CLINICAL KAMP

Edition 1.0

THE STUDENTS NURSING JOURNEY		
WEEK TRACKER	COURSE	
○○○○○○○○○○○○○○○○	NURSING V	

Nursing V Course Schedule Outline FALL 2025

WEEK	Lecture Tues	Lecture Wed	Clinical Wed EVE	Clinical Thurs Eve	Clinical Thurs Day	Clinical Friday Day
1	CARDIAC	CARDIAC	LAB 8/27	LAB 8/28	LAB 8/28	LAB 8/29
2	CARDIAC	CARDIAC	CLINICAL	CLINICAL	CLINICAL	CLINICAL
3	CARDIAC	CARDIAC	CLINICAL	CLINICAL	CLINICAL	CLINICAL
4	EXAM	CARDIAC	LAB 9/17	CLINICAL	CLINICAL	LAB 9/19
5	Cardiac Quiz	PULMONARY	CLINICAL	CLINICAL	CLINICAL	CLINICAL
6	PULMONARY	PULMONARY	CLINICAL	CLINICAL	CLINICAL	CLINICAL
7	EXAM	RENAL	CLINICAL	CLINICAL	CLINICAL	CLINICAL
8	RENAL	RENAL	CLINICAL	CLINICAL	CLINICAL	CLINICAL
9	RENAL EXAM	NEURO	CLINICAL	CLINICAL	CLINICAL	CLINICAL
10	NEURO	NEURO	CLINICAL	CLINICAL	CLINICAL	CLINICAL
11	NEURO EXAM	SHOCK	CLINICAL	CLINICAL	CLINICAL	CLINICAL
12	SHOCK	TRAUMA B	LAB 11/12	CLINICAL	CLINICAL	LAB 11/14
13	SHOCK EXAM	PHARM PRESENTATIONS Leadership ATI	CLINICAL	LAST CLINICAL	CLINICAL	LAST CLINICAL
14	B	R	E	A	K	
15	PHARM TBD	MED SURG TBD			COMP PREDICTOR 12 PM	
16	FINAL TBD		LIVE ATI	LIVE ATI	LIVE ATI	

St Peter's Hospital College of Nursing

Nursing 5 - Seniors

Nursing Faculty - Keira Harris RN

On Floor -

POINT
Nursing Student

Assignment	STUDENT NURSE - Lunch
Vitals Nurse	
IV/IO	
Dietary/Nutrition	
Shadow	
Shadow	

Area of Study

WEEKS TO GO!

ROOMS	STUDENT NURSE – Lunch

	STUDENT
ER	
ICU	
VN	

St Peter's Hospital College of Nursing

Nursing 5 - Seniors

Nursing Faculty - Michael Macken RN

On Floor -

POINT
Nursing Student

Assignment	STUDENT NURSE - Lunch
Vitals Nurse	
IV/IO	
Dietary/Nutrition	
Shadow	
Shadow	

Area of Study

WEEKS TO GO!

ROOMS	STUDENT NURSE – Lunch

	STUDENT
ER	
ICU	
VN	

St Peter's Hospital College of Nursing

Nursing 5 - Seniors

Nursing Faculty - Kevin Pommenville RN

On Floor -

Assignment	STUDENT NURSE - Lunch
Vitals Nurse	
IV/IO	
Dietary/Nutrition	
Shadow	
Shadow	

ROOMS	STUDENT NURSE – Lunch

POINT
Nursing Student

Area of Study

WEEKS TO GO!

	STUDENT
ER	
ICU	
VN	

St Peter's Hospital College of Nursing

Nursing 5 - Seniors

Nursing Faculty - Jamie Clarke RN

On Floor -

Assignment	STUDENT NURSE - Lunch
Vitals Nurse	
IV/IO	
Dietary/Nutrition	
Shadow	
Shadow	

ROOMS	STUDENT NURSE – Lunch

POINT
Nursing Student

Area of Study

WEEKS TO GO!

	STUDENT
ER	
ICU	
VN	

The Clinical Flow
NURSING V

ICU ER OFFSITES

ICU /ER
PAPERWORK
REFLECTION

FACULTY

PRE-CONFERENCE

POINT

WHO WE ARE SENIORS
TIME WE ARE HERE
WE HAVE A VITALS PERSON/TRAYS
WHAT WE CAN or CAN'T DO
WHAT PATIENTS CAN/CAN't HAVE
ONE NURSE WE CAN SHADOW

CHARGE

TAKE ASSIGNMENT
ASSESS VITALS
DO PAPERWORK
HELP WITH TRAYS
WORK WITH TECHS
EVALUATE VITALS

VS

PRE-CONFERENCE

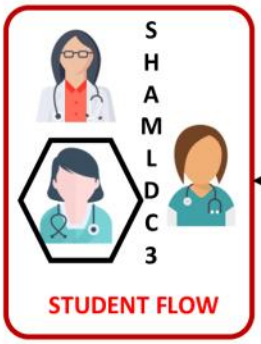
Get Assignment Go To Computers

SHADOW

RN

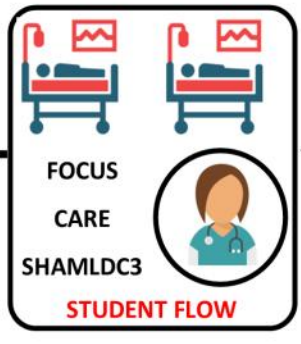
SHAMLDC3 –3 Patients
OBSERVATION

CAMP STAR MED EVALUATIONS – POST ITS
STUDENT FLOW



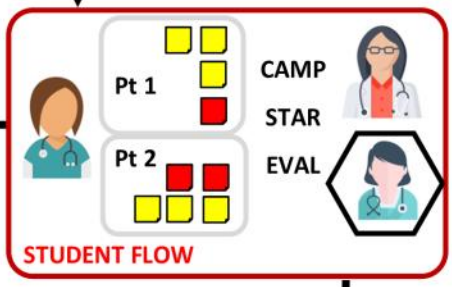
S H A M L D C 3

STUDENT FLOW



FOCUS
CARE
SHAMLDC3

STUDENT FLOW



Pt 1
Pt 2
CAMP
STAR
EVAL

STUDENT FLOW

MAP
SHAMLDC3

POST-CONFERENCE STUDENT FLOW

POINT (CHARGE) ASSIGNMENT

NURSING V

FACULTY

In Clinical Skills

Evaluate REDS - YELLOW - GREEN

Develop Plan for Day or Evaluate Understanding may Focus on CARD of The Day

PRE-CONFERENCE

Red Requires Validation

Yellow Observation

OBSERVES VALIDATES SAFE GIVES GREEN CARD IF NEEDS REMEDIATION GIVE NO GREEN ? BOOK Might send TO LRC

LRC

OBSERVES VALIDATES SAFE GIVES YELLOW-CARD IF NEEDS REMEDIATION GIVE RED TO LRC– BOOK

WORKS WITH STUDENT Evaluates Book

WORKS WITH STUDENT VALIDATES GIVES YELLOW SET Evaluates Book

SHADOW

Re-Evaluate Understanding

With Focus CARD may incorporate Skill teaching

CLINICAL KAMP Edition 1.0

CLINICAL FLOW OF AN ASSIGNMENT
MED ACUITY SURVEY
Purpose and Objective of the CAMP STAR Nursing Assignment Flow

Purpose:
The CAMP STAR method is designed to help nursing students approach patient care assignments in a structured, safe, and clinically focused manner. By emphasizing early review and organization of medications by acuity, the method ensures students are prioritizing high-risk interventions, preparing thoroughly for medication administration, and engaging in timely communication with faculty.

Objective:

To develop critical thinking in distinguishing between **acute vs. chronic medications**.

To ensure **safety** by preparing for unfamiliar medications and identifying those already mastered.

To promote **time management** by establishing a clear med-pass schedule in collaboration with the instructor.

To reinforce **accountability** and organized clinical planning by using visual tools (Post-its, stars) for tracking readiness.

To prepare students for **real-world nursing workflows** where medication safety and prioritization are essential.

This assignment flow supports safe practice, encourages student-instructor communication, and fosters independence while maintaining clinical oversight.

PRECONFERENCE—RECEIVE ASSIGNMENT & ROLE		
PRIMARY ROLE—CAMP STAR FIRST		
	Step	**Description**
C	**C**hart Check	Open each patient's chart (start with overview and current info).
A	**A**ctive Med Review	Look only at **medications** in the MAR/EMR.
M	**M**ed Type Tag	Determine if each medication is **Acute (RED or other color Post-it)** or **Chronic (YELLOW Post-it)**, and write the **med name** on the note.
P	**P**reviously Given?	Place a ★ next to meds you've **administered before** and **have a med card** for already.
S	**S**ort by Acuity	Go to instructor, **lay out Post-its** according to **acuity** (acute first).
T	**T**alk with Instructor	**Discuss meds, verify** your med pass plan & confirm **med pass times**.
A	**A**ssign Med Cards	Create new med cards for those **without stars**; **update** cards for starred ones.
R	**R**esume Care	Resume your nursing **assignment flow** (**FOCUS CARE**).

Times to complete

INITIAL POST IT NOTE ASSESSMENT

730 Days

330 Eves

10 minutes per student To-gether

Or not

Requirement

2 Packs of Post it notes

Yellow

&

Pink or Red

If there is a ★ Card Must be provided at this time

FACULTY

PT **PT**

SN

PT **PT**

M1 M3 M4 M5

SN goes to patient charts defines all meds name generic and analyses whether **Acute** or **Chronic** & puts ★ **if had the med before and time due Once completed they report to faculty**

M1 M★ M2 M4 M★

FACULTY

SN

SN shows faculty Post-it notes to faculty.

Faculty evaluates if **Acute** or **Chronic** is Accurate ask questions

Have them then put them in order of priority and defining the organ affect-ed- ie heart, lungs

Patient 1

M1 M2 M3 M4

Patient 2

M1 M★ M2 M4 M★

Additional Questions to ask if ★ is on post it note indicating student has card so has some experience

How does it work?

Ask Hold when?

Assess Before After Labs

Eating/ diet?

FACULTY

Faculty Assigns Either Virtual Med Pass or Actual Based on Assessment and student completes **actual med card before med pass**

DAYS

800-900

1100-1200

100-200

EVES

400-500

600-700

800-900

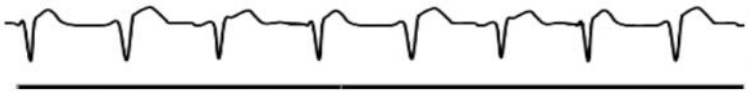
2

Client Information	Past Medical History (PMHX) KAMP General Hospital
Name: Paull R **Age:** 72 years old **Sex:** Male **Code Status:** Full Code **Allergy:** XXXXXXXXX **Chief Complaint:** ""I have crushing chest pain that started 30 minutes ago. It's radiating to my left arm and jaw."	Coronary Artery Disease (CAD) (stent placement 5 years ago) Peripheral Vascular Disease (PVD) Hypertension, hyperlipidemia Type 2 Diabetes Mellitus Smoker (20 pack-years, quit 3 years)

Presenting Triage History

Mr. R. was brought to the ED via EMS with acute chest pain radiating to the jaw and arm. **Cardiology & Interventional Consult STAT**
Due to high-risk features and diagnostic uncertainty (possible thrombus or mural clot), a **TEE (transesophageal echocardiogram)** is scheduled **prior to PCI**, especially due to past stent and new wall motion abnormalities.

ER Orders		Current Medications
Morphine sulfate 2 mg IV for pain PRN **Oxygen 2 L/min** nasal cannula (SpO_2 < 94%) **Nitroglycerin** 0.4 mg SL q5 min x3 (Hold if SBP < 100) **Aspirin** 325 mg chewable STAT Clopidogrel 300 mg PO loading dose **Heparin drip**: 60 units/kg IV bolus → 12 units/kg/hr infusion, titrate per protocol **Metoprolol tartrate** 5 mg IV q5 min x3 doses (if not contraindicated) **Atorvastatin** 80 mg PO once STAT **Insulin** sliding scale initiated NPO status Consent for PCI obtained IV access x2 large bore	**12-lead ECG** → ST elevations in V2–V5 (anterior STEMI) **Portable chest X-ray** (to rule out dissection or pulmonary causes) **Cardiac monitor**, telemetry initiation **Bedside glucose:** 272 mg/dL	Tiotropium (Spiriva) 18 mcg inhaled daily Albuterol inhaler 2 puffs q6h PRN Lisinopril 20 mg PO daily Furosemide 40 mg PO daily Metformin 1000 mg PO BID Atorvastatin 20 mg PO nightly



LAB DATA

	Lab Test	Result
0h	**Troponin I**	0.05 ng/mL
	CK-MB	24 U/L
	BMP	Na 138, K 4.1, Cl 101, CO_2 24, BUN 18, Cr 1.1, Glu 272
	CBC w/ Diff	WBC 9.8, Hgb 11.0, Hct 33.2%, Plt 210
	HbA1c	8.1%
	Lipid Panel	LDL 138, HDL 32, Total Chol 212, Trig 180
	PT/INR	INR 1.1

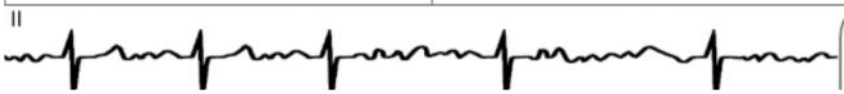
10

Client Information	Past Medical History (PMHX) KAMP General Hospital
Name: David T **Age:** 64 years old **Sex:** Male **Code Status:** Full Code **Allergy:** Penicillin **Chief Complaint:** ""Sudden shortness of breath and chest pain when I breathe."	Hypertension (HTN) Atrial Fibrillation (AFib) Type 2 Diabetes Mellitus (T2DM)

Presenting Triage History

David reports sudden onset dyspnea, sharp right-sided chest pain worse with inspiration, and lightheadedness that began about 2 hours before ED arrival. He denies fever or productive cough. No recent surgery or travel, but he has been more sedentary the past week due to a sprained ankle.

ER Orders		Current Medications
Heparin IV bolus and infusion protocol **IV Lines:** Two **IV fluids:** Normal Saline @ 75 mL/hr **Pain :** Acetaminophen 650 mg PO Avoided antibiotics due to no signs of infection and allergy history	**CT Pulmonary Angiogram:** confirmed large embolus in the right pulmonary artery **EKG**: Atrial fibrillation with controlled ventricular response **ABG:** Hypoxemia, respiratory alkalosis	Metformin 1000 mg PO BID Apixaban 5 mg PO BID Atenolol 50 mg PO daily Lisinopril 20 mg PO daily Atorvastatin 20 mg PO nightly



Start with this
Admission — Med-Surg
- Oxygen via nasal cannula (goal SpO_2 >92%)

ER Orders
Morphine sulfate 2 mg IV for pain PRN **Oxygen 2 L/min** nasal cannula (SpO_2 < 94%) **Nitroglycerin** 0.4 mg SL q5 min x3 (Hold if SBP < 100) **Aspirin** 325 mg chewable STAT Clopidogrel 300 mg PO loading dose **Heparin drip**: 60 units/kg IV bolus → 12 units/kg/hr infusion, titrate per protocol **Metoprolol tartrate** 5 mg IV q5 min x3 doses (if not contraindicated) **Atorvastatin** 80 mg PO once STAT **Insulin** sliding scale initiated NPO status Consent for PCI obtained IV access x2 large bore

Current Medications
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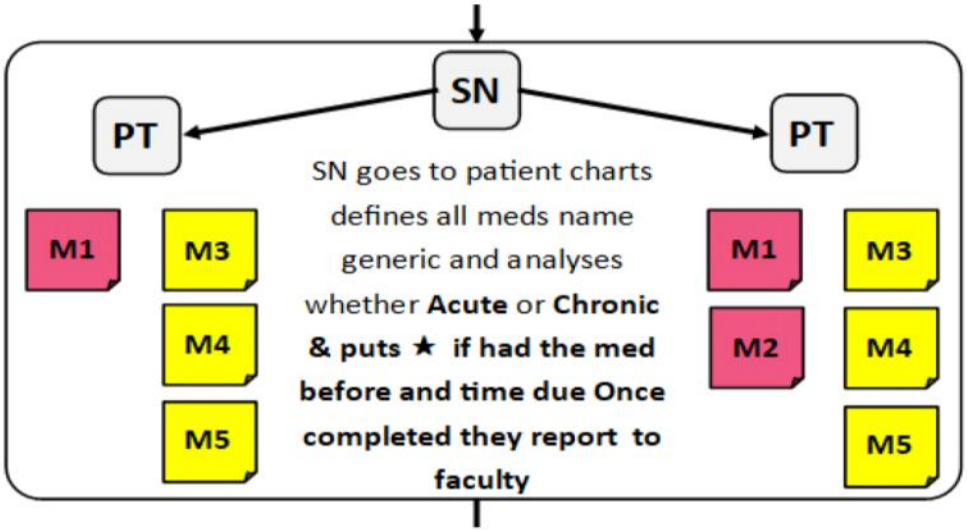

Requirement
2 Packs of Post it notes
Yellow
&
Pink or Red

ER Orders
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Current Medications
Metformin 1000 mg PO BID Apixaban 5 mg PO BID Atenolol 50 mg PO daily Lisinopril 20 mg PO daily Atorvastatin 20 mg PO nightly

ASSESS ○ ORTHO

○ BP ○ P ○ T ○ R

○ Heart Sounds ○ Apical

○ S3 ○ S4 ○ BNP ○ ECG

○ Lung Sounds ○ W

○ ABG ○ O2 ○ C

○ UO ○ BUN ○ Cr

○ GFR ○ HgbA1c ○ Glucose/BS

○ AST ○ ALT ○ ALB ○ Bili

○ amylase ○ lipase ○ Ammonia

○ Bleeding ○ Hgb ○ HCT ○ Plt

○ PT ○ INR ○ PTT ○ HepXa

○ WBC ○ Na ○ K ○ Ca ○ Mg ○ Phos

○ Blood Level Normal

Blood Level **TOXIC**

○ ○ ○ ○ ○ ○

MED NAME

MED CLASS

DIAGNOSIS

Other Considerations

A Acute Chronic MED

W

H

Before

A

After

L

E

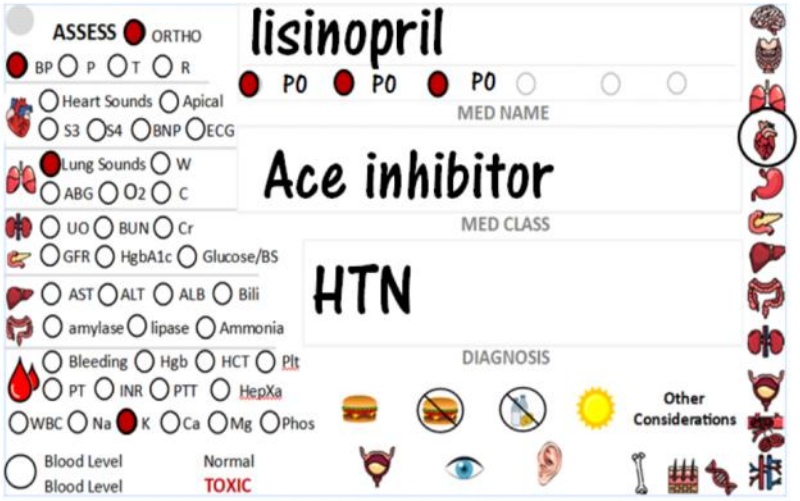
S 1 2 3

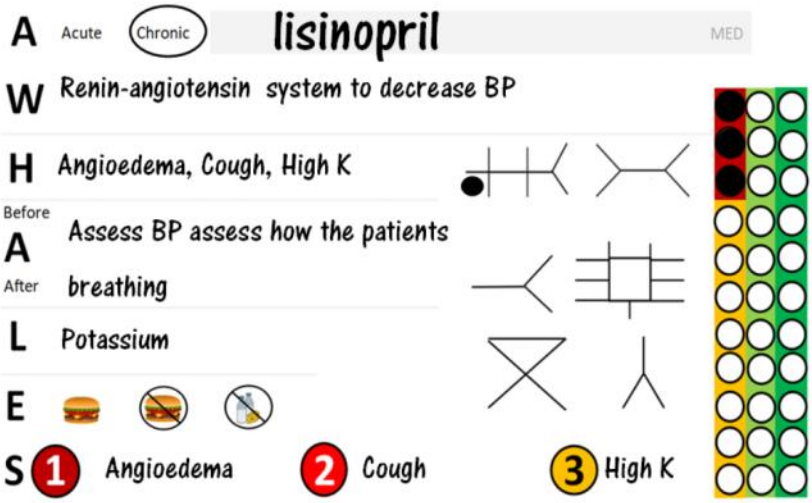
SN

Student returns to chart after meeting on Initial Survey and completes cards prior to Med Pass

M★

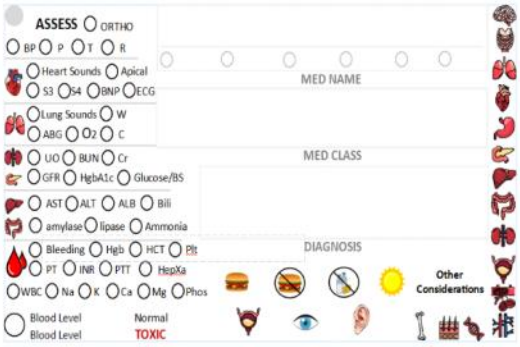
Student has previously had **lisinopril** so has card already completed





M4

Student has **NOT** had Lasix PO before so FILLS OUT CARD (Provided by **FACULTY) Prior to Med Time**



Purpose and Objective of the FOCUS CARE Process

Purpose:

The FOCUS CARE process provides a **structured clinical workflow** to guide nursing students through a safe, prioritized, and reflective patient care experience. It aligns nursing actions with clinical reasoning and emphasizes continuous assessment, documentation, and communication throughout the shift.

Objectives:

To ensure **safe and effective patient handoff** by beginning with proper identification and understanding of patient history.

To promote **clinical judgment** by having students assess orders, objectives, and determine priority interventions.

To reinforce the importance of a **comprehensive head-to-toe assessment** at the start of care.

To teach students to identify and act on **urgent patient needs**, using priority-setting frameworks.

To emphasize **environmental and patient safety** through routine checks.

To encourage **timely and accurate documentation**, enhancing accountability and continuity of care.

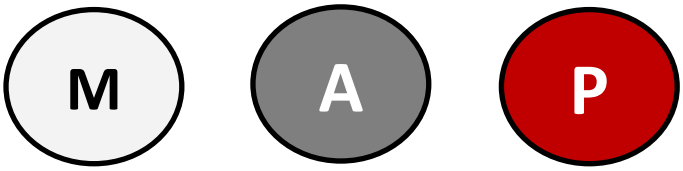
To foster **ongoing evaluation** of interventions, helping students see the outcomes of their care.

To support **professional communication** and critical reflection during faculty handoff and debrief.

This process builds professional habits that mirror the real-world responsibilities of nurses, preparing students to deliver patient-centered, organized, and evidence-informed care.

