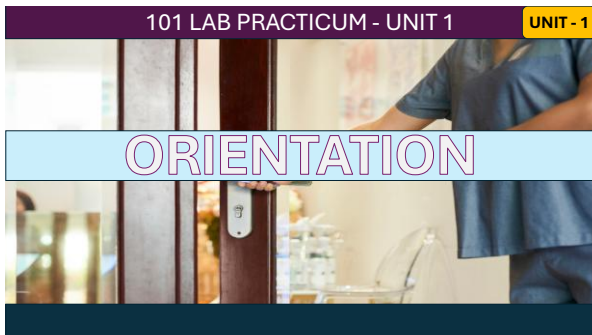




1

What is the Purpose of Labs **UNIT - 1**

Take concepts and put them into
practice and to validate that
practice

Practice = Lab Time

Validation = Verified by Faculty 

ASSESSMENT

2

LAB REQUIREMENTS **UNIT - 1**

Be On time

Be in Uniform- No Nails, Be Professional

Bring Stethoscope

Blood Pressure Cuff

Book - Pens

Be THAT nurse, Not that nurse...

ASSESSMENT

3

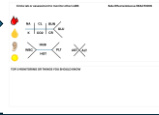
REQUIREMENTS
UNIT - 1



Walk through SBAR



All Case Study **MEDS** covered in lab & class must be completed for entry of next weeks lab



ASSESSMENT

4

The Book
UNIT - 1

* Task, Assessment, Assignments to be demonstrated in front of Faculty, Course Chair, Clinical Coordinator or LAB instructors these must be STAMPED AND COMPLETED BY END OF SEMESTER

+
= LAB Concepts covered in Lab & Clinical



THE BOOK

THE UNITS

Unit 1- Orientation

Unit 2 Vital Signs

Unit 3- Cardiac Assessment

Unit 4- Musculoskeletal

Unit 5- Pulmonary

Unit 6- Integumentary

Unit 7-Abdominal Assessment

Unit 8- Genitourinary Assessment

Unit 9 – Neurological Assessment

ASSESSMENT

5

LAB PRACTICUM
UNIT - 1



ORIENTATION

6

LAB PRACTICUM

UNIT - 1

BOOT KAMP BASELINE

15 Minutes to Complete

7

LAB PRACTICUM

UNIT - 1

BRAINSHEET

PURPOSE & OVERVIEW

The Nursing 7 on the Nursing Process

1. Assessment is what you see. It is the data you collect, and you base your interventions on it.
2. Intervention/Implementation is what you do.
3. Nurse assessments are performed the same way in an organized process.
4. Assessment is continuous — you keep collecting data throughout the patient's care.
5. Assessments are generally completed before implementation.
6. Brain sheets are a nurse's documentation of assessment.
7. Nurses complete the primary (baseline) assessment first, then secondary assessments to look for more specific data.

All Brain sheets are based on the Nurses Assessment

ASSESSMENT & DOCUMENTATION

8

LAB BRAINSHEET UNITS

UNIT - 1

UNIT 1 Statistics Every Patient

Pulmonary Assessment Unit 5

Cardiac Assessment Unit 3

BMP & CBC Labs

Vital Signs Unit 2

MEDS

GI UNIT 7/8

Endocrine UNIT 8

IV FLUIDS & Venous Access LINES

ASSESSMENT FLOW How the nurse organizes

Some Abbreviations of task a nurse does in a shift

A Nurse Will know Everything on This Brainsheet

9

LAB PRACTICUM- LAB TO KNOW

UNIT - 1



ASSESSMENT

16

LAB PRACTICUM- MEDS TO KNOW

UNIT - 1



0.9% NS Flush
0.9% NS Infusion
0.45% Sodium Chloride
Influenza Vaccine
Tuberculin PPD
Cyanocobalamin
Pyridoxine
Vitamin E
Folic Acid

ASSESSMENT

17

LAB PRACTICUM- DEVICE TO KNOW

UNIT - 1



ASSESSMENT

18

LAB PRACTICUM- DEVICE TO KNOW UNIT - 1



ASSESSMENT

19

LAB PRACTICUM- TERMS TO KNOW UNIT - 3

TERMS TO KNOW FOR UNIT 1 2							
Airborne	Na	Contact	Temporal	Hypotension	INFLUENZA	Glucose	Cr
Hgb	Hyperoxia	Measles	Duffing	Vesicular	Rales	Hyperoxia	BVM
C-Diff	CI	K	Tachycardia	Supine	Femoral	Systolic	Varicella
HTN	TB	Pit	Fever	37 Celsius	CO2	Standard	Popliteal
12-20	CAD	BUN	HCT	Bradycardia	SOB	Built	Post-Tibial
Wheezes	Pertussis	S1	Apical	CHF	Ascuscation	Rhronchi	Radial
Bronchial	Diastolic	Diaphragm	Brachial	Yankaur	NRB	Tracheal	WBC
Donning	Steidor	Mumps	Apneustic	Bradypnea	Emphysema	Mitral	Edema
Tachypnea	Tricuspid	VRE	S1	95-100%	Pne	Podal	Troponin
Crackles	S2	BUN	Dyspnea	60-100	CHF	95-100%	Rubeola

ASSESSMENT

20

LAB PRACTICUM UNIT - 1

Nursing 7: Hand Washing (Hand Hygiene)

1. Hand hygiene is the single most effective way to prevent healthcare-associated infections. It interrupts the chain of infection more reliably than any other routine nursing action.
2. Use the 5 Moments of Hand Hygiene.
 1. Before touching a patient.
 2. Before clean/aseptic procedures.
 3. After body fluid exposure/risk.
 4. After touching a patient.
 5. After touching patient surroundings.
3. Alcohol-based hand rub is preferred in most situations. Use it when hands are not visibly soiled. It is faster, more effective against most organisms, and better tolerated by skin than soap and water.

Soap and water is required when hands are visibly dirty or specific pathogens are present. Mandatory for C. difficile, norovirus, and after contact with spore-forming organisms or heavy soiling. Wash for at least 20 seconds with friction.
4. Correct technique matters more than the product. Cover all surfaces (palms, backs of hands, between fingers, thumbs, fingertips, wrists). Allow alcohol-based rub to dry completely before touching anything.

Gloves do not replace hand hygiene. Perform hand hygiene before putting on gloves and immediately after removing them. Contaminated gloves are a major source of cross-contamination.
5. Keep nails short, natural, and free of artificial enhancements. In most clinical settings, artificial nails and chipped polish harbor higher bacterial counts and increase infection risk, especially in high-risk units.

Bloodborne Pathogens

HANDWASHING



21

LAB PRACTICUM

UNIT - 1

HANDWASHING



22

LAB PRACTICUM

UNIT - 1

OPEN LAB

23

LAB PRACTICUM

UNIT - 2

VITAL SIGNS NEXT

UNIT 2 –VITAL SIGNS

24



25



26

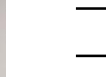


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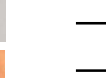
LAB PRACTICUM- DEVICE TO KNOW
UNIT - 1



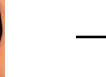








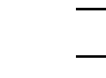
ASSESSMENT

28

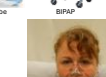
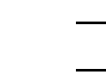
LAB PRACTICUM- DEVICE TO KNOW
UNIT - 1



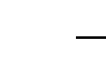








ASSESSMENT

29

From Numbers to Nursing Judgment
UNIT - 2



Vital Signs include
 Temperature, Pulse, Respirations
 Blood Pressure, Oxygen
 Saturation
 Documented - T P R BP-O2

VS

Digital?
 Manual?

How Often, ordered?

UNIT 2 - VITAL SIGNS

30

From Numbers to Nursing Judgment

UNIT - 2



Vital signs are clinical data
 • Data must be interpreted, not memorized
 • In lab, accuracy and thinking matter
 • This is how nurses prevent deterioration

UNIT 2 - VITAL SIGNS

31

From Numbers to Nursing Judgment

UNIT - 2



Nursing 7 On Vital Signs

1. Vitals are generally first in assessment
2. UAP/CNA/LPN can take vitals but don't assess
3. RN-Nurses take admission vitals
4. RN's are the only ones that Assess Vitals
5. First part of ASSESSMENT is VS
6. Take vitals on admission, before discharge, or whenever a patient leaves or comes back to the floor or any indicator of a baseline or acute situation.
7. Manual supersedes digital VS

Subjective = Patient, Family, Other States or Says

VITAL SIGNS are OBJECTIVE DATA

32

VITAL SIGNS

UNIT - 2



33

TEMPERATURE

UNIT - 2

THE BOOK



TEMPERATURE ASSESSMENT

34

From Numbers to Nursing Judgment

UNIT - 2

Nursing 7 on Temperature

1. Normal ranges differ by route

- Rectal: higher than oral
- Axillary: lower than oral
- Tympanic/Temporal: closest to core when done correctly

2. Fever threshold >100.4°F (38°C) Treat the patient, not the number—assess for clinical instability, source, and risk factors.

3. Most accurate routes (in order) Rectal (cont.) > Temporal/Tympanic > Oral, Axillary

4. High Readings: recent exercise, hot environment, infection, inflammation, certain meds (e.g., anticholinergics) (Cool down!)

5. Lower Readings: cold environment, age extremes (elderly & neonates), hypothyroidism, sedation, shock/sepsis (Up)

6. Hyperthermia is just as critical as fever! Watch for altered mental status, arrhythmias, and coagulopathy.

7. High-risk populations that need closer monitoring Neonates, elderly, immunocompromised (NEUTROPENIC), post-operative, neurologically injured

Subjective = Patient, Family, Other States or Says

VITAL SIGNS are OBJECTIVE DATA

35

VITAL SIGNS TEMPERATURE METHODS

UNIT - 2

Route	Take, noninvasive, accurately if done correctly	Affected by eating, drinking, oxygen, mouth breathing	Stable status
Rectal	Most accurate core temperature	Invasive, contraindicated in rectal surgery, hemorrhoids, rectal bleeding	Shock, hypothermia, unconscious patients, infants, confused or combative patients
Axillary	Safe, noninvasive	Least accurate, reads lower	Emergency settings
Tympanic	Fast, reflects core temp	Technique sensitive, affected by earwax	Screening, pediatrics
Temporal	Noninvasive, quick	Less accurate with sweating	

Priority nursing actions

- Always Confirm abnormal reading with a second method
- Assess for source (infection, environment, endocrine, neurologic)
- Support airway, breathing, circulation first
- Implement cooling or warming measures based on cause and patient stability
- Recheck frequently and always trend

TEMPORAL/FOREHEAD

TYMPANIC

ORAL

RECTAL

AXILLARY



Assessment = Objective Data

36

VITAL SIGNS

UNIT - 2

TEMPERATURE

ASSESSMENT VITALS

- Temperature reflects metabolic activity
- Core temperature is most accurate
- Route of measurement affects interpretation
 - Always assess in context

LAB 2 - 3

37

TEMPERATURE-Numbers to Know

UNIT - 2

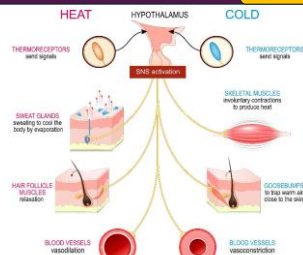
• Hypothermia – Less than 36

• Normal temperature 36-37.5

• Fever— 38-39

• Hyperthermia 39-40

• Hyperpyrexia-Greater than 40

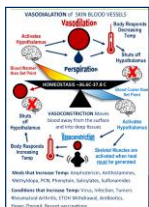


VITAL SIGNS- Terms to know

38

TEMPERATURE & ASSESSMENT INTERVENTIONS

UNIT - 2



- Increased temperature
 - Vasodilation
 - Sweating
 - Heat loss through skin



- Decreased temperature
 - Vasoconstriction
 - Shivering
 - Increased heat production



- Nursing role is to support or correct these responses

VITAL SIGNS- Main Concepts

39

TEMPERATURE & ASSESSMENT INTERVENTIONS
UNIT - 2

- High fever with confusion
- Severe shivering or blue or gray skin
- Temperature changes with tachycardia
- Temperature changes that do not respond to interventions

VITAL SIGNS TEMPERATURE - RED FLAGS

40

VITAL SIGNS
UNIT - 2

BLOOD PRESSURE

ASSESSMENT VITALS

41

VITAL SIGNS
UNIT - 2

42

VITAL SIGNS

UNIT - 2

BLOOD PRESSURE

Systolic = Squeeze (top number **S=Sky**)This is the pressure when the heart **contracts** and pushes blood out.**Diastolic = Dilate / Down** (bottom number **D=Dirty**)This is the pressure when the heart **relaxes** and fills with blood.

43

VITAL SIGNS

UNIT - 2

Nursing 7 on Blood Pressure

1. **Know the current classification ranges** Normal: <120/<80 mmHg Elevated: 120-129/<80 Stage 1 & 2 of Hypertension are often variable and changing.
2. **Cuff size and placement are critical for accuracy** Bladder should encircle 80% of the arm circumference. Too small = falsely high reading; too large = falsely low. Place cuff on bare upper arm with the artery marker over the brachial artery.
3. **Patient position and preparation matter** Patient should be seated, back supported, feet flat on the floor, arm supported at heart level, and resting for at least 5 minutes. Avoid measuring over clothing, immediately after exercise, caffeine, or smoking.
4. **Always confirm abnormal readings** Recheck in the opposite arm and/or after a few minutes of rest. Document both the reading and the conditions under which it was obtained (position, arm used, cuff size).
5. **Assess for orthostatic (postural) hypotension** when indicated Measure BP and heart rate supine, then after standing for 1 and 3 minutes. A drop of ≥20 mmHg systolic or ≥10 mmHg diastolic, or symptoms of dizziness, indicates orthostasis—common in elderly, dehydrated, or medicated patients.
6. **Interpret BP in clinical context** High BP may signal pain, anxiety, fluid overload, or true hypertension. Low BP may indicate hypovolemia, shock, medication effect, or cardiac dysfunction. Always correlate with heart rate, mental status, urine output, and overall perfusion.
7. **Intervention is usually required in**
Hypertensive Crisis: >180 and/or >120 (evaluate for end-organ damage)
Hypotension: Generally <90/60, but treat the patient, not the number.

