CPNE TIPS

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This is a collection of several documents I prepared for my studies for the CPNE. The sections I used the most were my mnemonics and my lab station steps. These I kept with me at all times and referred to them constantly. As it has been a few years since I graduated from Excelsior College (EC), I have asked Lisa Sarao, a recent EC grad, to help me update these notes based on her experience.

As you are studying for the CPNE, make sure that if you don't know how to do something or come across a concept that you are unfamiliar with, that you ask someone for clarification or research it. Buy a clinical skills book and refer to it often. As paramedics, Lisa and I did not have the same training that LPNs received. We were able to supplement our paramedic knowledge, skills, and training by working in an emergency department. This was a wise move as the physicians and RNs proved to be invaluable resources when questions arose or guidance was needed.

There are several forums on the internet with many people who are in the same boat as you. Get involved with a forum. Students at traditional programs do not go through this alone, and neither should you.

Presented here is basic information on five areas:

1. Lab Stations.
2. Mnemonics.
3. Care plans/planning phase.
4. The game plan for organizing your PCS using the infamous "grid."
5. Charting, evaluation phase.

As you read through this strategy, please refer to the PCS form and kardex that are located in your study guide. There are several of these within your study guide with examples provided. They were invaluable to me during my studies.

We must say at this point that the strategy presented here is just one approach among hundreds of ways to prepare for the CPNE. This is not foolproof and will not guarantee that you will pass. Did it work for me? I passed my CPNE the first time with no repeats of lab stations or PCSs. Additionally, I was told by the CA and some of the CEs at my exit interview that they thought I was well prepared.

Good luck with your studies. We hope this helps you.

Sincerely,

Ivan Hart
Lisa Sarao

Lab Stations

A discussion of the lab stations is warranted because they are the first hurdle at the CPNE. Passing the lab stations on the first time is crucial, but not the end of the world if you don't. Labs can be retaken if failed, but then you go into the second day with the additional pressure of having to retake your labs after your first two PCSs.

What I did was simple. I set up a lab in my kitchen using medical supplies to simulate what I needed. There are sources for supplies and kits on the internet or perhaps your supervisor at work might let you borrow some. I had a 1000 ml bag of saline, two 50 ml bags of saline, four 10ml vials of saline for IV flushes, three syringes including an insulin syringe, some 4x4s, an abdominal (ABD) pad, alcohol prep pads, tape, gloves, and my fake wound. Excelsior has a vendor that sells the exact same wound they use during the CPNE. I know I have seen it on eBay.

The lab stations skills bag can be ordered online from Coursey Enterprises at http://www.courseyenterprises.com/ — click on "Student Log In." The user name is excelsior (lower case) and the password is k1411. You can choose to order the skills bag with a few options (stethoscope with skills bag, wound with skills bag, just the skills bag, just the wound, or the whole enchilada — stethoscope, wound, and skills bag). Included in the Coursey/EC skills bag is a step-by-step guide to the lab stations. Another resource for just the wound is http://www.initialresponse.com/ — the wound is the compound fracture of the humerus, product 6816.

If you can't get the wound that Excelsior uses, there are several ways to make your fake wound. People have used clay or foam padding. I used a foam/metal (SAM) splint from an ambulance that I was able to cut out the shape of the wound. Bottom line: make something that works for you.

My lab stayed set up in the kitchen for one month prior to my CPNE. I would partially break it down when not in use, but the supplies stayed there ready to go everyday.

So basically, I typed out all my steps in an MS Word document and printed that out. I then would go to my lab and practice. Here the key is to go *slow* and *verbalize* everything. You have plenty of time for each station. After you have it down, ask someone to watch you. Have them use your practice sheets so they can critique you. It is best if you have another medical person do this. I was lucky: my wife was a nursing student at a traditional program, so she would "grade" me from time to time, and then more often during the days right before the CPNE.

I live near the city where I tested, so I actually got to practice my lab stations in my house the day of the CPNE. I understand that most do not live near their testing site. Opinions vary, but I will say that it helped me to go over the labs the day of the test. If you have any opportunity to do so, I recommend it, even if you just verbalize the steps out loud or to a significant other if you didn't travel alone.

When you are actually testing, again, *verbalize* everything as you are doing it. Go slow and don't get rushed. You have *plenty* of time to complete the steps.

I was tested under the 11th edition of the study guide. I know that in subsequent editions things have changed. Please verify which edition you have, and by which edition you will be tested. You might have to call Excelsior for that information. You can then adapt any of the new changes into what has been put into these notes. With Lisa's help, these notes have been updated to the best of our knowledge in accordance with the 16th edition of the study guide, which is in effect beginning the weekend of October 2, 2009. Please be aware that the changes between the 15th and 16th editions are not extensive, but will be mentioned in the corresponding sections of this guide.

Following are the steps I used to pass my labs. Now some of these steps might have sub-steps of their own, so these lists are not 100-percent inclusive of every single step.

Wound protection (15 minutes)

- ID patient against the treatment administration record (TAR). (This is an optional step. Not all wound stations at all test sites will even have a TAR near the wound. This is not a critical element for this station.)
- Prepare/gather equipment. Tear new tape and write date, time, and initials. Make new tape same length as old tape.
- Put on clean gloves.
- Peel old tape toward the dressing.
- Remove dressing without contaminating wound (pinch up gently from center and remove all of the old dressing in one motion). Remove gloves inside-out, enclosing the old dressing in the glove.
- Dispose of dressing/gloves in designated container. (This will likely be a trash can at the wound station.)
- Open sterile packages. I opened mine in order of use, with the boat of 4x4s nearest me, the 4x4 gauze pad next, and the ABD pad furthest to avoid reaching over and contaminating items.
- Pour a little of the sterile saline into trash can (known as "lipping," this is optional and not a critical element for this station).
- Pour some sterile saline into the 4x4 boat.
- Don sterile gloves
- Prepare gauze for application to wound bed.
- Pack wound by applying moist gauze.
- Apply a sterile 4x4 sponge over packed wound.
- Apply sterile ABD pad over the 4x4 without contaminating wound.
- Secure dressing with tape (around all four edges, or you can do three strips — top, middle, and bottom; the important thing is that it's secure).
- Aseptic technique
- Recheck tape is signed with date, time, and initials.

A tip about the sterile gloves: during lab orientation, you can open and try on sterile gloves at the wound station. Please, do this to make sure you're choosing the gloves with the best fit for you, and to check out the quality of the gloves. Some sites have cheap, wrinkled gloves. If you have a problem getting the gloves on during the actual station, discard them and get a new pair — don't waste too much time on an uncooperative pair of gloves. I saw one successful student go through about 4 pairs of sterile gloves for this reason, and she still had plenty of time to complete the station and pass.

