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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
SpO₂	96% on 2 L via nasal cannula	92% on 2 L via nasal cannula

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

The nurse should first :

- ✓ *Elevate the head of the bed*
- Administer 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.

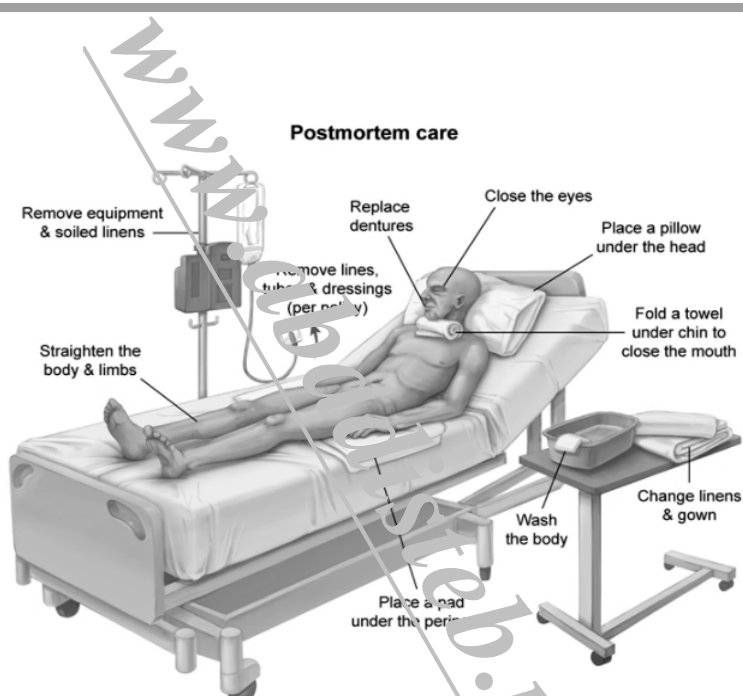
Nurses' Notes

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	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Remove the client's abdominal staples	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Remove identifying name tags from the client	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Notify the organ and tissue donation organization	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Allow family to be present during postmortem care	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Remove the drains, urinary catheter, and peripheral IV catheters	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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
SpO₂	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
PaO₂ 80-100 mm Hg (10.6-13.3 kPa)	95 mm Hg (12.6 kPa)
PaCO₂ 35-45 mm Hg (4.66-5.98 kPa)	48 mm Hg (6.4 kPa)
HCO₃⁻ 21-28 mEq/L (21-28 mmol/L)	30 mEq/L (30 mmol/L)