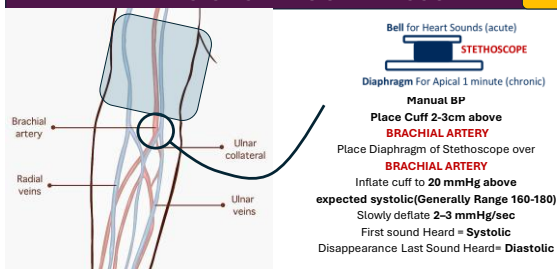


LAB 2 - 3

44

VITAL SIGNS – BLOOD PRESSURE

UNIT - 2



SKILL Steps

45

VITAL SIGNS BLOOD PRESSURE

UNIT - 2

Blood Pressure is the pressure of the blood in the circulatory system, often measured for diagnosis since it is closely related to the force and rate of the heartbeat and the diameter and elasticity of the arterial walls.

Blood Pressure Classification				SYSTOLIC DIASTOLIC
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	

Blood Pressure Terms & Numbers to Know

46

VITAL SIGNS – BLOOD PRESSURE

UNIT - 2



BLOOD PRESSURE

ASSESSMENT VITALS

- Baroreceptors detect changes in pressure
- Signals are sent to the brain vasomotor center
- The autonomic nervous system responds
 - Goal is restoration of homeostasis

PHYSIOLOGY

47

VITAL SIGNS – BLOOD PRESSURE

UNIT - 2



BLOOD PRESSURE

ASSESSMENT VITALS

- Low blood pressure reduces organ perfusion
- High blood pressure damages organs over time
 - Sudden changes are priorities
 - Always compare to baseline

PATHO-PHYSIOLOGY

48

VITAL SIGNS – BLOOD PRESSURE

UNIT - 2

MAP= How well the organs are perfusing

Normal MAP $\approx$ 70–100 mmHg

MAP < 65 mmHg → organs may not be getting enough perfusion

Mean Arterial Pressure (MAP)

$$\text{MAP} = \frac{\text{Diastolic} + \text{Diastolic} + \text{Systolic}}{3}$$

(3DDS)

PATHO-PHYSIOLOGY

49

BLOOD PRESSURE & ASSESSMENT INTERVENTIONS

UNIT - 2

VITAL SIGNS **BLOOD PRESSURE RED FLAGS**

50

LAB PRACTICUM

UNIT - 1

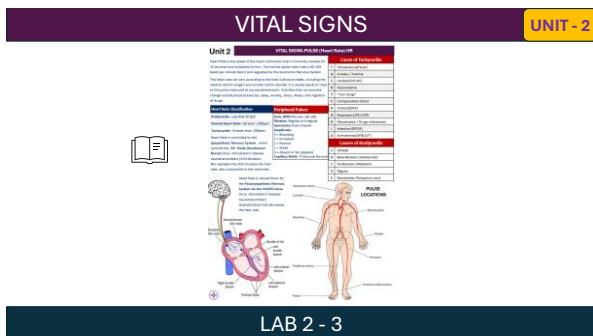
PRACTICE

15 Minutes to Complete

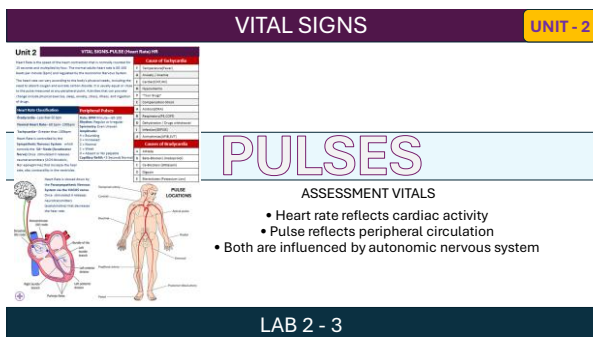
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52



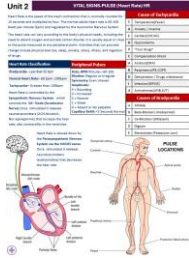
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54

VITAL SIGNS

UNIT - 2



Nursing 7 on Pulses

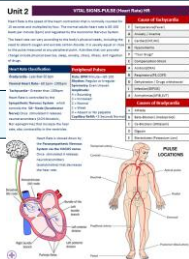
- 1. Know the major pulse sites and correct technique** Always use the pads of your fingers (never the thumb). The most clinically important sites are:
- 2. Assess rate accurately** Count for a full 15 seconds x 4 if the rhythm is irregular 1 minute.
- 3. Evaluate rhythm** Determine if the pulse is regular or irregular. Note patterns (regularly irregular vs irregularly irregular).
- 4. Grade strength/amplitude using the 0-4 scale**
0 = Absent 1+ = Weak/thready 2+ = Normal 3+ = Strong/increased 4+ = Bounding
- 5. Always compare bilaterally** Check corresponding pulses on both sides of the body for equality. Inequality can indicate vascular diseases, obstruction, or injury.
- 6. Understand and assess for pulse deficit** When the apical rate is higher than the radial rate, a pulse deficit exists (common with atrial fibrillation). This requires simultaneous apical-radial assessment.
- 7. Recognize and act on abnormal finding**

LAB 2 - 3

55

VITAL SIGNS

UNIT - 2



PULSES

ASSESSMENT VITALS

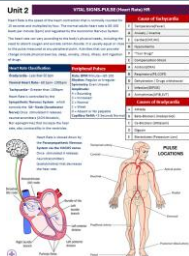
- Sympathetic nervous system increases heart rate
- Parasympathetic nervous system decreases heart rate
 - Balance maintains stability
 - Stress disrupts balance

LAB 2 - 3

56

HEART RATE CLASSIFICATION

UNIT - 2



- Bradycardia
– Less than 60 beats per minute



- Normal heart rate
– 60 to 100 beats per minute



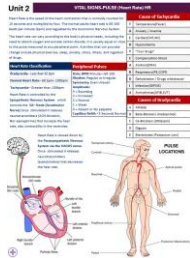
- Tachycardia
– Greater than 100 beats per minute

VITAL SIGNS

57

VITAL SIGNS – PERIPHERAL PULSE ASSESSMENT

UNIT - 2



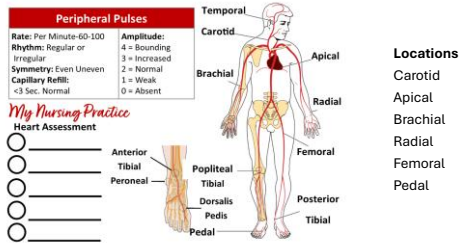
- Rate
- Rhythm
- Strength
- Symmetry
- Capillary refill less than three seconds is normal

Subjective – Objective Assessment Data

58

VITAL SIGNS – PULSE ASSESSMENT

UNIT - 2

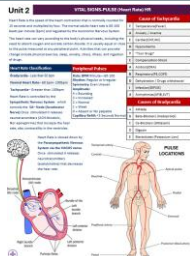


LAB 2 - 3

59

VITAL SIGNS – PERIPHERAL PULSE ASSESSMENT

UNIT - 2



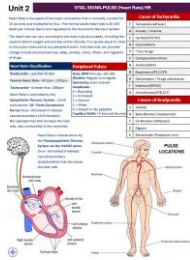
- Bounding pulse may occur with fever or anxiety
- Normal pulse indicates adequate perfusion
- Weak pulse suggests poor perfusion
- Absent pulse is an emergency

Critical thinking Application

60

VITAL SIGNS – TACHYCARDIA UNDERLYING CAUSES

UNIT - 2



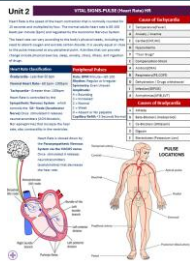
- Medications
- Oxygenation problems
- Stress or pain
- Trauma or hemorrhage
- Infection or sepsis
- Dehydration
- Thyroid dysfunction

Tachycardia Underlying Conditions

61

VITAL SIGNS – HEART RATE CLINICAL THINKING

UNIT - 2



- Tachycardia with fever suggests increased metabolic demand
- Bradycardia may be expected in athletes or with medications
- Tachycardia with hypotension suggests shock
- Heart rate trends matter more than one reading
- Never palpate both carotids at the same time

Critical Thinking Assessment Application

62

BLOOD PRESSURE & ASSESSMENT INTERVENTIONS

UNIT - 2



63

LAB PRACTICUM

UNIT - 1

PRACTICE

Radial Pulse
Pedal Pulse
Apical Pulse
Carotid Pulse
Blood Pressure

64

LAB PRACTICUM- DEVICE TO KNOW

UNIT - 1



ASSESSMENT

65

LAB PRACTICUM- DEVICE TO KNOW

UNIT - 1



ASSESSMENT

66

LAB PRACTICUM

UNIT - 2

OPEN LAB

Radial Pulse
Pedal Pulse
Apical Pulse
Carotid Pulse
Blood Pressure

67

VITAL SIGNS

UNIT - 2

RESPIRATIONS

Next Week

68

VITAL SIGNS

UNIT - 2

RESPIRATIONS

ASSESSMENT VITALS

69

LAB PRACTICUM

UNIT - 1

BOOT KAMP

15 Minutes to Complete

70

VITAL SIGNS-RESPIRATIONS

UNIT - 2

Unit 2 Vital Signs-Respirations (Lung Sounds & Pulse Oximetry)

Learning Objectives:

- Identify normal and abnormal lung sounds.
- Identify normal and abnormal pulse oximetry readings.
- Identify normal and abnormal respiratory rates.
- Identify normal and abnormal respiratory patterns.
- Identify normal and abnormal respiratory effort.
- Identify normal and abnormal chest expansion.
- Identify normal and abnormal chest symmetry.
- Identify normal and abnormal chest expansion.
- Identify normal and abnormal chest symmetry.

Respiratory Rate and Pattern:

Normal: 12-20 breaths per minute.

Abnormal: Tachypnea (>20), Bradypnea (<12), Apnea (0), Cheyne-Stokes, Biot's, Kussmaul's, or agonal breathing.

Respiratory Effort:

Normal: Quiet, effortless breathing.

Abnormal: Increased work of breathing (use of accessory muscles, nasal flaring, intercostal or supraclavicular retractions, pursed-lip breathing, or tripod positioning).

Respiratory Pattern:

Normal: Regular, rhythmic breathing.

Abnormal: Irregular, shallow, or deep breathing.

Respiratory Symmetry:

Normal: Symmetrical chest expansion.

Abnormal: Asymmetrical chest expansion.

Respiratory Expansion:

Normal: Full, symmetrical expansion.

Abnormal: Decreased or absent expansion.

Respiratory Sounds:

Normal: Clear, vesicular sounds.

Abnormal: Crackles, wheezes, rhales, stridor, or decreased breath sounds.

Nursing 7 on Respirations

- Assess without the patient knowing** Never tell the patient you are counting respirations. After taking the pulse, keep your fingers in place and count breaths for 30-60 seconds so the rate remains natural.
- Know normal rate ranges** Adult: 12-20 breaths per minute. Know age-specific norms and that both bradypnea (<12) and tachypnea (>20) require investigation.
- Evaluate rhythm and pattern** Determine if breathing is regular or irregular. Recognize abnormal patterns such as Cheyne-Stokes, Biot's, Kussmaul's, or agonal breathing.
- Assess depth** Note whether respirations are shallow, normal, or deep. Depth affects alveolar ventilation and gas exchange.
- Evaluate effort / work of breathing** Look for signs of increased work: use of accessory muscles, nasal flaring, intercostal or supraclavicular retractions, pursed-lip breathing, or tripod positioning.
- Observe chest symmetry and expansion** Chest movement should be equal bilaterally. Asymmetry may indicate pneumothorax, pneumonia, atelectasis, or trauma.
- Integrate findings and know when to escalate** Always combine rate, rhythm, depth, and effort with SpO₂, color, mental status, and lung sounds. Report and act on:

71

VITAL SIGNS- PULSE OXIMETRY

UNIT - 2

Unit 2 Vital Signs-Pulse Oximetry (Lung Sounds & Pulse Oximetry)

Learning Objectives:

- Identify normal and abnormal pulse oximetry readings.
- Identify normal and abnormal pulse oximetry waveforms.
- Identify normal and abnormal pulse oximetry sites.
- Identify normal and abnormal pulse oximetry factors.
- Identify normal and abnormal pulse oximetry correlates.
- Identify normal and abnormal pulse oximetry when to escalate.
- Identify normal and abnormal pulse oximetry recheck.
- Identify normal and abnormal pulse oximetry when to escalate.

Pulse Oximetry:

Normal: 95-100%.

Abnormal: <90%, >100%.

Pulse Oximetry Waveform:

Normal: Strong, consistent plethysmographic waveform.

Abnormal: No waveform or an irregular, weak waveform = unreliable number.

Pulse Oximetry Sites:

Normal: Right index and the sensor is aligned properly (emitter and detector opposite each other). Rotate sites regularly to prevent skin breakdown.

Abnormal: Poor perfusion (shock, cold extremities, hypotension), Motion artifact, Dark nail polish or artificial nails, Severe anemia, Carbon monoxide poisoning (reads falsely high), Bright ambient light or probe mismatch.

Pulse Oximetry Factors:

Normal: Normal SpO₂ for most adults: 95-100%. Know patient-specific targets (e.g., 88-92% for some COPD patients). Always interpret the number in clinical context.

Abnormal: Always assess waveform and signal quality. A strong, consistent plethysmographic waveform is required for a reliable reading. No waveform or an irregular, weak waveform = unreliable number.

