

PENGEMBANGAN

**MODULE MATA KULIAH BAHASA INGGRIS  
FOR THE FOURTH SEMESTER STUDENT OF NURSING  
DEPARTEMENT AT POLITEKNIK MAKASSAR**



Digunakan Dilingkungan Sendiri

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JURUSAN KEPERAWATAN  
TAHUN 2020/2021

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## CHAPTER THREE

### Unit 13.

#### EXPRESSING DAILY ACTIVITY

#### 1. Directions and Locations

Excuse me, would you kindly tell me (the) ....., please?  
Excuse me, where is (the)....., please?  
Excuse me, I'm trying to find .....(Name of street)  
Excuse me, I'm looking for ..... (Name of street)  
Excuse me, can you help me? I want to get .....(Name of street)  
Excuse me, do you know where the .....is location, please?  
Could you tell me where (the) .....is, please?  
Can you tell me where (the) ..... is, please?  
Do you know where (the) ..... is, please?  
Excuse me, but where exactly is the Export-Import Bank .....?  
Excuse me, is the road leading to ..... (Name of Street or (Name of a place?

#### How to get to .....?

Does this bus go to (the) .....?  
Does the 9 go to (the) .....?  
Which/what bus goes to (the).....?  
What bus do I take to go to (the) .....?  
Excuse me, could you tell me which (bus/train) to catch for ..... , please?  
Excuse me, do you know which (bus/train) to catch for ..... , please?  
Excuse me, sorry to trouble you, but could possible tell me which (bus/train) goes ...?  
Excuse me, how do I get to ..... , please?  
How could I get to .....from here, please?  
How can I get to ..... from here, please?

#### 2. Getting the Right Bus

Foreigner : Excuse me; does this bus go to the new campus?  
Student : No, it doesn't. You should take a number 07.  
It leaves every hour.  
Foreigner : Thank you very much. You've been very helpful.  
Student : You're welcome.

#### 3. In the Street

Woman : Excuse me, sorry to bother you, but could you tell me the way to the Public Librery, please?  
Man : The Public Library? Yes, certainly. Just go along here until you get to the traffic lights. Then turn left into Jl. Sultan Alauddin. Carry on down Jl. Sultan Hasanuddin for about 700 meters. The Public Library is on your right. You can't miss it  
Woman : I see. Straight along down to the traffic lights, then turn left to Jl. Sultan Hasanuddin. Go for about 700 meters.. On the right side.  
Man : Yes, that's correct.  
Woman : Well, you've most helpful.  
Thank you very much indeed  
Man : Not at all.

4. Expressing Thanks

I'm very much obliged to you.

Thank you very much.

Thank you so 'much.

Thank you.

That's nice of you. Thank you.

That's really very kind of you

You are very kind , Thank you.

Thanks for every thing

Thanks for all

Thanks

Thanks a million

I'm very grateful for.....

your help

your concern

the invitation

I'm so grateful for .....

your hospitality

the drive

your suggestion

Thank you (very/so much) for .....

coming

caring

your advice

Thank a lot for .....

the information

the meal

your participation

I really appreciate .....

the invitation

your idea

your correction

I'd like to say thanks to you for.....

the drink

the gift

kindness

5. Expressing Apologies

Forgive me, I'm terribly sorry about .....

that letter

my rudeness to you last night

losing your dictionary

I'm very sorry for .....

Missing for the first part of to lecture

Being rude to you last night

what I said yesterday

I'm extremely sorry for.....

that

doing that

saying that

telling you lies

Please, except my apologies for .....  
 breaking my promise to you  
 having been angry with you  
 my son's rudeness  
 I'm sorry, I (really) didn't mean to .....  
 hurt your feelings  
 upset you  
 insult you  
 I hope you'll forgive me if I .....  
 upset you  
 do wrong to you  
 make silly mistake  
 I hope you'll excuse me, if I .....  
 speak much about myself and my family  
 leave earlier  
 cannot tell you the answer  
 Will you forgive (excuse) me if I ....  
 do not come to your lecture tomorrow?  
 come late to your class?  
 ask you private question?  
 I apologize (to you)  
 I do apologize  
 Please forgive me  
 Do forgive me  
 I beg your pardon  
 I hope I haven't offended you  
 You mustn't be upset  
 Oh, no! Did I do that? I'm sorry.  
 Oh!, sorry!  
 Sorry about that  
 Oops. (pernyataan maaf)

## 6. Expressing Regrets

I feel sorry for .....  
 you  
 him/her  
 your sister  
 I 'm sorry about .....  
 losing your job  
 the accident  
 that  
 I'm sorry that.....  
 I cannot accompany you to the party  
 You missed the first lecture  
 You have to sit for another test  
 I feel bad that.....  
 I can't help you  
 I must leave you here alone  
 You cannot go with me

I regret to .....  
tell you this  
tell you that I leave early  
announce that the meeting is canceled

I regret (ed) ....  
having to do this  
telling her the news  
asking her to leave early

I have my regret about ....  
leaving the party early  
doing the job  
buying the bike

I should/ would (have) .....  
done it  
accepted it  
refused the offer

I could have .....  
rejected the offer  
told her the case  
reminded them

I must have .....  
submitted the report  
finished the work  
reduced the expenses

I should (would/could/must) not have....  
told her  
met him  
bought it

Astagfirullahul adzim = I'm sorry.

I'm terribly sorry  
I'm awfully sorry  
I'm really sorry for that  
How silly I am  
How foolish I am  
How stupid I am  
How silly of me  
I cannot blame anyone but me  
That's my fault  
That's my mistake  
I was really mistaken

## 7. Congratulation

Expressing Congratulation  
Congratulation on .....  
your engagement  
moving in a new house

Let me congratulate you on your .....  
new job  
new position  
winning the competition  
Let me say congratulation on ....

your succes  
passing all your subjects  
I'd like to congratulate you on ....  
your new invitation  
your successfull efforts  
doctorate promotion  
your happy marriage  
the birth of your first baby

## 8. COMPLIMENTS

### Expressing Compliments

I would like to compliment on .....  
your new hair style  
the nice house you have  
your report

I must compliment you on your ....  
tennis game, You played well  
typing. You typed neatly  
report. It was really comprehensive

I just love your .....

bag  
furniture  
garden

I really like your ....

car  
hat  
ideas

I 'm just admiring your .....

watch  
blouse. It's really nice  
earrings

That's a beautiful .....

dress you wear on  
tie you wear on  
hat you put on

I think your ....

apartement is fantastic  
boy/girl friend is attractive  
father is really generous

You certainly have a good tastes in .....

clothes  
food  
housing

## 9. Condolences

### Expressing condolences

I'm sorry to hear about .....  
your sister passed away  
brother's accident

I'm sorry to hear that ....

you lost your motor cycle  
your sister got an air accident

Let me tell you how sorry I am to hear about .....

your father

the death of your baby

Please accept my deepest sympathies on ....

the death of your mother

the death of your dog

You must feel terrible about .....

losing your wife like this

losing your sister

Let me offer my condolence

Please except my hertfelt sypathies.

I know how you must feel

It must be pretty hard on you

My condolences in your bereavement (Innalillah....)

#### TYPICAL RESPONSES

Thank you

That very kind of you

There is nothing, that can be done about it

It's God's will, I suppose

Oh, well, such is life.

God giveth and God taketh away

(Mina menyampaikan pernyataan belasungkawa kepada Suzan atas eninggalnya adik perempuannya)

Mina : I was shocked to hear that your yanger ister, Anne, passed away yesterday'

I know how you mustfeel..

It must be pretty hard on you.

Please accept my heatfelt sympathies.

Suzan : There is nothing that can be done about it

It's God's will, I suppose.

Thanks very much for the sympathies

(Topan datang menghadiri upacara pemakaman adik laki-laki Sallabah)

Topan : Inna Lillahi Wainna Ilaihi Rajiun

I'm very sorry to hear about your yonger brother's death.

It must be pretty hard on you.

He was so young.

Why did he have t die?

Sallaba: It is really hard for me

But, God giveth and God taketh away,

And well, ....such is life.

I can only say Inna Lillahi Wainna .....



Unit 14  
NURSING MANAGING FOR THE CLIENT WITH HIPERTENSION



A. Definition

Hypertension is an abnormal increase in systolic pressure of 140 mmHg or more and diastolic pressure of 120 mmHg (Sharon, L. Rogen, 1996). Hypertension is the increase in systolic blood pressure over 140 mmHg and diastolic blood pressure over 90 mmHg (Luckman Sorensen, 1996). Hypertension is a condition where an increase in systolic blood pressure 140 mmHg or more and diastolic blood pressure 90 mmHg or more. (Barbara Hearrison 1997)

B. Etiology

In general, hypertension has no specific cause. Hypertension occurs in response to increased cardiac output or increased peripheral pressure. But there are several factors that influence the occurrence of hypertension:

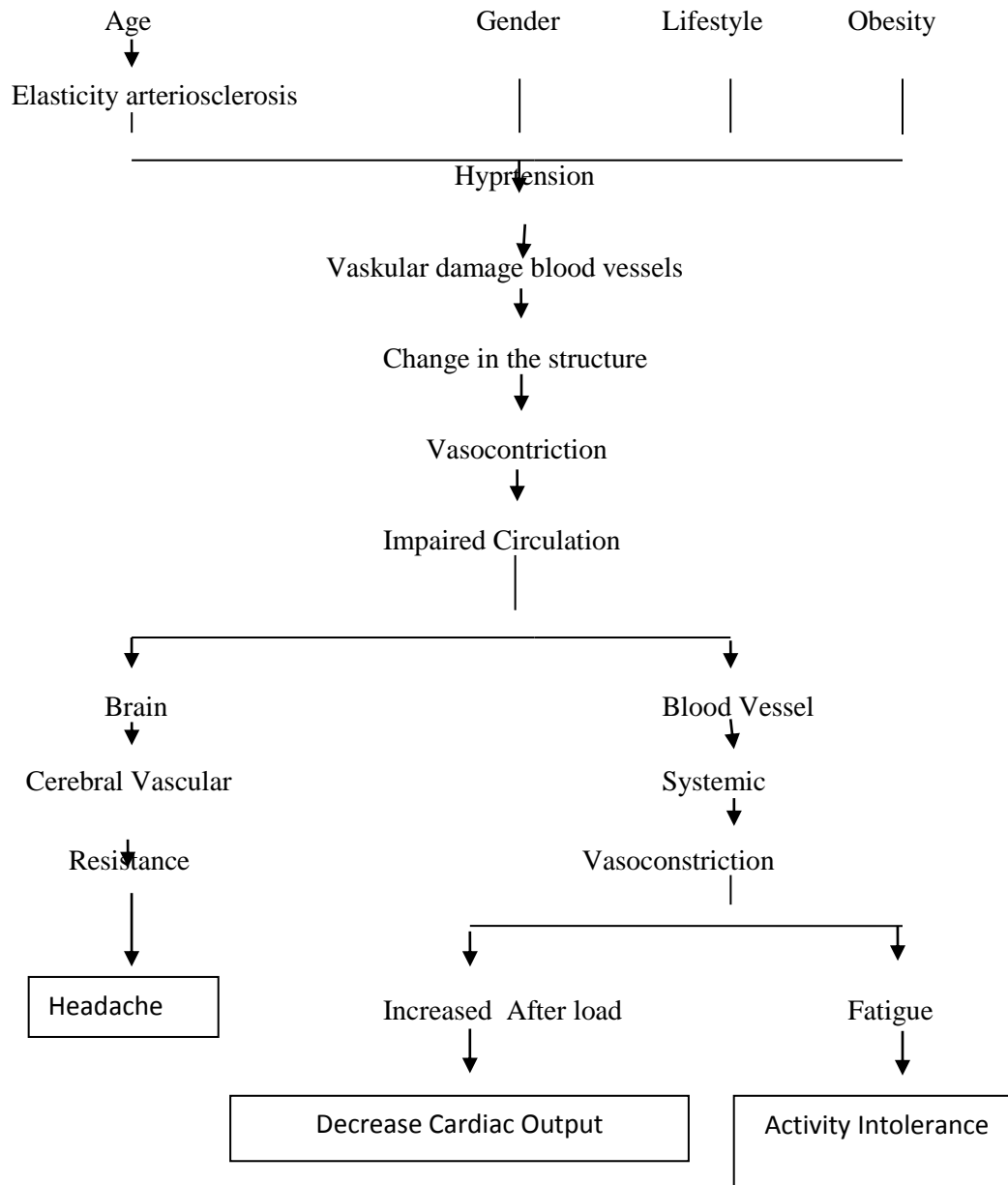
- Genetics: Response to stress or disorder neurology.
- Obesity: associated with high insulin levels which increase blood resulting in pressure.
- Environmental Stress.
- The loss of elastic tissue in the elderly and arteriosclerosis

Based on the etiology Hypertension is divided into 2 groups, namely:

1. Essential Hypertension (Primary) The cause is unknown but many factors that influence such as genetics, environment, hyperactivity, sympathetic nervous system, angiotensin system rennin, the effect of excretion of Na, obesity, smoking and stress.