I felt like this was a hard station. This is the only station that requires any real dexterity. I was fortunate because my fake wound was awesome as far as shape and depth, but when I got to the actual station during the CPNE, their wound was not flat because it was strapped to a fake leg. Also their leg moved so it was unsteady. Just go slowly and verbalize everything.

Intravenous Medication (20 minutes)

- Put pen on MAR.
- Select correct minibag.
- Calculate correct gtts/min rate. Calculate 15 and 30 second rates as well.
- Write gtts/min on form.
- Identify the patient using the MAR. Students must identify the patient immediately before administering the medication by comparing the name, DOB, or MRN (two of those in any combination) against the MAR. Be obvious about this. Say the information out loud.
- Put gloves on.
- Assess IV site for temp changes/edema/discoloration. Say this out loud!
- Remove gloves.
- Check for air in tubing. Say this out loud.
- Spike secondary bag, kink tubing, don't touch spike.
- Lower primary bag
- Close primary bag. Open secondary bag all the way.
- Regulate gtts by slowly opening the primary bag.
- Count the drops for one full minute.
- Inform the CE you are ready for gtts rate to be verified.
- Document/sign/initial med given on MAR.
- Re-check that you documented, initialed, and signed MAR!! When the CE asks if you've completed all the critical elements for this station, that includes signing the MAR.

I put my pen on the MAR so I wouldn't forget to sign it. This station was pretty easy. They give you plenty of time for this station so you can count and recount your drop rate.

I have a friend that failed for not signing the MAR. She had to repeat the whole CPNE. She passed the second time, but at 1900 bucks a pop, I would consider signing the MAR!

The calculations for this station will be relatively easy. For example, your MAR might have an order of 1.5 gm Omnicef in 50 ml over 20 minutes with 10 drop set. Calculation: 50 ml multiplied by 10 gtts/ml divided by 20 minutes = 25 gtts/min. You can further break this down into 15-second increments, which would be approximately 6 drops every 15 seconds. After you let the tubing settle (because that will change the rate!), count for a full minute to ensure that you're within 5 gtts/min of the desired rate before telling the CE you are ready to have him/her count with you.

IM/SQ meds (15 minutes)

- Put pen on MAR.
- Select correct medications.
- Calculate doses to be mixed on calculation form.
- Let CE verify your dosages.
- Select correct syringe/needle. (There will be an assortment. Know the correct sizes for IM injections. If you are assigned insulin, you would obviously use an insulin syringe.)
- Decide which med is first. (Roll NPH, clear before cloudy, no bubbles.)
- Roll NPH here if assigned NPH.
- Wipe each bottle top with separate alcohol prep pad.
- Draw up meds.
- CE inspects each draw for correct dose.
- Recap needle. (Verify with the CA if you need to re-cap; some test sites do not require recapping. If they do, be sure to use the scoop technique/one-handed re-cap.)
- Identify the patient using the MAR. Students must identify the patient immediately before administering the medication by comparing the name, DOB, or MRN (two of those in any combination) against the MAR. Be obvious about this. Say the information out loud.
- Gloves on
- Select site
- Wipe site clean with alcohol prep pad.
- Aspirate. (According to the study guide, aspirating is not required for SQ injection, only for IM.)
- Inject med.
- Sharps in sharp container.
- Gloves off.
- Document/sign/initial med given on MAR.
- Re-check that you documented, initialed, and signed MAR!!

Again, place your pen on the MAR so you won't forget to sign. Remember when drawing up your two meds:

- Clean tops with alcohol pads.
- Inject appropriate amount of air into SECOND med. Don't let the needle touch the med.
- Remove needle.
- Inject appropriate amount of air into FIRST med but then don't remove needle.
- Draw up first med remove needle.
- Draw up second med remove needle. Do one-handed recap (only if recapping is required).
- If mixing two insulins the first med actually drawn up first needs to be the "clear" insulin.

These should not be complex calculations. For the IM meds, you do not have to worry about compatibility, or which medication to draw first. But you do need to demonstrate how many ml you will draw up for each med, and the total ml to be administered. Your MAR might show something like an order for an IM Injection of Compazine 2.5 mg (5 mg/ml vial) and Nubain 7.5 mg (5 mg/ml vial). The Compazine would be 2.5 mg divided by 5 mg/ml = 0.5 ml. For the Nubain, 7.5 mg divided by 5 mg/ml = 1.5 ml. You would total that up on the form to show 2 ml to be administered IM. You then draw up your medications, one at a time, and the CE approves each draw. You do not have to worry about the total ml being too much for any injection site that you choose, but be sure to correctly locate the site; verbalizing the landmarks is a good idea. Do NOT forget to aspirate for an IM injection!

IV Push (15 minutes)

- Put pen on MAR.
- Select correct medication.
- Calculate dose volume and time on calculation form. Also calculate half and quarter way amount/time.
- Let CE verify your dosages.
- Wipe vial adapter port with alcohol prep pad.
- Draw up medication (because the med vials have vial adapters with ports, and you can push extra air and/or medication back into the vial).
- Let CE inspect syringe for correct dose.
- Wipe port of saline bag with alcohol prep pad.
- Draw up first of two flushes. Keep med separate from flushes. (Note: this is a one-way valve on the IV bag port from which you draw your flushes. You will not be able to push air back in. You may overdraw a bit so that you can tap out air bubbles.)
- Wipe port of saline bag with alcohol prep pad.
- Draw up second of two flushes. Keep med separate from flushes.
- Gloves on
- Identify patient with the MAR. Students must identify the patient immediately before administering the medication by comparing the name, DOB, or MRN (two of those in any combination) against the MAR. Be obvious about this. Say the information out loud.
- Assess IV site for temp changes/edema/discoloration. Say this out loud!
- Make sure IV tubing is unclamped.
- Wipe port with alcohol prep
- Attach first flush and ASPIRATE. Do NOT forget to aspirate! Flush one over 8 to 10 seconds.
- Dispose of flush in sharps container
- Wipe port with alcohol prep
- Give med at right rate, ensuring that you don't push for five seconds and pause for 10; this could be considering bolusing the patient, which could be a point of failure.
- Dispose of syringe in sharps
- Wipe port with alcohol prep
- Flush two over 8 to 10 seconds
- Dispose of syringe in sharps container (Always, Always, Always! This will fail you if you don't!)
- Gloves off
- Document/sign/initial med given on MAR.
- Re-check that you documented, initialed, and signed MAR!!

I cannot stress enough that as you are going through your stations that you verbalize your steps out loud. **I literally would say, "I am wiping the port…I am putting the sharps in the sharps box…I am signing my MAR…I am rechecking that I signed my MAR, etc."** (those are not in any order, just examples). It may sound pretty foolish (I did get some looks), but by speaking out loud, you cue yourself on the correct steps. While I was taking my lab stations, I did not hear anyone else verbalizing, and many had to retake lab stations.

