Your everyday practice is filled with assessments, documentation, planning, interventions, and evaluations. Then there’s patient and family education, medication reconciliation, communication with other healthcare professionals, and transferring and discharging patients. The list goes on and on. The point is that as nurses, our days are full!

The clinical team here at Lippincott’s NursingCenter.com has assembled this list of nursing tips to help make your days run a little smoother, improve your practice, and optimize patient care. Here you’ll find handy mnemonics, definitions, practice pointers, and more. Do you have a nursing tip to share? You can send it to us at editor@nursingcenter.com. Thanks!

Professionalism

1. The nursing process: assess, diagnose, plan, implement, evaluate (ADPIE).

2. Nursing is a 24/7 operation that requires teamwork — do your best to prioritize and work safely & pass on the rest.

3. Organize tasks by “must do” (within 30 minutes), “should do” (within 4 hours), and “could do” (before end of shift).

4. When the number of tasks to be done seems out of control, stop and take a deep breath, even a 5-second break can help!
Professionalism — continued...

5. Five rights for delegating care: right person, right task, right circumstances, right direction, right supervision.

6. Take the lead to inspire teamwork — pitch in and help your colleagues. Perhaps others will follow your lead!

7. Key to a fulfilling work life...have a goal and focus on working toward it; goal should be realistic & attainable.

8. When caring for an abuse victim — establish trusting relationship, treat immediate injuries, record factual account, & refer

Assessment

9. A successful assessment requires critical thinking. Think “how does this finding fit in with the big picture?”

10. A patient’s behavior & appearance can offer subtle clues about his health. Carefully observe for unusual behavior or signs of illness.

11. When assessing the abdomen, inspect first, then auscultate, percuss, and palpate.

12. In general, the younger a child, the higher the pulse and respiratory rates.

13. Accurate measurements of height and weight are important for evaluating nutritional status, calculating medication dosages, and assessing fluid loss or gain.

14. Four parts of nutritional assessment: health history, lab tests, body systems assessment, anthropometric measurements.

15. If a patient is frightened or ticklish, begin palpation of the abdomen with your hand on top of his or her hand.

16. When listening to heart or breath sounds, close your eyes to help focus your attention.

17. Use the bell of the stethoscope to hear low-pitched sounds; the diaphragm to hear high-pitched sounds.

18. When assessing a patient, palpate tender areas last.

19. Percussing over a solid organ, such as the liver or kidney, should create a dull sound.


21. PQRST to evaluate symptom: Provocative/Palliative (what makes it better/worse), Quality/Quantity, Region/Radiation, Severity, Timing.
Assessment – continued...

22. Think "CURVES" to evaluate decision making ability: Choose & Communicate, Understand, Reason, Value, Emergency, Surrogate.

23. Suspect abuse? SEE: Screening, Evidence (gather it), Effort (to report findings & direct patient to appropriate agencies).

Documentation

24. When documenting a patient’s behavior, include only the facts — not your opinion on why the patient is behaving a certain way.

25. When documenting the reason for seeking care, record the information in the patient’s own words.

26. When in doubt, spell it out. Are you familiar with acceptable abbreviations where you work?

27. PIE — Problem, Intervention, Evaluation – include all 3 in your documentation.

28. The null sign (Ø) is on the ISMP’s List of Error-Prone Abbreviations, Symbols, and Dose Designations. Write ‘0’ or ‘zero’ instead.

Communication

29. At start of shift, tell patient what is expected to occur and what treatments & procedures are planned.

30. Don’t forget common courtesy — introduce yourself to patients and identify yourself as a nurse.

31. Believe in yourself and your instincts, but always listen to the patient.

32. Consider asking, “Does anyone have any ethical concerns with this patient’s care?” to open dialogue during rounding.

33. Communication technique — Clarification — For example, “I’m not sure I understood what you said.”

34. Working with students? Offer warm greeting, include in daily routine, treat with respect, and model professional behavior.

35. To conclude history taking — “I think I have all the information I need now. Is there anything you’d like to add?”

36. Humor can help put a patient at ease, but avoid sarcasm and keep jokes in good taste. Know where to draw the line.
Communication — continued...

37. Closed questions elicit yes/no or 1-2 word answers; can help you zoom in on specific points, but don’t allow patient to elaborate.