FOCUS CARE PRIMARY NURSING STUDENT ASSIGNMENT		
	Step	**Action / Purpose**
F	**Find your patient & check report**	Receive **handoff report**, verify **room/location**, check ID, and get brief history.
O	**Observe orders and objectives**	Review the **chart**, look at **MD/nursing orders**, medications, labs, and goals for care.
C	**Collect initial assessment**	Perform **head-to-toe assessment**, check vitals, IVs, drains, pain, mobility, etc.
U	**Understand priorities**	Identify **urgent needs** (e.g., pain, blood sugars, mobility risk, oxygen), note what needs to be done **first**.
S	**Safety checks**	Check **bed position, call light, fall risk signs, equipment function**, and environment.
C	**Care interventions**	Carry out assigned **medications, hygiene, repositioning, feeding**, or wound care.
A	**Active documentation**	Record **nursing notes**, assessments, med administration, and patient response in real time.
R	**Reassess and reflect**	Go back to reassess pain, wounds, vitals, response to meds; reflect on your clinical reasoning.
E	**End-of-shift handoff**	Report back to Faculty, review goals met, outstanding issues, and your own learning for the day.

POST CLINICAL MAP PROCESS



MAP is a quick, structured reflection tool to help nursing students consolidate learning after patient care.

M – Medical Insight Reflect on what you learned about the patient's **diagnosis, condition, or disease process**.

A – Assessment Awareness Identify what you learned through **observation, patient interaction, or physical assessment**.

P – Plan of Care or Priorities Note what you learned about the **treatment plan**, **nursing interventions**, or **clinical priorities** for your patient.

EXAMPLE

M: My patient has CHF; I learned how fluid overload can affect lung sounds and blood pressure.

A: I noticed the patient became short of breath when lying flat, which reinforced the importance of positioning.

P: I learned that the patient's diuretic must be given before breakfast and that daily weights are critical for monitoring fluid status.

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Nursing V Clinical Vital Nursing Assignment

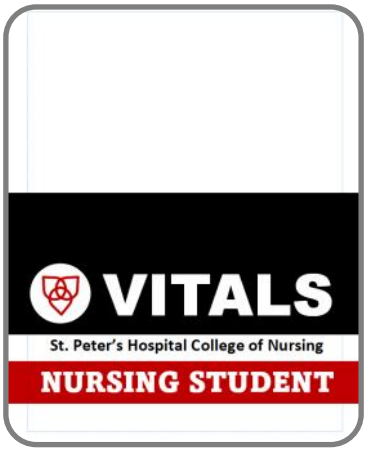
Purpose of the Nursing Assignment

The purpose of this nursing assignment is to comprehensively evaluate and prioritize patient care by assessing vital signs, reviewing laboratory results, understanding patient history, and analyzing medication regimens. This process ensures early identification of clinical concerns and promotes effective collaboration among healthcare team members. The assignment aims to develop critical thinking and delegation skills while fostering clear communication using the SB AR framework.

Assignment Objectives

1. **Assess and Prioritize Vital Signs:**

- Identify and document vital signs for all patients.
- Determine which vital signs are the highest priority for specific diagnoses (e.g., high blood pressure for hypertensive patients, heart rate in cardiac patients).
- **Delegation and Escalation of Concerns:**
- Recognize which vital signs warrant reporting by an LPN to an RN and the rationale (e.g., abnormal blood pressure or heart rate requiring immediate intervention).
- Determine which vital signs would be reported by a UAP to an RN and why (e.g., critical temperature changes or respiratory distress).
- **Critical Analysis of Patient Status:**
- Identify clients with high heart rates and explore the underlying causes (e.g., infection, pain, or cardiac conditions).
- Analyze clients with low or high blood pressure and correlate with potential causes (e.g., medication effects, dehydration, or underlying conditions).

1: Work with the nurse, CNA, or LPN and inform them of your intent to assist with vital signs on the floor, providing two sets of vitals or any other stat vitals. Additionally, express your willingness to assist with new admissions, transfers, and vitals. 2. Wear Vital Nursing Student Badge and reporting when off or on floor 3. Fill out Vital Registry Assignment and answer objectives	

Nursing V Clinical Vital Nursing Assignment

- **SBAR Framework:**
- Research and complete 2 SBAR reports for clients identified as most concerning, detailing significant issues and rationale for concerns.
- Submit and present 2 SBAR reports to faculty for review and feedback.
- Help with Dinner trays det up and retrieving

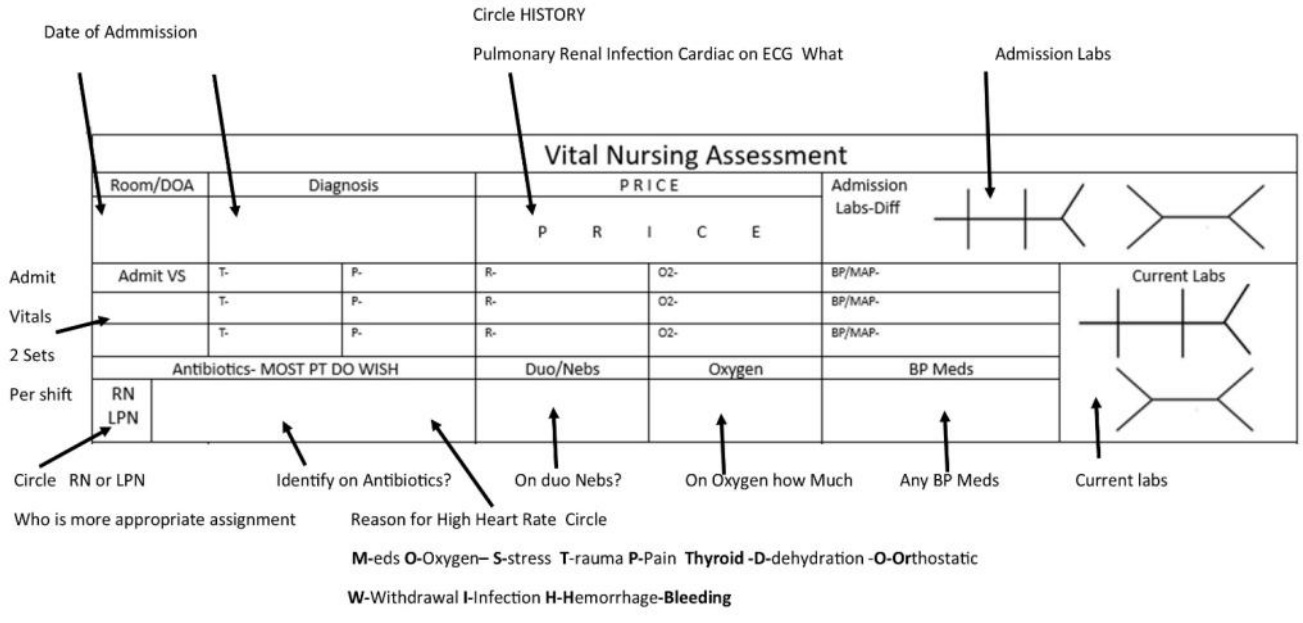
Expected Outcomes

By completing this assignment, students will:

- Demonstrate the ability to assess and prioritize vital signs based on clinical significance.
- Understand appropriate delegation of care tasks to team members.
- Develop effective communication skills using the SBAR format.

Enhance their ability to identify and escalate concerning patient conditions to promote safety and quality care.
This exercise strengthens decision-making, delegation, and teamwork, essential components of professional nursing practice.

Outline for filling out Vital Sign Assignment Sheet (15 Patients)



Vital Nursing Assessment

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

Room/DOA	Diagnosis		PRICE		Admission Labs-Diff	
			P R I C E			
Admit VS	T-	P-	R-	O2-	BP/MAP-	Current Labs
	T-	P-	R-	O2-	BP/MAP-	
	T-	P-	R-	O2-	BP/MAP-	
Antibiotics- MOST PT DO WISH			Duo/Nebs	Oxygen	BP Meds	
RN LPN						

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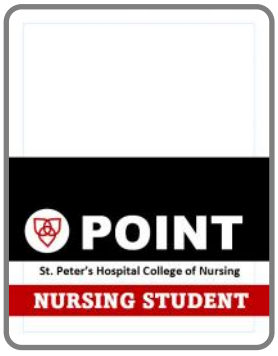
Student Charge Nurse Assignment Objectives



Demonstrate Leadership and Professional Communication: Collaborate effectively with the unit Charge Nurse to clarify student patient assignments, appropriate shadowing opportunities, and time constraints for clinical rotation hours.

Coordinate Student Assignments and Unit Coverage: Organize and document all student-patient assignments, including IO/Vital Sign room coverage and CAMP STAR completion, ensuring equitable distribution and visibility for faculty and staff.

Manage Clinical Workflow and Prioritize Time-Sensitive Tasks: Ensure timely completion of all required student documentation (e.g., SHAMLDS by 0930/1730) and coordinate lunch schedules to maintain safe patient coverage.

Promote Interdepartmental Exposure and Accountability: Facilitate structured student visits to ER, ICU, and CVICU, verify completion of brainsheets, and ensure accurate and timely submission to faculty.

Exhibit Situational Awareness and Team Supervision: Monitor clinical activities throughout the shift, assist peers as needed, participate in debriefing/report with faculty, and complete the Student Charge Sheet with reflections on clinical decision-making and student team support.

Charge Responsibilities

- ○ Meet with Charge Nurse– Find out which patients students can have, not have, and who a nurse could shadow, explain what times we are here until
- ○ Schedule Random assignments for floor nurses (students)
- ○ **Begin IO Assessment of Student assignments to include VS Rooms PRIORITY**
- ○ Have students do there CAMP STAR by 800 AM DAYS and 430 EVES
- ○ Fill out Student Floor Assignment and complete sheet of all patients make copy post
- ○ Schedule 30 min lunches in two groups
- ○ Ensure SHAMLDS are done by set time 930 Days 530 Evenings
- ○ Visit ER by (11-12 PM Days 7-8 Evenings) ensure brainsheets are completed deliver to Faculty
- ○ Visit ICU by (1-2 PM Days 8-9 Evenings) ensure brainsheets are completed deliver to faculty
- ○ Visit CVICU by (1-2 PM Days 8-9 Evenings) ensure brainsheets are completed
- ○ Sit with Instructor during reports from students SHAMLDC3 & MED ACUITY SURVEYS
- ○ Fill out Charge Sheet is all **STUDENTS ASSIGNMENTS and** answer questions
- ○ Take care of 1 or 2 patients and Complete SHAMLDC3

Name:

Unit: Census:

IV/IO Line Assessment Survey

1. Greet
2. Let Them know we are here
3. Ask
4. Document

Room	IV	TLC	PICC	PORT	Foley	CT	W	GI	DSNG	D/C	Notes
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	
	○	○	○	○	○	○	○	○	○	○	

CHARGE TRACKER—CHARGE NURSE ORDER PATIENTS ON THIS SHEET AS HIGHEST ACUITY TO LOWEST—Whether you would assign them to RN or LPN

Room	Nurse	DX	T	P	R	BP	MAP	O2	IV Meds/Devices	LABS
ACUITY #		C P D						02	NC F TELE	
RN LPN			**IV**							
ACUITY #		C P D						02	NC F TELE	
RN LPN			**IV**							
ACUITY #		C P D						02	NC F TELE	
RN LPN			**IV**							
ACUITY #		C P D						02	NC F TELE	
RN LPN			**IV**							
ACUITY #		C P D						02	NC F TELE	
RN LPN			**IV**							

Lunch A LUNCH B

STUDENTS: ER ICU CVICU SVH 6 GAB

Room/Name
Age Gender
HCP

Allergies

☐ FC
☐ DNR
☐ DNI
☐ LW
☐ HCP
☐ MOLST

Admit Date: DX PCP

Consults: ☐ C ☐ P ☐ R ☐ ID ☐ PSY ☐ Neuro ☐ Surg ☐ Wound ☐ Ortho ☐ PT ☐ OT ☐ SW

PMHX: ☐ CAD ☐ HTN ☐ PVD ☐ ACS ☐ MI ☐ A-FIB ☐ Aflutter ☐ Cath ☐ CABG x ☐ Stent x ☐ CHF R L BNP
☐ PE ☐ DVT ☐ COPD ☐ Asthma ☐ Emphysema ☐ PNA ☐ COVID ☐ CKD

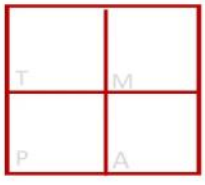
ESR S M T W T F S ☐ PD ☐ DM 1 ☐ DM 2 ☐ AKI ☐ Stroke ☐ CA
☐ Depression Thyroid ↑ ↓ ☐ Seizure
☐ Smoker ☐ ETOH **SCALE**_____**SCORE**_____

Precautions	LOC	A&O x ☐ 1 ☐ 2 ☐ 3 ☐ Confused ☐ Lethargic		
☐ **FALL**	**TIME**			MEDICATIONS & TREATMENTS
☐ D	**TEMP**			_____@_____
☐ A				
☐ S	**PULSE**			_____@_____
☐ C				
☐ CDIFF	**RESP**			_____@_____
☐ MRSA				
☐ VRE	**BP**			
☐ OBS				
☐ 1:1	**SPO2**			
☐ Neut				
☐ Sitter	**PAIN**			

☐ WNL ☐ NCL % ☐ CPAP ☐ BiPap

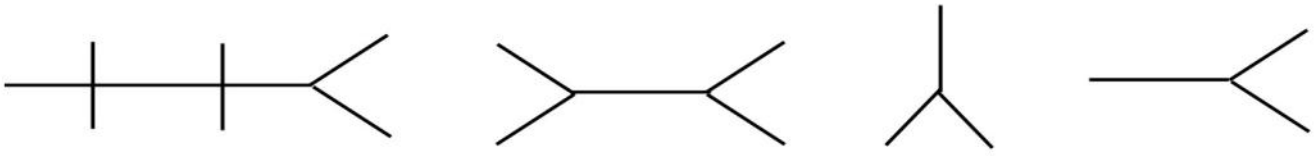
☐ NEBS ☐ Chest Tube
Trach # ☐ C ☐ U
☐ Incentive S@BS

ECG—Lead ☐ NSR ☐ ST ☐ SB ☐ A- fib ☐ A-Flutter
RATE ☐ PAC ☐ PVC ☐ AV Block ☐ 1 ☐ 2 ☐ 3
EF % ☐ S1 ☐ S2 ☐ S3 ☐ S4 ☐ MURMUR
☐ VALVE T P M A



☐ NG ☐ R - ☐ L ☐ PEG ☐ ILIOST ☐ COLOST
☐ NPO-
☐ TPN
DIET BM
☐ Foley **Output:** **Intake:**

BS **BS** **BS** **BS** **A1C**



HEMODYNAMICS—Ranges	Lines GTT's
☐ Aline ☐ Emco ☐ CRRT	☐ TLC R L F I J
☐ SWANN ☐ Impella	☐ PICC ☐ Port A D
☐ CVP	☐ V#
☐ PAWP	☐ IV #
☐ SVR	☐ IV #
☐ CO	☐ IV #
☐ CI	☐ TPN ☐ LIPIDS
Temp	
HR	
Systolic	
Diastolic	
MAP	
SpO2	

_____@_____

_____@_____

_____@_____

_____@_____

_____@_____

To Do/ Orders

☐

☐

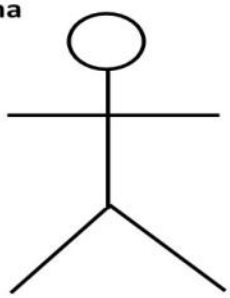
☐

☐

☐

Edema es

0
1
2
3
4
P
W



Puls-

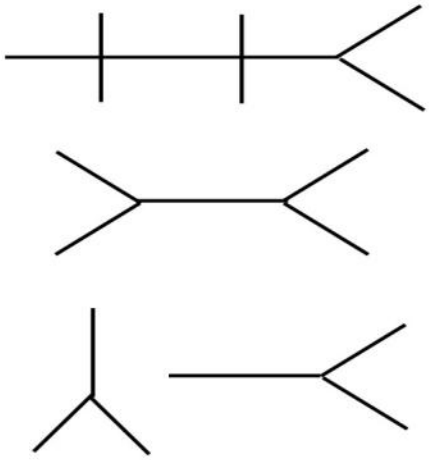
1
2
3
4
Dopp

Drains ☐ SCD

JP HV WV

SCHEDULED

☐ Cath ☐ US ☐ MRI
☐Stress ☐ Dop ☐ CT
☐CXR ☐Surg



D-Dimer	
Troponin	
BNP	
Lactic Acid	
AST	
ALT	
BS	
BS	
BS	
A1C	

07	19	☐
08	20	☐
09	21	☐
10	22	☐
11	23	☐
12	24	☐
13	01	☐
14	02	☐
15	03	☐
16	04	☐
17	05	☐
18	06	☐
19	07	☐

AS HE VS SK TU LI DR RX ET WO CT RE I/O

Discharge: ☐ Home ☐ Home Health ☐ Rehab ☐ SNF ☐ ALF ☐ Hospice ☐

RM:
Name/Age

C/O

Allergies ☐ NKDA

☐ FC
☐ DNR
☐ LW

☐ AMB ☐ TRIAGE ESI GCS **PREC:** ☐ ☐ ☐ -

Consults ☐ C ☐ P ☐ R ☐ ID ☐ PSY ☐ Neuro ☐ Surg ☐ Wound ☐ Ortho ☐ PT ☐ OT ☐ SW • **ADMIT TO:**

LOC A &Ox 1 2 3 ☐ Confused ☐ Lethargic ☐ Sedated ☐ **PERRLA** • **SAFETY:** ☐ Fall ☐ SI ☐ ASP ☐ RESTRAINTS ☐ Sitter

T	
P	
R	
B/P	
02	

TELE: ☐

Trop - + BNP

NC ☐

NEBS: ☐

PAIN

☐ IV # ☐ IV # ☐ PICC ☐ IP ☐ TLC

_____ @ _____

_____ @ _____

_____ @ _____

☐ EKG-

☐ CXR-

☐ US -

☐ CT -

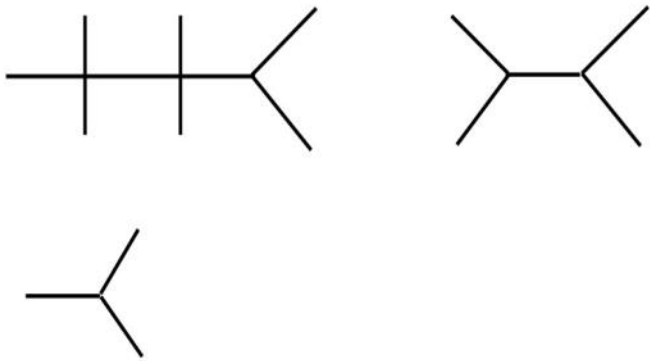
☐ ECHO -

Diagnostics & Pending Notes

Labs:

GI - WNL ☐

PRN's



Foley ☐

INTAKE:

OUTPUT:

☐ Belongings ☐ Meds ☐ Consent

Mentoring Experience Reflective Paper Nursing 1

During clinical, Nursing V students may be scheduled to mentor one Nursing I student. After completing this experience, Nursing V students will answer the following questions in a three-page paper using APA format. Please include a cover page.

Nursing I Student Mentoring Experience:

1. What three things did you observed during the experience that were expected?
2. What three things did you observe that were unexpected?
3. As a Nursing V student, how do you feel you were able to facilitate the growth of your mentees (Nursing I students) during this experience?
4. How will this experience affect your practice?
5. What three things do you feel you did well during this mentoring experience?
6. What three things do you feel you should improve upon to be a better mentor?

Prep Seven

Mentoring Experience Reflective Paper Nursing 2

During clinical, Nursing V students may be scheduled to mentor two to three Nursing II students. After completing this experience, Nursing V students will answer the following questions in a three-page paper using APA format. Please include a cover page.

Nursing II Student Mentoring Experience:

1. What three things did you observed during the experience that were expected?
2. What three things did you observe that were unexpected?
3. As a Nursing V student, how do you feel you were able to facilitate the growth of your mentees (Nursing II students) during this experience?
4. How will this experience affect your practice?
5. What three things do you feel you did well during this mentoring experience?
6. What three things do you feel you should improve upon to be a better mentor?

My Notes...

FLOW OF SHAMLD PROCESS–

DO NOT LOOK AT H&P OR ER REPORT UNTIL AFTER YOUR ASSESSMENT SHAMLD PROCESS

Look At Labs look do your fishbones– Circle your abnormal

Think what meds would I expect this patient to have–

CRIPL Cardiac Pulmonary, Renal, Infection IV, Level meds-

Then open meds write just meds and IV's no dosages

Then look at vitals, and ECG, EKG Tele I & O Assessment

Think what history would this patient have? CPRI Cardiac Pulmonary Renal Infection?

Then think what diagnostics they may have then open it and read it.

Complete your assessment while asking SHAMLDC with the patient—Compare with what you thought?

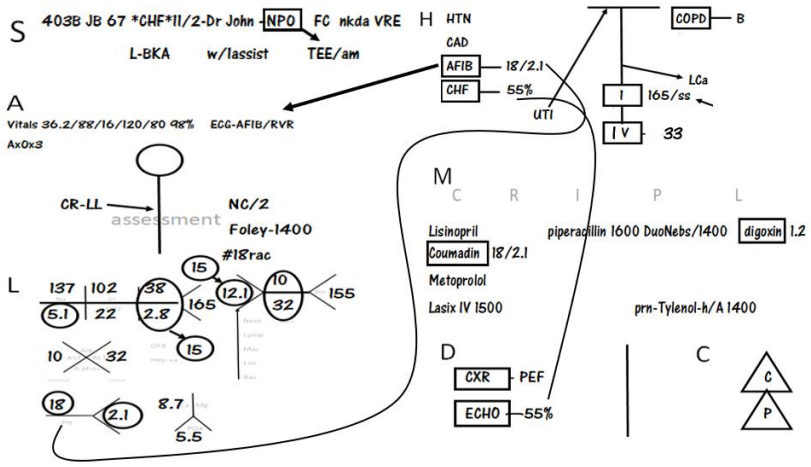
Complete Extensive Brain Sheet– give to Faculty

Complete SBAR scenario

SHAMLDC3

SHAMLDC3 is an organic patient reporting method that uses a concept map–style framework to guide and structure handoff communication. This approach helps students organize their reports within a defined structure, emphasizing the delivery of pertinent information while relying on their memory and organizational skills.

The SHAMLDC3 format is divided into seven patient care domains, concluding with a final analysis in which the student identifies three potential critical concerns. These are areas the nurse should monitor closely and, if necessary, communicate promptly to the physician should complications arise.



