

YOUR CRITICAL THINKING



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YOUR CRITICAL THINKING



COURSE OBJECTIVES

TEAM EFFORT

YOUR CRITICAL THINKING IS A REFLECTION OF YOUR ORGANIZATIONAL SKILLS. FOR THIS REASON, THE TOPIC IS DIRECTED AT DEMONSTRATING SOME EXAMPLES OF HOW TO APPLY GOOD CLINICAL NURSING.

THE SUBJECT MATTER INCLUDES:

- KNOWING WHEN TO ACT
- DESIGNATING RESPONSIBILITIES
- ADDRESSING HIPAA
- TEAM EFFORT
- GOOD CLINICAL JUDGEMENT WITH EXPECTED OUTCOMES
- PLAN OF ACTION
- ASSESSMENT, INTERVENTION AND DOCUMENTATION

YOUR CRITICAL THINKING

I WISH I COULD PUT THE PIECES OF THE PUZZLE TOGETHER.



YOUR CRITICAL THINKING CAN BE A CHALLENGE IN THE CLINICAL SETTING. KNOWING HOW TO PUT THE PIECES OF THE PUZZLE TOGETHER WILL MAKE THAT CHALLENGE REALLY EASY.


HELPFUL HINTS :

- GATHER RELEVANT INFORMATION ABOUT HISTORY, DIAGNOSIS AND TREATMENT FOR THE PATIENTS YOU ARE ASSIGNED TO.
- FAMILIARIZE YOURSELF WITH THE PLAN OF CARE
- DELEGATE RESPONSIBILITY TO OTHER STAFF MEMBERS IF YOU ARE IN CHARGE
- KNOW YOUR UNIT'S POLICIES AND PROCEDURES
- ASSESS PATIENT / FAMILY NEEDS FOR SOCIAL SERVICES



WOULD YOU KNOW WHAT TO DO IF YOU FOUND A PATIENT WHO WAS NOT RESPONDING?





I HAVE NO IDEA WHAT TO DO, SO I AM JUST GOING TO STAND OUT OF THE WAY.

HR-82


BP-115/77

RESPS=14

O2 SATS=97%



THE NURSE MONITORS THE VITAL SIGNS.



THIS PATIENT IS IN THE ER AND IS HAVING DIFFICULTY BREATHING.

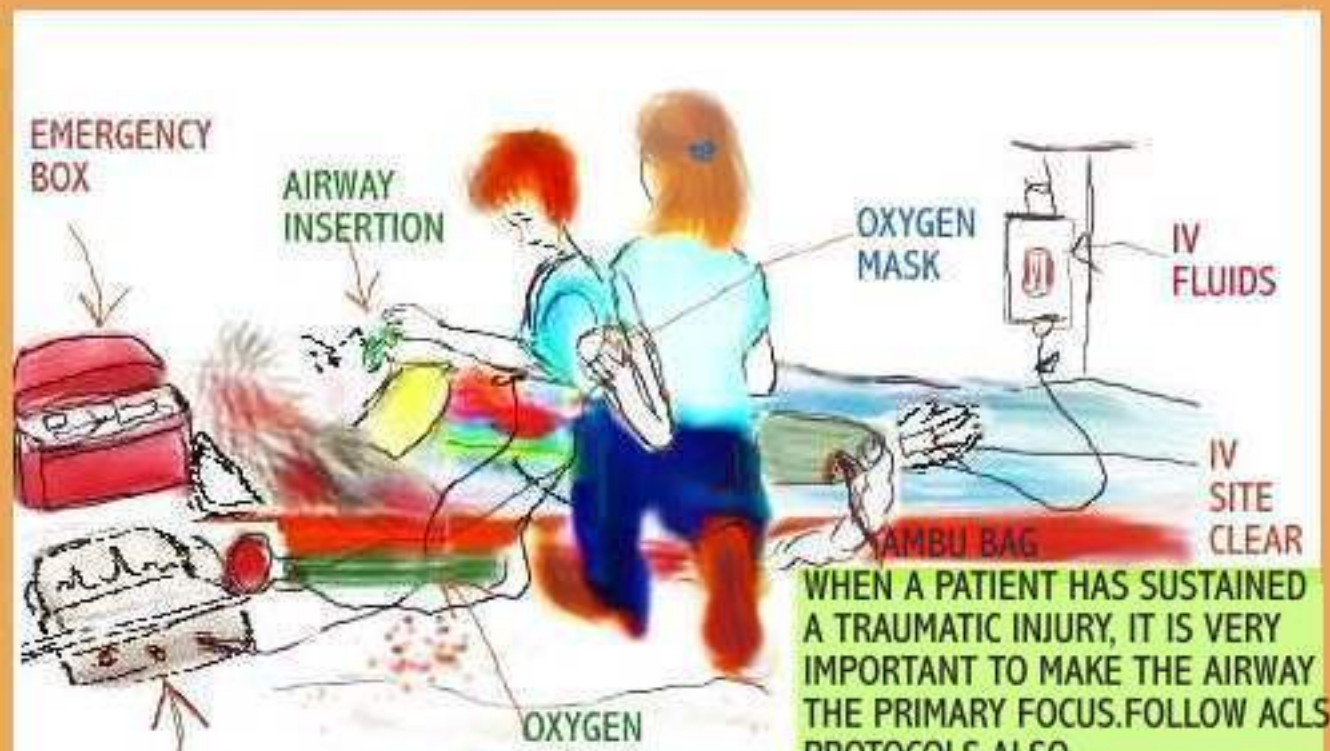
JOHN IS NEW TO THE ER AND HAS NO IDEA WHAT HE CAN DO TO HELP. HE NEEDS TO APPLY CRITICAL THINKING AS THIS IS AN EMERGENCY. HELPFUL SUGGESTIONS FOR A NURSE IN THIS SITUATION :

