

Patricia M. Nugent  
Barbara A. Vitale

# Fundamentals **SUCCESS**

FOURTH EDITION

**A Q&A Review**

**Applying Critical Thinking  
to Test Taking**

- ✓ A complete review of Fundamentals
- ✓ Over 1,000 NCLEX-style questions – including alternate formats
- ✓ Rationales for correct and incorrect answers

**TWO BOOKS IN ONE** • Q&A Course Review  
• NCLEX Exam Prep

# Fundamentals **Success**

A Q & A Review Applying Critical Thinking to  
Test Taking

FOURTH EDITION





# Fundamentals Success

## A Q & A Review Applying Critical Thinking to Test Taking

FOURTH EDITION

### **Patricia M. Nugent, RN, MA, MS, EdD**

Professor Emeritus  
Adjunct Professor  
Nassau Community College  
Garden City, New York  
Private Practice—President of Nugent Books, Inc.

### **Barbara A. Vitale, RN, MA**

Professor Emeritus  
Nassau Community College  
Garden City, New York  
Private Practice—Professional Resources for Nursing

F.A. DAVIS COMPANY



F.A. Davis Company • Philadelphia

F. A. Davis Company  
1915 Arch Street  
Philadelphia, PA 19103  
www.fadavis.com

Copyright © 2015 by F. A. Davis Company

Copyright © 2015 by F. A. Davis Company. All rights reserved. This book is protected by copyright. No part of it may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without written permission from the publisher.

Printed in the United States of America

Last digit indicates print number: 10 9 8 7 6 5 4 3 2 1

*Publisher, Nursing:* Robert G. Martone  
*Director of Content Development:* Darlene D. Pedersen  
*Content Project Manager:* Jacalyn C. Clay  
*Electronic Project Editor:* Sandra A. Glennie  
*Design and Illustration Manager:* Carolyn O'Brien

As new scientific information becomes available through basic and clinical research, recommended treatments and drug therapies undergo changes. The author(s) and publisher have done everything possible to make this book accurate, up to date, and in accord with accepted standards at the time of publication. The author(s), editors, and publisher are not responsible for errors or omissions or for consequences from application of the book, and make no warranty, expressed or implied, in regard to the contents of the book. Any practice described in this book should be applied by the reader in accordance with professional standards of care used in regard to the unique circumstances that may apply in each situation. The reader is advised always to check product information (package inserts) for changes and new information regarding dose and contraindications before administering any drug. Caution is especially urged when using new or infrequently ordered drugs.

ISBN: 978-0-8036-4414-4

Authorization to photocopy items for internal or personal use, or the internal or personal use of specific clients, is granted by F. A. Davis Company for users registered with the Copyright Clearance Center (CCC) Transactional Reporting Service, provided that the fee of \$.25 per copy is paid directly to CCC, 222 Rosewood Drive, Danvers, MA 01923. For those organizations that have been granted a photocopy license by CCC, a separate system of payment has been arranged. The fee code for users of the Transactional Reporting Service is: 978-0-8036-4414-4/15 0 + \$.25.

*Dedicated to*

*Neil Nugent  
and  
Joseph Vitale*

*For their love, support, sense of humor, enthusiasm for life,  
and attempts to keep our compulsive natures under control.*





# Reviewers

**Cynthia Aaron**  
Stillman College  
Tuscaloosa, Alabama

**Carol Alexander**  
Palm Beach State College  
Lake Worth, Florida

**Bonnie Allen**  
Illinois Central College  
East Peoria, Illinois

**Cindy Baker**  
Murray State College  
Tishoming, Oklahoma

**Cynthia Bostick**  
California State University, Dominguez  
Hills  
Carson, California

**Barbara Bozicevich**  
Hibbing Community College  
Hibbing, Minnesota

**Barbara Britton**  
Fayetteville Technical Community College  
Fayetteville, North Carolina

**Christine Brooks**  
Palm Beach Atlantic University  
West Palm Beach, Florida

**Catherine Caston**  
Concordia University  
Irvine, California

**Amy C. Chavarria**  
South Texas College  
McAllen, Texas

**Rita Ciccone**  
Ohio Valley General Hospital  
McKees Rocks, Pennsylvania

**Cathy Coram**  
Pueblo Community College—Freemond  
Campus  
Canon, City, Colorado

**Kelli Davis**  
Gadsden State Community College  
Centre, Alabama

**Amanda Day**  
Academy of Medical and Health Science  
Pueblo, Colorado

**Donna Dexter**  
Citizens School of Nursing  
New Kensington, Pennsylvania

**Lori Evans**  
Greater Lowell Tech  
Tyngsboro, Massachusetts

**Vesta Fairley**  
Bishop State Community College  
Mobile, Alabama

**Cris Finn**  
Regis University  
Denver, Colorado

**Karen L. Fuqua**  
South Texas College  
McAllen, Texas

**Dawana Gibbs**  
College of Coastal Georgia  
Brunswick, Georgia

**Sharlene Georgesen**  
Morningside College  
Sioux City, Iowa

**Geraldine Valencia-Go**  
College of New Rochelle  
New Rochelle, New York

F.A. DAVIS COMPANY



**Lois Gotes**

Carl Albert State College  
Poteau, Oklahoma

**Deborah Henderson**

Bay Path PN Program  
Charlton, Massachusetts

**Kara Hoffman**

Ohio Valley General Hospital  
McKees Rocks, Pennsylvania

**Monica Holland**

Oklahoma City Community College  
Oklahoma City, Oklahoma

**Anita Jones**

Murray State College  
Tishomingo, Oklahoma

**Susan Karcher**

Harold B. and Dorothy A. Snyder  
Schools  
Plainfield, New Jersey

**Kathleen Kavanagh**

Felician College  
Lodi, New Jersey

**Elizabeth Kawecki**

South University West Palm Beach  
Royal Palm Beach, Florida

**Patricia Kelly**

Saint Xavier University  
Chicago, Illinois

**Maggie King**

Xavier University  
Cincinnati, Ohio

**Mary Kovarna**

Morningside College  
Sioux City, Iowa

**Christine Kowal**

Cumberland University  
Lebanon, Tennessee

**Rhonda Lansdell**

Northeast Mississippi Community  
College  
Booneville, Mississippi

**Tracy Lopez**

Dona Ana Community College  
Las Cruces, New Mexico

**Judy Maynard**

Fayetteville Technical Community  
College  
Fayetteville, North Carolina

**Tammie McCoy**

Mississippi University for Women  
Columbus, Mississippi

**Victoria Newton**

Northeastern Hospital School of Nursing  
Philadelphia, Pennsylvania

**Amanda M. Reynolds**

Grambling State University  
Grambling, Louisiana

**Deborah A. Roberts**

Sonoma State  
Rohnert Park, California

**Jane Rosati**

Daytona State College  
Daytona Beach, Florida

**Jeffrey Ross**

Bainbridge College  
Bainbridge, Georgia

**Laura Saucer**

South University Montgomery  
Montgomery, Alabama

**Beverly Schaefer**

Ursuline College  
Pepper Pike, Ohio

**Dianne Scott**

Northwest Mississippi Community  
College  
Senatobia, Mississippi

**Patty Shanaberger**

El Paso Community College  
El Paso, Texas

**Patricia A. Sharpnack**

Ursuline College  
Pepper Pike, Ohio

**Jeanne Siegel**

University of Miami  
Miami, Florida

**Nancy Simpson**

University of New England  
Portland, Maine

**Julia Skrabal**

BryanLGH College of Health Sciences  
Lincoln, Nebraska

**Pamela Sonney**

Durham Technical Community College  
Durham, North Carolina

**Susan Stone**

Valencia Community College  
Orlando, Florida

**Mary Tan**

Holmes Community College  
Ridgeland, Mississippi

**Lois Thomas**

Roxborough Memorial Hospital School of  
Nursing  
Philadelphia, Pennsylvania

**Diane Thorup**

Cumberland University  
Lebanon, Tennessee

**Lynne Tier**

Florida Hospital College of Health  
Sciences  
Orlando, Florida

**Carol Tingle**

Baton Rouge General MC School of  
Nursing  
Baton Rouge, Louisiana

**Dianna Tison**

University of the Incarnate Word  
San Antonio, Texas

**June Vermillion**

New Mexico State University  
Las Cruces, New Mexico

**Robin Weaver**

Ohio Valley Hospital School of Nursing  
McKees Rocks, Pennsylvania

**Kathleen Weigel**

North Dakota State College of Science  
Wahpeton, North Dakota

**Lisa White**

Arnot Ogden School of Nursing  
Elmira, New York

**Jo-Ann Whitesell**

St. John's River Community College  
Palatka, Florida

**Patricia Wolpert**

Mulhenberg Snyder School of Nursing  
Plainfield, New Jersey

**Jean Zlomke**

Laramie County Community College  
Cheyenne, Wyoming

**Item Writers****Mary Ann Hellmer Saul, PhD, RN,  
CNE**

*Professor*  
Nassau Community College  
Garden City, New York

**Michael W. Mangino, Jr., RN,  
NP-Psychiatry**

*Associate Professor*  
Suffolk Community College  
Selden, New York

**Medical Consultant****Joanne M. Vitale, RPA-C**

*Physician Assistant*  
Romanelli Cosmetic Surgery  
Huntington, New York  
Huntington Hospital  
North Shore LIJ Health System



# Acknowledgments

Many people at F. A. Davis were essential to the production of this book. We especially want to thank Bob Martone, Publisher for Nursing, whose skills of listening and focusing as well as expertise in publishing were instrumental to the production of this edition. He has shared our passion for this project through seven editions and we value his knowledge and especially his friendship over the last 23 years. We thank the entire F.A. Davis staff who competently transformed our manuscript into a book. We salute Jacalyn Clay, Project Editor, for her editorial expertise. She always was available, answered our every request, and supported and encouraged us throughout the revision. We also thank Lisa Thompson, Production Editor, who managed every detail skillfully and was never ruffled; Julia Curcio, Content Project Manager who expertly managed all the illustrations with finesse; and Holly Lukens, copy editor, who was phenomenal with the details of grammar and content. A special thanks to F. A. Davis sales representatives who have done a spectacular job of highlighting the strengths of our texts to nursing faculty.

Special recognition goes to all the nursing students and faculty who participated in field-testing sessions and focus groups for their commitment to excellence and generosity in sharing their time, energy, and intellect. We also thank the nursing educators who reviewed manuscript that provided feedback for us to fine tune the content and its presentation. Finally, and most importantly, we thank our husbands, Neil and Joseph, for their love and support, which were essential to the revision of this book. They are loved and appreciated by us.

F.A.

PANY



# A Message to Nursing Educators

**Nurses are required to use critical thinking in every domain of nursing practice.**

- Accrediting bodies of educational programs have increased the emphasis on maximizing the cognitive abilities of learners.
- Licensing examinations are designed to evaluate the test taker's ability to engage in clinical reasoning.
- Agency accrediting bodies have developed standards that require creative, evidenced-based practice.
- Health care, health-care environments, and technology have increased in complexity, requiring sophisticated health-care practitioners.

**The premise of this book is based on the beliefs that:**

- People use critical thinking all the time in their daily lives.
- People can enhance their critical-thinking skills.
- Students can use critical-thinking skills when taking a nursing examination.
- Nurses continue to use critical thinking in their professional lives.

**How can nursing educators help students think critically?**

- Help students develop their critical-thinking abilities through the information contained in Chapter 1.
  - Help students identify and develop their cognitive and personal competencies by exploring the Helix of Critical Thinking.
  - Support students who are maximizing their critical-thinking abilities by being positive, reflective, inquisitive, and creative.
  - Help students use the RACE Model, a formula for applying critical thinking, when answering nursing questions.
- Encourage students to practice test taking by answering the questions and reviewing the answers and their rationales in Chapters 2 through 5 to:
  - Reinforce what they know.
  - Learn new information.
  - Identify what still needs to be learned.
  - Set priorities for future learning.
- Have students practice answering alternate format questions (e.g., exhibit, multiple response, drag-and-drop [ordered response], hot spot, fill-in-the-blank, audio, and items using a chart, table, or graphic image) presented in Chapter 6 to develop critical-thinking skills in relation to questions that authentically evaluate unique nursing interventions (e.g., calculations, setting priorities, interpreting sounds, and analyzing data from multiple sources).
- Have students practice taking comprehensive examinations with integrated fundamental content gleaned from sub-units of nursing information. Chapter 7, Comprehensive Final Book Exam, has a 100-item integrated examination. The RACE Model is applied to every question on this 100-item examination. This role-models the clinical reasoning that can be employed when answering a nursing test question.
- Encourage students to practice answering nursing questions on the computer. In addition to this book's 100-item Comprehensive Final Book Exam, DavisPlus.com has two accompanying 75-item integrated tests. The student can access these tests or they can self-select questions based on content area.

- Encourage students to review the keywords at the beginning of each clinical sub-unit in Chapters 2 through 5. Knowing the definition of these words and understanding concepts and principles associated with them will build a theoretical base for answering the questions in the content area.
- Encourage students, particularly those who speak English as a second language, to learn the words in the Glossary of English Words Commonly Encountered on Nursing Examinations. This will allow students taking a test to concentrate on nursing content rather than being distracted by a lack of comprehension of English words.



# A Message to Nursing Students

If you are similar to the average nursing student, you read assigned chapters in your textbook and articles in nursing journals, review your classroom notes, complete computer instruction programs related to nursing content, practice nursing skills in a simulated laboratory, and apply in the clinical area what you have learned. All these activities are excellent ways for you to expand and strengthen your theoretical base and become a safe practitioner of nursing. However, these activities may not be enough for you to be successful when taking a nursing examination. You need to practice test taking as early as possible in your program of study with questions appropriate for your level of nursing education. In addition, you must be aware of, strengthen, and expand your cognitive competencies (intellectual reasoning skills) and personal competencies (individual attitudes or qualities) reflected in **The Helix of Critical Thinking** and then utilize these components of critical thinking when answering nursing questions.

## Nursing students keep making the same statements:

- I need more examples of nursing test questions, especially alternate format items.
- I need to practice taking nursing examinations on the computer.
- I need to learn how to answer a nursing test question.
- **I need to pass my nursing examinations!**

This book addresses these needs.

## WHY YOU SHOULD READ THIS TEXTBOOK

FEATURES	BENEFITS
A discussion of maximizing your critical-thinking abilities, including the attitudes and qualities of successful critical thinkers and strategies to overcome barriers to critical thinking.	This discussion provides a basis for a self-assessment in relation to these qualities and introduces strategies that you can use to overcome barriers to your critical thinking. This discussion should motivate you to maintain a positive mental attitude and be reflective, inquisitive, and creative when thinking.
Keyword list at the beginning of each chapter that includes vocabulary, and nursing/medical terminology, essential to the content of nursing.	These words encourage you to focus on the critical components of a topic of study. Understanding these critical words expands your theoretical base and provides a strong foundation for more advanced concepts.
The <b>RACE Model</b> is introduced and applied to a variety of sample questions and every question in the 100-item Comprehensive Final Book Exam.	These specific examples model the critical-thinking processes involved when answering increasingly complex questions in nursing. This facilitates imitating the critical-thinking activities used in answering questions in the practice of nursing. Ultimately, when you can critically analyze a question and answer it correctly, you will feel empowered, and your test anxiety will decrease.

*continued*



continued

Over 1,300 quality fundamentals of nursing questions.	These questions allow you to practice test taking and apply critical thinking via the RACE Model. This practice should increase your critical-thinking skills, promote your self-confidence, build your stamina when taking tests, and reduce test anxiety.
Over 475 questions with formats other than multiple choice. More than 35—Chart exhibit items 22—Hot-spot items 35—Illustration/graphic items 58—Drag and drop items 43—Fill-in-the-blank items 286—Multiple-response items 35.5% of questions in the text are alternate item formats.	These questions will: Expose you to the alternate types of question formats that appear in NCLEX examinations, particularly the new audio question. Allow you to practice nursing questions that incorporate multiple-response, fill-in-the-blank, hot-spot, chart/exhibit, drop and drag (ordered response), and audio items and questions that refer to an image such as an illustration, chart, table, or photograph. Reduce anxiety concerning alternate formats you will be confronted with on the NCLEX examination.
Rationales for the correct and incorrect answers for every question.	Reviewing the rationales for every question will: Reinforce what you know—this increases trust in your ability and promotes a sense of security. Teach you new information—this increases your knowledge and builds self-confidence. Identify what you still need to learn—this focuses and prioritizes your study activities so that the return on your effort is maximized.
100-item Comprehensive Final Book Exam	This provides you with an opportunity to integrate fundamental content learned in sub-units of study into one examination. The RACE Model is applied to every question to demonstrate the critical thinking that is employed when answering nursing test questions.
Two 75-item Comprehensive Exit Exams available on DavisPlus.com.	These provide you with an opportunity to practice test taking on a computer. They allow you to take two comprehensive examinations that integrate sub-units of fundamentals of nursing content.
Create your own test accessing the questions available from this text on DavisPlus.com based on self-selected areas within Integrated Processes, Client Need, Cognitive Level, and/or Difficulty Level.	This allows you to focus on questions in a unit of study, steps in the nursing process, client need category, or cognitive domain of your choice. This allows you then to design a test with a lower level of difficulty and then to move onto questions that are on a higher level of difficulty. This supports confidence.
Glossary that identifies and defines ordinary English words that appear frequently in nursing examinations.	Familiarity with these words reduces the challenge of a test question because you can center your attention on the theoretical content presented in the question.

To increase your knowledge of fundamentals of nursing theory and be successful on nursing examinations, it is important for you to use this book—*Fundamentals Success: A Q & A Review Applying Critical Thinking to Test Taking, Fourth Edition*. Although this book is valuable for all nursing students regardless of their level of nursing education, it is essential for beginning nursing students. The related knowledge, attitudes, and skills that you develop early in your fundamental nursing courses influence your present and future

educational performance. A house will stand and survive only when it is built on a strong foundation. The same concept can be applied to your nursing education. The components of a strong foundation in nursing are a comprehensive understanding of the fundamentals of nursing theory, well-developed critical-thinking abilities, and an inventory of strategies for successful test taking.

Another textbook you may find helpful toward maximizing your success when preparing for and taking examinations in nursing is *Test Success: Test-Taking Techniques for Beginning Nursing Students* (Nugent & Vitale, F. A. Davis Company). This book focuses on empowerment, critical thinking, study techniques, the multiple-choice question, the nursing process, test-taking techniques, testing formats other than multiple-choice questions (including alternate formats on NCLEX examinations), and computer applications in education and evaluation. It also contains hundreds of fundamentals of nursing questions, of which more than 25% are alternate format items. Every question has test-taking techniques and rationales for correct and incorrect answers. It includes a 100-item Comprehensive Final Book Exam and a two 75-item Comprehensive Exit Exams available on DavisPlus.com.