38. Good communication is essential —> when transferring care to another person, speaking with and educating patients, interacting with families and other visitors.

39. When giving report or transferring care, think SBAR: Situation, Background, Assessment, Recommendation.

40. Use open-ended questions to assess for abuse: When do you feel safe? When do you not feel safe?

Pain management

41. Goals of pain management - reduce pain intensity, improve ability to function, improve quality of life.

42. The goal of pain management is to keep the patient as comfortable as possible. It is not to use as little pain medication as possible.

43. A patient’s self-report is considered the most accurate way to detect and measure pain.

44. When choosing a pain rating scale, consider the patient’s visual acuity, age, reading ability, and level of understanding.

45. Patients with dementia who are in pain may have atypical behaviors (i.e. aggression). Remember: behavioral changes can signal pain.

46. Don’t expect to find physiologic markers of pain, such as vital sign changes, grimacing, or diaphoresis, in a patient with chronic pain.

47. Breakthrough pain = worsening of pain that occurs intermittently and spontaneously or in association with certain activity.

Lab Values

48. Four causes of hyperkalemia = excess intake, decreased excretion, cellular disruption, & intracellular-to-extracellular shifts.

49. Signs of hyperkalemia (level > 5.5 mEq/L) - wide QRS complex, peaked T waves, dysrhythmias, nausea, hypotension.

50. The general goal for hemoglobin A1C levels among nonpregnant adults is less than 7%. (2010 ADA standards).

51. Low TSH level indicates hyperthyroidism; high TSH level indicates hypothyroidism.
Lab Values – continued...

52. When thyroid gland is hypoactive, thyroid stimulating hormone (TSH) level is high; when overactive, TSH level is low.

53. Myxedema coma occurs when thyroid hormone levels drop too low; thyroid replacement with levothyroxine (T4) is priority.

54. ABG analysis...pH less than 7.35 = acidosis (more Acid), pH greater than 7.45 = alkalosis (more Base)...

55. Severe or prolonged hypoxemia leads to tissue hypoxia & anaerobic metabolism, altering patient's acid-base status.

56. pH reflects the concentration of hydrogen ions (H+) in arterial blood. Low pH = more acid (H+) in blood.

57. The 2 causes of metabolic acidosis you are most likely to see in hospitalized patients: lactic acidosis and ketoacidosis.

58. Serum lactate is a marker of anaerobic metabolism (occurs when tissue oxygenation demands are greater than supply).

59. The most common cause of an acute lactate elevation is shock (including septic, cardiogenic, & hemorrhagic).

60. Normal hemoglobin values: men – 14 to 17.4 g/dL; women – 12 to 16 g/dL. (Be sure to check reference range for your lab).

61. Causes of decreased albumin levels - burns, malnutrition, liver or renal disease, heart failure, major surgery, infections, and cancer.

Medications

62. Five rights of medication administration: right patient, right medication, right dose, right time, right route.

63. When asking about medications, don’t forget to ask about OTC products, vitamins, & complementary & alternative therapies!

64. Double-checks work best when done independently; calculate dose separately & then compare answers.

65. When asking about drug use, tell patient that honest disclosure of all drug use will lead to improvement, not denial, of care.

66. The vastus lateralis muscle is the preferred site for giving an I.M. injection to a newborn.

67. Extravasation = the infiltration of a vesicant drug from an I.V. line into surrounding tissue.
### Medications – continued...

| 68. | When floating to a different unit, look up unfamiliar drugs or familiar drugs in unfamiliar places — doses may differ. |
| 69. | Don’t refill a syringe after it’s already been used, even for the same patient. |
| 70. | Elderly patients taking an anticoagulant have an increased risk of bleeding, especially if they also take NSAIDs. |
| 71. | Half-life = amount of time required for a drug’s plasma concentration to decrease by 50%. |
| 72. | Use lowercase letter “g” to abbreviate the word “gram” or “grams.” |
| 73. | Before giving a medication through an enteral feeding tube, flush the tube with at least 15 ml of sterile water. Flush again after med administration. |
| 74. | Avoid mixing meds before giving them through an enteral feeding tube; each should be administered separately. |
| 75. | Live attenuated influenza vaccine (nasal spray) is not for anyone with asthma or kids < 2 years with recurrent wheezing. |
| 76. | Nimodipine (Nimotop) capsules should be given only by mouth or through an NG tube and never by I.V. administration. |
| 77. | Green halo sign = seeing green halo around lights; one of the most common signs of digoxin toxicity. |
| 78. | Flumazenil is the reversal agent for benzodiazepines; naloxone is used to reverse opioids. |