- PLACE THE CRASH CART CLOSE TO THE BEDSIDE
- CHECK VITAL SIGNS, EKG STRIP AND DOCUMENT
- CHECK TO SEE IV FLUIDS NEED REPLACING AND GET SOME MORE, IF NOT ENOUGH
- GET A TRASH CAN CLOSE BY, FOR USE IF NEEDED



THE NURSE ATTEMPTS TO REMOVE THE GOWN AND START CPR.

AIRWAY MANAGEMENT



WHEN A PATIENT HAS SUSTAINED A TRAUMATIC INJURY, IT IS VERY IMPORTANT TO MAKE THE AIRWAY THE PRIMARY FOCUS. FOLLOW ACLS PROTOCOLS ALSO.

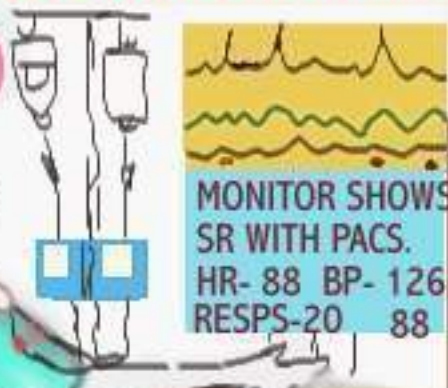
THE TONGUE MAY OBSTRUCT THE AIRWAY, MAKING THE FLOW OF AIR DIFFICULT. FOLLOW YOUR CPR GUIDELINES FOR AIRWAY MANAGEMENT. THE SPINE AND NECK SHOULD BE IMMOBILIZED AS SOON AS POSSIBLE. A BACK BOARD AND CERVICAL COLLAR ARE GENERALLY USED. CERVICAL AND SPINAL X-RAYS ARE

USUALLY ORDERED BY THE DOCTOR WHEN THE PATIENT ARRIVES IN THE ER. FOLLOW YOUR MD ORDERS FOR REMOVAL OF THE CERVICAL COLLAR. A TRAUMA PATIENT MAY HAVE TO BE INTUBATED AT THE SCENE. MONITOR RESPIRATORY, CARDIAC AND NEUROLOGICAL STATUS AND DOCUMENT FINDINGS.

CARDIOPULMONARY ARREST IN THE ICU

MR. H IS AWAKE,
ALERT AND
ORIENTED.
OXYGEN
O2 SATS
=98%

1



MONITOR SHOWS
SR WITH PACS.
HR-88 BP-126
RESPS-20 88

3



CODE BLUE

MR. H WAS ADMITTED TO THE ICU FOR A CARDIAC
WORKUP. HE HAS A KNOWN HISTORY OF CAD.

THE NURSE PASSES THE
CODE BUTTON TO ALERT THE
ICU STAFF OF A CARDIO-
PULMONARY ARREST.

2

MR. H HAS NO
PULSE. HIS
MONITOR
SHOWS
V-FIB.
OXYGEN



MR. H
CAN
YOU
HEAR
ME?

4



MR. H'S NURSE HEARS THE MONITOR ALARM GO
OFF AND CHECKS ON HIM. HE IS UNRESPONSIVE.

THE NURSE ATTEMPTS TO REMOVE
THE GOWN AND START CPR.

CARDIAC RHYTHM SHOWS
THIRD DEGREE AV BLOCK

88

PHARMACIST

DEFIBRILLATOR

NURSE

2

ATS

8%

LINE

D

CRASH CART

DEFIBRILLATION IS A FORM OF ELECTRICAL SHOCK TREATMENT USED TO CHANGE THE HEART FROM A LIFE-THREATENING CARDIAC RHYTHM TO A NORMAL ONE. IT IS USUALLY DONE BY MEDICAL TRAINED PERSONNEL.

THE NURSE MONITORS THE VITAL SIGNS



IN THE CLINICAL SETTING, TEAM EFFORT IS OFTEN NECESSARY FOR EFFECTIVE OUTCOMES.

HR-82

CARDIOVERSION

BP-115/77

RESPS=14

O2 SATS-97%

ALL CLEAR!



ATRIAL FIBRILLATION

SINUS RHYTHM

THIS RESPIRATORY THERAPIST WAS ABOUT TO ENJOY HER COFFEE WHEN HER PAGER ALERTED HER TO A CODE BLUE IN THE ER.



