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Chapter 1

Basic Care and Comfort

1) The nurse initiates prescribed intravenous (IV) therapy on an 86-year-old hospitalized client. Which life span concept(s) should be considered when initiating IV therapy and caring for an older adult receiving IV therapy? **Select all that apply**.

1. *Avoid infusion devices in confused clients as alarms can be disruptive*

2. *Cardiac and renal changes may put the client at risk for hypervolemia*

3. *Older adults may have more fragile veins, increasing the risk of infiltration*

4. *Skin protectants and nonporous tape are helpful in reducing skin tears on fragile skin*

5. *Use a 30-45-degree angle on insertion because older adults have deeper veins that roll*

✓**Answer: 2, 3, 4**

The nurse must consider several life span changes that occur with **aging** when initiating **IV therapy** and caring for IV infusions in the older adult. Important considerations include the following:

• The age-related cardiovascular and renal function changes that can occur in the elderly, such as a mild increase in the size and thickness of the heart,

prolonged filling time, and **declined glomerular filtration rate**, may put the client at risk for rapid development of **hypervolemia**.

• Use of an **infusion pump** is recommended, even in clients with dementia, as they are at increased risk for fluid imbalance **(Option 1)**.

• Older adults with **fragile veins** are at increased risk for IV **infiltration**; therefore, the site should be monitored carefully by the nurse every 1-2 hours.

• **Fragile skin** may tear easily; use **nonporous tape**, skin protectant solutions, and **minimal tourniquet** pressure.

• Because hearing and visual impairments may pose a problem for client education, the nurse should speak clearly and face the client when speaking.

• Use the smallest gauge catheter **(24-26 gauge)** indicated for the client's therapy as veins are more fragile.

• Consider vein sites to promote client independence (non-dominant arm, avoiding back of the hand).

• Use a **5-15-degree angle** on insertion as veins of the elderly are usually more superficial **(Option 5)**.

Educational objective:

Important age-related considerations for the older adult receiving IV therapy include consideration of renal and cardiac function to prevent hypervolemia, use of an infusion pump for control, close monitoring of the site for infiltration and infection, measures to prevent skin tears, and use of small-bore **(24-26 gauge)** IV catheters and correct technique **(5-15-degree angle)** for insertion of an IV into fragile veins.

2) The nurse teaches safety precautions of home oxygen use to a client with emphysema being discharged with a nasal cannula and portable oxygen tank. Which client statement indicates the **need for further teaching**? **Select all that apply**.

1. *"I can apply Vaseline to my nose when my nostrils feel dry from the oxygen."*

2. *"I can cook on my gas stove as long as I have a fire extinguisher in the kitchen."*

3. *"I can increase the liter flow from 2 to 6 liters a minute whenever I feel short of breath."*

4. *"I should not polish my nails when using my oxygen."*

5. *"I should not use a wool blanket on my bed."*

✓Answer: 1, 2, 3

Oxygen is a colorless, odorless gas that supports combustion and makes up about 21% of the atmosphere. Oxygen is not combustible itself, but it can feed a fire if one occurs. When using home oxygen, safety precautions are imperative.

1. **Vaseline** is an oil-based, **flammable** product and should be avoided. A water-soluble lubricant may be used instead.

2. Oxygen canisters should be kept at least **5-10 feet away from gas stoves**, lighted fireplaces, wood stoves, candles, or other sources of open flames. Clients should use precautions as cooking oils and grease are highly flammable.

3. The prescribed concentration of oxygen, usually 24%-28% for clients with COPD, should be maintained. Oxygen is prescribed to raise the PaO_2 to 60-70 mm Hg and the saturations from 90%-93%. A flow rate of 2 L/min provides approximately 28% oxygen concentration, and 6 L/min provides approximately 44%. **Higher rates** usually **do not help** and can even be **dangerous** in clients with COPD as they can decrease the drive to breathe. The client should notify the care provider about excessive shortness of breath as additional treatment may be indicated.

(Option 4) The client understands that **nail polish** remover and nail polish contain acetone, which is highly **combustible**.

The stress of receiving a life-threatening diagnosis often causes clients to feel very vulnerable. There is a tendency to keep feelings and concerns closed off; clients may not be able to express how distressed they feel or find the right words to express feelings and concerns. In asking, "Is this disease going to kill me?," the client is most likely not looking for a direct "yes" or "no" answer. This would immediately close off the conversation and create a missed opportunity for a meaningful engagement and communication with the nurse. It is more likely that this question is being asked to provide an opening for further discussion about the meaning of this devastating diagnosis as well as the client's thoughts and feelings.

The nurse can facilitate a sense of trust, connection, and collaboration by the following:

• Providing empathy - acknowledging the distressing nature of the diagnosis

• Providing situations (eg, broad opening for discussion) in which the client can share thoughts and feelings in a safe environment

• Active listening - being very attentive to what the client is saying and trying to understand what the client is thinking and feeling

• Focusing - going beyond words and explanations to attain new awareness of a client's concerns

• Communicating effectively will assist the client in coping with difficult situations, reducing stress, and developing approaches for making necessary life changes

(Option 2) This response attempts to give reassurance but does not address the client's thoughts and concerns.

(Option 3) This is a very trite response and will close down any opportunity for further discussion.

(Option 4) This response gives advice to the client and is non-therapeutic; it does not acknowledge the client's current concerns.

Title IV of the Civil Rights Act of 1964 initiated national standards for appropriate care of culturally diverse clients. Clients with limited English proficiency have the right to receive medical interpreter services free of charge.

When working with an interpreter, the nurse should apply the following best practices to maximize communication and understanding with the client:

• Address the client directly in the first person

• Speak in short sentences, pausing to allow the interpreter to speak **(Option 5)**

• Ask only one question at a time

• Avoid complex issues, idioms, jokes, and medical jargon

• Hold a pre-conference with the medical interpreter to review the goals of the interview **(Option 3)**

• Use a qualified professional interpreter whenever possible

The nurse should avoid using interpreters from conflicting cultures (eg, Palestinian, Jewish) and be mindful of any cultural, gender, or age preferences **(Option 4)**.

(Option 1) The nurse should speak directly to the client, not the interpreter.

(Option 2) A family member or friend may not have the vocabulary, knowledge, or skills to provide the best communication for the client. Untrained interpreters may omit or simplify critical pieces of information if they do not understand the terminology.

Educational objective:

When working with a medical interpreter, the nurse should apply best practices to maximize communication and understanding with the client. Key practices include speaking to the client directly; using short, simple sentences; avoiding the use of family members as interpreters; and being mindful of cultural, gender, or age preferences.

8) The nurse is caring for a client with a feeding tube that has become obstructed. Which intervention should the nurse implement **first** to unclog the tube?

1. *Flush and aspirate the tube with warm water*

2. *Instill a digestive enzyme solution into the tube*

3. *Instill cola or cranberry juice into the tube*

4. *Use a small-barrel syringe to flush the tube*

✓Answer: 1

Enteral **feeding tubes** are more likely to become obstructed if the tube is not flushed frequently enough, medications are not adequately crushed or diluted before administration, a thick feeding formula is used, or a small-bore feeding tube is required. Interventions to **unclog** a feeding tube are more successful if they are initiated immediately. The nurse should first attempt to dislodge the clogged contents by using a large-barrel syringe to **flush and aspirate warm water** in a back-and-forth motion through the tube **(Option 1)**.