### Cardiovascular system

| 79. | When measuring pulse rate, if the rhythm is irregular or the patient has a pacemaker, count the beats for a full minute. |
| 80. | When taking a patient’s pulse for the 1st time or when obtaining baseline data, count the beats for 1 full minute. |
| 81. | Use the pads of your middle and 4th fingers to take a pulse. Don’t use your thumb; it has a strong pulse of its own. |
| 82. | Don’t palpate both carotid arteries at the same time or press too firmly; patient could faint or become bradycardic. |
| 83. | If you need to repeat a BP measurement, wait at least 2 minutes before retaking. |
| 84. | To calculate mean arterial pressure (MAP), add systolic BP and twice the diastolic BP, then divide result by 3. |
Cardiovascular system — continued...

85. Three positions for cardiac auscultation — supine with HOB elevated 30-45 degrees, sitting up, lying on left side.

86. If heart sounds are faint, try repositioning patient in left lateral decubitus position or seated, forward-leaning position.

87. Six characteristics of heart sounds: location, intensity, duration, pitch, quality, and timing.

88. Thrill = palpable vibration felt over the heart or a blood vessel; results from turbulent blood flow.

89. A displaced apical impulse may indicate an enlarged left ventricle. Possible causes = heart failure or hypertension.

90. Describing a murmur: crescendo = increases in intensity; decrescendo = decreases in intensity.

91. Four valves of the heart - 2 atrioventricular (tricuspid & mitral valves) and 2 semilunar (pulmonic & aortic valves)

92. The first heart sound, S1, which produces the "lub" sound, is associated with closure of mitral and tricuspid valves.

93. The second heart sound, S2, which produces the "dub" sound, is associated with closure of pulmonic and aortic valves.

94. S4 heart sound may be heard in elderly patients or those with hypertension, aortic stenosis, or history of MI.

95. Blood from the myocardium returns to the heart through the coronary sinus which empties into the right atrium.

96. Right side of heart pumps blood to lungs to get oxygen; left side of heart pumps oxygenated blood to rest of body.

97. Three layers of the heart wall - epicardium (outer), myocardium (middle), endocardium (inner).

98. Myocardium is middle layer of heart wall; has striated muscle fibers that cause heart to contract.

99. Pericardium is the sac that surrounds the heart and roots of the great vessels; two layers: fibrous pericardium and serous pericardium.

100. Cardiac output (CO) is the amount of blood the heart pumps in 1 minute. CO= heart rate X stroke volume (amount of blood ejected with each heartbeat).

101. Stroke volume depends on 3 factors: preload, contractility, and afterload.

102. Preload = stretching of muscle fibers in the ventricles. This stretching results from blood volume in the ventricles at end-diastole.
**Cardiovascular system – continued…**

103. Contractility = inherent ability of the myocardium to contract normally; influenced by preload (the greater the stretch, the more forceful the contraction).

104. Afterload = pressure that the ventricular muscles must generate to overcome the higher pressure in the aorta to get blood out of the heart.

105. The normal pacemaker of the heart is the sinoatrial (SA) node; generates impulses 60-100 times/minute.

106. On the horizontal axis of ECG paper, a large block = 0.2 seconds & a small block = 0.04 seconds.

107. The QRS complex represents ventricular depolarization; it’s normally 0.10 second or less.

108. The QRS complex in bundle branch block is 0.12 second or greater because the ventricles aren’t depolarized simultaneously.

109. Predisposing factors for VTE (Virchow triad) — venous stasis, endothelial or vessel wall injury, & hypercoagulable states.

110. A serious consequence of atrial fibrillation is the development of thrombi in the atrium.

111. Post-op afib usually occurs within 5 days after open heart surgery, with peak incidence on day 2.

112. Clinical consequences of atrial fibrillation: Decreased cardiac output and potential for thrombus formation.

113. Administering supplemental oxygen to patient experiencing an MI is top priority of care.

114. An enlarged waist circumference indicates central obesity, a key risk factor for metabolic syndrome.

115. Classic signs of cardiac tamponade — increased JVP, hypotension, and muffled heart sounds — also known as Beck’s triad.