Pulse Oximetry Correlates:

Normal: Look at the whole picture: respiratory rate, work of breathing, color, mental status, and lung sounds. Treat the patient, not the monitor.

Abnormal: Recheck with a different site or device if the reading seems inconsistent with the patient. Escalate for:

Nursing 7 on Pulse Oximetry

- Know what pulse oximetry actually measures** It estimates oxygen saturation of hemoglobin (SpO₂). It does not measure ventilation (CO₂), acid-base balance, or total oxygen content. A normal SpO₂ does not guarantee adequate breathing.
- Use the correct site and probe** Choose a site with good perfusion (finger, earlobe, forehead, or heel). Ensure the probe is the right size and the sensor is aligned properly (emitter and detector opposite each other). Rotate sites regularly to prevent skin breakdown.
- Recognize factors that cause false readings** Common causes of inaccurate SpO₂:
 - Poor perfusion (shock, cold extremities, hypotension)
 - Motion artifact
 - Dark nail polish or artificial nails
 - Severe anemia
 - Carbon monoxide poisoning (reads falsely high)
 - Bright ambient light or probe mismatch
- Know normal and target values** Normal SpO₂ for most adults: 95-100%. Know patient-specific targets (e.g., 88-92% for some COPD patients). Always interpret the number in clinical context.
- Always assess waveform and signal quality** A strong, consistent plethysmographic waveform is required for a reliable reading. No waveform or an irregular, weak waveform = unreliable number.
- Correlate with the patient, not just the number** Look at the whole picture: respiratory rate, work of breathing, color, mental status, and lung sounds. Treat the patient, not the monitor.
- Know when to escalate and recheck** Recheck with a different site or device if the reading seems inconsistent with the patient. Escalate for:

72

RESPIRATIONS & ASSESSMENT INTERVENTIONS

UNIT - 2

Pulse Oximetry SpO2 goes together with respirations
 Respiration greater than 24 requires further assessment or interventions
 Respirations less than 12 requires assessment of SpO2
 Respirations greater than 30 is acute and requires intervention

VITAL SIGNS **RESPIRATIONS RED FLAGS**

73

LAB PRACTICUM

UNIT - 1

PRACTICE

Heart Rate Pulses,
 Blood Pressure
 Respirations
 SPO2

74

PPE- PERSONAL PROTECTIVE EQUIPMENT

UNIT - 2

PPE

PERSONAL PROTECTIVE EQUIPMENT

75

[illegible]

76

PPE- PERSONAL PROTECTIVE EQUIPMENT **UNIT - 2**

Unit 2 PPE & HANDWASHING

	Personal Protective Equipment (PPE)	Contact	Respirator	Alcohol
Clinical Situation	Apron	Gloves	Goggles	Hand Sanitizer
Respirator	Goggles	Gloves	Mask	Hand Sanitizer
Goggles	Gloves	Goggles	Mask	Hand Sanitizer
Mask	Gloves	Goggles	Mask	Hand Sanitizer
Gloves	Gloves	Goggles	Mask	Hand Sanitizer
Hand Sanitizer	Gloves	Goggles	Mask	Hand Sanitizer

Donning Order

1. Hand Sanitizer

2. Mask

3. Goggles

4. Apron

5. Gloves

Doffing Order

1. Gloves

2. Apron

3. Goggles

4. Mask

5. Hand Sanitizer

DONNING= GERM
Go Make Good Gloves"
G = Gown
Make = Mask
Good = Goggles / Face shield
Gloves = Gloves
(WASH FIRST)

DOFFING= GERM
G = Gloves
E = Eye Glass's (goggles)
R = Robe
M = Mask
(WASH LAST)

77

PPE- PERSONAL PROTECTIVE EQUIPMENT UNIT - 2

Unit 2 PPE & HANDWASHING

	Resistant	Contact	Barrier	Alkaline
Clinical Shout	Latex glove	Gloves	Gloves	Hy. Mask, Goggles, Apron, Long-sleeved gown
Household	Latex glove	Gloves	Gloves	Hy. Mask, Goggles, Apron, Long-sleeved gown
Gloves	Latex glove	Gloves	Gloves	Hy. Mask, Goggles, Apron, Long-sleeved gown
Mask	Latex glove	Gloves	Gloves	Hy. Mask, Goggles, Apron, Long-sleeved gown
Gown	Latex glove	Gloves	Gloves	Hy. Mask, Goggles, Apron, Long-sleeved gown

Donning Order
Wash Hands

Doffing Order
Wash Hands

① Any unknown risk wear Goggles, Mask, Gown

② Latex glove

③ Latex glove

④ Latex glove

⑤ Latex glove

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78

PPE- PERSONAL PROTECTIVE EQUIPMENT

UNIT - 2

Unit 2 PPE & HANDWASHING

Category	Standard	Control	Barrier
Clothing	Full-body protective suit	Gown	Full-body protective suit
Head	Cap	Cap	Cap
Face	Mask	Mask	Mask
Gloves	Gloves	Gloves	Gloves
Shoes	Shoes	Shoes	Shoes

Donning Order
1. Mask
2. Goggles
3. Cap
4. Gown
5. Gloves

Doffing Order
1. Gloves
2. Gown
3. Cap
4. Goggles
5. Mask

Any unknown risk wear Goggles, Mask, Gown

Handwashing
Wash hands for 20 seconds with soap and water.

MTV AIRBORNE
Measles
TB
Varicella
CRIMP DROPLET
Covid-19
Rubeola
Influenza
Mumps
Pertussis

MRS VRE WEE -CONTACT
MRSA
RSV
VRE
Scabies
Enteric (C-Diff)
Eye infections Pink Eye

79

LAB PRACTICUM

UNIT - 1

PRACTICE -PPE

Rest of class

80

ASSESSMENT OF THE CARDIOVASCULAR SYSTEM

UNIT - 3

CARDIOVASCULAR

81

LAB PRACTICUM

UNIT - 1

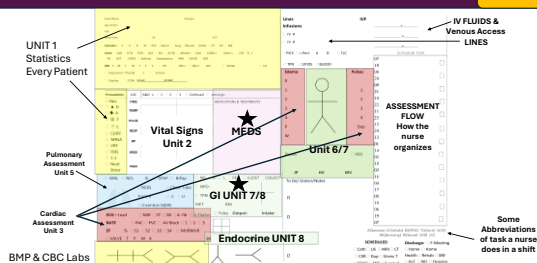
BOOT KAMP

15 Minutes to Complete

82

LAB BRAINSHEET UNITS

UNIT - 4

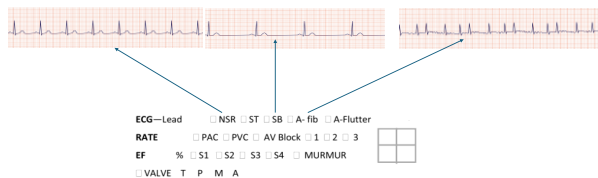


A Nurse Will know Everything on This Brainsheet

83

LAB PRACTICUM- BRAINSHEET

UNIT - 3



ASSESSMENT

84

LAB PRACTICUM

UNIT - 3



ASSESSMENT

85

LAB PRACTICUM- BRAINSHEET

UNIT - 3

ECG—Lead ☐ NSR ☐ ST ☐ SB ☐ A- fib ☐ A-Flutter ☐ Foley ☐

RATE ☐ PAC ☐ PVC ☐ AV Block ☐ 1 ☐ 2 ☐ 3

EF % ☐ S1 ☐ S2 ☐ S3 ☐ S4 ☐ MURMUR

☐ VALVE T P M A



BS BS

ASSESSMENT

86

LAB PRACTICUM- TERMS TO KNOW

UNIT - 3

TERMS FOR UNIT 1,2, 3-5							
Albume	Na	Contact	Temporal	LDL	INFLUENZA	Glucose	ACS
Hgb	Hyperoxia	Measles	Dorling	S4	S3	Hyperoxia	Cane
C-Diff	Cl	K	Tachycardia	Orthopedic	Clubbing	Systolic	Lithotomy
HTN	TB	Pit	Fever	Troponin	High Fowler's	Standard	Popliteal
Desaturation	CAD	BUN	HCT	HYPERTRYPHY	Flattened Diaphragm	Belt	Cardiomyopathy
Wheezes	Purpura	S1	Apical	Trendelenburg	3-Point	Rhombic	HEMOPTYSIS
Bronchial	Diastolic	Diaphragm	Brachial	Yankauer	NIB	Tachycard	WBC
Diming	Stridor	Mumps	Apneustic	Tach	Emphysema	Mitral	Edema
Tachypnea	Tricuspid	VRE	S1	HDL	Prone	Patel	Troponin
Crackles	S2	BUN	Dyspnea	2-Point	CHF	95-100%	Rubella
Bradypnea	Hypoglycemia	Cheyne Stokes	Auscultation	INCENTIVE SPIROMETER	Post Tibial	Cap-Refill	Triglycerides
Radial	Bradycardia	SOB	CO2	MI	Chest Tube	Pulmonic	Ischemic
Femoral	Supine	Aortic	Varicella	BVM	Orthopnea	Rales	Vesicular
5 th ICS MCL	Cr	Hypotension					

ASSESSMENT

87

LAB PRACTICUM- LABS BMP-CBC

UNIT - 3

NURSINGKAMP BMP Basic Metabolic Panel Check? Quantity? Level 1

What does the BMP test? BMP is a group of blood tests that measure various electrolytes, kidney function, and blood sugar. These tests are used to help identify and monitor various conditions, such as dehydration, electrolyte imbalances, kidney disease, and diabetes.

High to Low?

- Na - Sodium:** High to Low (Normal range: 136-145 mEq/L)
- Cl - Chloride:** High to Low (Normal range: 98-106 mEq/L)
- BUN - Blood Urea Nitrogen:** High to Low (Normal range: 7-22 mg/dL)
- Cr - Creatinine:** High to Low (Normal range: 0.7-1.4 mg/dL)
- Glucose:** High to Low (Normal range: 70-100 mg/dL)
- K - Potassium:** High to Low (Normal range: 3.5-5.0 mEq/L)
- CO2 - Carbon Dioxide:** High to Low (Normal range: 22-29 mEq/L)

NURSINGKAMP CBC Complete Blood Count? Level 1

What does the CBC test? CBC is a group of blood tests that measure the number of red blood cells, white blood cells, and platelets in the blood. These tests are used to help identify and monitor various conditions, such as anemia, infection, and blood disorders.

High to Low?

- WBC - White Blood Cells:** High to Low (Normal range: 4,000-11,000 cells/mm³)
- Hgb - Hemoglobin:** High to Low (Normal range: 12-16 g/dL)
- Hct - Hematocrit:** High to Low (Normal range: 37-47%)
- Platlets - Platelets:** High to Low (Normal range: 150,000-400,000 cells/mm³)

NEED TO KNOW LOCATIONS AND VALUES

Na	Cl	BUN	Glu	Hgb	
K	CO2	Cr	WBC	Hct	Ptt

ASSESSMENT

88

CARDIOVASCULAR ASSESSMENT

UNIT - 3

Unit 3 STARTING THE PRIMARY ASSESSMENT

What is the primary assessment? The primary assessment is the first step in the assessment process. It is a rapid, systematic assessment of the patient's airway, breathing, and circulation (ABCs). The primary assessment is used to identify and address any life-threatening conditions.

What is the secondary assessment? The secondary assessment is a more detailed assessment of the patient's condition. It is used to identify and address any non-life-threatening conditions.

What is the tertiary assessment? The tertiary assessment is a final assessment of the patient's condition. It is used to identify and address any remaining issues.

Walking into the room

What are the first things you should do when walking into the room? The first things you should do are to ensure the patient's safety, introduce yourself, and establish rapport.

Placing the BP cuff

How do you place the BP cuff? The BP cuff should be placed on the upper arm, over the brachial artery.

Unit 3 PRIMARY ASSESSMENT OF CARDIAC

What is the primary assessment of the cardiac system? The primary assessment of the cardiac system is a rapid, systematic assessment of the patient's heart and blood vessels. It is used to identify and address any life-threatening conditions.

What is the secondary assessment of the cardiac system? The secondary assessment of the cardiac system is a more detailed assessment of the patient's heart and blood vessels. It is used to identify and address any non-life-threatening conditions.

What is the tertiary assessment of the cardiac system? The tertiary assessment of the cardiac system is a final assessment of the patient's heart and blood vessels. It is used to identify and address any remaining issues.