STAFF MEMBERS ARE USUALLY TRAINED IN ACLS.

CODE BLUE
EMERGENCY
ROOM

THIS ER NURSE WAS PRESENT WHEN A CODE BLUE WAS CALLED.

THIS PHARMACIST WAS CHECKING HIS STOCK WHEN HE WAS ALERTED TO A CODE BLUE IN THE ER.



MANAGING A CODE BLUE IS A TEAM EFFORT. EACH SHIFT, STAFF MEMBERS ARE ASSIGNED TO RESPOND TO A CODE BLUE.

SHE IMMEDIATELY GOT THE CRASH CART AND TOOK IT TO THE PATIENT'S BEDSIDE.



What would you do if your patient was having chest pain?

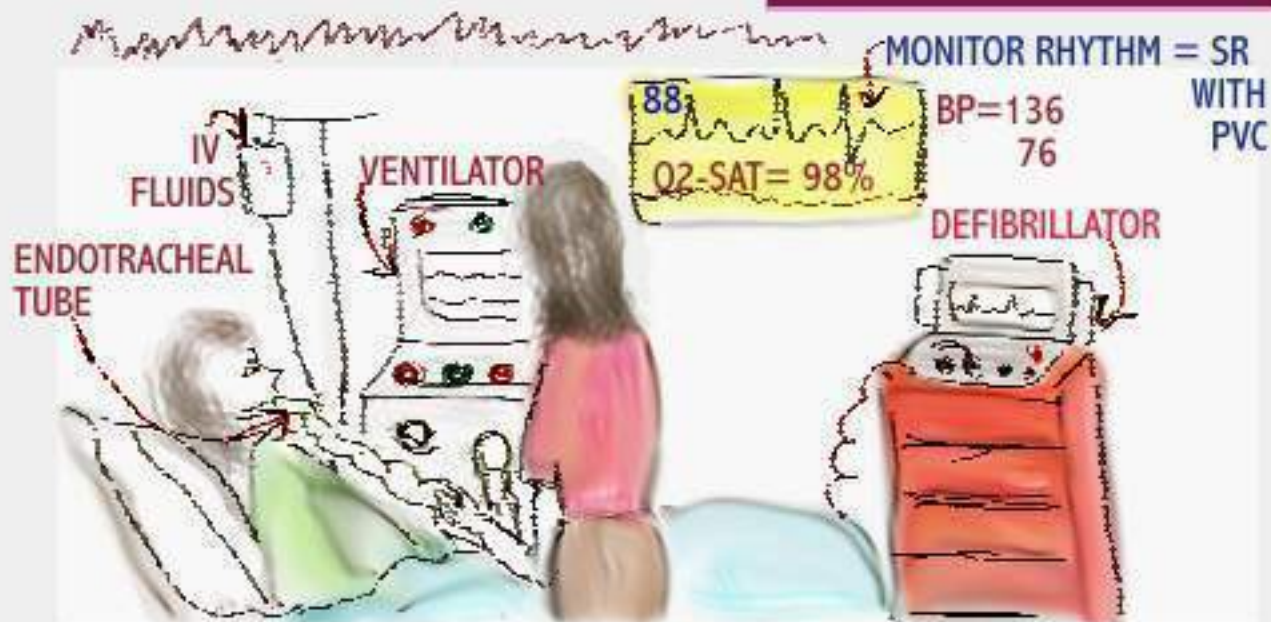
How is your day going Sally?

My patient was having chest pain when I left, so I told her to be calm and rest till I get back.



VENTRICULAR FIBRILLATION

THIS IS THE PATIENT THAT SALLY LEFT WITH CHEST PAIN.



VENTRICULAR FIBRILLATION

IN CCU

Q - What is Ventricular Fibrillation?

A - V-Fib is a lethal rhythm which requires immediate intervention. Above is a sample of V-Fib. There are no heart contractions and the ventricles are considered to be "quivering". V-Fib is commonly seen in cardiac arrest.

IF THERE IS CHEST PAIN ACT FAST!



Chest pain may seem like pressure, or heaviness in the chest



PAIN ASSESSMENT



NUMERICAL
RATING
SCALE

0- NO
PAIN

1-3 MILD
PAIN

7-10 SEVERE PAIN

Chest pain may feel like an extra pair of hands squeezing the chest.

4-6 MODERATE
PAIN



Chest pain may be severe and stabbing.

ASK PATIENT TO
DESCRIBE CHARACTER
AND DURATION OF
CHEST PAIN



DVT (DEEP VEIN THROMBOSIS)

JENNA (42 YEARS OLD) HAD A LAMINECTOMY 5 DAYS AGO. SHE REFUSES TO WEAR HER TED HOSE AND MOVE IN BED.

ASSESSMENT

If a patient complains of heat and pain in the calf. Assessment of the calf should be done.



Document findings and notify the doctor as soon possible.



