client, be sure to review the concept maps in chapters 3 and 4.

### Case 2: Decreased Perfusion from Hypertension and Heart Failure

*Related Concepts: Oxygenation, Mobility, Acid-base Balance*

*Threaded Topics : Legal Issues, Error Identification, Communication, Teamwork, Patient Education, Medication Safety*

William Jones is a 69-year-old man with a 25-year history of hypertension. He was discharged from the Veteran’s Hospital last week after a 2-day stay for hypertensive crisis. The home care nurse is making an initial visit to his home today. Mr. Jones greets the nurse at the door. He is tall with a large build. He walks with a limp and is mildly short of breath. His home is small but neat and well-kept. There are no stairs or throw-rugs. There is a small dog, barking as the nurse enters. The smell of food cooking comes from the kitchen.




The nurse performs an environmental assessment. Why would each observation listed be a potential concern? What are the areas for further assessment by the nurse? List the action that the nurse should take.

- Large build \_\_\_\_\_
- Walks with a limp \_\_\_\_\_
- Mildly short of breath \_\_\_\_\_
- Small dog \_\_\_\_\_
- Smell of food \_\_\_\_\_

After completing the initial admission paperwork and physical assessment of Mr. Jones, the nurse documents the findings in the electronic record using a tablet computer.



Nursing | Flow Sheets | Provider | Labs & Diagnostics | MAR | Collaborative Care | Other


Name: William Jones | Age: 69 years  
Health Care Provider: K. Kumar M.D. | Allergies: NKDA  
Code Status: No intubation

**NURSING NOTE**

Sept. 5  
0930

69-year-old man discharged from the Veteran's Hospital last week after a 2-day stay for hypertensive crisis. Health history includes hypertension x 25 years, diabetes x 2 years, and an enlarged prostate gland. Surgical history includes cholecystectomy 30 years ago and significant orthopedic surgery after a "blown out left knee" in Vietnam at the age of 20 years. Client lives with his wife who was his "high-school sweetheart." VS = T 97.6°F (36.4°C), RR 22 breaths, HR 110 beats, BP 167/89 (115) mmHg, Sat 93% on room air. Alert and oriented (A & O) x 3. Moves all extremities. Grips and pushes equal in upper extremities. Left foot weaker than right and knee is swollen. States knee pain of 5 on a 1-10 scale. Pulses strong in upper extremities. In feet, S3 heart sounds with some irregular beats. Fine bibasilar crackles. States feeling short of breath with activity. Bowel sounds active x 4. Last bowel movement yesterday noted "normal." States hesitancy with urine flow but denies burning. Up to void 1-2 times each night. Patient states morning blood glucose is 178, and he checks it daily. Ht. 6'1" Wt. 263 pounds. BMI 34.7.

**2. NurseThink® Prioritization Practice**

Evaluate the information within the assessment notes and pick the **Top 3 Priority** assessment concerns.

1. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Next, the nurse reviews the client's medication list.

**MY MEDICATIONS**

Lisinopril 40 mg once a day by mouth  
 Atenolol 50 mg once a day by mouth  
 Metformin 1000 mg twice a day by mouth  
 Tamsulosin 0.4 mg once a day by mouth  
 Celecoxib 200 mg twice a day by mouth as needed

**Clinical Hint:** Always compare the actual medication bottles to a written/typed list that the client provides. Dosages may have changed and the list may be outdated.

**Next Gen Clinical Judgment:** For each of these medications, review the drug category and priority teaching point.



3. After further inquiry, it is discovered that no morning medications have been taken. Which medications should the nurse suggest Mr. Jones take now? Select all that apply.

- 1. Lisinopril.
- 2. Atenolol.
- 3. Metformin.
- 4. Tamsulosin.
- 5. Celecoxib.

Read what the American Heart Association says about blood pressure management and hypertensive Crisis. →

[www.heart.org](http://www.heart.org)



Explain why you chose each medication as a priority.

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4. The nurse completes a Fall Risk Assessment for Mr. Jones. His score is 13 (at-risk is >10). Which intervention(s) would be most appropriate? Select all that apply.

- 1. Ask him to find a new rug for his room.
- 2. Request a physical therapist evaluation.
- 3. Request a occupational therapy by referral.
- 4. Get a brace for his knee.
- 5. Suggest grab bars in the bathroom.
- 6. Place a red "fall risk" band on his wrist.

**Clinical Hint:** Early fall risk assessment and interventions can save lives. The death rate from unintentional falls for adults aged 65 or more years has been increasing an average of 4.9% per year, according to the Centers for Disease Control and Prevention.