We are firm believers in the old sayings, “You get out of it what you put into it!” and “Practice makes perfect!” The extent of your learning, the attitudes you develop, and the skills you acquire depend on the energy you are willing to expend. It is our belief that if you give this book your best effort, you will strengthen and expand your theoretical foundation of fundamentals of nursing and your critical-thinking abilities in testing situations. We expect your efforts to be rewarded with success on your nursing examinations!



F.A. DAVIS

COMPANY

# Figure Credits

## Chapter 1

**Page 20** from Vitale [2013]. NCLEX-RN Notes, 2nd ed. Philadelphia: F.A. Davis Company, with permission.

## Chapter 2

**Page 33, 42** from Dunn, H. L. High level wellness for man and society. American Journal of Public Health. 1959; 49(6): 786-7 88, with permission.

## Chapter 3

**Page 133, 140, 163** from Wilkinson and Treas [2011]. Fundamentals of Nursing, 2nd ed. Vol. 1. Philadelphia, F.A. Davis Company, with permission.

## Chapter 4

**Page 197, (top)** from Dillon [2007]. Nursing Health Assessment, 2nd ed. Philadelphia: F.A. Davis Company, with permission.

**Page 197 (bottom), 206** Courtesy of Kingfisher Regional Hospital. Kingfisher, OK.

**Page 212** From Wilkinson and Van Leuven [2007]. Fundamentals of Nursing. Philadelphia: F.A. Davis Company, with permission.

**Page 211, 219, 227, 229, 234, 237, 248, 254:** From Wilkinson and Treas [2011]. Fundamentals of Nursing, 2nd ed. Vol. 1. Philadelphia, F.A. Davis Company, with permission.

**Page 243, 246, 257** from Nugent and Vitale [2014]. Fundamentals of Nursing: Content Review Plus Practice Questions. Philadelphia: F.A. Davis Company, with permission.

## Chapter 5

**Page 321, 330, 425, 436** from Nugent and Vitale [2014]. Fundamentals of Nursing: Content Review Plus Practice Questions. Philadelphia: F.A. Davis Company, with permission.

**Page 323, 341** from Burton and Ludwig [2011]. Fundamentals of Nursing Care. Philadelphia: F.A. Davis Company, with permission.

**Page 340, 373, 424** from Wilkinson and Treas [2011]. Fundamentals of Nursing, 2nd ed. Vol. 2. Philadelphia, F.A. Davis Company, with permission.

**Page 390, 398** from Phillips [2010]. Manual of I.V. Therapeutics: Evidence-Based Practice for Infusion Therapy, 5th ed. Philadelphia: F.A. Davis Company, with permission.

**Page 405** FLACC Behavioral Scale. © 2002 The Regents of the University of Michigan. All Rights Reserved.

**Page 423** from Aldrete, J. A. [1995]. Reprinted from Journal of Clinical Anesthesia, Vol. 7/ Issue 1, Post-anesthesia recovery score revisited, pp.89-9 1, with permission from Elsevier.

## Chapter 6

**Page 440 (bottom), 441 (bottom), 442 (top), 460 (top left and right), 461 (top left)** from Burton and Ludwig [2011]. Fundamentals of Nursing Care. Philadelphia: F.A. Davis Company, with permission.

**Page 443 (bottom), 449, 461 (bottom right)** from Wilkinson and Treas [2011]. Fundamentals of Nursing, 2nd ed. Vol. 2. Philadelphia, F.A. Davis Company, with permission.

## Chapter 7

**Page 478** from Wilkinson and Treas [2011]. Fundamentals of Nursing, 2nd ed. Vol. 2. Philadelphia, F.A. Davis Company, with permission.

**Page 480, 483, 510, 519** from Burton and Ludwig [2011]. Fundamentals of Nursing Care. Philadelphia: F.A. Davis Company, with permission.

# Contents

<b>1</b>	<b>Fundamentals of Critical Thinking Related to Test Taking</b>	<b>1</b>
	INTRODUCTION	1
	Definition of Critical Thinking	1
	MAXIMIZE YOUR CRITICAL-THINKING ABILITIES	6
	Be Positive: You Can Do It!	6
	OVERCOME BARRIERS TO A POSITIVE MENTAL ATTITUDE	6
	Be Reflective: You Need to Take One Step Backward Before Taking Two Steps Forward!	6
	OVERCOME BARRIERS TO EFFECTIVE REFLECTION	9
	Be Inquisitive: If You Don't Go There, You'll Never Get Anywhere!	9
	OVERCOME BARRIERS TO BEING INQUISITIVE	10
	Be Creative: You Must Think Outside the Box!	11
	OVERCOME BARRIERS TO CREATIVITY	11
	CRITICAL THINKING APPLIED TO TEST TAKING	12
	Educational Domains	12
	Components of a Multiple-Choice Question	12
	Cognitive Levels of Nursing Questions	13
	CRITICAL-THINKING STRATEGY TO ANSWER NURSING QUESTIONS:	
	THE RACE MODEL	13
	Knowledge Questions: Remember Information!	14
	COGNITIVE REQUIREMENTS	14
	USE THE RACE MODEL TO ANSWER KNOWLEDGE-LEVEL QUESTIONS	14
	Comprehension Questions: Understand Information!	17
	COGNITIVE REQUIREMENTS	17
	USE THE RACE MODEL TO ANSWER COMPREHENSION-LEVEL QUESTIONS	17
	Application Questions: Use Information!	21
	COGNITIVE REQUIREMENTS	21
	USE THE RACE MODEL TO ANSWER APPLICATION-LEVEL QUESTIONS	21
	Analysis Questions: Scrutinize Information!	24
	COGNITIVE REQUIREMENTS	24
	USE THE RACE MODEL TO ANSWER ANALYSIS-LEVEL QUESTIONS	25
	SUMMARY	28
<b>2</b>	<b>Nursing Within the Context of Contemporary Health Care</b>	<b>29</b>
	THEORY-BASED NURSING CARE	29
	KEYWORDS	29
	QUESTIONS	29
	ANSWERS AND RATIONALES	36

<b>LEGAL AND ETHICAL ISSUES</b> .....	<b>45</b>
KEYWORDS .....	45
QUESTIONS .....	46
ANSWERS AND RATIONALES .....	52
<b>LEADERSHIP AND MANAGEMENT</b> .....	<b>60</b>
KEYWORDS .....	60
QUESTIONS .....	60
ANSWERS AND RATIONALES .....	67
<b>HEALTH-CARE DELIVERY</b> .....	<b>77</b>
KEYWORDS .....	77
QUESTIONS .....	78
ANSWERS AND RATIONALES .....	86
<b>COMMUNITY-BASED NURSING</b> .....	<b>98</b>
KEYWORDS .....	98
QUESTIONS .....	98
ANSWERS AND RATIONALES .....	104
<b>3 Psychosociocultural Nursing Care</b> .....	<b>113</b>
<b>NURSING CARE ACROSS THE LIFE SPAN</b> .....	<b>113</b>
KEYWORDS .....	113
QUESTIONS .....	114
ANSWERS AND RATIONALES .....	119
<b>COMMUNICATION</b> .....	<b>128</b>
KEYWORDS .....	128
QUESTIONS .....	128
ANSWERS AND RATIONALES .....	135
<b>PSYCHOLOGICAL SUPPORT</b> .....	<b>142</b>
KEYWORDS .....	142
QUESTIONS .....	143
ANSWERS AND RATIONALES .....	149
<b>TEACHING AND LEARNING</b> .....	<b>157</b>
KEYWORDS .....	157
QUESTIONS .....	157
ANSWERS AND RATIONALES .....	164
<b>4 Essential Components of Nursing Care</b> .....	<b>173</b>
<b>NURSING PROCESS</b> .....	<b>173</b>
KEYWORDS .....	173
QUESTIONS .....	174
ANSWERS AND RATIONALES .....	180
<b>PHYSICAL ASSESSMENT</b> .....	<b>189</b>
KEYWORDS .....	189
QUESTIONS .....	190
ANSWERS AND RATIONALES .....	199
<b>INFECTION CONTROL</b> .....	<b>208</b>
KEYWORDS .....	208
QUESTIONS .....	208
ANSWERS AND RATIONALES .....	215
<b>SAFETY</b> .....	<b>223</b>
KEYWORDS .....	223
QUESTIONS .....	223
ANSWERS AND RATIONALES .....	230
<b>MEDICATION ADMINISTRATION</b> .....	<b>238</b>
KEYWORDS .....	238

QUESTIONS .....	239
ANSWERS AND RATIONALES .....	249
<b>PHARMACOLOGY</b> .....	<b>260</b>
KEYWORDS .....	260
QUESTIONS .....	261
ANSWERS AND RATIONALES .....	270
<b>5 Basic Human Needs and Related Nursing Care</b> .....	<b>283</b>
<b>HYGIENE</b> .....	<b>283</b>
KEYWORDS .....	283
QUESTIONS .....	283
ANSWERS AND RATIONALES .....	291
<b>MOBILITY</b> .....	<b>299</b>
KEYWORDS .....	299
QUESTIONS .....	300
ANSWERS AND RATIONALES .....	308
<b>NUTRITION</b> .....	<b>316</b>
KEYWORDS .....	316
QUESTIONS .....	317
ANSWERS AND RATIONALES .....	325
<b>OXYGENATION</b> .....	<b>334</b>
KEYWORDS .....	334
QUESTIONS .....	335
ANSWERS AND RATIONALES .....	343
<b>URINARY ELIMINATION</b> .....	<b>352</b>
KEYWORDS .....	352
QUESTIONS .....	353
ANSWERS AND RATIONALES .....	360
<b>FLUIDS AND ELECTROLYTES</b> .....	<b>368</b>
KEYWORDS .....	368
QUESTIONS .....	369
ANSWERS AND RATIONALES .....	376
<b>GASTROINTESTINAL SYSTEM</b> .....	<b>384</b>
KEYWORDS .....	384
QUESTIONS .....	384
ANSWERS AND RATIONALES .....	391
<b>PAIN, COMFORT, REST, AND SLEEP</b> .....	<b>400</b>
KEYWORDS .....	400
QUESTIONS .....	401
ANSWERS AND RATIONALES .....	408
<b>PERIOPERATIVE NURSING</b> .....	<b>416</b>
KEYWORDS .....	416
QUESTIONS .....	417
ANSWERS AND RATIONALES .....	426
<b>6 Alternate Item Formats</b> .....	<b>437</b>
ALTERNATE ITEM FORMATS .....	437
Multiple-Response Items .....	437
Hot-Spot Items .....	439
Fill-in-the-Blank Calculation Items .....	443
Graphic Items (Items Using a Graphic, Chart, Table, or Illustration) .....	445
Drag and Drop/Ordered Response Items .....	449
Exhibit Items .....	450
ANSWERS AND RATIONALES .....	456

<b>7 Comprehensive Final Book Exam</b> .....	<b>473</b>
QUESTIONS .....	.473
ANSWERS AND RATIONALES .....	.489
<b>Glossary of English Words Commonly Encountered on Nursing Examinations</b> .....	<b>537</b>
<b>Bibliography</b> .....	<b>541</b>
<b>Index</b> .....	<b>545</b>



# Fundamentals of Critical Thinking Related to Test Taking

## INTRODUCTION

To prepare for writing this chapter we did what all writers should do. We performed a detailed search of the literature about critical thinking, we reviewed all the significant materials that related to test taking or nursing practice, and we wrote an outline for a comprehensive discussion of critical thinking in relation to nursing examinations. The introductory section of the chapter was to be titled “The Historical Perspective of Critical Thinking.” When we typed the chapter heading and reread it, we had written “Hysterical” instead of “Historical.” Having a relatively good sense of humor and the ability to laugh at ourselves, our response was peals of laughter. We realized that this was a Freudian slip! Loosely defined, a *Freudian slip* occurs when unconscious mental processes result in a verbal statement that reflects more accurately the true feelings of the speaker than does the originally intended statement. Being true believers in the statement that *all behavior has meaning*, we could not continue until we explored why we wrote what we wrote.

When we looked up the word *hysterical* in the dictionary, its definitions were *an uncontrollable outburst of emotion or out of control* and *extremely comical or hilarious*. Associating the word “hysterical” with the concept of critical thinking raised two thoughts. Are we overwhelmed, frantic, and out of control when considering the relationship between critical thinking and nursing, or do we find this relationship funny, comical, and hilarious? If you feel overwhelmed, frenzied, or out of control when considering critical thinking, carefully read the section in this chapter titled *B Positive: You Can Do It!* When we personalized the word to our own experiences, we recalled that when we believe that something is funny, our internal communication is “Isn’t that hysterically funny?” So, now we were faced with the task of exploring why we thought reviewing the historical perspective of critical thinking was so funny or why it could be overwhelming. We actually spent several hours pursuing this goal. At the completion of this process, we arrived at three conclusions:

- The words “critical thinking” are just buzzwords. *Critical thinking* is a skill that we all possess uniquely, and we use this skill routinely in all the activities of our daily living. It is funny to profess that critical thinking is something new and different.
- Who cares about the historical perspectives of critical thinking! Information about the abstract topic of critical thinking must be presented in a manner that the information learned today can be implemented tomorrow.
- Feelings of being overwhelmed can be conquered because critical-thinking abilities can be enhanced.

## Definition of Critical Thinking

As we sat back and reflected on our morning’s work in relation to Alfaro-LeFevre’s (1995) definition of critical thinking, we recognized and appreciated the fact that we had been thoroughly involved with critical thinking. We had:

- Engaged in purposeful, goal-directed thinking.
- Aimed to make judgments based on evidence (fact) rather than conjecture (guesswork).
- Employed a process based on principles of science (e.g., problem solving, decision making).



- Used strategies (e.g., metacognition, reflection, Socratic questioning) that maximized our human potential and compensated for problems caused by human nature.

**Critical thinking is a cognitive strategy by which you reflect on and analyze your thoughts, actions, and decisions.** Critical thinking often is integrated into traditional linear processes. Linear processes usually follow a straight line, with a beginning and a product at the end. Some linear-like processes, such as the nursing process, are considered cyclical because they repeat themselves. Some formal reasoning processes include the following:

- **Problem Solving** involves identifying a problem, exploring alternative interventions, implementing selected interventions, and arriving at the end product, which is a solution to the problem.
- **Decision Making** involves carefully reviewing significant information, using methodical reasoning, and arriving at the end product, which is a decision.
- **Diagnostic Reasoning** involves collecting information, correlating the collected information to standards, identifying the significance of the collected information, and arriving at the end product, which is a conclusion or nursing diagnosis.
- **The Scientific Method** involves identifying a problem to be investigated, collecting data, formulating a hypothesis, testing the hypothesis through experimentation, evaluating the hypothesis, and arriving at the end product, which is acceptance or rejection of the hypothesis.
- **The Nursing Process** involves collecting information (Assessment); determining significance of information and making a nursing diagnosis (Analysis/Diagnosis); identifying priorities, goals, expected outcomes, and nursing interventions (Planning); carrying out nursing interventions (Implementation/Intervention); and assessing the patient's response to interventions and comparing the actual outcomes with expected outcomes (Evaluation), ultimately to arrive at the end product of meeting a person's needs.

Each of these methods of manipulating and processing information incorporates critical thinking. They all are influenced by intellectual standards, such as being focused, methodical, deliberate, logical, relevant, accurate, precise, clear, comprehensive, creative, and reflective. It is helpful to incorporate critical thinking into whatever framework or structure that works for you.

The purpose of this discussion is to impress on you that you:

- Use critical thinking in your personal life.
- Will continue to use critical thinking in your professional life.
- Should enhance your critical-thinking abilities when studying.
- Can employ critical-thinking skills when taking a nursing examination.

In an attempt to make the abstract aspects of critical thinking more concrete, we have schematically represented our concept of critical thinking by the **Helix of Critical Thinking**. In Figure 1-1, the Helix of Critical Thinking has been unwound and enlarged so that the components of the cognitive competencies and personal competencies can be viewed easily. The cognitive competencies are the intellectual or reasoning processes employed when thinking. The personal competencies are the characteristics or attitudes of the individual thinker. These lists of competencies represent the cognitive abilities or personal qualities commonly associated with critical thinkers. No one possesses all of these competencies, and you may identify competencies that you possess that are not on these lists. The lists are not all inclusive. Make lists of your own cognitive and personal competencies. Your lists represent your repertoire or inventory of thinking skills. As you gain knowledge and experience, your lists will expand. The more cognitive and personal competencies you possess, the greater your potential to think critically.

The Helix of Critical Thinking, when wound (Fig. 1-2), demonstrates the integration of cognitive competencies and personal competencies essential to thinking critically. Not all of these competencies are used in every thinking situation. You can pick or choose from them as from a smorgasbord when you are confronted with situations that require critical thinking. Initially, you may have to stop and consciously consider what cognitive competencies (i.e., intellectual skills) or personal competencies (i.e., abilities, attitudes) to use. As you gain knowledge and experience and move toward becoming an expert critical thinker, the

use of these competencies will become second nature. The Helix will contract or expand depending on the competencies you use in a particular circumstance. In addition, there is constant interaction among cognitive competencies, among personal competencies, and between cognitive competencies and personal competencies.

The interactive nature of the Helix of Critical Thinking and the Nursing Process is demonstrated in Figure 1-3. **The Nursing Process is a critical thinking framework that involves assessing and analyzing human responses to plan and implement nursing care that meets patient needs as evidenced by the evaluation of patient outcomes.** The Nursing Process provides a precise framework in which purposeful thinking occurs.