(Option 2) If a feeding tube cannot be unclogged with warm water, the nurse may then attempt to use a digestive enzyme solution. These commercial declogging kits contain prefilled syringes of enzymatic solution that must be added to the tube and dwell in it for a period of time (usually 30 minutes to 1 hour) before flushing and aspiration are attempted.

(Option 3) Instilling a carbonated beverage (eg, dark cola) or cranberry juice into a clogged feeding tube is not appropriate. The acidity of either liquid can worsen an obstruction, and the dark color may mask gastrointestinal bleeding.

(Option 4) Flushing a feeding tube with a small-barrel syringe can create too much pressure and rupture the tube.

Educational objective:

When a feeding tube becomes clogged, the nurse should first attempt to unclog the tube by using a large-barrel syringe to flush and aspirate warm

Educational objective:
Therapeutic communication techniques such as acknowledgement of feelings, focusing, and listening can help establish a dialogue and relationship with a client that is protective, supportive, nurturing, and caring.

10) The unit implemented a quality improvement program to address client pain relief. Which set of criteria is the **best** determinant that the goal has been met?

1. *Chart audits found clients' self-reported pain scores improved by 10%*

2. *Number of narcotics used on the unit increased by 20%*

3. *Positive comments on returned client satisfaction surveys increased by 30%*

4. *Survey found that 90% of the nurses believed clients had better pain control*

✓Answer: 1

Measurements should be objective, rather than subjective. Evidence-based criteria should be used, if applicable. These survey results are objective, retrospective measurements of a positive change.

(Option 2) This increase in use could be attributed to many other factors, including difference in the number or type of clients on the unit and theft of the narcotics. In addition, clients may obtain pain relief by alternate means.

(Option 3) These are subjective criteria. It is possible to consider satisfaction as an outcome, but there is no indication in the option that the percentage of returned surveys is a satisfactory amount. There is no indication whether the positive comments are about pain relief or other aspects of care. There is no indication if these clients had pain relief as part of their nursing needs.

(Option 4) This is a subjective perception on the part of the nurses that may or may not be accurate.

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Chapter 1

Maternity

1) The nurse assesses a client who is 2 days postoperative breast reconstruction surgery. The client has 2 closed-suction Jackson Pratt bulb drains in place. There is approximately 10 mL of serosanguineous fluid in each one. One hour later, the nurse notices the bulbs are full of bright red drainage and measures a total output of 200 mL. What is the nurse's **priority** action?

1. *Notify the health care provider (HCP)*

2. *Open the collection bulb to release excessive negative pressure*

3. *Record the amount in the output record as wound drainage*

4. *Reposition the client on the right side*

✓Answer: 1

A **closed-wound drainage** system device (eg, **Jackson-Pratt**, Hemovac) consists of fenestrated drainage tubing connected to a flexible, vacuum (self-suction) reservoir unit. The distal end lies within the wound and can be sutured to the skin. It is usually inserted near the surgical site through a small puncture wound rather than in the surgical incision. The purpose of the drain is to **prevent fluid buildup** (eg, blood, serous fluid) **in a closed space**.

Although it depends on the client and type of surgical procedure, about 80-120 mL of serosanguineous or sanguineous drainage per hour during the first 24 hours after surgery can be expected. The priority action is to **notify the HCP** due to the change in type and amount of drainage after the first 24 hours

3. *"I can still spread the infection, even if I do not have any of the symptoms."*

4. *"I should have screening yearly for chlamydia even if I do not have symptoms."*

5. *"I will make sure my partner gets checked and treated to prevent reinfection."*

✓Answer: 1, 3, 4, 5

Chlamydia is the **most common sexually transmitted infection** and is diagnosed frequently among women, adolescents, and those with multiple sexual partners. Many clients are **asymptomatic** or have minor symptoms (eg, spotting after sex, dysuria, abnormal vaginal discharge) but can still transmit the infection **(Option 3)**.

Therefore, all sexually active women age <25 and any client age ≥25 at high risk (eg, new or several sexual partners) are **screened annually** for chlamydia and gonorrhea **(Option 4)**. The clients' **sexual partners** should also **receive treatment** to prevent transmission and reinfection **(Option 5)**.

If not treated appropriately, chlamydia can ascend the female genital tract, producing serious complications such as **pelvic inflammatory disease** and **infertility (Option 1)**. Clients should also be instructed in general safe sex practices (eg, using condoms, avoiding multiple partners) to help prevent transmission of sexually transmitted infections.

Clients should be taught to **abstain from sexual intercourse** for **7 days after initiation** of drug therapy (eg, single dose of azithromycin, 7 days of doxycycline). This client received treatment today and therefore must wait 7 days before resuming intercourse **(Option 2)**.

Educational objective:

Clients with a chlamydial infection may be asymptomatic or experience minor symptoms (eg, spotting after sex, dysuria, abnormal vaginal discharge). Clients should abstain from sexual intercourse for 7 days after antibiotic

treatment is initiated and until all sexual partners have completed treatment to prevent transmission and serious complications. Sexually active clients age <25 or those age ≥25 at high risk should be screened annually.

4) After six months of unprotected intercourse and failing to conceive, a 37-year-old female client reports feeling anxious and depressed because of her situation. Which response by the nurse is **most** appropriate?

1. *"It is recommended to try to conceive for one year before undergoing a fertility evaluation."*

2. *"Let's review how you are timing intercourse, as optimal timing will increase your chances."*

3. *"Reflecting on positive things in your life may help alleviate your anxiety and depression."*

4. *"Tell me more about how this has affected you and your family in the last six months."*

✓Answer: 4

Infertility is diagnosed when a couple **fails to conceive after 12 months** (women age < 35) **or 6 months** (women age ≥ 35) of frequent, unprotected intercourse. Difficulty achieving pregnancy may affect a couple's social, financial, and intimate relationships. Therefore, clients may benefit from a holistic approach to care. The nurse should be alert for signs of **psychosocial distress** such as expressions of **guilt**, denial, anger, or **isolation**.

Anxiety and **depression** are common among couples with infertility concerns and require further evaluation of the client's emotions. **Active listening** and **open-ended questions** may help clients speak more openly and honestly about their feelings **(Option 4).**

(Option 1) Women age ≥ 35 and couples with certain medical indications (eg, endometriosis, history of male subfertility) should generally seek fertility evaluation after 6 months of regular, unprotected intercourse.

(Option 2) Assessing intercourse timing helps the nurse discuss awareness of fertility and natural conception methods. However, the nurse should prioritize the client's psychosocial needs before providing this type of education.

(Option 3) Encouraging the client to focus on the positive aspects of life does not address the client's emotional concerns, places the client's feelings on hold, and invalidates the client's feelings.

Educational objective:

When caring for clients with infertility concerns, the nurse should be alert for signs of psychosocial distress and expressions of guilt, denial, anger, isolation, anxiety, or depression. Evaluation of the client's emotions using active listening and open-ended questions is the primary intervention.

5) The nurse is providing teaching about contraception to a group of clients. Which statement by the nurse is appropriate to include?

1. *"Backup contraception is required for the first 3 months after initiation of oral contraceptives."*

2. *"Diaphragm contraceptive devices, when used with spermicide, also provide protection from HIV infection."*

3. *"Over-the-counter emergency contraceptives should be taken within 3 days of unprotected intercourse."*

4. *"Use of an intrauterine device should be avoided in sexually active adolescent clients."*

✓Answer: 3

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(Option 3) An 18-month-old might be able to scribble but would not be able to draw a picture; an 18-month-old can throw a ball and point to body parts.