5. The nurse reviews Mr. Jones advanced directives. The forms indicate that he is agreeable to everything except being on life support. He has identified his wife as his Power of Attorney. How should the nurse implement these preferences? Select all that apply.

- 1. His wife is the proxy and will make his health care decisions.
- 2. No intubation, should he stop breathing.
- 3. Perform defibrillation if his heart stops.
- 4. Provide nutritional support if he is in a vegetative state.
- 5. Perform CPR if he is found unconscious and not breathing.

6. NurseThink® Prioritization Power!

What additional concerns did the nurse not address on this visit?

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7. One week later, Mr. Jones calls the home care nurse saying that he feels very short of breath since he awoke three hours ago and is having a hard time breathing. What actions should the nurse take next?

1. Change the plan for the day and make a visit to Mr. Jones.
2. Ask him to check his blood pressure and call you back.
3. Have him take an extra antihypertensive medication and lay down.
4. Tell him to hang up the phone and call an ambulance.

Mr. Jones chooses to have his wife drive him to the emergency department, where he is admitted. The nurse makes these notes in the electronic health record.

The screenshot shows a patient record for William Jones, 69 years old, with allergies to NKDA. The record includes a table of vital signs for September 13, 2010, at 10:10 AM. The vital signs are: BP (MAP) 100/114 (146), RR 28, and Sats 90% RA. A note below the table states: "Brought in by wife per private vehicle, short and on bed x 3. Crackles bilaterally anteriorly & posteriorly. Moist cough. Some nasal flaring. Patient feeling like can't get his breath."

Time	BP (MAP)	RR	Sats
Sept. 13 1010	100/114 (146)	28	90% RA

Brought in by wife per private vehicle, short and on bed x 3. Crackles bilaterally anteriorly & posteriorly. Moist cough. Some nasal flaring. Patient feeling like can't get his breath.

8. NurseThink® Prioritization Power!

Evaluate information within the emergency department note and pick the **Top 3 Priority** actions.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

9. The nurse discusses the situation with the emergency department provider. Which prescription(s) should the nurse question? Select all that apply.

1. IV 0.9% sodium chloride at 100 mL/hr.
2. Delivery of sodium nitroprusside intravenously.
3. Portable chest x-ray.
4. Furosemide 5 mg intravenously.
5. Oxygen at 15 L by non-rebreather mask.
6. Arterial blood gas.

**Clinical Hint:** A prescription can be a medication, therapy, or anything ordered by the health care provider.

LABORATORY REPORT		
<b>Arterial Blood Gas</b>	<b>Normal</b>	<b>Admit</b>
pH	7.35-7.45	7.28 L
PO <sub>2</sub>	80-100 mmHg	65 L
PCO <sub>2</sub>	35-45 mmHg	52 H
HCO <sub>3</sub>	22 to 26 mEq/L	
SaO <sub>2</sub>	95-100%	91 L
O <sub>2</sub> Delivery		2 L/NC

10. The nurse receives the arterial blood gas results above. What conclusions should the nurse make about the client's situation?

1. In metabolic acidosis and has impaired renal function.
2. In respiratory acidosis and needs more oxygen.
3. Needs more oxygen and to breathe into a paper bag.
4. Needs a bronchodilator and intubation.


**Clinical Hint:** It is not important to "name" the blood gas but rather determine the best action the nurse should take in response to the lab report, based on the situation.



### Handoff Report to ICU:

Mr. Jones is a 69-year-old with a history of hypertension, diabetes mellitus (DM) type II, and knee pain from a war injury. He came to the emergency department (E.D.) via private vehicle this morning after feeling severely short of breath. Upon admission to the E.D., he was found to be severely hypertensive and short of breath. His blood gases showed respiratory acidosis with hypoxemia, and his chest x-ray confirmed he is in acute cardiogenic heart failure. He's on 4 L/NC, and his saturations are at 93%. We gave him the "now" dose of furosemide 40 mg of IV about 10 minutes ago and started him on sodium nitroprusside intravenously at 0.1 mcg/kg/minute 15 minutes ago, and his last blood pressure was 211/115 (147) mmHg, heart rate is 120 in a sinus tachycardia, with rare premature ventricular contraction (PVC), respirations are 24 breaths per minute. His wife is in the intensive care unit (ICU) waiting room.