THE PATIENT WHO IS ON PROLONGED BEDREST IS AT RISK FOR DVT (DEEP VEIN THROMBOSIS). TAKING MEASURES TO PREVENT DVT SHOULD NOT BE IGNORED. CARE PLANNING AND PATIENT EDUCATION ARE A MUST. VEINS HAVE VERY SLUGGISH BLOOD FLOW, UNLIKE ARTERIES WHICH HAVE VERY HIGH PRESSURE. BLOOD CLOTS TEND TO FORM AS A RESULT OF LACK OF MOVEMENT. TED HOSE, SCD AND ENCOURAGING PATIENT TO MOVE LEGS WHILE CONFINED TO BED, SHOULD BE INCLUDED IN THE PLAN OF CARE.

MECHANICAL VENTILATION

AGITATION

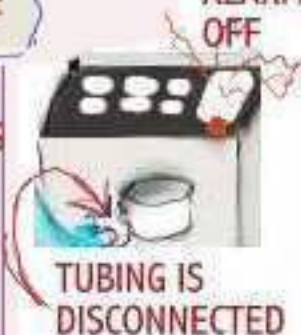


THERE GOES THOSE ALARMS AGAIN. I AM REALLY BUSY RIGHT NOW, I'LL BE BACK IN 10 MINUTES.

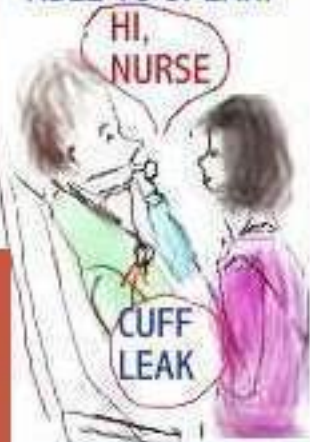
FOR MORE HELPFUL INFORMATION ON THIS TOPIC, PLEASE GO TO: WWW.DEARNURSES.NET AND ENJOY READING :THE CLINICAL SETTING STEP BY STEP (CHAPTER 13).

NEVER WALK AWAY FROM A PATIENT WHO IS AGITATED OR WHOSE ALARMS ARE ACTIVATED. TROUBLESHOOT PATIENT AND VENTILATOR BEFORE LEAVING. AN AGITATED PATIENT MAY REMOVE THE ET TUBE (EXTUBATION).

ALARM GOES OFF



A VENTED PATIENT SHOULD NOT BE ABLE TO SPEAK!



TRUBLESHOOTING IS VERY IMPORTANT.



WATER IN THE TUBING

SEIZURE ACTIVITY

CARE PLANNING FOR THE SEIZURE PATIENT



Mrs.S was involved in a car accident a week ago and has no prior history of seizures. She now has generalized seizures about twice a day.

HERE IS A SAMPLE OF A CARE PLAN FOR THE SEIZURE PATIENT:

- POTENTIAL FOR SEIZURES
- ASSESS AND MAINTAIN A PATENT AIRWAY,
- O2, SUCTION
- SIGN OVER BED
- PADDED BED RAILS

SEIZURE PRECAUTIONS

FOR MORE INFORMATION ON SEIZURES, PLEASE READ: SIMPLIFYING SEIZURES.

- BED RAILS UP AT ALL TIMES
- HOB OF BED UP 30 DEGREES OR AS ORDERED BY MD
- ROOM CLOSE TO DESK
- PATIENT AND FAMILY EDUCATION ABOUT SEIZURES

NEVER put a tongue blade or artificial airway into the mouth of a patient having a seizure



SEIZURES



ASSESSMENT

If you suspect there is seizure activity, here are some helpful hints:

- check for airway patency
- remove any object that may cause injury

After the seizure:

- give O₂ if necessary
- assess level of consciousness
- check vital signs (pulse, BP and respirations)
- assess and document the character and duration of the seizure

HELPFUL HINT

Ask someone to stay with the patient while you notify the doctor and receive further orders.



FALLS

Mr.H seemed okay when he was put to bed. He was given a sleeping pill and 2 hours later, his nurse finds him on the floor.



HELPFUL HINTS TO AVOID FALLS



THE INFORMATION BELOW MAY BE USEFUL TOOLS IN FALL PREVENTION.

A LOW LIGHT IN A PATIENT'S ROOM, MAY HELP TO PREVENT DISORIENTATION AND FALLING.

PATIENTS MAY BE AT RISK FOR FALLS FOR VARIOUS REASONS. CARDIAC, SLEEPING, ANTI-ANXIETY AND BLOOD PRESSURE MEDICATIONS ARE ONLY SOME OF THE REASONS THAT MAY CONTRIBUTE TO PATIENT FALLS.



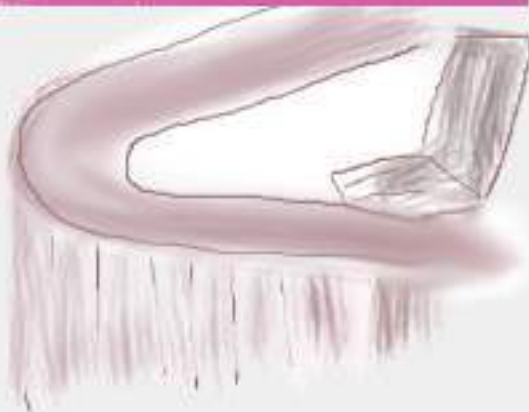
DIZZINESS, LOW BLOOD PRESSURE, STROKES, SURGICAL PROCEDURES AND VISUAL DISORDERS ARE SOME OF THE OTHER CAUSES RESPONSIBLE FOR FALLS.