Educational objective:

An 18-month-old should have a vocabulary of at least 10 words and be able to use a spoon.

5) The parent of a 1-year-old says to the nurse, "I would like to start toilet training my child as soon as possible." What information does the nurse provide to the parent that correctly describes a child's readiness for toilet training?

1. *"A good time to start toilet training is when your child can dress and undress autonomously."*

2. *"When your child can sit on the toilet until urination occurs, you can start toilet training."*

3. *"Your child may be ready to start toilet training when able to communicate and follow directions."*

4. *"Your child will be ready to start toilet training at about age 15 months."*

✓Answer: 3

Toilet training is a major developmental achievement for the toddler. The degree of readiness progresses relative to development of neuromuscular maturity with voluntary control of the anal and urethral sphincters occurring at age **18-24 months**. Bowel training is less complex than bladder training; bladder training requires more self-awareness and self-discipline from the child and is usually achieved at age $2^1/_2$-$3^1/_2$ years.

In addition to physiological factors, developmental milestones rather than the child's chronological age signal a child's readiness for toilet training. These include the ability to:

• Ambulate to and sit on the toilet

• Remain dry for several hours or through a nap

• Pull clothes up and down

• Understand a two-step command
• Express the need to use the toilet (urge to defecate or urinate)
• Imitate the toilet habits of adults or older siblings
• Express an interest in toilet training

(Option 1) In order to achieve toilet training, the child will need to be able to pull clothing up and down but not necessarily dress and undress autonomously.

(Option 2) Having the child sit on the toilet until urination occurs is not appropriate and will not facilitate bladder control; any urination that occurs is accidental and not due to sphincter control. However, the child should have the ability to remain on the toilet for about 5 - 8 minutes without getting off or crying.

(Option 4) Age 15 months is too early to begin toilet training; voluntary control of the anal and urethral sphincters does not occur until age 18-24 months.

Educational objective:

Readiness for toilet training is dependent on the child's ability to voluntarily control the anal and urethral sphincters, which usually occurs at age 18-24 months. Other developmental and behavioral indicators of toilet training readiness include the child's ability to express the urge to defecate or urinate, understand simple commands, pull clothing up and down, and walk to and sit on the toilet.

6) The nurse is caring for a 10-year-old diagnosed with osteomyelitis. What is the **best** activity the nurse can suggest to promote age-specific growth and development during hospitalization?

1. *Fantasy play with puppets*
2. *Invite friends to come visit*
3. *Provide missed schoolwork*
4. *Watch favorite movies*

✓Answer: 3

4. *Keep the injection needle out of the child's view*

✓Answer: 1

Children are often **fearful of injections**, exhibiting unpredictable and/or uncooperative behavior. The nurse should explain the procedure to the child using **simple, age-appropriate language** (eg, "medicine under the skin") to reduce anxiety. According to **Piaget's cognitive developmental stages**, **school-age** children develop **concrete thought** and may fear a **loss of control**. To improve the child's sense of control, the nurse should offer a specific, task-based **coping technique** (eg, counting aloud, deep breathing) **(Option 1)**.

(Option 2) A caregiver should hold or embrace a child during the injection process, with the child on the caregiver's lap or standing in front of a seated caregiver. Tightly holding the child's arms is extreme and may distress the child and caregiver.

(Option 3) The child should be told the truth about pain that accompanies an injection. The nurse should use appropriate language, such as "the skin may hurt for a minute," and emphasize that the pain is quick and transient.

(Option 4) Keeping objects that may alarm the child out of view is an appropriate intervention for a toddler but not for a school-age child. Hiding a procedural object from a 7-year-old will hinder rapport with the nurse and may heighten the child's anxiety.

Educational objective: School-age children possess concrete thinking and fear loss of control. When administering an injection to a school-age child, the nurse should offer a specific, task-based coping technique (eg, instruct the child to count aloud or breathe deeply) to increase the child's sense of control and thereby reduce anxiety.

8) A 10-year-old weighs 99 lb (44.9 kg) and has a BMI of 24.8 kg/m^2 (>95th percentile). Which is the **most important** assessment for the nurse to make before initiating a weight loss plan?

1. *Child's pattern of daily physical activity*

2. *Family's eating habits*

3. *Family's financial resources for purchasing healthy foods*

4. *Family's readiness for change*

✓Answer: 4

Before initiating a treatment plan for weight loss, it is most important to make certain that the child and family are ready for change. Attempting to engage the family and child in weight loss strategies and dietary changes before they are ready could easily result in frustration, treatment failure, and reluctance to try new approaches in the future. The nurse needs to explore the reasons and desire for weight loss by assessing

• Motivation and confidence

• Willingness to change behaviors and food choices

• Perceived importance of a weight loss treatment plan

• Confidence in ability to take on healthier eating habits

(Option 1) Physical activity is an important component of a weight loss treatment plan, but it is not the priority nursing assessment.

(Option 2) The family's eating habits will have a strong influence on the child's ability to make changes and need to be assessed. However, it is more important to assess the family's readiness for change.

(Option 3) Assessing the family's financial resources is important in planning education about healthy food choices, but it is not the priority nursing action.

Educational objective:

Before initiating a treatment program that requires a client and family to make major lifestyle and behavior changes, the nurse needs to assess readiness for

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Chapter 1

Integumentary Problems of the Adult Client

1) An obese client with diabetes who had a bowel resection 5 days ago says, "I felt like I split open when I was coughing." On assessment, the nurse notes that the incision edges are separated and a loop of bowel is protruding through the wound. Which nursing actions would be appropriate? **Select all that apply.**

1. *Administer one oral tablet of oxycodone prescribed PRN for pain*

2. *Assess a full set of vital signs*

3. *Cover the viscera with sterile dressings saturated in normal saline (NS) solution*

4. *Notify the health care provider (HCP) immediately*

5. *Place the client in low Fowler's position with knees slightly flexed*

✓Answer: 2, 3, 4, 5

Total separation of wound layers with protrusion of the internal viscera through the incision is known as **evisceration**. Evisceration is a medical emergency that can lead to localized ischemia, peritonitis, and shock. **Emergency surgical repair** is necessary. Clients at risk for poor wound healing (eg, obesity, diabetes mellitus) are at increased risk for evisceration.

When an abdominal wound evisceration occurs, the nurse should take the following actions:

• **Remain calm and stay with the client**. Have someone **notify the HCP** immediately and bring sterile supplies. Instruct the client not to cough or strain.

• **Place the client in low Fowler's position (no more than 20 degrees)** with knees slightly flexed to relieve pressure on the abdominal incision and have the client maintain **absolute bed rest** to prevent tissue injury.

• **Assess vital signs** (and repeat every 15 minutes) to detect possible signs and symptoms of shock (eg, hypotension, tachycardia, tachypnea).

• **Cover the viscera with sterile dressings saturated in NS** solution to prevent bacterial invasion and keep the exposed viscera from drying out.

• **Document** interventions taken and the appearance of the wound and eviscerated organ (eg, color, drainage). If the blood supply is interrupted, the protruding organs can become ischemic (dusky) and necrotic (black).

(Option 1) This client should immediately be made **NPO** in preparation for possible emergency surgery. Only IV analgesics should be administered if the client is in pain.