SHAMLDC3 is an organized way to evaluate and give report less writing is better

LAYOUT FORMAT 1 /2 of sheet of normal sized paper enough for 4 patients per sheet

S

H

A

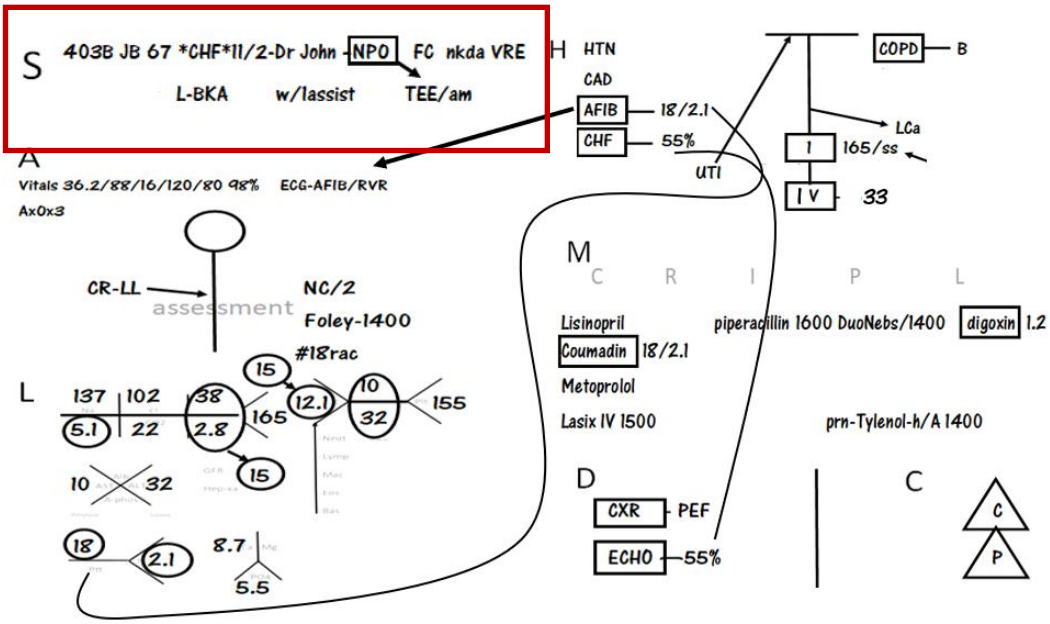
M

L

D

C

SHAMLDC3



First Section: STATISTICAL Data

This section provides the **foundational patient profile**—the critical identifiers and safety information a receiving nurse must know immediately during report. It includes:

- **Room number**
- **Name**
- **Age**
- **Gender**
- **Admission date**
- **Admission diagnosis** *(specific medical condition, not presenting symptoms)*
- **Code status** (e.g., Full Code, DNR)
- **Allergies** (with reaction details)
- **Precautions** (e.g., isolation type, fall risk)
- **NPO status** (if applicable)
- **Specific abnormalities** or unique considerations for care

To ensure no critical details are missed, nurses use the mnemonic **BLEACH** for special conditions that impact care:

- **B – Blind:** Indicate if the patient is blind and specify which eye(s) are affected.
- **L – Language:** State the patient's primary language and if interpreter services are required.
- **E – Ears:** Note if the patient is hard of hearing or uses hearing aids.
- **A – Amputee:** Specify any limb loss and whether prosthetics are used.
- **C – Chemo:** Indicate if the patient is receiving chemotherapy, has a port, and whether it is accessed or deaccessed.
- **H – Hemodialysis:** Include dialysis schedule, location, and time of transport.

Purpose in Nursing Handoff:

Starting with this information ensures the incoming nurse has immediate awareness of identification, safety considerations, and unique care requirements—allowing them to quickly prioritize assessments, interventions, and patient safety measures.

SHAMLDC3

HISTORY – Purpose and Structure

The HISTORY section of SHAMLDC3 is designed to analyze and report acute, admission-relevant conditions that directly impact the patient's current hospitalization. This section organizes the patient's significant medical history into a visual, body-system–based map, making it easier to prioritize care and connect conditions to their current status.

It is divided into four key areas on the concept map:

1. Cardiac – Left Side

List cardiac conditions in order of acuity from least to most severe (e.g., CAD → Angina → MI).

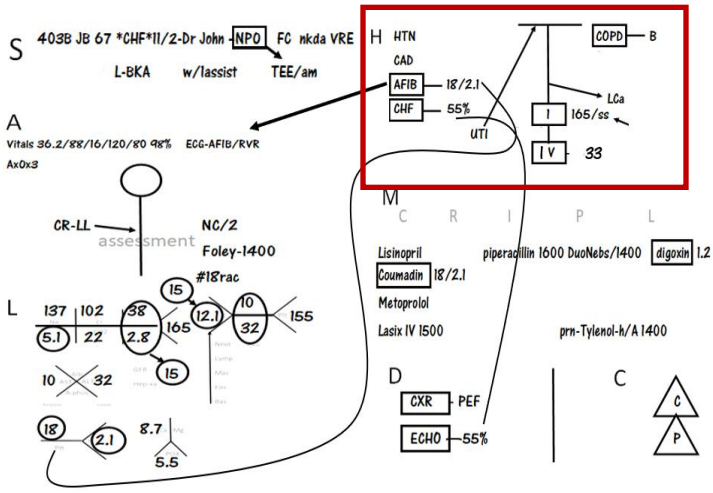
Boxed conditions indicate the need for secondary assessment.

Example: AFib is boxed because the nurse should confirm:

- Is AFib present on the monitor?
- Is the patient anticoagulated?
- What are relevant lab values (INR, platelets)?
- Are they on medications for AFib?

Example: CHF is boxed because the nurse should identify:

- Right-sided or left-sided?
- Ejection fraction (EF)?



2. Pulmonary – Right Side

Divided by a vertical line on the right side.

Boxed conditions require clarification of type or severity.

- Example: COPD → Boxed with type specified (Chronic bronchitis vs. Emphysema).
- Example: Pneumonia → Boxed with WBC count noted and antibiotics listed.

Use arrows to connect conditions to related diagnostic or treatment details (e.g., WBC trend, antibiotic regimen).

3. Renal / Diabetes – Bottom

Diabetes: Place a box at the bottom labeled with "1" or "2" for type.

- Record last blood glucose next to the box.
- Mention whether they are Sliding Scale (SS) Diet controlled (DC) or routine coverage (RC)

Chronic Kidney Disease (CKD): Place a second box directly under the diabetes box (if present).

- Stage CKD from 1–5.
- Include current GFR with a line pointing to the value.

4. Infection – Arrows to Site

If an infection is present, draw an arrow to the affected system/area.

Example: Pneumonia → arrow from infection note to pulmonary box.

Include WBC count, differential, and any relevant culture results.

Other Chronic Conditions

Non-priority chronic conditions (e.g., gout, hypothyroidism) are written on the pulmonary side without boxing, unless directly relevant to acute care.

Why It Matters in Nursing Handoff:

This HISTORY section helps nurses quickly connect the patient's past medical background to the current admission. By using a visual, boxed, and arrowed format, it prompts secondary assessments, reveals potential complications, and ensures the incoming nurse knows exactly what to watch, trend, and act on first.

SHAMLDC3

ASSESSMENT – SHAMLDC3

The ASSESSMENT section provides a snapshot of the patient's current status based on the most recent nursing assessment. It is not a full head-to-toe—only relevant abnormalities and changes that affect care or require follow-up. This is where the incoming nurse gains an immediate understanding of the patient's present condition and trends from the previous shift.

1. Alertness & Orientation

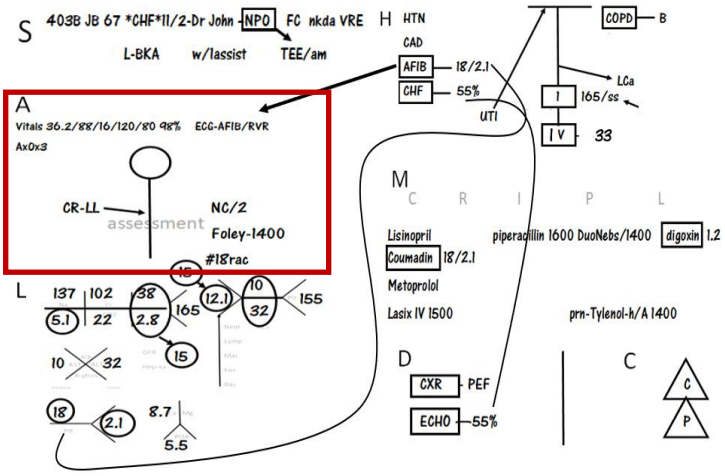
- Begin with level of consciousness and orientation status (A&O ×4, lethargic, confused, etc.).
- Include any changes from baseline or prior shift.

2. ECG / Telemetry

- Indicate whether the patient is on telemetry.
- Label ECG with rhythm and rate. Example: Sinus rhythm, HR 78 or AFib, HR 110 irregular.
- Note significant rhythm changes from the previous shift.

3. Vital Signs & Trends

- Record current vital signs: BP, HR, RR, Temp.
- Indicate changes/trends compared to the previous shift (e.g., BP trending down from 140/88 to 110/70).



4. Oxygenation

- Document Pulse Oximetry (SpO_2) reading.
- Specify oxygen delivery: Room air— Device & flow rate (NC 2 L/min, simple mask, 6 L/min, HFNC, CPAP/BiPAP, ventilator settings).

5. Focused Head-to-Toe (Abnormalities Only)

Use concise, system-based notes—normal findings are omitted.

Heart: Abnormal heart sounds, rhythms, murmurs, edema.

Lungs: Diminished sounds, crackles, wheezes, consolidation.

Abdomen: Quadrant findings, distension, tenderness.

Ostomies/Drains:

- Specify type (JP drain, NG tube, chest tube).
- Document drainage amount & type (serosanguinous, sanguineous, purulent, etc.).
- Box any drains or tubes to indicate they require secondary assessment (e.g. high output, new placement, troubleshooting)

Foley Catheter: Assess urine color, clarity, output amount, odor.

Dressings:

Use a # symbol to note dressings on a stick-figure diagram of the patient.

Draw lines indicating where drains/tubes are located.(ie: JP drain to RLQ surgical dressing # at midline abdomen.

IV Lines

Document each IV site with:

Gauge (e.g., 20G, 18G)

Location (e.g., left forearm, right hand)

Date inserted

Condition of site (clean/dry/intact, redness, swelling)

Use arrows from IV documentation to point toward Med in the next SHAMLDC3 section

6. Creativity & Readability

While this section allows for individualized notation style, the priority is clarity—the nurse must be able to quickly read and understand their diagram and abbreviations. Students are encouraged to practice drawing clean, quick, and consistent diagrams.

Why we do this:

The ASSESSMENT section distills the most important current patient findings into a rapid, visual, and trend-focused report. By boxing drains/tubes for secondary assessment, noting only abnormalities, and linking changes to the previous shift, it ensures the student can quickly prioritize care, anticipate needs, and maintain patient safety.

SHAMLDC3

The MEDICATIONS section organizes all active medications into six categories using the mnemonic CRIPLP:

C – Cardiac
R – Renal
I – IV Medications
P – Pulmonary
L – Level Medications
P – PRN

All medications should be listed in order of acuity—from highest priority/most acute to lowest.

This encourages the student to critically analyze medication impact in relation to the patient's current condition.

C – Cardiac Medications

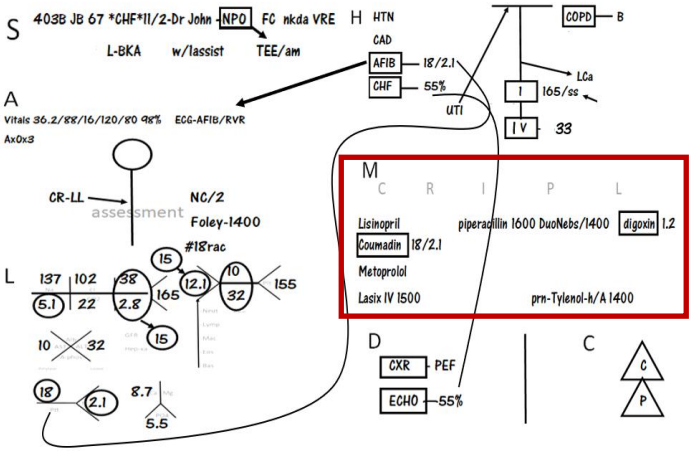
Include antiarrhythmics, beta blockers, calcium channel blockers, vasopressors, anticoagulants, antiplatelets, nitrates, etc.

Only box if the medication requires special monitoring or secondary assessment (e.g., Amiodarone for AFib—box rhythm).

R – Renal Medications

Diuretics, phosphorus binders, erythropoiesis-stimulating agents, renal-dose antibiotics.

Box if medication timing, lab monitoring, or fluid balance is critical (e.g., Furosemide—box with K^+ and output note).



I – IV Medications (Include ACOR Assessment)

For each IV medication or infusion, assess:

A – Acute or Chronic – Is this for acute stabilization or ongoing therapy?

C – Compatible – Is it compatible with other IV meds running?

O – Ordered – When was the order placed/initiated?

R – Removed – Can it be discontinued?

Box all IV infusions and include:

- Rate (e.g., Heparin 12 units/kg/hr)
- Most recent relevant lab (e.g., last PTT 47 sec or anti-Xa 0.8)
- Duration (e.g., NS @ 100 mL/hr × 12 hrs)

P – Pulmonary Medications

- Inhalers, nebulizers, corticosteroids, mucolytics.
- Box meds when last given and for what reason.

Example: DuoNeb—last given 0830 for wheezing, post-nebulizer SpO_2 94%.

L – Level Medications

- Medications requiring serum level monitoring (e.g., Digoxin, Vancomycin, Phenytoin).
- Box with most recent level and timing.

Example: Digoxin—last level 1.0 ng/mL this AM.

P – PRN Medications

- Only document pertinent PRNs that were given and require follow-up or had significant effect.
- Box to note time and reason.

Example: Morphine 2 mg IV @ 1445 for chest pain—pain now 2/10.

Key Documentation Rules for this Section

- No need to write standard dose ranges or frequency unless boxed for assessment purposes.
- Use generic names unless the med is boxed—then include details for analysis.
- The goal is rapid medication handoff, not a complete MAR copy.

Why we do this?

The MEDICATIONS section provides a high-acuity-to-low-acuity overview of all active therapies, focusing on what truly impacts patient care right now. By using CRIPLP and ACOR for IV meds, students learn to think beyond "what" is being given—to why, how, when, and whether it should continue.

SHAMLDC3

LABS – SHAMLDC3

The LABS section organizes the patient's laboratory results into fishbone diagrams and other visual structures.

Students only write values from the most recent morning labs, circle all abnormal values, and—when appropriate—draw arrows linking those abnormalities to the patient's history or current condition. This section promotes pattern recognition, trending, and clinical correlation rather than just number recall.

1. Basic Fishbone Labs

A. BMP – Basic Metabolic Panel (Fishbone)

Circle abnormal values

Trend: Admission value → current value (note ↑ or ↓ trends for NA, K, BUN, Cr, GFR, glucose)

B. CBC – Complete Blood Count (Fishbone)

Circle abnormals, note trends (especially WBC, Hgb/Hct, PLT)

2. Specialty Fishbones & Lab Diagrams

- **Renal Fishbone**

  Calcium, Magnesium, Phosphorus

- **Coagulation Profile Fishbone**

  PT – PTT – INR – Hep Xa

  Circle abnormal and draw an arrow to related condition or IV infusion (e.g., Heparin gtt).

- **ABG Fishbone**

  pH – $PaCO_2$ – HCO_3 – PaO_2 – O_2 Sat

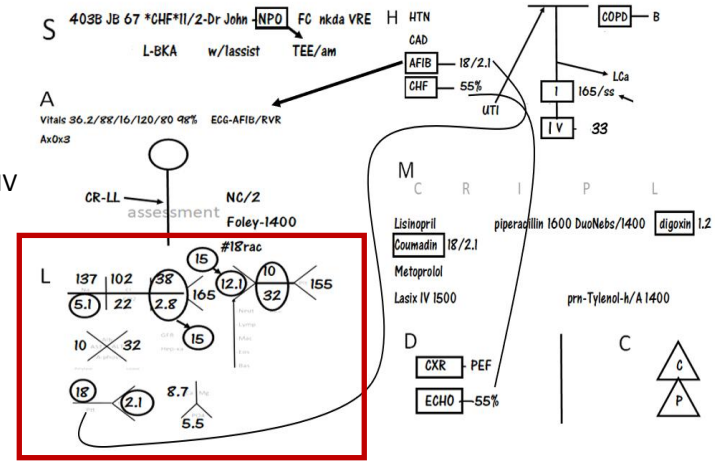
- **Cardiac Fishbone**

  HDL – LDL – Triglycerides – Troponin – BNP

  Circle acute values (e.g., Troponin elevation) and draw an arrow to acute cardiac history.

- **Liver & Pancreatic Enzymes**

  AST – ALT – Alk Phos – Bilirubin – Albumin – Amylase – Lipase



3. Abnormal Value Marking & Arrows

Circle: Any abnormal value.

Arrow: abnormal lab to patient's history/condition in SHAMLDC3 (e.g., ↑ WBC → arrow to pneumonia in HISTORY section).

This reinforces lab-to-condition linkage for critical thinking.

4. Trending Focus for Clinical Judgment

Students should trend the following priority labs over time:

Lab Trend Importance

- Na Fluid balance, neuro changes
- K Cardiac rhythm stability
- BUN / Cr / GFR Renal function
- WBC Infection/inflammation
- Hgb/Hct Oxygen-carrying capacity, bleeding
- PLT Bleeding/clotting risk
- PT/PTT/Hep Xa Coagulation monitoring
- Troponin Myocardial injury
- Glucose Endocrine & metabolic stability

Why do we do this?

The LABS section provides a visual and analytical representation of the patient's current biochemical and hematologic status, highlights abnormal trends, and directly connects those findings to the patient's active problems. This method trains students to

SHAMLDC3

DC – Diagnostics & Consults

This section is split into two columns:

- D – Diagnostics (Left side)
- C – Consults (Right side)

The purpose of this section is to visually connect tests and consultations with the reason they were ordered, and to include key results that influence care.

D – Diagnostics (Left Side)

- Box each diagnostic test the patient has had during the admission.
- Write the result or key impression on the side of the box.
- Draw an arrow from the box to the related admission diagnosis or reason for testing.

Examples:

CXR – Boxed

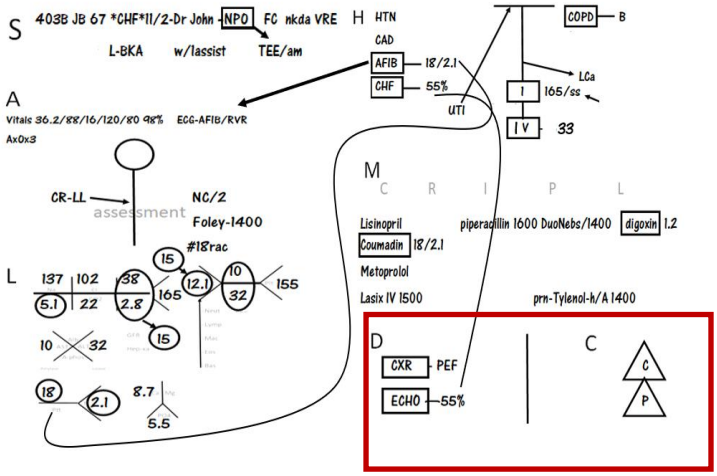
- Arrow to Pneumonia in admission diagnosis
- Impression: RLL pneumonia

ECHO – Boxed

- Arrow to CHF exacerbation in admission diagnosis
- Impression: EF 35%, mitral regurg, LV hypertrophy

CT Head – Boxed

- Arrow to Acute confusion
- Impression: Negative



C – Consults (Right Side)

Represent each specialty consult with a triangle containing the letter for the specialty.

Draw an arrow to the related diagnosis or reason for consult.

Common Examples:

P – Pulmonary

- Arrow to Pneumonia
- Note: Assisting with respiratory management

C – Cardiology

- Arrow to CHF exacerbation
- Note: EF trending, medication optimization

N – Nephrology

- Arrow to CKD Stage 4
- Note: Dialysis planning, electrolyte management

ID – Infectious Disease

- Arrow to Sepsis
- Note: Antibiotic recommendations

Why do we do this?

The DC section visually links diagnostics and consults to the patient's underlying problems. By boxing tests with results on one side, and marking consults with triangles on the other, the receiving nurse can immediately see what has been done, why, and what the findings mean for ongoing care.

SHAMLDC3

3 – Three Critical Areas

The "3" in SHAMLDC3 is the closing analysis of the patient's status.

It synthesize all previous sections—Statistical, History, Assessment, Medications, Labs, Diagnostics/Consults—into three priority focus areas for the incoming nurse.

Purpose

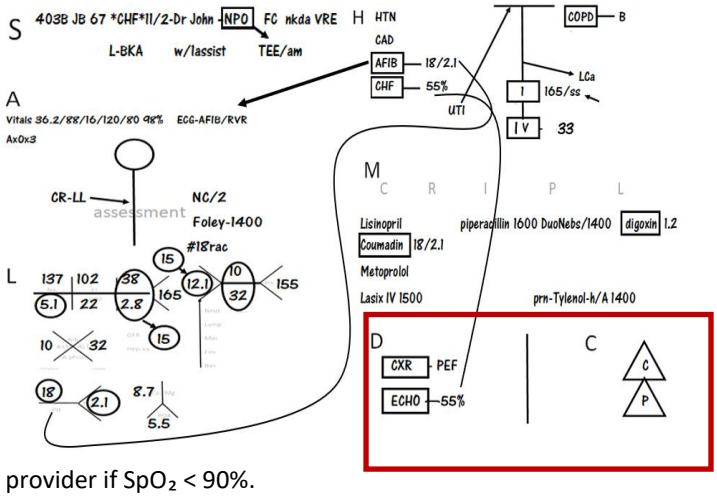
- Prioritize what matters most right now for safe, effective care.
- Identify potential complications early.
- Give the receiving nurse a clear roadmap for their first rounds and assessments.

How to Document

Number them 1–3 in order of urgency.

Phrase each as a monitoring or action statement (e.g., "Monitor for signs of…" or "Assess for changes in…").

Box anything that requires immediate reassessment or potential provider notification.



Example Format

1. Monitor for worsening hypoxia

Reason: Pneumonia on admission; SpO_2 92% on 3 L NC; CXR confirms RLL consolidation; WBC ↑.

Action: Assess lung sounds q4h, maintain oxygen therapy, notify provider if $SpO_2 < 90\%$.

2. Assess for cardiac decompensation

Reason: CHF exacerbation; EF 35%, BNP elevated; receiving Lasix IV.

Action: Monitor weight, intake/output, daily BNP if ordered, assess for new crackles or edema.

3. Monitor anticoagulation status

Reason: AFib on Heparin infusion @ 12 units/kg/hr; last anti-Xa 0.8 (therapeutic range high).

Action: Check next anti-Xa at 0600, monitor for bleeding signs, hold if per protocol.

The "3" is not a repeat of the assessment—it's an interpretation of the data.