Mnemonics

Developing Your Mnemonics

This really was the meat of my studies. There is nothing new here. If you have been surfing the internet or are following any chat groups, then you have read that people use mnemonics. I am going to tell you how I came up with my mnemonics, how I learned and practiced them, and give you my mnemonics as examples.

Please note however the importance of coming up with your own. Even if you modify someone else's, it becomes your own. Why do I think that is important? ***Because when you develop your own mnemonics you will remember and recall them better than if you just copy someone else's and not put any thought into them.*** Also when I say "develop" mnemonics, it is because I found myself tweaking them as I went along to make them better.

So how did I create my mnemonics? To be honest, at first I didn't. I used others' mnemonics because I loved the cool little words that people were using. I remember thinking, "This is sweet! So easy!" Then I found that these little words were taking AOCs that were really complex and *over*simplifying them, and in the process, completely omitting steps. That means you run the risk of omitting a critical element and therefore failing the PCS. So I scrapped all the cute little words in favor of longer, more complex mnemonics.

What I did was pick an AOC from the study guide. Step by step I would come up with a key word for each step. The key word was either the main word, a synonym of the main word, or a word that best described the main concept of the step.

Let me show how I came up with my mnemonic for abdominal assessment. Initially it was:

PLL FG RR
Position patient.
Look for scars, distention, etc
Listen for bowel sounds in all 4 quadrants, etc
Feel for rigidity, tenderness, etc
Girth: measure if assigned (please note: girth assignment has been eliminated in the 16th edition)
Response of patient
Record everything.

So the first word was from the book: position, but the second word "look" was probably "observe" in the study guide. Both words work fine, but I preferred "look" because I am used to "look, listen, feel," not "observe, auscultate, palpate."

When I got to girth, I could have used for my key word "measure," but I opted for "girth." I did this because, to me, my mnemonic almost looks like "pull finger." Many of my key word choices were made to help my mnemonics easier to remember.

So that is how my abdominal assessment mnemonic started, but that is not how it ended. Later I added another word in the beginning and changed it to: PPLL FG RR. I also was expanding the information after each key word. So my mnemonic now was like this on my sheet:

ABDOMINAL ASSESS
PPLL FG RR (pull finger)
PEE AND TURN SUCTION OFF
POSITION-HAVE PT PEE THEN FLAT WITH KNEES UP (NO MORE THAN 30 DEGREES)
LOOK FOR DISTENTION
LISTEN FOR BOWEL SOUNDS IN 4 QUADS
FEEL FOR TENDERNESS/RIGIDITY IN 4 QUADS
GIRTH, MEASURE IF ASSIGNED (eliminated from the 16th edition)
RESPONSE/RECORD TURN SUCTION BACK ON IF TURNED OFF

So I did this for each AOC from the study guide. Now my mnemonics didn't really make cool little words, but I felt like I was covering all the critical elements of each AOC so it was worth the extra work when it came time to learn them. So how did I learn them? Actually, it was pretty easy.

Learning the Mnemonics

First, I took a stack of index cards and wrote the name of the AOC on the front (Abdominal Assessment). On the back I wrote the mnemonic, and under that I wrote out each key word and the info to the right of the key word. Then, five to seven cards at a time, I would practice the mnemonic and the mnemonic only; no key words at first. I did this by laying the card out in front of me and either writing on paper or typing in a blank MS Word document that I would not save (by the end of my studying I had quit using paper and was only typing into blank MS Word documents). After I learned all my mnemonics, I then started working on the key words that the letters represented. I did this the same way. I would take my stack of index cards (about 21-23 cards), mix them, and go through them again, this time typing out the mnemonic and under that, each key word. Another method is using an erasable whiteboard. You can also use this whiteboard when you're practicing writing out your grid.

After I had learned all the key words, I started on the info to right of the key word; for example, "Position" (that's the key word) and then "have patient lay flat on back with knees slightly bent" (that's the expanded information or definition of the key word: position).

Again, I would mix up my cards and lay them on my desk. I would then type out the AOC. Under that I would type the mnemonic and under that, the key word with all the information I had about the key word.

So here are the phases I went through as I was learning my critical elements:

Phase one: I would look at my card that said "Abdominal Assessment" and then I would type out:
ABDOMINAL ASSESS
PPLL FG RR

Phase two: After I learned the mnemonics, I would look at the same card, and now I would type out:
ABDOMINAL ASSESS
PPLL FG RR
PEE
POSITION
LOOK
LISTEN
FEEL
GIRTH (eliminated from the 16th edition)
RESPONSE/RECORD

Phase three: I was typing everything, and it would look like this:
ABDOMINAL ASSESS
PPLL FG RR
PEE AND TURN SUCTION OFF
POSITION-HAVE PT PEE THEN FLAT WITH KNEES UP (NO MORE THAN 30 DEGREES)
LOOK FOR DISTENTION'
LISTEN FOR BOWEL SOUNDS IN 4 QUADS
FEEL FOR TENDERNESS/RIGIDITY IN 4 QUADS
GIRTH, MEASURE IF ASSIGNED (eliminated from the 16th edition)
RESPONSE/RECORD TURN SUCTION BACK ON IF TURNED OFF

And that is what I did to learn my critical elements. Now my mnemonics might look hard because they don't make words, and so it might seem difficult to learn the jumbled letters. It was not hard, because, and this is important, I came up with my own! That meant I read the study guide step by step, thought about what I was going to use for my key word, and then wrote it down. That part actually took a bit of time: approximately two days to go through each AOC, figure out my key word, and write it down. So by the time you are typing out your mnemonics, you already partially know the key words.

It took me about three to four days, start to finish, before I was typing out the mnemonics and the key words. As for phase three with the extra info, that took approximately two to three more weeks. I found I would type out more and more info beside each key word as I went along, so by the end I was typing everything out. This included notes that I was learning along the way that perhaps were not there originally.

Just some additional notes: I ended nearly all my mnemonics with "RR" for response/record, "response" meaning the patients' response to something I did. Another word for response would be "reassess." When I was typing out my mnemonics and key words, I would press the caps lock on my computer. You can set MS Word to not spell check words in all caps. Because I was not typing for spelling, I didn't want the computer telling me that "ppll fg rr" was not word.

Every once in a while I would compare my mnemonics and key words with the study guide. This did several things: it ensured I didn't leave out any critical elements, and also helped because I was reading and reviewing the study guide so much.

You will find your mnemonics changing and evolving as you are also studying from other resources. As I would research areas of care with which I wasn't familiar, I might come across information that I would put on my mnemonic sheet. Remember that some of the AOCs have as a first step "complies with established guidelines." That could mean a lot of steps in just that one little sentence.