116. Prehypertension = systolic BP between 120-139 mm Hg and diastolic BP between 80 - 89 mm Hg.

117. Narrow pulse pressure and tachycardia are two of the earliest signs of sepsis.

118. ARVC = arrhythmogenic right ventricular cardiomyopathy. Characterized by severely thinned and dilated right ventricle.

119. Educate patients about heart disease modifiable risk factors - tobacco use, physical activity, diet, weight management, BP, & lipid levels.

120. From the American Heart Association – 7 D’s of stroke care: Detection, Dispatch, Delivery, Door, Data, Decision, Drug.

121. An S3 is a normal finding in a child. In an adult, however, this heart sound can indicate heart failure.

122. Pulsus paradoxus = increases and decreases in pulse amplitude associated with the respiratory cycle (decreased with inhalation). Associated with pericardial tamponade, heart failure, constrictive pericarditis.
Cardiovascular system – continued...

123. Pulsus alternans = alternating pattern of weak and strong pulse; associated with left-sided heart failure.

124. A fever, plus a new or changed heart murmur, is the classic sign of endocarditis.

125. The most common causes of orthostatic hypotension are volume depletion and autonomic dysfunction.

126. Patients with metabolic syndrome are at increased risk for coronary artery disease, stroke, and type 2 diabetes.

Respiratory system

127. The left lung has 2 lobes; the right lung has 3 lobes. (Remember L comes before R, 2 comes before 3).

128. Assess respiratory rate while taking patient’s pulse (if patient knows you are counting respirations, he may subconsciously alter rate)

129. Don’t leave your stethoscope out in the cold — it can freeze & crack.

130. During auscultation, keep the stethoscope tubing off patient’s body & other surfaces to avoid picking up extraneous sounds.

131. The rate of inspiration to expiration (I:E) is normally about 1:2.

132. Remove artificial nail or nail polish before applying a pulse oximeter probe to a patient’s finger.

133. If a patient has a suspected cervical spine injury, the jaw-thrust maneuver should be used to open the airway.

134. To check back of thorax for tactile fremitus, ask patient to fold his arms across chest; this shifts scapulae out of the way.

135. Production of pink, frothy sputum is a classic sign of acute pulmonary edema.

136. In ARDS, alveolar membranes are more permeable & spaces are fluid filled. Alveoli collapse, impairing gas exchange.

137. PEEP reduces cardiac output by increasing intrathoracic pressure and reducing the amount of blood delivered to left side of heart.

138. “Blue bloater” refers to patients with chronic obstructive bronchitis (think ‘B’...Blue Bloater, Bronchitis).

139. “Pink puffer” refers to patients with emphysema (think ‘P’...Pink Puffer, emPhysema).

140. A patient with orthopnea (shortness of breath while lying down) tends to sleep with upper body elevated. Ask how many pillows he uses.
Respiratory system – continued...

141. Most common causes of massive hemoptysis – lung cancer, bronchiectasis, active TB, cavitary pulmonary disease from necrotic infections or TB.

142. If subcutaneous emphysema involves the neck or upper chest, airway patency may be compromised.

143. Clubbing = thickening of flesh under the toenails and fingernails, causes nails to curve down. Seen in patients with chronic lung disease causing hypoxia.

144. Clubbing is typically a sign of pulmonary or cardiovascular disease, such as emphysema, chronic bronchitis, lung cancer, or heart failure.

145. Be alert for post-op respiratory complications: hypoventilation, atelectasis, airway obstruction, aspiration, pneumothorax.

146. Respiratory alkalosis results from alveolar hyperventilation; decreased PaCO₂ (less than 35 mmHg) and increased pH (over 7.45).

147. Crepitus feels like puffed rice cereal crackling under the skin; indicates air leaking from the airways or lungs.

148. Pre-op teaching for pneumonia prevention - deep breathing, coughing (teach patient to splint), and incentive spirometry.

149. A decrease in blood pH stimulates the respiratory center, causing hyperventilation. This causes CO₂ to decrease to help normalize pH.

150. Barrel chest indicates loss of lung elasticity and flattening of diaphragm; seen in patients with COPD.

151. Pleural space is between visceral pleura (outer lining of lung) and parietal pleura (inner lining of thoracic cavity).