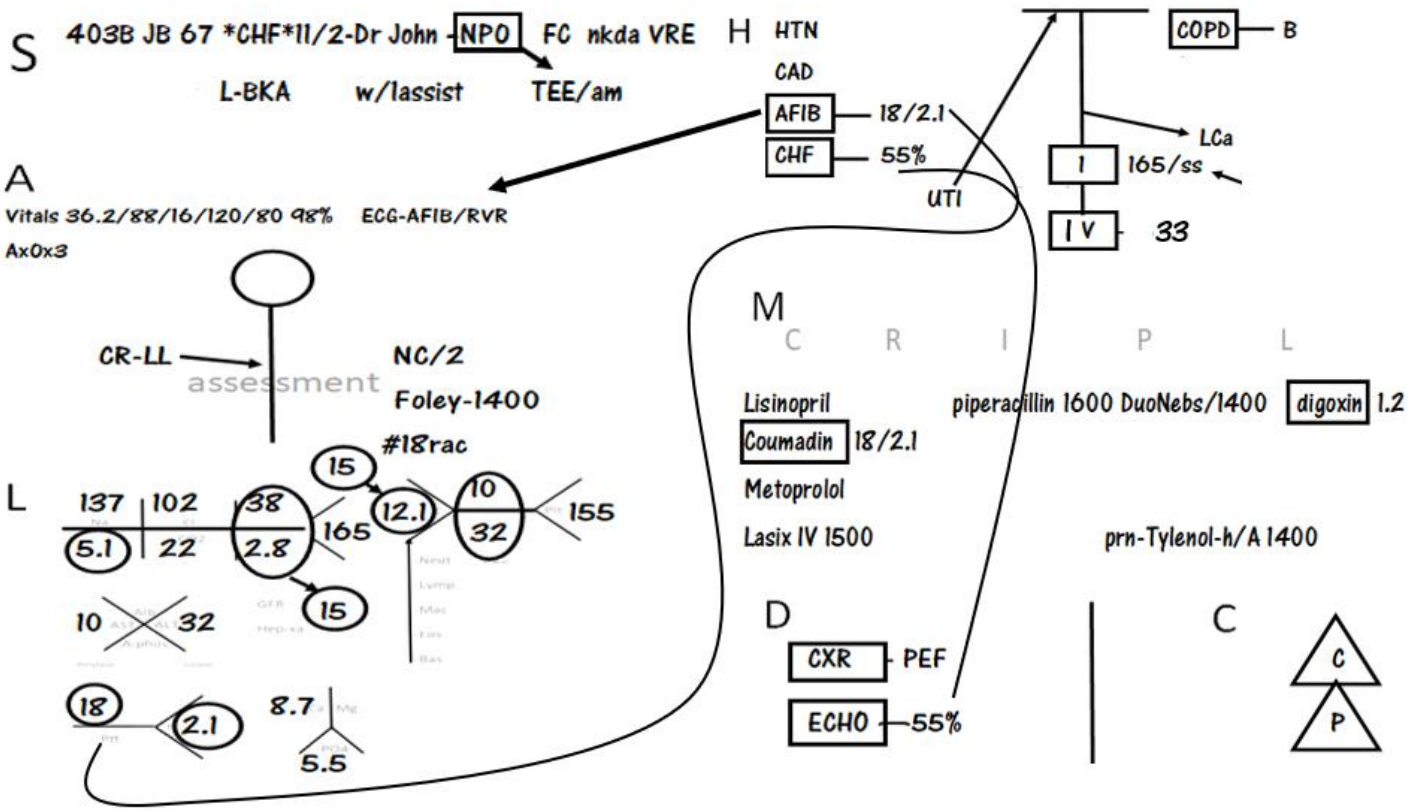
Focus on highest-risk changes that could occur during the next shift.

Use it as your shift-start checklist for patient safety priorities.

Why do we do this?

The Three Critical Areas section transforms the SHAMLDC3 from a data collection tool into a clinical judgment tool. It ensures that the incoming nurse walks away from the report with clear priorities, a sense of urgency, and a plan to address potential complications before they escalate.

SHAMLDC3



USE CASE STUDIES TO PRACTICE

S

H

A

M

H

D

C

S 403B JB 67 *CHF*II/2-Dr John NPO FC nkda VRE

HD/m (w) f L-BKA w/lassist TEE/am

ROOM
N=Name
A=Age
G=Gender
A-Admit For ? Date ? DR
D-Diet
U-Up Down Mobility
C-Code Status
K-Known Allergies
S-Standard Precautions or other
B-Blind?
E-Ears?
A-Amputee
C-Chemo
H-Hemodialysis PT

Statistics

This section is the statistical information that is important to start out in report and lay the foundation of presentation—Notable obvious deformities should be expressed at this time considered BEACH

B-Blind
E-Ears– Hard of hearing
A-Amputees
C-Chemo Patients
H-Hemodialysis Patients

H HTN
CAD
AFIB — 18/2.1
CHF — 55%

Cardiac

History

COPD — B

Pulmonary

Bronchitis

LCa — Lung Cancer

I — 165/ss

Renal

V — 15

UTI

Last Blood sugar on Sliding Scale

Chronic Kidney Disease Stage V—GFR

Boxing an item indicates
There is a second assessment
That should be reported
Ie AFIB(on anticoagulants?
What was the PT/INR/ are they
AFIB Now on monitor)

This is sectioned into the three main areas that would cause complication of the patient. Other medical comorbidities are less likely to cause immediate complications The Complex Conditions include **CPRI C-Cardic P-Pulmonary R-Renal I-Infection**

A

Vitals 36.2/88/16/120/80 98% ECG-AFIB/RVR

AxOx3

Physical

Medical

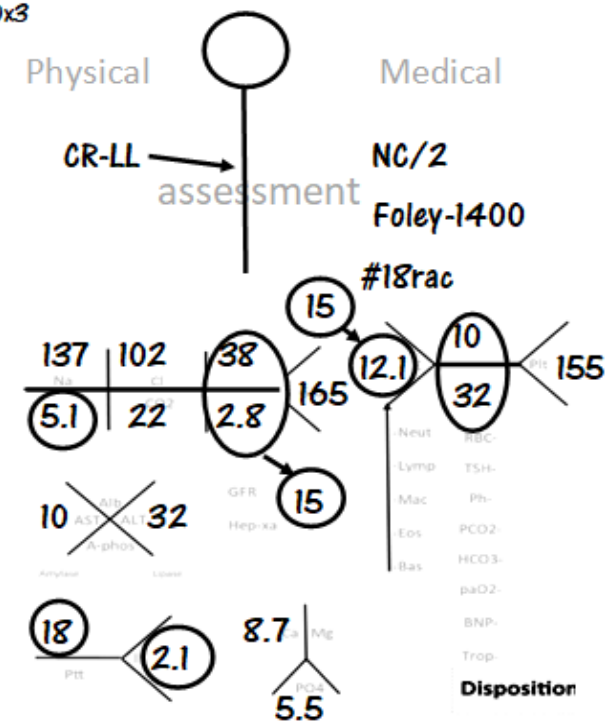
CR-LL

NC/2

assessment

Foley-1400

#18rac



M Medications of Consequence

C R I P L

Lisinopril
Coumadin 18/2.1
Metoprolol
Lasix IV 1500

piperacillin 1600 DuoNebs/1400

digoxin 1.2

prn-Tylenol-h/A 1400

This is section is Meds of Consequence mainly representing mediations that are acute or that you need to know and should report on these are called **CRIPL C Renal IV Infection (antibiotics) Pulmonary (only duo-nebs) Level Medications (coumadin, digoxin etc)**

D

CXR — PEF

ECHO — 55%

Diagnostics

C

C
P

Consults

Shamldc3 Reporting

CLINICAL REFERENCE SHEETS FOR CLINICAL PRACTICE

ASSESSMENT = ACUTE OR CHRONIC

Category	Acute	Chronic
Onset	Sudden or recent	Slow or progressive
Pain	Sharp, severe, new	Dull, persistent, managed
Vital Signs	Unstable (e.g., ↑HR, ↓BP, ↑RR, fever)	Often within baseline or compensated
Oxygenation	Sudden desaturation, dyspnea at rest	Dyspnea on exertion, baseline SpO_2 managed w/ home oxygen
Neuro Status	New confusion, change in LOC, slurred speech	Stable cognitive changes (e.g., dementia baseline)
Skin	Warm, flushed, cyanosis, acute rash, diaphoresis	Chronic ulcers, scarred tissue
Labs	Rapid changes (H&H drop, troponin rise, sudden hyperkalemia)	Mild to moderate ongoing abnormalities (anemia of CKD)
Pain Meds Needed	Immediate, high doses for control	Controlled with routine analgesics
Functional Status	New weakness, falls, inability to perform ADLs	Gradual decline; uses assistive devices
Red Flags	New symptoms, unstable vitals, altered mental status	Longstanding, documented history

INTERVENTIONS = ACUTE OR CHRONIC

Domain	Acute Interventions	Chronic Interventions
Airway/ Breathing	Apply O_2, rapid response, suctioning, ventilator support	Maintain oxygen via nasal cannula, teach pursed-lip breathing
Circulation	IV fluids, vasopressors, transfusion	Monitor BP, adjust meds like diuretics or antihypertensives
Pain Management	STAT opioid admin, frequent reassessment	Scheduled non-opioids, chronic pain consult
Neurological	Stroke protocol, neuro checks q1h, seizure precautions	Safety education, orienting cues, maintain baseline cognition
Medications	Hold/review meds for acute decline, titrate drips	Medication adherence, long-term side effect monitoring
Monitoring	Continuous telemetry, labs q4h, hourly vitals	Weekly labs, daily weights, routine checkups
Teaching	Teach on new diagnosis, surgical recovery, red flags	Focus on lifestyle management, med adherence, symptom tracking
Mobility	Bedrest, fall precautions, PT eval	Encourage ambulation, ROM exercises, assistive devices
Nutrition	NPO status, TPN/NG feeding, acute calorie support	Diet education (low Na, diabetic), oral supplements
Discharge Planning	May not be applicable (admitted or critical)	Referrals to home care, chronic disease management programs

AWHALES3– MEDICATION ANALYSIS

The **AWHALES3** technique is a practical, focused critical thinking model that helps nursing students analyze medications in a meaningful and clinically applicable way. Instead of memorizing hundreds of drug facts from a pharmacology book, AWHALES3 teaches students to ask targeted, priority-based questions that reflect real-world decision-making in patient care.

This approach narrows down what is most important to know at the bedside:

- Is this drug safe to give right now?
- What are my must-check assessments?
- How does it affect the patient's system?
- What labs, foods, or side effects do I need to act on?

AWHALES3 allows nursing students to approach pharmacology systematically while building clinical judgment, making it easier to retain relevant information and make safer medication decisions in both exams and real-life practice.

	Category	Guiding Questions & Process
A	**Acute vs. Chronic Use**	Is the medication for short-term (acute) treatment (e.g., nitroglycerin for chest pain)?- Or is it for long-term (chronic) management (e.g., lisinopril for hypertension)?- Why is the patient on this med now?
W	**What Organ It Works On**	What is the target system/organ (e.g., kidneys, lungs, heart, brain)?- Does it suppress, stimulate, dilate, block, or replace a function?- General mechanism of action (no need for memorizing molecular pathways—focus on clinical effect).
H	**When to Hold It**	What are the red flags that tell you not to give it? • Lab abnormalities (e.g., K+ too high for spironolactone) • Vitals out of range (e.g., low HR for beta-blockers) • Adverse effects (e.g., angioedema from ACE inhibitors)- Any medication interactions to be aware of?
A	**Assessment Before & After**	What do you **need to assess before** giving this med? (e.g., BP, HR, glucose, pain scale)- What must be assessed **after** administration to evaluate effect or side effects?
L	**Labs**	Which lab values are relevant? (e.g., electrolytes, kidney function, liver enzymes, drug levels)- Any **trends** to monitor?
E	**Eating & Food Interactions**	Does it require food (to prevent GI upset)?- Avoid with dairy, grapefruit, high-fat meals, or antacids?- Teach any necessary dietary changes or restrictions (e.g., limit potassium)?
S3	**3 Standout Nursing Facts**	What are 3 key things **a nurse must remember**?Example for digoxin: • Check apical HR before giving • Toxicity risk increases with hypokalemia • Narrow therapeutic index

Metoprolol—Beta Blocker

	AWHALES3
A	**Chronic**: Used for long-term management of hypertension, heart failure, and angina. **Acute**: IV form may be used for atrial fibrillation or tachycardia control in hospital settings.
W	Acts primarily on the **heart** – slows down heart rate and reduces contractility by blocking beta-1 receptors in the myocardium.
H	**HR < 60 bpm**, **SBP < 90 mmHg**. New onset of **wheezing, bradycardia**, or signs of **heart block**. Use caution if on other meds that suppress heart rate (e.g., digoxin, diltiazem).
A	**Before**: Check **HR and BP**. **After**: Monitor for bradycardia, hypotension, dizziness, and fatigue.
L	Check **electrolytes** if on concurrent diuretics. May affect **blood glucose** (masks hypoglycemia).Monitor **BUN/Creatinine** in long-term CHF patients.
E	Can take with or without food. Taking with food may reduce GI upset. No specific dietary restrictions.
S3	Always check HR before giving.Can mask symptoms of hypoglycemia in diabetics. Do not stop abruptly—can cause rebound hypertension or MI.

FURSOSEMIDE—LOOP DIURETIC

	AWHALES3
A	**Acute**: Used in pulmonary edema or acute volume overload. **Chronic**: For heart failure, liver disease, chronic kidney disease with fluid retention.
W	Works in the **kidneys** – specifically the loop of Henle – to **excrete sodium, potassium, and water**, reducing fluid overload.
H	Hold for **K+ < 3.5**, **SBP < 90**, or signs of **dehydration**.Monitor for **ototoxicity** with high IV doses or rapid infusion.
A	**Before**: Check **BP, K+, weight, edema**, lung sounds. **After**: Monitor **urine output**, **BP**, **electrolytes**, and for signs of dehydration.
L	Monitor **K+, Na+, Mg++, BUN/Creatinine**. Watch for **increased glucose and uric acid** in chronic use.
E	Administer with food or milk to prevent GI upset. Encourage **foods high in potassium** (bananas, oranges) unless contraindicated.
S3	Causes significant **potassium loss** – watch for hypokalemia.Risk of **orthostatic hypotension** – educate to rise slowly.**Daily weight** is the best indicator of fluid status.

ALEAPPS3– MEDICATION ANALYSIS

The **ALEAPPS3 technique** provides a simple, structured approach for nursing students to critically analyze and understand **procedures** without memorizing endless protocol lists. Instead of feeling overwhelmed by every step or detail, ALEAPPS3 guides students to focus on:

Why the procedure is being done (**purpose**)

What to look for before and after (**assessment & safety**)

How food, meds, and potential complications influence outcomes (**preparation & prevention**)

This model is useful **at the bedside, in clinical pre-conference, and during exam prep**. It encourages **clinical reasoning** by focusing on relevant and repeatable steps a nurse should consider every time a procedure is ordered or performed.

Just like we assess medications using AWHALES3, **ALEAPPS3 brings structure to procedural thinking**—helping students become confident, proactive, and safe in their nursing care.

	Category	Guiding Questions & Process
A	**Acute or Chronic Use**	Is this procedure for an **acute/emergent condition** (e.g., lumbar puncture for possible meningitis)?- Or part of **chronic/ongoing care** (e.g., dialysis access maintenance)?- Is this a one-time, diagnostic, or repeating procedure?
L	**Look For – What the Procedure Evaluates**	What is this test/procedure **looking for** or **trying to fix**?- What organ system or condition does it assess or treat?- Diagnostic (e.g., biopsy), therapeutic (e.g., paracentesis), or monitoring (e.g., central line insertion)?
E	**Eating – NPO or Not**	Is the patient **NPO** prior to the procedure?- For how long? Full NPO or just solids?- Any **dietary teaching or restrictions** post-procedure?- Examples: NPO for EGD, or light meal OK before X-ray.
A	**Assessment – Before & After**	What must you **assess before** the procedure? (e.g., vitals, consent, labs, allergies)- What should you monitor **after**? (e.g., site, vitals, sedation recovery, bleeding, infection signs)
P	**Prescriptions**	Any **meds to hold**? (e.g., anticoagulants before biopsy)- Any **pre-meds required** (e.g., atropine before bronchoscopy)?- What **acute meds** may impact safety (e.g., insulin if NPO)?
P	**Potential Problems**	What are the **complications** or **risks**?Bleeding, infection, respiratory depression, perforation, allergic reaction, etc.?- What **red flags** should trigger action?
S3	**3 Standout Nursing Priorities**	What are **three essential facts** every nurse should know about this procedure? Think about **safety, outcomes, and timing**. Example for lumbar puncture:• Must lie flat post-procedure • Risk for spinal headache• Monitor for CSF leak and neuro changes

PARACENTESIS

ALEAPPS—PROCEDURE

A	**Acute**: Used to relieve respiratory distress or severe abdominal discomfort from rapid ascites accumulation (e.g., in liver failure or cancer). **Chronic**: May be repeated periodically for ongoing ascites management in cirrhotic patients.
L	Removes and/or tests **peritoneal fluid** Diagnoses **infection (SBP)**, malignancy, or cause of ascites.Can be both **diagnostic** and **therapeutic**.
E	Typically **not NPO**, unless heavily sedated (rare).▪ Encourage patient to void before the procedure to avoid bladder injury.
A	**Before**: Vitals, abdominal girth, consent, coag labs (INR, platelets). **After**: Monitor vitals for hypotension, bleeding, or dizziness. Check dressing for drainage.
P	May need to **hold anticoagulants** (warfarin, heparin, apixaban).▪ **Albumin** may be given afterward to reduce hypotension risk if large volume removed.
P	**Hypotension**, **bleeding**, **infection**, **bladder perforation**, or **persistent leakage** from site.
S3	Must check coagulation labs before procedure.Monitor for hypotension afterward, especially with large volume removal. Patient should void before procedure to reduce bladder puncture risk.

CENTRAL LINE INSERTION

ALEAPPS

A	**Acute**: Needed urgently for rapid medication, fluid, or vasopressor administration. **Chronic**: Used for long-term therapies like chemo, TPN, or dialysis (e.g., tunneled line or port).
L	Allows **central venous access** to administer caustic drugs or measure CVP. Placement confirmed by **chest X-ray** to avoid misplacement or pneumothorax.
E	**NPO** not typically required.▪ If sedation is involved (rare), short-term NPO may be advised.
A	**Before**: Consent, allergy to chlorhexidine/iodine, **coag labs**, and baseline vitals. **After**: Monitor insertion site, breath sounds (for pneumothorax), dressing integrity, and signs of infection or bleeding.
P	May hold **anticoagulants** if risk of bleeding.▪ **Sedation or local anesthetics** may be used depending on setting.
P	**Pneumothorax**, **bleeding**, **air embolism**, **infection**, **malposition** (confirmed by chest X-ray).
S3	Always verify **placement with chest X-ray** before using. Monitor for **pneumothorax** – sudden SOB, decreased breath sounds. Maintain **sterile dressing** and assess for signs of infection.

ASLEAPPS3 = CONDITION

The **ASLEAPPS3 model** helps nursing students **analyze disease conditions logically and critically**—not just memorize symptoms. By breaking down a condition into a **start-to-finish, nurse-focused framework**, you can better understand:

What causes it

How it appears

What labs, meds, and risks are involved

And what the **nurse must know right away**

This model mirrors the decision-making nurses must do **in real clinical practice** and on the **NCLEX**—focus on what's **relevant, observable, and treatable**.

	Category	Description & Guiding Questions
A	**Acute vs. Chronic**	Is this condition **sudden (acute)** or **ongoing (chronic)**?Is the patient currently **stable, decompensating**, or at **risk of progressing** (e.g., stable angina vs. acute MI)?
S	**Start of the Condition – How It Begins**	What **organ** is affected? What is the **pathophysiology** from **start to complication**? ▪ What triggers it (e.g., clot, inflammation, degeneration) Use "Cause → Effect → Complication" to outline condition progression.
L	**Labs**	What labs help diagnose or monitor the condition? Are there trending values that show **improvement or worsening**?Examples: Troponin, BNP, potassium, CBC, ABG, glucose.
E	**Eating/Nutrition**	Are there any **dietary restrictions**? Is there **malnutrition** or **specific needs** (e.g., low sodium, low fat, fluid restriction, increased protein)?
A	**Assessment (Priority Signs/Symptoms)**	What does the **condition look like at onset**? What are **priority signs, symptoms**, and **red flags** to assess? Think "How would this patient present in the ED?"
P	**Prescriptions**	What **medications** are commonly prescribed? Which meds **prevent complications**, **manage symptoms**, or **treat the root cause**?Examples: Nitroglycerin, beta-blockers, ACE inhibitors, insulin.
P	**Problems**	What are the **potential complications**? Can it **worsen** (e.g., CHF after MI)? What **emergency outcomes** can occur? What other **organs are affected secondarily**?
S3	**3 Standout Nursing Priorities**	What **3 must-know facts** about this condition must the nurse always remember? Think **presentation**, **treatment**, and **red flags**.

DKA

ASLEAPPS

A	**Acute** emergency that develops rapidly. Occurs most often in **Type 1 diabetes**, but can occur in severe insulin deficiency of Type 2 (especially in younger or stressed patients). May occur on top of **chronic poorly controlled diabetes**.
S	Begins in the **pancreas**, which fails to produce insulin → body can't use glucose → fat is broken down → ketones are produced → metabolic acidosis. **Patho chain**: ↓Insulin → ↑Glucose → Lipolysis → Ketones → Acidosis → Dehydration & Electrolyte Imbalance.**Triggers**: infection, missed insulin, stress, trauma, MI.
L	**Blood glucose > 250 mg/dL**. **Ketones** in blood/urine. **ABG**: Metabolic acidosis (low pH, low HCO_3^-). **K+ may appear high but total body potassium is depleted**. ↑BUN/Creatinine (due to dehydration), ↑Anion Gap.
E	NPO during acute phase until blood sugar normalizes and acidosis resolves. Once stabilized: transition to regular diet + insulin. Long-term: consistent carb intake and meal timing education.
A	**Presentation**: Kussmaul respirations, fruity breath odor, polyuria, polydipsia, abdominal pain, vomiting, weakness, altered LOC. **Priority assessments**: Vitals, LOC, breath sounds, hydration status, BG and ketones.
P	**IV insulin drip** (regular insulin). **IV fluids**: NS initially, then add D5 once BG < 200. **Potassium replacement** (even if initial K+ is normal/high). Antibiotics if infection is the trigger.
P	**Cerebral edema** (especially in children if fluids given too fast). **Severe hypokalemia** during insulin therapy. **Shock, coma, arrhythmias** if untreated.Risk of **recurrent DKA** if education is not reinforced.
S3	**Start IV fluids first**, then insulin drip.Monitor **K+ closely before and during insulin therapy**.Watch for signs of **worsening acidosis or neuro changes** (LOC, confusion, cerebral edema).

MI

ASLEAPPS

A	**Acute condition**: Sudden blockage of coronary artery causing ischemia and myocardial death. Can occur on top of **chronic** CAD.
S	Begins in the **coronary arteries**. **Plaque rupture → thrombus formation → vessel occlusion → myocardial ischemia → infarction**.Complication: Heart failure, cardiogenic shock, arrhythmia, cardiac arrest.
L	**Troponin** (most specific), CK-MB, myoglobin. Electrolytes (esp. K+, Mg++).ABG, BNP, D-dimer (if PE suspected).
E	**Low sodium, low fat, heart-healthy diet**. Monitor for **fluid overload** in post-MI heart failure. Avoid caffeine or stimulant-heavy foods in acute phase.
A	C**lassic signs**: Chest pain (crushing, radiating), SOB, diaphoresis, nausea, anxiety. **Atypical signs** in elderly, diabetics, women (fatigue, dyspnea, indigestion).**Priority**: 12-lead ECG, VS, SpO_2, pain scale.
P	**MONA**: Morphine, Oxygen, Nitrates, Aspirin.**Beta blockers, ACE inhibitors, statins** post-MI. Antiplatelets (e.g., clopidogrel), heparin.
P	**Arrhythmias**, **heart failure**, **shock**, **cardiac arrest**.Pericarditis, ventricular rupture, reinfarction.
S3	Immediate ECG and troponin on presentation. Time is muscle—**intervention within 90 min (door-to-balloon time)**. Monitor closely for **arrhythmias and hypotension** post-MI.