2. Secondary Hypertension caused by renal parenchym disease / renal vakuler. The use of oral contraceptives are pills. Endocrine disorders, etc

### . C. Pathway Hypertension



### Assessment

#### Subjektive Data

- The Patient says he has a headache, neck stiff, occipital stiff, dizziness, painful, insomnia, nausea, vomiting, and blurred vision
- The patient says his body feels weak and difficult to carry out its activities independently

### Objective Data

No.	Category	Systole (mmHg)	Dyastole(mmHg)
1.	Optimal	<120	<80
2.	Normal	120 – 129	80 – 84
3.	High Normal	130 – 139	85 – 89
4.	Hypertension		
5.	Grade 1 (mild)	140 – 159	90 – 99
6.	Grade 2 (moderate)	160 – 179	100 – 109
7.	Grade 3 (severe)	180 – 209	110 – 119
8.	Grade 4 (threatening)	>210	>120

### D. Nursing Diagnosis

1. Decrease high risk for cardiac output associated with increased after load, vasoconstriction, myocardial ischemia, ventricular hypertrophy.

*Objective: The Increased after load is not, there is no vasoconstriction, myocardial ischemia did not occur.*

*Criteria: acceptable, showing stable norms and cardiac frequency in the normal range*

### Nursing care plan:

- 1) Monitor the blood pressure

- Rationale : ( ratio of pressure Gives a more complete picture about the involvement / field of vascular problems

- 2) Monitor the color, moisture, temperature, and capillary refill time

- Rational (the pale, cool, moist skin and slow capillary refill time Reflects as decreased cardiac output).

- 3) The presence of fever, general / specific.

- Rationale: (may indicate heart failure, kidney damage or vascular)

- 4) Provide a comfortable environment, quiet, reduce the activity / fray circle, and limit the number of visitors and length of stay.
    - Rationale: (helping to reduce sympathetic stimulation, increasing relaxation).
  - 5) Encourage relaxation techniques, your imagination and distraction
    - Rationale: (Can lower the stimulus that causes stress, create a calming effect, thereby decreasing blood pressure).
  - 6) Collaboration with doctors in hypertension therapy anti awards, deuritik.
    - Rationale: (lowers blood pressure).
- 2 Activity intolerance related to general weakness, imbalance between supply and demand O<sub>2</sub>.
- Objective: Meet the clients need*
- Criteria: Clients can participate in activities at the desired / required, reported an increase in tolerance activity can be measured.*

### **Nursing care plan**

- 1) Assess the patient's tolerance to activity by using parameters: pulse frequency above 20 minute frequency of breaks, increased blood pressure readings, dyspnea, or chest pain, severe fatigue and weakness, sweating, or fainting.
 

*Rationale:* (Parameter shows the stress the patient's physiological responses, activities and indicators of the degree of influence of the excess / heart).
- 2) Assess readiness to increase activity eg reduction of weakness / fatigue, stable BP, heart rate, increased attention to activities and self-care.
 

*Rational* (resting physiological stability necessary to promote individual activity level).
- 3) Push to promote the activities / tolerance of self-care.
 

*Rationale:* (Consumption miokardia oxygen during various activities can increase the amount of available of oxygen Progress to Prevent gradual increase in the activity of a sudden on the work of the heart.).
- 4) Provide assistance as needed and encourage the use of bath seats, brushing my teeth / hair with sitting and so on.
 

*Rationale:* (energy saving techniques to lower energy use and thus help balance supply and demand of oxygen).
- 5) Encourage the patient to choose the period of participation in the activity.

*Rationale:* (As the schedule increases the tolerance to withstand the progress of activities and weakness).

3. Impaired sense of comfort: pain (headache) is associated with cerebral vascular increased pressure

*Objective:* Cerebral vascular pressure did not increase is.

*Criteria:* The patient revealed the absence of a headache and looked comfortable.

**Nursing care plan:**

- 1) Maintain bed rest during the acute phase.

*Rationale:* (Minimize stimulation / increase of relaxation).

- 2) Give the non-pharmacological measures to relieve headaches, for example: a cold compress on the forehead, neck and back massage and relaxation techniques.

*Rationale:* (Actions that reduce the pressure with a cerebral vascular inhibit / block sympathetic response, effective in relieving pain head and its complications).

- 3) Help Patients in ambulation as needed.

*Rationale:* (Minimize the use of oxygen and excessive activity that aggravate the condition of the client)

- 4) Teach relaxation techniques and distraction

*Rationale:* (minimization pain)

- 5) Collaboration with physicians in the delivery of analgesics, anti-anxiety, diazepam etc.

*Rationale:* (Analgesics reduce pain and Decrease sympathetic neuronal excitability).

**E. Nursing implementation**

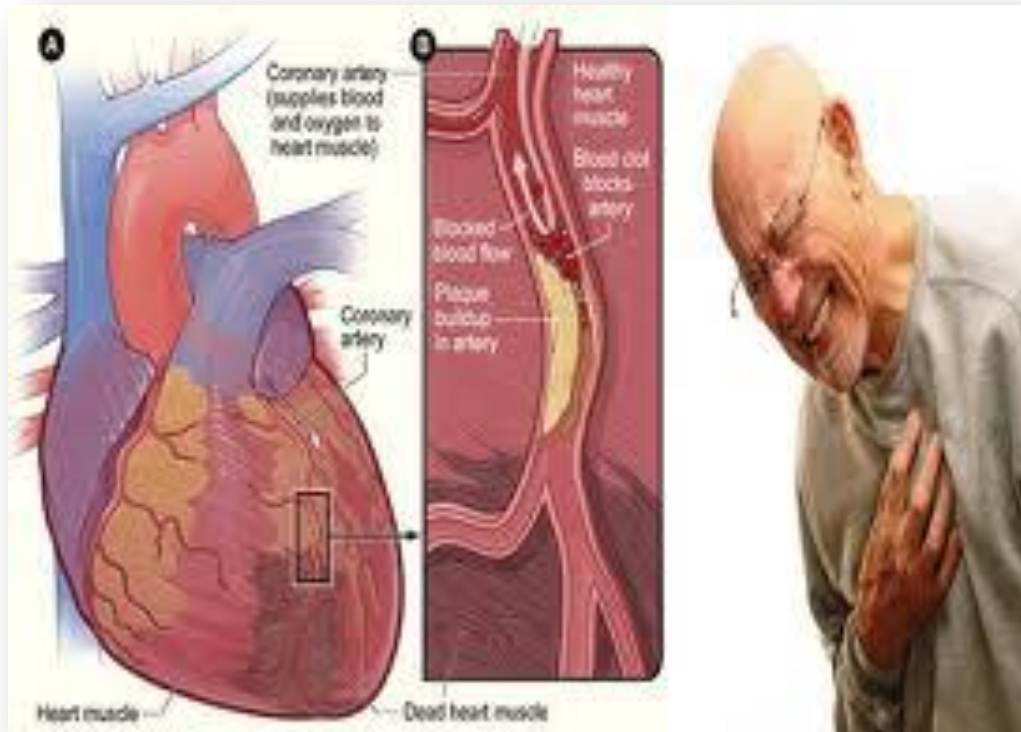
In nursing implementation the nurses apply the nursing care plan that have been planned to meet the clients need. During the nursing implementation phase is done, the nurses evaluate the responses of the clients toward the nursing care given. And what have done by the nurses should be noted as nursing documentation of all nursing care taken and its result .

**F. Nursing evaluation**

Risk of cardiac decline does not occur , activity intolerance can resolved , the headpain is reduced and even disappear .

Unit 15  
NURSING MANAGING FOR THE CLIENT WITH MYOCARDIAL INFARCTION (MI)

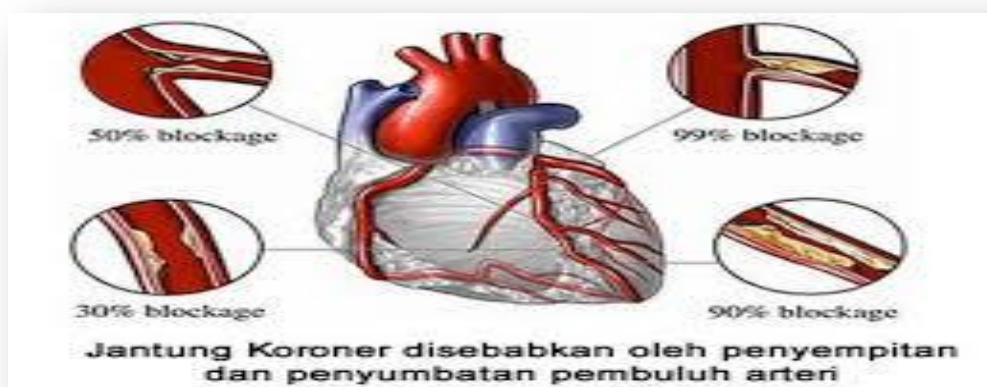
**A. definition**



action of the heart , which supplies the body with blood.

3. Myocardial infarction is a condition infarction or necrosis of the heart muscle due to lack of blood and oxygen supply to the myocardium (the imbalance between myocardial oxygen supply and demand)

**B. Etiology**



Myocardial Infarction broadly speaking there are risk factors for everyone to affected myocardial infarction is. (cassowary, 2002) include with:

- a. Atherosclerosis of coronary artery (coronary occlusion).
- b. Age (35 – 70 years old)
- c . Men more than women until menopause
- d . Life style
- e . Stress
- f . High –cholesterol diet (specifically low density lipoproteins).
- g . Obesity
- h . Chronic illness (Diabetic and Hypertension)
- i . Lack of exercise Diabetes

Reduced of myocardial oxygen supply to that caused by three factors:

1) Blood vessels Factors:

- a). Atherosclerosis.
- b). Spasms
- c). Arthritis

2) Circulation Factors :

- a) . Hypotension
- b) Stenos aorta
- c). Insufficiency

3) Blood Factors :

- a). Anemia
- b) Hypoxemia

### **C. Pathophysiology**

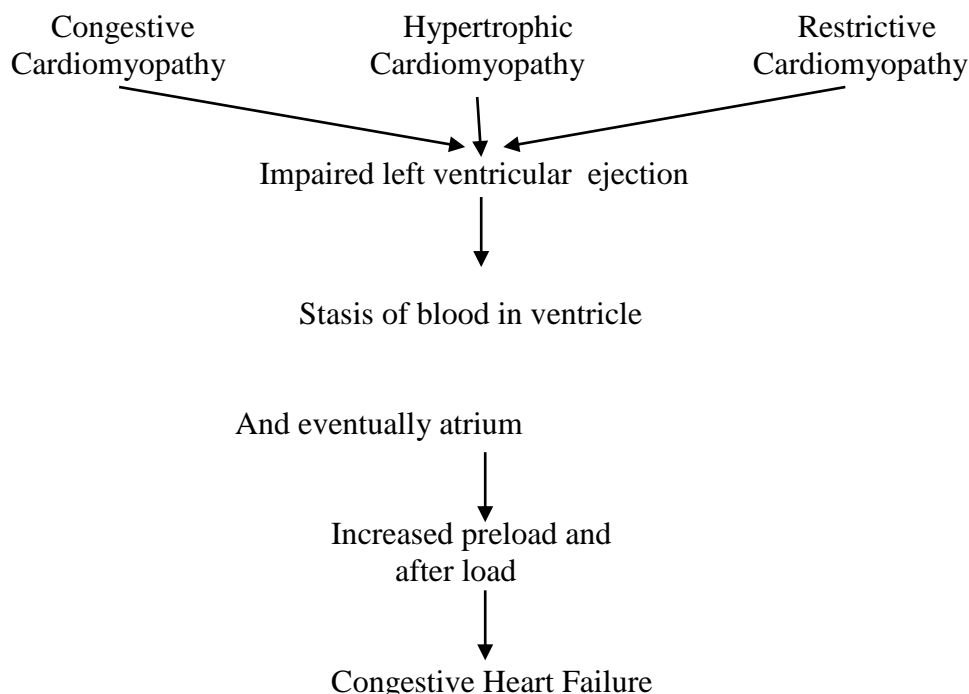
Immediately after myocardial infarction myocardial area locals will show systolic protrusion (dyskinesia) with a result of reduced ejection fraction, stroke volume, and increased end-systolic volume and left ventricular end diastolic. Left ventricular and diastolic pressure rose due to left atrial pressure also rose. The increase in left atrial pressure above 25 mmHg long will cause transudes fluid into interstitial of lung tissue (heart failure). Hemodynamic deterioration is not only due to the infarct region, but also the surrounding ischemic areas. Myocardium is still relatively good will compensate, especially with the help of adrenergic stimulation to maintain cardiac output but with increased myocardial oxygen demand. Compensation is clearly inadequate if the relevant regions are also experiencing ischemia or even fibrotic. When small

and myocardial infarction still normal compensation, the hemodynamic deterioration will be minimal. Conversely, if comprehensive and myocardial infarction should be compensated too badly due to ischemia or infarction old, end-diastolic pressure will rise and heart failure occur.