Nursing Flow Sheets **Provider** Labs & Diagnostics MAR Collaborative Care Other



**Name:** William Jones **Age:** 69 years  
**Health Care Provider:** K. Kumar M.D. **Allergies:** NKDA  
**Code Status:** No intubation

### HEALTH CARE PROVIDER PRESCRIPTIONS

Sept. 13 1300	<ol style="list-style-type: none"> <li>O<sub>2</sub> to maintain saturations &gt; 94%</li> <li>Labs: Complete Blood Cell Count (CBC), Comprehensive Metabolic Panel (CMP), Brain Natriuretic Peptide (BNP) stat</li> <li>Chest X-Ray in morning</li> <li>Blood glucose monitoring before meals (AC) and at bedtime (HS)</li> <li>Sodium nitroprusside titrate for Systolic BP &lt;160 mmHg and Diastolic BP &lt;100 mmHg. Do not exceed 10 mcg/kg/min</li> <li>Furosemide 40 mg IV now and in 8 hours</li> <li>Metformin 1,000 mg twice a day by mouth</li> <li>Acetaminophen 650 mg every 4 hours PRN headache</li> <li>1800 calorie American Dietetic Association low sodium diet</li> <li>indwelling catheter – strict</li> <li>Baseline and daily weight</li> </ol>
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Over the next couple of hours, the intensivist in the ICU, nurse cares for Mr. Jones and documents the care in the electronic health record (EHR). Review the sequence of events listed below.

Nursing Flow Sheets **Provider** Labs & Diagnostics MAR Collaborative Care Other


**Name:** William Jones **Age:** 69 years  
**Health Care Provider:** K. Kumar M.D. **Allergies:** NKDA  
**Code Status:** No intubation

### NURSING NOTE

Sept. 13 1530	Handoff report received from the emergency department. Orders reviewed. Head of bed elevated. O <sub>2</sub> at 4 L/NC, sats 92%. Crackles bilaterally. 3+ pedal edema, positive for jugular venous distension (JVD). BP 215/117 (150) mmHg. Nitroprusside at 0.1 mcg/kg/min in right forearm 20 g IV. States having a headache and feeling tired. Weight obtained by bed scale.
1600	BP 210/110 (143) mmHg. Nitroprusside increased to 0.2 mcg/kg/min. Headache a 4 on 1-10 scale. Administered acetaminophen 650 mg orally. Resting with cool cloth over eyes. Voided 100 mL clear urine. States breathing is “better.”
1630	BP 200/105 (137) mmHg. Nitroprusside infusing at 0.2 mcg/kg/min. Resting quietly, wife at bedside. Labs show K+ 3.3 mEq/L, BUN 32 mg/dL, Creatinine 2.3 mg/dL, Brain natriuretic peptide (BNP) 452 pg/mL.
1700	BP 192/100 (131) mmHg. Voided 500 mL clear urine. States headache is a dull ache now.
1715	Increasing premature ventricular contractions on EKG monitor, 4-8 per minute. BP 195/101 (132) mmHg. Nitroprusside continues at 0.2 mcg/kg/min. O <sub>2</sub> at 4 L/NC sats 93%, crackles in lungs continue. Glucose meter reading 190 mg/dL, metformin delivered, refuses dinner.



11. After reviewing the last two hours of care in the intensive care unit, identify which prescription(s) the nurse did not complete correctly. Select all that apply.

1. Oxygen titration.
2. Completion of labs draw.
3. Blood glucose monitoring.
4. Sodium nitroprusside titration.
5. Metformin.
6. Acetaminophen.
7. Diet.
8. Indwelling catheter.
9. Baseline weight.

**Clinical Hint:** To use high-level clinical judgment, begin by identifying clinical cues that establish a concern for the nurse and require additional exploration.

12. Which priority data collected by the nurse should have been communicated to the health care provider?

1. Crackles, edema, jugular venous distension (JVD).
2. Headache.
3. Premature ventricular contraction (PVCs).
4. Labs.

13. The nurse gathers information and begins to prepare an SBAR telephone conversation for the health care provider. Complete each section of the communication form.

S - \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 A - \_\_\_\_\_  
 \_\_\_\_\_  
 R - \_\_\_\_\_  
 \_\_\_\_\_

**Clinical Hint:**  
 S - Situation  
 B - Background  
 A - Assessment  
 R - Recommendation

14. The nurse obtains additional directions from the provider to administer potassium chloride 10 mEq intravenously “now.” Which action should the nurse perform first?

1. Input the new order into the computer.
2. Confirm that the dosing is safe for administration.
3. Restate the order to the provider.
4. Review the policy on potassium administration.

