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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.

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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

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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

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(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.

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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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