Changes in hemodynamics of myocardial infarction are not static. When more quiet myocardial infarction cardiac function improved, although not treated. This is due to the areas that had ischemic improved. Hemodynamic changes will occur when prolonged ischemia or infarction widespread. The occurrence of mechanical complications such as ventricular septal rupture, acute mitral regurgitation and ventricular aneurysm will exacerbate hemodynamic function of the heart.

Arrhythmia is a complication of myocardial infarction is the most common and occurs at the time of the first attack. This is because changes in refractory period, conductivity excitatory and sensitivity to stimuli. The autonomic nervous system also contributes to the occurrence of arrhythmias. Myocardial Infarction Patients generally experience an increase in parasympathetic tone with bradyarrhythmias due to a tendency to increase. While an increase in sympathetic tone on the anterior myocardial infarction will increase the likelihood of ventricular fibrillation and infarct expansion.

**Pathway:**





#### **D. Clinical Manifestation**



- a. Chest pain that suddenly ongoing retrosternal , will be more severe pain to unbearable. Sharp pain, distress, and heavier until intolerable spread soldier and usually the left arm. In contrast to angina resulting from heavy work or emotion but spontaneous pain that persist up to several hours (over 30 minutes ) / day and will not go away with rest or nitroglycerin. Some cases the pain spread to her chin and neck.
- b . feeling weak
- c . Shortness of breath
- d . Cold and pale skin
- e . Decreased urine output
- f . cold sweats
- g . Dizziness / mild headache
- h . Nausea and vomiting
- i. Very scary clients
- j . tachycardia
- k . Jugular venous distention ( on right ventricular infarction )
- l . ECG showed ST-segment elevation , T-wave inversion and Q waves were real.

#### **D. Nursing Diagnoses**

1. Chest pain relathest pained to reduced coronary blood flow.
2. Potential ineffective breathing patterns related to fluid over load.
3. Potential altered tissues perfusion related to decreased cardiac output.
4. Anxiety related to fear of death
5. Potential noncompliance with self care program related to denial of diagnosis of MI.

## **E. Nursing Care Plan**

Goals: the major goals of the patients include relief of chest pain, observes of respiratory difficulties, maintenance or attainment of adequate perfusion, reduction of anxiety, and adherence to the self care program.

## **F. Nursing Intervention**

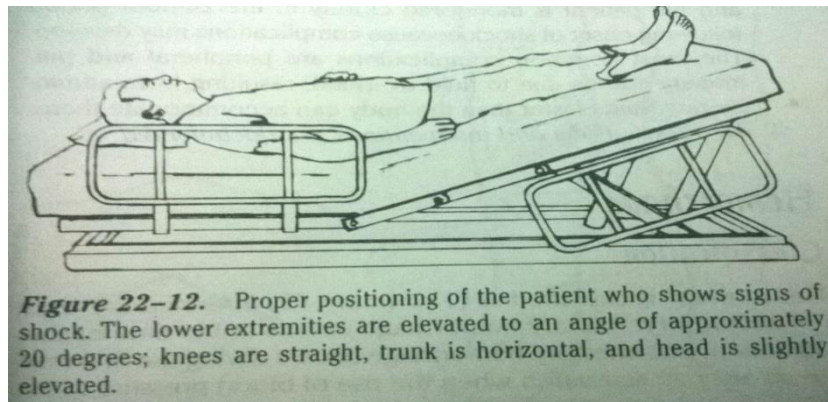
1. Relief of chest pain, intravenous administration of an analgesic agent, as prescribed by the physician. The drug of choice is morphine sulfate (has euphoria effect its produces) and also an effective preload and after load reducer and serves to reduce myocardial workload.
2. Administration of oxygen should occur in tandem with analgesia to assure maximum relief of pain. Inhalation of oxygen even in low doses raises the circulation level of oxygen and reduces pain associated with low levels of circulating oxygen.
3. Vigorous assessment of all vital signs should take place as long as the patients are experiencing pain. Physical rest in bed with the backrest elevated or in cardiac chair, will assist in decreasing chest discomfort and dyspnea. The head up position is beneficial for the reason: 1) tidal volume is improved because there is reduced pressure from abdominal contents on the diaphragm, and 2) drainage of the upper lobes of the lungs is improved, 3) venous return to heart is reduced (preload) , which reduces the work of the heart.
4. Absence of respiratory difficulties, regular and vigorous assessment of respiratory function can help the nurse detect early signs of complication associated with the lungs. Encouraging the patient to breathe deeply and change position frequently will prevent stagnation of fluid in the lung bases.
5. Maintenance or attainment of adequate tissues perfusion. Keeping the patient on the bed or chair rest is particularly helpful in reducing MVO<sub>2</sub>. Checking skin temperature and peripheral pulses with frequency is important to maintenance of adequate tissues perfusion. Oxygen may be administered to enrich the supply of circulating oxygen.
6. Reduction of anxiety, developing trusting and caring relationship with such patients is critical in reducing their anxiety. An atmosphere of acceptance helps them to know that their feelings are both realistic and normal.
7. Compliance with a self care program. The most effective way to increase the probability of compliance with self care regimen is adequate education about diseases process . Working with patients in the development of plans streamlined to meet their specific need further enhances potential for compliance.

**G. Evaluation**

Expected outcome:

1. Patients experiences relief of pain.
2. Shows no signs of respiratory difficulties
3. Maintain adequate tissues perfusion,
4. Anxiety is reduced
5. Compliance with self care program

Unit 16  
NURSING MANAGING FOR CLIENT WITH SHOCK



A. Definition.

Shock is a life-threatening medical condition as a result of insufficient blood flow throughout the body. Shock often accompanies severe injury or illness. Medical shock is a medical emergency and can lead to other conditions such as lack of oxygen in the body's tissues (*hypoxia*), heart attack (*cardiac arrest*) or organ damage. It requires immediate treatment as symptoms can worsen rapidly.

Shock is a serious medical condition where the tissue perfusion is insufficient to meet demand for oxygen and nutrients because the body is not getting enough blood flow. This can damage multiple organs and can get worse very rapidly.

Shock can be classified into several groups:

1. Cardiogenic shock (associated with heart defects)
2. hypovolumic shock (due to decreased blood volume)
3. Anaphylactic shock (due to allergic reactions)
4. Septic shock (associated with infection)
5. Neurogenic shock (due to damage to the nervous system).

B. Etiology.

Shock can be caused by:

1. Hemorrhage (hypovolemic shock)
2. Dehydration (hypovolemic shock)
3. Heart attack (cardiogenic shock)
4. Heart failure (cardiogenic shock)
5. Trauma or severe injury
6. Infection (septic shock)
7. An allergic reaction (anaphylactic shock)

8. Spinal cord injury (neurogenic shock)

9. There are several main causes of shock include:

- Heart conditions (heart attack, heart failure)
- Heavy internal or external bleeding, such as rupture of a blood vessel
- Dehydration, especially when severe or related to heat illness.
- Infection (septic shock)
- Severe allergic reaction (anaphylactic shock)
- Spinal injuries (neurogenic shock)
- Burns
- Persistent vomiting or diarrhea

### C. Pathophysiology

There are four stages of shock development that took place in a progressive and sustainable, include:

#### 1. Initial

During this stage, a state of hypoperfusion that causes lack of / insufficient oxygen supply to the need to provide cellular metabolism. This leads to hypoxia, the fermentation of lactic acid in the cells. This happens because in the absence of oxygen, the process of entry of pyruvate in the Krebs cycle is lowered, resulting in the accumulation of pyruvate. The pyruvate is converted to lactate by lactate dehydrogenase resulting in lactate accumulation is causing lactic acidosis.

#### 2. Compensatory

At this stage the body undergo physiological mechanisms to return to normal conditions, including neural, humoral, and bio-chemistry. Acidosis occurring in the body against which the state of hyperventilation with the purpose to remove CO<sub>2</sub> from the body, due to indirect CO<sub>2</sub> plays a role in acid-base balance in a way to acidify and lower the pH in the blood. Thus when the CO<sub>2</sub> released through hyperventilation can raise the pH of the blood in the body so as to compensate acidosis occurs.

In shock also hypotension which then in a certain threshold is detected by baroreceptor then the body responds by producing norepinephrine and epinephrine. Norepinephrine plays a role in vasoconstriction of blood vessels but it gives a mild effect on the increase in heart rate. While epinephrine effect is predominantly on increasing the heart rate and gives a mild effect on vasoconstriction of blood vessels. Thus the combination of the two effects may

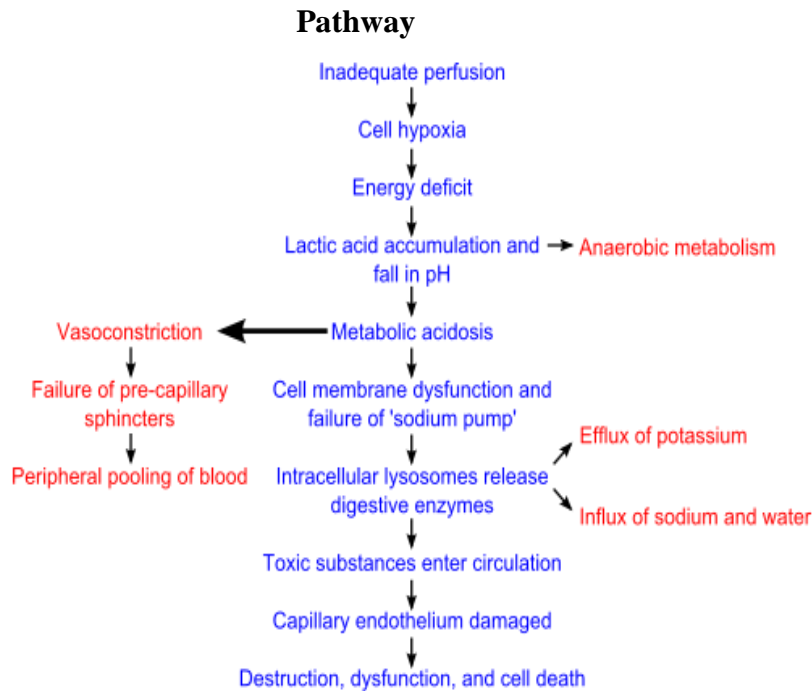
have an impact on the increase in blood pressure. In addition to release of norepinephrine and epinephrine, RAA (renin angiotensin aldosterone system) is also activated and there is also the release of hormones vasopressor or ADH (anti-diuretic hormone), which acts to increase blood pressure and maintain the fluid in the body by decreasing urine output.

### 3. Progressive

When the shock is not successfully treated, then the shock will experience a progressive stage and the compensatory mechanisms begin to fail. At this stage, the more severe metabolic acidosis, smooth muscle in blood vessels causing relaxation of blood accumulation in blood vessels. This resulted in an increase in hydrostatic pressure combined with his loose histamine resulted in the leaking of fluid into the surrounding tissue. This resulted in the concentration and viscosity of the blood increases and possible blockage in the blood flow so as to cause the death of many networks. If the digestive organs also undergo necrosis, can cause the entry of bacteria into the bloodstream which then can exacerbate complications of endotoxic shock.

### 4. Refractories

At this stage there is a failure to organ function and shock becomes irreversible. Brain and cellular death was held. Shock became irreversible because many ATP to adenosine is degraded when there is a shortage of oxygen in the cells. Adenosine is formed out of the cell and cause capillary vasodilation. Adenosine subsequently transformed into uric acid which then in renal excretion. At this stage, the administration of oxygen becomes futile because there is no adenosine can be phosphorylated to ATP.