Educational objective:

Emergency nursing management of wound evisceration includes the following:

• Stay with the client and have someone bring sterile supplies

• Notify the HCP and make the client NPO in preparation for emergency surgery

• Place the client in low Fowler's position with knees slightly flexed

• Cover viscera with sterile dressings saturated in NS solution

• Assess vital signs and monitor for signs of shock

2) A parent calls the nursing triage line during the evening. The parent says that a 7-year-old was found playing in an area with poison ivy and asks what to do. Which is the **most** important instruction to give the parent?

1. *Apply cool, wet compresses for itching*

2. *Apply topical cortisone ointment to the area*

carcinoma, and melanoma. **Melanomas** grow rapidly and are **highly metastatic**, making them the deadliest form of skin cancer. Basal cell and squamous cell carcinomas generally have a much lower risk of metastasis. **Risk factors** for skin cancer include:

• Family or personal history of skin cancer **(Option 1)**

• Celtic ancestry traits (eg, **light skin,** red or blond hair, blue or green eyes, many freckles)

• Aging

• Atypical or high number of **moles** because some skin cancers develop from pre-existing moles **(Option 2)**

• **Immunosuppression** (eg, immunosuppressant medications, HIV), which lowers the body's ability to defend against cancerous mutations **(Option 4)**

• Ultraviolet light exposure (eg, chronic sun exposure, **outdoor occupation**, tanning bed use, history of **severe sunburns) (Option 5)**

Clients should be taught to avoid overexposure to sunlight, perform monthly skin checks with the **ABCDE assessment**, and immediately report any abnormal findings to their health care provider. Early detection and treatment significantly improve outcomes.

(Option 3) Acne is not a known risk factor for skin cancer.

Educational objective:

Risk factors for skin cancer include family or personal history of skin cancer, Celtic ancestry traits (eg, light skin, blue eyes), aging, atypical or high number of moles, immunosuppression, and ultraviolet light exposure (eg, chronic sun exposure, outdoor occupation).

9) The nurse is caring for a client in the intensive care unit who suffered partial-thickness burns to 36% of the body. During the first 24 hours, the nurse would anticipate which of the following assessments?

1. *Hemoglobin 10.2 g/dL (102 g/L)*

2. *Hyperactive bowel sounds*

3. *Serum sodium 152 mEq/L (152 mmol/L)*

4. *Tall, peaked T waves on ECG*

✓Answer: 4

Burn injuries cause tissue damage that leads to increased vascular permeability and fluid shifts (eg, second and third spacing). In the emergent phase after a burn (first 24-72 hours), fluid, proteins, and intravascular components leak into the surrounding interstitium, causing decreased intravascular oncotic pressure and decreased intravascular volume, and resulting in fluid shifts and **hypovolemia**.

Potassium, the predominant intracellular cation, is released when cellular damage occurs, resulting in **hyperkalemia** (potassium > 5.0 mEq [5.0 mmol/L]). Clients with hyperkalemia experience muscle weakness, ECG changes (**tall, peaked T waves**, shortened QT interval), and cardiac arrhythmias **(Option 4).**

(Option 2) The sympathetic nervous system is activated in response to a burn, causing decreased peristalsis. Nausea, vomiting, gastric distension, and paralytic ileus may occur.

(Option 3) Sodium is the most abundant extracellular cation. **Hyponatremia** (sodium <135 mEq/L [135 mmol/L]) occurs as sodium is lost via fluid shifts and insensible losses.

Educational objective:

Burn injuries cause cellular destruction, capillary leaking, and fluid shifts. Fluids are lost during the emergent phase (first 24-72 hours), resulting in hypovolemia and hyponatremia. The blood becomes more viscous and increased hematocrit and hemoglobin values result. Cellular damage releases potassium, which causes hyperkalemia.

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(Option 3) Clients who are able to remove and reinsert the pessary on their own will have the choice to remove it weekly, possibly even nightly, for cleaning. Clients who are sexually active may prefer to remove the pessary prior to intercourse, although this is not necessary. When the client cannot remove the pessary regularly, removal by an HCP at 2- to 3-month intervals is recommended.

(Option 4) Increased vaginal discharge is a common side effect. However, if an odor is present, the client should be instructed to notify the HCP to be treated for a possible infection.

Educational objective:

A pessary is a vaginal support device recommended for pelvic organ prolapse. Pessaries are fitted by an HCP; many clients can then remove, clean, and replace these themselves. Clients can remain sexually active with a pessary in place.

2) A client diagnosed with end-stage renal disease comes to the dialysis clinic for treatment. Which actions should the nurse take to prepare the client for hemodialysis? **Select all that apply**.

1. *Administer subcutaneous heparin to decrease clotting during dialysis*

2. *Administer the client's morning doses of carvedilol and lisinopril*

3. *Check the client's medical records to determine the last post-dialysis weight*

4. *Obtain a set of client vital signs and the client's current weight*

5. *Palpate the fistula in the client's arm for a thrill and auscultate for a bruit*

✓Answer: 3, 4, 5

Prior to dialysis treatment, the nurse should assess the client's fluid status (weight, blood pressure, peripheral edema, lung and heart sounds), vascular access (arteriovenous fistula, arteriovenous grafts), and vital signs **(Option 4)**.

The amount of fluid removed (ultrafiltration) is determined by calculating the difference between the last post-dialysis weight and the client's current pre-dialysis weight **(Option 3)**.

After the client is connected to the dialysis machine, **IV heparin is added to the blood** from the client to prevent clotting that can occur when blood contacts a foreign substance. Giving subcutaneous heparin prior to initiation is not necessary **(Option 1)**.

(Option 2) During dialysis, excess fluid is removed, making the client prone to hypotension. In addition, medications are removed from the blood during hemodialysis, making them ineffective. Many medications that are taken once daily can be held until after the dialysis treatment to prevent their removal. If blood pressure medications are given prior to dialysis, the client can develop hypotension during the dialysis and then uncontrolled hypertension (decreased drug concentrations).

(Option 5) Arteriovenous fistulas are created by anastomosing an artery to a vein; a **thrill** can be **felt** when palpating the fistula, and a **bruit** can be heard during **auscultation** when the fistula is functioning properly.

Educational objective:

The nurse is responsible for assessing the client diagnosed with end-stage renal disease for risks associated with dialysis. These risks include medication removal, hemodialysis access dysfunction, hypotension, and fluid and electrolyte imbalances.

3) The nurse is conducting a pain assessment on a client with dysuria. Which pain description is **most likely** associated with pyelonephritis?

1. *Constant; increased by pressure over the suprapubic area*

2. *Dull and continuous; occasional spasms over the suprapubic area*

3. *Dull flank pain; extending toward the umbilicus*

4. *Excruciating; sharp flank pain radiating to the groin*

✓Answer: 3

1. *Douche with a water and vinegar solution after intercourse*

2. *Increase daily intake of fluids*

3. *Use a spermicidal contraceptive jelly*

4. *Use fragrance-free perineal deodorant products*

5. *Void immediately after intercourse*

6. *Wear underwear with a cotton crotch*

✓Answer: 2, 5, 6

The nurse should encourage a sexually active female client to implement the following interventions to help **prevent recurrent UTIs**:

• **Take all antibiotics as prescribed** even if symptoms have improved as bacteria may still be present.

• **Increase fluid intake**; this dilutes the urine (minimizing bladder irritation), promotes frequent urination, and prevents urinary stasis. The client should void at least every 2-4 hours. Some health care providers recommend drinking cranberry juice as it inhibits bacterial attachment to the bladder wall, but there is no clinical evidence to support its effectiveness in preventing UTIs **(Option 2)**.

