

Nursing study guide block 4 final

[Health & Medicine](#), [Nursing](#)



Study Guide for the Final Exam Here are the rules: please do not call me or email me questions about the study guide. I will answer questions about the study guide during the brief review before the exam itself. You cannot memorize the answers to the questions and do well on the exam- the questions are meant to stimulate thinking, not to be answers. Please remember to review the chapters on shock and MODS as there are questions on this content. 1.

There are several ABG questions; remember these also include oxygen numbers so be prepared to determine oxygenation in addition to acid base PH: 7. 35- 7. 45 PCO₂: 35-45 HCO₃: 22-26 O₂: 94-100 2. Review the care of the patient with pneumonia, including applicable nursing diagnoses and measurable outcomes Restrictive respiratory disorder: decreased lung expansion- low PaO₂, decreased lung compliance, normal to low P/Q ration, shunt, respiratory alkalosis (blowing off CO₂, more bicarbonate) increased RR, TV smaller.

SOB/cough, dyspnea= how many words can they say in one breath chest pain, fatigue, wt. loss, lung crackles, care: HOB 30deg, fluids to clear secretions, tidal volume--normal breathing 500mL Nursing dx: impaired gas exchange, ineffective breathing pattern, acute pain Outcomes: maintains adequate alveolar oxygen-carbon dioxide exchange, clears lungs of fluids and exudates. Demonstrates effective RR, rhythm, and depth of respirations. Reports control of pain following relief measures. . Review the treatment for TB (look in Lewis), including medications, length of treatment, evaluation of treatment plan, who is most likely to get TB infection, and side effects of the medications Medications: aggressive TB treatment: four drugs for 6 months,

(INH, rifampin [Rifadin], pyrazinamide [PZA], and ethambutol) Newer: rifamycins, rifubin, rifapentine, first line for special situations Length of treatment: 6 months- 1 Year

Evaluation of treatment plan: resolution of the disease, normal pulmonary function, absence of any complication, no transmission of TB, Most likely to contract: Asians have the highest TB rate, followed by Hawaiians and pacific islanders. African Americans are the highest rate inside the US. (45%) Higher rates of TB infections with patients with HIV infections Side effects of meds: alcohol increases hepatotoxicity of INH, monitor liver function.

PZA may not be included in initial phase (due to liver disease or pregnancy)

4. Review the care of a patient with lung surgery, including chest tube management To keep lung inflated & Drain fluid from interpleural space How do you know if collapsed lung: Blood gases, Chest X-ray, Vital signs, Color Air leaks – bubbling in water chamber: check your tubes for air leak & make sure they're always free of kinks. Don't milk the chest tube (unless ordered).

Continued bubbling = pneumothorax not resolved yet, Constant vigorous bubbling = air leak in system Should see tidaling if not attached to suction > 100cc/hr. of drainage = call doc Determine if working correctly by: Monitor output, pain, breath sounds, assess patient breathing, auscultate, ABG, pulse ox (SPO2), skin/mucous membrane coloring, and respiratory effort Chest tube pain is common- give pain meds > 7/10 5.

Review heartfailure: right-sided (acute and chronic), left- sided (acute and chronic), pulmonary edema, cardiomyopathy and management of the patients; remember to review the hemodynamic changes (and values)

associated with right and left sided failure RIGHT SIDED HF: (FLUID RETENTION): Corpulmonale, systemic edema, neck vein distention, weight gain, fluid retention, Risk: COPD, hypoxia (pulmonary HTN), causes pulmonary vasoconstriction.

CVP = increased; PVR = increased; SVR = increased; wedge = increased; contractility = decreased medication: nitroglycerine to decrease venous return, fix preload LEFT SIDED HF: (RESPIRATORY) DYSPNEA ON EXERTION, back up in lungs, pink frothy sputum, decreased O₂ sat, increase RR. CVP = increased; PVR = increased; SVR = increased; wedge = increased; contractility = decreased HEART FAILURE: Usually starts out with one ventricle.

Nitroglycerine, aspirin, O₂, pericardial thump, Lasix, ACE, + inotrope, Class 4, transplant, symptomatic. ACUTE HF: Dig, Lasix, ACE, ARBS, Betas, Calcium Channel, Nitro, and Aspirin, compensatory mechanism is ok. CHRONIC HF: both ventricles can fail (left to right), Dig, Lasix, ACE, BETA, ARBS (if cough), calcium channel blocker, Primacore, compensatory mechanism makes it worse. 2 CLASSIFICATIONS OF HF: 1. Systolic: problems pushing volume out problem with too much afterload: HTN. TX: decrease SVR with dig, Lasix (diuretics), ACE. 2.

Diastolic: problem with filling and getting blood in (Hypertrophic cardio) less room for blood TX: Beta blockers to reduce contraction or calcium channel then ACE. If you give them DIG it will kill them (will increase heart working too hard). PULMONARY EDEMA: hallmark: pink frothy sputum, Left- sided heart failure. Decreased albumin, decreased oncotic pressure, increased hydrostatic pressure. Dilated: Left vent is dilated (stretched out of shape)

decreasing the ejection fraction. Vent is overstretched from CHF or chronic hypertension.

Diagnose with chest X-ray: heart is BIG. TX: Dig, Lasix, Ace. Arrhythmias will increase mortality rate HYPERTROPHIC: L vent hypertrophy decreases the ability of the chamber to relax, decrease contractility (athlete, hereditary.) TX: BB, CCB Constricted/restricted: normal size heart with decreased cardiac muscle compliance. Scarred= fibrosis, radiation, infection (rheumatic fever) control of volume overload is AGGRESSIVE: Ace, Diuretic, Dobutamine, Nitroglycerin/Nitroprusside, exercise restriction . Review patho and management of COPD, especially related to acute respiratory failure. COPD: obstructive, exhalation problem, air flows in but then becomes trapped, teach pursed lipped breathing to improve FRC. Clinical manifestations: increased lung expansion, normal to increased TLC, decreased forces expiratory volume, increased functional residual capacity, decreased vital capacity, increased CO₂, O₂ sat-80-100, PaO₂- 60 Best mask to use is vent mask, most precise O₂ is delivered.

Barrel chest- chronic hyperinflation of torso Corpulmonale, > expiratory time, wheezing or rhonchi, A fib from chronic overuse of right ventricle TX: beta agonist/beta stimulant= dilates airway (epinephrine, albuterol) Anticholinergic bronchodilators, corticosteroids, mucolytic= thin out secretions, Mucinex or SVN mucomist, pulmonary vasodilators not common, prostaglandin E₂, supposed to dilate pulmonary vessels but BP can plummet too.

Nitrous oxide can temporarily improve pulmonary HTN but doesn't improve outcomes Respiratory Failure: ALOC- confusion, restless. Nasal flaring, <https://assignbuster.com/nursing-study-guide-block-4-final/>

increased HR, increased BP, increased RR, increased depth, PVCs, Pulmonary Embolism= blue very fast, otherwise cyanosis is a late sign 7. Review management of patients on ventilators, including process of weaning and recognition of weaning failure AC - assist control: doing all the breathing for the patient. It's providing Tidal volume and oxygen.

For your unstable patient NO pressure support needed SIMV - synchronized intermittent mandatory ventilation: For weaning: Makes it easier for patient to take their own spontaneous breath. Tidal volume off and O2 on. Pressure support adjunct PEEP - positive end expiratory pressure, Keeps alveoli open by use of positive pressure. Increases FRC - air left in after exhalation. ARDS patient. Little bit of positive pressure at the end of exhalation. Use with SIMV or AC. Keep between 5-10, and not over