#### D. Assessment.

The symptoms depend on the etiology and type of shock:

- restless
- Lips and fingernails look bluish
- Clammy skin
- The formation of urine is reduced or completely formed urine
- dizzy
- low blood pressure
- Excessive sweating, moist skin
- Rapid and shallow pulse
- Shallow breathing
- Unconscious,
- Weakness, mental status changes (anxiety, nausea, thirst, and fear.)
- Rapid breathing, shallow and irregular
- Pale face and cyanosis (blue lips)
- Dilated pupils

#### E. Nursing Diagnosis

1. Altered tissue perfusion related to vasoconstriction or decreased myocardial contractility
2. Impaired gas exchange related to ventilation perfusion imbalance.

3. Decreased cardiac output related to loss of circulating blood volume (diminished cardiac contractility).
4. Altered urinary elimination related to decreased renal function.
5. Fluid volume deficit related to blood loss.
6. Anxiety related to severity of condition.

#### F. Nursing Care Plan

Goals: Promote venous return and circulatory perfusion by doing:

1. Position: foot of bed elevated about 20 degrees, knees straight and trunk horizontal, head slight elevated. Avoided trendelenburg position.
2. Upper way ventilation: monitor respiratory effort, loosen restrictive clothing, O<sub>2</sub> as ordered.
3. Maintain of fluid: giving intravenous infusion, blood plasma expanders as ordered.
4. Control the vital signs:
  - a. Blood Pressure, Pulse rate, respiratory rate and body temperature.
  - b. Monitor urine output:
  - c. Monitor ECG if there is arrhythmias.
5. Medication, depending on the type of shock as ordered:
  - a. Antihypertensive: epinephrine (Adrenaline), nor epinephrine, isoproterenol (isuprel), dopamine (intropin).
  - b. Antiarrhythmics
  - c. Cardiac glycosides
  - d. Antibiotics
  - e. Vasodilators (nitroprusside).
  - f. Beta-adrenergics (Dobutamine)

#### G. Evaluation;

- a. Vital signs stables, within normal limits.
- b. Alert, oriented,
- c. Urine output > 30 ml/h



## F. NURSING CARE PLAN

NO .	Diagnosis	Nursing Care Plan		
		Aim	Intervention	Rational
1.	Ineffective breathing pattern associated with impaired gas exchange is characterized by shortness of breath, increased respiratory rate, coughing	<p>Having given nursing care expected effective breathing patterns outcomes:</p> <ul style="list-style-type: none"> <li>• The client does not shortness of breath</li> <li>• Frequency normal breathing</li> <li>• No coughing</li> </ul>	<ol style="list-style-type: none"> <li>1. Evaluation of respiratory rate and depth. Record the respiratory effort, an example of the dyspnea, drug use assistive breath, nasal dilation</li> <li>2. Auscultation of breath sounds. Please note the area is decreased or absence of breath sounds and their additional breath sounds, samples or crackles.</li> <li>3. collaboration with supplemental oxygen with a cannula or face mask as indicated</li> </ol>	<ol style="list-style-type: none"> <li>1. The patient's response varies. Speed and effort may be increased because of pain, fear, fever, decreased volume reduction of circulating (blood or fluid loss), accumulated secret, hypoxia or gastric distention. Respiratory suppression (reduced speed) can occur from excessive use of analgesics. The introduction here and abnormal ventilation treatment can prevent complications</li> <li>2. Auscultation of breath sounds aimed to determine the additional breath sounds</li> <li>3. Improve the delivery of oxygen to the lungs for circulation needs, in particular the reduction / interruption ventilation</li> </ol>

2.	Peripheral tissue perfusion associated with impaired blood flow secondary to vascular disorder characterized by pain, cardiac output decreased, cyanosis, edema (venous).	<p>Expected outcomes:</p> <ul style="list-style-type: none"> <li>• Client not pain</li> <li>• Cardiac output normal</li> <li>• There is no cyanosis</li> <li>• No edema (venous)</li> </ul>	<ol style="list-style-type: none"> <li>1. Encourage active or passive leg exercise, avoid isometric exercise.</li> <li>2. Collaboration and Monitor laboratory data, for example: GBA, BUN, creatinine, and electrolytes.</li> <li>3. Give the drug as indicated: sodium heparin or warfarin (Coumadin)</li> </ol>	<ol style="list-style-type: none"> <li>1) Lowering static veins, improve venous return and reduce the risk tromboflebis.</li> <li>2) Indicators organ perfusion or function</li> <li>3) Low-dose heparin may be given prophylactically in patients at high risk may be to lower the risk of tromboflebitis or trombusmural formation. Coumadin drug of choice for the treatment of long-term anti koangulan / post-return</li> </ol>
3.	Activity intolerance related to imbalance of oxygen supply to the needs (reduction or limitation of cardiac output) is characterized by fatigue, weakness, pale	<p>After being given the nursing care of patients is expected to perform activities independently</p> <p>Criteria Results;</p> <ul style="list-style-type: none"> <li>• The client does not get tired easily</li> <li>• The client does not limptheclien does not pale.</li> </ul>	<ol style="list-style-type: none"> <li>1. Check vital signs before and immediately after the event, especially if the patient is using a vasodilator, diuretic</li> <li>2. Record the cardiopulmonary response to activity, record tachycardia, dysrhythmia, dyspnea, sweating, paleness</li> <li>3. Assess precipitator or cause weakness, sample treatment, pain</li> </ol>	<ol style="list-style-type: none"> <li>1) Orthostatic hypertension may occur with activity due to drug effects (vasodilation), fluid displacement, (diuretics) or to influence heart function</li> <li>2) Decrease or inability of the myocardium to increase the volume to taste during the activity, may cause an immediate increase in heart frequency and oxygen requirements, as well as increased fatigue and weakness.</li> <li>3) The downside is the side effect of some medications (beta blockers, Trakuiliser and sedatives). Pain and stress-filled program also requires energy and causes weakness.</li> </ol>

#### G. NURSING IMPLEMENTATION

Implementation based on the Nursing Care Plan

#### H. NURSING EVALUATION

Evaluation based on expected outcome

Unit 17  
NURSING MANAGING FOR CLIENT WITH ASTHMA

A. Definitions

Asthma is a disease of the airway that can not be recovered due to bronchial spasms that occur due to various causes (Hudak& Gallo, 1997).

Asthma is an obstructive airway disease intermittent, reversible where the trachea and bronchi are hyperactive respond to stimulation in certain (Smeltzer, Suzanne, 2002)

B. Etiology

The etiology of asthma can be divided into 3, (according to AndraSaferiWijaya&Yessie daughter Marisa. 2013):

1. extrinsic asthma / allergy

Asthma caused by elergen known since his time there have been such children erhadap protein allergy pollen, fuzz, bianatang and dust.

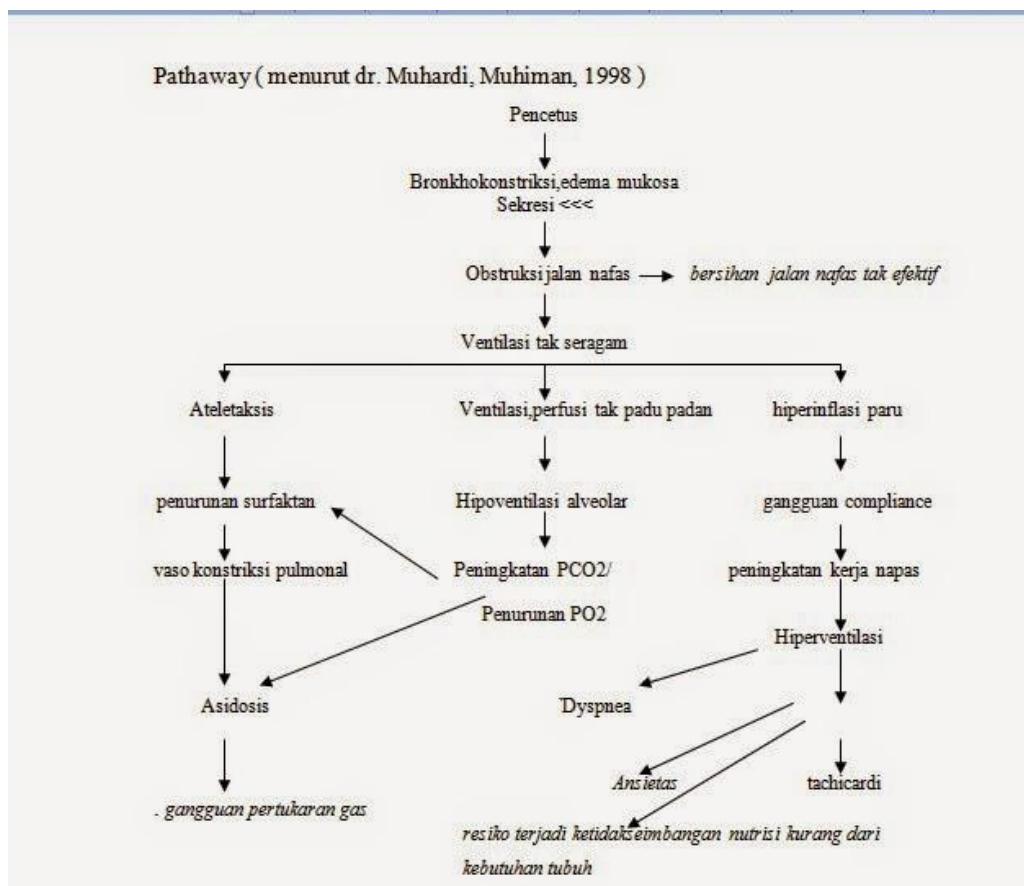
2. Asthma intrinsic / idopatik

Asthma that is not found obvious precipitating factors, but their non spesifik factors such as: flu, physical exercise or emotional often trigger asthma attacks. Asthma often appears / develop after the age of 40 after suffering from a sinus infection / branch trakeobronkhial.

3. Asthma mix

Asthma happens / Timbu because adnya component of extrinsic and intrinsic.

### C. Pathophysiology



Asthma is reversible diffuse airway obstruction caused by one or more of the following factors.

1. The contractions of the muscles that surround the bronchi constrict the airway.
2. Swelling of the membrane lining the bronchi.
3. Charging bronchi by mucus Kenta

In addition, the bronchial muscles and enlarged glands. Sputum that is thick, are produced and alveoli become hyperinflammatory with air trapped in the lungs. The resulting antibody (IgE) then attacked the mast cells in the lungs. Repeated exposure to an antigen results in antigen binding with antibodies causes the release of the products of mast cells (mediators) such as histamine, bradykinin, and prostaglandins as well as anaphylaxis from suptamin that react slowly.

The release of these mediators affect smooth muscle and glands airway causes broncho spasm, swelling of the mucous membranes and the formation of mucus very much

Autonomic nervous system affects the lungs, bronchial muscle tone pagal regulated by nerve impulses through the sympathetic system. In idiopathic asthma /

non-allergenic, when the nerve endings in the airway is stimulated by factors such as: infections, exercise, cold air, smoke, emotions and pollutants. Increasing the amount of acetylcholine released.

The release of this astilkolin directly cause bronchikonstriksi also stimulates the formation of chemical mediators.

In severe asthma attack that has been accompanied by toxemia, the body will hold hyperventilation to provide for O<sub>2</sub>. This hyperventilation will cause excessive spending and further CO<sub>2</sub> CO<sub>2</sub> result in arterial blood pressure (pa CO<sub>2</sub>) decreases causing respiratory alkalosis (increased blood pH). When more severe asthma attacks, many alveolar covered by mucus that did not participate at all in gas exchange. Now the ventilation is not sufficient anymore, hypoxemia gain weight, respiratory muscles work to gain weight and increased CO<sub>2</sub> production with decreased alveolar ventilation causes retention of CO<sub>2</sub> in the blood (hypercapnia) and respiratory acidosis (pH decreases). This stage we are familiar with respiratory failure.

Hypothermia prolonged will lead to metabolic acidosis and pulmonary vascular network construction and subsequent edit circulatory causes blood vessels to larger units without going through a good gas exchange. Edit this also results hipercapni so that will make things worse.