MEDICATION CROSS-WALK

The medication crosswalk highlights drugs commonly encountered throughout the nursing curriculum—both in lectures and clinical practice. These medications are essential to understand

ADEK	Duloxetine	Lansoprazole	Quetiapine	cimetidine
Acetylcysteine	Edrophonium	Leflunomide	Racemic epi	clomid/clomiphene
Adalimumab	Empagliflozin	Leuprorelin	Regular insulin	clonazepam
Albendazole	Enoxaparin	Levofloxacin	RhoGAM	clonidine
Albumin	Epogen	Levothyroxine	Ribavirin	clopidogrel
Albuterol	Enoxaparin	Lipids	Rifampin	cromolyn sodium
Alendronate/ Fosamax	Epogen	Lisinopril	Risperidone	deoxycorticosterone acetate
Allopurinol	Erthropoetin	Lispro	Salbutamol	dextran
Alum. hydroxide	Escitalopram	Lofibra	Salmeterol	diazepam
Amitriptyline	Evista	Loratadine	Sertraline	diltiazem
Amoxicillin	FFP	Lorazepam	Simvastatin	epinephrine
Apixaban	Factor VIII	Losartan	Sotalol	eptifibatide
Aspirin	Famotidine	Lurasidone	Spironolactone	gentamycin
Ativan	Feosol	MVI	Steroids	ginseng
Azithromycin	Filgrastim	Mag hydroxide	Succimer	guanfacine
BLOOD Products	Finasteride	Magnesium sulfate	Supplemental Calcium	hydroxyzine
Baclofen pump	Fluoxetine	Mesalamine	Surfactant	labetalol
Benztropine	Fluphenazine	Metformin	TPN/Lipids	lamotrigine
Bictegravir	Fluticasone	Methimazole	TUCKS-witchhazel	leucovorin
Brexpiprazole	Fluvoxamine	Methotrexate	Tiptropium	lithium carbonate
Budesonide	Folic acid	Methylprednisolone	Topiramate	mannitol
Bumetanide	Teriparatide	Metoclopramide	Trazodone	meperidine
Calcium carbonate	Furosemide	Metoprolol	Valproate	methadone
Calcium gluconate	Gabapentin	Metronidazole	Valproic acid	methylergonovine
Calcium/VITD	Gardasil	Metyrapone	Vermox	methylphenidate
levodopa	Giapreza	Midodrine	Versed	mirtazapine
Celecoxib	Glargine	Mifepristone	Vincristine	misoprostol/ cytotec
Epogen	Lanoxin	Pyrostigmine	clonidine	bupropion
Doxorubicin	Isoniazid	Propanolol	caffeine	Dolasetron
Duloxetine	Ketoconazole	Propofol	calcitonin	Ipratropium
Edrophonium	Lactulose	Propylthiouracil	captopril	Prednisolone
Empagliflozin	Lamictal	Psyllium	carbamazepine	zolpidem
Enoxaparin	Lanolin cream	Pyrazinamide	ceftriaxone	bronchodilators
Epogen	Lanoxin	Pyrostigmine	clonidine	Warfarin
Cephalexin	Glipizide	Montelukast	Vistaril	mucomyst
Chlordiazepoxide	Glucagon	Morphine	WBC	narcan

MEDICATION CROSS-WALK

Chlorpromazine	Gonadotropin	HIVprophylaxis	Tamoxifen/Nolvadex	neurontin
Ciprofloxacin	HCG	VITK	Zidovudine	nifedipine
Cisplatin	HCTZ	Erythromycin	Ziprasidone	nortriptyline
Citalopram	Haloperidol	NPH	acetaminophen	ondansetron
Colace	Heparin	NSAIDS	acutevschronic	oxytocin
Colchicine	Hydrocortisone	Natalizumab	adenosine	pancreatic enzymes
Cryoprecipitate	Hydromorphone	Nevirapine	alprazolam	prazosin
Darunavir	Hydroxychloroquine	Octreotide	amiodarone	promethazine
Decadron	IGG	Olanzapine	amlodipine	pulmicort
Desmopressin	IV Fluids	Oxybutynin	aripiprazole	spermicides
Dexamethasone	IVIG	Oxycodone	atomoxetine	tamsulosin
Dextroamphetamine	Ibandronate	Paliperidone	betamethasone	valtrex/Zovirax
Digoxin	Ibuprofen	Pantorazole	bisacodyl	vancomycin
Diphenhydramine	Inderal	Phenylephrine	bisphosphonates	verapamil
Ditropan	Infliximab	Phenytoin	botulism	vitK
Docusate sodium	Insulin	Platelets		

HIGH RISK HIGH ALERT ACUTE ASSESSMENT MEDICATION

High-alert medications are considered high-risk due to their potential for serious side effects and administration errors. Nurses must be especially vigilant and prepared when handling these drugs

Alemtuzumab	aldesleukin	etoposides	melphalan	pemetrexed
Alitretinoin	amphotericin B	fentanyl	methadone	pentazocine
Amiodarone	arsenic trioxide	fludarabine	methotrexate	pramlintide
Argatroban	buprenorphine	fluorouracil	metoprolol	procarbazine
Asparaginase	busulfan	fondaparinux	midazolam	promethazine
Azacitidine	cetuximab	gefitinib	mitomycin	propofol
Bendamustine	chlorambucil	gemcitabine	mitoxantrone	propranolol
Bevacizumab	cisplatin	gemtuzumab	morphine	repaglinide
Bivalirudin	cladribine	heparins	nalbuphine	rituximab
Bleomycin	codeine	hydrocodone	nateglinide	sodium chloride
Bortezomib	colchicine (IV)	hydromorphone	nesitride	sunitinib
Butorphanol	cyclophosphamide	hydroxurea	nilotinib	temsirolimus
Capecitabine	cytarabine	idarubicin (oral)	nitroprusside	thioguanine
Carboplatin	dacarbazine	ifosfamide	norepinephrine	thrombolytic agents
Carmustine	decitabine	imatinib	oxaliplatin	tirofiban
Clofarabine	digoxin	insulins	oxycodone	topotecan
DAUNOrubicin	docetaxel	ixabepilone	oxymorphone	trastuzumab
DOBUTamine	epinephrine	labetalol	oxytocin	vinblastine
DOPamine	epirubicin	lapatinib	paclitaxel	vincristine
DOXOrubicin	eptifibatide	lidocaine	panitumumab	vinorelbine
Milrinone	erlotinib	magnesium sulfate	pazopanib	warfarin
Potassium	esmolol	mechlorethamine	pegaspargase	

SYMPTOMOLOGY BURN LIST TERMS COVERED THROUGHOUT NURSING			
Abdominal distention	Breast nodule	Deep tendon reflexes (hyper	Flank pain
Abdominal mass	Breast pain	Deep tendon reflexes (hypo)	Flatulence
Abdominal pain	Breast ulcer	Delirium	Fontanel (bulging)
Abdominal rigidity	Breath odor (ammonia)	Depression	Fontanel depression
Accessory muscle use	Breath odor (fecal)	Diaphoresis	Footdrop
Agitation	Breath odor (fruity)	Diarrhea	Gag reflex abnormalities
Alopecia	Brudzinski sign	Diplopia	Gait (bizarre)
Amenorrhea	Bruit	Dizziness	Gait (propulsive)
Amnesia	Buffalo hump	Doll's eye reflex (absent)	Gait (scissors)
Analgesia	Butterfly rash	Drooling	Gait (spastic)
Anhidrosis	Café-au-lait spots	Dysarthria	Gait (steppage)
Anorexia	Capillary refill time (increased)	Dysmenorrhea	Gait (waddling)
Anosmia	Carpopedal spasm	Dyspareunia	Gallop, atrial (S4)
Anuria	Cat's cry	Dyspepsia	Gallop, ventricular (S3)
Anxiety	Chest expansion (asymmetrical)	Dysphagia	Genital lesions (male)
Aphasia (dysphasia)	Chest pain	Dyspnea	Gum bleeding
Apnea	Cheyne-Stokes respirations	Dystonia	Gum swelling
Apneustic respirations	Chills	Dysuria	Gynecomastia
Apraxia	Chorea	Earache	Halitosis
Arm pain	Chvostek sign	Edema (arm)	Halo vision
Ascites	Clubbing	Edema (face)	Headache
Asterixis	Cogwheel rigidity	Edema (generalized)	Hearing loss
Ataxia	Cold intolerance	Edema (leg)	Heat intolerance
Athetosis	Confusion	Enophthalmos	Heberden nodes
Babinski reflex	Conjunctival injection	Enuresis (nocturnal)	Hematemesis
Back pain	Constipation	Epistaxis	Hematochezia
Barrel chest	Corneal reflex (absent)	Erectile dysfunction	Hematuria
Battle sign	Costovertebral angle tenderness	Eructation	Hemianopsia
Biot respirations	Cough (barking)	Erythema	Hemoptysis
Bladder distention	Cough (nonproductive)	Exophthalmos	Hepatomegaly
Blood pressure decrease	Cough (productive)	Eye discharge	Hiccups
Blood pressure increase	Crackles	Eye pain	Hirsutism
Bowel sounds (absent, silent)	Crepitation (bony)	Facial pain	Hoarseness
Bowel sounds (hyperactive)	Crepitation (subcutaneous)	Fasciculations	Homans sign
Bowel sounds (hypoactive)	Cry (high-pitched, cerebral)	Fatigue	Hyperpigmentation
Bradycardia	Cyanosis	Fecal incontinence	Hyperpnea
Bradypnea	Decerebrate posture	Fetor hepaticus	Hypopigmentation
Breast dimpling	Decorticate posture	Fever	Insomnia

SYMPTOMOLOGY BURN LIST TERMS COVERED THROUGHOUT NURSING			
Intermenstrual bleeding	Nuchal rigidity	Pulsus bisferiens	Tachycardia
Intermittent claudication	Nystagmus	Pulsus paradoxus	Tachypnea
Janeway lesions	Ocular deviation	Pupils (nonreactive)	Taste abnormalities
Jaundice	Oligomenorrhea	Pupils (sluggish)	Tearing (increased)
Jaw pain	Oliguria	Purple striae	Throat pain
Jugular vein distention	Opisthotonos	Purpura	Thyroid enlargement
Kehr sign	Orofacial dyskinesia	Pustular rash	Tics
Kernig sign	Orthopnea	Pyrosis	Tinnitus
Leg pain	Orthostatic hypotension	Raccoon eyes	Tracheal deviation
Level of consciousness	Ortolani sign	Rebound tenderness	Tracheal tugging
Lid lag	Osler nodes	Rectal pain	Tremors
Light flashes	Otorrhea	Respirations (grunting)	Trismus
Low birth weight	Pallor	Respirations (shallow)	Tunnel vision
Lymphadenopathy	Palpitations	Respirations (stertorous)	Uremic frost
Masklike facies	Papular rash	Retractions (costal sternal)	Urethral discharge
McBurney sign	Paralysis	Rhinorrhea	Urinary frequency
McMurray sign	Paresthesia	Rhonchi	Urinary hesitancy
Melena	Paroxysmal nocturnal dyspnea	Romberg sign	Urinary incontinence
Menorrhagia	Peau d'orange	Salivation (decreased)	Urinary urgency
Miosis	Pericardial friction rub	Salivation (increased)	Urine cloudiness
Moon facies	Peristaltic waves (visible)	Salt craving	Urticaria
Mouth lesions	Photophobia	Scotoma	Vaginal bleeding (postmen)
Murmurs	Pleural friction rub	Scrotal swelling	Vaginal discharge
Muscle atrophy	Polydipsia	Seizures (focal aware)	Venous hum
Muscle flaccidity	Polyphagia	Seizures (focal awareness)	Vertigo
Muscle spasms	Polyuria	Seizures (generalized absence)	Vesicular rash
Muscle spasticity	Postnasal drip	Seizures (gen. tonic-clonic)	Violent behavior
Muscle weakness	Priapism	Setting sun sign	Vision loss
Mydriasis	Pruritus	Skin (bronze)	Visual blurring
Myoclonus	Psoas sign	Skin (clammy)	Visual Floaters
Nasal flaring	Psychotic behavior	Skin (mottled)	Vomiting
Nasal obstruction	Ptosis	Skin (scaly)	Vulvar Lesions
Nausea	Pulse (absent or weak)	Skin turgor (decreased)	Weight Gain
Neck pain	Pulse (bounding)	Spider angioma	Weight Loss
Night blindness	Pulse pressure (narrowed)	Splenomegaly	Wheezing
Nipple discharge	Pulse pressure (widened)	Stools (clay-colored)	Wrist Drop
Nipple retraction	Pulse rhythm (abnormal)	Stridor	
Nocturia	Pulsus alternans	Syncope	

Room/Name Age Gender

Full Code DNR DNI HCP MOST Advanced Directive

Allergies:

Admit Date | Primary

Admit Dx

Mobility: AD-LIB Assist 1 2 FULL Cane Walker Bedrest

BR Priv Commode Neuro Checks Restraints Bed Alarms

Precautions- FALL – Elope

CDIFF MRSA VRE FLU

OBS 1:1 Neutropenic

LOC

AOx3

D P P

Confused

Diet

NPO

Strict I&O

Daily Weights

Last BM

PAST HISTORY

Angina	CAD	HTN	↑ Lipid	PVD	ACS
MI	Cath	CABG	Stent	CHF R	CHF L
Cardiac Other					
DVT	PE	COPD-E	COPD-B	Asthma	PNA
Pulmonary—Other					↑ Thyroid ↓
HD	PD	CKD	DM 1	DM 2	
AKI	Ulcer	Divert	Seizure	Smoker	ETOH
Seizure	CA	Glaucoma	Hepatitis	Cataracts	Dementia
Other HX					

CURRENT CONSULTS TEST

XRAY	MRI	CT	ECHO

US **CATH**

T	P	R	BP	MAP	O2
T	P	R	BP	MAP	O2
T	P	R	BP	MAP	02

IV #_____ R L SL **DATE:**

Site: AC FA HAND Wrist

Central: IJ TLC PICC Port

Dialysis G S

IVF: NS 0.45 NS D51/2 D5NS LR

_____cc/hr

_____ukg/hr

Blood TPN Lipids

IV #_____ R L SL **DATE:**

Site: AC FA HAND Wrist

Central: IJ TLC PICC Port

Dialysis G S

IVF: NS 0.45 NS D51/2 D5NS LR

_____cc/hr

_____ukg/hr

Blood TPN Lipids

CARDIOVASCULAR — EKG Telemetry Lead Rate

NURSINGKAMP

SB NS ST Afib Aflutter A-Paced F D V-Paced F D

AV Paced AICD Block 1 2 3 PAC's PVC's

Heart Sounds: S1 S2 S3 S4 **Murmur** I II III IV V

Pulses: R I W T B Doppler

Pulse Trend:____100——90——80——70—-60—-50 ____

VTE Prophylaxis: SCD's Foot Pumps Heparin Lovenox Coumadin Other

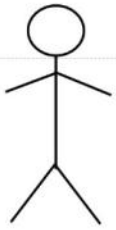
Pulses

1

2

3

4



Edema

0

1

2

3

4

P W

T G

PULMONARY — O2@____L NC VM PRB NRB CPAP BIPAP FIO2_____ TRACH # F NF C U

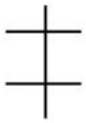
Breath Sounds: Clear Diminished Coarse Wheezes Crackles

Cough: Productive Non-Productive—

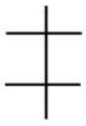
Treatments: Nebs _____ ISP_____CPT

O2 Sats Trend: 100————95————-90____

Rate Trend: ____24————20————16_____



ANTERIOR



POSTERIOR

Chest Tube: R L Pneumo Hemo

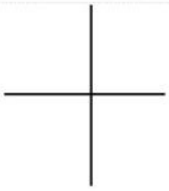
Endocrine/GU Voiding Anuria Urinal Bedside Commode Bedpan Incontinence Assist 1 2 I

Bowel Sounds: Hypo Hyper Active Nausea Vomiting ____ Diarrhea ____

NGT: R L — Green Clear Red _____Amount:_____

G - J TUBE: **CKD Dialysis:** M T W T F Sa Su

Foley: # F Clear Cloudy Amber Bloody Intake_____ Output_____



Skin/Drains/Dressings CDI Dressings 1 2 3 4 5

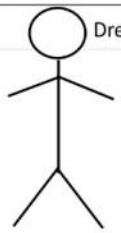
Weakness: RUE LUE RLE LLE

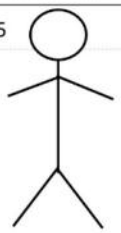
Numbness: RUE LUE RLE LLE

Pain: 1 2 3 4 5 6 7 8 9 10 **Location:**

Med: **Frequency:**

Trend Pain: 1 2 3 4 5 6 7 8 9 10





JP-

HV-

WV-

JP- HV- WV-

MEDICATIONS

MEDS PRN

HgA1c	BG	AC B	AC L	AC D	HS

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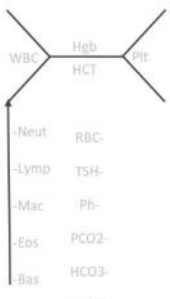
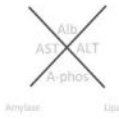
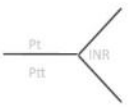




GFR

Hep-xa



New Orders/Pending

Disposition: Home Home Health NH ALF SCF REHAB

Consulted:

Speech

CM

PT

OT

GI

Cardiology

Neuro

Renal

Wound

Ortho

Pulm

Surgical

S– SITUATION

I am calling about- (Room/Name/Age/Gender)

Code Status ☐ FC ☐ DNR ☐ DNI ☐ HCP ☐ MOLST - Admit Date-

Primary Admit Dx Allergies

The Problem I am calling about-

I just assessed the pt personally vitals are

T P R BP 02

Previously they were MAP MAP

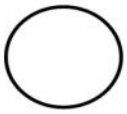
T P R BP 02

I am concerned about the

BP >200_____ <200_____ 30mm Diff.

Pulse >130_____ <50_____ Pulse OX

Resp <8_____ >30_____



Temp

<96F/35.5C

>103F/39.4C

B-Background

Dementia Ca Angina MI AFIB CABG HTN ACS

CHF COPD Asthma CKD DM I II HD PD Seizure other

Patient is Currently – A&O x T PL P

Mentation Changed - Yes No

☐ **Confused** - Cooperative Non Cooperative

☐ **Agitated** Combative Verbally Abusive Threatening

☐ **Lethargic** but conversant able to swallow

☐ **Stuporous** not talking clearly might not be able to swallow

☐ **Comatose**-Eyes Closed not responding to stimulation

Skin is

☐ Warm ☐ Dry ☐ Pale ☐ Mottled ☐ Diaphoretic

Extremities are **Edema**

☐ Hot ☐ Cold ☐ +1 ☐ +2 ☐ +3 ☐ +4 ☐ Pitting

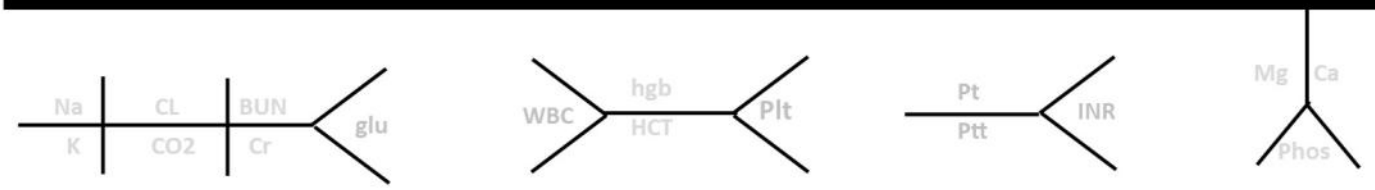
Pulses ☐ S ☐ W ☐ I ☐ B ☐ A ☐ Doppler

Patient is: ☐ On Oxygen ☐ Not on Oxygen

The patient has been on: (l/pm) % for _____Hrs/min o2 Sats _____ NEBS— ☐ ☐ ☐

ABG ☐ Ph PaCo2 HCO3 PaO2 Lactic Acid Troponin

A-Assessment



IV's-PRN's

This is what I think the problem is that it seems to be: ☐ Cardiac ☐ Pulmonary ☐ Infection ☐ Neuro ☐ Meds

☐ I'm not sure what the Problem is but the patient is deteriorating.

☐ The patient seems unstable and may get worse, we need to do something.

R-Recommendation

I would like to suggest:

☐ Transfer to ICU

☐ Come to see the patient

☐ Talk to family about code status

☐ Ask on-call to see pt now

☐ Ask for a consult from:

Are there any test needed:

☐ CXR ☐ ABG ☐ EKG ☐ CBC ☐ BMP _____

Would you like any changes?

How often would you like vitals?

How long do you think this problem will last?

If the patient doesn't get better would you want to be called back? When?

CLINICAL KAMP

What do you like to be called?	What is your motivational animal? Why	
Specialty Interested in:	What do you do for work now? Hours	How many miles from school?