THE CALL LIGHT WITHIN EASY REACH WILL ALSO HELP.



BED RAILS UP FOR SAFETY. ADVISE PATIENT OF THE REASON WHY.

A ROOM CLOSE TO THE NURSES' STATION WILL MAKE IT EASY FOR THE STAFF TO LOOK IN OFTEN.





Ali is anxious to go home. It is shift change and she hurriedly empties IV solution in the sink, but has made no attempt to put the the tubing in the disposal can near the sink. Misty has just arrived to wash her hands. She did not notice the puddle on the floor and slips. Could this have been prevented?

WHAT IS HIPAA?

Sally has no idea she is talking to her patient's employer. Her patient was involved in a car accident.



Yes sir, he had a blood alcohol level twice the legal limit.

**FOLLOW YOUR INSTITUTION'S POLICY FOR HIPAA.
HIPAA IS THE LAW!**

Your husband just called and I explained your diagnosis to him.

I do not have a husband.



Tom is a RN who is assigned to Sherrie a new admission. He has already spoken to "someone" about her diagnosis. He never took the trouble to find out who it was.

HIPAA

This nurse is giving information about a post-op patient. Does she know to whom she is giving the information?



LEARN MORE ABOUT HIPAA BY VISITING: DEARNURSES.COM

H-EALTH
I-NSURANCE
P-ORTABILITY
A-CCOUNTABILITY
A-CT

CARE PLAN

- DISCUSS WITH PATIENT AND FAMILY HIPAA
- DISCUSS DURABLE POWER OF ATTORNEY
- EXPLAIN YOUR INSTITUTION'S POLICIES AND PROCEDURES



HIPAA IS THE LAW!



These are her patient's neighbors.



My boss said we have to follow HIPAA, but I still don't get it.

This is the admission Melinda left for the night shift. Pay close attention to what happens next.

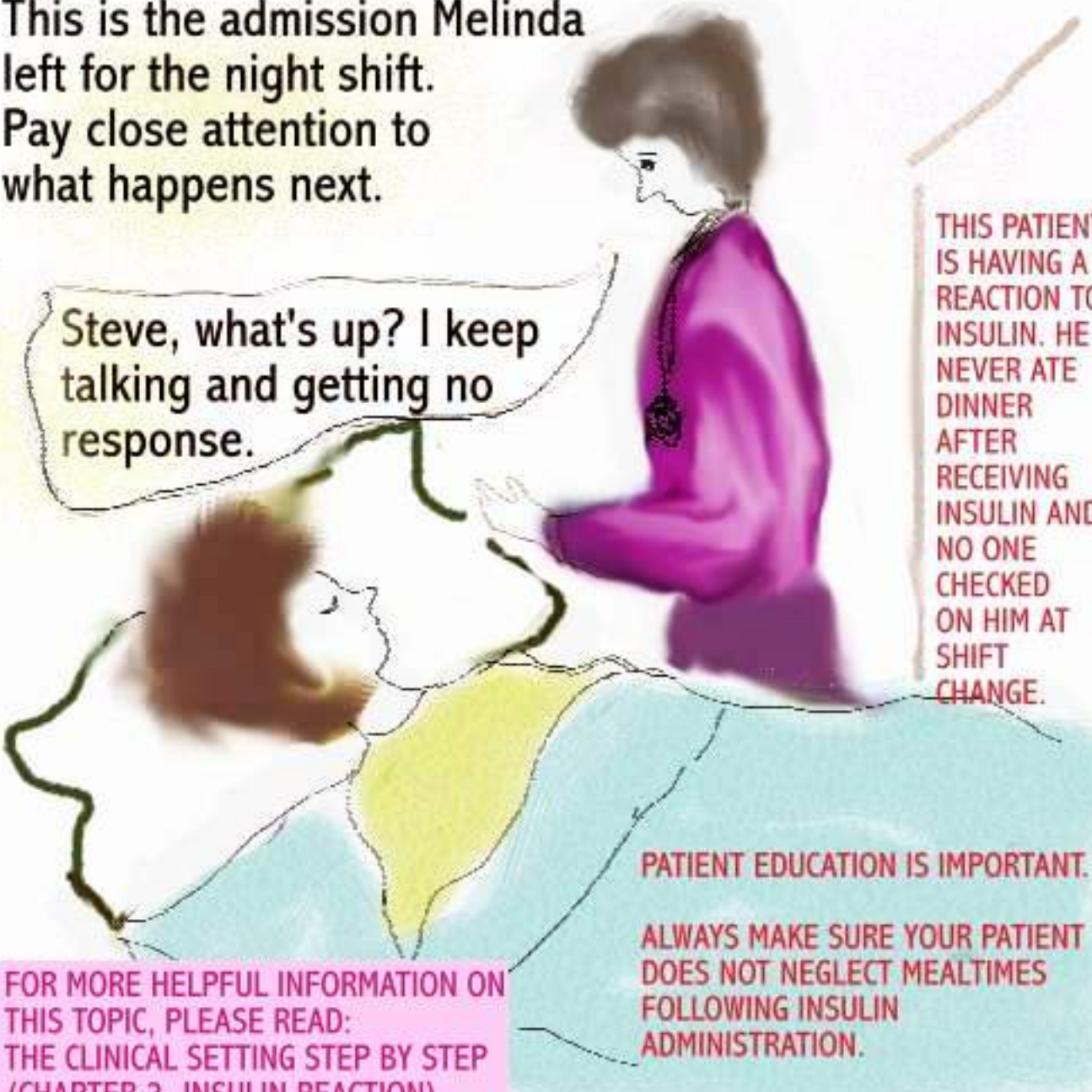
Steve, what's up? I keep talking and getting no response.