• **Wipe from front to back** to prevent introducing bacteria from the vagina and anus into the urethra

• **Avoid synthetic fabrics** as these materials (eg, nylon, spandex) seal in moisture and create an environment conducive to bacterial proliferation; cotton underwear is recommended instead **(Option 6)**.

• **Void after sexual intercourse** to flush out bacteria that may have entered the urethra **(Option 5)**.

(Options 1 and 4) Avoid douching and using **feminine perineal products** (eg, deodorants, powders, sprays), as they can alter the vaginal pH and normal flora, increasing the risk for infection. Take showers instead of baths as bath products (eg, bubble bath, oils) and bacteria in bath water can irritate the urethra and increase the risk of infection.

(Option 3) Avoid spermicidal contraceptive jelly as it can suppress the production of protective vaginal flora. Discontinue diaphragm use temporarily (until symptoms subside and antibiotic course is completed); a diaphragm increases pressure on the urethra and bladder neck, which may inhibit complete bladder emptying.

Educational objective:

Interventions to help prevent recurrent UT's in sexually active female clients include avoiding use of feminine perineal products, vaginal douches, and spermicidal contraceptive jelly. Protective factors include wearing cotton underwear, increasing water intake, and voiding immediately after sexual intercourse.

5) The nurse assesses a client diagnosed with chronic kidney disease who had an internal arteriovenous fistula performed on the left arm yesterday. Which assessment finding would require **immediate** follow-up?

1. *A bruit cannot be auscultated over the fistula site*

2. *Capillary refill of 2 seconds is assessed on the left hand*

3. *Client reports squeezing a rubber ball with the left hand several times daily*

4. *Incision is dry with no redness and has sterile skin closures in place*

✓Answer: 1

An **arteriovenous fistula** is a surgical connection of an artery to a vein created to provide vascular access for hemodialysis therapy in clients with kidney disease. Arterial blood flowing through this vein causes it to engorge and thicken (mature) over a period of several weeks, after which it can sustain frequent access by 2 large-bore needles required for dialysis. Maturing of the fistula is aided by having the client perform hand exercises, such as **squeezing a rubber ball**, that increase blood flow through the vein.

Following fistula placement, it is important to monitor for patency. A palpable **thrill (vibration)** over the fistula or an auscultated **bruit** (blowing or swooshing sound caused by turbulent blood flow) indicates a patent fistula. Absence of the thrill or bruit can indicate potential clot formation in the fistula. Client reports of numbness or tingling as well as decreased capillary refill can also signal potential clotting.

(Option 2) Capillary refill of < 3 seconds is considered normal and indicates acceptable blood flow to the area.

(Option 3) Daily hand exercises such as squeezing handgrips or a rubber ball are performed to help properly mature the fistula.

(Option 4) A dry surgical incision without redness, warmth, and induration is an optimal finding. Sterile skin closures (eg, Steri-Strips) are used to help hold the incision together as it heals.

Educational objective:

Following placement of an arteriovenous fistula, it is imperative to monitor for signs of potential clotting of the fistula such as absence of a bruit, absence of a thrill, decreased capillary refill, and coolness of the extremity below the fistula.

6) The nurse provides post-procedure teaching for a female client who had a cystoscopy as an outpatient. Which client statement indicates the **need for additional instruction**?

1. *"I can expect pink-tinged urine for at least 24 hours."*

2. *"I can take a warm bath and acetaminophen if I have discomfort or bladder spasms."*

3. *"I should expect frequency and burning when I urinate."*

4. *"I should expect to see blood clots in my urine for up to 24 hours."*

✓Answer: 4

Mental Health Nursing

1) The nurse is caring for a client with paranoid personality disorder. When the nurse directs the client to go to the dining room for dinner, the client says, "And eat that poisonous food? You better not make me go anywhere near that room." Which statement **best** explains the client's behavior?

1. *The client has a problem with authority figures*

2. *The client has an intense need to control the environment*

3. *The client is hearing voices*

4. *The client is trying to control anger*

✓Answer: 2

Individuals with **paranoid personality** disorder have a pervasive **distrust** and **suspicion** of others; they believe that people's motives are malicious and assume that others are out to exploit, harm, or deceive them.

These thoughts permeate every aspect of their lives and interfere with their relationships. Individuals with paranoid personality disorder are usually difficult to get along with as they may express their suspicion and hostility by arguing, complaining, making sarcastic comments, or being stubborn. Because these clients do not trust others, they have a strong need to be self-sufficient and maintain a high degree of control over their environment.

(Option 1) This statement best describes an individual with antisocial personality disorder.

hidden food wrappers from binging, discarded food from unfinished meals). Clients should be monitored around meal times, and particularly for **1-2 hours after eating** to observe for purging. Purging behaviors, particularly vomiting, may result in **electrolyte imbalances**, such as hypokalemia, that can cause cardiac arrhythmias.

(Option 1) Clients with bulimia nervosa often use laxatives inappropriately to rid their bodies of undigested food in an effort to control their weight. Such measures should not continue in the treatment setting.

(Option 4) A food diary helps the client and caregivers track the type and amount of food that the client has eaten. It is also an excellent means of helping the client understand the health implications of the disorder.

Educational objective:

Clients with bulimia nervosa should be monitored for signs of hidden binging or purging activity, particularly for 1-2 hours after meals. Excessive vomiting may result in electrolyte imbalances, including hypokalemia.

4) A client with generalized anxiety disorder is referred to outpatient mental health department for cognitive behavioral therapy (CBT). The CBT includes which interventions and strategies? **Select all that apply**.

1. *Desensitization to a specific stimulus or situation*

2. *Discussing the interpersonal difficulties that have led to the client's psychological problems*

3. *Helping the client develop insight into the psychological causes of the disorder*

4. *Relaxation techniques*

5. *Self-observation and monitoring*

6. *Teaching new coping skills and techniques to reframe thinking*

✓Answer: 1, 4, 5, 6

Cognitive behavioral therapy (CBT) can be effective in treating anxiety disorders, eating disorders, depressive disorders, and medical conditions such as insomnia and smoking. These types of disorders are characterized by **maladaptive reactions to stress, anxiety, and conflict**. CBT requires that the client learn the skill of self-observation and to apply more adaptive coping interventions.

CBT involves 5 basic components:

• Education about the client's specific disorder

• Self-observation and monitoring - the client learns how to monitor anxiety, identify triggers, and assess the severity

• Physical control strategies — deep breathing and muscle relaxation exercises

• Cognitive restructuring — learning new ways to reframe thinking patterns, challenging negative thoughts

• Behavioral strategies — focusing on situations that cause anxiety and practicing new coping behaviors, desensitization to anxiety-provoking situations or events

(Option 2) This describes interpersonal psychotherapy.

(Option 3) This describes psychodynamic or psychoanalytic therapy.

Educational objective:

CBT teaches clients to reframe their thought processes and develop new adaptive approaches for coping with anxiety, stress, and conflict. CBT requires that the client learn about the disorder and engage in self-observation and monitoring, relaxation techniques, desensitization activities, and changing negative thoughts.

5) An 87-year-old client has been admitted to the hospital with signs and symptoms of a urinary tract infection along with agitation, confusion, and disorientation to time and place. What is the **most important** nursing action?