CHOOSE YOUR DOMINANT LEARNING STYLE

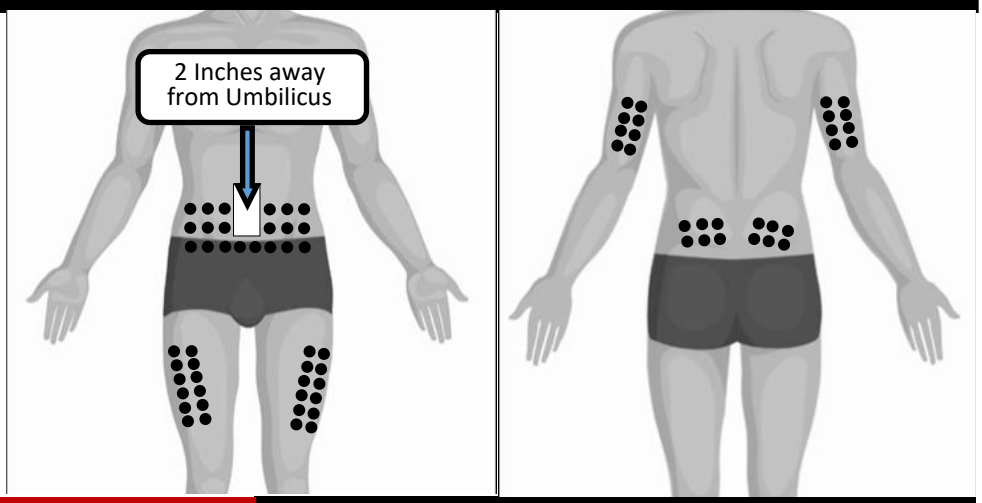
	Learning Style	Definition	Characteristics	Effective Study Strategies
○○○○○	**Visual (Spatial)**	Learns best through **seeing**	Prefers charts, diagrams, color coding - Remembers images more than words	- Use mind maps, flashcards, charts - Highlight key ideas in color
○○○○○	**Auditory (Aural)**	Learns best through **hearing**	Enjoys lectures and discussions - Remembers spoken instructions	- Record lectures or self-read aloud - Join study groups or use songs/ mnemonics
○○○○○	**Reading/Writing**	Learns through **text-based input**	Prefers written explanations - Learns well through reading & note-taking	- Recopy notes, make outlines - Use written quizzes and reading assignments
○○○○○	**Kinesthetic (Tactile)**	Learns through **movement and doing**	Prefers hands-on experiences - Learns by touching or moving	- Practice skills, use simulations - Walk while studying, use role-playing
○○○○○	**Multimodal**	Uses **a mix of styles**	Flexible learner - Benefits from combining methods	- Combine visual aids, spoken review, and hands-on practice for deeper understanding

Identify and relate to a Nursing Theorist

Aspect	Jean Watson– Nurturing	Patricia Benner-Methodical
	●●●●●●●●●●	●●●●●●●●●●
Theory Name	Theory of Human Caring	From Novice to Expert Model
Core Focus	**Caring as the essence of nursing** and a moral ideal	**Development of clinical competence** through experience
Philosophical Basis	**Humanism, existentialism, phenomenology**	**Dreyfus Model of Skill Acquisition**, phenomenology, Building on experience and application
Key Concepts	Carative factors / Caritas processes - Transpersonal caring - Healing environment	5 levels of proficiency (Novice to Expert) - Clinical judgment and skill development
View of the Nurse	A **healing presence** who connects deeply with the patient	A **practitioner who evolves** through experience and learning
View of the Patient	A **whole person**—mind, body, and spirit	A **person in a lived situation**, influenced by real-life context
Main Goal	Promote **holistic healing** through authentic caring	Support **clinical skill development** and understanding over time
Practice Emphasis	Emphasizes **relationship-centered care**, empathy, and spirituality	Emphasizes **clinical reasoning, situational awareness**, and reflection
Use in Education	Teaches students to see nursing as **a moral, humanistic act**	Guides **clinical preceptorships and performance evaluation**
Application Setting	Ideal in **palliative, mental health, and holistic care**	Widely used in **clinical education, staff development**

SUBCUTANEOUS INJECTION

Heparin & Lovenox should only be administered in the abdomen



INSULIN & OTHER SQ INJECTIONS

SQ

W – Wash hands & wear gloves

Always perform hand hygiene and don gloves to maintain standard precautions.

A – Alcohol the site

Cleanse the chosen injection site (abdomen, thigh, upper arm) with an alcohol swab using circular motion outward.

S – Select and pinch the site

Choose an appropriate subcutaneous site and pinch the skin to lift the fat away from the muscle.

H – Hold at 45°–90° angle & insert

Insert the needle quickly and smoothly at a 45° angle (for thin patients) or 90° angle (for most others).

D – Deliver the med & dispose properly

Inject medication slowly, withdraw needle, release skin, and dispose of the needle in a sharps container.

HEPARIN & LOVENOX INJECTIONS

SQHL

P – Pinch the skin

Grasp a fold of subcutaneous tissue to avoid intramuscular injection.

A – Avoid rubbing after

Do not massage or rub the site post-injection to reduce bruising and bleeding.

S – Site: Abdomen only

Inject 2 inches away from the umbilicus; alternate sites in the lower abdomen.

S – Slow and steady injection

Inject the medication slowly to minimize tissue trauma and burning sensation.

S – Safety device activation

Engage needle safety device immediately and dispose of the syringe in a sharps container.

Good to know!

- Always wash hand & wear gloves
- Always check 6 rights and perform 3 med checks.
- Rotate sites when giving repeated injections.
- Use a 90° angle (especially for pre-filled Lovenox syringes).
- Do not expel the air bubble in Lovenox—it helps seal the medication.
- Monitor for signs of bleeding, hematoma, or bruising around the injection site.

My Nursing Practice

SQ	HEPARIN LOVENOX
○ _____	○ _____
○ _____	○ _____
○ _____	○ _____
○ _____	○ _____
○ _____	○ _____

INTRAMUSCULAR INJECTION

R – Review the order and identify the patient

Perform 3 med checks and verify the 6 rights of medication. Use 2 identifiers.

A – Alcohol wipe and site selection

Select the correct site (deltoid, ventrogluteal, vastus lateralis).

Cleanse the area with an alcohol swab, using a circular motion outward. Let dry.

I – Insert at 90° angle

Hold the muscle taut and insert the needle in a swift, dart-like motion at a 90° angle to reach the muscle layer.

S – Steady injection

Inject the medication slowly and steadily (about 1 mL per 10 seconds) to reduce pain and promote absorption.

E – Exit needle and engage safety

Withdraw the needle smoothly, apply gentle pressure (do not massage), activate the safety device, and discard in sharps container. Then document.

Ventrogluteal Muscle

Deltoid Muscle ≤ 1 ml

Vastus Lateralis (infants/children)

Patient Type	Site	Needle Gauge	Needle Length	Max Volume
Adult (average)	Deltoid	22–25 G	1"	≤ 1 mL
Adult (average)	Ventrogluteal	20–23 G	1–1.5"	≤ 3 mL
Adult (obese)	Ventrogluteal	20–21 G	1.5"–2"	≤ 3–5 mL
Adult (thin)	Vastus lateralis	22–25 G	1"	≤ 2 mL
Child (1–12 yrs)	Vastus lateralis	22–25 G	⅝"–1"	≤ 2 mL
Infant (<12 mos)	Vastus lateralis	25–27 G	⅝"	≤ 1 mL
Neonates	Vastus lateralis	25–27 G	⅝"	≤ 0.5 mL

Good to know!

- Always wash hand & wear gloves
- Always check 6 rights and perform 3 med checks.
- Rotate sites when giving repeated injections.
- Monitor for signs of bleeding, hematoma, or bruising around the injection site.

My Nursing Practice

○ _____ ○ _____

○ _____ ○ _____

○ _____ ○ _____

Medication Administration

INHALER-SHAKER

INH

S – Shake the inhaler

Shake well (especially for metered-dose inhalers) to mix medication properly.

H – Hold upright & exhale

Hold inhaler upright, breathe out fully to empty lungs.

A – Activate & Inhale slowly

Press the inhaler and inhale slowly and deeply at the same time.

K – Keep holding breath (10 seconds)

Hold breath for up to 10 seconds to allow medication to settle in lungs.

E – Exhale slowly

Breathe out gently through the mouth or nose.

R – Rinse or Brush (for steroids)

Rinse mouth or brush teeth after use if it's a steroid inhaler (like fluticasone) to prevent thrush.

NASAL SPRAY

NS

BLOW CLOSE AIM SPRAY CLEAN

B – Blow your nose first

Clear nasal passages to allow better medication absorption.

C – Close one nostril

Gently press one side shut to direct spray into the other nostril.

A – Aim away from septum

Insert tip and aim **outward**, toward the **ear**, not the nasal septum, to prevent irritation.

S – Spray and sniff gently

Spray once while gently inhaling **through the nose**, not sharply.

C – Clean the nozzle

Wipe tip with a clean tissue and replace cap to maintain hygiene.

Good to know about Inhalers!

Know the Type of Inhaler—Understand if it's a **metered-dose inhaler (MDI)**, **dry powder inhaler (DPI)**, or **soft mist inhaler**, as each has different administration techniques.

Always Shake MDIs Before Use MDIs (like albuterol) should be shaken **5–10 seconds** before each use to mix the medication.

Use a Spacer for Better Delivery -
For MDIs, a **spacer or holding chamber** helps medication reaches the lungs

Rinse Mouth After Steroid Inhalers Inhalers like **fluticasone (Advair, Symbicort)** require **mouth rinsing after use** to prevent oral candidiasis (thrush).

Wait Between Puffs and Inhalers

Wait 30 seconds to 1 minute between puffs of the same inhaler;
Wait 5 minutes between different types (e.g., bronchodilator first, then steroid).

Assess & Document Response
Monitor for effectiveness (e.g., improved breath sounds, decreased wheezing) and **document** time, dose, and patient response.

Metered Dose Inhaler (MDI)
Teach to take **slow and deep** breath

DPI (like Advair - Diskus)
quick and forceful breath

My Nursing Practice

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Medication Administration

TRANSDERMAL

TD

S – Site rotation—Always **rotate application sites** to avoid skin irritation.

C – Clean, dry, hairless skin -Apply to **clean, dry, and intact** skin—preferably hairless (do not shave, trim if needed).

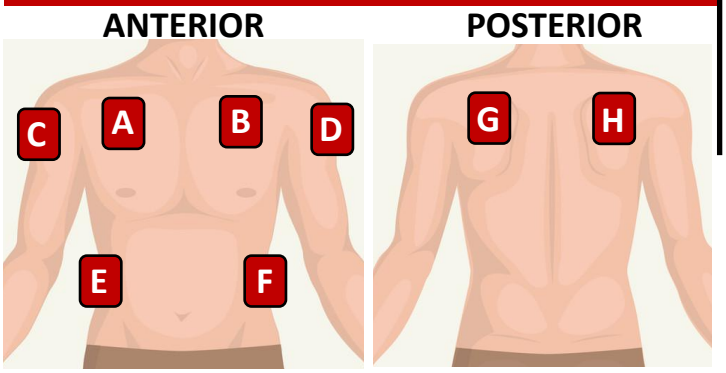
R – Remove old patch -**Always remove the old patch first** to avoid overdose.

U – Use gloves -Wear **gloves when applying or removing** to prevent absorption through your own skin.

B – Border secure -Ensure patch is **fully adhered** and edges are sealed.

P – Press and document -**Press firmly** for 10–30 seconds and **document** the date, time, site, and initials (if required).

TRANSDERMAL PATCH ROTATION



EYE DROPS

EYE

D-Don't touch tip- Keep dropper tip sterile—never touch eye or lashes.

R -Recline the head -Tilt head back or have patient lie supine. Ask them to look upward.

O- One drop in conjunctival sac- Gently pull down lower lid and place drop in lower conjunctival sac, not directly on the eye.

P Press nasolacrimal duct -Gently press inner canthus (nasolacrimal duct) for 1–2 minutes to prevent systemic absorption.

I Interval between drops If giving multiple eye drops, wait 5 minutes between different medications to prevent washout.

T Tissue for excess Blot excess fluid with a clean tissue, avoiding rubbing or wiping the eye.

My Nursing Practice

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Good to know Nursing Information about Specific Transdermal Patches

Clonidine Patch (Catapres-TTS)

Weekly Patch – Long Acting

Applied **once every 7 days**. Use calendar reminders and educate on consistent scheduling.

Apply to Upper Arm or Chest

Choose a **flat, hairless, non-irritated site** on upper outer arm or upper chest—rotate weekly.

Don't Stop Abruptly

Never remove abruptly—can cause **rebound hypertension**, agitation, or tachycardia. Taper off under provider guidance.

Cover Patch for Security if Needed

Use the **provided overlay** if edges lift, but **never tape directly over** the medication area.

Monitor BP & CNS Effects

Watch for **sedation, dry mouth, bradycardia**, and **BP regularly**.

Nitroglycerin Patch (Nitro-Dur)

Time-Off Schedule – Prevent Tolerance

Use a **12-hour on / 12-hour off** schedule (e.g., patch on in AM, off at bed) to prevent nitrate tolerance.

Rotate Sites Daily

Remove Before Defibrillation or MRI

Contains **aluminum backing** – remove prior to **MRI or defibrillation** to prevent skin burns.

Don’t Touch the Medication Side

Wear **gloves** to avoid absorbing nitro into your own skin.

Monitor for Hypotension & Headache

Common side effects include **orthostatic hypotension and headache**—monitor BP educate patients to rise slowly.

CENTRAL VENOUS ACCESS DEVICES

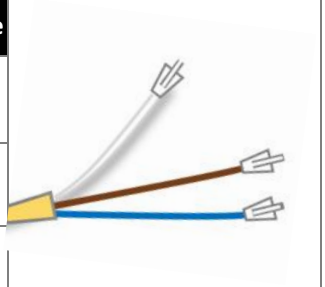
CVAD Assessment

C	**Catheter site**	Inspect **insertion site** for redness, swelling, drainage, or skin breakdown.
A	**Adhesive/ dressing**	Check that dressing is **clean, dry, and occlusive**. No lifting edges or moisture.
T	**Tubing integrity**	Ensure tubing is **intact, not kinked, cracked, or leaking**. Clamps functional.
H	**Hub hygiene**	Confirm hub is clean; use **alcohol or CHG swabs** before accessing ("scrub the hub").
E	**Exit site length**	Measure exposed catheter length, compare to baseline. Document any **migration**.
T	**Temperature & Tenderness**	Ask about and assess for **localized pain** or **fever**—possible signs of infection.
E	**Equipment securement**	Is the **securement device in place** (e.g., StatLock)? Check suture less device integrity.
R	**Response to flush**	Flush each lumen with **normal saline** (using 10 mL syringe); check for resistance, pain, or sluggish return. Aspirate for blood return as indicated.

CVAD DRESSING CHANGE

S	**Supplies & Setup**	Gather sterile dressing kit, mask, sterile gloves, chlorhexidine, securement device, label, and trash bag. Apply **mask** to yourself and patient. Maintain aseptic environment.
A	**Assess the site**	Inspect for **redness, swelling, drainage, pain**, or signs of infection. Ask patient about **tenderness or discomfort**.
S	**Sterile field setup**	Open sterile dressing kit using proper technique. Don **sterile gloves**, and maintain sterile field throughout. Do **not touch sterile contents with bare hands**.
H	**Hand hygiene**	Perform hand hygiene **before and after** the procedure. This reinforces infection prevention and professional habits.
E	**Exit old dressing & clean site**	Carefully remove old dressing using clean gloves. Use **chlorhexidine swab**: scrub in a back-and-forth motion for 30 seconds, allow to **air dry completely**. Never blot dry.
S	**Secure with new dressing**	Apply sterile dressing, transparent film, securement device, and date/time label. Ensure catheter is well stabilized and tubing is not kinked or pulled. Document procedure and site condition.

Port	Color	Common Use	Gauge
Proximal Port *(closest to insertion)*	**White**	Blood draw- Medication administration- IV fluids	18 G
Medial Port	**Blue**	**TPN (Total Parenteral Nutrition)**- Medication infusion	18 G
Distal Port *(furthest from insertion site)*	**Brown**	**CVP monitoring**- High-volume or viscous fluids- Blood products	16 G



Good to know!

Always Maintain Sterile Technique
Scrub the Hub Every Time
Flush with a 10 ML Syringe Only
Assess for Complications Every Shift
Never Force a Flush
Label and Track Lumen Use

Complications

Redness, swelling, drainage at the insertion site
Catheter migration or dislodgement
Signs of air embolism (sudden SOB, chest pain, hypotension)
Signs of occlusion or thrombosis (resistance to flush, arm swelling)

My Nursing Practice

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INTRAVENOUS MEDICATION PUSH

NURSING TIPS ON IVP

S	**Syringe size = 10 mL**	Always use a **10 mL syringe** for flushing—especially with central lines—to avoid high pressure and catheter damage.
A	**Assess for patency**	**Flush before** giving the IVP med. If there's **resistance, pain, or infiltration**, do **not administer** the med.
F	**Flush–Push–Flush**	Use the **flush–med–flush** technique to prevent drug incompatibility and ensure full delivery of the medication.
E	**Evaluate the drug**	Know your med: **push rate, dilution, compatibility, and risk level** (e.g., vesicant or high-alert). Always verify in a drug reference.
P	**Push at correct rate**	Administer the med **slowly**, as directed (e.g., 1–5 minutes). Use a **watch or timer** to ensure safety.
A	**Assess the patient**	**Stay with the patient** during and after administration. Watch for **immediate adverse reactions** (e.g., hypotension, anaphylaxis).
C	**Check mixing precautions**	Do not mix meds in the same line without a flush. Prevent **incompatibility reactions** by **flushing between IVP meds**.
T	**Thorough documentation**	Record the **med, dose, site, time, push rate, and patient response**. Include **pre- and post-vitals** when required.

IVP ADMINISTRATION STEPS

IVP

P	**Patient check & 6 Rights**	Verify **patient ID**, and confirm the **right medication, dose, route, time, patient, documentation**. Check allergies.
R	**Review compatibility & dilution**	Check if the med is compatible with existing IV fluids. Know if **dilution is required** and the **recommended IVP rate**. Use a reliable drug reference.
E	**Equipment setup**	Gather a **flush (10 mL NS), syringe with med, alcohol swabs**, and gloves. Use a **10 mL syringe** for flushing.
P	**Patency check**	**Flush IV first** to confirm patency—look for resistance, pain, or swelling. Do not proceed if the IV is infiltrated.
A	**Administer slowly**	Give the med **at the recommended rate** (e.g., morphine over 4–5 minutes). Use a watch or timer if needed.
R	**Re-flush the line**	After administering, **flush with 10 mL NS** again to ensure all med enters circulation and clears the line. Watch for patient reaction.
E	**Evaluate and document**	Monitor the patient's **vitals, LOC, and tolerance** to the med. Document **time, site, dose, and response**. Report adverse effects.

My Nursing Practice

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PO MEDICATION

PO

W	**Wash hands & wear gloves (if needed)**	Perform hand hygiene and wear gloves if required (e.g., contact precautions or handling hazardous drugs).
A	**Assess patient**	Check for ability to **swallow**, **level of consciousness**, **gag reflex**, and **NPO status**. Hold if contraindicated.
T	**Timing & 6 Rights**	Verify the **6 Rights of Medication**: right patient, med, dose, time, route, documentation. Check if med should be given **with or without food**.
C	**Check for contraindications**	Confirm no **drug allergies**, interactions, or GI issues (e.g., nausea, vomiting, recent surgery) that would prevent oral administration.
H	**Hydrate & Help position**	Offer **water** unless contraindicated. Sit patient **upright** (≥ 30°) to prevent aspiration. Watch for pocketing in cheeks if dysphagia is suspected.

My Nursing Practice

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IVF

IV FLUID Administration

IVPB

IV Fluid Administration

	Step	Action & Nursing Tip
S	**Select IV fluid & tubing**	Verify the **correct fluid** order and choose appropriate tubing (**macro/microdrip**).
C	**Check clarity & compatibility**	Inspect for **particles, discoloration, expiration**; verify fluid compatibility.
R	**Remove air from tubing**	**Prime the line completely** to prevent air embolism; ensure no bubbles are present.
U	**Understand the rate ordered**	Confirm **prescribed flow rate** (e.g., 125 mL/hr); use **roller clamp or IV pump**.
B	**Back-check for infiltration**	Inspect the IV site for **redness, swelling, pain, or leakage** before connection.
F	**Flush to check patency**	Use **normal saline flush** (if needed) to confirm IV patency before starting fluids.
L	**Label everything**	Label **IV tubing, fluid bag, and IV site** with **date, time, and initials**.
U	**Upright bag & secure tubing**	Hang bag above heart level; ensure **tubing is anchored and secure**.
I	**Inspect flow & drip rate**	Open clamp and check for **steady flow**; count **drops/min** if not using a pump.
D	**Document**	Record **fluid type, rate, time, site condition, and patient response** in chart.

IV Piggyback Administration

	Step	Nursing Action & Tip
H	**Hang secondary bag higher**	Place the **IVPB (secondary) bag higher** than the primary bag to allow gravity to control flow properly. Use a second hook on the IV pole.
A	**Assess compatibility**	Confirm the IVPB medication is **compatible with the primary IV fluid** to prevent reactions or precipitation. Use a compatibility chart.
N	**Never skip safety checks**	Complete the **3 checks and 6 rights** of medication administration. Verify patient, drug, dose, route, time, and documentation.
G	**Gravity prime the line**	Prime the **secondary tubing by gravity** (or backflush from primary line if allowed). Ensure **no air bubbles** are present.
S	**Set the IV pump rate correctly**	Program the **secondary rate and total volume** exactly as ordered. Be sure to select **"secondary" mode** on the pump to prioritize piggyback.
A	**Alcohol wipe the Y-site port**	Clean the Y-site or secondary port for **15–30 seconds** with alcohol to maintain sterility before connecting.
F	**Flow & site monitoring**	During the infusion, **observe the drip chamber**, and assess the IV site for **patency, infiltration, or phlebitis**.
E	**Evaluate & document**	After infusion: assess the IV site, **flush if required**, and **document** the medication, dose, rate, time completed, and patient's response.

Good to know about IV Fluids!

Type	Definition	Common Examples	Primary Clinical Uses
Isotonic	Same osmolarity as blood. Stays in intravascular space.	0.9% NaCl (Normal Saline) Lactated Ringer's (LR) D5W* (initially)	Fluid resuscitation Dehydration Hypovolemia Post-op fluid replacement
Hypotonic	Lower osmolarity than blood. Shifts fluid into cells.	0.45% NaCl (½ NS) D5W** (once metabolized)	Cellular dehydration (e.g., DKA) Hypernatremia Rehydrating cells
Hypertonic	Higher osmolarity than blood. Pulls fluid out of cells into vasculature.	D10W 3% NaCl D5NS D5½NS	Severe hyponatremia Cerebral edema Volume expansion in shock
Colloids	Contain large molecules that **stay in vascular space**, expanding volume.	Albumin (5%, 25%) Dextran Plasma	Hypovolemia with hypoalbuminemia Burns Liver failure - Shock

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VITAL SIGNS CARDIAC ASSESSMENT

Heart Rate Classification

Bradycardia– Less than 60 bpm

Normal Heart Rate– 60bpm- 100bpm

Tachycardia– Greater than 100bpm

Heart Rate is controlled by the **Sympathetic Nervous System** which controls the **SA– Node (Accelerator Nerve)** Oncestimulated it releases neurotransmitters (ACH-Nicotinic, Norepinephrine) that increase the heart contractility in the ventricles

Heart Rate is slowed down by the **(Parasympathetic Nervous System) via the VAGUS nerve** Once stimulated it releases neurotransmitters (acetylcholine) decreasing heart rate.