Cognitive Competencies	Personal Competencies
Dissect	Thinking independently
Modify	Tolerant of ambiguity
Analyze	Self-confident
Interpret	Open-minded
Examine	Accountable
Correlate	Courageous
Synthesize	Persevering
Investigate	Imaginative
Recall facts	Disciplined
Categorize	Risk taking
Summarize	Committed
Understand	Inquisitive
Demonstrate	Motivated
Self-examine	Confident
Translate data	Reflective
Query evidence	Objective
Make inferences	Authentic
Manipulate facts	Assertive
Present arguments	Intuitive
Establish priorities	Rational
Make generalizations	Creative
Compare and contrast	Humble
Determine significance	Curious
Determine implications	Honest
Determine consequences	Moral

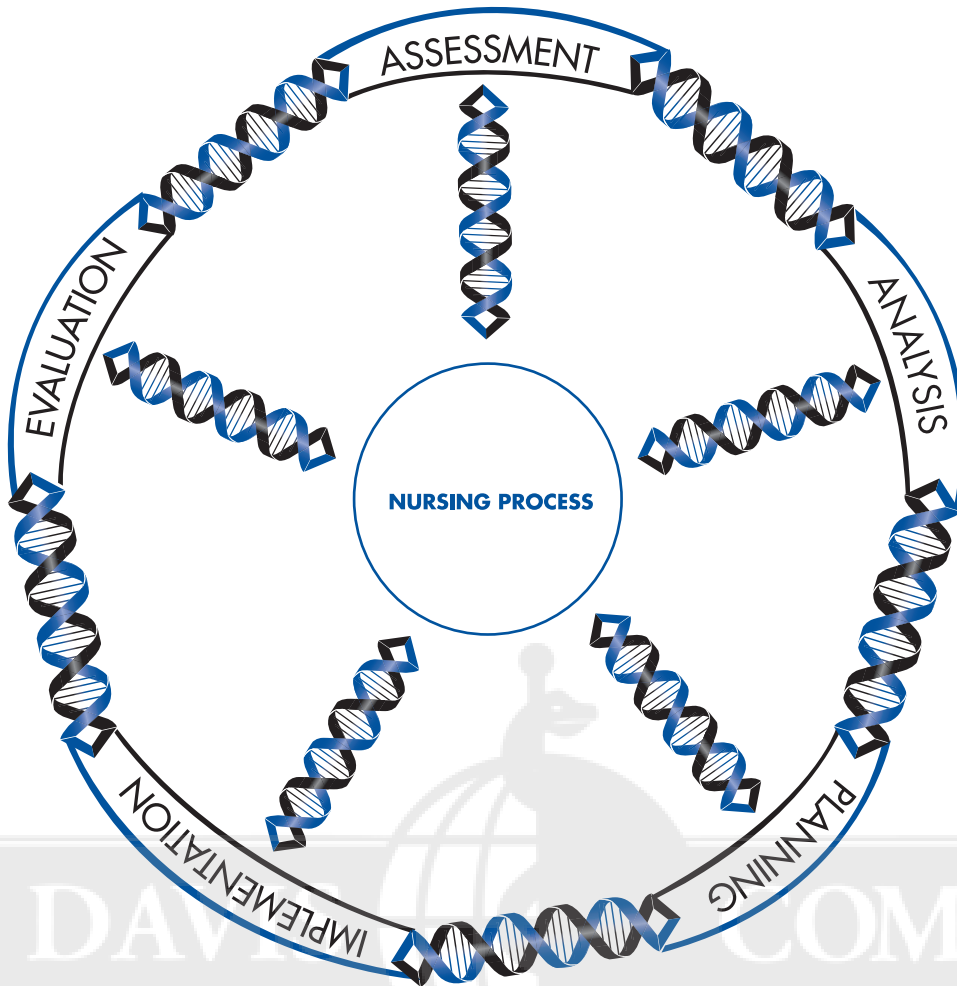
**Figure 1-1.** The Helix of Critical Thinking is schematically elongated to demonstrate the components of cognitive competencies and personal competencies. The more cognitive competencies and personal competencies a person possesses, the greater the potential the person has to think critically.



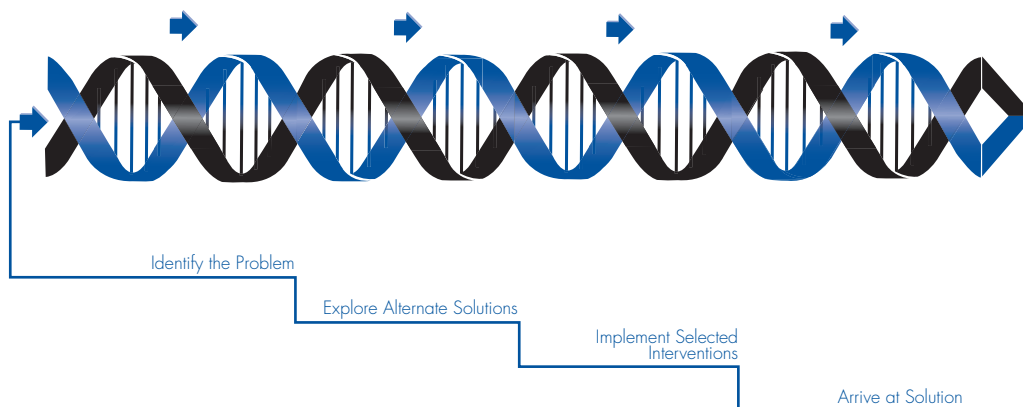
**Figure 1-2.** The Helix of Critical Thinking demonstrates the interwoven relationship between cognitive competencies and personal competencies essential to thinking critically. Throughout the thinking process there is constant interaction among cognitive competencies, among personal competencies, and between cognitive and personal competencies.

Critical thinking is an essential component within, between, and among the phases of the Nursing Process. Different combinations of cognitive and personal competencies may be used during different phases of the Nursing Process.

The interactive nature of the Helix of Critical Thinking and the Problem-Solving Process is demonstrated in Figure 1-4. **The Problem-Solving Process is a dynamic, linear process that has a beginning and an end, with a resolution of the identified problem.** It provides a progressive step-by-step method in which goal-directed thinking occurs. Critical thinking is an essential component within and between the steps of the Problem-Solving Process, and different combinations of cognitive and personal competencies may be used during the various steps involved.



**Figure 1–3.** The interactive nature of the Helix of Critical Thinking within the Nursing Process. The Nursing Process is a dynamic, cyclical process in which each phase interacts with and is influenced by the other phases of the process. Critical thinking is an essential component within, between, and among phases of the Nursing Process. Different combinations of cognitive and personal competencies may be used during the different phases of the Nursing Process.



**Figure 1–4.** The interactive nature of the Helix of Critical Thinking within the Problem-Solving Process. The Problem-Solving Process is a dynamic, linear process that has a beginning and an end, with the resolution of the identified problem. Different combinations of cognitive and personal competencies may be used during the different steps of the Problem-Solving Process.

## MAXIMIZE YOUR CRITICAL-THINKING ABILITIES

### Be Positive: You Can Do It!

Assuming responsibility for the care one delivers to a patient and desiring a commendable grade on a nursing examination raise anxiety because a lot is at stake: to keep the patient safe; to achieve a passing grade; to become a nurse ultimately; and to support one's self-esteem. The most important skill that you can learn to help you achieve all of these goals is to be an accomplished critical thinker. We use critical-thinking skills every day in our lives when we explore these questions: "What will I have for breakfast?" "How can I get to school from my home?" "Where is the best place to get gas for my car?" Once you recognize that you are *thinking critically* already, it is more manageable to *think* about *thinking critically*. If you feel threatened by the idea of critical thinking, then you must do something positive to confront the threat. You must be disciplined and work at increasing your sense of control, which contributes to confidence! *You can do it!*

### OVERCOME BARRIERS TO A POSITIVE MENTAL ATTITUDE

Supporting a positive mental attitude requires developing discipline and confidence. **Discipline** is defined as self-command or self-direction. A disciplined person works in a planned manner, explores all options in an organized and logical way, checks for accuracy, and seeks excellence. When you work in a planned and systematic manner with conscious effort, you are more organized and therefore more disciplined. Disciplined people generally have more control over the variables associated with an intellectual task. Effective critical thinkers are disciplined, and discipline helps to develop confidence.

**Confidence** is defined as poise, self-reliance, or self-assurance. Confidence increases as one matures in the role of the student nurse. Understanding your strengths and limitations is the first step to increasing confidence. When you know your strengths you can draw on them, and when you know your limitations you know when it is time to seek out the instructor or another resource to help you with your critical thinking. Either way, you are in control! For example, ask the instructor for help when critically analyzing a case study, share with the instructor any concerns you have about a clinical assignment, and seek out the instructor in the clinical area when you feel the need for support. Failing to use your instructor is like putting your head in the sand. Learning needs must be addressed, not avoided. Although your instructor is responsible for your clinical practice and for stimulating your intellectual growth as a nursing student, you are the consumer of your nursing education. As the consumer, you must be an active participant in your own learning by ensuring that you get the assistance and experiences you need to build your abilities and confidence. When you increase your theoretical and experiential knowledge base, you will increase your sense of control, which ultimately increases your confidence. This applies not just to beginning nursing students but to every level of nursing practice because of the explosion in information and technology. When you are disciplined you are more in control, when you are more in control you are more confident, and when you are more confident you have a more positive mental attitude.

### Be Reflective: You Need to Take One Step Backward Before Taking Two Steps Forward!

**Reflection** is the process of thinking back or recalling a situation or event to rediscover its meaning. It helps you to seek and understand the relationships among information, concepts, and principles and to apply them in future clinical or testing situations. Reflection can be conducted internally as quiet thoughtful consideration, in a one-on-one discussion with an instructor or another student, or in a group.

As a beginning nursing student, you are just starting to develop an experiential background from the perspective of a provider of nursing care. However, you have a wealth of

experiences, personal and educational, that influence your development as a licensed nurse. Your personal experiences include activities using verbal and written communication, such as delegating tasks to family members or coworkers, setting priorities for daily activities, using mathematics when shopping or balancing a checkbook, and so on. A nursing program of study incorporates courses from a variety of other disciplines, such as anatomy and physiology, chemistry, physics, psychology, sociology, reading, writing, mathematics, and informatics. Every experience is a potential valuable resource for future learning. Recognize the value of the “you” you bring to your nursing education and incorporate it into your reflective processes.

Engaging in reflection is a highly individualized mental process. One form of reflection is writing a journal. A **journal** is an objective and subjective diary of your experiences. It is a chronicle that includes cognitive learning, feelings, and attitudes, and it requires you actively to develop skills related to assessing, exploring the meaning of critical incidents, documenting, developing insights into thoughts and actions that comprise clinical practice, and evaluating. Journal writing is a rich resource that provides a written record of where you have been, where you are, and where you are going. It helps you to incorporate experiences into the development of your professional being. After an examination, explore your feelings and attitudes regarding the experience. Be honest with yourself. Did you prepare adequately for the test? Did you find the content harder or easier than content on another test? Were you anxious before, during, or after the test and, if so, was your anxiety low, medium, or high? What would a low score or high score on the test mean to you? When you were confronted with a question that you perceived as difficult, how did you feel and how did you cope with the feeling? You do not necessarily have to ask yourself all of these questions. You should ask yourself those questions that have meaning for you.

Another form of reflection is making mental pictures. **Mental pictures** are visual images that can be recalled in the future. For example, when caring for a patient who has Parkinson’s disease, compare the patient’s signs and symptoms with the classic clinical manifestations associated with the disease. Then make a visual picture in your mind. Visualize the pill-rolling tremors, mask-like face, drooling, muscle rigidity, and so on, so that in the future you can recall the visual picture rather than having to remember a memorized list of symptoms.

**Retrospective (after the event) reflection** involves seeking an understanding of relationships between previously learned information and the application of this information in patient-care situations or testing experiences. This type of reflection helps you to judge your personal performance against standards of practice. A self-assessment requires the willingness to be open to identifying one’s successful and unsuccessful interventions, strengths and weaknesses, and knowledge and lack of knowledge. The purpose of retrospective reflection is not to be judgmental or to second-guess decisions but rather to learn from the situation. The worth of the reflection depends on the abilities that result from it. When similar situations arise in subsequent clinical practice, previous actions that were reinforced or modified can be accessed to have a present successful outcome.

A *clinical postconference* is an example of retrospective reflection. Students often meet in a group (formally or informally) after a clinical experience to review the day’s events. During the discussion, students have an opportunity to explore feelings and attitudes, consider interventions and alternative interventions, assess decision-making and problem-solving skills, identify how they and other students think through a situation, and so on. You can also review your own thinking when reviewing an experience with a patient by speaking aloud what you were thinking. For example:

“When I went into the room to take my postoperative patient’s vital signs I realized that the patient had an IV in the right arm. I knew that if I took a blood pressure in the arm with an IV it could interfere with the IV so I knew I had to take the blood pressure in the left arm. When I looked at my patient, he looked very pale and sweaty. I got a little nervous but I continued to get the other vital signs. I put the thermometer in the patient’s mouth and started to take his pulse. It was very fast and I knew that this was abnormal so I paid special attention to its rhythm and volume. It was very thready but it was regular. The temperature and respirations were within the high side of the expected range.”

A beginning nursing student may immediately respond by saying, “I don’t know what is going on here so I better take this information to my instructor.” A more advanced student could say, “What could be happening? Maybe the patient is bleeding or has an infection. I think I should inform my instructor but I’ll inspect the incision first.”

When you review an experience such as this example, you can identify your thinking skills. Taking the blood pressure in the left arm and assessing the rate, rhythm, and volume of the pulse were habits because you did not have to figure out a new method when responding to the situation. Remembering the expected range for the various vital signs used the thinking skill of total recall because you memorized and internalized these values. Determining further assessments after obtaining the vital signs required inquiry. You collected and analyzed information and did not take the vital sign results at face value. You recognized abnormalities and gaps in information, collected additional data, considered alternative conclusions, and identified alternative interventions.

Another example of retrospective reflection is reviewing an examination. When reviewing each question, determine why you got a question wrong. For example, several statements you could make are:

- I did not understand what the question was asking because of the English or medical vocabulary used in the question.
- I did not know or understand the content being tested.
- I knew the content being tested but I did not apply it correctly in the question.

When a limited English or medical vocabulary prevents you from answering a question correctly, you must spend time expanding this foundation. A list of English words that appear repeatedly in nursing examinations is included in a glossary at the end of this textbook. In addition, nursing/medical keyword lists have been included in each content area in this textbook. You can use these word lists to review key terminology used in nursing-related topics. To expand your vocabulary, keep English and medical dictionaries at your side when studying and look up new words, write flash cards for words you need to learn, and explore unfamiliar words with which you are confronted on tests.

When you answered a question incorrectly because you did not understand the content, make a list so that you can design a study session devoted to reviewing this information. This study session should begin with a brief review of what you do know about the topic (5 minutes or less). The majority of your efforts should be devoted to studying what you identified as what you need to know. You should do this after reviewing every test. This exercise is based on the axiom *strike while the iron is hot*. The test is over, so your anxiety level is reduced, and how nursing-related content is used in a test question is fresh in your mind. Study sessions that are goal directed tend to be more focused and productive.

When you know the content being tested but have applied the information incorrectly, it is an extremely frustrating experience. However, do not become discouraged. It is motivating to recognize that you actually know the content! Your next task is to explore how to tap into your knowledge successfully. Sometimes restating or summarizing what the question is asking places it into your own perspective, which helps to clarify the content in relation to the test question. Also, you can view the question in relation to specific past experiences or review the information in two different textbooks to obtain different perspectives on the same content. Another strategy to reinforce your learning is to use the left page of your notebook for taking class notes and leave the facing page blank. After an examination, use the blank page to make comments to yourself about how the content was addressed in test questions or add information from your textbook to clarify class notes. How to review thinking strategies in relation to cognitive levels of nursing questions is explored later in this chapter.

Examine your test-taking behaviors. For example, if you consistently changed your initial answers on a test, it is wise to explore what factors influenced you to change your answers. In addition, determine how many questions were converted to either right or wrong answers. The information you collect from this assessment should influence your future behaviors. If you consistently changed correct answers to incorrect answers, you should examine the factors that caused you to change your answers. If you changed incorrect answers to correct answers, you should identify what mental processes were used to arrive at your second choice so that you can use them the first time you look at a question.

Reflection is an essential component of all learning. How can you know where you are going without knowing where you have been? Therefore, to enhance your critical-thinking abilities you must *take one step backward before taking two steps forward!*

## OVERCOME BARRIERS TO EFFECTIVE REFLECTION

Reflecting on your knowledge, strengths, and successes is easy, but reflecting on your lack of knowledge, weaknesses, and mistakes takes courage and humility. **Courage** is the attitude of confronting anything recognized as dangerous or difficult without avoiding or withdrawing from the situation. Courage is necessary because when people look at their shortcomings they tend to be judgmental and are their own worst critics. This type of negativity must be avoided because it promotes defensive thinking, interferes with the reception of new information, and limits self-confidence.

**Humility** is having a modest opinion of one's own abilities. Humility is necessary because it is important to admit your limitations. Only when you identify what you do and do not know can you make a plan to acquire the knowledge necessary to be successful on nursing examinations and practice safe nursing care. Arrogance or a "know-it-all" attitude can interfere with maximizing your potential. For example, when reviewing examinations with students, the students who benefit the most are the ones who are willing to listen to their peers or instructor as to why the correct answer is correct. The students who benefit the least are the ones who consistently and vehemently defend their wrong answers. A healthy amount of inquiry, thoughtful questioning, and not accepting statements at their face value are important critical-thinking competencies; however, self-righteous or obstructionist attitudes more often than not impede, rather than promote, learning.

## F.A. Q. & A. COMPANY

### Be Inquisitive: If You Don't Go There, You'll Never Get Anywhere!

To **inquire** means to question or investigate. The favorite words of inquisitive people are: *what, where, when*, and, most important, *how, why, if . . . then*, and *it depends*. When studying, ask yourself these words to delve further into a topic under consideration. The following are examples:

- You raise the head of the bed when a patient is short of breath. You recognize that this intervention will facilitate respirations. Ask yourself the question, "*How* does this intervention facilitate respirations?" The answer could be, "Raising the head of the bed allows the abdominal organs to drop by gravity, which reduces pressure against the diaphragm, which, in turn, permits maximal thoracic expansion."
- You insert an indwelling urinary catheter and are confronted with the decision as to where to place the drainage bag. Ask yourself *what* questions. "*What* will happen if I place the drainage bag on the bed frame?" The answer could be, "Urine will flow into the drainage bag by gravity." "*What* will happen if I place the drainage bag on an IV pole?" The answer could be, "Urine will remain in the bladder because the IV pole is above the level of the bladder and fluid does not flow uphill, and if there is urine in the bag, it will flow back into the bladder."
- When palpating a pulse you should use gentle compression. Ask yourself the question, "*Why* should I use gentle compression?" The answer could be, "Gentle compression allows you to feel the pulsation of the artery and prevents excessive pressure on the artery that will cut off circulation and thus obliterate the pulse."
- The textbook says that in emergencies nurses should always assess the airway first. Immediately ask, "*Why* should I assess the airway first?" There may be a variety of answers. "In an emergency, follow the ABCs (Airway, Breathing, and Circulation) of assessment, which always begin with the airway. Maslow's Hierarchy of Needs identifies that physiological needs should be met first. Because an airway is essential for the passage of life-sustaining gases in and out of the lungs, this is the priority." Although all of these responses answer the question *why*, only the last answer really provides an in-depth



answer to the *why* question. If your response to the original *why* question raises another *why* question, you need to delve deeper. “*Why* do the ABCs of assessment begin with the airway?” “*Why* should physiological needs be met first?”

- When talking with a patient about an emotionally charged topic, the patient begins to cry. You are confronted with a variety of potential responses. Use the method of *if . . . then* statements. *If . . . then* thinking links an action to a consequence. For example, *if* I remain silent, *then* the patient may refocus on what was said. *If* I say, “You seem very sad,” *then* the patient may discuss the feelings being felt at the time. *If* I respond with an open-ended statement, *then* the patient may pursue the topic in relation to individualized concerns. After you explore a variety of courses of action with the *if . . . then* method, you should be in a better position to choose the most appropriate intervention for the situation.
- You will recognize that you have arrived at a more advanced level of critical thinking when determining that your next course of action is based on the concept of *it depends*. For example, a patient suddenly becomes extremely short of breath and you decide to administer oxygen during this emergency. When considering the amount and route of delivery of the oxygen, you recognize that *it depends*. You need to collect more data. You need to ask more questions, such as, “Is the patient already receiving oxygen? Does the patient have a chronic obstructive pulmonary disease? Is the patient a mouth breather? What other signs and symptoms are identified?” The answers to these questions will influence your choice of interventions.