(Option 1) Telling family members that a nurse is busy is not a helpful response. They may feel guilty about asking for the nurse's time and attention. If needed, the nurse can ask coworkers to help with other assigned clients.
(Option 2) Although calling clergy members may be appropriate, it may take several hours for them to arrive. This is not the most helpful response.
(Option 4) Family members who ask the nurse to stay for a few minutes may have questions or need emotional support. In such cases, it is not helpful for the nurse to decline.

Educational objective:
During the end-of-life process, the client and family members typically go through several emotional stages, each requiring therapeutic communication techniques by the nurse. The nurse can help the client and family by providing a few minutes of time and attention. The nurse should validate the family's needs by providing emotional support.

9) A client recently diagnosed with schizophrenia is brought to the mental health clinic by the identical twin sibling for the first follow-up visit after hospitalization. The client's sibling says to the nurse, "I read that schizophrenia runs in families. I guess I'm doomed." Which is the **best** response by the nurse?

1. *"At the moment, I would worry more about how your sibling is doing."*
2. *"The odds are about 50-50 that you will come down with the disease as well."*
3. *"Would you like to talk to a health care provider about this?"*
4. *"You are at risk for the disease. However, there are other factors that contribute to the development of schizophrenia."*

✓Answer: 4

The best response should acknowledge the reality of the sibling's concern, provide information, and open the door to further discussion about the development of the disease.

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Chapter 1

Maternity and Newborn Medications

1) A client diagnosed with vaginal candidiasis is instructed on self-care management techniques and proper administration of the prescribed miconazole vaginal cream. Which statement by the client indicates that **further teaching** is needed?

1. *"Each time I use the bathroom, I will wipe myself from the front to the back."*

2. *"I should choose loose-fitting cotton underwear instead of nylon undergarments."*

3. *"I will refrain from having sex until my partner is also tested and treated for the infection."*

4. *"Prior to going to bed at night, I will apply miconazole cream using the vaginal applicator."*

✓Answer: 3

Candida albicans (yeast) can colonize and cause infections of the vulvovaginal region. **Vaginal candidiasis** often causes itching and painful urination due to urine stinging the inflamed areas of the vulva. Assessment shows a **thick**, **white**, **curd-like** vaginal discharge and reddened vulvar lesions.

Miconazole (Monistat), an antifungal cream commonly prescribed to treat vaginal candidiasis, is **inserted high into the vagina** using an applicator. It is best applied at **bedtime** so that it will remain in the vagina for an extended period **(Option 4).** Sexual intercourse is avoided until the inflammation is resolved, typically for the duration of treatment, approximately 3-7 days **(Option 3).** However, sexual activity is not a significant cause of infection or reinfection of candida, and partner evaluation is not needed. Trichomoniasis, syphilis, gonorrhea, and HIV are mainly sexually transmitted; therefore, partners should be evaluated and treated.

Other teaching points for this client should include:

• Ensuring proper hygiene of the perineum - cleansing from anterior to posterior (front to back) to prevent accidental introduction of fecal organisms **(Option 1)**

• Wearing loosely fitted cotton underwear and avoiding synthetic undergarments to promote ventilation, decrease friction, and reduce moisture **(Option 2)**

• Refraining from douching, which can introduce organisms higher up into the vaginal canal and cervix

Educational objective:

Miconazole cream is commonly prescribed to treat vaginal candidiasis. Miconazole is best applied at bedtime so that it will remain in the vagina longer. Clients being treated for vaginal candidiasis should wear loose-fitting cotton underwear and refrain from sexual intercourse for the duration of treatment.

2) The registered nurse and practical nurse are conducting a workshop on contraceptive methods for a group of outpatient clients. Which instructions should the nurses include when discussing combined estrogen-progestin oral contraceptives? **Select all that apply**.

1. *Consult the health care provider (HCP) if you experience leg pain or swelling*

2. *Discontinue contraceptives if you experience spotting between menses*

3. *Do not smoke while taking combined contraceptives*

4. *Immediately report any breast tenderness to the HCP*

5. *Seek immediate medical treatment if you experience vision loss*

✓Answer: 1, 3, 5

ACHES with contraceptive use		
ACHES	**Symptom**	**Potential etiology**
A	• **A**bdominal pain	• Ischemic bowel
C	• **C**hest pain	• Pulmonary embolism or myocardial infarction
H	• **H**eadaches	• Stroke
E	• **E**ye problems	• Retinal blood vessel ischemia
S	• **S**evere leg pain	• Deep venous thromboembolism

The use of hormonal contraception (ie, estrogen with or without progestin) places women at a **2- to 4-fold increased risk** for developing **blood clots** due to resulting hypercoagulability. Hormone levels vary among contraceptives, and higher levels of hormone content correlate to an increased risk of adverse thrombotic events (eg, stroke, myocardial infarction). Clients who are prescribed oral contraceptive pills (OCPs) containing estrogen should be educated on potential warning signs (eg, chest pain, vision loss, severe leg pain) **(Options 1 and 5).** In addition, clients should be instructed **not to smoke** while taking combined OCPs due to an increased risk of blood clots **(Option 3).**

(Option 2) Irregular bleeding and spotting between menses are common side effects of combined OCPs. These side effects may be bothersome but are not serious and may improve within 3 months of initiation. If the client cannot tolerate side effects, a different OCP may be considered.

(Option 4) Clients should be counseled that breast tenderness is a common side effect of combined OCPs and does not warrant emergent reporting to the health care provider.

Educational objective:

Clients who are prescribed oral estrogen contraceptives (with or without progestin) have an increased risk for developing blood clots. Clients should be educated on warning signs to report to the health care provider (eg, severe leg pain, vision loss) versus common side effects (eg, breast tenderness, spotting).

3) The nurse is conducting a hospital admission history and assessment. The client informs the nurse of taking the herb black cohosh (*Actaea racemosa*) daily. What is the **best** nursing response?

1. *Ask the client about menopausal symptoms*

2. *Ask the health care provider to write a prescription for use of the herb during hospitalization*

3. *Contact the pharmacy to see if the herb interacts with the client's medications*

4. *Tell the client to stop taking it*

✓Answer: 3

The nurse should follow up regarding the quantity of the herb and how it is used. Black cohosh is used by some clients for menopausal hot flashes. The main side effects are thickening of the uterine lining and potential liver toxicity. Herbs can cause harmful reactions when taken in combination with other drugs. It is most important to determine that an herb does not interfere with other medications. Herbal therapy is usually stopped 2-3 weeks before any surgery.

(Option 1) Although black cohosh is typically used for menopausal symptoms, this is not the most important issue.

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Chapter 1

Assignment and Delegation

1) The unit is staffed with an experienced registered nurse, an experienced licensed practical nurse, and unlicensed assistive personnel (UAP). Which tasks can the charge nurse appropriately delegate to UAP? **Select all that apply**.

1. *Apply protective skin ointment after perineal cleansing*

2. *Determine if a client has adequate relief after administration of an analgesic*

3. *Document daily weight for a client with congestive heart failure*

4. *Feed a client who had a stroke 24 hours after admission*

5. *Perform passive range-of-motion exercises for a client on a ventilator*

✓Answer: 1, 3, 5

Scope of practice		
RN	**LPN/LVN**	**UAP**
• Clinical assessment • Initial client education • Discharge education • Clinical judgment • Initiating blood transfusion	• Monitoring RN findings • Reinforcing education • Routine procedures (eg, catheterization) • Most medication administrations • Ostomy care • Tube patency & enteral feeding • Specific assessments*	• Activities of daily living • Hygiene • Linen change • Routine, stable vital signs • Documenting input/output • Positioning

* Limited assessments (eg, lung sounds, bowel sounds, neurovascular checks).