Underlying Cause Bradycardia

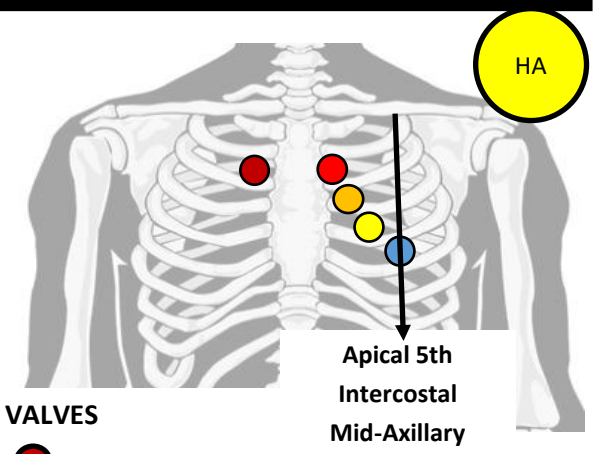
A-Athlete
B–Beta Blockers
C-Calcium Channel Blockers
D-Digoxin
K-Potassium Low

Peripheral Pulses

Rate: Per Minute—60-100
Rhythm: Regular or Irregular
Symmetry: Even Uneven
Amplitude:
4 = Bounding
3 = Increased
2 = Normal
1 = Weak
0 = Absent or No palpable

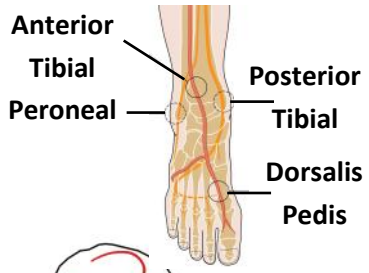
Underlying Causes of Tachycardia

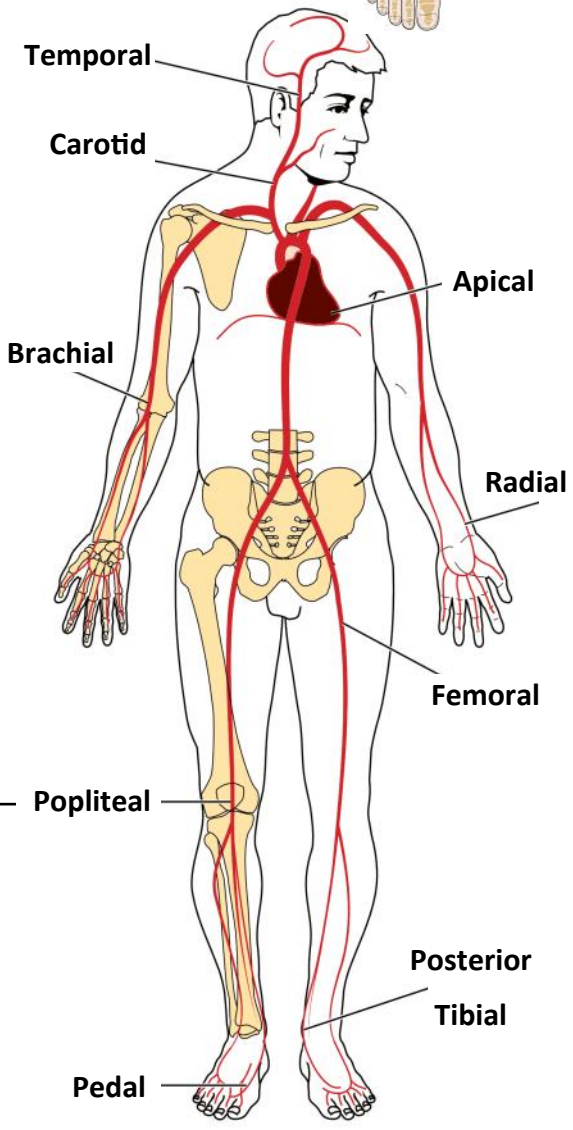
M–Medications-Albuterol
O-Oxygen Complications
S– Stress
T– Trauma
P– Pain
T– Thyroid (hyper)
S-Sepsis
D– Dehydration
O– Orthostatic Hypotension
W-Withdrawal
I-Infection
S-Sympathetic Nervous System



VALVES

- **Aortic**
- **Pulmonic**
- **ERBS**
- **Tricuspid**
- **Mitral**



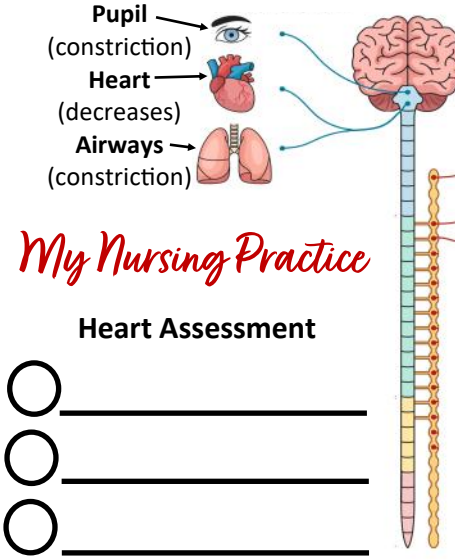


PARASYMPATHETIC

Pupil (constriction)
Heart (decreases)
Airways (constriction)

SYMPATHETIC

Pupil (dilation)
Heart (increases)
Airways (dilation)



My Nursing Practice

Heart Assessment

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Good to know!

Right-sided murmurs (Tricuspid, Pulmonic): Louder with inspiration

Left-sided murmurs (Mitral, Aortic): Louder with expiration

Use the bell for low-pitched (diastolic rumbles like mitral stenosis), and diaphragm for high-pitched murmurs

VITAL SIGNS BLOOD PPRESSURE

Blood Pressure Classification

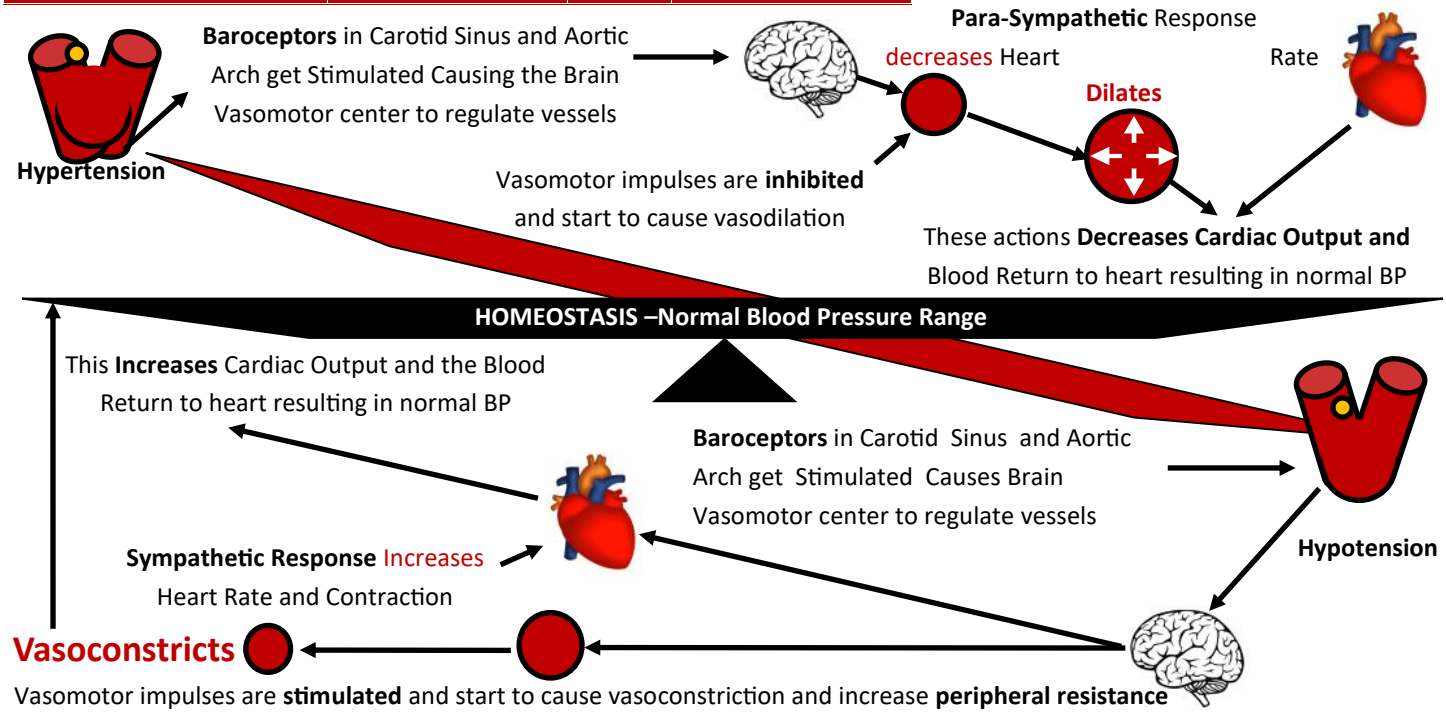
CLASSIFICATION	SYSTOLIC-mm hg		DIASTOLIC mmHg
Hypotension	Less than 100	or	Less than 60
NORMAL	100-120	and	60-80
ELEVATED	120-129	and	Less than 80
Hypertension Stage 1	**130-139**	**an**	**80-89**
Hypertension Stage 2	**140 or Higher**	**OR**	**90 or Higher**
HYPERTENSIVE CRISIS	**More than 180**	**and/or**	**120 or Higher**

Mean Arterial Pressure (MAP)

[(2 x Diastolic) + Systolic] ÷ 3

Normal MAP: 70–100
Minimum for perfusion: ≥65
Less than: <65 organ hypoperfusion

BP MAP



My Nursing Practice

B/P Assessment

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Orthostatic Blood Pressure Measurement Process

Purpose: To assess for orthostatic hypotension, defined as a drop in systolic ≥ 20 mmHg or diastolic ≥ 10 mmHg within 3 minutes of changing positions (lying → sitting → standing), often accompanied by dizziness or lightheadedness.

Step	Action
Preparation	Explain procedure to patient. Ensure they have not eaten, smoked, or taken medications that could affect BP recently.
Baseline BP & HR – Supine	Have patient lie down for **5 minutes**. Measure and record **BP and HR** while supine.
Sitting BP & HR	Assist patient to **sit**. Wait **1–2 minutes**, then measure and record **BP and HR**.
Standing BP & HR	Assist patient to **stand**. After **1–3 minutes**, measure and record **BP and HR**. Observe for dizziness or unsteadiness.
Monitor Symptoms	Ask patient if they feel dizzy, lightheaded, weak, or faint during each position change.
Document Findings	Record all **positions, times, BPs, HRs**, and **any symptoms** experienced.
Notify Provider if Abnormal	If systolic drops ≥20 mmHg or diastolic ≥10 mmHg **or** if symptomatic, notify healthcare provider.

VITAL SIGNS RESPIRATORY ASSESSMENT

Respirations are counted for 30 seconds and multiplied by 2 if normal and 1 minute if they appear abnormal

Normal Respirations are 12-20

Cheyne Stokes-progressively deeper, , and sometimes faster, *breathing* followed by a gradual decrease that results in a temporary stop in *breathing* called an apnea.

Kussmaul: Rapid Deep, labored, Hyperventilate

Abnormal Breath Sounds

Hyperventilation > 24 Breaths a min.

Tachypnea > 20 Breaths a Minute

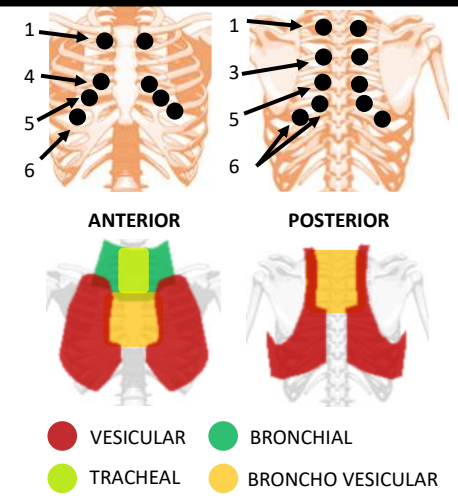
Bradypnea < 12 Breaths per minute

Apneustic– Period of deep gasping and pause at full inspiration then breathing

RESPIRATION REGULATION

Respirations are managed by changes in ACID BASE balances in the blood stream. This imbalance can be affected by underlying causes like infections, metabolic conditions. Once the PH is affected the pulmonary regulatory system takes effect correcting the imbalance through the respiratory rate and receptors in the brain

LUNG BREATH SOUNDS



My Nursing Practice

Respiratory Assessment RA

OXYGEN DELIVERY

Oxygen Device	Liter	Percent
Nasal Cannula Can Eat, Drink, Talk Higher flow can be dry to nasopharyngeal area use humidifier Front Line for Alert, Oriented Patients-Not as accurate % O2	1	24 %
	2	28 %
	3	32 %
	4	36 %
	5	40 %
	6	44 %

Venturi Mask (Venti-mask)

Precision titration of oxygen

Flow Rate set 4-8 Liters/minute

B	24 %
W	28 %
O	31 %
Y	35 %
R	40 %
G	60 %

OXYGEN DELIVERY DEVICES

Simple Face Mask For more acute actions that allows for exhaled CO2 to escape Allows for humidification

6 L	35 %
7 L	41 %
8 L	47 %
9 L	53 %
10 L	60 %

Non-Rebreather Mask

Delivers up up to 95-100% Oxygen with both flaps intact Mask has two flaps that may be removed to change FiO2 %

10-15	80-100 %

80-85% Both Flaps Removed

85-90% One Flap Removed

Bag Valve Mask (BVM) - 100% Oxygen

Manual ventilation, for unconscious patients or unable to oxygenate.

Humidification Systems

Prevents drying of membranes for longer term oxygen therapy (sterile

ABDOMINAL ASSESSMENT

AA

RIGHT

LEFT

RIGHT HYPOCHONDRIUM Gallstones, Cholecystitis Stomach Duodenal Ulcer, Hepatitis	**EPIGASTRIC** Heartburn, GERD, Stomach Ulcer Pancreatitis	**LEFT HYPOCHONDRIUM** Stomach Ulcer Duodenal Ulcer Biliary Colic
RIGHT FLANK Kidney Stones Kidney Infection Inflammatory BD Constipation, UTI	**UMBILICAL** Pancreatitis Early Appendicitis Inflammatory BD - Hernia	**LEFT FLANK** Kidney Stones Kidney Infection Inflammatory BD Diverticulitis
RIGHT ILIAC FOSSA Appendicitis Inflammatory BD Constipation, GYN	**SUPRAPUBIC REGION** UTI, GYN Pain Diverticulitis IBS,	**LEFT ILIAC FOSSA** Appendicitis Inflammatory BD Constipation, GYN

Always Inspect First

Begin by looking at the abdomen before touching it. Note contour, symmetry, scars, distention, or visible pulsations.

Auscultate Before Palpation or Percussion

Do not touch the abdomen before listening. Palpation can alter bowel sounds.

Use All Four Quadrants

Divide the abdomen into RUQ, LUQ, RLQ, and LLQ to systematically inspect, auscultate, percuss, and palpate.

Warm Your Hands and Stethoscope

Cold instruments or hands can cause abdominal muscles to tense, altering findings.

Ask About Pain First

Assess pain location and severity before palpation. Always palpate painful areas last to avoid guarding or tensing too early.

Listen for Bowel Sounds for at Least 5 Minutes if Absent

Bowel sounds can be irregular. If none are heard, listen for a full 5 minutes before documenting absent sounds.

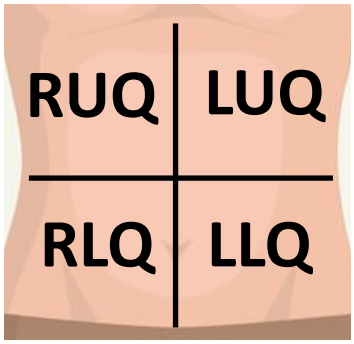
Percuss for Tympany vs Dullness

Tympany suggests air (normal over intestines); dullness may indicate fluid, mass, or organomegaly.

Note Rebound Tenderness or Guarding

These are signs of peritoneal irritation and require prompt attention. Document and notify the provider.

GENERAL QUADRANTS



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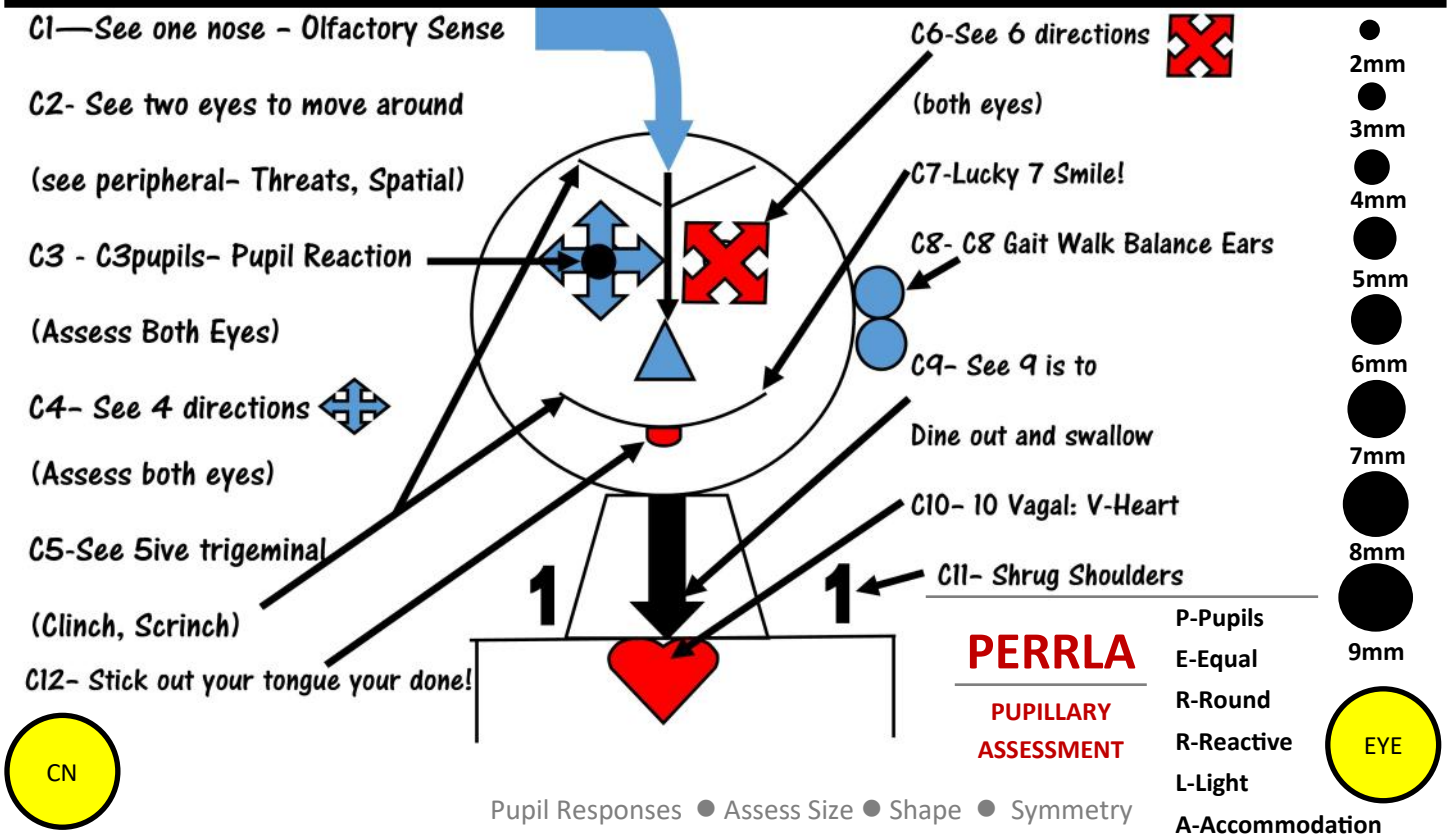
NEURO ASSESSMENT



Cranial Nerve	Function	Type	Normal Finding	Abnormal Finding
I – Olfactory	Smell	Sensory	Identifies familiar scents (e.g., coffee)	Anosmia (loss of smell), unable to identify scent
II – Optic	Vision	Sensory	Reads text, sees clearly; intact visual fields	Blurred vision, visual field loss, abnormal Snellen test
III – Oculomotor	Eye movement, pupil constriction	Motor	Pupils equal, round, reactive to light and accommodation (PERRLA); eyelid elevation	Dilated pupils, ptosis (drooping eyelid), non-reactive pupils
IV – Trochlear	Eye movement (down/in)	Motor	Eyes move downward and inward smoothly	Diplopia (double vision), impaired downward gaze
V – Trigeminal	Facial sensation, chewing	Both	Intact facial sensation; strong jaw movement	Numbness in face; weak or absent corneal reflex; difficulty chewing
VI – Abducens	Eye movement (lateral)	Motor	Eyes move laterally without nystagmus	Inability to move eye laterally, diplopia
VII – Facial	Facial expression, taste (anterior 2/3 tongue)	Both	Symmetrical facial movements; identifies sweet/salty taste	Facial droop, asymmetry, Bell's palsy; loss of taste
VIII – Vestibulocochlear (Acoustic)	Hearing, balance	Sensory	Identifies whispered words; maintains balance	Hearing loss, vertigo, positive Romberg test
IX – Glossopharyngeal	Swallowing, taste (posterior 1/3 tongue)	Both	Swallow intact; gag reflex present	Dysphagia, impaired gag reflex
X – Vagus	Voice, swallowing, parasympathetic	Both	Speech clear; uvula rises midline; no hoarseness	Hoarseness, dysphagia, uvula deviates
XI – Accessory (Spinal)	Shoulder & neck movement	Motor	Shrugs shoulders, turns head against resistance	Weak shoulder shrug or head turn
XII – Hypoglossal	Tongue movement	Motor	Tongue midline; articulates clearly	Tongue deviation; slurred or garbled speech

Foley Catheter Insertion Removal

Foley Catheter Insertion

	Step	Nursing Action
C	**Confirm order & ID patient**	Check physician's order and use **2 patient identifiers**. Explain the procedure.
L	**Level supplies & position patient**	Gather sterile supplies, place patient in **dorsal recumbent** (female) or **supine** (male) position.
E	**Establish sterile field**	Open catheter kit using **aseptic technique**. Don sterile gloves.
A	**Apply antiseptic & drape**	Clean meatus front to back (female) or in circular motion (male). Apply sterile drape.
N	**No-touch technique**	Handle catheter by **connector end only**; **don't touch sterile tip**.
F	**Feed catheter gently**	Insert catheter until **urine flows**, then **advance 1–2 inches more**.
L	**Lower balloon and secure**	Inflate balloon with ordered amount of sterile water. Gently pull until resistance is felt.
O	**Organize securement & drainage**	Secure tubing to thigh and position **drainage bag below bladder** level.
W	**Wash hands & document**	Dispose of equipment, **wash hands**, and **document** insertion, size, tolerance, and output.

Catheter Removal

	Step	Nursing Action
R	**Review order & ID patient**	Confirm provider's order and verify **2 patient identifiers**. Explain procedure to the patient.
E	**Empty the drainage bag**	Record **final output** before removal. Dispose of urine per facility protocol.
M	**Minimize balloon volume**	**Deflate the balloon completely** using a syringe (usually 10 mL or amount documented at insertion).
O	**Out slowly & gently**	Instruct patient to relax. **Withdraw catheter slowly** and steadily once balloon is deflated.
V	**Visualize for intact tip**	Inspect catheter tip to ensure it is **fully intact** (no breakage or retained fragments).
E	**Educate & document**	Instruct patient to report first void, burning, or discomfort. **Document time of removal**, appearance of urine, and any patient response.

CI

CR

BS

My Nursing Practice

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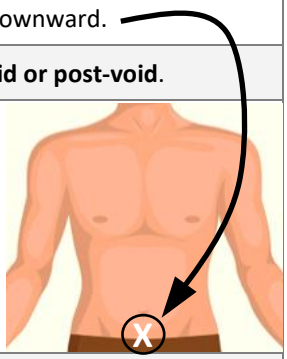
Good to know about Bladder Scanning!