I had my mnemonics sheet as a separate MS Word document that I would print out or have called up on my computer to refer to as I was typing out my mnemonics. I can't tell you how many hundred's, possibly more than a thousand times I typed out my mnemonics! I am serious. It was many times. Don't just say them out loud. Type, write, and say them out loud! It will improve your memory and recall of them!

Following are my mnemonics that I developed. As you will see, they look very complicated. I maintain that they are more thorough than just using cute little words that may leave out a critical step or two. In any case, they are included just as examples. ***I really hope you try to come up with your own.***

Example Mnemonics

RESPONSE/RECORD(RR) MEANS TO REASSES AND CHART EVERYTHING!

TWENTY MINUTE CHECKS

- **WIGAAS**
- **W**ASH HANDS
- **I**NTRODUCE SELF/ ID PATIENT
- **G**LOVE/GTTS RATES
- **A**SSES IV/ ADVISE PT RE: I/O
- **A**SK PT RE: PAIN/COMFORT/AIR
- **S**AFETY/SKIN TURGOR/SAVE TRAY/SLIPPERS

Please note that in Enteral Feeding and Fluid Management AOCs, the 16th edition has added critical elements that states comparing any running IV solution and/or enteral feeding with the Assignment

Kardex is required within the first 20 minutes of the Implementation Phase (i.e., as part of the 20-minute checks). Many students already incorporate this into their 20-minute checks because it is a logical thing to do when checking drip or pump rates, which were already critical elements. Be deliberate in comparing the solution and/or feeding with the Kardex so that the CE can see that you've done it.

EVERY TIME YOU LEAVE ROOM:

- **B**EDRAIL UP X 2
- **B**ED LOWERED ALL THE WAY.
- **C**ALL LIGHT IN REACH.
- **P**HONE IN REACH.
- **R**EMIND ABOUT I/O
- **W**ASH HANDS.

ASEPSIS

WPDCE (watch police catch everybody, with police can't escape)

- **W**ASH HANDS
- **P**ROTECT SELF/PT
- **D**ISPOSE OF MATERIAL PROPERLY
- **C**ONFINE CONTAMINATED MATERIAL
- **E**STABLISH STERILE FIELD

CARING

IT LR DR (it lactated ringers doctor)

- **I**NTRO
- **T**HERAPEUTIC COMMUNICATION
- **L**ET PT EXPRESS
- **R**ESPOND TO EXPRESSION
- **D**ON'T ABUSE OR PATRONIZE (ADDRESS EVERYONE AS MA'AM OR SIR!!!)
- **R**ELATE

MOBILITY

AMDA RR (kind of makes a word, rhymes with NANDA)

- **A**SSESS LEVEL OF MOBILITY, DEVICES, BALANCE
- **M**OVE: SUPPORT WEAK, INJURED, HEAD, SHOULDER, PELVIS
- **D**EVICES: REDUCE PRESSURE, SUPPORT POSITION, NO SHEARING
- **A**SSIST WITH MOVING/AMBULATION, USE EQUIP AND MAINTAIN BALANCE
- **R**ESPONSE/RECORD

VITAL SIGNS

REMEMBER:

- TO WEAR GLOVES FOR ORAL/RECTAL TEMPS
- ZERO SCALE AND PLACE BARRIER ON IT

FLUID MGMT

HEPARRIIN RR (like heparin but with 2 r's, 2 i's)

- **H**YDRATION: TURGOR, MUCOUS MEMBRANE, FONTANEL
- **E**NTERAL DETERMINES KINDS TO BE INGESTED. ADMINISTERS OR RESTRICTS AS DESIGNATED.
- **P**ARENTERAL** VERIFY ACCURACY OF FLOW RATE BY COUNTING GTTS OR RECORDING EXACT ICD READING.
- **A**SSESS** IV SITE FOR TEMP/EDEMA

- **R**EGULATE**GTTS WITHIN 5 GTTS/MIN OR EXACT WITH ICD
- **R**ECORD PRESCRIBED FLUID INFUSING ON PCS FORM
- **I**V LAW: TREAT IV'S/IVAD FLUSHES AS MEDS
- **I**/O WHEN ASSIGNED MEASURE/COLLECT/RECORD WITHIN 10%
- **N**EED TO DOCUMENT
- **R**ESPONSE/RE-ASSESS/RECORD
- **TWENTY MINUTE CHECK!**

Please note that in Fluid Management AOC, the 16th edition has added two critical elements: one states that students must offer fluids to patients if "encourage fluids" is assigned, and the other is that comparing the running IV solution (if any) with the Assignment Kardex is required as part of the 20 minute checks [i.e., students must do this in the first 20 minutes of entering the room]).

ABDOMINAL ASSESS

PPLL FG RR (pull finger)

- **P**EE AND TURN SUCTION OFF
- **P**OSITION-HAVE PT PEE THEN FLAT WITH KNEES UP (NO MORE THAN 30 DEGREES)
- **L**OOK FOR DISTENTION
- **L**ISTEN FOR BOWEL SOUNDS IN 4 QUADS
- **F**EEL FOR TENDERNESS/RIGIDITY IN 4 QUADS
- **G**IRTH, MEASURE IF ASSIGNED (deleted as a critical element/assignment in 16th edition)
- **R**ESPONSE/RECORD TURN SUCTION BACK ON IF TURNED OFF

NEURO ASSESSMENT

LPP MN RR (lpp, yeah you know me, Minnesota)

- **L**OC (TIME, PLACE, PERSON or ABILITY TO RECOGNIZE, PRESENTING STIMULI TO CHILD, NON COMMUNICATING ADULT)
- **P**ALPATE FONTANEL IN CHILD LESS THAN 1 YEAR OLD-CHILD MUST BE UPRIGHT.
- **P**UPILS
- **M**OTOR RESPONSE (SQUEEZE HANDS SIMULTANEOUSLY and PLANTAR/DORSIFLEX FEET SIMULTANEOUSLY or OBSERVE SYMMETRY/MOVEMENT IN CHILD UNDER 3 OR NON COMMUNICATING PATIENT)
- **N**AIL BED/NOXIOUS STIMULI
- **R**ESPONSE/RECORD

PERIPHERAL VASCULAR ASSESSMENT (PVA)

PMS CTC RR (premenstrual syndrome…)

- **P**ULSES: PRESENCE/ABSENCE OF MOST DISTAL PULSES, COMPARE LEFT TO RIGHT
- **M**OTOR ASK PT TO MOVE EXTREMITIES OR NOTE MOVEMENT IN CHILD UNDER 3 OR NON COM ADULT
- **S**ENSATION IN DISTAL PORTION OF EXTREMITIES
- **C**AP REFILL
- **T**EMP
- **C**OLOR
- **R**ESPONSE/RECORD