THIS PATIENT IS HAVING A REACTION TO INSULIN. HE NEVER ATE DINNER AFTER RECEIVING INSULIN AND NO ONE CHECKED ON HIM AT SHIFT CHANGE.

PATIENT EDUCATION IS IMPORTANT.

ALWAYS MAKE SURE YOUR PATIENT DOES NOT NEGLECT MEALTIMES FOLLOWING INSULIN ADMINISTRATION.

FOR MORE HELPFUL INFORMATION ON THIS TOPIC, PLEASE READ: THE CLINICAL SETTING STEP BY STEP (CHAPTER 2-INSULIN REACTION).



ACCURATE PATIENT ASSESSMENT

GCS

THE GLASGOW COMA SCALE IS THE COMMONLY USED NEUROLOGICAL ASSESSMENT SCALE, IN THE CLINICAL SETTING.



1. If your patient does not respond when spoken to (following commands) Try some simple form of stimulation for example, shaking the shoulder or a gentle tap. Be sure to document your assessment .
2. If your patient continues not to respond, assess the airway for patency.
3. Check vital signs and oxygen saturation.
4. Document findings and notify MD. Your patient may need a work-up and a higher level of care if not in a monitored area.

1. If your patient does not respond when spoken to (following commands) Try some simple form of stimulation for example, shaking the shoulder or a gentle tap. Be sure to document your assessment .

GCS=1-15

EYE OPENING RESPONSE

SPONTANEOUS=4

VERBAL=3

PAIN=2

NO RESPONSE=1

VERBAL RESPONSE

ORIENTED=5 CONFUSED=4

INAPPROPRIATE =3

INCOMPREHENSIBLE=2

NO RESPONSE=1

MOTOR RESPONSE OBEYS COMMANDS=6

PAIN=5 WITHDRAWS=4 FLEXION=3

EXTENSION = 2 NO RESPONSE = 1

GLASGOW
COMA
SCALE

THIS PATIENT IS ON A HEPARIN DRIP.

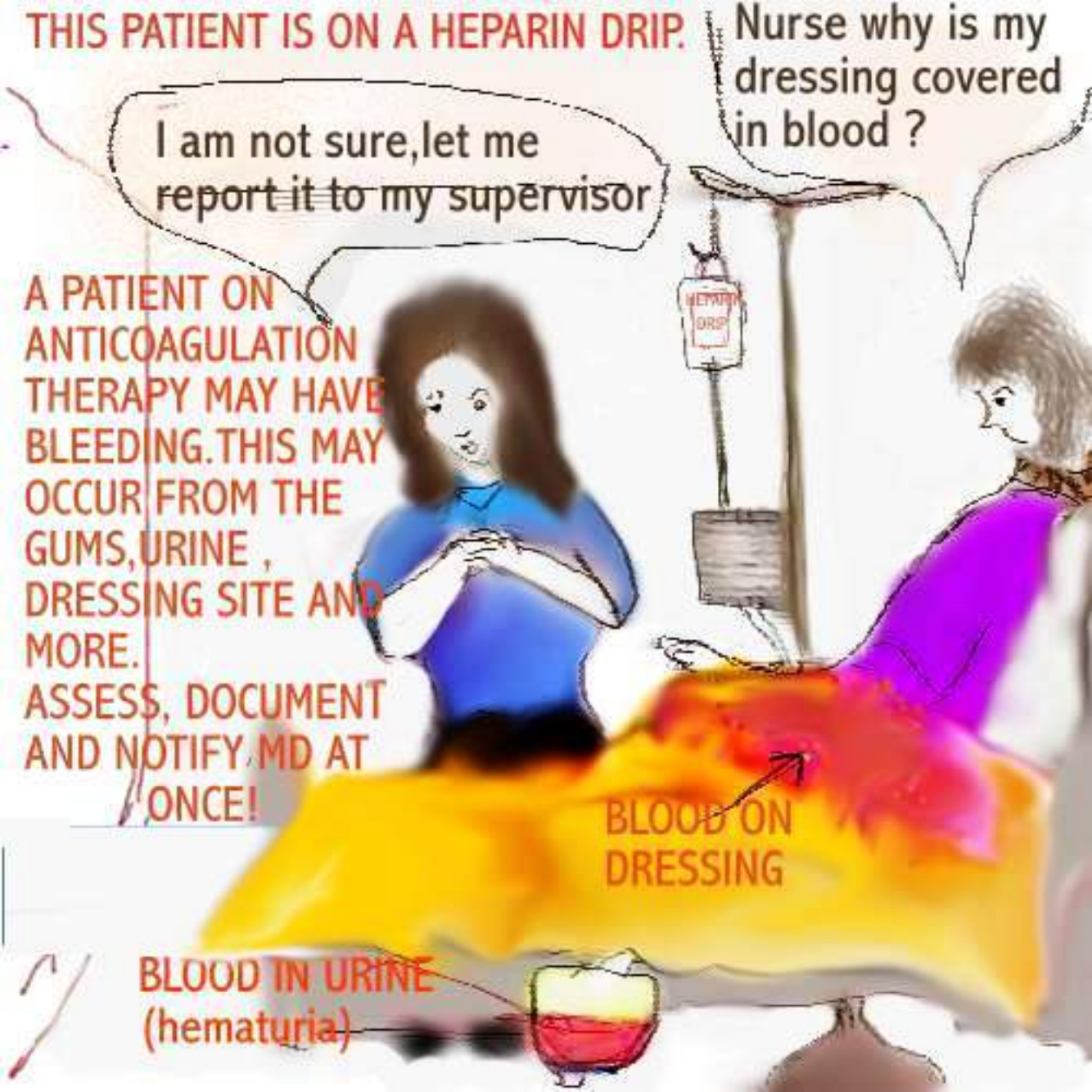
Nurse why is my dressing covered in blood ?