When exploring the *how, what, where, when, why, if . . . then*, and *it depends* methods of inquiry, you are more likely to arrive at appropriate inferences, assumptions, and conclusions that will ensure effective nursing care.

These same techniques of inquiry can be used when practicing test taking. Reviewing questions that have rationales is an excellent way to explore the reasons for correct and incorrect answers. When answering a question, state why you think your choice is the correct answer and why you think each of the other options is an incorrect answer. This encourages you to focus on the reasons why you responded in a certain way in a particular situation. It prevents you from making quick judgments before exploring the rationales for your actions. After you have done this, compare your rationales with the rationales for the correct and incorrect answers that are provided. Are your rationales focused, methodical, deliberate, logical, relevant, accurate, precise, clear, comprehensive, creative, and reflective? This method of studying not only reviews nursing content but also fosters critical thinking and applies critical thinking to test taking.

During or after the review of an examination, these techniques of inquiry also can be employed, particularly with those questions you got wrong. Although you can conduct this review independently, it is more valuable to review test questions in a group. Your peers and the instructor are valuable resources you should use to facilitate your learning. Different perspectives, experiential backgrounds, and levels of expertise can enhance your inquiry. Be inquisitive. *If you don't go there, you'll never get anywhere.*

## OVERCOME BARRIERS TO BEING INQUISITIVE

Effective inquiry requires more than just a simplistic, cursory review of a topic. Therefore, critical thinkers must have curiosity, perseverance, and motivation. **Curiosity** is the desire to learn or know and is a requirement to delve deeper into a topic. If you are uninterested in or apathetic about a topic, you are not going to go that extra mile. Sometimes you may have to “psych yourself up” to study a particular topic. Students frequently say they are overwhelmed by topics such as fluids and electrolytes, blood gases, or chest tubes. As a result, they develop a minimal understanding of these topics and are willing to learn by trial and error in the clinical area or surrender several questions on an examination. Never be willing to let a lack of knowledge be the norm, because this results in incompetence and an unsafe nursing care provider. Overcome this attitude by maximizing your perseverance.

**Perseverance** means willingness to continue in some effort or course of action despite difficulty or opposition. Critical thinkers never give up until they obtain the information

that satisfies their curiosity. To perform a comprehensive inquiry when studying requires time. Make a schedule for studying at the beginning of the week and adhere to it. This prevents procrastination later in the week when you may prefer to rationalize doing something else and postpone studying. In addition, studying 1 hour a day is more effective than studying 7 hours in 1 day. Breaks between study periods allow for the processing of information, and they provide time to rest and regain focus and concentration. The greatest barrier to perseverance is a deadline. When working under a time limit you may not have enough time to process and understand information. The length of time to study for a test depends on the amount and type of content to be tested and how much previous studying has been done. If you study 2 hours every day for 2 weeks during a unit of instruction, a 1-hour review may be adequate for an examination addressing this content. If you are preparing for a comprehensive examination for a course at the end of the semester, you may decide to study 3 hours a night for 1 to 2 weeks. If you are studying for a National Council Licensure Examination (NCLEX), you may decide to study 2 hours a day for 3 months. Only you can determine how much time you need to study or prepare for a test. Perseverance can be enhanced by the use of motivation strategies.

**Motivation** strategies inspire, prompt, encourage, or instigate you to act. For example, divide the information to be learned into segments and set multiple short-term goals for studying. Cross a segment off the list after you reach a goal. Also, this is the time to use incentives. Reward yourself after an hour of studying. Think about how proud you will be when you earn an excellent grade on the examination. Visualize yourself walking down the aisle at graduation or working as a nurse during your career. Incentives can be more tangible (e.g., eating a snack, reading a book for 10 minutes, playing with a child, or doing anything that strikes your fancy). You should identify the best pattern of studying that satisfies your needs; use motivation techniques to increase your enthusiasm, and then draw on your determination to explore in depth the *how, what, where, when, and whys, if . . . then, and it depends* of nursing practice.

### Be Creative: You Must Think Outside the Box!

**Creative** people are imaginative, inventive, innovative, resourceful, original, and visionary. To find solutions beyond common, predictable, and standardized procedures or practices, you must be creative. Creativity is what allows you to be yourself and individualize the nursing care you provide to each patient. With the explosion of information and technology, the importance of thinking creatively will increase in the future because the “old” ways of doing things will be inadequate. No two situations or two people are ever alike. Therefore, *you must think outside the box!*

### OVERCOME BARRIERS TO CREATIVITY

To be creative you must be open-minded, have independence of thought, and be a risk taker. It is difficult to think outside the box when you are not willing to color outside the lines! Being **open-minded** requires you to consider a wide range of ideas, concepts, and opinions before framing an opinion or making judgments. You must identify your opinions, beliefs, biases, stereotypes, and prejudices. We all have them to one extent or another, so do not deny them. However, they must be recognized, compartmentalized, and not imposed on patients. Unless these attitudes are placed in perspective, they will interfere with critical thinking. In every situation you need to remain open to all perspectives, not just your own. When you think that your opinion is the only right opinion, you are engaging in egocentric thinking. *Egocentric thinking* is based on the belief that the world exists or can be known only in relation to the individual’s mind. This rigid thinking creates a barrier around your brain that obstructs the inflow of information, imaginative thinking, and the outflow of innovative ideas. An example of an instance in which you have been open-minded is one in which you have changed your mind after having had a discussion with someone else. The new information convinced you to think outside of your original thoughts and opinions.

**Independence of thought** means the ability to consider all the possibilities and then arrive at an autonomous conclusion. To do this you need to feel comfortable with ambiguity. *Ambiguous* means having two or more meanings and is therefore being uncertain, unclear, indefinite, and vague. For example, a nursing student may be taught by an instructor to establish a sterile field for a sterile dressing change by using the inside of the package of the sterile gloves. When following a sterile dressing change procedure in a clinical skills book, the directions may state to use a separate sterile cloth for the sterile field. When practicing this procedure with another student, the other student may open several 4 × 4 gauze packages and leave them open as their sterile fields. As a beginning nursing student, this is difficult to understand because of a limited relevant knowledge base and experiential background. Frequently, thinking is concrete and follows rules and procedures, is black and white, or is correct or incorrect. It takes knowledge and experience to recognize that you have many options and may still follow the principles of sterile technique. Remember, “There is more than one road to Rome!”

To travel a different path requires taking risks. *Risk* in the dictionary means the chance of injury, damage, or loss. However, **risk taking** in relation to nursing refers to considering all the options, eliminating potential danger to a patient, and acting in a reasoned, logical, and safe manner when implementing unique interventions. Being creative requires intellectual stamina and a willingness to go where no one has been before. Risk takers tend to be leaders, not followers. The greatest personal risk of creativity is the blow to the ego when confronted with failure. However, you must recognize that throughout your nursing career you will be faced with outcomes that are successful as well as those that are unsuccessful. How you manage your feelings with regard to each, particularly those that are unsuccessful, will influence your willingness to take future creative risks. Successful outcomes build confidence. Unsuccessful outcomes should not be defeating or prevent future creativity when appropriately examined. The whole purpose of evaluation in the nursing process is to compare and contrast patient outcomes with expected outcomes. If expected outcomes are not attained, the entire process must be re-examined and then re-performed. You must recognize that:

- Unsuccessful outcomes do occur.
- Unsuccessful outcomes may not be a reflection of your competence.
- The number of successful outcomes far outnumbers the number of unsuccessful outcomes.

When you accept these facts, then you may feel more confident to take risks with your creativity.

## CRITICAL THINKING APPLIED TO TEST TAKING

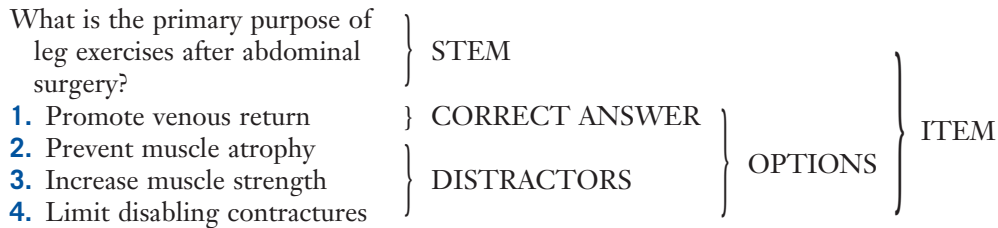
### Educational Domains

Nursing as a discipline includes three domains of learning—**affective**, **psychomotor**, and **cognitive**. The **affective domain** is concerned with attitudes, values, and the development of appreciations. An example of nursing care in the affective domain is the nurse quietly accepting a patient’s statement that there is no God without the nurse imposing personal beliefs on the patient. The **psychomotor domain** is concerned with manipulative or motor skills related to procedures or physical interventions. An example of nursing care in the psychomotor domain is the nurse administering an intramuscular injection to a patient. The **cognitive domain** is concerned with recall, recognition of knowledge, comprehension, and the development and application of intellectual skills and abilities. An example of nursing care in the cognitive domain is the nurse clustering collected information and determining its significance.

### Components of a Multiple-Choice Question

A multiple-choice question is called an **item**. Each item has two parts. The **stem** is the part that contains the information that identifies the topic and its parameters and then asks a

question or forms the beginning portion of a sentence that is completed by the correct option. The second part consists of one or more possible responses, which are called **options**. One of the options is the correct answer, and the others are wrong answers (also called **distractors**).



## Cognitive Levels of Nursing Questions

Questions on nursing examinations reflect a variety of thinking processes that nurses use when caring for patients. These thinking processes are part of the cognitive domain and they progress from the simple to the complex, from the concrete to the abstract, and from the tangible to the intangible. There are four major types of thinking processes represented by nursing questions:

- **Knowledge Questions**, in which the emphasis is on recalling remembered information.
- **Comprehension Questions**, in which the emphasis is on understanding the meaning and intent of remembered information.
- **Application Questions**, in which the emphasis is on remembering understood information and utilizing the information in new situations.
- **Analysis Questions**, in which the emphasis is on comparing and contrasting a variety of elements of information.

## CRITICAL-THINKING STRATEGY TO ANSWER NURSING QUESTIONS: THE RACE MODEL

Answering a test question is like participating in a race. Of course, you want to come in first and be the winner. However, the thing to remember about a race is that success is based not just on speed but also on strategy and tactics. The same is true about success on nursing examinations. Although speed may be a variable that must be considered when taking a timed test so that the amount of time spent on each question is factored into the test strategy, the emphasis should be on the use of critical-thinking strategies to answer test questions. The RACE model presented here is a critical-thinking strategy to use when answering nursing questions. If you follow the RACE model every time you examine a test question, its use will become second nature. This methodical approach will improve your abilities to analyze a test question critically and will improve your chances of selecting the correct answer.

The RACE model has four steps to answering a test question:

**R Recognize keywords.**

**A Ask what the question is asking.**

**C Critically analyze each option in relation to the question and the other options.**

- Critically scrutinize each option in relation to the information in the stem.
- Critically identify a rationale for each option.
- Critically compare and contrast the options in relation to the information in the stem and their relationships with one another.

**E Eliminate incorrect options.**

- Eliminate one option at a time.
- Eliminate as many incorrect options as possible.

The following discussion explores this critical-thinking strategy in relation to the thinking processes represented in nursing test questions. Thoughtfully read the *Cognitive Requirements* under each type of question (e.g., Knowledge, Comprehension, Application, and Analysis). It is important to understand this content to apply the critical-thinking strategies inherent in each cognitive-level question. In addition, three sets of sample test questions are presented to demonstrate the increasing complexity of thinking reflected in the various cognitive levels focusing on specific fundamentals of nursing content. Also, each cognitive level includes the RACE model applied to an alternate-type item.

## Knowledge Questions: Remember Information!

### COGNITIVE REQUIREMENTS

**Knowledge** is information that is filed or stored in the brain. It represents the elements essential to the core of a discipline. In nursing, this information consists of elements such as terminology and specific facts including steps of procedures, phenomena, expected laboratory values, classifications, and the expected ranges of vital signs. This type of information requires no alteration from one use or application to another because it is concrete. The information is recalled or recognized in the form in which it was originally learned. This information is the foundation of critical thinking. You must have adequate, accurate, relevant, and important information on which to base your more theoretical, abstract thinking.

Beginning nursing students find knowledge-level questions the easiest because they require the recall or regurgitation of information. Information may be memorized, which involves repeatedly reviewing information to place it and keep it in the brain. Information also can be committed to memory through repeated experiences with the information. Repetition is necessary because information is forgotten quickly unless reinforced. When answering knowledge-level questions you either know the information or you don't. The challenge of answering knowledge-level questions is defining what the question is asking and tapping your knowledge. See our textbook *TEST SUCCESS Test-Taking Techniques for Beginning Nursing Students* (F.A. Davis) for specific study techniques related to knowledge-level questions.

### USE THE RACE MODEL TO ANSWER KNOWLEDGE-LEVEL QUESTIONS

1. Which is the classification of the medication docusate sodium?
  1. Stool softener
  2. Cardiac glycoside
  3. Histamine H<sub>2</sub> antagonist
  4. Calcium channel blocker

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	Which is the <b>classification</b> of the medication <b>docusate sodium</b> ?
Ask what the question is asking.	What category of medication is docusate sodium?
Critically analyze each option in relation to the question and the other options.	<p>This question does not require complex understanding, comparative analysis, or application skills; it requires only recall of information about docusate sodium.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. <b>Stool softeners are medications that promote the elimination of fecal material. Docusate sodium is a stool softener.</b></li> <li>2. Cardiac glycosides increase cardiac output by decreasing the heart rate and strengthening cardiac contractions. Docusate sodium is not a cardiac glycoside.</li> </ol>

	<ol style="list-style-type: none"> <li>3. Histamine-2 (H<sub>2</sub>) antagonists are medications that inhibit histamine at H<sub>2</sub> sites in the parietal cells in the stomach, which reduces gastric acid secretion. Docusate sodium is not an H<sub>2</sub> antagonist.</li> <li>4. Calcium channel blockers are medications that inhibit calcium ion influx across cell membranes during cardiac depolarization. They dilate coronary and peripheral arteries, relax coronary vascular smooth muscles, and slow sinoatrial/atrioventricular node conduction time. Docusate sodium is not a calcium channel blocker.</li> </ol>
Eliminate incorrect options.	Because options 2, 3, and 4 are not the names of the classification of docusate sodium, they can be eliminated. If you know the action of one or more of the incorrect options it may help you eliminate them.

2. Which is the description of the interviewing technique of paraphrasing?
1. Asking the patient to repeat what was just said
  2. Condensing a discussion into an organized review
  3. Restating what the patient has said using similar words
  4. Asking goal-directed questions concentrating on key concerns

#### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	Which is the <b>description</b> of the interviewing technique of <b>paraphrasing</b> ?
Ask what the question is asking.	How is the interviewing technique of paraphrasing implemented?
Critically analyze each option in relation to the question and the other options.	<p>To answer this question you must know the definition or characteristic of paraphrasing. It is information that you must recall from your memory. You do not have to know other interviewing skills or their descriptions and characteristics to answer this question correctly.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. Asking a patient to repeat what was just asked is known as clarifying, not paraphrasing.</li> <li>2. Reviewing a discussion is known as summarizing, not paraphrasing.</li> <li>3. <b>Paraphrasing or restating is an interviewing skill in which the nurse listens for a patient's basic message and then repeats the contents of the message in similar words. This validates information from the patient without changing the meaning of the statement and provides an opportunity for the patient to hear what was said.</b></li> <li>4. Asking goal-directed questions that concentrate on key concerns is known as focusing, not paraphrasing.</li> </ol>
Eliminate incorrect options.	Options 1, 2, and 4 are not examples of paraphrasing and can be eliminated. Although you do not have to know the characteristics of interviewing skills other than paraphrasing to answer this question correctly, knowing this information may help you eliminate incorrect options.

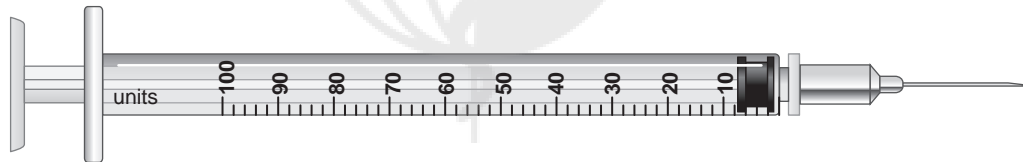
3. What is another name for a decubitus ulcer?
1. Skin tear
  2. Pressure ulcer
  3. Surface abrasion
  4. Penetrating wound

**IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY**

Recognize keywords.	What is <b>another name</b> for a <b>decubitus ulcer</b> ?
Ask what the question is asking.	What is an alternate name for a decubitus ulcer?
Critically analyze each option in relation to the question and the other options.	To answer this question you must know the alternate name for a decubitus ulcer. It is information you must recollect from your memory. You do not have to know the description or characteristics of other types of wounds to answer this question. <b>Rationales:</b> <ol style="list-style-type: none"> <li>1. A skin tear is a break in the continuity of thin, fragile skin caused by friction or shearing force.</li> <li>2. <b>A pressure ulcer is impaired skin (reddened area, sore, or lesion characterized by sloughing of tissue) over a bony prominence caused by pressure that interferes with the delivery of oxygen to body cells.</b></li> <li>3. An abrasion is the scraping or rubbing away of the superficial layers of the skin.</li> <li>4. A penetrating wound occurs when a sharp object pierces the skin and injures underlying tissues.</li> </ol>
Eliminate incorrect options.	Options 1, 3, and 4 are not other names for a decubitus ulcer and can be eliminated. Although it is not necessary to know the description and characteristics of other types of wounds to answer the question correctly, knowing this information may help you eliminate incorrect options.