PRIMARY VS SECONDARY ASSESSMENT

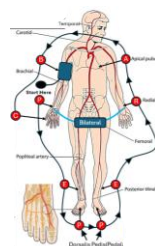
89

CARDIOVASCULAR ASSESSMENT- PEPPERABC

UNIT - 3

CARDIAC ASSESSMENT-PEPPERABC

P	P-Palpates PULSE for 15 seconds x 4 – Verbalizing assessing for RAINBOW (Regular, Absent, Irregular, Normal, Bounding, 0 not palpable, Weak)
E	E-Palpates EDEMA – Verbalizes PUB DREW (Present Unilateral Bilateral Dry Rebounds Erythema Warm)
P	P-Palpates PEDAL pulses for PAD (Present, Absent states if absent would get a Doppler)
P	P-Palpates PEDAL pulses for PAD (Present, Absent states if absent would get a Doppler)
E	E-Palpates EDEMA – Verbalizes PUB READ (Present Unilateral Bilateral & Rebounds Erythema Absent Diaphoretic)
R	R-Palpates RADIAL PULSE opposite side for 5 seconds with other radial at same time for RUB (Regular, Unilateral, Bilateral)
A	A-Auscultates – APICAL impulse (in 5th intercostal space, midclavicular line) for 1 minute (Notes Listening for S1 – Tricuspid and Mitral Valves closing, S2 Pulmonic and Aortic Valves Closing – Murmurs)
B	B-Assesses BLOOD PRESSURE (Converts mean arterial pressure-3-DDS Diastolic + Systolic / 3)
C	C-Palpates CAPILLARY REFILL < 3 seconds



PRIMARY VS SECONDARY ASSESSMENT

90

CARDIOVASCULAR ASSESSMENT- PEPPERABC

UNIT - 3

PRIMARY VS SECONDARY ASSESSMENT

91

CARDIOVASCULAR ASSESSMENT- SBAR

UNIT - 3

SBAR ASSIGNMENT – CASE STUDIES

92

CARDIOVASCULAR ASSESSMENT

UNIT - 1

CAD – CASE STUDY

93

CARDIOVASCULAR ASSESSMENT

UNIT - 1

Unit 101 – Room 100 – Bed A

Patient Name: Joseph T. Age / Gender: 67-year-old male

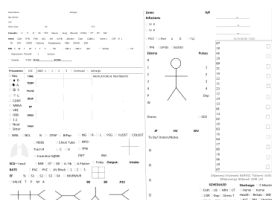
Admit Date: 07/27/2026 Primary Diagnosis: Coronary Artery Disease (CAD) – rule-out unstable angina / NSTEMI Code Status: Full Code Tobacco: Former smoker (quit 2019, 40-pack-year history) Allergies: Denies Special

Variable: Hard of hearing (bilateral hearing aids in place; speak facing patient, raise volume slightly, confirm understanding) Mobility: Ambulates with front-wheeled walker, assist of 1 for safety and balance. Independent with ADLs once at bedside, SCD's while in bed. Diet:

Cardiac diet – 2 g sodium, low cholesterol, heart-healthy

Precautions: Standard IV Access: 20-gauge peripheral

IV, left forearm, saline locked, site clean/dry/intact



CAD – CASE STUDY

94

CARDIOVASCULAR ASSESSMENT

UNIT - 1

Labs

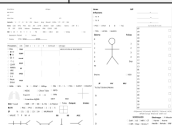
Admission Labs (07/27)

- Troponin I: 0.08 ng/mL
- BNP: 285 pg/mL
- WBC: 8.4
- Hgb: 13.1 Hct: 39.2
- Platelets: 228
- Na: 138 -Cl: 97
- K: 3.9 -CO₂: 24
- BUN: 22
- Creatinine: 1.1
- Glucose: 118
- PT/INR: 12.1 / 1.0
- Total Cholesterol: 214

Current Labs (07/29 AM)

Troponin I: 0.04 ng/mL (trending down)
BNP: 210 pg/mL
K: 3.6
Creatinine: 1.2
Digoxin level: pending (drawn this morning)

Vitals	Admission (07/27 14:20)	Current (07/29 08:00)
BP	158/92	142/84
HR	92	78
RR	20	18
T	98.6°F (37.0°C)	98.4°F (36.9°C)
SpO ₂	95% on RA	97% on RA
Pain	4/10 (substernal pressure)	1/10



CAD – CASE STUDY

95

CARDIOVASCULAR ASSESSMENT

UNIT - 3

Medications	Atorvastatin 40 mg PO at bedtime
Aspirin 81 mg PO daily	Lisinopril 10 mg PO daily
Metoprolol tartrate 25 mg PO BID	Digoxin 0.125 mg PO daily

MED CARDS DUE NEXT WEEK

CAD – CASE STUDY

96

CARDIOVASCULAR ASSESSMENT

UNIT - 3

Admission Head-to-Toe Assessment (07/27)

General: Alert, oriented x4. Appears anxious. Hard of hearing – responds appropriately when facing him and speaking clearly. Hearing aids in place and functional.

Neurological: Pupils equal, round, reactive to light. Strength 5/5 all extremities. No focal deficits. Steady gait with walker.

Cardiovascular: Heart rate regular, S1S2, no murmurs, rubs, or gallops noted on admission. Capillary refill < 3 seconds. Mild +1 bilateral ankle edema. No JVD.

Respiratory: Breath sounds clear bilaterally. Mild increased work of breathing with activity. SpO₂ 95% on room air. No cough or sputum.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present x4. Last BM yesterday. Tolerating cardiac diet.

Genitourinary: Voids independently. Clear yellow urine. No dysuria or frequency reported.

Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site left forearm clean, dry, intact, no redness or swelling.

Musculoskeletal: Ambulates with front-wheeled walker, steady with assist of 1. Full ROM all extremities. No jointswelling or tenderness.

Psychosocial: Cooperative, anxious about possible heart attack. Wife at bedside. States he "just wants to get home and back to normal."

CAD – CASE STUDY

97

CARDIOVASCULAR ASSESSMENT

UNIT - 1

Unit 101 – Room 100 – Bed B

Patient Name: Ruth K. **Age / Gender:** 72-year-old female

Admit Date: 07/28/2026 **Primary Diagnosis:** Hypertension – uncontrolled

Code Status: Full Code **Tobacco:** Never smoker

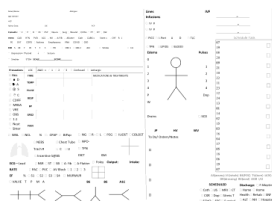
Alcohol: Occasional glass of wine (1–2 per week) **Special**

Variable: Hard of hearing (uses one hearing aid in right ear; faces speaker, speaks clearly)

Mobility: Independent with cane for longer distances; steady gait, no assist needed for short distances

Diet: Low-sodium (2 g) cardiac diet

Precautions: VRE **IV Access:** 22-gauge peripheral IV, right forearm, saline locked, site clean/dry/intact



HTN – CASE STUDY

98

CARDIOVASCULAR ASSESSMENT

UNIT - 1

Labs

Admission Labs (07/28)

- Na: 141
- K: 3.8
- BUN: 19
- Cr: 98 Co2: 27
- Creatinine: 0.9
- Glucose: 102
- WBC: 7.1
- Hgb: 12.8
- Hct: 38.4
- Platelets: 245

Current Labs (07/29 AM)	VITALS	Admission (07/28 11:40)	Current (07/29 07:45)
K: 3.7 Creatinine: 0.9 Na: 140	BP	178/98	152/86
	HR	88	76
	RR	18	16
	Temp	98.2 °F (36.8 °C)	98.1 °F (36.7 °C)
	SpO ₂	98% on RA	98% on RA
	Pain	0/10	0/10

HTN – CASE STUDY

99

CARDIOVASCULAR ASSESSMENT

UNIT - 1

Medications

Amlodipine 10 mg PO daily
 Losartan 50 mg PO daily
 Hydrochlorothiazide 25 mg PO daily
 Metoprolol succinate 50 mg PO daily

MED CARDS DUE NEXT WEEK

HTN – CASE STUDY

100

CARDIOVASCULAR ASSESSMENT

UNIT - 1

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented x4. Cooperative. Hard of hearing – responds well when facing her and speaking at moderate volume. Hearing aid in place.

Neurological: Pupils equal, round, reactive. Strength 5/5 all extremities. No focal deficits. Steady gait with cane.

Cardiovascular: Heart rate regular, S1S2, no murmurs or extra sounds. Capillary refill < 3 seconds. No edema. No JVD.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO₂ 98% on room air.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present x4. Last BM this morning.

Genitourinary: Voids independently. Clear yellow urine. No complaints.

Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site right forearm clean, dry, intact.

Musculoskeletal: Full ROM. Uses cane for longer walks. Independent with ADLs.

Psychosocial: Calm. States she "didn't realize her pressure was that high." Daughter at bedside

HTN – CASE STUDY

101

CARDIOVASCULAR ASSESSMENT

UNIT - 3

NURSING **CONGESTIVE HEART FAILURE – Right vs Left CHF & Cardiomyopathies**
 Congestive Heart Failure (CHF) is a serious, and preventable, condition that the heart cannot pump the blood forward or the blood gets backed up in that area. This can be caused by long term valve issues and myocardial infarction. Heart Failure includes - Right vs Left Sided & Cardiomyopathies with a primary goal of preventing exacerbations. Capable to handle low flow O2 is necessary.

Right Sided Heart Failure	EXACERBATION SIGNS	Left Sided Heart Failure
This side is more chronic since the Right Ventricle cannot pump blood through the pulmonary artery causing it to back up into the body causing increase fluid in the body or "edema". Think "SWELL" HEED (H2 H2ET) meaning H2T (Congestive symptoms)	1. Hypertension 2. Dysrhythmias (Tachycardia) 3. Anemia 4. Renal Issues (Azotemia) 5. Thyroid Issues (Hyperthyroidism) 6. Alcohol Intake 7. Lung Issues (Pneumonia) 8. Medications	This side is more acute since the Left Ventricle cannot pump blood through the aorta or it backs up into the lungs causing increase fluid in the lungs or "crackles". Think "LEFT LUNG" (CHF & LEFT) THE DEADLY DUTY (Meaning SOB and Crackles, COPD, Cough, Hemoptysis, Orthopnea, Paroxysmal nocturnal dyspnea & fatigue and risk of organ perfusion failure) HEED (H2 H2ET) (CHF & LEFT)
Other Causes of RHF Heart Failure Dilated Cardiomyopathy (enlarged heart) Hypertrophic Cardiomyopathy (thickened heart) Restrictive Cardiomyopathy (stiff heart) Conduction System Disease (arrhythmias)	HEED (H2 H2ET) (CHF & LEFT) THE DEADLY DUTY (Meaning SOB and Crackles, COPD, Cough, Hemoptysis, Orthopnea, Paroxysmal nocturnal dyspnea & fatigue and risk of organ perfusion failure) HEED (H2 H2ET) (CHF & LEFT)	HEED (H2 H2ET) (CHF & LEFT) THE DEADLY DUTY (Meaning SOB and Crackles, COPD, Cough, Hemoptysis, Orthopnea, Paroxysmal nocturnal dyspnea & fatigue and risk of organ perfusion failure) HEED (H2 H2ET) (CHF & LEFT)

Diagnosis: BNP - Chest x-ray, ECG, Echocardiogram
Management: Diuretics, ACE inhibitors, Beta-blockers, Aldosterone antagonists, SGLT2 inhibitors, Mineralocorticoid receptor antagonists, Digoxin, IV inotropes, Mechanical circulatory support, Transcatheter aortic valve replacement, Coronary artery bypass grafting, Heart transplantation

CHF – CASE STUDY

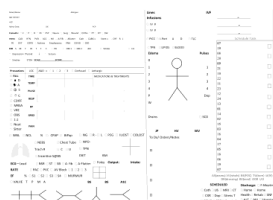
102

CARDIOVASCULAR ASSESSMENT

UNIT - 3

Unit 101 – Room 102 – Bed A

Patient Name: Samuel M. **Age / Gender:** 74-year-old male **Admit Date:** 07/22/2026 **Primary Diagnosis:** Congestive Heart Failure (CHF) exacerbation **Code Status:** Full Code **Tobacco:** Former smoker (quit 12 years ago) **Alcohol:** Denies **Special Variable:** Right below-knee amputation (BKA) – prosthetic available but not currently in use **Mobility:** Wheelchair for distances; transfers with assist of 1–2; stands at edge of bed with assist **Diet:** NPO for TEE Echo in AM **Precautions:** MRSA - **IV Access:** 20-gauge peripheral IV, left forearm, saline locked, site clean/dry/intact



CHF – CASE STUDY

103

CARDIOVASCULAR ASSESSMENT

UNIT - 3

Lab

Admission Labs (07/28)

- BNP: 1,240 pg/mL
- Na: 136
- K: 3.5
- Cr: 102 CO2: 26
- BUN: 29
- Creatinine: 1.3
- Glucose: 126
- WBC: 8.9
- Hgb: 12.4
- Hct: 37.1
- Platelets: 210

Current Labs (07/29 AM)

- BNP: 890 pg/mL
- K: 3.7
- Creatinine: 1.3
- Na: 137

VITALS	Admission (07/28 16:15)	Current (07/29 08:30)
BP	162/94	138/78
HR	98	82
RR	24	18
Temp	98.5 °F (36.9 °C)	98.3 °F (36.8 °C)
SpO2	93% on RA → 96% on 2 L NC	96% on 2 L NC
Pain	2/10 (generalized fatigue)	1/10

CHF – CASE STUDY

104

CARDIOVASCULAR ASSESSMENT

UNIT - 3

Medications

Furosemide 40 mg PO BID
 Lisinopril 10 mg PO daily
 Carvedilol 6.25 mg PO BID
 Spironolactone 25 mg PO daily

MED CARDS DUE NEXT WEEK

CHF – CASE STUDY

105

CARDIOVASCULAR ASSESSMENT

UNIT - 3

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented x4. Mild respiratory distress at rest. Appears fatigued.

Neurological: Pupils equal, round, reactive. Strength 5/5 left lower extremity and both upper extremities. Right BKA residual limb intact, well-healed.

Cardiovascular: Heart rate regular, S1S2 with soft S3. +2 pitting edema bilateral lower extremities (left leg and right residual limb). Capillary refill 3 seconds. Mild JVD noted.

Respiratory: Bilateral crackles. Mild increased work of breathing. SpO₂ 93% on room air, improved to 96% on 2 L nasal cannula.

Gastrointestinal: Abdomen soft, slightly distended, non-tender. Bowel sounds present x4. Last BM yesterday.

Genitourinary: Voids independently. Clear yellow urine. Intake and output being strictly monitored due to fluid restriction.

Integumentary: Skin warm, intact. Sacrum and residual limb skin intact without breakdown. Peripheral IV site left forearm clean, dry, intact.

Musculoskeletal: Transfers with assist of 1-2. Uses wheelchair. Right residual limb soft, no signs of infection or pressure.

Psychosocial: Cooperative but frustrated with limited mobility. Wife at bedside. States he "just wants to get the fluid off so I can breathe better."