15. The pharmacy delivers KCl 10 mEq in 100 mL NS to infuse over 1 hour. Before administering the medication, what action(s) should the nurse take? Select all that apply.

1. Start a new IV site.
2. Confirm the medication to the order.
3. Confirm allergies.
4. Check a single patient identifier.
5. Determine the safe rate of administration.



16. The next day, the client's blood pressure is stable and he is weaned off the nitroprusside. As the nurse reviews the intake and output record below, what assessment changes are anticipated?

1. Crackles will be increased.
2. O<sub>2</sub> saturations will be improved.
3. Weight will have stabilized.
4. A fluid restriction is needed.

**Clinical Hint:** The nurse must review data in trends (hours or days worth of data) to make the best clinical judgment. Anything with numbers should be explored in trends. This includes labs, weights, intake/output, vital signs, etc.

NurseThink HEALTHCARE SYSTEM			
Name: William Jones      Age: 69 years			
Health Care Provider: K. Kumar M.D.      Address: NKDA			
Code Status: No intubation			
INTAKE AND OUTPUT RECORD			
Day/Shift	Intake	Output	Total
Sept. 13 7a-7p	Oral = 100 mL IV = 447 mL	Urine = 900 mL Emesis = 50 mL	-103 mL
Sept. 13 7p-7a	Oral = 240 mL IV = 100 mL	Urine = 1,200 mL	-684 mL
<b>Total</b>	<b>1,063 mL</b>	<b>2,150 mL</b>	<b>-1,087 mL</b>
Sept. 14 7a-7p	Oral = 240 mL IV = 187 mL	Urine = 850 mL	-423 mL
Sept. 14 7p-7a			
<b>Total</b>			

17. NurseThink® Prioritization Power!



Mr. Jones is being discharged today. List what needs to be included in his discharge planning and teaching based on these discharge instructions:

**Discharge to home**

Furosemide 40 mg each day, orally \_\_\_\_\_

Digoxin 0.25 mg each day, orally \_\_\_\_\_

Continue previous medications \_\_\_\_\_

Home care nurse to see client beginning tomorrow \_\_\_\_\_

**Clinical Hint:** Reviewing discharge instructions is the time for the nurse to evaluate that the instructions are comprehensive and inclusive. For example, does the client require some dietary limitations that were not specified? It is the nurse's role to seek clarification before discharge.

**18. NurseThink® Time!**

Complete the Medication Reconciliation form below.

**NurseThink**  
HEALTHCARE SYSTEM

Name: William Jones  
Health Care Provider: K. Kumar M.D.  
Code Status: No intubation

Age: 69 years  
Allergies: NKDA

**MEDICATION RECONCILIATION**

Admission Medications	Discharge Medications

**19. During the discharge conversations, Mr. Jones shares with the nurse “I grew up in the church but lost my faith during the war. I feel my days are getting closer to the end and wonder if there’s something more in the afterlife. Are you a believer?” How should the nurse begin the conversation?**

1. “It’s common when someone experiences what you’ve been through to feel a sense of wonder.”
2. “I’m a strong Christian and go to church every week.”
3. “It sounds like you have questions for the hospital chaplain, let me see if she’s available to see you before you go home.”
4. “Do you have a church close to your home?”

**20. On the way home after the shift, the discharging nurse gets a call from a nursing colleague who happens to be Mr. Jones neighbor. The colleague is at Mr. Jones house and asks about his discharge instructions since he has some questions. How should the nurse respond?**

1. Ask the colleague to read the discharge instructions to you.
2. Provide the information being asked.
3. Ask to speak to Mr. Jones.
4. Suggest Mr. Jones call the home care nurse.

# Conceptual Debriefing & Case Reflection



1. Compare the impaired perfusion that Kandice Sheridan experienced with the impaired perfusion of William Jones. How are they the same and how are they different?

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2. What was your single greatest learning moment while completing the case of Kandice Sheridan? What about William Jones?

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3. How did the nursing (not medical) care provided to Kandice Sheridan and William Jones change the outcome for each of them?

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4. Identify safety concerns for both Kandice Sheridan and William Jones for each case.

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5. Identify how the nurse provided basic care and comfort to best meet the client's needs.

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6. What steps in each case did the nurse take that prevented hospital-acquired injury?

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7. How did the nurse provide culturally sensitive/competent care?

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8. How will learning about the case of Kandice Sheridan and William Jones impact the care you provide for future clients?