I am not sure,let me report it to my supervisor

A PATIENT ON ANTICOAGULATION THERAPY MAY HAVE BLEEDING.THIS MAY OCCUR FROM THE GUMS, URINE , DRESSING SITE AND MORE. ASSESS, DOCUMENT AND NOTIFY MD AT ONCE!

BLOOD ON DRESSING

BLOOD IN URINE (hematuria)



ASSESSMENT

The nurse is on rounds at shift change and assesses Mrs.S. He notices she is having difficulty raising her right arm. He also notices her speech is slurred.



MRS.S HAD BRAIN SURGERY 4 DAYS AGO AND WAS DOING WELL. SHE IS NOW DISPLAYING STROKE SYMPTOMS



INTERVENTION:
THE NURSE DOES A NEUROLOGICAL ASSESSMENT AND CHECKS THE VITAL SIGNS AND OXYGEN SATURATION.

NOTIFY MD AS SOON AS POSSIBLE!

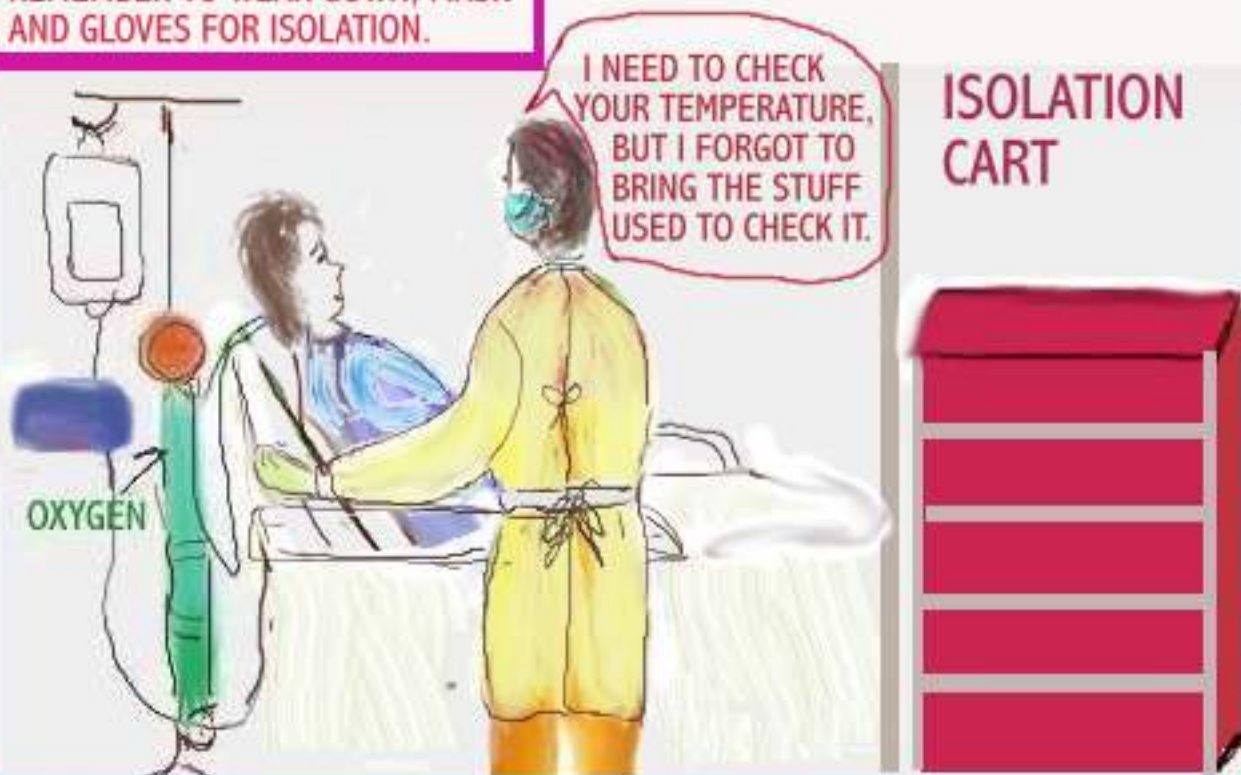
DOCUMENTATION:
THE NURSE DOCUMENTS HIS FINDINGS AND NOTIFIES MD.