CHF – CASE STUDY

106

MUSCLESKELETAL SYSTEM & MOBILITY

UNIT - 4



107

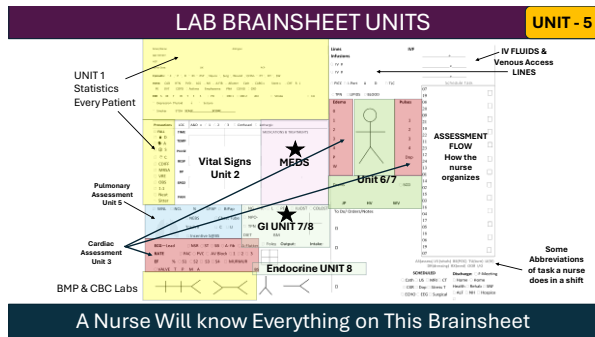
LAB PRACTICUM

UNIT - 1

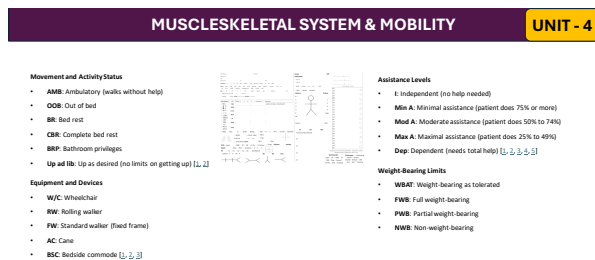
BOOT KAMP

20 Minutes to Complete

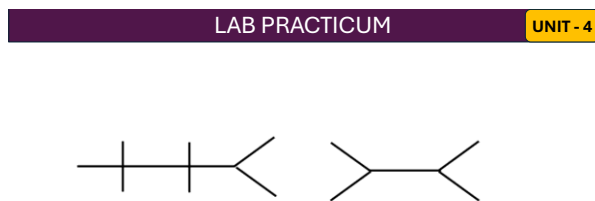
108



109



110



ASSESSMENT

111

LAB PRACTICUM- TERMS TO KNOW

UNIT -

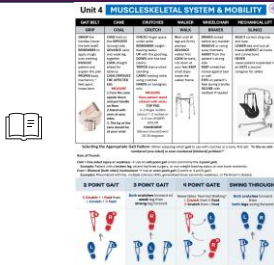
TERMS FOR UNIT 1,2, 3-5							
Airborne	Na	Contact	Temporal	LDL	INFLUENZA	Glucose	ACS
Hgb	Hyperoxia	Measles	Dorfing	S4	S3	Hyperoxia	Cere
C-Off	Cl	K	Tachycardia	Orthostatic	Clubbing	Systolic	Lithotomy
HTN	T8	Pit	Fever	Tropoin	High Forfens	Standard	Popliteal
Desaturation	CAD	BUN	HCT	HYPERTRYPHY	Flattened Diaphragm	BeII	Cardiomyopathy
Wheezes	Pertussis	S1	Apical	Trendelenburg	3-Point	Rhynch	HEMOPTYSIS
Brachial	Diastolic	Diaphragm	Brachial	Yankaur	NIB	Tracheal	WBC
Donning	Strider	Mumps	Apneustic	Trach	Emphysema	Mitral	Edema
Tachypnea	Tricuspid	VRE	S1	HDL	Prona	Pedal	Tropoin
Crackles	S2	BUN	Dyspnea	2-Point	CHF	95-100%	Rubeola
Bradypnea	Hypoglycemia	Cheyne Stokes	Auscultation	INCENTIVE SPIROMETER	Post Tibial	Cap-Refill	Triglycerides
Radial	Bradycardia	SOS	CO2	MI	Chest Tube	Pulmonic	Ischemic
Femoral	Supine	Aortic	Varicella	BVM	Orthopnea	Rates	Vascular
5 th ICS MCL	Cr	Hypotension					

ASSESSMENT

112

MUSCLESKELETAL SYSTEM & MOBILITY

UNIT - 4



113

MUSCLESKELETAL SYSTEM & MOBILITY

UNIT - 4



114

MUSCLESKELETAL SYSTEM & MOBILITY

UNIT - 4

- Medications**
- Prednisone 40 mg PO daily
 - Metformin 1000 mg PO twice daily
 - Baclofen 10 mg PO three times daily
 - Insulin lispro per sliding scale before meals

MED CARDS DUE NEXT WEEK

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented x4. Appears fatigued. Hard of hearing – responds appropriately when facing her and speaking clearly. Hearing aids in place.

Neurological: Pupils equal, round, reactive. Strength 4/5 bilateral lower extremities with mild spasticity. Upper extremities 5/5. Reports numbness and tingling in both feet. No acute focal deficits beyond baseline MS.

Cardiovascular: Heart rate regular, 55/2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO₂ 98% on room air.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present x4. Last BM yesterday.

Genitourinary: Voided independently. Clear yellow urine. Occasional urgency reported (baseline).

Integumentary: Skin warm, dry, intact. No pressure injuries. Feet inspected – no open areas or breakdown. Peripheral IV site left hand clean, dry, intact.

Musculoskeletal: Ambulates with bilateral crutches, steady but fatigues quickly. Mild bilateral lower extremity spasticity. Full ROM upper extremities.

Psychosocial: Cooperative and knowledgeable about MS and diabetes. Frustrated with current flare and increased weakness. Husband at bedside. States she "just needs the steroids to kick in so I can get back on my feet."

118

MUSCLESKELETAL SYSTEM & MOBILITY

UNIT - 4

Unit 101 - Room 108 - Bed A

Patient Name: Isaac P. **Age / Gender:** 78-year-old male **Admit Date:** 07/28/2024

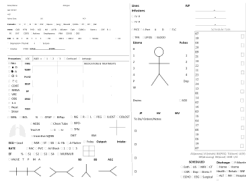
Primary Diagnosis: Parkinson's disease with GAD and dementia **Code Status:** Full Code **Tobacco:** Former smoker (quit 15 years ago)

Allergy: None **Special Needs:** Need of hearing aids, hearing aids bilaterally, face patient, speak clearly, reorient frequently due to dementia)

Mobility: Shuffling gait with front-wheeled walker, assist of 2-3 for safety, high fall risk due to cardiac diet, mechanical soft (aspiration risk secondary to Parkinson's).

Precautions: Standard

IV Access: 27-gauge peripheral IV, right forearm, saline locked, site clean/dry/intact



119

MUSCLESKELETAL SYSTEM & MOBILITY

UNIT - 4

Admission Labs (07/28)

- Na+ 138
 - K+ 4.1
 - BUN 22
 - Creatinine 1.2
 - Glucose 108
 - WBC 6.8
 - Hgb 12.0
 - Hct 37.0
 - Platelets 198
- Current Labs (07/29 AM)**
- K+ 4.0
 - Creatinine 1.1
 - Glucose 102

	07/28 17:40	07/29 08:20
SBP	148/82	136/76
HR	78	72
RR	16	16
Temp	98.1°F (36.7°C)	98.0°F (36.7°C)
SpO ₂	98% on RA	97% on RA
Pain	0/10	0/10

120

MUSCLESKELETAL SYSTEM & MOBILITY

UNIT - 4

- Medications**
- Carbidopa/Levodopa: 25/100 mg PO three times daily
 - Aspirin 81 mg PO daily
 - Acetaminophen 400 mg PO at bedtime
 - Doxapram 12 mg PO at bedtime

MED CARDS DUE NEXT WEEK

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented to person only. Appears pleasant but easily confused. Hard of hearing – responds better when facing him and speaking slowly. Hearing aids in place.
Neurological: Pupils equal, round, reactive. Resting tremor bilateral upper extremities (right > left). Mild cogwheel rigidity. Mask-like facial expression. Strength 4/5 all extremities. Follows simple one-step commands inconsistently.
Cardiovascular: Heart rate regular, 51/52, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.
Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO₂ 96% on room air. Occasional soft cough.
Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present x4. Last BM yesterday.
Genitourinary: Incontinent of urine at times; uses briefs and timed toileting. Clear yellow urine.
Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site right forearm clean, dry, intact.
Musculoskeletal: Shuffling gait with walker. Stooped posture. Requires assist of 1-2 for transfers and ambulation. High fall risk related to Parkinson's and dementia.
Psychosocial: Cooperative when approached calmly. Wife at bedside and provides history. Becomes anxious when routines change. Responds well to simple, repeated instructions.

121

PULMONARY ASSESSMENT

UNIT - 5



122

LAB PRACTICUM

UNIT - 5

BOOT KAMP

20 Minutes to Complete

123

LAB BRAINSHEET UNITS
UNIT - 5

UNIT 1 Statistics Every Patient

Pulmonary Assessment Unit 5

Cardiac Assessment Unit 3

BMP & CBC Labs

Vital Signs Unit 2

MEBS

GI UNIT 7/8

Endocrine UNIT 8

IV FLUIDS & Venous Access LINES

ASSESSMENT FLOW How the nurse organizes

Some Abbreviations of task a nurse does in a shift

A Nurse Will know Everything on This Brainsheet

124

PULMONARY ASSESSMENT
UNIT - 5

Vital Signs Unit 2

MEBS

GI UNIT 7/8

Endocrine UNIT 8

Pulmonary Assessment Unit 5

Cardiac Assessment Unit 3

BMP & CBC Labs

IV FLUIDS & Venous Access LINES

ASSESSMENT FLOW How the nurse organizes

Some Abbreviations of task a nurse does in a shift

125

PULMONARY ASSESSMENT
UNIT - 5

☐ WNL ☐ NCL % ☐ CPAP ☐ BiPap

☐ NEBS ☐ Chest Tube

Trach # ☐ C ☐ U

☐ Incentive S@BS

126

PULMONARY ASSESSMENT

UNIT - 5

SITUATION

You are a member of the **Marketing Department** of the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.

You are a member of the **Marketing Department** of the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.

ASSESSMENT

You are a member of the **Marketing Department** of the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.

You are a member of the **Marketing Department** of the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.
 The Marketing Department has been asked to develop a marketing plan for the **ABC Company**.

127

LAB PRACTICUM- TERMS TO KNOW

UNIT -

TERMS FOR UNIT 1-5 6-7								
Airborne	Na	Contract	Temporal	LOL	INFLUENZA	Glucose	ACS	
High	Hypertensia	Measles	Duffing	S4	C3	Hypertensia	Cane	
C-Diff	Cl	K	Tachycardia	Orthopedic	Clubbing	Systolic	Lithotom	
HTN	TB	Pit	Fever	Typhoid	High Flowlers	Standard	Popliteal	
Dehydration	CAD	BUN	HCT	HYPOPROTHY	Flattened diaphragm	Beil	Cardiomyopathy	
Wheezes	Peritussis	S1	Apical	Trendelenburg	3-Point	Rhombic	HEMOPTYSIS	
Bronchial	Diastolic	Diaphragm	Brachial	Yankauer	NRB	Tachaeal	WBC	
Draining	Shiver	Mumps	Apeuvae	Tach	Empyema	Mistal	Edema	
Wheezing	Triclosin	S1	Chlorine	Point	Post	Triclosin	Triclosin	
Cocles	S2	BUN	Dyspnea	3-Point	CHF	95-100%	Rubella	
Bradypnea	Hypoglycemia	Cheyne Stokes	Asuccation	INCENTIVE SPYROMETER	Post Tibial	Cat-Rettif	Triglycerides	
Radial	Bradycardia	SOB	CO2	MI	Chase Tube	Pulmonic	Ischemic	
Femoral	Supine	Aortic	Varicella	BVM	Orthopnea	Rates	Vascular	
90° ICB MCL	Cr	Hypertension	Clear Liquid	Bruit	POC	STOMA	Hyperglycemia	
PEG	RLQ	DIABETES 1	Bladder Scan	Kusmaul	Flutula	24 hour urine	Tarsal Colostomy	
Clean Catch	PBS	NJ	Ileostomy	Sigmoid colostomy	RUQ	Surgical gravity	UA	
Ketones	Barbituric	HgbA1c	Tube	Sterile	Nitrites	LUQ	Descending Colostomy	
Foley	CAUTI	GFR	GERD	Ascending colostomy	LQ	PH Stomach	NPO	

ASSESSMENT

128

LABS to Know Pulmonary

UNIT - 5

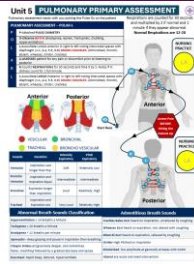


ASSESSMENT

129

PUMONARY ASSESSMENT

UNIT - 5

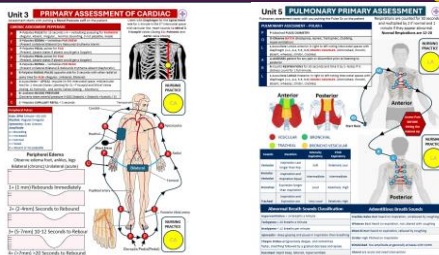


ASSESSMENT

130

PUMONARY ASSESSMENT

UNIT - 5



PUTTING THE ASSESSMENT TOGETHER

131

LAB PRACTICUM

UNIT - 5

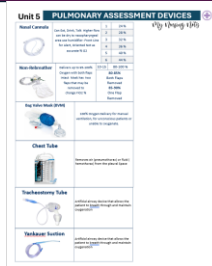
PRACTICE

30 Minutes to Cardiac & Pulmonary Complete

132

PULMONARY DEVICES TO KNOW

UNIT - 5



133

PULMONARY DEVICES TO KNOW

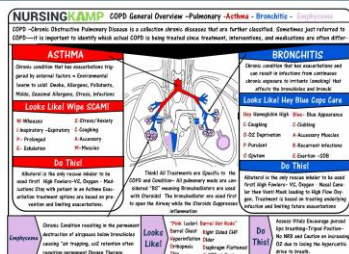
UNIT - 5



134

PULMONARY CONDITIONS TO KNOW

UNIT - 5



135

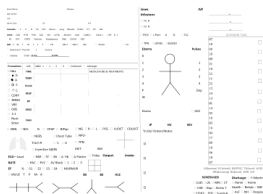
PULMONARY CONDITIONS TO KNOW

UNIT - 5

Unit 101 - Room 102 - Bed 8

Patient Name: Elgin S. Age / Gender: 69-year-old male Admit Date: 07/28/2026 **Primary Diagnosis:** COPD exacerbation - **Emergency Code Status:** Full Code **Tobacco:** Current (smoker 12 PYO - 40 years) - counseling initiated **Alcohol:** Denies **Special Variable:** Limited English proficiency (primary language Spanish) - use interpreter in language line for teaching and consent **Mobility:** Ambulates independently short distances with frequent rest, uses front-wheeled walker for longer distances **Diet:** High-calorie, high-protein, small frequent meals