4. Which is the name of this type of syringe?

1. Insulin
2. Irrigation
3. Intradermal
4. Subcutaneous



**IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY**

Recognize keywords.	Which is the <b>name</b> of this type of <b>syringe</b> ?
Ask what the question is asking.	Identify the name of the type of syringe that is marked in units depicted in the illustration?
Critically analyze each option in relation to the question and the other options.	To answer this question you must identify that the syringe in the illustration is an insulin syringe. This question does not require complex understanding, comparative analysis, or application skills; it requires only recall of the name of this type of syringe. <b>Rationales:</b> <ol style="list-style-type: none"> <li>1. <b>This is an illustration of an insulin syringe. It is a U-100 syringe marked in units, of which there are 100 units per mL.</b></li> <li>2. This is not an illustration of a syringe used for irrigating a wound. Generally a piston syringe that can contain up to 50 mL of solution is used to irrigate a wound; it has a tip to which a catheter can be attached.</li> </ol>

	<p>3. This is not an illustration of a syringe used to administer a medication via the intradermal route. Generally a 1-mL tuberculin syringe marked in 0.01 mL (1/100th of a milliliter) and minims (16 minims is equal to 1 mL) is used to administer a medication via the intradermal route.</p> <p>4. This is not an illustration of a syringe that is used to administer a medication via the subcutaneous route. Generally a 3-mL standard syringe marked in whole milliliters and 0.1 mL (1/10th of a milliliter) with a 5/8-, 3/4-, or 1-inch length needle is used to administer a medication into subcutaneous tissue.</p>
Eliminate incorrect options.	Because options 2, 3, and 4 are not the names of the type of syringe depicted in the illustration, they can be eliminated.

## Comprehension Questions: Understand Information!

### COGNITIVE REQUIREMENTS

**Comprehension** is the ability to understand that which is known. To be safe practitioners, nurses must understand information such as reasons for nursing interventions, physiology and pathophysiology, consequences of actions, and responses to medications. To reach an understanding of information in nursing you must be able to translate information into your own words to personalize its meaning. Once information is rearranged in your own mind, you must interpret the essential components for their intent, corollaries, significance, implications, consequences, and conclusions in accordance with the conditions described in the original communication. The information is manipulated within its own context without being used in a different or new situation.

Beginning nursing students generally consider comprehension-level questions slightly more difficult than knowledge-level questions but less complicated than application-level and analysis-level questions. Students often try to deal with comprehension-level information by memorizing the content. For example, when studying local signs and symptoms of an infection, students may memorize the following list: heat, erythema, pain, edema, and exudate. Although this can be done, it is far better to understand why these adaptations occur. Erythema and heat occur because of increased circulation to the area. Edema occurs because of increased permeability of the capillaries. Pain occurs because the accumulating fluid in the tissue presses on nerve endings. Exudate occurs because of the accumulation of fluid, cells, and other substances at the site of infection. The mind is a wonderful machine, but unless you have a photographic memory, lists of information without understanding often become overwhelming and confusing. The challenge of answering comprehension questions is to understand the information. See our textbook *TEST SUCCESS Test-Taking Techniques for Beginning Nursing Students* for specific study techniques related to comprehension-level questions.

### USE THE RACE MODEL TO ANSWER COMPREHENSION-LEVEL QUESTIONS

1. How does the medication docusate sodium facilitate defecation?
  1. Softens stool
  2. Forms a bulk residue
  3. Irritates the intestinal wall
  4. Dilates the intestinal lumen



### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	<b>How</b> does the medication <b>docusate sodium facilitate defecation</b> ?
Ask what the question is asking.	How does docusate sodium work in the body to promote the passage of stool?
Critically analyze each option in relation to the question and to the other options.	<p>The word in the stem that indicates this is a comprehension-level question is <i>facilitate</i>.</p> <p>You should scrutinize each option to identify whether the description in the option correctly explains how or why docusate sodium works to facilitate defecation.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li><b>1. Docusate sodium softens and delays the drying of feces by lowering the surface tension of water, permitting water and fat to penetrate the feces.</b></li> <li>Bulk-forming laxatives, such as psyllium hydrophilic mucilloid, increase the fluid, gaseous, or solid bulk in the intestines.</li> <li>Irritants or stimulants, such as bisacodyl, irritate the intestinal mucosa or stimulate intestinal wall nerve endings, which precipitates peristalsis.</li> <li>Large-volume enemas, not medications, enlarge the lumen of the intestine, which precipitates peristalsis.</li> </ol>
Eliminate incorrect options.	Options 2, 3, and 4 do not accurately describe the therapeutic action of docusate sodium and can be eliminated. You do not have to know the therapeutic action of other medications that facilitate defecation to answer the question correctly. However, this information may help you eliminate incorrect options.

- How does the interviewing technique of paraphrasing promote communication?
  - Requires patients to defend their points of view
  - Limits patients from continuing a rambling conversation
  - Allows patients to take their conversations in any desired direction
  - Offers patients an opportunity to develop a clearer idea of what they said

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	<b>How</b> does the interviewing technique of <b>paraphrasing promote communication</b> ?
Ask what the question is asking.	How does paraphrasing encourage communication?
Critically analyze each option in relation to the question and to the other options.	<p>The word in the stem that indicates that this is a comprehension-level question is <i>promote</i>.</p> <p>You should scrutinize each option to identify whether the description in the option correctly explains the consequence of using paraphrasing as a communication technique.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>Requiring patients to defend their points of view describes the results of challenging statements that usually are barriers to communication.</li> <li>Limiting patients from continuing a rambling conversation describes one purpose of the interviewing skill of focusing, which is the use of questions or statements to center on one concern mentioned within a wordy, confusing conversation.</li> <li>Allowing patients to take their conversations in any desired direction is the purpose of open-ended questions or statements.</li> </ol>

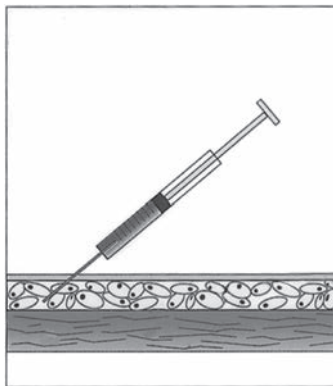
	<b>4. Paraphrasing involves actively listening for the patient's concerns, which are then restated by the nurse in similar words. This intervention conveys that the nurse has heard and understood the message and gives the patient an opportunity to review what was said.</b>
Eliminate incorrect options.	Options 1, 2, and 3 do not accurately describe how paraphrasing works to promote communication and can be eliminated. You do not have to know how other interviewing skills work to facilitate communication to answer the question correctly. However, this information may help you eliminate incorrect options.

3. How does turning patients every 2 hours prevent pressure ulcers from developing?
1. Relieves weight on the capillaries, allowing oxygen to reach body cells
  2. Promotes muscle contractions, increasing the basal metabolic rate of the body
  3. Keeps the extremities dependent, permitting blood to flow to distal cells by gravity
  4. Drops the organs in the abdominal cavity by gravity, relieving pressure against the diaphragm

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	<b>How</b> does <b>turning</b> patients every 2 hours <b>prevent pressure ulcers</b> from developing?
Ask what the question is asking.	How does turning a patient prevent decubitus ulcers?
Critically analyze each option in relation to the question and to the other options.	<p>The word in the stem that indicates that this is a comprehension-level question is <i>prevent</i>. You should scrutinize each option to identify whether the description in the option correctly explains how turning a patient relieves pressure and prevents a pressure ulcer.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. <b>Capillary beds are compressed and blood flow is obliterated with excessive external pressure (12 to 32 mm Hg). Changing position removes the weight of the body off dependent areas, permitting blood to flow through the capillaries, thus supporting gaseous exchange at the cellular level.</b></li> <li>2. Muscle contraction expends energy that raises the basal metabolic rate; however, this is unrelated to the development of pressure ulcers.</li> <li>3. Blood flow to the extremities increases when the extremities are kept below the level of the heart; however, this is unrelated to the development of pressure ulcers.</li> <li>4. Relieving pressure against the diaphragm by abdominal organs allows for greater thoracic expansion; however, this is unrelated to the development of pressure ulcers.</li> </ol>
Eliminate incorrect options.	Options 2, 3, and 4 do not accurately explain how turning relieves pressure, thereby preventing a pressure ulcer, and can be eliminated. Understanding the concept of gravity in relation to options 3 and 4 may help you eliminate these options because they are unrelated to pressure ulcer development.

4. Which is the purpose of administering a medication using a 45° angle and 1½-inch needle length as indicated in the illustration?
1. Injects medication via the intramuscular route
  2. Injects medication via the subcutaneous route
  3. Injects medication via the intravascular route
  4. Injects medication via the intradermal route



### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	Which is the <b>purpose of administering</b> a medication using a 45° angle and 1 -inch needle length <b>as indicated in the illustration</b> ?
Ask what the question is asking.	Which route of administration is performed when an injection is given using a 1 -needle at a 45° angle?
Critically analyze each option in relation to the question and to the other options.	<p>To answer this question you must know that when using a 1 -inch length needle at a 45° angle medication is injected into subcutaneous tissue.</p> <p><b>Rationale:</b></p> <ol style="list-style-type: none"> <li>1. A muscle is not accessed via a 45° angle using a 1 -inch needle. A 90° angle of insertion is standard for administering medication via the intramuscular route. A muscle is below the level of subcutaneous tissue. A needle length of 1 inches is necessary to reach muscle tissue in most adults, a 2-inch length needle is used to administer an intramuscular injection to an obese adult, and a 1-inch needle length is used when administering an intramuscular injection in the deltoid muscle.</li> <li>2. <b>This is an illustration of a medication injected via the subcutaneous route. A syringe with a 1½-inch needle inserted at a 45° angle ensures that medication is injected into subcutaneous tissue and not into a muscle.</b></li> <li>3. A vein is not accessed via a 45° angle using a 1 -inch needle. The intravascular route requires administration of a medication directly into a vein. This can be accomplished by adding medication to a large-volume bag of intravenous fluid, a single dose of medication mixed with a small volume of fluid in its own intravenous bag via secondary tubing attached to a current primary intravenous line (Piggyback) or via a Bolus (push) single dose of medication inserted directly into a primary line or venous access device.</li> <li>4. Below the epidermis is not accessed via a 45° angle using a 1 -inch needle. A 15° angle of insertion is used to administer medication via the intradermal route.</li> </ol>
Eliminate incorrect options.	Options 1, 3, and 4 can be eliminated because these routes inject medication into areas of the body other than subcutaneous tissue that is depicted in the illustration. If you know the names of the routes that require other than a 45° angle of insertion such as option 1 (intramuscular 90° angle) or option 3 (intradermal 15° angle), you can eliminate these 2 options from consideration, thereby increasing your chances of selecting the correct answer.

## Application Questions: Use Information!

### COGNITIVE REQUIREMENTS

**Application** is the ability to use known and understood information in new situations. It requires more than just understanding information because you must demonstrate, solve, change, modify, or manipulate information in other than its originally learned form or context. With application questions you are confronted with a new situation that requires you to recall information and manipulate the information from within a familiar context to arrive at abstractions, generalizations, or consequences regarding the information that can be used in the new situation to answer the question. Application questions require you to make rational, logical judgments.

Beginning nursing students frequently find these questions challenging because they require a restructuring of understood information into abstractions, commonalities, and generalizations, which are then applied to new situations. You do this all the time. Although there are parts of your day that are routine, every day you are exposed to new, challenging experiences. The same concept holds true for application questions. With application questions you will be confronted by situations that you learned about in a book, experienced personally, relived through other students' experiences, or never heard about or experienced before. This will happen throughout your entire nursing career. The challenge of answering application questions is going beyond rules and regulations and using information in a unique, creative way. See our textbook *TEST SC CESS Test-Taking Techniques for Beginning Nursing Students* for specific study techniques related to application-level questions.

### USE THE RACE MODEL TO ANSWER APPLICATION-LEVEL QUESTIONS

1. A patient complains about not having had a bowel movement in 3 days. Which classification of drugs is helpful in relieving this problem?
  1. Stool softener
  2. Cardiac glycoside
  3. Histamine H<sub>2</sub> antagonist
  4. Calcium channel blocker

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient complains about <b>not having had a bowel movement</b> in 3 days. Which <b>classification of drugs</b> is <b>helpful</b> in <b>relieving</b> this problem?
Ask what the question is asking.	Which classification of drugs is most helpful in facilitating defecation, thus relieving constipation?
Critically analyze each option in relation to the question and to the other options.	<p>The words in the stem that indicate that this is an application question are <i>helpful in relieving</i>.</p> <p>To choose which classification of drugs will be most helpful in relieving this patient's problem, you must know that a patient who has not had a bowel movement in 3 days may be constipated, the therapeutic action and outcome of various classifications of drugs, and which classification of drugs would be helpful in relieving constipation.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. <b>Docosate sodium is a stool softener. It increases water and fat penetration of feces, which softens the stool.</b></li> <li>2. Cardiac glycosides increase the force of cardiac contractions, which increases the cardiac output (positive inotropic effect), and decrease electrical conduction in the heart, which decreases the heart rate (positive dromotropic effect). Docosate sodium is not a cardiac glycoside.</li> </ol>

*continued*

continued

	<ol style="list-style-type: none"> <li>3. Histamine-2 (H<sub>2</sub>) antagonists inhibit histamine at H<sub>2</sub> receptor sites in parietal cells, and this inhibits gastric acid secretion. Docusate sodium is not an H<sub>2</sub> antagonist.</li> <li>4. Calcium channel blockers inhibit calcium ion influx across cell membranes during cardiac depolarization. They relax coronary vascular smooth muscles, dilate coronary and peripheral arteries, and slow sinoatrial/atrioventricular node conduction times. Docusate sodium is not a calcium channel blocker.</li> </ol>
Eliminate incorrect options.	Because options 2, 3, and 4 are unrelated to facilitating the passage of stool, they can be eliminated. You do not have to know the expected outcome of the drug classifications in the incorrect options to answer the question correctly. However, if you know this information it may help you eliminate these options.

2. A patient scheduled for major surgery, who is perspiring and nervously picking at the bed linen, says, "I don't know if I can go through with this surgery." The nurse responds, "You'd rather not have surgery now?" Which interviewing technique was used by the nurse?
1. Focusing
  2. Reflection
  3. Paraphrasing
  4. Clarification

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient scheduled for major surgery, who is perspiring and nervously picking at the bed linen, says, "I don't know if I can go through with this surgery." The nurse responds, " <b>You'd rather not have surgery now?</b> " Which interviewing <b>technique</b> was used by the nurse?
Ask what the question is asking.	What interviewing technique is being used by the nurse when the nurse says in response to the patient, "You'd rather not have surgery now?"
Critically analyze each option in relation to the question and to the other options.	<p>The words in the stem that indicate that this is an application question are <i>was used</i>.</p> <p>To identify which technique was used by the nurse you have to understand the elements of a paraphrasing statement and you must recognize a paraphrasing statement when it is used.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. The example in the stem is not using focusing because the patient's statement was short and contained one message that was reiterated by the nurse. Focusing is used to explore one concern among many statements made by the patient.</li> <li>2. The example in the stem is not using reflection because the nurse's statement is concerned with the content, not the underlying feeling, of the patient's statement. An example of reflection used by the nurse is, "You seem anxious about having major surgery."</li> <li>3. <b>The nurse used paraphrasing because the patient's and nurse's statements contain the same message but they are expressed with different words.</b></li> <li>4. The example in the stem is not using clarification. When clarification is used, the nurse is asking the patient to further explain what is meant by the patient's statement. An example of clarification used by the nurse is, "I am not quite sure that I know what you mean when you say you would rather not have surgery now."</li> </ol>

Eliminate incorrect options.	Options 1, 2, and 4 can be eliminated because these techniques are different from the technique portrayed in the nurse's response in the stem. Although it is helpful to understand the elements of the other interviewing techniques because it will help you eliminate incorrect options, it is not necessary to understand this information to answer the question correctly.
------------------------------	--

3. A nurse identifies that a patient on prolonged bed rest may be developing a pressure ulcer. Which color of the skin over a bony prominence supports this conclusion?
1. Red
  2. Blue
  3. Black
  4. Yellow

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse identifies that a patient may be developing a <b>pressure ulcer</b> . Which <b>color of the skin</b> over a <b>bony prominence</b> supports this conclusion?
Ask what the question is asking.	Which early sign indicates a pressure ulcer over a bony prominence?
Critically analyze each option in relation to the question and to the other options.	<p>The words in the stem that indicate that this is an application question are <i>identifies</i> and <i>developing a pressure ulcer</i>. To answer this question you have to understand how and why pressure can cause a pressure ulcer and know the common early sign that indicates the formation of a pressure ulcer.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. Erythema is a red discoloration generally caused by local vasodilation in an attempt to bring more oxygen to the area.</li> <li>2. Cyanosis is a bluish color caused by an increased amount of deoxygenated hemoglobin associated with hypoxia, not pressure.</li> <li>3. Eschar generally appears black and is the scab or dry crust that results from death of tissue.</li> <li>4. Jaundice is a yellow-orange color caused by increased deposits of bilirubin in tissue, not a response to pressure.</li> </ol>
Eliminate incorrect options.	Options 2, 3, and 4 are not early signs of a pressure ulcer and are incorrect answers. Although it is helpful to know what is happening when the skin reflects each of the colors indicated in the options so that you can eliminate incorrect answers, it is not necessary to know this information to answer the question.

4. A patient has a prescription for regular insulin coverage before meals. The prescription states to administer regular insulin based on blood glucose results.
- 150 to 175 mg/dL: 2 units  
 176 to 225 mg/dL: 4 units  
 226 to 275 mg/dL: 6 units  
 276 mg/dL or more: notify primary health-care provider
- The patient's blood glucose level before breakfast is 177 mg/dL. How many units of regular insulin should the nurse administer? **Record your answer using a whole number.**
- Answer: \_\_\_\_\_ u nits

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	<p>A patient has a prescription for regular insulin coverage before meals. The prescription states to administer regular insulin based on blood glucose results.</p> <p><b>150 to 175 mg/dL: 2 units</b>  <b>176 to 225 mg/dL: 4 units</b>  <b>226 to 275 mg/dL: 6 units</b>  <b>276 mg/dL or more: notify primary health-care provider</b></p> <p>The patient's blood glucose level before breakfast is <b>177 mg/dL</b>.  <b>How many units of regular insulin should the nurse administer?</b>  Record your answer using a whole number.  Answer: _____ Units</p>
Ask what the question is asking.	How many units of regular insulin should the nurse administer when the patient's blood glucose level is 177 mg/dL?
Critically analyze each option in relation to the question and to the other options.	<p>A fill-in-the-blank question does not have several options within the question. Generally you have to insert the information contained in the question into a mathematical formula to manipulate the information to arrive at an answer. However, this fill-in-the-blank item does not require a formula to answer the question. You have to compare the patient's glucose level of 177 mg/dL with the regular insulin prescription to arrive at the correct answer.</p> <p><b>Rationale:</b>  <b>The patient's glucose level is 177 mg/dL. The prescription for regular insulin indicates that if the patient's glucose level is 176 to 225 mg/dL the patient should receive 4 units of regular insulin.</b></p>
Eliminate incorrect options.	Because the patient's glucose level is 177 mg/dL the other parameters for glucose levels and their accompanying regular insulin doses can be eliminated.

### Analysis Questions: Scrutinize Information!

#### COGNITIVE REQUIREMENTS

**Analysis** is the separation of an entity into its constituent parts and examination of their essential features in relation to each other. Analysis questions assume that you know, understand, and can apply information. They ask you to engage in higher-level critical-thinking strategies. To answer analysis-level questions, you first must examine each element of information as a separate entity. Second, you need to investigate the differences among the various elements of information. In other words, you must compare and contrast information. Third, you must analyze the structure and organization of the compared and contrasted information to arrive at a conclusion or answer. Analysis questions often ask you to set priorities and in the stem frequently use words such as *first*, *initially*, *best*, *priority*, and *most important*.