#### D. Clinical Manifestations

##### **Subjective Data**

1. The patient complained of shortness of breath
2. The patient complained of cough slimy
3. The patient complains of difficulty secretions out
4. The patient complains of chest pain

##### **Objective Data**

1. RR: 30x / m
2. The patient is claustrophobic
3. breath sounds weezing
4. Clients appear to be breathing fast and deep
5. The client seems restless

##### **Nursing Diagnoses**

1. Ineffective airway clearance related to accumulation of secretions
2. Ineffective breathing pattern associated with a decreased ability to breathe
3. Damage to gas exchange associated with CO<sub>2</sub> retention

## **Nursing Care Plan**

### **1. Nursing Diagnosis: Ineffective airway clearance associated with buildup secret**

Objective: airway re-effective

Expected outcomes:

- can demonstrate effective cough
- can declare a strategy to reduce the viscosity of secretions

#### **Intervention**

- a. Auscultation of breath sounds, record their breath sounds, eg; wheezing, krekels, crackles.  
R: some degree of bronchospasm occurs obstruction in the airway
  - b. Assess / monitor respiratory frequency  
R: tachypnea normally exist in some degree and can be found at the reception or during stress
  - c. Assess the patient to a comfortable position eg: raising the head of the bed, sitting on the back of the bed.  
R: clod elevation makes it easier to breathe
  - d. Push / aids abdominal breathing exercises / lip  
R: give patients a way to remedy and resolve dyspnea memgontrol
  - e. Observation cough characteristics eg settling, hacking cough, wet  
R; short cough, moist secretions usually come out with a cough
  - f. Perform suctioning  
R: to lift off the road respiratory ssekret
  - g. collaboration with physicians  
R: for drug delivery
2. Ineffective breathing pattern b / d decreased ability to breathe.
- Objective: patient breathing pattern becomes effective
- Expected outcomes:
- Chest no disturbance development
  - Breathing becomes normal 18-24 x / min

#### **Intervention**

- a. Monitor frequency, rhythm and depth of breathing  
R: dyspnea and an increase in employment of breath, respiratory depth varies throughout
- b. Elevate the head and help reposition  
R: high dududk enables lung expansion and ease breathing
- c. Observations pattern of coughing and secret characters  
R: menegtahuikeribg or wet cough as well as the color of the secretions
- d. Give the patient practice deep breathing or coughing effective  
R: may increase secretions in which there is an interruption in breathing inconveniences ventilationsitambah

- e. Provide supplemental O<sub>2</sub>  
R: maximize breathing and lower the breath work
- f. chest physiotherapy  
R: facilitate efforts to breathe preformance and increase secretions draenase
- 2. Damage to gas exchange associated with CO<sub>2</sub> retention,  
Objective: gas exchange to be effective  
Results Criteria: Shows improvement vertilasi and adequate tissue oxygen within the range intervention:
  - a. observation of vital signs  
R: TD changes occur with the severity of hypoxemia and acidosis
  - b. Assess the level of awareness / mental changes  
R: systemic hypoxemia can be demonstrated first by the restless and sensitive excitatory
  - c. Observation of cyanosis  
R: systemic Menunjukkanhipokseミア
  - d. Elevate the head of the bed within their patients' needs  
R: improving chest expansion and make breathing easier
  - e. Give O<sub>2</sub> sesui indication  
R: maximizing the dosage of oxygen to exchange g

### **Implementation Of Nursing**

in accordance with the implementation of the intervention

### **Evaluation Of Nursing**

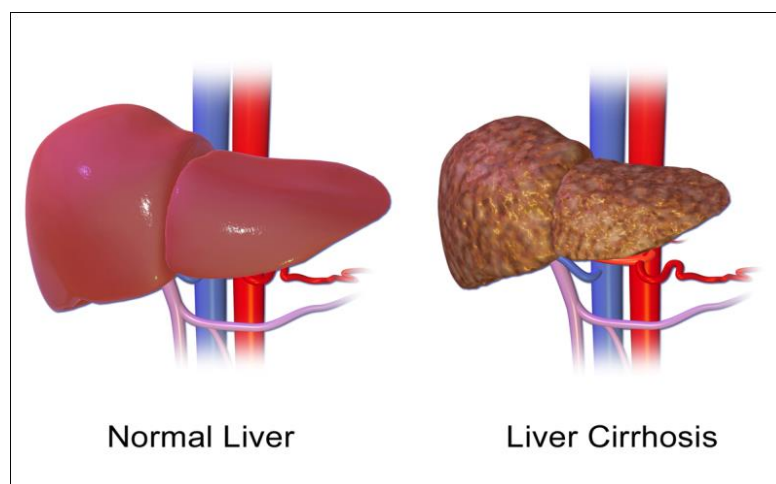
in accordance with the evaluation criteria of the expected

Unit 18  
NURSING MANAGING FOR CLIENT WITH  
CIRRHOSIS HEPATIC

**A. Definition**

Cirrhosis Hepatic (cirrhosis liver) is a chronic liver disease of unknown cause with certainty. It is known that this disease is the final stage of chronic liver disease and a sclerosis of the liver (Sujono H, 2002).

Cirrhosis Hepatic (cirrhosis liver) is a chronic diffuse liver disease, characterized by the formation of nodules accompanied tissue. Starting with the inflammation process, extensive necrosis of liver cells, the formation of connective tissue and regenerating nodular effort. (Ilinayah, 2004). The picture bellow shows the different between the normal and abnormalities of the parenchyma liver.



**B. Etiology**

Morphologically, causes of liver cirrhosis cannot be ascertained. But there are two causes that are considered the most common cause of liver Cirrhosis the:

1. Hepatitis virus

Hepatitis B virus is mainly the type often referred to as one of the causes cirrhosis heart, what more after the discovery of Australian antigen by Blumberg in 1965 in the blood of patients with chronic liver disease, it is suspected to have played a large role for the liver cells resulting nekrosachirrosisi. The clinic has been known that hepatitis B viruses have a tendency to be a lot more settled and gave symptom of chronic and show the trip, when compared with the hepatitis virus.



## 2. Hepatotoxic substances or Alcoholism

Some of drugs and chemicals may cause damage to the liver cells in acute and chronic. Acute liver damage will result in necrosis or fatty degeneration, whereas chronic damage will be in the form of cirrhosis of the liver. Hepatotoxic substances often mention is alcohol. Liver cirrhosis due to alcoholism is very rare, but the drink that years may lead to damage to the liver parenchyma.

## 3. Haemochromatosis

Form of cirrhosis happened and usually the type of portal. There are two possible onset hemochromatosis, they are:

- a. Since was born of the patient increased absorption of Fe.
- b. Possible in the can after birth (acquisition), for example encountered in patients with alcoholic liver disease. Increased absorption of Fe, the possibility of causing liver cirrhosis.

4. Postnecrotic cirrhosis is a complication of viral, toxic or idiopathic (autoimmune) hepatitis.

5. Biliary cirrhosis is associated with chronic biliary obstruction and infection. There is diffuse fibrosis of the liver with jaundice as the main feature.

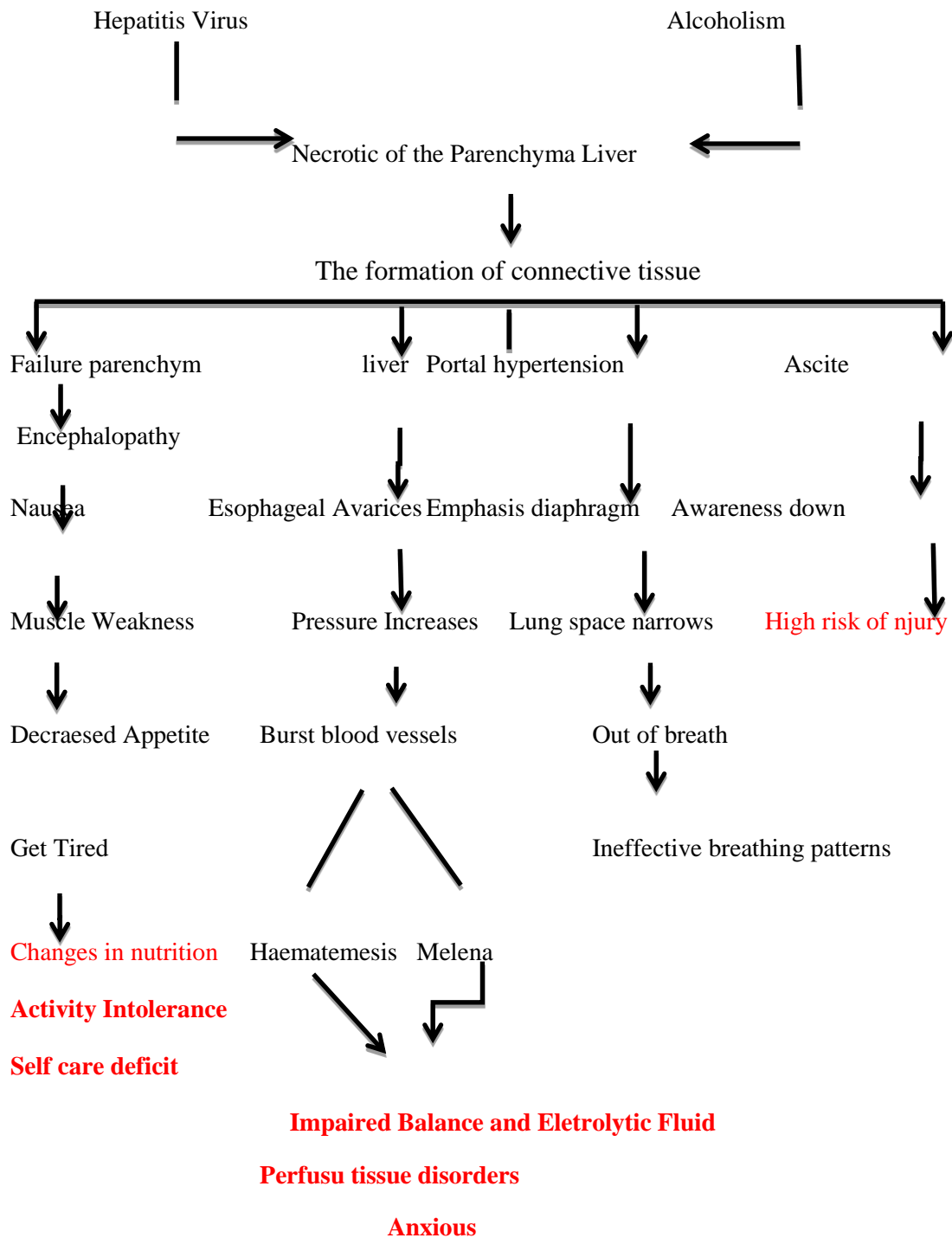
## C. Patophysiology and Pathway

### Patophysiology

Infection with hepatitis virus type B / C cause inflammation of the liver cells. This inflammation causes necrosis covers a wide area (hepatocellular), collapse occurs liver lobule and spur scarring accompanied by the formation of septa of fibrous diffuse and nodules of liver cells, although the etiology is different, histological features of liver cirrhosis same or nearly the same, septa may be formed from reticulum cell buffer to collapse and turn into a scar. This scar tissue can connect with the central port area. Some cells grow back and nodules of various sizes and this leads to distortion of branching vessels and impaired hepatic portal blood flow, and lead to portal hypertension. It thus can also occur in alcoholic cirrhosis but the process is longer. The next stage of inflammation in necrosis of the cells ductless, sinusoid, reticulo endothelial happen fibrinogenesis and active septa. The collagen network of a reversible change becomes irreversible when it has formed a permanent septa acellular the port area and the liver parenchyma. Septa picture depends on the etiology of cirrhosis. On the etiology of cirrhosis with hemochromatosis, an iron resulted in periportal areas fibrosis, alcoholic cirrhosis fibrosis raised central area. T lymphocytes

and macrophages produce lymphokines and monokin, may mediate the onset of fibrinogen. The mediator does not require active inflammation and necrosis. Septal active these are local porta spread to the liver parenchyma.