RESP ASSESS

PAIL LO RR (kind of like J-Lo)

- **P**OSITION PT TO FACILITATE ASSESSMENT

- **A**SSESS RESPIRATORY STATUS BY:
- **I**NSTRUCT TO BREATH IN/OUT AS DEEPLY AS POSSIBLE
- **L**ISTEN LEFT TO RIGHT UPPER/LOWER X 2
- **L**OOK FOR BREATHING PATTERNS
- **O**2 SATS IF ASSIGNED
- **R**ESPONSE/RECORD

SKIN ASSESS

TEMIC R (sounds like a person's name)

- **T**EMP
- **E**DEMA
- **M**OISTURE
- **I**NTEGRITY
- **C**OLOR
- **R**ECORD

Also, students must assess at least 2 areas — usually a designated area, plus another from the following: heels, sacral/coccyx, occiput, trochanter, skinfolds, peri anal. Please note that the 16th edition clarifies that bilateral body parts (heels, trochanters, etc.) count as ONE area, not two.

COMFORT MGMT

AP RR (A & P)

- **A**SSESS COMFORT: ASK, LOOK FOR BEHAVIOR
- **P**ROVIDE 3 OF 8 POSSIBLE: HEAT/COLD, BACKRUB, REPOSITION, WASH, MED, LINEN CHANGE, RELAX/DISTRACT, ORAL CARE
- **R**E-ASSESS/RESPONSE/RECORD

MUSCOSKELETAL MGMT

AAA P-DAT RR (triple "A" "pee" dat, like puff daddy)

- **A**SSESS JOINT MOVEMENT
- **A**SSESS MUSCLES OF THE EXTREMITIES FOR STRENGTH AND FLEXIBILITY
- **A**CTIVE ROM-PICK EITHER AD-ABDUCTION OR FLEX/EXTEND
- **P**ASSIVE ROM-PICK EITHER AD-ABDUCTION OR FLEX/EXTEND SUPPORT JOINT
- **D**EVICES, USE SUPPORTIVE/THERAPEUTIC ON DESIGNATED PARTS
- **A**PPLY HEAT/COLD, PROTECT SKIN SURFACES, APPLY FOR 20 MINUTES
- **T**RACTION-RIGHT WEIGHT, KEEP ROPES/WEIGHTS FREE/CLEAR. POSITION BODY FOR COUNTER TRACTION AND ALIGNMENT
- **R**E-ASSESS/RESPONSE/RECORD

O2 MGMT

ASS PRESH RR (LOL, sounds like 'ass pressure')

- **A**SSESS RESPONSE TO ACTIVITY
- **S**TATUS OF OXYGENATION: COLOR, CAP REFILL, CLUBBING OR O2 SAT
- **S**KIN SURFACES ARE PROTECTED AT CONTACT AREAS W/ EQUIP
- **P**OSITION PT TO FACILITATE RESPIRATION
- **R**ATE OF O2 FLOW MAINTAINED IN LITERS OR PERCENT
- **E**QUIPMENT: INSERT/APPLY, MAINTAIN, ENSURE NO SPARKS
- **S**ATS IF ASSIGNED
- **H**UMIDIFY, SET/MAINTAIN IF ASSIGNED
- **R**E-ASSESS/RESPONSE/RECORD

PAIN MGMT

LM RRR RR (L & M railroad, plus more r's)

- **L**EVEL: 1-10, FACES, BEHAVIOR
- **M**EDICATE OR
- **R**EPORT TO RN
- **R**ELIEVE WITH 1 OF THESE: REPOSITION, BACKRUB, RELAX/DISTRACT, HEAT/COLD
- **R**E-ASSES
- **R**ESPONSE/RECORD

RESP MGMT

PAIL LO RECEPTACLE DCD PSR RR (deep sea diving pisser)

- **D**O ASSESS PLUS ADD RECEPTACLE
- **D**EEP BREATHING REPEAT PRN/AS ORDERED
- **C**OUGH EXERCISE: DEEP BREATHING 3 TIMES, COUGH ON THIRD, SPLINT PRN, REPEAT PRN, USE TISSUE
- **D**EVICES, SPIROMETER
- **P**ERCUSSION/VIBRATION
- **S**UCTION, INSURE PATENTCY, SET PRESSURE ON SUCTION UNIT, DON'T SUCTION GOING IN, <15 SECONDS, ROTATE CATH CONSTANTLY
- **R**E-ASSESS
- **R**ESPONSE/RECORD

WOUND MGMT

AICTD RR (like AICD but with a t)

- **A**SSESS WOUND LOCATION, TYPE, APPEARANCE, DRAINAGE (COCA)
- **I**RRIGATE IF ASSIGNED
- **C**LEANS WITH DESIGNATED SOLUTION
- **T**OPICAL IF ASSIGNED
- **D**RESSING
- **R**E-ASSESS/RESPONSE/RECORD

DRAINAGE AND SPECIMEN

DC CIR SOPLT RR (almost dc 'sir', Standard operating procedure lieutenant)

- **D**RAINAGE
- **C**OCA COLOR, ODOR, CONSISTENCY, AMOUNT
- **C**LEAN SURROUNDING TISSUE/SKIN WHEN ASSIGNED
- **I**NSERT TUBE IN APPROPRIATE CAVITY
- **R**EMOVES TUBE WHEN ASSIGNED

SPECIMEN

- **O**BTAINS SPECIMEN
- **P**LACE IN CONTAINER
- **L**ABEL CONTAINER
- **T**RANSPORT CONTAINER
- **R**ESPONSE/RECORD

ENTERAL FEEDING

SPDCBR ACVRTA CRVRAR (this one was tough: Seattle police dept, Honda CBR…AC check {v looks like a check} rapid transit authority….Honda CRV, rar file{like a zip file})

- **S**ELECT, **P**OSITION, **D**ELIVER

- **C**HOOSE DEVICE, **B**URP <6 MOS, **R**OOM TEMP
- INTERMITTENT: **A**MOUNT, **C**ALCULATE GTTS, **V**ERIFY NG, 10-20 ML AIR, 5 ML AIR LESS THAN 2 YEARS OLD RESIDUAL: MEASURE/**R**E-INSTILL, **T**IMELY, **A**DJUST GTTS
- CONTINUOUS: **C**OUNT GTTS, **R**EGULATE GTTS, **V**ERIFY NG, **R**ESIDUAL MEASURE/RE-INSTILL, **A**MOUNT TO GIVE BASED ON RESIDUAL RECORD NAME/STRENGTH/KIND/AMOUNT
- **R**ESPONSE/RECORD ** NG tube placement must be verified by 2 methods (aspiration gastric contents + instilling air), not just 1.**

Please note that in Enteral Feeding AOC, the 16th edition has added a critical element that states comparing any running enteral feeding with the Assignment Kardex is required as part of the 20 minute checks [i.e., students must do this in the first 20 minutes of entering the room]).