Beginning nursing students find analysis-level questions the most difficult to answer. Analysis questions demand scrutiny of individual elements of information as well as require identification of differences among elements of information. Sometimes students cannot identify the structural or organizational relationship of elements of information. The challenge of answering analysis questions is performing a complete scrutiny of all the various elements of information and their interrelationships without overanalyzing or “reading into” the questions. See our textbook *TEST SUCCESS Test-Taking Techniques for Beginning Nursing Students* for specific study techniques related to analysis-level questions.

### USE THE RACE MODEL TO ANSWER ANALYSIS-LEVEL QUESTIONS

1. A frail, malnourished older adult has been experiencing constipation. Which medication does the nurse anticipate that the primary health-care provider will **most** likely prescribe?
  1. Bisacodyl
  2. Mineral oil
  3. Docusate sodium
  4. Magnesium hydroxide

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	A <b>frail, malnourished older adult</b> has been experiencing <b>constipation</b> . Which <b>medication</b> does the nurse anticipate that the primary health-care provider will <b>most likely prescribe</b> ?
Ask what the question is asking.	Which medication that promotes defecation is least likely to cause problems in a debilitated older adult?
Critically analyze each option in relation to the question and the other options.	<p>Analysis questions often ask you to set priorities as indicated by the words <i>most likely prescribe</i> in the stem of this question. This question requires you to: understand that frail, malnourished older adults have minimal compensatory reserve in various body systems to manage responses to cathartics and laxatives; know the physiological action, outcome, side effects, and toxic effects of all four medications presented in the stem; contrast and compare the drugs and the risks they pose in the older adult to arrive at which drug would be the least risky drug. The least risky drug is the one that is most likely to be prescribed.</p> <p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. Bisacodyl irritates the intestinal mucosa, stimulates nerve endings in the wall of the intestines, and causes rapid propulsion of waste from the body. Bisacodyl is not the best choice of a laxative for an older adult because it can cause intestinal cramps, fluid and electrolyte imbalances, and irritation of the intestinal mucosa.</li> <li>2. Mineral oil lubricates feces in the colon; however, it can inhibit the absorption of fat-soluble vitamins and is not the best laxative for an older adult.</li> <li>3. <b>Docusate sodium permits fat and water to penetrate feces, which soften stool. Of all the options, docusate sodium has the fewest side effects in older adults.</b></li> <li>4. Magnesium hydroxide draws water into the intestine by osmosis, which stimulates peristalsis. It is contraindicated for an older adult because it can cause fluid and electrolyte imbalances and inhibit absorption of fat-soluble vitamins.</li> </ol>
Eliminate incorrect options.	Options 1, 2, and 4 are more potent than the correct answer and therefore are least likely to be ordered to relieve constipation in a debilitated older adult. Because you must compare and contrast the drugs in the options presented, the more you know about these medications, the more options you may be able to eliminate, increasing your chances of selecting the correct answer.

2. The mother of a terminally ill child says, “I never thought that I would have such a sick child.” Which is the **best** initial response by the nurse?
  1. “How do you feel right now?”
  2. “What do you mean by sick child?”
  3. “Life is not fair to do this to a child.”
  4. “A sick child is something you never expected.”



### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	The mother of a terminally ill child says, "I never thought that I would have such a sick child." What is the <b>best initial response</b> by the nurse?
Ask what the question is asking.	Which is an example of the best interviewing skill to use when initially responding to a statement made by the mother of a terminally ill child?
Critically analyze each option in relation to the question and the other options.	Analysis questions often ask you to set priorities as indicated by the words <i>best initial response</i> in the stem of this question. To answer this question you need to: identify which interviewing techniques are portrayed in the statements in each option; understand how and why each interviewing skill works; compare and contrast the pros and cons of each technique if used in this situation; and identify which technique is the most supportive, appropriate, and best initial response by the nurse.
	<p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. Direct questions cut off communication and should be avoided.</li> <li>2. This response focuses on the seriousness of the child's illness, which is not the issue raised in the mother's statement.</li> <li>3. This statement reflects the beliefs and values of the nurse, which should be avoided.</li> <li>4. <b>This is a declarative statement that paraphrases the mother's comment. It communicates to the mother that the nurse is attentively listening and invites the mother to expand on her thoughts if she feels ready.</b></li> </ol>
Eliminate incorrect options.	Options 1, 2, and 3 can be eliminated because they do not focus on the content of the mother's statement.

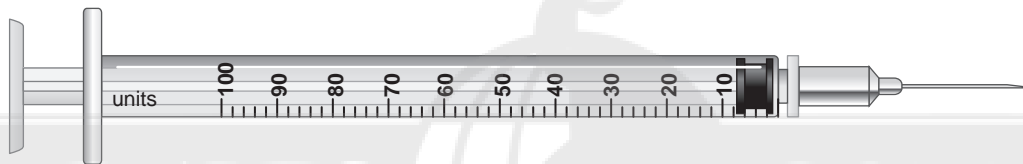
3. Which patient has the greatest risk for developing a pressure ulcer?
1. An older adult on bed rest
  2. A toddler learning to walk
  3. A thin young woman in a coma
  4. An emotionally unstable middle-aged man

### IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY

Recognize keywords.	Which patient has the <b>greatest risk</b> for <b>developing a pressure ulcer</b> ?
Ask what the question is asking.	Which patient in the various age groups is at the greatest risk for a pressure ulcer?
Critically analyze each option in relation to the question and to the other options.	Analysis questions often ask you to set priorities as indicated by the words <i>greatest risk</i> in the stem of this question. To answer this question you need to know what major risk factors contribute to the development of a pressure ulcer, identify the risk factors for pressure ulcer development in all four of the specific categories of the life span represented in the options, and assign a level of risk to each of the individuals identified in the options in comparison with each of the other individuals. Once you complete this intellectual analysis, you will identify the individual at greatest risk.
	<p><b>Rationales:</b></p> <ol style="list-style-type: none"> <li>1. Although the skin of older adults is vulnerable to the development of pressure ulcers because of decreased subcutaneous fat, reduced thickness and vascularity of the dermis, and decreased sebaceous gland activity, older adults are still capable of changing position and moving around in bed, which relieves pressure on integumentary tissue.</li> </ol>

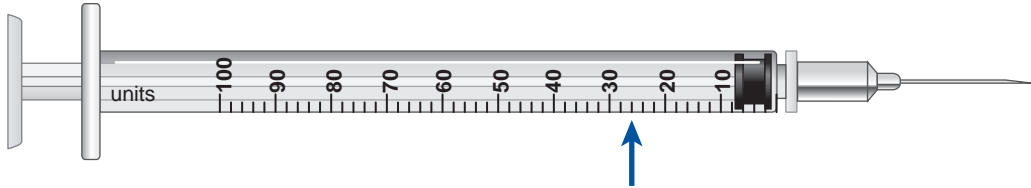
	<p>2. A toddler learning to walk is not immobile. In addition, the skin of toddlers usually has adequate circulation, subcutaneous tissue, and hydration and is supple. A toddler may fall and develop bruises (contusions) or scrapes (abrasions), not pressure ulcers.</p> <p>3. <b>Of the options offered, a thin young woman in a coma is the most vulnerable for developing a pressure ulcer. A thin person has little protective subcutaneous fat over bony prominences, and a person in a coma is immobile and unable to move or turn purposefully. Immobility results in prolonged pressure, which interferes with the oxygen supply to body cells.</b></p> <p>4. Middle-aged men usually do not exhibit the effects of aging on the integumentary system. In addition, emotionally unstable people are able to move and change positions, which permit circulation to the cells of the skin.</p>
Eliminate incorrect options.	Individuals presented in options 1, 2, and 4 are at less of a risk for the development of pressure ulcers than a thin person who is immobile.

4. A patient has a prescription for 20 units of NPH insulin and 6 units of regular insulin to be administered subcutaneously at 0800. Insert an arrow at the line on the barrel of the syringe to where the total insulin solution will fill the syringe.



F.A. DAVIS COMPANY

**IMPLEMENT THE RACE MODEL: A CRITICAL-THINKING STRATEGY**

Recognize keywords.	A patient has a prescription for <b>20 units</b> of NPH insulin and <b>6 units</b> of regular insulin to be administered subcutaneously at 0800. <b>Insert an arrow</b> at the line on the <b>barrel of the syringe</b> where the <b>total insulin solution will fill the syringe</b> .
Ask what the question is asking.	What is the total amount of units of insulin to be administered and where is this amount of solution on an insulin syringe?
Critically analyze each option in relation to the question and to the other options.	<p>There are no options to consider in a Hot Spot item. The words in the stem that indicate that this is a hot spot question are <i>Insert an arrow</i>. To answer this question you must add the two doses of insulin (20 units + 6 units = 26 units) and then identify where the resulting single dose will be on an insulin syringe.</p> <p><b>Rationales: The prescription is for 20 units of NPH insulin and 6 units of regular insulin. These medications can be combined into one syringe. The total dose is 26 units (20 units of NPH insulin and 6 units of regular insulin). Each line on this insulin syringe represents 2 units of insulin. Therefore, the answer should indicate that the total solution of insulin will reach line 26 on the insulin syringe.</b></p> 
Eliminate incorrect options.	There are no incorrect options presented.

## SUMMARY

Thinking about thinking is more strenuous than physical labor. A physical task is always easier if you use the right tool. This concept also is true for mental labor. A critical-thinking strategy, such as the RACE model, provides a methodical, analytical approach to answering questions in nursing. As with any strategy, it takes practice and experience to perfect its use. Therefore, you are encouraged to use this critical-thinking strategy when practicing test taking or reviewing examinations.



# Nursing Within the Context of Contemporary Health Care

## Theory-Based Nursing Care

### KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Actualization  
Adaptive capacity  
Beliefs  
Critical time  
Defense mechanism  
Developmental task  
Erikson, Erik—Personality Development  
Freud, Sigmund—Psychoanalytic Theory  
Gordon, Marjorie—Functional Health Patterns  
Health  
Health belief  
Health-illness continuum  
Homeostasis  
Human behavior  
Jung, Carl—Personality Theory  
Kübler-Ross, Elisabeth—Stages of Grieving  
Libido  
Maslow, Abraham—Hierarchy of Basic Human Needs  
Model  
Moral development  
Multiplicity of stressors  
Philosophy of nursing  
Piaget, Jean—Theory of Cognitive Development  
Stress  
Stressor (primary, secondary)  
Theory  
Values  
Wellness

### THEORY-BASED NURSING CARE: QUESTIONS

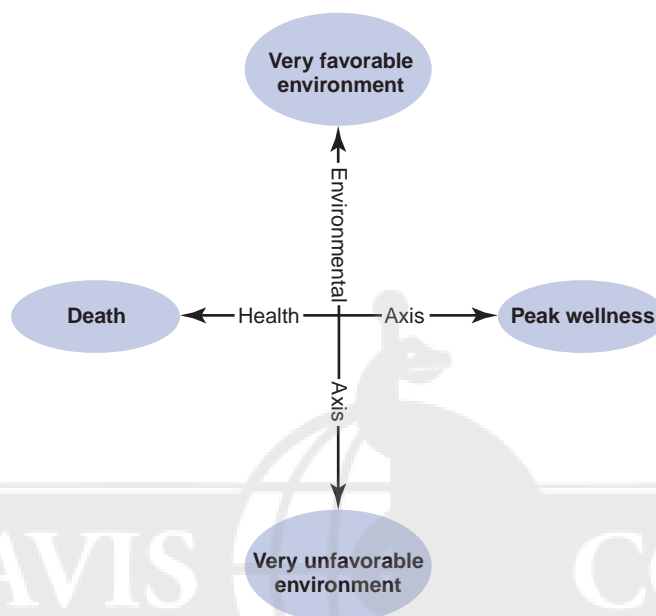
1. A nurse is considering the Faith Development Theory by James Fowler while assessing several patients. Which patients does the nurse expect to assume responsibility for their own beliefs about faith?
  1. Older adolescents
  2. Young adolescents
  3. Older school-age children
  4. Young school-age children
2. A nurse is caring for a group of patients. A patient experiencing which of the following situations does the nurse anticipate will have the hardest time coping?
  1. Scheduled for a biopsy
  2. Unable to control the course of illness
  3. Challenged by a multiplicity of stressors
  4. Having to relocate to an assisted-living facility

3. A nurse inadvertently commits a medication error without the knowledge of other nursing team members. According to Freud, which part of the personality guides the nurse to initiate an Incident Report?
  1. Id
  2. Ego
  3. Libido
  4. Superego
4. Which statement does the nurse understand is related to adaptations associated with the General Adaptation Syndrome?
  1. Adaptations depend on the nature of the stressor.
  2. Adaptations can be conscious or unconscious.
  3. Adaptations become secondary stressors.
  4. Adaptations are maladaptive responses.
5. A patient with terminal cancer is willing to try new therapies. Which stage of Kbler-Ross Stages of Grieving does the nurse identify that the patient is experiencing?
  1. Denial
  2. Depression
  3. Bargaining
  4. Acceptance
6. A nurse gives a resident in a nursing home a choice about which color shirt to wear. Which level need, according to Maslow's Hierarchy of Needs, has the nurse just met?
  1. Self-esteem
  2. Physiological
  3. Safety and Security
  4. Love and Belonging
7. A nurse is assessing a child in relation to the stages of Jean Piaget's Theory of Cognitive Development. Which behavior indicates that the child has reached the Formal Operations stage of cognitive development according to Piaget?
  1. Employs logical thought to organize collected information
  2. Utilizes deductive reasoning to examine alternatives
  3. Explores objects by placing them in the mouth
  4. Uses language to communicate with others
8. Which statement **best** reflects a principle common to all theories of health, wellness, and illness?
  1. Health is synonymous with a sense of well-being.
  2. People are able to control factors that affect health.
  3. Many variables influence a person's perception of health.
  4. Being able to meet the demands of one's role is necessary for health.
9. According to Maslow, which characteristic is **least** associated with a person who is self-actualized?
  1. Is autonomous
  2. Is able to see the good in others
  3. Has the ability to problem-solve
  4. Has an external locus of control
10. Which concept identified by the nurse is basic to the health-illness continuum model?
  1. People can be both healthy and ill at the same time on the continuum.
  2. Actualization must be achieved to be on the healthy end of the continuum.
  3. When variables are balanced people are in the exact center of the continuum.
  4. There is no distinct boundary between health and illness along the continuum.

11. A prospective nurse is being interviewed for a job by the nurse manager in an urgent care center. The nurse manager states that the facility adheres to a clinical model of health/illness. Which should the nurse anticipate will be expected of the nurses within this facility?
  1. Consider patients as holistic human beings.
  2. Make assessment of patients in the physiological domain.
  3. Identify the relationship between patients' beliefs and actions.
  4. Recognize if patients are able to perform their role within the family.
12. Which person is considered healthy when referring to the Role-Performance Model of Health?
  1. Coal miner who retires after acquiring black lung disease
  2. Coach who continues to coach after becoming a paraplegic
  3. Brick layer who takes a leave of absence while recovering from hernia surgery
  4. Police officer who sells alarm systems after leaving the force because of being shot while on duty
13. Freedom from which situation demonstrates a safety and security need in Maslow's Hierarchy of Human Needs?
  1. Pain
  2. Hunger
  3. Ridicule
  4. Loneliness
14. A nurse is caring for patients who have experienced a variety of stressful life events. Which event has the greatest potential to contribute to stress-related illness?
  1. Retirement
  2. Pregnancy
  3. Adoption
  4. Divorce
15. A nurse is facilitating a support group for people who are coping with the death of a significant other. Which patient behavior reflects complicated grieving?
  1. Remarrying within 6 months after the death of a wife
  2. Being continuously angry 3 months after the death of a parent
  3. Keeping a child's room unchanged for 4 years after the death of the child
  4. Displaying clinical symptoms of depression 9 months after the death of a husband
16. A nurse identifies that love and belonging needs associated with Maslow's Hierarchy of Needs are related to which of Gordon's Functional Health Patterns?
  1. Values-belief pattern
  2. Role-relationship pattern
  3. Cognitive-perceptual pattern
  4. Sexuality-reproductive pattern
17. Which statement identifies a basic principle associated with Sigmund Freud and his work?
  1. The reality principle reflects man's need for immediate gratification.
  2. Defense mechanisms are a common means of conscious coping.
  3. The id controls the personality.
  4. No behavior is accidental.
18. Which concept about health do nurses need to appreciate?
  1. Perceptions of health vary among cultures.
  2. To be considered healthy a person needs to be productive.
  3. There must be an absence of illness for a person to be considered healthy.
  4. Underlying consensus exists among theorists about the definition of health.

19. A nurse is caring for an immobilized patient who was admitted to the hospital with a pressure ulcer. Which type of stressor precipitated the pressure ulcer?
1. Microbiological
  2. Physiological
  3. Chemical
  4. Physical
20. The Health Belief Model attempts to explain and predict health behaviors and focuses on which of the following?
1. One's ability to fulfill one's assigned roles
  2. Constructs associated with perceived threat and net benefit
  3. Locus of control being important in one making choices about health behaviors
  4. People moving along a continuum from health on one end to illness on the other end
21. A nurse is assessing a patient who is experiencing prolonged stress. For which **most** serious complication should the nurse monitor the patient?
1. Altered sleeping
  2. Impaired immunity
  3. Increased muscle tension
  4. Decreased intestinal peristalsis
22. A nurse is analyzing information about a patient. Which of the following does Maslow's Hierarchy of Needs theory help the nurse to identify?
1. Patient's problem that has top priority
  2. Developmental level of the patient
  3. Coping patterns of the patient
  4. Patient's health beliefs
23. A nurse is teaching a course about death and dying to a community group. Which is **most** important for the nurse to teach parents about preparing a child for the death of a grandparent?
1. Wait until the child asks a question about the situation.
  2. Encourage the child to participate in mourning rituals.
  3. Begin at the child's level of understanding.
  4. Praise the child for being strong.
24. A nurse is assessing a patient who experienced an emotional stress. Which **most** common response should the nurse anticipate the patient will exhibit?
1. Anger
  2. Denial
  3. Anxiety
  4. Depression
25. A nurse is assessing patients in the postanesthesia care unit. For which physiological responses to stress should the nurse monitor this patient? **Select all that apply.**
1.  Dilated pupils
  2.  Slow, bounding pulse
  3.  Delayed response time
  4.  Inability to concentrate
  5.  Rapid, shallow breathing
  6.  Increased muscle tension
26. Which nursing interventions support a problem in the Role-Relationship Pattern category of Gordon's Functional Health Patterns? **Select all that apply.**
1.  Seeking the assistance of a spiritual advisor
  2.  Teaching the patient self-care in preparation for going home
  3.  Referring a patient to a self-help group to learn colostomy care
  4.  Assessing a family member's readiness to provide care in the home
  5.  Protecting a patient from family members who disagree with the patient's medical choices

27. A nurse is differentiating between primary and secondary stressors. Which stressors are examples of secondary stressors? **Select all that apply.**
1.  Pain
  2.  Cold weather
  3.  Death of a spouse
  4.  Shortness of breath
  5.  Ingested microorganisms
  6.  Increased blood pressure
28. Of the patients presented, which patient's level of wellness does the nurse determine best represents the placement of the X on Dunn's Health Grid?