### Pathway



## **D. Assessment**

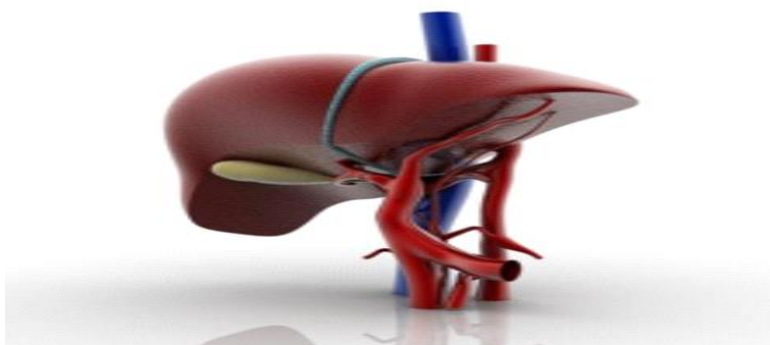
### **a. Subjective Data**

1. Patient has nausea and vomiting
2. Patient has lack of appetite
3. Patient has if the activity quickly tired
4. Patient has dark urination
5. Patient has a big belly and a loudly

### **b. Objective Data**

1. Patient look pale
2. Patient seem less appetite
3. Patient seem limp
4. Patient apparent grimace
5. Observation of vital signs

## **E. Nursing Diagnosis**



1. Imbalanced nutrition less than body requirements related to
2. Ineffective tissues perfusion related to bleeding tendencies and varices that may hemorrhage.
3. Skin Integrity, risk for impaired
4. Breathing Pattern, risk for ineffective
5. Risk for injury [hemorrhage]

Changes in nutritional status, less of a need body b / d anorexia and gastrointestinal disorders.

1. Lack of fluid volume b / d diarrhea.
2. Activity intolerance b / d rapid fatigue, physical weakness of the secondary common systemic metabolic changes.
3. Actual or risk Ineffective breathing pattern b / d expansion declined

## **F. Planning**

### **1. Imbalanced nutrition less than body requirements**

Objective: Meet the nutritional status

Intervention

- a. Assess dietary intake, diet Measure income, balanced body weight every week.

R /: Assist in identifying deficiencies and dietary needs. General physical condition, the symptoms of uremic (nausea, vomiting, anorexia, and disruption to taste) and dietary restrictions can affect food intake, each nutrient needs to be reckoned with right order needs in accordance with the patient's condition, body weight was weighed to determine the additions and loweringweight periodically ,.

- b. Provide food little and often correspond with the diet.

R /: Minimizing anorexia and nausea in connection with uremic status.

- c. Identify a preferred food including cultural need.

R /: If the preferred food the patient can be included in meal planning, it can improve the patient's appetite.

- d. Motivation patients to spend diet, advise-eat soft food.

R /: Helps digestion and easy absorption of food, for patients with impaired digestive system.

- e. Give the medicine in accordance with the indications: Supplement vitamin, thiamin, iron, folic acid and digestive enzymes.

R /: Heart damaged can not store Vitamin A, B complex, D and K, as well as a shortage of iron and folic acid that causes anemia. Improved digestion and fat and can reduce diarrhea.

- f. Collaboration of antiemetic

R /: to eliminate nausea / vomiting and can improve oral revenue.

### **2. Ineffective tissues perfusion related to bleeding tendencies and varices that may hemorrhage.**

Objective: Maintain adequate hydration evidenced by stable vital signs, good skin turgor, capillary refill, strong peripheral pulse and urine output appropriate individuals.

**Intervention:**

- a. Supervise the input and output, compared with body weight daily.

R /: Provides information about the need for replacement / therapeutic effect.

- b. Assess vital signs, peripheral pulse, capillary refill, skin turgor, and mucous membranes.

R /: Indicator volume circulation / percussion.

- c. Check the ascites or edema formation. Measure the circumference of the abdomen as indicated.

R /: Reducing the chance of bleeding into tissue.

- d. Observe signs of bleeding example hematuria / melena, ecchymosed.

R /: Protombin levels decreased and the coagulation time extends when vitamin K absorption is impaired in the GI tract and the synthesis protombin declined because it affects the liver.

- e. Keep an eye on the value of the laboratory, for example, HB / HT, Na + albumin, and clotting time.

R /: Indicates hydration and identifying retention of sodium / levels of a protein that can cause edema formation.

- f. Activity intolerance b / d rapid fatigue, physical weakness of the secondary common systemic metabolic changes.

**Objective:** Within 3x24 hours of treatment the patient optimally fit individual tolerance level Intervention:

1. Assess changes in the central nervous system and cardiorespiratory status.

R/: Identification of the condition decreased level of consciousness, especially in cirrhotic patients with hepatic encephalopathy.

2. Monitor individual response to event

R/: Some patients with liver cirrhosis, is associated with liver function impairment conditions with manifestations. Anemia, fatigue, the condition is considered to meet the patient's daily activities.

3. Increase your activity gradually

R/: This intervention is easier to recover in patients with liver cirrhosis, ascites fluid and post-evacuation of patients who have a tolerance improved.

4. Instruct the patient to the activity of energy saving methods.  
R/: Methods of energy efficiency can reduce the need for metabolism in patients with liver cirrhosis.
  5. Provide assistance as the tolerance level (eating, drinking, bathing, dressing and elimination).  
R/: Mechanical energy efficiency lowers energy usage.
  6. Help the patient's daily activities  
R/: Nurse help facilitate the needs of patients to perform self-care, elimination still needs to do in bed. Maintain general awareness is by using gloves, aprons and masks, especially in liver cirrhosis patients with a history of hepatitis B and C.
- a. Actual or risk Ineffective breathing pattern decreases bd expansion.  
Objective: In 1x24 hours, no changes in breathing patterns.
- Intervention:
1. Assess factors causing breathing pattern ineffective  
R/: Identify to address the root causes of alkalosis.
  2. Assess vital signs  
R/: Changes in vital signs will have an impact on the increased risk of severe alkalosis and indicated the immediate intervention to make corrections alkalosis.
  3. Rest the patient with Fowler position  
R/: Position fowler will increase the optimal lung expansion. Break will reduce the heart's work, improve backup power of the heart and lowers blood pressure.
  4. Measure intake and output  
R/: Decrease in cardiac output resulting in renal perfusion, retention of sodium / water, and decreased urine output.
  5. Give the quiet environment and limit visitors  
R/: A quiet neighborhood will reduce external pain stimulus and visitor restrictions will help increase oxygen conditions room that would be reduced if a lot of visitors who are in the room.
  6. Give oxygen 3 liters / minute  
R /: maintenance therapy for oxygenation needs.

#### G. Nursing Implementation

Implementation carried out based interventions that have been made in treatment plan.

#### H. Nursing Evaluation

The evaluation can be made in from of formative and summative (SOAP) evaluation conducted on the achievement made in accordance outcomes / evaluation criteria are made in the tretment plan.

Unit 19  
NURSING MANAGING FOR CLIENT WITH DIABETIC MELLITUS (DM)

In Diabetes there may be a decrease in the body's ability to respond to insulin and / or a decrease or absence of insulin produced by the pancreas. This leads to abnormalities in the metabolism of carbohydrate, protein, and fats. The resulting hyperglycemia may lead to acute metabolic complication such as diabetic ketoacidosis and hyperosmolar non ketotic syndrome. Long-term hyperglycemia may contribute to chronic microvascular complication (kidney and eye disease) and neuropathic complication. Macrovascular diseases, including myocardial infarction, stroke and peripheral vascular disease.

**A. Definition**



DM is a metabolic disorder characterized by hyperglycemia which is marked with hyperglycemia associated with abnormalities in the metabolism of carbohydrates, fats, and proteins caused by the decrease in insulin or decreased insulin sensitivity or both and cause complications of chronic microvascular, macrovascular, and neuropathy. (Juliana Elin, 2009). DM is a metabolic disorder resulting from lack of insulin hormone.

**B. Etiology of Diabetes Mellitus**

DM or better known as diabetes has some factors that trigger the disease, among others:

**1. Diet**

Eating excessive and exceeds the caloric content required by the body can stimulate the onset of DM. Consumption of excessive eating and not offset by the secretion of insufficient quantities of insulin can cause high blood glucose levels if the disturbance of insulin production



## 2. Obesity

Obese people with a body weight over 90 kg tend to have a greater chance of disease dm.

## 3. Genetic factors

DM can be inherited from parents to their children health experts also mentioned dm is a disease-linked sex or pregnancy. Usually men into real patients, whereas women as those who carry the gene for inherited to his children

## 4. Chemicals and pharmaceuticals

The chemicals can irritate the pancreas which causes inflammation of the pancreas, inflammation of the pancreas will result in decreased pancreatic function so that no secretion of hormone-hormone for the metabolism of the body, including insulin. All types of drug residues accumulated in a long time can irritate the pancreas.

## 5. Diseases and infections of the pancreas microorganisms and viruses can also cause inflammation of the pancreas which will automatically cause the pancreas function down so no-hormone secretion of hormones for the metabolism of the body, including insulin. Diseases such as high cholesterol and dyslipidemia may increase the risk of diabetes.

## 6. Lifestyle

If people are lazy to exercise at high risk for the disease of diabetes because exercise is used to burn excess calories in tubuh.kalori that accumulate in the body is a major contributing factor to the cause of diabetes in addition to pancreatic dysfunction.

## 7. The high levels of corticosteroid

## 8. Pregnancy gestational diabetes, which will disappear after delivery

## 9. Drugs that can damage the pancreas

## 10. Toxins that affect the formation or effect of insulin.

# C. Pathophysiology

In the process of metabolism , insulin plays an important role , the introduction of glucose into the cells that are used as fuel . Insulin is a substance or a hormone produced by the beta cells in the pancreas . When insulin is not there then the glucose can not enter cells with glucose result will remain in the blood vessels , which means the levels of glucose in the blood rises .

In Diabetes mellitus type 1 abnormalities of insulin secretion by pancreatic beta cells, This type of diabetes patients inherit a genetic susceptibility which predispose to autoimmune destruction of pancreatic beta cells .

In type 2 diabetes mellitus which frequently occurs in the elderly , the amount of normal insulin but the number of insulin receptors located on the cell surface that are less so glucose into the cells a bit and glucose in the

#### **D. Clinical Manifestations**

1. Polyuria (frequent urinary)
2. Polidipsi (much to drink)
3. Polifagi (increased desire to eat)
4. Weight loss, fatigue, quickly tired, lacking energy
5. Blurred vision
6. Recurrent infections of the skin
7. High sugar levels in the blood and glucosuria.

#### **E. Assessment**

Assessment on the client with the endocrine system disorders Diabetes Mellitus carried out from data collection that includes: bio, medical history, the main complaint, the nature of the complaint, past medical history, physical examination, the pattern of daily activities. Things need to be assessed on the client degan Diabetes Mellitus:

- Activity and rest:  
Weakness, difficulty walking / moving, muscle cramps, rest and sleep disorders, tachicardi / tachipnea during activity and coma.
- Circulation  
History of hypertension, heart disease such as IMA, pain, numbness in the lower extremities, which are difficult to heal wounds, dry skin, red, and sunken eyes.
- Elimination  
Polyuria, nocturi, pain, burning sensation, diarrhea, flatulence and pale.
- Nutrition  
Nausea, vomiting, weight loss, poor skin turgor, nausea / vomiting.
- Neurosensori  
Headache, said such like vomiting, tingling, muscle weakness, disorientation, lethargy, coma and confusion.

- Pain  
Abdominal swelling, grimacing.
- Respiration  
Tachipnea, Kussmaul, Ronchi, wheezing and shortness of breath.
- Security  
Damaged skin, lesions / ulcers, decreased general strength.
- Sexuality  
Inflammation of the vaginal area, and orgasm decreased and impotence occurs in men.