	Step	Action / Clinical Tip
S	**Supine position**	Position the patient **flat on their back** with the abdomen exposed and relaxed.
C	**Confirm settings**	Choose correct gender on scanner. **Use "male" setting for females with hysterectomy.**
A	**Aim above pubic bone**	Place scanner **1 inch above the symphysis pubis**, angled slightly downward.
N	**Note last void**	Ask patient when they last urinated to determine if scan is **pre-void or post-void**.
V	**Volume interpretation**	**<100 mL** = Normal **100–150 mL** = Borderline **>300 mL** = Likely retention → Notify provider
O	**Observe image quality**	Ensure bladder is **fully visible and centered** on the screen — repeat if cutoff occurs.
I	**Interpret with context**	Consider conditions like **BPH, spinal cord injury, medications, mobility issues.**
D	**Document and decide**	Chart **volume, position, time, void status**, and whether the provider was notified.



PRECAUTIONS & PPE

	Standard	Contact	Droplet	Airborne
Clinical Situation	Everyone	Resistant Organism, Diarrhea, Wound Drainage	Upper Respiratory Infections Unknown	TB, Measles, Chicken Pox, Laryngeal Disease
Room	Private, Semi Pvt	Private Cohorting	Private or Cohorting 3 ft	Private Negative pressure Door Closed
Gloves	ⓘ	✋	ⓘ	ⓘ
Mask	ⓘ	ⓘ	😷	😷 **N-95**
Gown	ⓘ	🥼	ⓘ	ⓘ

Donning Order
Wash First

PPE

Doffing Order
Wash Last

ⓘ Any unknown risk wear Gloves, Mask, Gown

- AIDS/HIV
- Adenovirus
- Anthrax (Lesions)
- Aspergillosis
- Babesiosis
- Botulism
- Bronchiolitis
- Chicken Pox (Varicella)
- Clostridium difficile (C-Diff)
- Colorado Tick Fever'
- CMV-Cytomegalovirus
- Corona –Covid-19
- Hepatitis B,C,D,E,G
- Herpes Zoster (Lesions)
- Histoplasmosis
- Influenza
- Lice (scabies)
- MRSA
- MDRO-VRSA
- Measles
- Meningococcal Disease
- Mumps
- Parainfluenza
- Parvovirus B19
- Pertussis-Whooping Cough
- Respiratory Syncytial Virus
- Rota Virus
- TB Tuberculosis
- VRE

My Nursing Practice

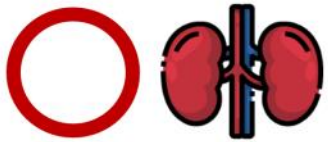
○ _____ GLOVE REMOVAL ○ _____ STERILE GLOVE REMOVAL ○ _____ PPE

NURSINGKAMP BMP Basic Metabolic Panel Chem7 Chemistry 7 Level 1

The Basic Metabolic Panel (BMP) is a set of lab tests used to evaluate a patient's electrolyte balance and kidney function. These tests are typically performed daily for inpatients, during acute situations, or before diagnostic procedures or surgeries. It's important to note that lab values can vary between institutions, so always refer to your agency's policy for interpreting results. The NCLEX exam will provide reference ranges for these labs, but it's crucial for nurses to understand the underlying causes of any abnormalities, as well as the appropriate assessments and interventions. Units of measurement (such as mEq/L, mmol/L, etc.) are not emphasized here because the focus is on understanding the reference ranges.

Plasma is 55% of the blood tube indicating the fluid portion of blood. When considering the labs included in the Basic Metabolic Panel (BMP), it's helpful to remember that all of these tests measure components found in the fluid portion of the blood, known as plasma. Therefore, changes in these lab results are often linked to fluid imbalances in the body. Such imbalances can occur due to illness that causes dehydration, the use of diuretics that increase urine output, or any medical procedures that remove fluids from the body .

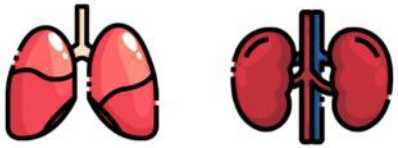
High is Dry!



Na - Sodium

135-145

Respiratory Metabolic?



Cl - Chloride

95-105

Kidney Issues - Diabetic?

BUN - Blood Urea Nitrogen

8-22

GLU - Glucose

70-110

Low Acute

Think BS

3.5-5.1

K - Potassium

High & Low Acute!

22-26

CO2-Carbon Dioxide

Respiratory or Metabolic?

0.7-1.4

Cr- Creatinine

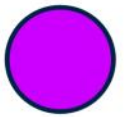
Kidney Issues - Diabetic?

NURSING I FISHBONE

NURSINGKAMP CBC Complete Blood Count Level 1

A Complete Blood Count (CBC) is a common blood test that measures several components of blood that is used to assess overall health and detect a variety of conditions, such as anemia, infection, and other blood disorders. These tests are typically performed daily for inpatients, during acute situations, or before diagnostic procedures or surgeries. It's important to note that lab values can vary between institutions, so always refer to your agency's policy for interpreting results. The NCLEX exam will provide reference ranges for these labs, but it's crucial for nurses to understand the underlying causes of any abnormalities, as well as the appropriate assessments and interventions. Units of measurement (such as mEq/L, mmol/L, etc.) are not emphasized here because the focus is on understanding the reference ranges.

Think Purple
Platelets Purple Tube



Acute High Infection

WBC - White Blood Cells

4k-10k

Hemoglobin—Hgb

12-18

(12-16 Female or 14-18 Male)

Platelets

145k—450k

Hematocrit—HCT(riple)

36-48%

White Count "Buffy White" 1%

Notice it is a small part of the blood < 1% which makes sense since an elevated WBC is often an indicators of infection

The "formed elements" of blood, which make up about 45% of its volume, refer to the cellular components of blood

1. **White Blood Cells (WBCs):** Part of the immune system, they help fight infections.
2. **Hemoglobin:** The protein in red blood cells that carries oxygen.
3. **Hematocrit:** The proportion of blood that consists of red blood cells.
4. **Red Blood Cells (RBCs):** Carry oxygen from the lungs to the rest of the body.
5. **Platelets:** Help with blood clotting to stop bleeding.

NURSING I FISHBONE

NURSINGKAMP BMP Basic Metabolic Panel - Chem7 - Chemistry 7

The BMP is a collection of labs evaluating the current electrolyte & Kidney functioning of the patient more important labs are Potassium K and Sodium- Chloride and CO2 are indicators requiring looking at Respiratory or Metabolic problems- BUN & Creatine Evaluate Kidney related issues whether acute or chronic along with along with glucose.

Sodium Low is most acute - only raise 1 mEq an hour due to risk for herniation- Always monitor 6 Lit D's causes Drains, Diuretics, Diarrhea, DKA, Dehydration, Diet, & Lithium

Na	Cl	BUN	Glu
K	CO2	Cr	

BMP - ER - Fishbone

Could be life threatening, notify provider	>150
Assess pt, vitals, labs, might do Interventions may notify PCP	145-150
Normal Lab Values	135-145
Assess pt, vitals, labs, might do Interventions may notify PCP	130-135
Could be life threatening	<130

Na 135-145 Sodium

K 3.5-5.1 Potassium

Potassium high is an acute finding that should be addressed! Place on Monitor, EKG Notify PCP-May tx with CD-KING HEMO

"C D KING Hemo"- Calcium Chloride/ Gluconate- Diuretics Kayexalate, Insulin, Glucose, Hemodialysis

High or Low Look Somewhere else is it a Respiratory or Metabolic problem?

Cl 95-105 Chloride

CO2 22-26 Carbon Dioxide

High or Low Look Somewhere else is it a Respiratory or Metabolic problem?

BUN LOW CHRONIC-Liver

BUN High then look at Creatinine is it normal? If Yes think Dry!

If Both BUN & Creatinine is high think is it Acute or Chronic? ARF/CRD

BUN 8-22 Blood Urea Nitrogen

Cr 0.7-1.4 Creatinine

Creatinine Low Chronic Condition

Creatinine anytime High Stop and Think is it Acute or Chronic?

Acute Renal Failure (ARF)

Chronic Renal Disease (CKD)

GLU 70-110

High Why DIC?
Diabetic 1-2?
Infection
Corticosteroids?

High or Low always get a POC fingerstick Assess PT

Low Glucose may treat with G-50-20-30
Conscious? Glucagon
20-30 Carb
Unconscious D-50

Could be life threatening, notify provider	>5.4
Assess pt, vitals, labs, might do	5.1-5.4
interventions may notify Provider	3.5-5.1
Normal Lab Values	3.0-3.5
May replace- Stop NG Tubes, Diuretics	<3.0

K

Low K May Replace
Never Bolus Potassium
Give Only 10-20 meq hour
In Order to Raise 1 mEq/l
K3.0-3.5 = needs 100-200 mEq
K< 2.9 = needs 200-400 mEq

NURSING II-V FISHBONE

NURSINGKAMP CBC Complete Blood Count with Differential

High WBC >10-12K may be signs of infection, inflammation or steroids. Infection generally takes 72 hours to manifest. When the WBC is elevated you should further evaluate the Differential

Elevation of Differential

Neutrophils-Bacterial Infections

Lymphocytes- Viral Infections

Monocytes- Chronic Infections

Eosinophils- Eating Parasites

Basophils- Bee Stings Allergic

WBC 4k-10k

Fluctuations of WBC Causes

Autoimmune, Lupus - Leukemia

Aplastic Anemia, Chemotherapy

Low Platelets Risk For Bleeding Monitor Petechiae, Purpura, Stools

Low then look at HCT first is it low then it could be Acute or Chronic?
Low Acute is Bleeding!

Low Chronic could be Chronic Kidney Disease, Anemia, Cancer Leukemia

Hemoglobin

Hgb - 12-18

(12-16 Female or 14-18 Male)

Hematocrit—HCT

36-48%

HIGH HCT with Normal Hgb is DRY

If it is Low then look at Hgb first if is low then think is it Acute as in bleeding or Chronic causes ?

Invasive procedures, surgeries should be questioned if platelets are lower than <60k

High Chronic

Cancer

Platelets

145k—450k

Low Acute

Sepsis

Bleeding

Chronic

Liver

Cancer

Meds that cause BLEEDING

Clopidogrel NSAIDS

Heparin Escitalopram

ASA Coumadin

HERBS Garlic

Ginseng Ginger

Gingko

Meds that affect Platelets

Chemo Sulfonamides Antibiotics

Quinidine Meprobamate Phenybutazone

Thiazide Diuretics Streptomycin

NURSING II-V FISHBONE

NURSINGKAMP Renal Diagram Overview Mg, Ca, Phos

Calcium Magnesium Phosphorus Abnormalities—Think Renal, CKD Diuretics, Etoh abuse

Hypercalcemia Symptoms

Renal Stones-Diarrhea

Abdominal Pains – Confusion

Hypocalcemia Symptoms

Stridor, Trousseau's,

Tetany, Chvostek's, -Seizures

Low Ca will not correct until

Low Mg is Corrected

High Ca Tx = "HEAL"

H-Hydrate (3000-4000ml)

E-Ethacrynic

A-Acid

8.5 –10
Ca-Calcium

IV Calcium should be given in D5W—not Saline HIGH RISK Patients on Digoxin with high Calcium =Toxicity

Treatment: Hypocalcemia -Chronic = Vitamin D & Calcium Acute= Calcium "Go "Gluconate

MEDS That Effect Ca Levels	
	D-Vitamin
	Acetazolamide
	Magnesium Antacids
	Gentamycin
	Estrogen Preparations
	Cortisones-Laxatives
	Alkaline Antacids
	Insulin - Methicillin

Hypermagnesemia Symptoms

Slow Like Sx's - Weakness

Lethargy- Respiratory

Depression - Hypotension

1.5 - 2.5
Mg -Magnesium

Hypomagnesemia Symptoms

Nystagmus Confusion

Torsade's Des Pointes

Treatment: 1-2 G treats low Mg

Never Bolus Mg give <150 mg/min

Monitor Patella reflexes, Bradycardia Respiratory Depression, Hypotension

MEDS That Effect MG Levels		
	Calcium Gluconate	Salt-Epson
	Amphotericin B	Maalox
	Neomycin Diuretics	Antacids
	Insulin	Mylanta

Phos
Phosphorus

3.5-4.5
If low or high look at Calcium Level

Phosphorus

H	Twitching	L	Weakness
I	Irritability	O	Lethargy
g	Nausea	W	Nausea
h	Vomiting		

Replacement of Ph is a High Risk Due to risk of Hypocalcemia

Phosphorus levels should be monitored after 2 to 4 hours after each dose, also monitor serum potassium, calcium and magnesium. Cardiac monitoring

NURSING II-V FISHBONE

NURSINGKAMP

Liver Endocrine Diagram ★ Acute !

These labs are to evaluate the Liver and Pancreas-Elevations in this diagram generally indicate problems except low albumin

Ammonia 10-45 -High is Liver Disease- Cirrhosis ★

★ Low Malnutrition, Age, Liver Disease

Albumin (alb)

3.4 -5.6 g/dl

Any Bilirubin High is Acute Liver Disease, Sickle Cell Hepatitis ★

Conjugated-Bilirubin is 0.1-0.4

Total Bilirubin

0.3-1.1

"AST" (SGOT)

(Aspartate Aminotransferase)

NO IM INJECTIONS BEFORE DRAW

A"S"T- More "System" Specific but most still likely Liver but could be heart (MI) if High look at meds or Amylase=Pancreatitis

AST

10-40 u/l

"ALT" (SGPT)

(Alanine Aminotransferase)

A"L"T- MORE LIVER SPECIFIC - High Think Inside Liver or CHF if High look at Lipase = Pancreatitis

ALT

10-50 u/l

Aphos

Alkaline Phosphatase

20-160 u/l

★ Amylase 20-160 u/l

High

Pancreatitis
Gallbladder
Mumps,
Renal Failure

Low

IV D5W
Kidney Disease,
Cancer, Toxemia
Pregnancy

High Biliary Obstruction
Liver Disease, Cancer
Leukemia
Hyperparathyroidism

Lipase 20-160 u/l ★

NPO except Water 8-12 Hours Before Draw

Narcotics should be withheld 24 hours before draw* if given NOTE on LAB SLIP

High Acute Pancreatitis, Gallbladder, Kidneys

★ Lipase is more Specific than Amylase for Pancreatitis

NURSING II-V FISHBONE

NURSINGKAMP Coagulation Labs PT-Prothrombin Time & Partial Prothrombin Time -HEPXA

If a patient is on Coumadin or Heparin or there is unexplained bleeding these labs are often drawn to evaluate patient status to include heparin drips which would provide a baseline- Some facilities use HEPXA instead of PTT always follow agency policy

HIGH PT CAUSES

"Licked the PT"

L- Von Willi brand's

I-Increased Bleeding

C-Coumadin to HIGH

K-Vitamin K Antidote

E-Eating Deficiency

D-DIC

Affects Extrinsic Clotting Factor 7

HIGH PTT CAUSES

"Willi DIC Heparin HELPS"

W- Von Willi brand's

D-DIC

Heparin

H-Hemophilia

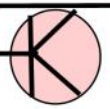
E-Eight (factor deficiency)

L-Liver Failure

P-Protamine

S-Sulfate(Antidote)

Reminder Vitamin K is the Antidote for Coumadin



If on Coumadin Look at INR for Therapeutic Range

PT—Prothrombin Time

10-13 seconds

PTT—Partial Prothrombin Time

25-35 seconds

If on Heparin PTT should be 1 .5 -2 Times normal

Protamine Sulfate- Antidote

2 IV Lines with Heparin Drips

Affects Clotting Factors 8-9-11-12

INR

1-2	Normal Range Not on Coumadin
2-3	Therapeutic For Being on Coumadin
3-4	Therapeutic For Patients with Valves
>4	ACUTE Think Vitamin K! Bleeding!

Monitoring with the HepXa allows for the ability to achieves coagulation quicker therefore is being used more than PTT (follow agency policy)

Heparin

Has 7 letters

HepXa X=10

7-10=3

0.3-0.7

HepXA Level

FOODS HIGH IN VITAMIN K

BECKS

Canola

CABS

B-Broccoli	Canola-Oil
E-Endive	C-Collard Greens
C-Cauliflower	A-Any Dark Green
K-KALE	B-Brussel Sprouts
S-Spinach	S-Soy Bean

Meds that Affect Bleeding

No Chance Quadruple G

C-Clopidogrel (Plavix)

H-Heparin

A-ASA

N-NSAIDS

C-Coumadin (warfarin)

E-Escitalopram

HERBS

G-Garlic

G-Ginger

G-Ginko

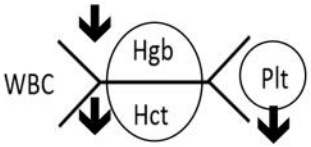
G-Ginseng

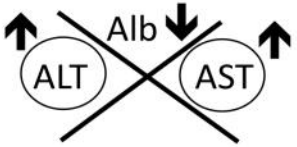
RISK BLEEDING!

Observe and monitor for Signs and Symptoms of Bleeding- PPS

Petechiae, Purpura- Stools ⊕ Hemoccult

Look at Other Labs





NURSING - V FISHBONE

NURSINGKAMP

Cardiac Labs

Chronic Labs are used to identify risk for CAD initially a total cholesterol is drawn then if that is >200 a fasting lipid panel is completed-the results of that lipid panel will silicate further action based on modifiable vs non-modifiable factors.

Acute Labs are used to identify risk or actual cardiac injury as a result of Myocardial Ischemia leading to Infarction. Generally, they are drawn in 3 sets 6-8 hours apart though policy may be different at your facility. If the enzymes keep rising further evaluation telemetry monitoring is necessary.

Total Cholesterol

First Screening for CAD or Risk if it is greater than 200 Lipid Panel is usually recommended

"Fasting" LIPID PANEL

Triglycerides Want Low
Bad Fats in the Bloodstream circulatory Risk for CAD

LDL "Lousy want them Low"
Bad Cholesterol

HDL—"Happy want it High"
Good Cholesterol removes LDL

Inflammation Risk for CAD

Total Cholesterol	C-Reactive Protein CRP
<200	<3

TRG<200

LDL <150

HDL >50M
>40F

T	M
P	A

Cardiac Enzymes 3 sets –Every 6-8 Hours

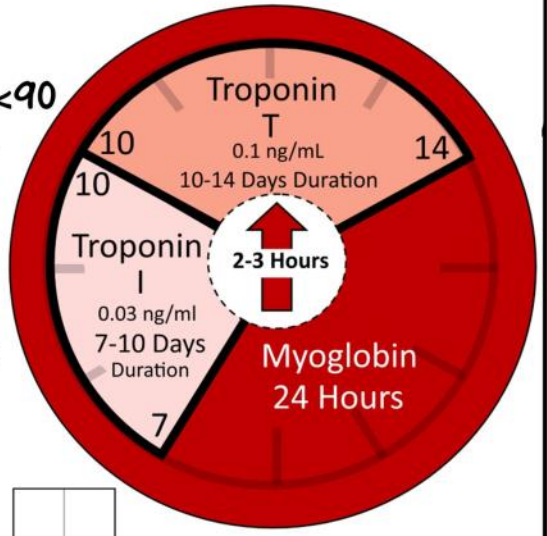
All Cardiac Enzymes begin to rise within 2-3 hours of injury Troponin T is First to Rise then Troponin I– Total CK % has a duration of 2– 3 days

Troponin T <0.1

Troponin I <.03

Myoglobin <90

Duration of Cardiac enzymes vary making timing of the patient imperative



BNP-Brain Natriuretic Peptide

BNP <150

Patient's suspected of having Congestive Heart Failure(CHF) anticipate a "BNP" being drawn if it is positive then there is a likelihood the patient has CHF. (Chronic CHF patients may be lower)

<150 No - Congested Heart Failure
>150-500 Probable CHF
>500 Indicative of CHF

T	M
P	A

The Heart Box is a Method to document your valve abnormalities by writing a letter like R in the box of the specific valve location and if it is Regurgitation or a valve or stenosis-examples

	R → Mitral "R" Regurgitation
	S → Aortic "S" Stenosis

V →	Tricuspid Valve "V"
S →	Pulmonic "S" Stenosis

Mitral "V" Valve

	V

Arrow points to either right or left sided CHF with BNP

450 (Left CHF)

450 (right sided heart failure)

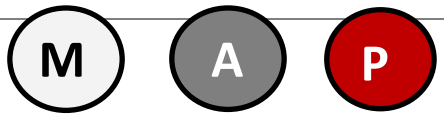
NURSING V FISHBONE

CLINICAL KAMP - THE CLINICAL FLOW

PRECONFERENCE—RECEIVE ASSIGNMENT & ROLE		
PRIMARY ROLE—CAMP STAR FIRST		
	Step	**Description**
C	**C**hart Check	Open each patient's chart (start with overview and current info).
A	**A**ctive Med Review	Look only at **medications** in the MAR/EMR.
M	**M**ed Type Tag	Determine if each medication is **Acute (RED or other color Post-it)** or **Chronic (YELLOW Post-it)**, and write the **med name** on the note.
P	**P**reviously Given?	Place a ★ next to meds you've **administered before** and **have a med card** for already.
S	**S**ort by Acuity	Go to instructor, **lay out Post-its** according to **acuity** (acute first).
T	**T**alk with Instructor	**Discuss meds, verify** your med pass plan & confirm **med pass times**.
A	**A**ssign Med Cards	Create new med cards for those **without stars**; **update** cards for starred ones.
R	**R**esume Care	Resume your nursing **assignment flow** (**FOCUS CARE**).

FOCUS CARE PRIMARY NURSING STUDENT ASSIGNMENT		
	Step	**Action / Purpose**
F	**Find your patient & check report**	Receive **handoff report**, verify **room/location**, check ID, and get brief history.
O	**Observe orders and objectives**	Review the **chart**, look at **MD/nursing orders**, medications, labs, and goals for care.
C	**Collect initial assessment**	Perform **head-to-toe assessment**, check vitals, IVs, drains, pain, mobility, etc.
U	**Understand priorities**	Identify **urgent needs** (e.g., pain, blood sugars, mobility risk, oxygen), note what needs to be done **first**.
S	**Safety checks**	Check **bed position, call light, fall risk signs, equipment function**, and environment.
C	**Care interventions**	Carry out assigned **medications, hygiene, repositioning, feeding**, or wound care.
A	**Active documentation**	Record **nursing notes**, assessments, med administration, and patient response in real time.
R	**Reassess and reflect**	Go back to reassess pain, wounds, vitals, response to meds; reflect on your clinical reasoning.
E	**End-of-shift handoff**	Report back to Faculty, review goals met, outstanding issues, and your own learning for the day.

YOUR NURSING PRACTICE MAP



MAP is a quick, structured reflection tool to help nursing students consolidate learning after patient care.

Purpose: Allows for clinical reflection, connect theory to practice, and support clinical reasoning development.

M – Medical Insight Reflect on what you learned about the patient's **diagnosis, condition, or disease process**.

A – Assessment Awareness Identify what you learned through **observation, patient interaction, or physical assessment**.

P – Plan of Care or Priorities Note what you learned about the **treatment plan**, **nursing interventions**, or **clinical priorities** for your patient.