1. A healthy, active older adult who has an apartment in an independent living facility that provides daily meals, weekly housekeeping, and services such as activities, medical and dental care on site, and banking available 2 days a week
  2. A person with a diagnosis of diabetes with a stable blood glucose who receives weekly visits from a public health nurse and has a home health aide who visits three mornings a week
  3. A person with a diagnosis of stage II-A lung cancer who lives in a men's shelter and who consistently misses clinic appointments
  4. A relatively healthy homeless person with a diagnosis of pneumonia and who is responding to medication
29. Which are examples of a health belief? **Select all that apply.**
1.  Eating foods that are low in fat
  2.  Accepting grim results of diagnostic tests
  3.  Concluding that illness is the result of being bad
  4.  Recognizing that smoking can cause lung cancer
  5.  Respecting a patient's decision regarding therapeutic treatment
30. Which are examples of a response to a physiological stressor? **Select all that apply.**
1.  Sunburn after being outside all day
  2.  Diarrhea after eating contaminated food
  3.  Shortness of breath when walking up a hill
  4.  Rapid heart rate during a final examination
  5.  Fluid volume excess as a result of renal disease



31. The Kubler-Ross Stages of Grieving theory reflects a process that progresses through several stages to final acceptance. List these patient statements in order according to the Kubler-Ross Stages of Grieving.
1. "I am going to get a second opinion."
  2. "I find it so hard to think about the fact that I don't have long to live."
  3. "I've never smoked in my life. I shouldn't be the one with lung cancer."
  4. "I'll have the chemotherapy because I want to see my children grow up."
  5. "I don't want a big funeral because I want people to remember me and be happy."
- Answer: \_\_\_\_\_
32. A nurse is caring for a patient recently diagnosed with advanced cancer. Which patient statements reflect the Kubler-Ross stage of denial in the grief process? **Select all that apply.**
1.  "Why did this have to happen to me now?"
  2.  "How could this happen when I quit smoking cigarettes?"
  3.  "Maybe they mixed up my records with someone else's records."
  4.  "I probably will not live long enough to see my children married."
  5.  "I don't want to talk about the fact that they tell me I have advanced cancer."
33. Which words describe the concept of adaptive capacity? **Select all that apply.**
1.  Adjust
  2.  Modify
  3.  Change
  4.  Etiology
  5.  Remission
  6.  Compliance
34. A nurse educator is conducting a class about child development for nurses. The nurse reviews the Stages of Moral Development Theory by Lawrence Kohlberg. Place the following patient statements about what motivates them to behave that reflects the reasoning typical of progression through Kohlberg's stages of moral development.
1. "I was following the rules."
  2. "I did not want to get punished."
  3. "I expected to receive a reward."
  4. "I thought it was the right thing to do."
  5. "I wanted others to see me as a good person."
  6. "I was doing what is acceptable in our community."
- Answer: \_\_\_\_\_
35. A nurse is caring for a newly admitted patient. The nurse collects data and reviews the patient's clinical record. Which level need is the priority for this patient according to Maslow's Hierarchy of Needs?
1. Physiologic
  2. Self-esteem
  3. Safety and security
  4. Love and belonging

**PATIENT'S CLINICAL RECORD****Vital Signs**

Temperature: 99.8°F, temporal

Pulse: 110 beats per minute

Respirations: 24 breaths per minute

**Pain Assessment**

Reports a pain level of 9 on a scale of 0 to 10

“Sharp, piercing pain”

Located in lower left abdomen

Pain started 3 days ago and became progressively worse

**Social History**

Sixty-five-year-old female

Smokes 1 pack of cigarettes daily for 45 years

Drinks alcohol socially on weekends

Husband of 45 years died of colon cancer 1 year ago

States that she “misses him a lot”

Daughter wants her to move in with her but patient states she wants to remain independent because she is able to take care of herself

Participates in a sewing group at her church making pillowcases for hospitalized children

F.A. DAVIS

COMPANY

## THEORY-BASED NURSING CARE: ANSWERS AND RATIONALES

- 1. Older adolescents and young adults assume responsibility for their own commitments, beliefs, and attitudes about faith. This reflects the individuative-reflective stage of faith development.**
  - Young adolescents begin to examine life-guiding beliefs, values, and attitudes about faith. This reflects the synthetic-conventional stage of faith development.
  - Older school-age children may accept the concept of God and appreciate the perceptions of others. This reflects the mythic-literal stage of faith development.
  - Children between 3 and 7 years of age imitate parental behaviors without thorough understanding. This reflects the intuitive-projective stage of faith development.
1. Although waiting for the results of a biopsy is stressful, it is not as stressful as one of the other options offered.
  2. Although being unable to control the course of illness is stressful, it is not as stressful as one of the other options offered.

**3. As the multiplicity of stressors increases, it becomes harder for a person to cope. As each stress is added, the accumulated impact is greater than just the sum of each individual stressor.**

  4. Relocation is stressful whether it is voluntary or involuntary. However, it is not as stressful as one of the other options offered.
1. The id will not guide a nurse to initiate an incident report because the id is the source of instinctive and unconscious urges, not the center of the conscience.
  2. The ego seeks compromise between the id and superego and represents the psychological aspect of the personality, not the center of the conscience.
  3. Libido refers to the psychic energy derived from basic biological urges, not the center of the conscience.
  - 4. The superego monitors the ego. The superego is concerned with social standards, ethics, self-criticism, moral standards, and conscience. If the nurse initiates an Incident Report, it is the superego that directs the achievement of ego-ideal behavior. If the nurse does not initiate an Incident Report, it is the superego that criticizes, punishes, and causes a sense of guilt.**
1. The General and Local Adaptation Syndromes involve automatic nonspecific responses that are not dependent on specific stressors. The body automatically responds in the same way physiologically regardless of the nature of the stressor.
  - 2. Reactions to stress are both conscious and unconscious. In the General and Local Adaptation Syndromes, automatic physiological responses are not under conscious control. Adaptations, such as behavioral responses, are often under conscious control.**
  3. Although an adaptation may become a secondary stressor, many do not.
  4. Adaptations can be maladaptive and fail to help a person achieve or maintain balance or they can be positive and help a person achieve or maintain balance.
1. A patient in the denial stage of grieving refuses to believe that the event is happening and is unable to deal with practical problems such as trying new therapies.
  2. A patient in the depression stage of grieving usually will acknowledge the reality and inevitability of the impending loss, will grieve the loss of present relationships and future experiences, and may stop all but palliative therapy.
  - 3. A patient in the bargaining stage of grieving seeks to avoid the loss and will try new therapies to gain more time.**
  4. A patient in the acceptance stage of grieving comes to terms with the loss. The patient begins to detach from surroundings and supportive people and generally no longer has the emotional or physical energy to try new therapies.
1. **Choosing which color shirt to wear provides a person with the opportunity to make a choice and supports feelings of independence, competence, and self-respect, which all contribute to a positive self-esteem.**

2. Providing choices does not meet needs on the physiological level of Maslow's Hierarchy of Needs. Physiological needs are related to having adequate air, food, water, rest, shelter, and the ability to eliminate and regulate body temperature.
  3. Providing choices does not meet needs on the safety and security level of Maslow's Hierarchy of Needs. Safety and security needs are related to being and feeling protected in the physiological and interpersonal realms.
  4. Providing choices does not meet needs on the love and belonging level of Maslow's Hierarchy of Needs. Love and belonging needs are related to giving and receiving affection, attempting to avoid loneliness and isolation, and wanting to feel as though one belongs.
- 7.**
1. Employing logical thought to organize information reflects the Concrete Operations stage of cognitive development. These individuals use logical thought to organize information and solve concrete problems. Also, they are less egocentric than when in previous stages.
  - 2. Using deductive reasoning to examine alternatives reflects the Formal Operations stage of cognitive development. These individuals use symbols related to abstract concepts and are capable of hypothetical and deductive reasoning.**
  3. Exploring objects by placing them in the mouth reflects the Sensorimotor stage of cognitive development. These individuals process information on the physical or emotional level primarily through the senses.
  4. Using language to communicate with others reflects the Preoperational stage of cognitive development. These individuals demonstrate an increasing ability to connect cognitively through language and actions.
- 8.**
1. Not all models of health agree with this view of health. For example, the Clinical Model has a narrow interpretation that views health as the absence of signs and symptoms of disease or injury. Well-being is a subjective perception of energy and vigor. A person able to carry out daily tasks, interact successfully with others, manage stress and emotions, and strive for continued growth and who has meaning or purpose in life has a sense of well-being, regardless of the severity of disease or infirmity.
  2. Not all definitions of health identify that a person is able to control factors that affect health. The Adaptive Model is one of the few that addresses a person's ability to use purposeful adaptive responses and processes in response to internal and external stimuli to achieve health.
  - 3. There is little consensus about any one definition of health, wellness, and illness. However, all definitions of health, wellness, and illness address the fact that there are a number of factors that influence health.**
  4. Not all definitions of health define health in terms of an individual's ability to fulfill societal roles. For example, the Clinical Model views people from the perspective of a physiological system with related functions with health being the absence of disease or injury.
- 9.**
1. Self-actualized people are autonomous, independent, self-directed, and governed from within.
  2. Self-actualized people are friendly and loving. They respect themselves and others and seek out the good in others.
  3. Self-actualized people are accurate in predicting future events, highly creative, and open to new ideas and have superior perception. All these qualities contribute to problem-solving abilities.
  - 4. An external locus of control least describes self-actualized people. People with an external locus of control respond to a reward or recognition that comes from outside the self. People who are self-actualized strive to develop their maximum potential based on motivation from within.**
- 10.**
1. Where people place themselves on the health-illness continuum is a self-perception of their status in relation to health and illness. From their perspectives they cannot be healthy and ill at the same time.
  2. Only the Eudaemonistic Model of Health incorporates the concept of actualization or realization of a person's potential as the major component of a definition of health.

3. Variables, such as genetic makeup, race, gender, age, lifestyle, risk factors, culture, environment, standard of living, support system, spiritual beliefs, and emotional factors, may be in balance and individuals may view themselves at the extremes of the continuum or they may be out of balance and view themselves in the center of the continuum.
  4. **Health and illness are on opposite ends of the health-illness continuum and there is no distinct boundary between health and illness. Only a person can place herself or himself somewhere along the health-illness continuum based on his or her own perceptions about what constitutes health and illness.**
11. 1. Holistic health care involves viewing all dimensions of the person including emotional, mental, spiritual, and physical. This is a broad approach when compared with the clinical model.
  2. **The clinical model, also known as the medical model, is concerned with the presence or absence of signs and symptoms of illness, disease, or injury. It is a narrow interpretation of health/illness because the focus is on the identification and treatment of a defect or dysfunction. Urgent care centers are concerned with meeting acute health-care needs.**
  3. Identifying the relationship between patients' beliefs and actions is a component of the Health Belief Model of Health Behavior. It is unrelated to the clinical model of health/illness.
  4. Performing societal roles (e.g., parent, spouse, friend, and employee) is related to the Role Performance Model of Health. It is a narrow interpretation of health and is unrelated to the clinical model of health/illness.
12. 1. If a person retires because of illness, the person has not met society's expectation in terms of role performance and, therefore, is considered unhealthy in light of the Role-Performance Model of Health.
  2. **According to the Role-Performance Model of Health, as long as a person can perform work associated with societal roles, even if a person is limited physically, the person is considered healthy. A coach who continues coaching even though ill or disabled is considered healthy in light of the Role-Performance Model of Health.**
3. According to the Role-Performance Model of Health, a person who cannot fulfill responsibilities associated with one's job is considered sick. Therefore, a person who takes a leave of absence from work to recover is someone who is considered unhealthy in this model.
  4. A strict interpretation of the Role-Performance Model of Health will most likely describe a police officer who changes jobs because of a physical or emotional inability to continue the first job as unhealthy. Even though the former police officer is still a wage earner, it is not in the same job.
13. 1. **According to Maslow's Hierarchy of Needs, freedom from pain is considered a safety and security need. Confusion sometimes occurs because other theorists, such as R. A. Kalish, believe that pain should be categorized along with adequate air, food, water, rest/sleep, shelter, elimination, and temperature regulation as a first-level physiological need.**
  2. According to Maslow's Hierarchy of Needs, freedom from hunger is considered a first-level physiological need, not a safety and security need.
  3. According to Maslow's Hierarchy of Needs, freedom from ridicule is associated with self-esteem needs, not safety and security needs.
  4. According to Maslow's Hierarchy of Needs, freedom from loneliness is associated with the need to feel loved and to belong, not to feel safe and secure.
14. 1. According to the Social Readjustment Rating Scale by Holmes and Rahe, retirement is ranked 10th on the list of life events likely to cause stress-related illness with a life-change unit score of 45 of 100. Retirement is considered less stressful than one of the other options offered.
  2. According to the Social Readjustment Rating Scale by Holmes and Rahe, pregnancy is ranked 12th on the list of life events likely to cause stress-related illness with a life-change unit score of 40 of 100. Pregnancy is considered less stressful than two other options offered.

3. According to the Social Readjustment Rating Scale by Holmes and Rahe, the gaining of a new family member is ranked 14th on the list of life events likely to cause stress-related illness with a life-change unit score of 39 of 100. All of the other options are considered more stressful than gaining a new family member.
  4. **According to the Social Readjustment Rating Scale by Holmes and Rahe, divorce is ranked second on the list of life events likely to cause stress-related illness with a life-change unit score of 73 of 100. Only death of a spouse, ranked first on the scale with a score of 100, is considered more stressful than divorce.**
15. 1. Moving on with one's life is a sign of successful grieving. Mourning periods may be abbreviated if the loss is replaced immediately by another equally respected person or if the person experienced anticipatory grieving, which is grieving experienced before the death.
  2. Being continuously angry 3 months after the death of a parent is within the realm of expected grieving behavior and is not complicated grieving. If a person is continuously angry after 1 year, it is considered complicated grieving.
  3. **Keeping a deceased child's room unchanged for years is outside the usual limits of grieving. Often a person can get stuck in a stage of grieving and is unable to progress to the next stage. Keeping a room unchanged for years reflects an inability to face the reality of the loss or to deal with the feelings associated with the loss.**
  4. Depression of this length is not uncommon, particularly if the relationship was meaningful or intense or no one was able to fill the role of the deceased. If depression does not resolve within a year after the death, it is considered complicated grieving.
16. 1. Love and belonging needs identified in Maslow's Hierarchy of Needs are not associated with Gordon's Value-Belief Pattern category. Gordon's Value-Belief Pattern category addresses topics such as spiritual distress and well-being, not love and belonging needs.
  2. **Love and belonging needs identified in Maslow's Hierarchy of Needs are associated with Gordon's Role-Relationship Pattern category. Gordon's Role-Relationship Pattern category addresses topics such as social issues, loneliness, and relationships among family members and others.**
3. Love and belonging needs identified in Maslow's Hierarchy of Needs are not associated with Gordon's Cognitive-Perceptual Pattern category. Gordon's Cognitive-Perceptual Pattern category addresses topics such as comfort, confusion, conflict, knowledge deficit, disturbed thought processes, and sensory perception, not love and belonging needs.
  4. Love and belonging needs identified in Maslow's Hierarchy of Needs are not associated with Gordon's Sexuality-Reproduction Pattern category. Gordon's Sexuality-Reproduction Pattern category addresses topics such as altered sexuality patterns and dysfunction, not love and belonging needs.
17. 1. The reality principle according to Freud is a learned ego function whereby a person is able to delay the need for pleasure rather than seek immediate gratification.
  2. Defense mechanisms are unconscious, not conscious, coping patterns that deny, distort, or reduce awareness of a stressful event in an attempt to protect the personality from anxiety.
  3. The ego, not the id, controls the personality. The ego mediates the urges of the id and the conscience of the superego and is therefore the part of the psyche that controls the personality.
  4. **Freud believed that all behavior has meaning and called this theory psychic determinism. He believed that every psychic event is determined by prior events. Behavior, mental phenomena, and even dreams are not accidental but rather an expression of thoughts, feelings, or needs that have a relationship to the rest of a person's life.**
18. 1. **Every individual is influenced by family, ethnic, and cultural beliefs and values. These beliefs and values influence a person's lifestyle through how one perceives, experiences, and copes with health, illness, and disability. The nurse must assess the impact of these influences on the patient's health and health practices.**

2. Only in the Role-Performance Model of Health is productivity or performance of one's role a necessary component to be considered healthy. While important to understand, it is a narrow definition of health and fails to include the multitude of other factors that impact on a definition of health.
  3. Absence of disease or injury is the foundation of the Clinical Model of Health and fails to include the multitude of other factors that impact on a definition of health.
  4. Health cannot be easily measured or defined in common terms. There is no consensus on a definition of health, because health is unique to each individual and is based on personal expectations and values.
- 19.**
1. Pressure is not a microbiological stressor. Microbiological stressors precipitate infection.
  2. Pressure is not a physiological stressor. Physiological stressors are disturbances in structure or function of any tissue, organ, system, or body part.
  3. Pressure is not a chemical stressor. Chemical stressors are drugs, poisons, and toxins.
  4. **The force of pressure is a physical stressor. Pressure is the continuous force of a body part on a surface as a result of gravity; compression of tissue occurs between a bony prominence and the surface on which the body part is resting. This force is external to the body. The pressure ulcer, which is the response, becomes a secondary stressor that is then physiological in nature.**
- 20.**
1. Fulfilling one's roles is the focus of the Role-Performance Model of Health and Wellness. This model states that health is defined in terms of a person's ability to fulfill societal roles; if roles are met, people perceive themselves as healthy even if they have an illness.
  2. **The Health Belief Model focuses on perceived threats, severity, benefits, barriers, cues to action, and self-efficacy, which all influence a person's "readiness to act" in response to a health threat; Rosenstock first proposed this model during the 1950s.**
  3. Locus of control is the focus of the Health Locus of Control Model. If the nurse knows that a patient is motivated by either internal or external forces, then the nurse can plan internal or external reinforcement training to motivate a patient toward better health.
  4. This is the focus of the health-illness continuum Model of Health and Wellness. This model focuses on health being on one end of the continuum and illness being on the other end. People move back and forth along the continuum based on their own perceptions with no distinct boundary between health and illness.
- 21.**
1. Difficulty sleeping is a common response to stress, but it is not life-threatening. Although it can contribute to fatigue, it is not as serious a concern as one of the other options offered.
  2. **Impaired immunity is a serious threat caused by prolonged periods of stress. Stressors elevate blood cortisone levels, which decrease anti-inflammatory responses, deplete energy stores, lead to a state of exhaustion, and decrease resistance to disease.**
  3. Increased muscle tension is a physiological indicator of stress. However, it is not as serious a concern as one of the other options offered.
  4. When stressed, the patient's parasympathetic nervous system precipitates a decrease in intestinal peristalsis. Constipation is a concern, but it is not as serious as one of the other options offered.
- 22.**
1. **Patient problems/needs can be ranked in order of ascending importance according to how essential they are for survival using Maslow's Hierarchy of Needs as a framework. Maslow identifies five levels of human needs. A person must meet lower-level needs before addressing higher-level needs. Physiological needs are first-level needs: air, food, water, sleep, shelter, etc.; safety and security needs are second; love and belonging needs are third; self-esteem needs are fourth; and self-actualization is the fifth-level need.**
  2. Erikson's Developmental Theory is designed to identify a patient's developmental level, not Maslow's Hierarchy of Needs.
  3. Maslow's Hierarchy of Needs is not designed to identify a person's coping patterns in response to illness.