152. Pleural space normally has about 50 mL of fluid; allows surfaces of visceral pleura and parietal pleura to glide smoothly during respiration.

153. To prevent VAP (ventilator associated pneumonia), keep HOB elevated 30-45 degrees for ventilated patients (unless contraindicated).

154. Ventilation-perfusion mismatch — amount of air in the alveoli does not match the amount of blood in the capillaries.

155. Dead space ventilation = normal ventilation (air movement) but without adequate perfusion (blood flow). Example of cause is pulmonary embolism.

156. Shunt = Perfusion without adequate ventilation; usually results from airway obstruction, such as atelectasis or pneumonia.
Respiratory system – continued...

157. Silent unit = inadequate ventilation and inadequate perfusion; usually results from multiple causes, for example, PE with resultant ARDS.

158. Signs and symptoms of PE: severe dyspnea, tachypnea, chest pain, cough, hemoptysis.

159. Key treatments for ARDS: Antibiotics (if bacterial infection), Respiratory support, Diuretics, Situate patient in prone position.

Gastrointestinal system

160. Normal range for bowel sounds is 5-35/minute.

161. Abdominal angina = abdominal pain in which perfusion to digestive tissue has been compromised; usually due to mesenteric atherosclerosis.

162. McBurney’s point — located between umbilicus and the right anterior iliac crest; pain here associated with appendicitis.

163. Suspect appendicitis? Check for Rovsing sign (RLQ pain during left-sided pressure) and referred rebound tenderness.

164. Appendicitis: pain typically begins near the umbilicus, and then shifts to RLQ. Coughing usually worsens the pain.

Renal system

165. Functions of kidneys: form urine to remove wastes from the body, maintain acid-base and fluid-electrolyte balance, and assist in BP control.

166. The kidneys help manage acid-base balance by regulating bicarbonate concentration of the blood.

167. The rate of bicarbonate formation by the kidneys is affected by the amount of CO$_2$ in the blood and the potassium content of the tubular cells.

168. Kidneys secrete erythropoietin in response to low arterial O$_2$ tension; it travels to bone marrow to stimulate RBC production.

169. In renal failure, the kidneys are no longer able to excrete potassium, resulting in hyperkalemia.

170. Wilm’s tumor, also known as nephroblastoma, is a tumor in the kidney; most common in children ages 2 to 4 years.

171. To help prevent catheter-related UTIs, keep the drainage bag below the level of the bladder at all times.
Renal system – continued...

172. Diabetes insipidus characterized by polydipsia and large amounts of waterlike urine with specific gravity 1.001 to 1.005.

173. Patients with SIADH need to be closely monitored for hyponatremia.

Musculoskeletal system


176. Osteoarthritis is a localized disease; rheumatoid arthritis is systemic.

177. To remember the functions of muscles, think MPH: Movement, Posture, and Heat.

Hematologic/Immunologic systems

178. Five types of WBCs = granulocytes (neutrophils, eosinophils, and basophils) and agranulocytes (monocytes and lymphocytes).

179. Neutropenia is defined as a neutrophil count less than 1000 cells/mm³. Infection risk increases as neutrophil count decreases.

180. Functions of the spleen: break down worn out RBCs, filter and remove bacteria and other foreign substances, interact with lymphocytes to initiate immune response.

181. Acute hemolytic transfusion reactions can occur anytime during transfusion, but usually appear within the first 5-15 min.

182. Compatible blood groups- type A with A or O; type B with B or O; Type AB with A, B, AB, or O; type O with O only.

Neurologic system

183. When assessing mental status, be sure to ask questions that require more than a yes or no answer.

184. Delusion = a false, fixed belief that has no basis in reality.

185. Apraxia = inability to perform coordinated movements, even though no motor deficit is present.

186. Ataxia = uncoordinated actions when voluntary muscle movements are attempted.
Neurologic system – continued...

187. When communicating with aphasic patient, use short phrases & pause between phrases to allow time for patient to process & understand.

188. Trigeminal nerve (CN V) has sensory (corneas, nasal & oral mucosa, facial skin) & motor functions (jaw & chewing muscles).