LPN = licensed practical nurse; **LVN** = licensed vocational nurse; **RN** = registered nurse; **UAP** = unlicensed assistive personnel.

Unlicensed assistive personnel (UAP) are assigned tasks for stable clients by the registered nurse (RN), who directs and manages overall client care. The RN cannot delegate the nursing process. UAP can perform active and passive range-of-motion exercises **(Option 5)**. Under the direction of the RN, UAP can apply protective ointment (such as zinc oxide) after cleaning a client **(Option 1)**.

UAP can obtain data but the RN is responsible for interpreting (evaluating) it. For example, UAP can obtain objective data such as the client's height and weight, but the RN will analyze this data to determine the need in the nursing care plan (eg, effect on drug dosing) **(Option 3)**.

(Option 2) UAP can collect data (eg, an objective pain score), but the RN is responsible for evaluating if the relief is adequate. The word "adequate" refers to the evaluation of treatment and is not part of UAP scope of practice. The RN may consider other aspects (eg, vital signs, body language) when making such evaluations, especially in a nonverbal client.

(Option 4) A stroke is not considered stabilized until approximately 48 hours have passed without changes. The client's risk of losing the gag reflex is still high as the stroke could be evolving. UAP should feed only stable clients.

• Performing passive and/or active range-of-motion **exercises (Option 5)**

• Measuring output (eg, urinary, drainage)

(Option 2) The tracheostomy is a surgically created airway with a high risk of infection. Only licensed individuals (eg, registered nurse, licensed practical nurse) should perform tracheostomy care.

(Option 3) Although an elevated head of bed (HOB) is necessary to prevent ventilator-acquired pneumonia and improve chest expansion, teaching is not within the scope of the UAP and should be performed only by nurses. However, after nurses provide teaching, the UAP may remind the family to keep the HOB elevated.

Educational objective:

When caring for a ventilated client, nurses may consider delegating the following tasks to unlicensed assistive personnel: vital sign measurement, oral care, personal hygiene, blood glucose testing, passive or active range-of-motion exercises, and measurement of urine and drainage output

3) The postpartum nurse receives report on 4 mother-baby couplets. Which tasks can be delegated to unlicensed assistive personnel? **Select all that apply**.

1. *Assisting the mother with morning hygiene*

2. *Demonstrating neonate bathing technique*

3. *Documenting intake and output on the mother*

4. *Evaluating caregiver interaction with the neonate*

5. *Obtaining an axillary temperature on the neonate*

6. *Swaddling the neonate after diaper changes*

✓Answer: 1, 3, 5, 6

Scope of practice		
RN	**LPN/LVN**	**UAP**
• Clinical assessment • Initial client education • Discharge education • Clinical judgment • Initiating blood transfusion	• Monitoring RN findings • Reinforcing education • Routine procedures (eg, catheterization) • Most medication administrations • Ostomy care • Tube patency & enteral feeding • Specific assessments*	• Activities of daily living • Hygiene • Linen change • Routine, stable vital signs • Documenting input/output • Positioning

* Limited assessments (eg, lung sounds, bowel sounds, neurovascular checks).

LPN = licensed practical nurse; **LVN** = licensed vocational nurse; **RN** = registered nurse; **UAP** = unlicensed assistive personnel.

Assisting clients with **activities of daily living** is within the scope of practice of unlicensed assistive personnel (UAP). Helping the mother with morning hygiene, documenting intake and output, taking vital signs of stable clients, and swaddling the neonate may be delegated to **UAP**. The registered nurse (RN) should follow the **5 rights of delegation** when planning care.

(Option 2) The RN assumes responsibility for initial client teaching and demonstration of home care. Once teaching and demonstration are complete, the UAP can assist the mother with bathing the neonate.

(Option 4) The RN should assess caregiver interaction with the newborn to identify any attachment issues. Elements of the nursing process (assessment, planning, and evaluation) and tasks requiring nursing judgment cannot be delegated.

Educational objective:

The registered nurse is responsible for any care requiring clinical judgment. Unlicensed assistive personnel can assist with activities of daily living, documenting intake and output, positioning, and taking the vital signs of stable clients.

4) The charge nurse in the emergency department assigns a client to a new nurse who has been off orientation for a week. Which client assignment is **most appropriate?**

1. *3-year-old with a temperature of 102.4 F (39.1 C) who had a seizure at home 30 minutes ago and is very irritable*

2. *8-year-old with a closed fracture of the clavicle following a fall who is talkative and rates pain as a "2" on the 0-10 FACES pain scale*

3. *32-year-old with asthma who has an upper respiratory tract infection and a peak expiratory flow rate that is 45% of personal best*

4. *72-year-old prescribed antibiotics 3 days ago to treat acute sinusitis who reports shortness of breath and has a rash*

✓Answer: 2

A fractured clavicle (collarbone) is not uncommon in children age <10 years and is usually treated conservatively. A new nurse should be competent in performing the basic skills needed to care for a client with a musculoskeletal injury (eg, pain and neurovascular assessments, analgesia administration, sling application). The 8-year-old client, who has minimal pain as indicated by the score of 2 on the FACES **pain assessment tool**, is the most stable. As a result, this is the most appropriate assignment for the new nurse.

(Option 1) A seizure can be associated with a fever-related illness (febrile seizure). This client who is very irritable and has fever may have an underlying serious infection such as meningitis and should undergo diagnostic testing (eg, blood cultures, imaging, lumbar puncture). Therefore, this is not an appropriate assignment.

(Option 3) A **peak flow meter** measures airflow out of the lungs. The client who has a severely reduced peak expiratory flow rate (<50% of personal best) needs emergency intervention and is not an appropriate assignment.

(Option 4) The client with dyspnea and a maculopapular **drug rash** is most likely experiencing an antibiotic-related allergic reaction, which can range from

mild to life-threatening anaphylaxis. This client is not an appropriate assignment.

Educational objective:

A new nurse should be competent in performing the basic skills needed to care for a client with a musculoskeletal injury (eg, pain and neurovascular assessments).

5) The nurse supervisor tells the psychiatric nurse to go to the telemetry unit ("Float") as the unit is short staffed and has 2 clients with cardiac arrest. The nurse is not familiar with this client population and does not want to go. What is the **best** response by the psychiatric nurse?

1. *Clarify the skills/knowledge that the nurse is able/unable to perform*

2. *Read the policy and procedure book for the unit before providing care*

3. *Refuse to go due to concerns about client safety*

4. *Tell the supervisor to send someone else instead*

✓Answer: 1

When asked to "float" to help out in another unit, the nurse should clarify the duties to be performed. Many skills/knowledge, such as vital signs and routine medication administration, are the same in all units. The nurse should be given a unit orientation. The nurse should then clarify applicable skills. For instance, the nurse could perform basic care but not feel comfortable watching the telemetry cardiac monitors or assisting with insertion of a pacemaker. These limitations are usually understood and respected. The qualified and experienced registered nurses on the unit perform specialized client needs, and the "float" nurse performs basic client needs.

The nurse is liable to provide safe care for the assigned duties and perform them in a competent manner. The nurse should personally document any concerns raised with the supervisor and avoid discussing personal feelings about the "float" with clients or other staff.