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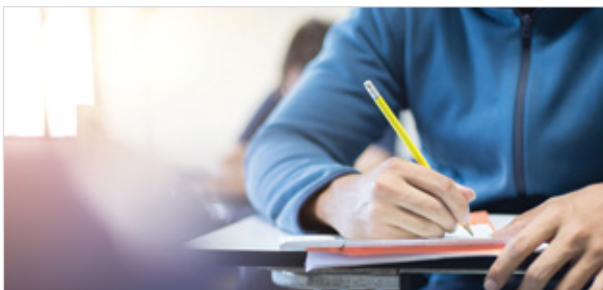
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# Conceptual Quiz: Fundamentals and Advanced

## Fundamental Quiz

- A nurse volunteering at a first aid station during a race is caring for a participant who is feeling dizzy and light-headed. What priority action should the nurse take?**
  - Have the runner drink some water.
  - Take the client's blood pressure.
  - Have the client lay down.
  - Determine how long the runner has felt poorly.
- A client with a history of clot formation is experiencing sudden pain in the left great toe. What should the nurse do next?**
  - Determine circulation, movement, and sensation (CMS) to the feet.
  - Offer pain medication.
  - Assess for popliteal and dorsalis pedis pulses.
  - Elevate the left foot.
- The nurse is caring for a client on extended bedrest. Which action(s) should the nurse take when moving the client out of bed for the first time? Select all that apply.**
  - Medicate for pain.
  - Request additional assistance.
  - Obtain orthostatic blood pressure.
  - Apply a gait belt.
  - Deliver additional intravenous fluids.
  - Raise the head of the bed.
- The school nurse is caring for a child with a newly placed cast on the right arm. The nurse notes that the fingers are cooler than those on the left hand. What should the nurse do next?**
  - Nothing, this is normal.
  - Ask the child if the cast feels tight.
  - Assess the fingertips on each hand for blanching.
  - Assess the radial pulse in the right wrist.
- The nurse is caring for a client taking clopidogrel after having an embolic event. The client shares that since starting the medication he has noticed that his stools are darker in color. What is an appropriate response by the nurse?**
  - That is typical with this medication.
  - Tell me what you mean by "darker"?
  - Often dietary changes can cause this.
  - When is the last time you had a bowel movement?



## Advanced Quiz

- The nurse is caring for a client who's mean arterial pressure has been < 60 mmHg for the last two hours. Which serum lab(s) should the nurse anticipate in response to this event?**
  - Elevation in the liver enzymes.
  - Decrease in potassium level.
  - Elevation in serum albumin level.
  - Decrease in BUN and creatinine.
- A client in the emergency department has been hydrated with normal saline over the last hour for hypovolemia. Assessment changes include a rapid bounding pulse and shortness of breath. What action should the nurse anticipate to the unlicensed assistive personnel?**
  - Raise the head of bed.
  - Apply oxygen.
  - Stop the fluids.
  - Obtain blood pressure.
- A client has been treated with a diuretic for fluid overload and shortness of breath. After voiding 900 mL clear yellow urine over an hour, the client says she feels funny. What should the nurse do next?**
  - Reassess the oxygen saturation reading.
  - Administer an additional dose of the diuretic.
  - Assess the blood pressure.
  - Obtain a serum potassium level.
- The nurse is caring for a client who has had significant uterine bleeding after childbirth. The client is now critical. The electronic health record shows this information. What can the nurse conclude from the information? Select all that apply.**

Time	BP (MAP)	HR	RR	Sats
0821	105/63	124	24	94% RA
0755	118/70	117	23	96% RA
0738	132/76	110	22	97% RA

- The client's condition is stabilizing.
- The changes indicate that an action is needed.
- The heart rate is increasing from the pain of delivery.
- The saturations are dropping because of the tachypnea.
- The respiratory rate and heart rate changes are a result of the loss of blood.







## Conceptual Quiz: Fundamentals and Advanced

10. For each condition, select a potential action to take. There is only 1 priority action for each condition. Each potential action can only be used once. Not all potential actions are used.

Potential Action to Take	Condition	Priority Action
A. Hourly urine output	Hypovolemic shock	
B. Recombinant tissue plasminogen activator	Pulmonary embolism	
C. Orthostatic blood pressure	Acute coronary syndrome	
D. High flow oxygen	Raynaud's Disease	
E. Oxygen at 2 L/nasal cannula	Cardiogenic shock	
F. Norepinephrine 2 mcg/min	Embolic stroke in atrial fibrillation	
G. Blood pressure	Deep vein thrombosis	
H. Nifedipine 20 mg by mouth		
I. Enoxaparin 1 mg/kg SC		

**SAMPLE**  
Sample only. Not for use.



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