FOR MORE HELPFUL INFORMATION ON STROKE, PLEASE READ:
THE CLINICAL SETTING STEP BY STEP;
CHAPTER 18.

(STROKE AND ITS CONSEQUENCES)
WWW.DEARNURSES.NET

JAKE IS IN ISOLATION FOR MRSA IN HIS WOUND. ALI IS ASSIGNED TO HIM AND HAS NO IDEA HOW TO ORGANIZE HERSELF.

REMEMBER TO WEAR GOWN, MASK AND GLOVES FOR ISOLATION.



HELPFUL HINTS :

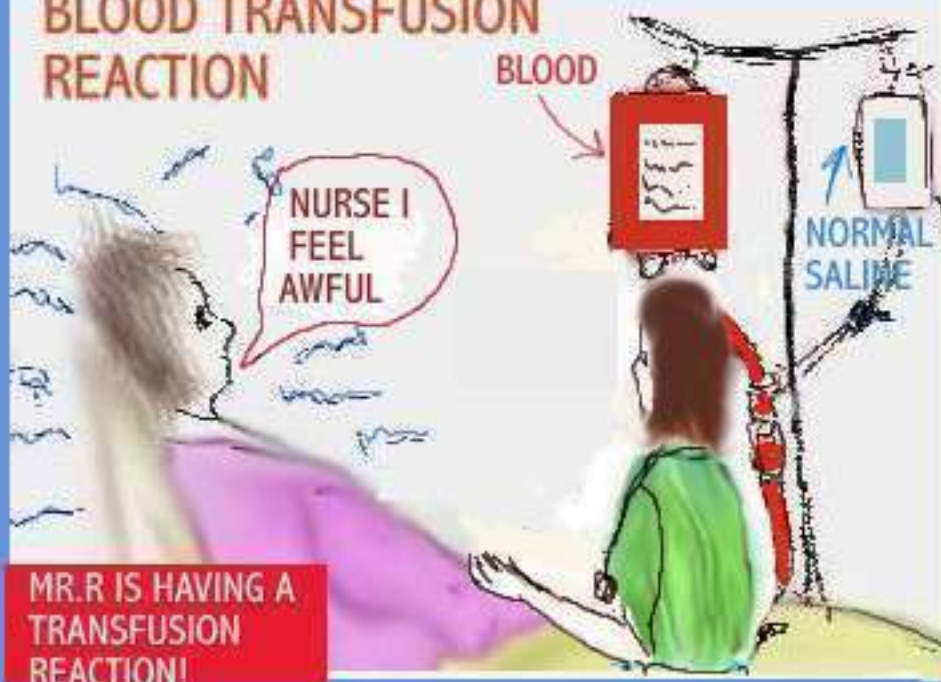
- WHEN ASSIGNED TO A PATIENT IN ISOLATION, MAKE SURE THE ISOLATION CART IS WELL STOCKED WITH GOWNS, GLOVES ETC.
- GATHER ALL NEEDS LIKE THERMOMETERS, MEDICATION, IV FLUIDS AND DRESSINGS BEFORE GETTING DRESSED TO ENTER ROOM.
- CHECK TO MAKE SURE THE TRASH CANS AND LINEN BINS ARE IN GOOD SUPPLY AND ALWAYS EMPTIED WHEN FULL.



DID SARA USE GOOD CLINICAL JUDGEMENT?

SARA HAS JUST HUNG A UNIT OF PACKED RED BLOOD CELLS. SHE DID NOT CHECK THE BLOOD WITH ANOTHER LICENSED PERSON. SHE DID NOT FOLLOW HER HOSPITAL'S POLICY. THERE ARE A 2 PATIENTS WITH THE SAME NAME AND THIS IS NOT THE ONE FOR WHOM THE BLOOD WAS ORDERED.

BLOOD TRANSFUSION REACTION




MR. R IS HAVING A TRANSFUSION REACTION!

HELPFUL HINT:
ALWAYS REMEMBER TO FOLLOW YOUR MD ORDERS AND INSTITUTION'S POLICY FOR BLOOD TRANSFUSION.

SARA HAS JUST ARRIVED TO CHECK ON HER PATIENT. MR. R IS HAVING CHILLS. HE IS HAVING A BLOOD TRANSFUSION REACTION.

YOUR CRITICAL THINKING



I FEEL
CONFIDENT
ABOUT MY
CRITICAL
THINKING.

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