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Chapter 1

Fundamentals

Basic Care & Comfort

1- The nurse is caring for an 88-year-old client with pneumonia

Medical-Surgical Unit		
0800:	The client has dyspnea that worsens on exertion, a productive cough, and fever. Crackles are heard in the bilateral lower lung lobes.	
1000:	The client is restless, coughs frequently, and struggles to breathe.	
	0800	**1000**
T	101.3 F (38.5 C)	100.6 F (38.1 C)
P	99	105
RR	22	24
BP	139/82	142/86
SpO_2	96% on 2 L via nasal cannula	92% on 2 L via nasal cannula

Complete the folowing sentence by choosing from the lists of options.

The nurese should first :

- ✓ *Elevate the head of the bed*
  Adminster albuterol nebulizer
  Assist the client to drink clear fluids

To :

Thin secretions

- ✓ *Increase lung expansion*
  Relax bronchial smooth muscle

Explanation:
Pneumonia, an inflammatory reaction in the lungs often due to infection, causes production of cellular debris and purulent secretions that obstruct the alveoli and impair gas exchange. Clinical manifestations include fever, tachypnea, hypoxemia, crackles to lung auscultation, and productive cough with purulent sputum. Significant impairment of gas exchange leads to insufficient oxygenation of organs (eg, brain), resulting in altered mental status, restlessness, agitation, and drowsiness.
The priority nursing action for a client with pneumonia who is experiencing respiratory distress is to **elevate the head of the bed** to at least 30 degrees to **increase lung expansion** and improve gas exchange.
(Incorrect) *Albuterol* is a short-acting beta-adrenergic agonist that promotes rapid bronchodilation (ie, *relaxes bronchial smooth muscle*) and improves hypoxia. This can be administered after elevating the head of the bed.
(Incorrect) The nurse should encourage the client to *increase fluid intake* to *thin secretions* and encourage deep breathing and coughing to facilitate secretion removal. This can be performed after elevating the head of the bed.

Educational objective:
The priority nursing action for a client with pneumonia who is experiencing respiratory distress is to elevate the head of the bed to at least 30 degrees to increase lung expansion and improve gas exchange.

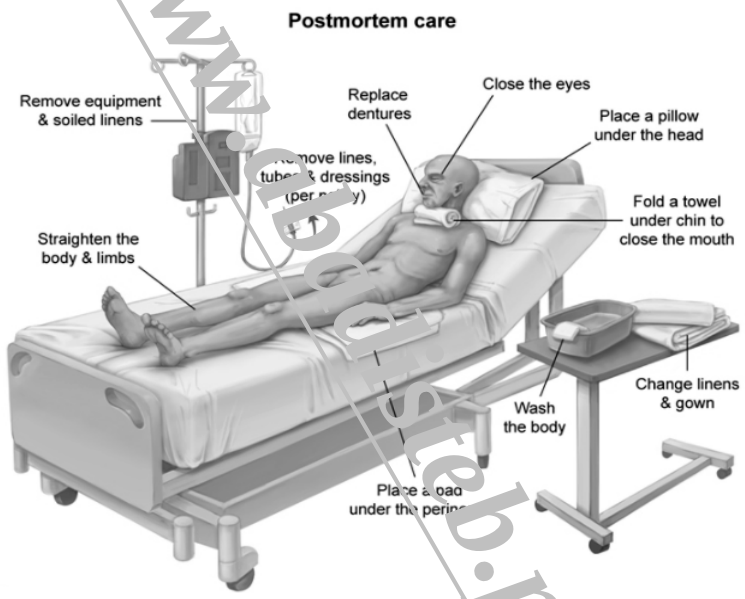
2. The nurse is providing care to a 66-year-old client in the medical-surgical unit.
Nurses' Notes

Medical-Surgical Unit	
Day 1	The client is admitted following an open bowel resection this morning. The client has a midline abdominal incision with staples covered in an adhesive dressing, bilateral Jackson-Pratt drains in the lower abdomen, an indwelling urinary catheter, and 2 peripheral IV catheters. Family is at the bedside.
Day 3	The client is found unresponsive and pulseless in the room. Resuscitative efforts are initiated. After 45 minutes of cardiopulmonary resuscitation, there is no return of spontaneous circulation; the health care provider stops the resuscitation, states the time of death, and confirms that an autopsy is not required.

For each potential intervention, click to specify if the intervention is indicated or not indicated for the care of the client.

Potential Intervention	Indicated	Not Indicated
Cleanse the client's body thoroughly	◉	○
Remove the client's abdominal staples	○	◉
Remove identifying name tags from the client	○	◉
Notify the organ and tissue donation organization	◉	○
Allow family to be present during postmortem care	◉	○
Remove the drains, urinary catheter, and peripheral IV catheters	◉	○

Explanation:



Postmortem care (care after death) is an important aspect of nursing care that must be conducted with respect and dignity for the client. The nurse should contact the client's family or next of kin immediately after the death to allow them the opportunity to grieve and exercise any final cultural practices or religious rites related to death. After a client's death, the nurse must verify whether an autopsy has been requested. For clients needing autopsy, the nurse should follow state and agency guidelines regarding care of the client's body and removal of equipment.

The nurse should **allow the family to be present** during postmortem care, which includes:

- Positioning the client (eg, straightening the body and limbs) and gently closing the client's eyes because it is difficult to reposition the client once rigor mortis (stiffening of the body after death) occurs.

- **Notifying the organ and tissue donation organization** because only specially trained personnel (ie, transplant coordinator) handle organ donation requests.
- **Cleansing the body**, placing a pad under the perineum, and changing the bed linens and gown.
- **Removing all medical equipment** (eg, tubes, drains, peripheral IV catheter, urinary catheter) because an autopsy is not indicated.

It is critical that the nurse leave **body identification tags** on the client for transportation to the morgue and/or funeral home.
The nurse should keep the surgical incision (eg, **abdominal staples**) intact to prevent any signs of trauma to the body (eg, open wound).

Educational objective:
Postmortem care is an important aspect of nursing care that must be conducted with respect and dignity for the client. Appropriate nursing interventions include cleaning the body, notifying the organ and tissue donation organization, allowing the family to be present, and removing all medical equipment (if an autopsy is not indicated).Clinical judgment is the observed outcome of critical thinking and decision-making.

Fluid, Electrolyte, Acid-Base Balance

1- The nurse is providing care to a 43-year-old client in the emergency department.

- Nurses' Notes

Admission	
1800:	The client reports fatigue, dizziness, and severe vomiting for the past 2 days. Emesis is clear, nonbilious and nonbloody. The client reports no fever or diarrhea. Mild epigastric tenderness is present but not abdominal distension. Lungs are clear, and extremities have no edema.

	1800
T	98.2 F (36.8 C)
P	90
RR	14
BP	100/70
SpO_2	96% on room air

Laboratory Results and Reference Range	
Basic Metabolic Panel	
Sodium 136-145 mEq/L (136-145 mmol/L)	138 mEq/L (138 mmol/L)
Potassium 3.5-5.0 mEq/L (3.5-5.0 mmol/L)	3.0 mEq/L (3.0 mmol/L)
Chloride 98-106 mEq/L (98-106 mmol/L)	95 mEq/L (95 mmol/L)
Arterial Blood Gas	
pH 7.35-7.45	7.49
PaO_2 80-100 mm Hg (10.6-13.3 kPa)	95 mm Hg (12.6 kPa)
$PaCO_2$ 35-45 mm Hg (4.66-5.98 kPa)	48 mm Hg (6.4 kPa)
HCO_3^- 21-28 mEq/L (21-28 mmol/L)	30 mEq/L (30 mmol/L)