Precautions: TB IV Access: 22 gauge peripheral IV, right hand, saline locked, site clean/dry/intact



136

PULMONARY CONDITIONS TO KNOW

UNIT - 5

Labs

Admission Labs (07/28)

- WBC: 11.2
 - Hgb: 15.8
 - Hct: 48.1
 - Platelets: 265
 - Na: 139
 - K: 4.1
 - Cl: 108 CO2: 20
 - BUN: 18
 - Creatinine: 0.9
 - Glucose: 122
- ABG (on 2 L):
pH 7.36 / PaCO₂ 52 / PaO₂ 64 / HCO₃ 28
- Current Labs (07/29 AM)**
- WBC: 9.8
 - K: 4.0
 - Creatinine: 0.9

	Admission (07/28 19:10)	Current (07/29 08:00)
BP	148/86	136/78
HR	102	88
RR	28	20
Temp	98.8°F (37.1°C)	98.4°F (36.9°C)
SpO ₂	88% on RA → 92% on 2 L NC	93% on 2 L NC
Pain	0/10	0/10

137

PULMONARY CONDITIONS TO KNOW

UNIT - 5

Medications

Albuterol 2.5 mg via nebulizer every 4 hours and PRN
Ipratropium 0.5 mg via nebulizer every 6 hours
Prednisone 40 mg PO daily
Azithromycin 250 mg PO daily

MED CARDS DUE NEXT WEEK

138

PULMONARY CONDITIONS TO KNOW

UNIT - 5

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented x4. Appears dyspneic at rest. Using pursed-lip breathing. Spanish-speaking; interpreter used for full assessment.

Neurological: Pupils equal, round, reactive. Strength 5/5 all extremities. No focal deficits.

Cardiovascular: Heart rate regular, S1S2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.

Respiratory: Barrel chest. Diminished breath sounds bilaterally with prolonged expiratory phase. Occasional mild expiratory wheezes. Increased work of breathing. SpO₂ 88% on room air, improved to 92% on 2 L nasal cannula.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present $\times 4$. Reports decreased appetite.

Genitourinary: Voids independently. Clear yellow urine.

Integumentary: Skin warm, dry, intact. No pressure injuries. Peripheral IV site right hand clean, dry, intact. Clubbing of fingers noted.

Musculoskeletal: Ambulates short distances independently, requires rest periods. Uses walker for hallway. Full ROM.

Psychosocial: Anxious about breathing. Cooperative once interpreter present. Daughter at bedside translating initially. States he "wants to get the breathing under control so I can go home."

139

INTEGUMENTARY ASSESSMENT

UNIT - 6

INTEGUMENTARY

140

LAB PRACTICUM- TERMS TO KNOW

UNIT - 3

[illegible]

ASSESSMENT

141

LAB PRACTICUM

UNIT - 6

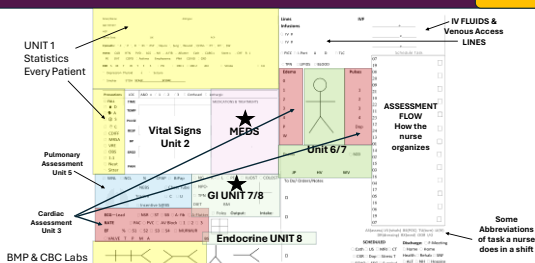
BOOT KAMP

25 Minutes to Complete

142

LAB BRAINSHEET UNITS

UNIT - 6

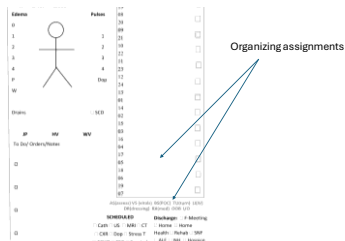


A Nurse Will know Everything on This Brainsheet

143

PULMONARY ASSESSMENT

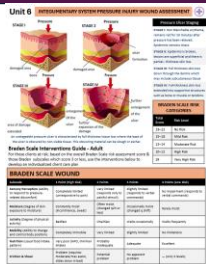
UNIT - 6



144

INTEGUMENTARY ASSESSMENT

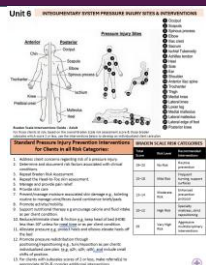
UNIT - 6



145

INTEGUMENTARY ASSESSMENT

UNIT - 6



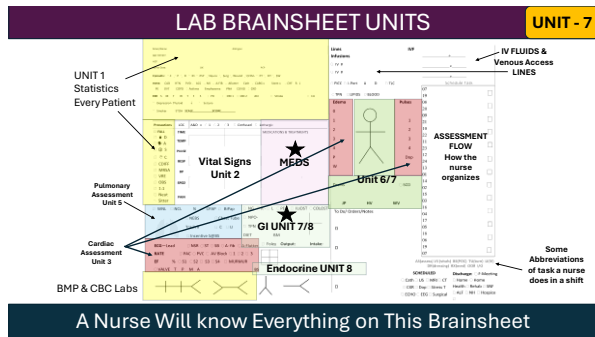
146

ABDOMINAL ASSESSMENT

UNIT - 7



147



148

ABDOMINAL ASSESSMENT **UNIT - 7**

☐ NG ☐ R- ☐ L ☐ PEG ☐ ILIOST ☐ COLOST ☐ NPO- ☐ TPN DIET BM ☐ A-Flutter ☐ Foley Output: Intake:	Drains ☐ SCD JP HV WV To Do/ Orders/Notes	1- 0- 1- 0- 1- 0- 1- 0-
--	--	--

149

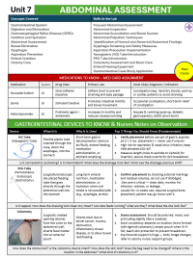
ABDOMINAL ASSESSMENT **UNIT - 7**

☐ NG ☐ R- ☐ L ☐ PEG ☐ ILIOST ☐ COLOST ☐ NPO- ☐ TPN DIET BM ☐ A-Flutter ☐ Foley Output: Intake:	Drains ☐ SCD JP HV WV To Do/ Orders/Notes	1- 0- 1- 0- 1- 0- 1- 0-
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150

ABDOMINAL ASSESSMENT

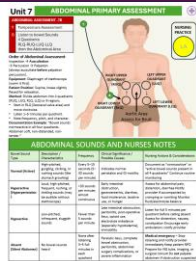
UNIT - 7



151

ABDOMINAL ASSESSMENT

UNIT - 7



152

LAB PRACTICUM

UNIT - 5

PRACTICE

30 Minutes to Complete

153

PRIMARY ASSESSMENT

UNIT - 7

Unit 1 PRIMARY ASSESSMENT OF CARDIAC

Unit 5 PULMONARY PRIMARY ASSESSMENT

Unit 7 ABDOMINAL PRIMARY ASSESSMENT

ABDOMINAL SOUNDS AND NURSES NOTES

Sound	Location	Normal Findings	Abnormal Findings
Heart Sounds	Apex, Base	S1, S2, S3, S4	Murmurs, Crackles, Wheezes
Lung Sounds	Anterior, Posterior	Crackles, Wheezes, Rhales	Hyperinflation, Decreased breath sounds
Abdominal Sounds	RUQ, RLQ, LLQ, LUQ	Bowel sounds, Tympany	Hyperactive, Hypoactive, Absent

PUTTING THE ASSESSMENT TOGETHER

154

LAB PRACTICUM

UNIT - 7

PRACTICE

30 Minutes to Complete

155

COLOSTOMY & STOMA

UNIT - 7

Unit 7 COLOSTOMY AND STOMA ASSESSMENT

COLOSTOMY TYPES AND LOCATIONS

Type	Location	Characteristics
Ascending	Right side of the abdomen	Stoma is red, moist, and protrudes from the abdomen.
Transverse	Across the middle of the abdomen	Stoma is red, moist, and protrudes from the abdomen.
Descending	Left side of the abdomen	Stoma is red, moist, and protrudes from the abdomen.

ASSESSMENT

Inspect the stoma for color, shape, and size. The stoma should be red, moist, and protrude from the abdomen. The surrounding skin should be healthy and free of irritation.

156

SWALLOWING ASSESSMENT

UNIT - 7

[illegible]

157

ENTERAL NUTRITION DEVICES

UNIT - 7

Unit 7 **INTEGRAL NUTRITION DEVICE**

Neural Cavity
 Esophagus
 Stomach (Gastric) - 10-12 cm
 Small Intestine
 Large Intestine

Feeding Routes Through Nose
 1. Nasopharynx (NG)
 2. Nasoenteral (NE)
 3. Mouth-Pharynx (MO)
 4. Mouth-Enteric (ME)
 5. Mouth-Enteral (ME)

Dorsal Digestory Tubes
 Gastroenteric tube (GE) - 1-2 cm
 Jejunostomy (J-tube)

Table 1: Digestive System Components

Component	Location	Function
Esophagus (MO)	Neural Cavity	Transports food from mouth to stomach
Stomach (Gastric)	Neural Cavity	Breaks down food into chyme
Small Intestine	Neural Cavity	Major site of nutrient absorption
Large Intestine	Neural Cavity	Absorbs water and electrolytes, forms feces

Table 2: Feeding Routes Through Nose

Route	Abbreviation	Description
Nasopharynx	NG	Feeding into the nasopharynx
Nasoenteral	NE	Feeding into the small intestine via the nose
Mouth-Pharynx	MO	Feeding into the mouth
Mouth-Enteric	ME	Feeding into the stomach
Mouth-Enteral	ME	Feeding into the small intestine

Table 3: Dorsal Digestory Tubes

Tube	Location	Function
Gastroenteric tube (GE)	Stomach	Feeding into the stomach
Jejunostomy (J-tube)	Small Intestine	Feeding into the small intestine

158

ENTERAL NUTRITION (TUBE FEEDING)

UNIT - 7

Unit 7

ENTERAL NUTRITION (Tube Feeding)

Enteral nutrition is a method of providing nutrition to a patient who is unable to eat orally. It involves the use of a tube to deliver food and fluids directly into the stomach or small intestine.

Indications for Enteral Nutrition:

- Inability to eat orally due to illness or surgery.
- Malabsorption of nutrients.
- Severe dehydration.
- Profound weakness.
- Altered mental status.
- Altered bowel function.

Contraindications for Enteral Nutrition:

- Intestinal obstruction.
- Severe diarrhea.
- Severe abdominal pain.
- Severe electrolyte imbalances.
- Severe coagulopathy.
- Severe hypotension.
- Severe hypoxemia.
- Severe acidosis.
- Severe alkalosis.
- Severe hypernatremia.
- Severe hyponatremia.
- Severe hyperkalemia.
- Severe hypokalemia.
- Severe hyperphosphatemia.
- Severe hypophosphatemia.
- Severe hypermagnesemia.
- Severe hypomagnesemia.
- Severe hypercalcemia.
- Severe hypocalcemia.
- Severe hyperuricemia.
- Severe hypouricemia.
- Severe hyperbilirubinemia.
- Severe hypobilirubinemia.
- Severe hypercreatininemia.
- Severe hypocreatinemia.
- Severe hyperammonemia.
- Severe hypammonemia.
- Severe hyperlactatemia.
- Severe hypolactatemia.
- Severe hyperglycemia.
- Severe hypoglycemia.
- Severe hypertriglyceridemia.
- Severe hypotriglyceridemia.
- Severe hypercholesterolemia.
- Severe hypocholesterolemia.
- Severe hyperfibrinogenemia.
- Severe hypofibrinogenemia.
- Severe hyperfibrinolysis.
- Severe hypofibrinolysis.
- Severe hypercoagulability.
- Severe hypocoagulability.
- Severe hyperinflammation.
- Severe hypoinflammation.
- Severe hyperimmunity.
- Severe hyp immunity.
- Severe hyperinfection.
- Severe hypoinfection.
- Severe hypersepsis.
- Severe hyposepsis.
- Severe hyperanemia.
- Severe hyp anemia.
- Severe hyperleukocytosis.
- Severe hypoleukocytosis.
- Severe hyperthrombocytosis.
- Severe hyp thrombocytosis.
- Severe hyperplateletosis.
- Severe hyp plateletosis.
- Severe hyperfibrinogenemia.
- Severe hypofibrinogenemia.
- Severe hyperfibrinolysis.
- Severe hypofibrinolysis.
- Severe hypercoagulability.
- Severe hypocoagulability.
- Severe hyperinflammation.
- Severe hypoinflammation.
- Severe hyperimmunity.
- Severe hyp immunity.
- Severe hyperinfection.
- Severe hypoinfection.
- Severe hypersepsis.
- Severe hyposepsis.
- Severe hyperanemia.
- Severe hyp anemia.
- Severe hyperleukocytosis.
- Severe hypoleukocytosis.
- Severe hyperthrombocytosis.
- Severe hyp thrombocytosis.
- Severe hyperplateletosis.
- Severe hyp plateletosis.