#### **F. Nursing Diagnosis**

1. Shortage of body fluid volume associated with osmotic diuresis.
2. Changes in nutritional status is less than body requirements related to insulin insufficiency, decreased oral input.
3. Risk of infection associated with hyperglycemia

#### **A. Nursing Interventions**

<b>No.</b>	<b>Nursing Diagnoses</b>	<b>Objectives and Expected Outcomes</b>	<b>Intervention</b>	<b>Rational</b>
1.	Fluid volume, deficient associated with osmotic diuresis.	<p>After nursing action 3 x 24 hours then expected no shortage of development of the body fluid volume with expected outcomes</p> <ul style="list-style-type: none"> <li>- Demonstrate adequate hydration evidenced by stable vital signs</li> <li>- Palpable peripheral</li> <li>- Skin turgor and capillary permeability</li> </ul>	<ol style="list-style-type: none"> <li>1. Monitor vital signs</li> <li>2. Monitor the input and output, record the specific gravity.</li> <li>3. Assess the peripheral pulses, capillary refill, skin turgor, and mucous membranes</li> <li>4. Weigh weight every day.</li> </ol>	<ol style="list-style-type: none"> <li>1. Hypovolemia may be manifested by hypotension and tachycardia</li> <li>2. Is an indicator of the level of dehydration, or adequate circulating blood volume.</li> <li>3. Provide estimates of the need for fluid replacement, kidney function</li> <li>4. Gives the best assessment of the fluid status of ongoing and further in providing replacement fluid.</li> <li>5. The type and amount of</li> </ol>

		- Right individually urine output and electrolyte levels within normal limits.	5. Give the fluid therapy as indicated.	liquid depends on the degree of lack of fluids and response of the individual patient.
2.	Nutrition imbalanced: less than body requirements related to insulin insufficiency, decreased oral input	<p>Changes in nutritional status of less than body requirements related to insulin insufficiency, oral Decreased input</p> <p>After nursing action 3 x 24 hours then expected to nutritional needs are met with outcomes</p> <ul style="list-style-type: none"> <li>• The client is able to spend a portion of a given meal</li> <li>• The general state of clients</li> <li>• Stable weight</li> </ul>	<p>1. Determine the diet and eating patterns of patients and compare it with the food that can be consumed by the patient.</p> <p>2. Weigh weight every day or as indicated</p> <p>3. Identify the food preferred / desired including the needs of ethnic / cultural.</p> <p>4. Involve the patient's family in meal planning as indicated</p> <p>5. Provide regular insulin treatment as indicated.</p>	<p>1. Identifying shortcomings and irregularities of therapeutic needs.</p> <p>2. Assessing adequate food intake (including absorption and utilization)</p> <p>3. If the preferred food the patient can be included in meal planning, this cooperation can be pursued after the return</p> <p>4. Increase the sense of involvement; provide information on the patient's family to understand nutrition.</p> <p>5. Regular Insulin has a rapid onset and therefore quickly as well to help move glucose into the cells.</p>

3.	Risk for infection associated with hyperglycemia .	Identify interventions to prevent lower the risk of infection. Demonstrating the technique, lifestyle changes to prevent infection.	<ol style="list-style-type: none"> <li>1. Observe signs of infection and inflammation</li> <li>2. Increase efforts to prevention by good hand washing on everyone</li> <li>3. Maintain aseptic technique for invasive procedures.</li> <li>4. Provide skin care regularly and earnestly.</li> <li>5. Change of body position regularly, encourage effective cough and breathe deeply.</li> </ol>	<ol style="list-style-type: none"> <li>1. Patients may sign with an infection that usually has sparked a state of ketoacidosis or may experience nosocomial infections.</li> <li>2. Preventing the emergence of cross-infection</li> <li>3. A high glucose levels in the blood would be the best medium for the growth of germs</li> <li>4. Peripheral circulation can be impaired which puts patients at increased risk of damage to the skin / skin irritation and infection</li> <li>5. Helps in all lung regions and mobilize secretions.</li> </ol>
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### **B. Implementation**

Implementation is the management and the realization of nursing plans that had been developed at the planning stage.

### **C. Evaluation**

Evaluation is the final step in the nursing process to identify to what extent the objectives of the nursing plan has been reached.

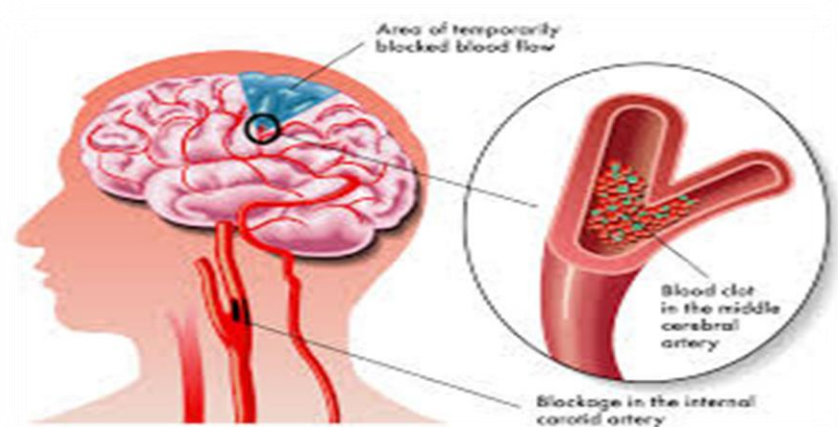
Unit 20  
NURSING MANAGEMENT CLIENT STROKE

### Introduction

Stroke occurs when there is ischemia (inadequate blood flow) to a part of the brain or hemorrhage into the brain that results in death of brain cells. Functions, such as movement, sensation, or emotions, that were controlled by the affected area of the brain are lost or impaired. The severity of the loss of function varies according to the location and extent of the brain involved.

This unit, the participant will be able to understand and integrate the theory and concepts including definition, etiologies, pathophysiology and risk factors and some clinical nursing skills in order to be able to give nursing care for patients with stroke problems.

### A. Definition

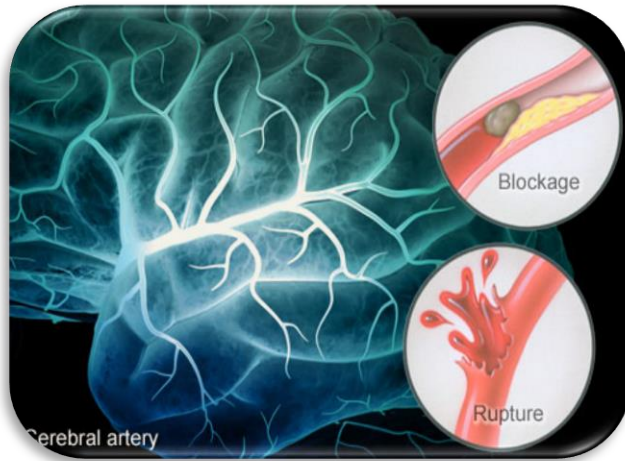


Cerebrovascular diseases refer to any functional or structural abnormality of the brain caused by a pathologic condition of the cerebral vessels or of the entire cerebral vascular system. Hemorrhage in the vessels wall or impairs the cerebral circulation by a partial or complete occlusion of the vessels lumen with transient or permanent effects. Stroke can be described as follows:

1. Stroke is a loss of brain function caused by the cessation of blood supply to part of the brain
2. According to Price & Wilson (2006) understanding of stroke is any sudden neurologic disorder that occurs as a result of restriction or cessation of blood flow through brain arteries supply system.

From the explanation above it can be concluded that the definition of stroke is a cerebral circulation disorder caused by blockage or narrowing of the arteries by embolism , thrombosis or cerebral hemorrhage resulting in decreased blood flow to the brain that the onset of a sudden.

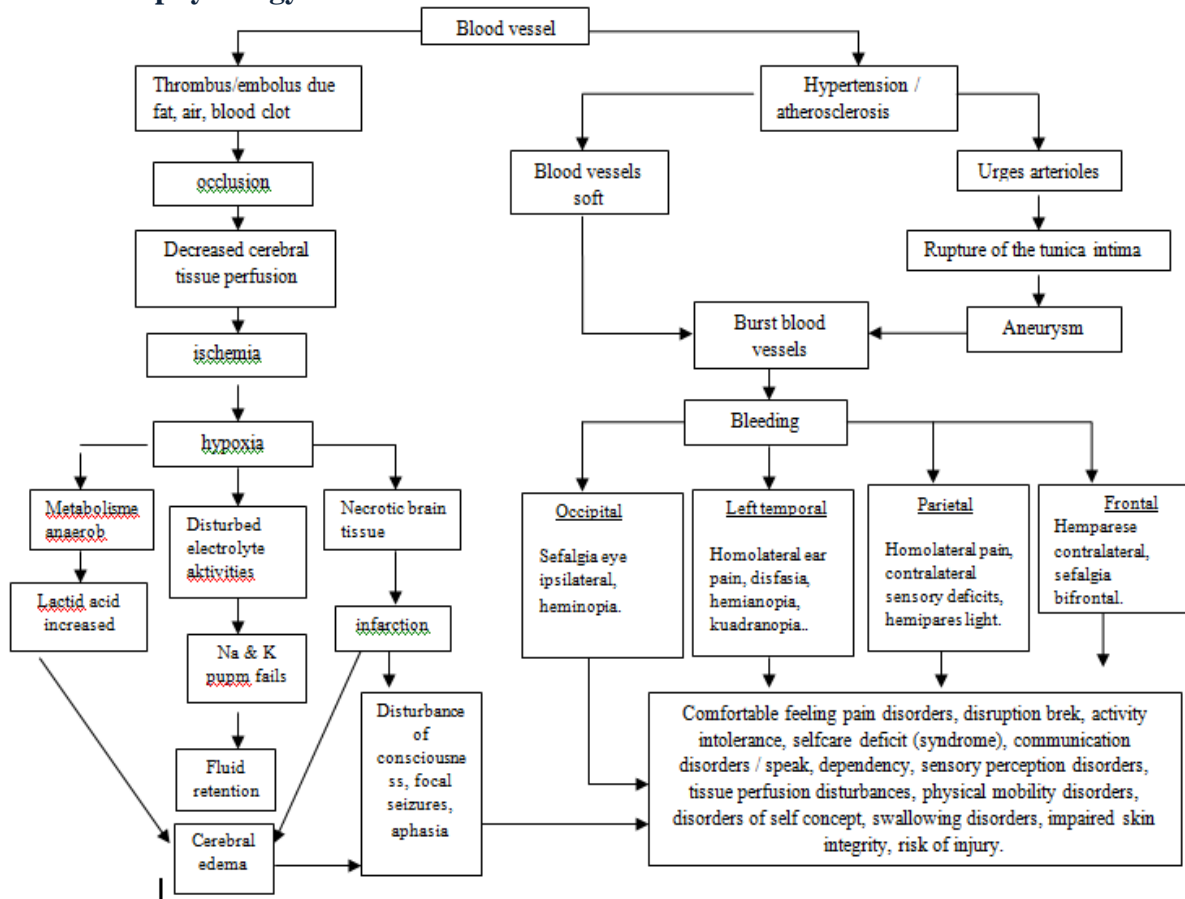
## **B. Etiology**



According Smeltzer& Bare (2002) stroke usually results from one of the four events bellows:

1. Thrombosis is a blood clot in the blood vessels of the brain or neck.
2. Cerebral embolism is a blood clot or other material is carried to the brain from another part of the body
3. Ischemia is a decrease in blood flow to areas of the brain
4. Cerebral hemorrhage is rupture of cerebral blood vessel and bleeding into the brain tissue or the space around the brain.

### C. Patophysiology



### D. Assesment

#### a. Subjective Data

- Patient say the arms and legs can not move
- Patient say sometimes feel dizziness and vertigo
- Patient said weak hands and feet when actuated
- Patient's family said that the patient can not get up , sit down and stand up
- Patient say she/he difficult to speak

#### b. Objective Data

- Arm and leg strength decreased
- The decline in taste and reflexes .
- Range of motion of the arms and legs is limited
- Words are not clear
- Patient has difficulty speaking
- The position of the tongue a bit to the left or to the right



## **E. Nursing diagnosis**

1. Ineffective cerebral tissue perfusion associated with the interruption of blood flow, cerebral edema
2. Ineffective airway clearance related inability to raise secretion as manifested by breath sounds, diminished breath sounds and ineffective cough
3. Impaired physical mobility associated with weakness
4. Impaired verbal communication associated with damage to the cerebral circulation, loss of muscle control facial
5. Impaired urinary elimination related to inability to reach toilet or many tasks of voiding as manifested by incontinence and flow of urine at unpredictable times.

## **F. Nursing Care Plan**

1. Ineffective cerebral tissue perfusion associated with the interruption of blood flow, cerebral edema

Objective: Cerebral tissue perfusion back to normal

Results Criteria :

- Maintain a level of consciousness, cognition and motor / sensory improved.
- Show vital signs were stable
- No recurrence deficits ( sensory, language, intellectual and emotional

### **Intervention:**

- a. Monitor / log neurologic status as often as possible and compare it to the normal state

Rationale : Knowing the tendency of the level of awareness and the potential increase in ICT and determine the location, spacious and advancement / resolution SPP damage

- b. Monitor vital signs

Rationale : Variations may occur due to stress / trauma on regional cerebral vasomotor brain .

- c. Assess the functions of conscious level if the patient is conscious

Rationale: Changes in cognitive content and talk is an indicator of cerebral disorders .

- d. Place the head with a slightly elevated position and in the anatomical position.

Rationale : Lowers arterial pressure and improved drainage and cerebral perfusion .

2. Ineffective airway clearance related inability to raise secretion as manifested by breath sounds, diminished breath sounds and ineffective cough

Objective: Effective clearance of airway and move sputum out and free of breath sounds.