IRRIGATION

TTP VI RR RR

- **T**YPE OF SOLUTION
- **T**EMP OF SOLUTION
- **P**OSITION PT TO FACILITATE
- **V**ERIFY CORRECT TUBE PLACEMENT
- **I**NSTILL SOLUTION INTO DESIGNATED AREAS
- **R**EGULATE FLOW
- **R**ECEPTACLE, PROVIDE FOR RETURN FLOW
- **R**ESPONSE/RECORD

MEDICATIONS

- RIGHT PT: NAME, DOB, MRN
- RIGHT DRUG: USING MAR
- RIGHT DOSE
- RIGHT ROUTE: USE CORRECT NEEDLE IF INJECTIONS
- RIGHT TIME W/I 30 MINUTES
- CHECK ALLERGIES

WOW IG SIS

- **W**ASH HANDS
- **O**BTAIN MEDS
- **W**ASH HANDS AGAIN
- **I**D PT TO MAR
- **G**LOVES ON
- **S**ITE CLEAN***
- **I**NJECT/GIVE MED
- **S**IGN MAR

***FOR IV MEDS:

RAA FRR RR

- **R**ECORD GTTS/MIN OR ML/HR ON PCS BEFORE GIVING MEDICATION
- **A**SSESS IV SITE
- **A**IR NOT IN TUBE
- **F**LUSH IVAD PRE/POST
- **R**ECORD FLUSH
- **R**EGULATE GTTS +/- 5 GTTS, EXACT WITH ICD

- **R**ESPONSE/RECORD

PT TEACHING

RAIL PD RR (the word rail + PD, police dept)

- **R**EADINESS TO LEARN
- **A**BILITY/MOTIVATION
- **I**D BARRIERS AND
- **L**EARNING NEEDS
- **P**ROVIDE ACCURATE INFO
- **D**ETERMINE UNDERSTANDING
- **R**ESPONSE/RECORD

As Lisa was helping me to update and edit this document, she remarked about the complexity of the enteral feeding mnemonic. It does seem overly complex until you consider that this mnemonic, like the others, evolved, and as I was the one who made it up, it was very easy to remember. Don't ask me why or how things like "Seattle Police Department" or "Honda CBR" popped into my mind, but they did. I submit to you that their uniqueness and the fact that I "owned" them helped me to remember them.

USE REST OF PAGE FOR NOTES

Organizing the PCS: Nursing Care Plans and the Grid

So how did I organize my PCS? This is where you put it all together. Your CE will give you your PCS form and tell you about your patient. You also have the opportunity to talk to the patient's RN as well as access to the patient's chart. From there, you will have to put together your care plan. This is also when you will write out your grid on the back of the PCS form. Please be aware that at some sites, the CE will want to review your care plan before allowing you to write your grid. Ask your CE for clarification. They will likely be familiar with the grid, as it is a widely used tool among students.

So first up is the care plan. Of course, this is a huge topic, and traditional nursing students spend many hours, if not days, learning about them. Excelsior also offers an online care plan course. I will give some tips on what I did, but please, if care plans are a weakness, seek some help. Take a course, do some research, but get help!

A few things to remember about care planning: first, keep it simple. You do not need to create elaborate care plans for the short time you'll be with these patients. Also, your goals should be measurable (i.e., "during my PCS") and your interventions should move the patient towards the goal. Never use a procedure, treatment, or person as the etiology ("related to") — for example, if you use "acute pain R/T surgery" you are blaming the surgeon for the patient's pain. Excelsior prohibits this. And finally, the diagnostic label you choose and write on your PCS form must exactly match the diagnostic label in your nursing diagnosis book (i.e., "acute pain," not just "pain."), but the goals and interventions should be customized to fit your patient.

Care Plans

I found this part of the PCS not as difficult as I expected. I made sure that whatever my nursing diagnoses were, my interventions were things I was actually assigned to do during my PCS.

As you may or may not know, before you start the "implementation" phase of your PCS, you have to submit a nursing care plan with two diagnoses, each with a measurable goal and two interventions for each diagnosis/goal, for a total of four interventions per PCS. At least one of the two diagnoses has to be an actual diagnosis. This means the second can be another actual diagnosis or a "risk for" diagnosis. This applies to each PCS.

The parts for your nursing diagnosis go like this. For the "actual" diagnosis you have the diagnostic label itself; for example, "Impaired gas exchange." The second part is the etiology, or "related to" (R/T) part. Here we might have "Impaired gas exchange R/T increased bronchotracheal secretions." That leaves the third part, which are the signs and symptoms, or the "as evidenced by" (AEB) part. So the whole thing would look like this:

Impaired gas exchange R/T increased bronchotracheal secretions AEB increased secretions present at trach site.

Now some people want to expand the second (related to) part by adding "secondary to" and then a medical diagnosis. That would look like this:

Impaired gas exchange R/T increased bronchotracheal secretions secondary to pneumonia AEB increased secretions present at trach site.

That's fine to do that, but it is not necessary.

For the "risk for" diagnosis, you only need two parts. Basically, it's the same set-up as an "actual" diagnosis, but without the "secondary to" or "as evidenced by." This is because in theory, this diagnosis isn't actually happening; it's *at risk* to happen. So this one would look like this:

Risk for injury/fall R/T weakness/unsteady gait.

So how did I put together my diagnoses? What I did was work backwards, starting with my assigned orders and taking into consideration my patient's reason for admission. I looked on my kardex, which is the sheet that has all of your assignments for your PCS, and looked at the items I was ordered to do. I then looked at the patient's chief complaint or reason for admission into the hospital.

When you are looking at your kardex and assignments and are setting up your grid, look at the actual task you will be doing. Pick a few of the key task and ask yourself, "***Why am I doing this?"*** For example, let's say two tasks assigned during your PCS are pain management and pain medication. The patient's admit reason is for a surgery that has been completed, and the patient is now a post-op patient. Why have I been assigned to do these tasks? Answer: to reduce pain. So it is likely that patient (who you haven't seen yet) is in pain, right? So here goes.

What are some of your responsibilities under the AOC "pain management?" They include back rub, reposition, distraction, etc. You also have orders to give a pain medication. So pick two of the individual task first. In this case I would pick "pain medication" and "reposition". I am not going to give a back rub because of time. Medicate and reposition are two interventions that take little time (just be careful about all the steps associated with giving a med). Now work backwards to get to your diagnosis: Pain medication and reposition are two interventions I will be doing based on my kardex assignment. Why am I giving a pain med and reposition the patient? ***For pain (now my nursing diagnosis)!*** So the reverse is:

Acute Pain. Patient will have a decrease in pain during my PCS. My two interventions are 1) give pain medication and 2) reposition patient.