Gastrostomy Tube (G-Tube)	Nasogastric Tube (NG-Tube)	Percutaneous Endoscopic Gastrostomy Tube (PEG-Tube)
Insertion: Insertion is performed by a gastroenterologist or surgeon. The tube is inserted through the abdominal wall into the stomach. Indications: Indications include long-term enteral nutrition, malabsorption, and severe dehydration. Contraindications: Contraindications include abdominal wall infection, severe coagulopathy, and severe hypotension. Advantages: Advantages include long-term use, no risk of aspiration, and no need for surgery. Disadvantages: Disadvantages include risk of infection, leakage, and discomfort.	Insertion: Insertion is performed by a nurse or physician. The tube is inserted through the nose into the stomach. Indications: Indications include short-term enteral nutrition, malabsorption, and severe dehydration. Contraindications: Contraindications include nasal obstruction, severe coagulopathy, and severe hypotension. Advantages: Advantages include short-term use, no risk of aspiration, and no need for surgery. Disadvantages: Disadvantages include risk of infection, leakage, and discomfort.	Insertion: Insertion is performed by a gastroenterologist or surgeon. The tube is inserted through the abdominal wall into the stomach. Indications: Indications include long-term enteral nutrition, malabsorption, and severe dehydration. Contraindications: Contraindications include abdominal wall infection, severe coagulopathy, and severe hypotension. Advantages: Advantages include long-term use, no risk of aspiration, and no need for surgery. Disadvantages: Disadvantages include risk of infection, leakage, and discomfort.



Gastrostomy Tube (G-Tube)



Nasogastric Tube (NG-Tube)



Percutaneous Endoscopic Gastrostomy Tube (PEG-Tube)

159

ENTERAL NUTRITION (TUBE FEEDING)

UNIT - 7

Unit 7 **ENTERAL NUTRITION (Tube Feeding)**

Topic	Key Concepts	Assessment	Intervention	Priority
Indications	Inability to eat orally, GI dysfunction, NPO status	Assess level of consciousness, gag reflex, bowel sounds	Insert NG tube, verify placement	High
Contraindications	GI obstruction, severe reflux, active GI bleeding	Assess for abdominal distention, vomiting, melena	Hold feeds, notify provider	High
Types of Tubes	NG, NJ, DLT, PEG	Check for kinks, leaks, and placement	Secure tube, flush with water	Medium
Formula	Commercial, homemade	Check expiration date, consistency	Warm to room temperature	Medium
Rate	Continuous, intermittent	Monitor for bloating, diarrhea	Adjust rate as needed	Medium
Complications	Aspiration, tube displacement, infection	Monitor for coughing, fever, tube displacement	Stop feeds, notify provider	High

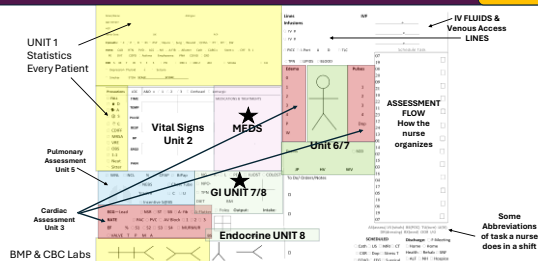
160

GENITOURINARY ASSESSMENT

UNIT - 8


161

LAB BRAINSHEET UNITS

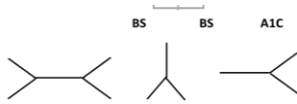
UNIT - 7


A Nurse Will know Everything on This Brainsheet

162

GENITOURINARY ASSESSMENT

UNIT - 8



163

GENITOURINARY ASSESSMENT

UNIT - 8

Unit 8

ENVIRONMENTAL MICROBIOLOGY

SEPTICEMY: DEVICES TO ENHANCE & MONITOR WATER QUALITY ON OCEANBOARDS

Learning Objectives:

- 1. Explain the importance of water quality monitoring on oceanboards.
- 2. Describe the components of a septicem system.
- 3. Discuss the role of septicem in preventing waterborne diseases.
- 4. Evaluate the effectiveness of septicem in maintaining water quality.

Key Concepts:

- Septicem: A device used to monitor and maintain water quality on oceanboards.
- Water Quality: The state of water in terms of its chemical, physical, and biological characteristics.
- Microbiology: The study of microorganisms and their interactions with the environment.

Activities:

- 1. Research the history and development of septicem.
- 2. Investigate the components and function of a septicem system.
- 3. Analyze the role of septicem in preventing waterborne diseases.
- 4. Evaluate the effectiveness of septicem in maintaining water quality.

Assessment:

- 1. Multiple-choice questions on septicem and water quality.
- 2. Short-answer questions on the role of septicem in preventing waterborne diseases.
- 3. Essay question on the effectiveness of septicem in maintaining water quality.

Water Quality Monitoring & Assessment:

- 1. Water Quality: The state of water in terms of its chemical, physical, and biological characteristics.
- 2. Assessment: The process of evaluating the quality of water.
- 3. Monitoring: The process of observing and measuring water quality over time.

Septicem System Components:

- 1. Septicem: A device used to monitor and maintain water quality on oceanboards.
- 2. Components: The parts that make up the septicem system.
- 3. Function: The role of each component in the septicem system.

Waterborne Diseases:

- 1. Diseases: Illnesses caused by microorganisms.
- 2. Prevention: Measures taken to avoid getting sick.
- 3. Role of Septicem: The part septicem plays in preventing waterborne diseases.

Water Quality Maintenance:

- 1. Maintenance: The process of keeping water quality at a certain level.
- 2. Effectiveness: The degree to which septicem maintains water quality.
- 3. Evaluation: The process of assessing the effectiveness of septicem.

SEPTICEM COLLECTION

Septicem Collection: The process of collecting septicem samples for analysis.

Septicem Collection Methods:

- 1. Septicem Collection: The process of collecting septicem samples for analysis.
- 2. Methods: The different ways to collect septicem samples.
- 3. Importance: The importance of proper septicem collection methods.

Septicem Collection Equipment:

- 1. Equipment: The tools and devices used in septicem collection.
- 2. Importance: The importance of using the right equipment.
- 3. Maintenance: The need to keep equipment in good working order.

Septicem Collection Procedures:

- 1. Procedures: The steps to follow when collecting septicem samples.
- 2. Importance: The importance of following proper procedures.
- 3. Safety: The need to follow safety protocols.

Septicem Collection Results:

- 1. Results: The data obtained from septicem collection.
- 2. Interpretation: The process of making sense of the results.
- 3. Action: The steps to take based on the results.

Septicem Collection Challenges:

- 1. Challenges: The difficulties encountered during septicem collection.
- 2. Solutions: The ways to overcome these challenges.
- 3. Prevention: The steps to avoid these challenges in the future.

Septicem Collection Best Practices:

- 1. Best Practices: The recommended ways to collect septicem samples.
- 2. Importance: The importance of following best practices.
- 3. Maintenance: The need to keep equipment in good working order.

164

GENITOURINARY ASSESSMENT

UNIT - 8

Unit 6

GENITOURINARY SYSTEM

GENITAL ORGANS (OBJECTS TO KNOW & KNOW-ABOUT) (Observation)

10

Genital	Anatomy	Physiology	Pathology	Clinical	Investigations	Management	Nursing
Male Penis Scrotum Urethra Prostate Vas Deferens Epididymis Seminal Vesicle Bladder Uterus Vagina Cervix Endometrium Ovary Fallopian Tube Uterine Tube Uterine Ligament Round Ligament Broad Ligament Transverse Ligament Uterine Artery Uterine Vein Uterine Nerve Uterine Lymphatics Uterine Blood Supply Uterine Innervation Uterine Function Uterine Development Uterine Aging Uterine Pathology Uterine Clinical Uterine Investigations Uterine Management Uterine Nursing	Female Penis Scrotum Urethra Prostate Vas Deferens Epididymis Seminal Vesicle Bladder Uterus Vagina Cervix Endometrium Ovary Fallopian Tube Uterine Tube Uterine Ligament Round Ligament Broad Ligament Transverse Ligament Uterine Artery Uterine Vein Uterine Nerve Uterine Lymphatics Uterine Blood Supply Uterine Innervation Uterine Function Uterine Development Uterine Aging Uterine Pathology Uterine Clinical Uterine Investigations Uterine Management Uterine Nursing	Male Female Penis Scrotum Urethra Prostate Vas Deferens Epididymis Seminal Vesicle Bladder Uterus Vagina Cervix Endometrium Ovary Fallopian Tube Uterine Tube Uterine Ligament Round Ligament Broad Ligament Transverse Ligament Uterine Artery Uterine Vein Uterine Nerve Uterine Lymphatics Uterine Blood Supply Uterine Innervation Uterine Function Uterine Development Uterine Aging Uterine Pathology Uterine Clinical Uterine Investigations Uterine Management Uterine Nursing	Male Female Penis Scrotum Urethra Prostate Vas Deferens Epididymis Seminal Vesicle Bladder Uterus Vagina Cervix Endometrium Ovary Fallopian Tube Uterine Tube Uterine Ligament Round Ligament Broad Ligament Transverse Ligament Uterine Artery Uterine Vein Uterine Nerve Uterine Lymphatics Uterine Blood Supply Uterine Innervation Uterine Function Uterine Development Uterine Aging Uterine Pathology Uterine Clinical Uterine Investigations Uterine Management Uterine Nursing	Male Female Penis Scrotum Urethra Prostate Vas Deferens Epididymis Seminal Vesicle Bladder Uterus Vagina Cervix Endometrium Ovary Fallopian Tube Uterine Tube Uterine Ligament Round Ligament Broad Ligament Transverse Ligament Uterine Artery Uterine Vein Uterine Nerve Uterine Lymphatics Uterine Blood Supply Uterine Innervation Uterine Function Uterine Development Uterine Aging Uterine Pathology Uterine Clinical Uterine Investigations Uterine Management Uterine Nursing	Male Female Penis Scrotum Urethra Prostate Vas Deferens Epididymis Seminal Vesicle Bladder Uterus Vagina Cervix Endometrium Ovary Fallopian Tube Uterine Tube Uterine Ligament Round Ligament Broad Ligament Transverse Ligament Uterine Artery Uterine Vein Uterine Nerve Uterine Lymphatics Uterine Blood Supply Uterine Innervation Uterine Function Uterine Development Uterine Aging Uterine Pathology Uterine Clinical Uterine Investigations Uterine Management Uterine Nursing	Male Female Penis Scrotum Urethra Prostate Vas Deferens Epididymis Seminal Vesicle Bladder Uterus Vagina Cervix Endometrium Ovary Fallopian Tube Uterine Tube Uterine Ligament Round Ligament Broad Ligament Transverse Ligament Uterine Artery Uterine Vein Uterine Nerve Uterine Lymphatics Uterine Blood Supply Uterine Innervation Uterine Function Uterine Development Uterine Aging Uterine Pathology Uterine Clinical Uterine Investigations Uterine Management Uterine Nursing	

165

GENITOURINARY ASSESSMENT

UNIT - 8

Unit 8

GENITOURINARY SYSTEM CHRONIC KIDNEY DISEASE

NURSING CAMP

Chronic Kidney Disease (CKD) Glomerular Filtration Rate (GFR)

CKD is a progressive condition that gradually reduces a kidney's function. It is often found in people with diabetes and high blood pressure. The condition is usually found and monitored through blood tests. Blood tests measure the amount of creatinine in the blood. Creatinine is a waste product that is normally filtered out of the blood by the kidneys. When the kidneys are not working properly, creatinine builds up in the blood. The level of creatinine in the blood is used to calculate the GFR. The GFR is a measure of how well the kidneys are filtering the blood. The GFR is usually expressed as a percentage of the normal GFR. The normal GFR is 100 mL/min/1.73 m². The GFR is usually divided into five stages. The stages are as follows:

Progressive Stages 1-5 of CKD

Stage	GFR (mL/min/1.73 m ²)	Common Signs and Symptoms
1	≥ 90	None
2	60-89	None
3	30-59	None
4	15-29	None
5	< 15	None

Complications of CKD

Complication	Signs and Symptoms
Anemia	Fatigue, weakness, pale skin
Hypertension	Headache, dizziness, blurred vision
Hyperkalemia	Weakness, numbness, tingling
Hyperphosphatemia	Itching, bone pain
Fluid overload	Swelling, shortness of breath
Uremia	Nausea, vomiting, loss of appetite

Medical Management of Chronic Kidney Disease

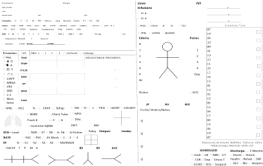
Management	Signs and Symptoms
Dietary changes	Weight gain, bloating
Medications	Nausea, vomiting, loss of appetite
Dialysis	Swelling, shortness of breath

169

GENITOURINARY ASSESSMENT

UNIT - 8

Unit 101 – Room 104 – Bed B
Patient Name: Daniel R. **Age / Gender:** 48-year-old male
Admit Date: 07/28/2026 **Primary Diagnosis:** Type 1 Diabetes Mellitus – hyperglycemia, rule-out mild DKA
Code Status: Full Code **Tobacco:** Never smoker **Alcohol:** Occasional beer (1–2 per month) **Special Variable:** Legally blind (diabetic retinopathy) – requires assistance with reading labels, insulin dosing verification, and written materials **Mobility:** Independent ambulation; steady gait **Diet:** Consistent carbohydrate diabetic diet / carb counting
Precautions: C-dif IV **Access:** 20-gauge peripheral IV, left forearm, saline locked, site clean/dry/intact



170

GENITOURINARY ASSESSMENT

UNIT - 8

Admission Labs (07/28)

- Glucose: 348 mg/dL
- Na: 134
- K: 4.8
- BUN: 24
- Cr: 1.1
- Anion gap: 14
- WBC: 9.1
- Hgb: 13.6
- Hct: 40.8
- Platelets: 232
- A1C: 9.8%

Current Labs (07/29 AM)

- Glucose: 186 mg/dL
- K: 4.2
- Creatinine: 1.0
- Anion gap: 11

	Admission (07/28 21:30)	Current (07/29 08:15)
BP	138/84	128/76
HR	104	86
RR	22	16
Temp	98.7 °F (37.1 °C)	98.3 °F (36.8 °C)
SpO ₂	98% on RA	98% on RA
Pain	0/10	0/10

171

GENITOURINARY ASSESSMENT

UNIT - 8

Medications

- Insulin glargine 20 units SQ at bedtime
- Insulin lispro per sliding scale before meals and bedtime
- Lisinopril 5 mg PO daily
- Atorvastatin 20 mg PO at bedtime

172

GENITOURINARY ASSESSMENT

UNIT - 8

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented x4. Mildly dehydrated appearance. Legally blind – requires verbal description of environment and assistance with printed materials.