Results Criteria:

- Free of breathing without difficulty
- Normal respiration

Intervention:

- a. Assist patient to a sitting position with head slightly flexed, shoulder relaxed, and knees flexed to provide optimal positioning for generating maximum intrathoracic pressure during cough.
  - b. Instruct patient to inhale deeply, bend forward slightly, and perform three or four huffs (again an open glottis) to expel secretion.
  - c. Encourage use of incentive spirometry to open collapsed alveoli, promote deep breathing, and prevent atelectasis.
3. Impaired physical mobility associated with weakness

Objective: Physical mobility back to normal

Results Criteria :

- To improve the strength and function of the body is affected.
- Clients can demonstrate techniques / behaviors enabling activities.
- Can maintain skin integrity

Intervention :

- a. Assess client's ability to functionally

Rationale: Identifies strengths/weaknesses and can provide information about recovery

- b. Change position at least into every 2 hours

Rationale : Reduce the risk of trauma / tissue ischemia ( decubitus )

- c. Perform active and passive motion exercises on all extremities

Rationale: Minimizing atrophy of muscles, improves circulation , helps prevent contractures

- d. Raise your hands and head.

Rationale: Changes in cognitive content and talk is an indicator of cerebral disorders

4. Impaired verbal communication associated with damage to the cerebral circulation, loss of muscle control facial

Objective: To communicate in accordance with the circumstances.

Expected outcomes: Clients express sign exactly, happened, language between the client and nurse and family.

Intervention:

- a. Assess the level of the client's ability to communicate

Rationale: Changes in cognitive content and talk is an indicator of the degree of cerebral disorders

- b. Ask the client to follow simple commands

Rationale : assessing the damage to sensory

- c. Show the object and ask the patient to name objects

Rationale : Conducting an assessment of their motor impairments

- d. Teach clients non-verbal communication techniques ( sign language )

Rationale : sign language can help to convey the contents of the message in question

- e. Listen attentively to convey the important of patient's thought.

Rational: to promote a positive environment for learning

- f. Use short, simple questions that elicit "yes" and "no" answer.

Rational: Adequate time for response to avoid overwhelming patient with verbal stimuli

### **Nursing Implementation**

Implementation made in accordance with intervention

### **Nursing Evaluation**

The expected result based on the purpose in accordance with the evaluation criteria

5. Impaired urinary elimination related to inability to reach toilet or many tasks of voiding as manifested by incontinence and flow of urine at unpredictable times.

Objective: Responds in timely manner to urge urine and maintains environment barrier free to independent.

Intervention:

- a. Establish interval of initial toileting schedule based on voiding pattern.

Rational: To initiate process of improving bladder functioning and increased muscle tone.

- b. Remain patient to void at prescribed intervals.

Rational: to assist patient in adapting to new toileting schedule

- c. Teach patient to consciously hold urine.

Rational: Schedule toileting time to improve muscle tone

- d. Discuss daily reestablishment of continence with the patient.

Rational: to provide reinforcement and to allow time to ask question, make comments or share concern.

- 6. Impaired swallowing related to weakness or paralysis of affected muscle as manifested by drooling, difficulty in swallowing, choking

Intervention:

- a. Assess patient to determine ability to swallow and presence of gag reflex.  
Rational: to know the ability of swallowing reflex.

- b. Assist patient to sit in an erect position (as close to 90-degree angle as possible) for feeding exercise.

Rational: to provide optimal position for chewing and swallowing without aspirating

- c. Teach patient to take small bites and place in unaffected side of mouth, keep chin down, and stroke throat.

Rational: to stimulate swallowing.

- d. Assist to maintain sitting position for 30 minutes after completing meal.

Rational: to prevent regurgitation of food.

- e. Instruct caregiver on emergency measures for choking.

Rational: to prevent complications in the home setting.

- f. After patient has eaten, check oral cavity for pocketed food and teach patient and family this technique.

Rational: to prevent collection and putrefaction of food and resultant risk of infection.

- g. Give oral care after meals.

Rational: to promote comfort and oral health.

- h. Monitor body weight

Rational: to determine adequacy of nutritional intake

Unit 21  
NURSING MANAGING CLIENT BURN

### **Introduction**

This unit requires the students to engage in active learning, using case analysis and simulation. This method allows the participant to use their previous knowledge in justify the patients problems and star to act as a nurse in solving the patient's problem.

### **A. Defenition Burns**

Burns is a form of tissue damage or loss caused by contact with a heat source such as a fire, hot water, chemicals, ellems or need electrical and radiation. Tissue damage due to fire and colloids (hot porridge) is heavier than hot water. The explosion can cause burns and lead to organ damage. Chemicals, especially acids cause severe damage due to tissue reactions that occure disconfiguration tissue causing disruption healing process.

Old network contact with a heat source to determine the extent and depth of tissue damage. The longer the contact time, the more broad and deep tissue damage that occurs (Moenadjat, 2003).

### **Etiology**

1. Exposure to fire, flame: As a result of direct contact between the network with an open fire and cause injury directly to the network.  
Hot objects (contact): occurs as a result of direct contact with hot objects. The resulting burns limited to an area of the body that are in contact. Examples include cigarette burns and tools such as soldering irons or cookware.
2. Scalds (hot water), occur due to contact with hot water. The more viscous the fluid and the longer the contact time, the greater the damage that will be caused.
3. Steam, especially common in industrial areas due to an accident or a car radiator.  
Hot steam causing extensive injuries due to the high heat capacity of steam and dispersion by high pressure steam.
4. Gas heat, inhalation causes thermal injury in the upper respiratory tract and airway occlusion due to edema.
5. Electricity, injuries arising from the flow of electricity passing penetrate body tissues. Generally the burn reaches the inner skin.

## **B. Pathophysiology**

Burns (combustion) caused by the transfer of energy from a heat source to the body. Heat can be transferred through conduction or electromagnetic radiation. Tissue destruction caused by coagulation, denaturation of proteins or ionization cell contents. Skin and upper respiratory tract mucosa is the site of tissue destruction. Deep tissue, including visceral organs can be damaged due to electrical burns or prolonged contact with the burning agent. Necrosis and organ malignancies may occur.

To the burns depends on the temperature of the causative agent burns and duration of contact with the agent. Exposure for 15 minutes in hot water with a temperature of 56.10 C resulting full thickness similar injury. Pathophysiologic the changes caused by severe burns during the initial period of shock, burns covering tissue hypoperfusion and organ hypofunction which occurs secondary to decreased cardiac output followed by a hyperdynamic phase and hypermetabolic. Systemic incident early after severe burns are hemodynamic instability due to loss of integrity of the capillaries and then the displacement of fluid, sodium and protein from the intravascular space into the interstitial space.

## **C. Assessment**

### **1. Subjective Data**

- a. Patients complain of shortness of breath
- b. Patients complain of pain in the area around the wound
- c. Patients complain of palpitations.
- d. Patients complain of chills.
- e. Patient complains of thirst.

### **2. Objective Data**

- a. Patients seemed to wince
- b. Blood pressure rising
- c. Decrease in body temperature
- d. There bullae
- e. Lesions
- f. Or dry scaly skin
- g. skin reddening
- h. blister
- i. The presence of edema.

#### **D. Nursing Diagnosis**

1. Acute pain related to damage to the nerve endings due to burns
2. Impaired skin integrity related to damage to the surface of the skin characterized by tissue necrosis.
3. Hypertermia related to increase in the body's metabolism
4. The risk of infection related to inadequate primary defense, skin damage, tissue trauma invasive procedures.

#### **E. Nursing Care Planning**

- a. Acute pain related to damage to the nerve endings due to burns

Objective: after being given 1 x 24/h nursing care during the patient's pain is reduced by the expected outcomes:

- Patients say the pain is reduced
- The patient relax
- Scale pain = 3
- pulse = 80-100 bpm

Nursing intervention:

1. Close the wound as soon as possible unless the treatment of burns methods of exposure to the open air  
Rational: Climate change and air movement it can cause severe pain in the nerve endings Exposure
2. Elevate the extremity burns periodically  
Rational: elevation may be necessary at the outset to reduce the formation of edema; after changes in position and elevation decrease the discomfort and the risk of joint contractures
3. Provide swing beds, according to indications  
Rational: linen elevation of the wound helps reduce pain
4. Change extremities position frequently using passive and active range of motion(ROM) as indicated  
Rational: movement and exercise may decrease joint stiffness and muscle fatigue but this type of exercise depends on the location and extent of injury
5. Assess patient's complaints of pain, note the location or character (scale 0-10)  
Rational: pain is almost always present in some degree of tissue

involvement severity or damage but is most severe during the replacement of dressing and debridement.

6. Involve patients in determining the schedule of activities, treatment, drug delivery.

Rational: increase the patient's sense of control and power of coping mechanisms.

7. Encourage patient to practice stress management techniques, relaxation technique, deep breathing, guided imagery and visualization.

Rational: refocused attention, promote relaxation and increase the sense of control that can reduce dependence pharmacological.

8. Administer analgesics as indicated.

Rational: Analgesics is often used at the beginning to maximize the effect of muscle.

- b. Impaired skin integrity related to damage to the surface of the skin characterized by tissue necrosis

Objective: after providing the nursing care for ... 24 hours, the patient is expected to show the regeneration of tissues with expected outcomes:

- Patient shows the progress of timely healing on the burn area.

Intervention:

1. Assess / record size, the color, the depth of the wound, note the necrotic tissue and surrounding skin condition

Rational: provides basic information on the needs of the skin and possible planting instructions on the circulation area of the graft.

2. Give proper treatment of burns and infection control measures.

Rational: preparing area for planting and reduce the risk of infection / graft failure.

collaborative

3. Prepare / auxiliary surgical procedures / biological dressings, for example:

- Homograft (allograft)

Rational: skin graft is taken from the skin of the person himself or the deceased person (donor die) is used for the temporary closure of the extensive burns to the skin of people that are ready to be planted (test graft), to close the open wounds quickly after escharotomy to protect network granulation.



- Heterograft (xenograft, porcine)

Rational: skin graft taken from an animal may dengan penggunaan same for homograft or for autograft are hollow

- Autograft

Rational: skin graft is taken from the patient who is injured; possible full thickness or partial thickness.

**c. Hyperthermia related to the increase of body metabolism**

Objectives: After providing nursing care for 1 X 24/h patient is expected to show temperature within normal limits, with expected outcomes:

- Temperature patients 36-37 °C
- Patients not cold
- There were no complications

**Intervention:**

1. Monitor the patient's temperature, shivering note / diaphoresis

Rational: temperature 38.8 - 41,1 °C showed an acute infection process. The pattern of a fever can help in the diagnosis. The use of antipyretics change the pattern of fever and may be limited until a diagnosis is made or if the fever remains greater than 38.9 C

2. Monitor the temperature of the environment, limit or add bed linen according to indications

Rational: room temperature or blankets should be changed to maintain a temperature close to normal

3. Give compress warm, avoid the use of alcohol

Rational: it can help reduce fever. The use of ice water or alcohol may cause freezing, increase body temperature. Alcohol may dry out the skin.

4. Give antipyretics, such as ASA (aspirin), acetaminophen (Tylenol)

Rational: Used to reduce fever with central action on the hypothalamus, although fever may be useful in limiting the growth of the organism, and improve auto destruction from infected cells

5. Give the cooling blanket.

Rational: Used to reduce the fever generally greater than 39,5- 40 C at the time of damage or disorder of the brain

- d. The risk of infection related to inadequate primary defense, skin damage, tissue trauma due to invasive procedures.

Objectives: After nursing action during ... x 24 hours, patient is expected to not show sign of infections, with outcomes

- No signs of infection
- The body temperature within normal limits

Intervention

1. Assess for signs of infection

Rational: detecting early infection

2. Keep asepsis for patients at risk.

Rational: minimizing the opportunity for contamination

3. Inspection of the skin and mucous membranes for redness, high heat or drainage

Rational: Change of color, temperature and drainage in wound indicating an inflammation process due to bacterias

4. Inspection condition of the wound / scar.

Rational: Anticipating the progress of wound healing

5. Encourage adequate nutrition intake.

Rational: maintaining a balance of nutrients to support perfusion and provide nutrients necessary for cellular regeneration and tissue healing

6. Teach the patient and family about the signs and symptoms of infection and report it to the nurse if signs and symptoms of infection are exist.

Rational: Increase the knowledge of patients and families  
collaboration:

7. Give antibiotics as indicated.

Rational: antibiotic may inhibit the infection process

## **F. Nursing Implementation**

Implementation carried out based interventions that have been made in treatment plan.

## **G. Nursing Evaluation**

The evaluation can be made in the form of formative and summative (SOAP) evaluation conducted on the achievements made in accordance outcomes / evaluation criteria are made in the treatment plan.

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