Remember you don't have to add the "related to" (r/t) or "as evidenced by" (AEB) until the evaluation/charting phase. So don't add them now because you haven't seen your patient yet. You then go in the room and during the PCS you give a pain med and reposition. Check these off on your grid.

When you get to the evaluation phase, you will do several things:
1) Add the r/t and AEB. Now it will look like this:

Pain R/Ttissue trauma AEB patient rating pain as a 7 on numeric scale. Patient will have a decrease in pain during my PCS. My two interventions are 1) give pain med 2) reposition patient

You then have to document if your measures worked or not. If they didn't don't sweat it. Just make sure you document it.

The key is to make sure your interventions you have chosen for your nursing diagnosis are items already assigned to you on your kardex. Do **NOT** add tasks that are not assigned. It will add more work and could cause you to fail the PCS.

For another example, one of my CPNE patients had pneumonia (his admission or medical diagnosis), so I looked up "pneumonia" in the table of contents in my nursing diagnosis book. You then go to the section for pneumonia, and it will list several nursing diagnoses that you can use for a patient with pneumonia. So my interventions were chosen making sure that I was assigned to do them, AND it would affect one of the patient's signs or symptoms or was somehow related to his admit diagnosis (his medical diagnosis).

Two of my assigned AOCs were oxygen management and respiratory assessment. So I asked myself, ***"Why are these orders necessary and how do they related to my patients admission diagnosis of pneumonia?"***

I knew that under oxygen management I had to maintain the oxygen equipment. Under respiratory assessment I had to assess lung sounds. So I decided to go with "Impaired gas exchange." During the planning phase of the PCS you are not required to have the "R/T" and "AEB" part if you don't want to. If you choose, you can add that part during the evaluation phase. That's exactly what I did. So what I turned in to my CE was:

Impaired gas exchange (NO r/t or AEB), 'patient will' remain without shortness of breath. My two interventions were 1) maintain oxygen at prescribed rate 2) assess lung sounds.

I did not add my R/T and AEB during planning because I wanted to see my patient first. I was pretty sure what they would be, but since they don't make you write those parts down during planning I thought it best to wait and see. It was a good call on my part. I walk in and the patient has secretions at the trach site. Here I am going to illustrate a point. It seems like I should have gone with suctioning as an intervention. However, I was not assigned "respiratory management," which has suctioning. I was assigned "respiratory assessment," which says **NOTHING** about suctioning. Also, he had been there for a while and was actually okay as long as he was in bed sitting up on oxygen, and his family was doing a good job of suctioning PRN.

So if I had added suctioning as an intervention I could have been in trouble as "suction patient" was not assigned on my kardex. I have heard that can fail you. I am not sure about that, but at the very least it will add more work for you and more opportunity to do something incorrectly.

Since I could see the secretions however I had the "R/T and AEB" part of my care plan. So during the evaluation phase, I went back to my care plan and made it look this:

Impaired gas exchange R/T increased tracheal secretions AEB by visible secretions at trach 'patient will' remain without shortness of breath. My two interventions were 1) maintain oxygen at prescribed rate 2) assess lung sounds.

So does that make sense? I am using my assigned task from the kardex to come up with my nursing diagnosis both actual and risk for. Remember you don't have to use a "risk for" diagnosis. You can use two "actual" ones. The choice is yours.

Make sure you are familiar with your nursing diagnosis book. Mark off some common diagnoses: acute pain, impaired gas exchange, impaired physical mobility, ineffective airway clearance, etc. These are all great ones to use, and they could, in theory, cover many areas, but they don't cover everything, so be sure to read up on nursing diagnoses. You don't want to spend too much time during planning.

As of October 3, 2008, the only nursing diagnosis book that can be used is *Mosby's Guide to Nursing Diagnosis* by Ladwig and Ackley. There are complaints listed in the front part of the book with suggested corresponding nursing diagnoses that could correspond to that complaint. Students may also tab and highlight their nursing diagnosis book; just take care to not write anything in the book itself, or you will not be allowed to use it.

The Grid

After I made my care plan I wrote out my "grid." "Grid" is just a term that means a grid is drawn on the back of the PCS form, and each box has related material in it. Each box might contain an AOC, 20-minute checks, or anything you want.

This is where your mnemonics come into play. For me, I would draw a line down the middle of the page. I would then start on the left side of the page and working down write my mnemonics going from up to down on the left side of the page. When I wrote the last letter of the mnemonic I would draw a horizontal line under that letter from the left side of the page to the middle line I had drawn at first. Exception: Under the last letter of the first section (20-minute checks for me) I would drawn that line all the way across the page. That first box at the top of right side would be my "safety" grid square. When I ran out of space on the left side I moved up and over to the right side of the page and continue on. I would then go back and write the whole key word and make a small blank underline mark to the right of each key word. My first boxes or grid squares were always twenty minute checks, mobility, fluid

management, vital signs. I would also always make a safety box or grid square (I always put this on the top right side of my page).

As I worked through my PCS I always had my form with me turned back page up with my grid very visible to me. As I did everything I needed to I place a check mark in the little blank beside the key word. That's it! That's how the grid works. You are actually writing out every step you are going to take and checking them off one by one as you do them. Remember, these are med-surg patients. You don't have to hurry. Take your time and check stuff off.

Some AOCs are timed like medication and feeding. Be mindful of the time. Also, I made sure everything on the kardex was on my grid with the exception of actual medication names. Here is why: I made a medication grid square with the critical elements for giving meds, but instead of copying the meds down and copying something WRONG, I would just refer to my kardex for the medication, dose, routes, etc. You can be assigned up to six meds by no more than two routes per PCS.

If the directions for making my grid sound confusing, don't worry. I am including an actual scan/photocopy of my grid setup. In some of the boxes I have written the key word out and others I have left just the first letter of the key word (which makes up the mnemonic) so you can see how I built my grid. My advice is to go back and write the rest of the key word in. You have the time, and it will help you avoid confusion later.

So now you have been give a report by the patient's RN and/or the CE, you have reviewed the chart, made your care plan, and setup your grid. At this point you take that to the CE. They will say something like "by turning in this care plan you are indicating that you have completed all the critical elements of the planning phase, and that you are ready to move on to the implementation phase." If that's the case, and you are sure then say yes. Take a few deep breaths, relax, SMILE, and start to work. Remember, you can ask the CE questions, you can ask the patients RN questions, and you don't have to rush. Just look at your grid, go step by step and you should be fine.