Neurological: Pupils equal, round, reactive (limited visual acuity). Strength 5/5 all extremities. No focal deficits. Reports mild bilateral foot numbness.

Cardiovascular: Heart rate regular, 51/52, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO₂ 98% on room air. Mild fruity odor to breath on admission.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present x4. Reports increased thirst and appetite recently.

Genitourinary: Polyuria on admission. Clear yellow urine. Now voiding normal volumes.

Integumentary: Skin warm, dry, intact. Multiple small healed injection sites on abdomen. No pressure injuries. Peripheral IV site left forearm clean, dry, intact.

Musculoskeletal: Independent ambulation. Full ROM. Steady gait.

Psychosocial: Cooperative and knowledgeable about. Type 1 diabetes. Frustrated with recent high readings. Wife at bedside assisting with visual tasks. States he "needs help making sure the insulin doses are correct while my vision is this bad."

173

GENITOURINARY ASSESSMENT

UNIT - 8

Unit 101 – Room 104 – Bed A

Patient Name: Martha L. **Age / Gender:** 71-year-old female **Admit**

Date: 07/28/2026 **Primary Diagnosis:** Chronic Kidney Disease (CKD)

Stage: 4 with fluid overload **Code Status:** Full Code **Tobacco:** Never

smoker Alcohol: Denies **Special Variable:** Hemodialysis (Monday-

Wednesday-Friday schedule; left arm AV fistula) Mobility:

Independent ambulation-short distances; uses walker for longer

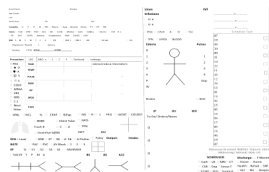
distances due to fatigue **Diet:** Renal diet – low potassium, low

phosphorus, controlled protein, 1500 mL fluid restriction

Precautions: Standard IV Access: 22-gauge peripheral IV, right

forearm, saline locked. Left arm AV fistula present (thrill and bruit

intact)



174

GENITOURINARY ASSESSMENT

UNIT - 8

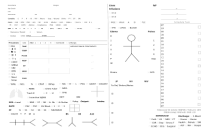
Admission Labs (07/28)

- BUN: 45
- Creatinine: 3.8
- GFR: 12
- Na: 137
- K: 5.2
- Cl: 108 CO2: 25
- Phosphorus: 5.8
- Calcium: 8.4
- Glucose: 118
- WBC: 7.6
- Hgb: 9.8
- Hct: 29.6
- Platelets: 198

Current Labs (07/29 AM)

- BUN: 44
- Creatinine: 3.6
- K: 4.9
- Phosphorus: 5.4

	Admission (07/28 14:00)	Current (07/29 07:00)
BP	168/92	154/84
HR	88	78
RR	20	18
Temp	98.3 °F (36.8 °C)	98.2 °F (36.8 °C)
SpO ₂	96% on RA	97% on RA
Pain	1/10 (generalized)	0/10



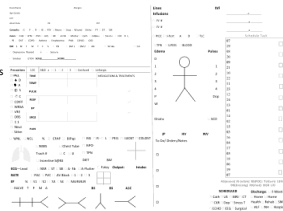
175

GENITOURINARY ASSESSMENT

UNIT - 8

Medications

- Sevelamer 800 mg PO three times daily with meals
- Lisinopril 5 mg PO daily
- Furosemide 40 mg PO daily
- Sodium bicarbonate 650 mg PO twice daily



176

GENITOURINARY ASSESSMENT

UNIT - 8

Admission Head-to-Toe Assessment (07/28)

General: Alert, oriented x4. Appears mildly fatigued. Cooperative.

Neurological: Pupils equal, round, reactive. Strength 5/5 all extremities. No focal deficits. Steady gait with walker.

Cardiovascular: Heart rate regular, S1S2, no murmurs. +1 pitting edema bilateral lower extremities. Capillary refill < 3 seconds. No JVD. Left arm AV fistula with palpable thrill and audible bruit.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO₂ 96% on room air.

Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present x4. Reports occasional nausea.

Genitourinary: Oliguric (urine output ~300–400 mL/day). Clear yellow urine when voiding. Strict intake and output monitoring.

Integumentary: Skin warm, dry, intact. Mild uremic frost not present. No pressure injuries. Peripheral IV site right forearm clean, dry, intact. AV fistula site without redness or drainage.

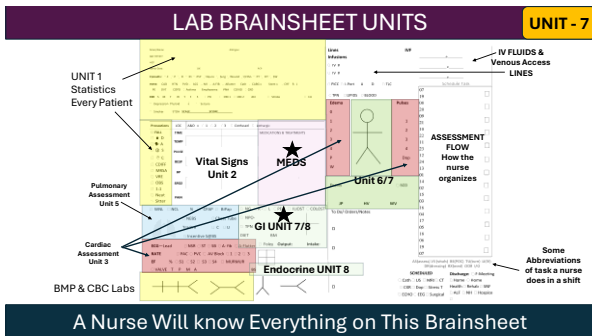
Musculoskeletal: Ambulates with walker for distances. Full ROM. Independent with most ADLs.

Psychosocial: Calm. Understands dialysis schedule. Daughter at bedside. States she "just needs to get the fluid under control before her next treatment."

177



178



179



Precautions	LOC	A&O	x	☐ 1	☐ 2	☐ 3	☐ Confused	☐ Lethargic
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180

NEUROLOGICAL ASSESSMENT

UNIT - 9

Unit 9 NEUROLOGICAL ASSESSMENT

Learning Objectives

- Identify the components of a neurological assessment.
- Perform a complete neurological assessment.
- Identify the components of a focused neurological assessment.
- Identify the components of a rapid neurological assessment.

Neurological Assessment

History

- Chief Complaint
- History of Present Illness
- Past Medical History
- Medications
- Social History
- Family History

Physical Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

181

NEUROLOGICAL ASSESSMENT

UNIT - 9

Unit 9 NEUROLOGICAL EXAM: HEAD AND NECK

Learning Objectives

- Identify the components of a neurological assessment.
- Perform a complete neurological assessment.
- Identify the components of a focused neurological assessment.
- Identify the components of a rapid neurological assessment.

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

182

NEUROLOGICAL ASSESSMENT

UNIT - 9

Unit 9 NEUROLOGICAL EXAM: HEAD AND NECK

Learning Objectives

- Identify the components of a neurological assessment.
- Perform a complete neurological assessment.
- Identify the components of a focused neurological assessment.
- Identify the components of a rapid neurological assessment.

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

Neurological Examination

- General
- Head and Neck
- Eyes
- Ears, Nose, and Throat
- Heart and Lungs
- Abdomen
- Extremities
- Neurological

183

NEUROLOGICAL ASSESSMENT

UNIT - 9

Unit 9 NEUROLOGICAL ASSESSMENT

NURSING CAMP General Vascular Accident (GVA) "Stroke" Right VC Left Side Stroke

A cerebrovascular accident (CVA), commonly called a stroke, is a sudden interruption of blood flow to part of the brain. Brain cells do not last long without oxygen, leading to permanent damage to cells. There are two types of CVA: ischemic (80%) where a clot blocks the blood vessel from delivering oxygen to part of the brain. The second type is hemorrhagic (20%) where a blood vessel in the brain ruptures, leading to bleeding into or around brain tissue, caused by hypertension, aneurysm, or other. These result in physical damage of the brain and could cause permanent brain dysfunction depending on the stroke "type" or "type" of stroke.

Left Hemisphere Stroke

RIGHT SIDE LEFT SIDE

1. Right-sided weakness/paralysis
2. Right-sided sensory deficit
3. Homonymous hemianopia
4. Higher cerebral dysfunction
5. Homonymous hemianopia
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Right Hemisphere Stroke

"LEFT HEMISPHERE"

1. Left-sided weakness/paralysis
2. Left-sided sensory deficit
3. Homonymous hemianopia
4. Higher cerebral dysfunction
5. Homonymous hemianopia
6. Homonymous hemianopia
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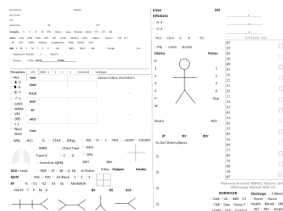
184

NEUROLOGICAL ASSESSMENT

UNIT - 9

Unit 101 - Room 106 - Bed A

Patient Name: Sarah J. **Age / Gender:** 76-year-old female **Admit Date:** 07/27/2026 **Primary Diagnosis:** CVA (left middle cerebral artery infarct) with residual right-sided weakness **Code Status:** Full Code **Tobacco:** Former smoker (quit 8 years ago) **Alcohol:** Denies **Special Variable:** Expressive aphasia and mild dysarthria - uses communication board and yes/no questions, allow extra time to respond **Mobility:** Right hemiparesis - assist of 2 for transfers; uses wheelchair; high fall risk **Diet:** Dysphagia Level 2 (mechanically altered) with nectar-thick liquids - speech therapy following **Precautions:** Contact IV Access: 20-gauge peripheral IV, left forearm, saline locked, site clean/dry/intact



185

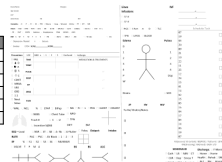
NEUROLOGICAL ASSESSMENT

UNIT - 9

Admission Labs (07/27)

- Na: 139
 - K: 3.9
 - BUN: 18 Creatinine: 0.9
 - Cl-98 CO2: 25
 - Glucose: 142
 - WBC: 8.4
 - Hgb: 12.9
 - Hct: 38.7
 - Platelets: 241
 - PT/INR: 12.4 / 1.1
- Current Labs (07/29 AM)**
- K: 4.0
 - Creatinine: 0.9
 - Glucose: 118

Admission (07/27 08:45)	Current (07/29 08:45)
BP	172/96
HR	148/92
RR	18
Temp	98.6 °F (37.0 °C)
SpO2	98% on RA
Pain	2/10 (right shoulder)



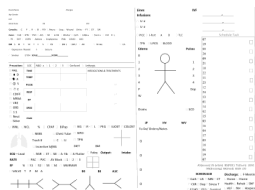
186

NEUROLOGICAL ASSESSMENT

UNIT - 9

Medications

- Aspirin 81 mg PO daily
- Atorvastatin 40 mg PO at bedtime
- Lisinopril 10 mg PO daily
- Docusate sodium 100 mg PO twice daily



187

NEUROLOGICAL ASSESSMENT

UNIT - 9

Admission Head-to-Toe Assessment (07/27)

General: Alert, oriented to person and place (time intermittent). Expressive aphasia present – follows simple commands, answers yes/no reliably, difficulty forming words. Contact precautions in place.

Neurological: Pupils equal, round, reactive. Right facial droop. Right upper and lower extremity strength 2/5. Left side strength 5/5. Mild right-sided neglect.

Cardiovascular: Heart rate regular, 55/2, no murmurs. Capillary refill < 3 seconds. No edema. No JVD.

Respiratory: Breath sounds clear bilaterally. Easy work of breathing. SpO₂ 97% on room air.

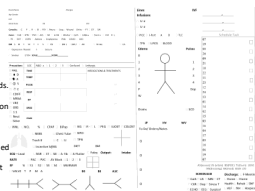
Gastrointestinal: Abdomen soft, non-tender, non-distended. Bowel sounds present x4. Last BM two days ago – stool softener started.

Genitourinary: Incontinent of urine on admission; now using purewick and timed toileting. Clear yellow urine.

Integumentary: Skin warm, dry, intact. No pressure injuries on admission. Right side of body requires careful positioning and skin checks. Peripheral IV site left forearm clean, dry, intact.

Musculoskeletal: Right hemiparesis. Requires assist of 2 for bed-to-chair transfers. High fall risk. Left side full ROM and strength.

Psychosocial: Frustrated with speech difficulty but cooperative. Husband at bedside. Uses communication board effectively for basic needs.



188

CARDIOVASCULAR ASSESSMENT- PEPPERABC

UNIT - 3

Vital Nursing Assessment									
Room/ODA	Diagnosis	P R I C E				Admission			
		P	R	I	C	E	Lab/DEF		
Admit V1		12	6	9	20	98	WBC		
Admit V2		12	6	9	20	98	WBC		
Admit V3		12	6	9	20	98	WBC		
Admit V4		12	6	9	20	98	WBC		
Admit V5		12	6	9	20	98	WBC		
Admit V6		12	6	9	20	98	WBC		
Admit V7		12	6	9	20	98	WBC		
Admit V8		12	6	9	20	98	WBC		
Admit V9		12	6	9	20	98	WBC		
Admit V10		12	6	9	20	98	WBC		
Admit V11		12	6	9	20	98	WBC		
Admit V12		12	6	9	20	98	WBC		
Admit V13		12	6	9	20	98	WBC		
Admit V14		12	6	9	20	98	WBC		
Admit V15		12	6	9	20	98	WBC		
Admit V16		12	6	9	20	98	WBC		
Admit V17		12	6	9	20	98	WBC		
Admit V18		12	6	9	20	98	WBC		
Admit V19		12	6	9	20	98	WBC		
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Admit V97		12	6	9	20	98	WBC		
Admit V98		12	6	9	20	98	WBC		
Admit V99		12	6	9	20	98	WBC		
Admit V100		12	6	9	20	98	WBC		

PRIMARY VS SECONDARY ASSESSMENT

189