189. Four major arteries (two vertebral and two carotid) supply the brain with oxygenated blood.

190. Four lobes of cerebrum: parietal, occipital, frontal, and temporal.


192. Methods used to assess extraocular muscles: corneal light reflex, cardinal positions of gaze, and cover-uncover test.

193. Corneal light reflex—ask patient to look straight ahead, shine light on bridge of nose (from about 12-15” away). Light should fall at about same spot on each cornea.

194. Regulatory functions of the hypothalamus—temperature control, pituitary hormone production, & water balance.

195. Consensual light reflex = constriction of the pupil of one eye when light is shined in the other eye.

196. To assess immediate memory, tell patient 3 words. Have him repeat and ask him to remember. Ask him to repeat again in 5 minutes.

197. To assess short-term memory, ask patient to describe something that happened in the last few days. Remember, you need to be able to verify his response!

198. Hallmark sign of severe neurologic injury is change in pupil size and reactivity.

199. Functions of the cerebellum—maintain muscle tone, coordinate muscle movement, & control balance.

200. When assessing orientation, keep in mind that hospitalized patients often know month & year, but not date or day of week.

201. Agnosia = inability to identify common objects.

202. Hyperopia = farsightedness; Myopia = nearsightedness; Presbyopia = impaired near vision associated with aging.

203. Use a wisp of cotton to assess corneal sensitivity; not gauze or a tissue (could cause corneal abrasion & irritation).

204. Stupor = patient lies quietly with minimal spontaneous movement & is unresponsive except to vigorous and repeated stimuli.

205. Not all self-destructive behavior is suicidal in intent.
**Neurologic system – continued...**

**206.** Expressive aphasia = inability to express words or thoughts. Patient knows what he wants to say, but can’t find the words.

**207.** Receptive aphasia = inability to understand the spoken word.

**208.** In a healthy adult, intracranial pressure (ICP) is between 0 and 10 mm Hg. Elevated ICP = sustained ICP of 15 mm Hg or more.

**Integumentary system**

**209.** Elements of a basic skin assessment: temperature, color, moisture, turgor, and integrity.


**211.** Risk factors for pressure ulcers - advanced age, immobility, incontinence, infection, low blood pressure, malnutrition.

**212.** Fluid-filled lesions transilluminate with red glow when penlight placed against side. Solid lesions don’t transmit light.

**213.** Psoriasis lesions are generally red and circular, with a patchy appearance, and covered with heavy, dry, silvery scales.

**214.** The deeper a burn, the more extensive the damage to nerve tissue and the more intense the pain.

**215.** Rule of 9’s for burns: posterior trunk, anterior trunk & legs each = 18%; head/neck & arms each = 9%; perineum = 1%

**216.** Four P’s to assess penetrating wounds: pain, pulselessness, paresthesia, and pallor.

**217.** Evaluate all wounds that penetrate the skin for embedded material.

**218.** Shaving with a razor isn’t recommended practice for hair removal at a surgical site.

**Endocrine system**

**219.** The 3 major components of the endocrine system are glands, hormones, and receptors.

**220.** Endocrine glands = pituitary, pineal, thyroid, parathyroid, thymus, adrenal, pancreas, ovary, testes

**221.** Diabulimia = skipping insulin to lose weight; can lead to rapid progression of macrovascular and microvascular complications.
**Endocrine system — continued...**

| 223. | To remember the location of the adrenal glands, think ADD RENAL. They’re “added” to the renal organs, the kidneys. |

**Other**

| 225. | Dark green, leafy vegetables are the best nondairy sources of calcium. |
| 226. | Complications of septic shock = myocardial dysfunction, acute renal failure, chronic renal dysfunction, DIC, & liver failure. |
| 227. | SIRS = systemic inflammatory response syndrome. Sepsis = SIRS with infection. Severe sepsis = sepsis + evidence of end-organ dysfunction. |
| 228. | Three A’s to help prevent exposure to blood and other body fluids: Awareness, Attentiveness, Anticipation. |
| 229. | I.V. insertion: After tourniquet is on, ask patient to open & close his fist several times to encourage venous distension. |
| 230. | To convert Celsius (C) to Fahrenheit (F), multiply C by 1.8 & add 32. To go from F to C, subtract 32 & divide by 1.8. |
| 231. | Advise patients not to smoke before surgery and for at least 2 weeks after. |