USE REST OF PAGE FOR NOTES

Wash hands_____

Intro _____

Gloves_____ GTTS_____

Assess IV_____ Advise RE I/O _____

Ask RE pain____ Comfort _____

Safety____ Save Tray____ Skin____

BR ↑ x 4_____ Call light_____

Slippers _____

I made these two lines first. →

The top two sections were always used for 20-minute checks and safety.

Wash hands_____
Intro _____
Gloves_____ GTTS_____
Assess IV_____ Advise RE I/O _____
Ask RE pain____ Comfort _____
Safety____ Save Tray____ Skin____

BR ↑ x 4_____ Call light_____
Slippers _____

MOBILITY

A
M
D
A
R
R

FLUID MANAGEMENT

H
E
P
A
R
R
I
I
N
R
R

Then, starting on the left side, I worked my way down to the bottom. Then I would come over to the right side under safety and begin again.

NOTE: I wrote the initials to my key words first, but I went back and wrote out the entire key word like so:

A		Assess_____
M		Move_____
D	then	Devices_____
A		Assist_____
R		Response____
R		Record_____

Wash hands_____

Intro _____

Gloves _____ GTTS _____

Assess IV_____ Advise RE I/O _____

Ask RE pain____ Comfort _____

Safety____ Save Tray____ Skin ____

MOBILITY

Assess Level_____ Bal_____ Devices____

Move_____

Devices_____

Assist_____

Response____

Record_____

FLUID MANAGEMENT

Hydration_____

Enteral_____

Parenteral_____

Assess IV_____

Regulate GTTS_____

Record Fluid_____

IV Law_____

I/O _____

Need To Document_____

Response/Re-Assess_____

Record_____

Vital Signs

BP_____

HR_____

RR_____

Sats_____

Temp_____

Weight_____

Pain_____

BR ↑ x 4_____ Call light_____

Slippers _____

MEDICATIONS

Wash Hands____ Record GTTS____

Obtain Meds____ Assess IV Site____

Wash Hands____ Air Not____

ID Pt____ Flush____

Gloves____ Record Flush____

Site Clean____ Regulate GTTS____

Inject/Give____ Response/Record____

Sign MAR____

ABDOMINAL ASSESSMENT

Pee_____

Position_____

Look_____

Listen_____

Feel_____

Girth_____

Response/Record_____

OXYGEN MANAGEMENT

Assess_____

Status of O2_____

Skin_____

Position_____

Rate of O2_____

Equipment_____

Sats_____

Humidify_____

Reassess/Response/Record_____

Evaluation Phase

Charting

So you have completed all of your critical elements and have done everything that was assigned to you on the kardex. It is now time for the evaluation phase. Here you will inform your CE that you are ready to start your evaluation phase and finish up some charting. Once again, that grid is going to be your buddy

During my evaluation phase, I would sit down, and for each AOC I would simply look at my grid and what was checked and what notes I took in each grid square. I would then go to the corresponding section on the PCS form and address each letter in my mnemonic. Each AOC has a section on the PCS. You can document anything anywhere on the form, but its best to keep it organized. Here are a couple of examples of what I mean. You will need to look at my grid for reference.

Let's look at the AOC mobility. I would refer to my grid under mobility and see what I checked and what my notes were. For the grid I used here under mobility I checked all the blanks. So I just went right down my mnemonic again for charting:

Under Mobility : (my mnemonic was AMDA RR)
Assesses patient for mobility. Pt in bed entire PCS but family states level is fine with assistance, pt/family denies unsteady gait, and that balance is normal, no mobility devices used by patient. Pt pulled up once in bed with help of family. Pillow used by patient for comfort. Pt denies any point/pressure soreness

Under respiratory assessment (my mnemonic was PAIL LO RR)
Pt positioned upright. Lungs assessed left to right, upper and lower. Pt instructed to breathe deeply in and out for each auscultation. Breathing patterns normal. Breath sounds abnormal (remember for the CPNE, you don't have to say wheezes, rhonchi, rales, etc.; lung sounds are either normal or abnormal) O2 sats 97% on 28% oxygen via trach. Pt tolerated assessment well.

And that's what I did for each area of care. There is a big "other" section you can use for miscellaneous charting. In that section I would cover medications again and document doses, routes, times, that I verified patient by ID band/MAR/DOB, etc. Here is also a good place to document all the safety steps you took. Basically anything that didn't have its own section was charted here. I found the charting to be very easy and I feel like I didn't miss anything because I just went right down the grid.

Take care to not use unapproved abbreviations in your documentation. The study guide contains a list of approved and unacceptable abbreviations in Appendix N, but that is just more to remember; it's easier and safer to write things out. The only abbreviations I used during the CPNE were "pt" for patient and units of measurement (ml, gm, gtts, mg, etc.).

Finish Care Plan

During the evaluation phase you have to finish your care plan as well. Here you MUST add the 'R/T' and 'AEB' statements if you left them out during the planning phase. Again, this is what I did because I wanted to see my patient first. You also have to complete the evaluation form of your care plan. On this form you have to indicate why your main nursing diagnosis is a priority diagnosis, and the effectiveness of your interventions.

As far as the priority diagnosis, that's easy. I wrote something along the lines of:

If not managed now will deter the progress of the patient to be able to adequately perform normal ADLs (activities of daily living)

You can go more in depth and state that the XYZ is a basic physiological need, state why it's a need, tell them a couple of complications it could cause if you didn't manage it now, as well as the fact that it'll interfere with the patient meeting goals and going home. An example for ineffective airway clearance:

An effective airway is needed to promote oxygenation, which is a basic physiological need. Oxygenation is needed for adequate cell and tissue perfusion. Without an effective airway and oxygenation, cells and tissue can become ischemic and die, or respiratory complications such as aspiration and pneumonia could occur. If airway clearance and oxygenation are not managed now, it could deter progress to meet outcomes, delay healing, negatively affect functional status and prolong the hospital stay.

That's a bit long, but you get the idea.

As to the effectiveness of your interventions they worked, kind of worked, or didn't work at all. No problem if they didn't work. You are not a miracle worker. Just write out why and you will be fine.

Once you have finished, checked, and re-checked your documentation. You will tell your CE that you are ready. Your CE will ask if you are sure, and you will be thinking "God, I hope so." If you are sure, you will give the CE your paperwork and they will tell you to go wait somewhere while they grade it. It seems long, and it is nerve-wracking. At this point, all you can do is cross your fingers and wait!

Conclusion

We hope these notes help you with your studies. Like I said in the beginning, this strategy worked for me, but it might not work for you. The more you customize your strategy and make it your own, the more second-nature it will feel to you. As a glimpse into what the future may hold for you, consider this: I am in my last year of graduate school working on my MSN/FNP. Lisa is now an ER nurse who is looking to begin an RN-to-BSN program very soon. We remember being right where you are, very vividly. We did it, as have many others. You can, too.
Good luck!

Ivan Hart
Lisa Sarao