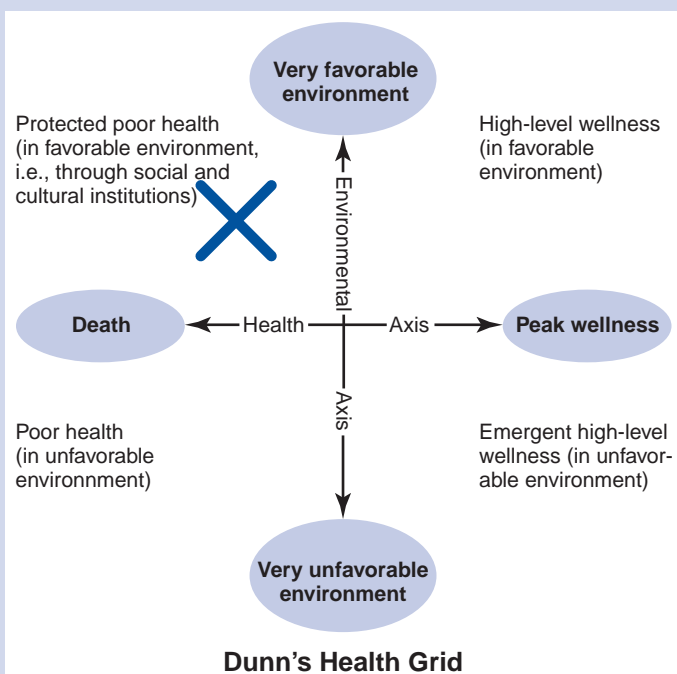
4. Rosenstock's and Becker's Health Belief Models, not Maslow's Hierarchy of Needs, identify the relationship between health beliefs and the use of preventive actions to promote health.
- 23.** 1. Waiting until the child asks a question is not an effective way to deal with childhood grieving. Children are perceptive and capable of recognizing that something is wrong but may not know what questions to ask. Avoiding discussing the loss with the child, may make the child feel afraid, lonely, or even abandoned.
2. The child's age, level of understanding, feelings, and fears will determine how much the child should engage in mourning rituals. Children should not be forced to attend mourning rituals, nor should they be pushed aside in an attempt to protect them from pain, because this can lead to feelings of abandonment, fear, or loneliness.
- 3. Beginning at the child's level of understanding is essential when preparing a child for the death of a grandparent. Because there is such a difference regarding how children of different ages view the concept of death, it is important first to assess the child's level of understanding.**
4. No one should be told how to feel or behave when it comes to reacting to loss. Expression of diverse feelings is essential if a child is to cope with the loss of the grandparent or develop positive coping strategies to deal with loss later as an adult.
- 24.** 1. Although anger may be identified as a reaction to stress, it is not the most common response to stress. Anger is more classically seen in the Kubler-Ross second stage of dying/grieving.
2. Denial is more commonly seen in the Kubler-Ross first stage of dying/grieving, not as the most common response to stress.
- 3. Anxiety is the most common response to all new experiences that serve as an emotional threat.**
4. Depression is an extreme response to prolonged stress and is not the most common human response to stress.
- 25.** 1. **Dilated pupils increase visual perception in reaction to a perceived threat.**
2. Whereas a bounding pulse is a physiological response to stress, a rapid pulse, not a slow pulse, is a physiological response to the body's neurohormonal reaction to stress. During the alarm phase of the General Adaptation Syndrome, the autonomic nervous system initiates the fight-or-flight response and releases large amounts of epinephrine and cortisone into the body that contribute to a rapid pulse.
3. The response time is shorter, not longer, when a person is exposed to a stressor as a result of an increase in alertness and energy associated with the alarm phase of the General Adaptation syndrome. In addition, level of alertness is considered a psychosocial, not physiological, response to stress.
4. Concentration is considered a psychosocial, not physiological, response to stress. Concentration and level of alertness are enhanced, not reduced, during the fight-or-flight response of the autonomic nervous system when large amounts of epinephrine and cortisone are released into the body.
- 5. Rapid, shallow breathing is a physiological response associated with the fight-or-flight response of the autonomic nervous system when large amounts of cortisone and epinephrine are released into the body as a person perceives a threat.**
- 6. Increased muscle tension prepares the body for fight or flight.**
- 26.** 1. This action supports the achievement of a goal in the Value-Belief category, not the Role-Relationship category.
2. This action supports achievement of a goal in the Cognitive-Perceptual category, not the Role-Relationship category.
3. This action supports the achievement of a goal in the Health Perception/Health Management category, not the Role-Relationship category.
- 4. This action supports achievement of a goal in the Role-Relationship category.**
- 5. This action supports achievement of a goal in the Role-Relationship category. Patients have a right to make medical decisions for themselves.**
- 27.** 1. Pain initially is a response to some previous primary stressor, threat, or



**stimuli. However, when pain stimulates additional responses in an effort to manage the pain, the pain becomes a secondary stressor.**

2. Cold weather is a primary physical stressor, not a response to some previous stressor.
3. Death of a spouse is a primary psychosocial stressor, not a response to some previous stressor.
4. **Shortness of breath is a response to a primary stressor such as cancer of the lung or a respiratory tract infection. Shortness of breath then becomes a secondary stressor precipitating further adaptations in the individual.**
5. Ingested microorganisms are a primary microbiological stressor, not a response to some previous stressor.
6. **Increased blood pressure is a secondary stressor. It is in response to a primary stressor such as a systemic infection or fear of the unknown.**

28. 1. This person is healthy, active, and lives in a favorable, supportive environment. This person reflects high-level wellness and should be plotted on the upper right side of Dunn's Health Grid.
2. **This person is in poor health but receives routine care from health team members. This person reflects protected poor health and should be plotted on the upper left side of Dunn's Health Grid.**



3. This person has a chronic health problem, is not receiving consistent health care, and lives in a men's shelter. This person reflects poor health and lives in an unfavorable environment and should be plotted on the lower left side of Dunn's Health Grid.
4. This person is relatively healthy and is recovering from pneumonia but is homeless, which is an environment that is unfavorable. This person reflects emergent high-level wellness and should be plotted on the lower right side of Dunn's Health Grid.

29. 1. Eating foods low in fat is a health practice, not a health belief. A health behavior, such as eating a low-fat diet, reflects the belief that preventive measures will minimize risk factors that contribute to disease/illness.
2. Accepting grim results of diagnostic tests reflects a behavior in response to bad news, rather than a behavior reflecting a health belief.
3. **This is an example of a health belief. A health belief is a conviction or opinion that influences health-care practices or decisions. If a person believes that illness is the result of being bad, the person may feel the need to suffer in silence as a form of penance.**
4. **This is an example of a health belief. If a person believes that smoking cigarettes can cause lung cancer, then the person may refrain from smoking.**
5. Respecting a patient's decision is not an example of a health belief. It reflects the nurse's acceptance of a patient as a unique individual and recognizes the patient's right to make personal choices about health care.

30. 1. A sunburn is a response to the ultraviolet rays of the sun, which is a physical, not a physiological, stressor. Once the person has a sunburn, the sunburn is a physiological stressor.
2. Diarrhea after eating contaminated food is a response to a microbiological, not a physiological, stressor.
3. **Shortness of breath is a response to the physiological stress of walking up a hill. The body is reacting via physiological mechanisms to take in more oxygen to meet the oxygen demand of cells when walking.**

4. The threat of a final examination is a psychological, not a physiological, stressor. The rapid heart rate during a final examination is a physiological response to a psychological stressor.
  5. **Fluid volume excess is a response to the physiological stress of kidney impairment. Because of impaired kidney function the body is unable to secrete urine and fluid, volume excess occurs.**
31. 1. **This statement reflects “doctor shopping,” which is a form of denial, the first stage of the Kübler-Ross Stages of Grieving theory. The patient is experiencing shock and disbelief.**
3. **This statement reflects the anger stage, the second stage of the Kübler-Ross Stages of Grieving theory. The patient is aware of the reality of the situation and is resentful and angry.**
  4. **This statement characterizes the bargaining stage, the third stage of the Kübler-Ross Stages of Grieving theory. The patient is negotiating for more time.**
  2. **This statement reflects depression, the fourth stage of the Kübler-Ross Stages of Grieving theory. The patient is grieving over what is happening and what will never be.**
  5. **This statement characterizes acceptance, the fifth stage of the Kübler-Ross Stages of Grieving theory. The patient has accepted the inevitable and is looking toward the future.**
32. 1. This statement characterizes the anger, not denial, stage in the grieving process. During the anger stage the person may vent hostile feelings or displace these feelings on others through acting out behaviors.
2. This statement characterizes the anger, not denial, stage of the grieving process. During the anger stage the person may question, “Why me when I did everything right?”
  3. **This statement characterizes the denial stage of the grieving process. When in denial a patient may identify reasons why the diagnosis is not possible.**
  4. This statement characterizes the depression stage of the grieving process. During the depression stage the patient realizes the full impact of the situation and grieves future losses.
5. **This statement characterizes the denial stage of the grieving process. The patient is using the defense mechanism of suppression. During denial the person is not ready to address or believe that the loss is happening.**
33. 1. Adaptive capacity refers to the quality and quantity of resources one can draw on to regain balance after one is threatened. This process requires an individual to adjust consciously or unconsciously in the physical, emotional, mental, or spiritual dimension in an effort to achieve balance or homeostasis.
2. Adaptive capacity refers to the quality and quantity of resources one can draw on to regain balance after one is threatened. This process requires an individual to modify consciously or unconsciously in the physical, emotional, mental, or spiritual dimension in an effort to achieve balance or homeostasis.
  3. Adaptive capacity refers to the quality and quantity of resources one can draw on to regain balance after one is threatened. This process requires an individual to change consciously or unconsciously in the physical, emotional, mental, or spiritual dimension in an effort to achieve balance or homeostasis.
  4. Etiology refers to the stressor or threat to homeostasis that stimulates a person to draw on personal resources within the physical, emotional, mental, or spiritual dimension.
  5. Remission refers to the abatement or lessened intensity of the symptoms of a disease or illness, not adaptive capacity.
  6. Compliance refers to adherence to an established therapeutic action plan, not adaptive capacity.
34. 2. **The first stage of moral development is Obedience and Punishment. The motivation for behavior is fear of negative consequences (e.g., punishment, disapproval).**
3. **The second stage of moral development is Individualism and Exchange. The motivation for behavior is the desire for a positive consequence (e.g., reward, good result).**

5. The third stage of moral development is **Interpersonal Relationships**. The motivation for behavior is based on pleasing others because it is what others expect.
  1. The fourth stage of moral development is **Maintaining Social Order**. The motivation for behavior is based on following the rules to uphold the law.
  6. The fifth stage of moral development is **Social Contract and Individual Rights**. The motivation for behavior is based on differing beliefs and values but adheres to standards agreed upon by society.
  4. The sixth stage of moral development is **Universal Principles**. Motivation for behavior is based on abstract reasoning, universal ethical principles, and principles of justice.
35. 1. A need in the *physiologic* level is not the priority. Although the pulse and respiratory rates are slightly higher than the expected (normal), ranges they are most likely a response to the pain experienced by the patient.
  2. There are no data to support the conclusion that a need in the *self-esteem* level exists. The patient reports that she wants to remain independent and is able to care for herself.
  3. **Pain is a *safety and security* level need based on Maslow's Hierarchy of Needs. Pain relief is the patient's priority need.**
  4. A need in the *love and belonging* level is not the priority. The patient's daughter appears to be concerned about the patient's well-being. However the patient disagrees with moving in with her daughter.

F.A. DAVIS

COMPANY

# Legal and Ethical Issues

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Accountability	Incident Report
Accreditation	Informed consent
Act of commission/omission	Invasion of privacy
Advanced directives:	Liability
Do Not Resuscitate	Libel
Health-care proxy	Licensure
Power of attorney	Litigation
American Nurses Association Standards of Nursing Practice	Malpractice
Assault	National Council Licensing Examinations (NCLEX)
Battery	National League for Nursing Accrediting Commission
Beneficence	Negligence
Breach of duty	Nonmaleficence
Certification	Nurse Practice Act
Civil law	Occupational Safety and Health Acts (OSHA)
Code of Ethics	Patient Care Partnership (formerly called Patient's Bill of Rights)
Common law	Plaintiff
Confidentiality	Professional liability insurance
Contract	Quality of life
Controlled substances	Reciprocity
Crime	<i>Res ipsa loquitur</i>
Criterion, Criteria	<i>Respondeat superior</i>
Defamation	Risk management
Defendant	Sigma Theta Tau International, Honor Society of Nursing
Defense	Slander
Ethics	Standards of care
Euthanasia	State Board of Nursing
False imprisonment	The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations)
Fraud	Tort
Functions of the nurse:	Veracity
Dependent	
Independent	
Interdependent	
Good Samaritan law	
Health-Care Quality Improvement Act	

## LEGAL AND ETHICAL ISSUES: QUESTIONS

1. When a nurse is administering a medication to a confused patient, the patient says, "This pill looks different from the one I had before." Which should the nurse do?
  1. Ask what the other pill looked like.
  2. Explain the purpose of the medication.
  3. Check the original medication prescription.
  4. Encourage the patient to take the medication.
2. A nurse administers an incorrect dose of a medication to a patient. Which is the primary purpose of documenting this event in an Incident Report?
  1. Record the event for future litigation.
  2. Provide a basis for designing new policies.
  3. Prevent similar situations from happening again.
  4. Ensure accountability for the cause of the accident.
3. When preparing to administer a medication the nurse identifies that the dose is larger than the standard dose recommended by the manufacturer. Which should the nurse do?
  1. Inform the supervisor.
  2. Give the drug as prescribed.
  3. Give the average dose of the medication.
  4. Discuss the prescription with the primary health-care provider.
4. When a nurse attempts to administer a medication to a patient, the patient refuses to take the medication because it causes diarrhea. The nurse provides teaching about the medication, but the patient continues adamantly to refuse the medication. Which should the nurse do **first**?
  1. Document the patient's refusal to take the medication.
  2. Discuss with a family member the need for the patient to take the medication.
  3. Explain again to the patient the consequences of refusing to take the medication.
  4. Notify the primary health-care provider of the patient's refusal to take the medication.
5. When caring for a terminally ill patient a family member says, "I need your help to hasten my mother's death so that she is no longer suffering." Which should the nurse do, based on the position of the American Nurses Association in relation to assisted suicide?
  1. Not participate in active euthanasia
  2. Participate based on personal values and beliefs
  3. Participate when the patient is experiencing severe pain
  4. Not participate unless two primary health-care providers are consulted and the patient has had counseling
6. Which organization is responsible for ensuring that Registered Nurses are minimally qualified to practice nursing?
  1. State Boards of Nursing
  2. American Nurses Association
  3. Sigma Theta Tau International
  4. Constituent Leagues of the National League for Nursing
7. For which primary reason is a nurse expert called to testify in a lawsuit regarding professional nursing malpractice?
  1. Strengthen the defense
  2. Support the prosecution
  3. Present standards of nursing care as they apply to the facts in the case
  4. Make judgments associated with laws governing the practice of nursing

8. A nurse initiates a visit from a member of the clergy for a patient. How is the nurse functioning when initiating this visit?
  1. Interdependently
  2. Independently
  3. Dependently
  4. Collegially
9. A patient is asked to participate in a medical research study. Which document should the nurse explain to the patient because it protects the patient's rights?
  1. Code of Ethics
  2. Informed Consent
  3. Nurse Practice Act
  4. Constitution of the United States
10. Which element of ethical practice is associated with fair policies and procedures guiding allocation of organs for transplantation?
  1. Justice
  2. Fidelity
  3. Veracity
  4. Nonmaleficence
11. A primary health-care provider orders out of bed to a chair as the activity level for a patient. How is the nurse functioning when moving this patient out of bed to a chair?
  1. Interdependently
  2. Collaboratively
  3. Independently
  4. Dependently
12. A Registered Nurse witnesses an accident and assists the victim who has a life-threatening injury. Which should the nurse do to meet an important standard of care when acting as a Good Samaritan at the scene of an accident?
  1. Seek consent from the injured party before rendering assistance.
  2. Implement every critical-care intervention necessary to sustain life.
  3. Stay at the scene until another qualified person takes over responsibility.
  4. Insist on helping because a nurse is the best-qualified person to provide care.
13. A faculty member of a nursing program is conducting an informational session for potential nursing students. Which information about licensure to practice nursing upon completion of a nursing program should the faculty member include in the session?
  1. "It is a responsibility of the American Nurses Association."
  2. "It is granted on graduation from a nursing program."
  3. "It is approved by the National League for Nursing."
  4. "It is required by law in each individual state."
14. When considering legal issues the word *contract* is to *liable* as *standard* is to which word?
  1. Rights
  2. Negligence
  3. Malpractice
  4. Accountability
15. An anxious patient repeatedly uses the call bell to get the nurse to come to the room. Finally the nurse says to the patient, "If you keep ringing, there will come a time I won't answer your bell." Which legal term is related to this statement?
  1. Slander
  2. Battery
  3. Assault
  4. Libel

16. A nurse is informed that a credentialing team has arrived and is in the process of assessing the quality of care delivered at the hospital. Employees who are reviewers of which one of the following organizations are associated with the credentialing of hospitals?
  1. The Joint Commission
  2. National League for Nursing
  3. American Nurses Association
  4. National Council Licensure Examination
17. A nurse changes a patient's dry sterile dressing. How is the nurse functioning when performing this task?
  1. Interdependently
  2. Collaboratively
  3. Independently
  4. Dependently
18. A nurse must administer a medication. Which should the nurse do **first**?
  1. Verify the prescription for accuracy.
  2. Check the patient's identification armband.
  3. Ensure the medication is in the medication cart.
  4. Determine the appropriateness of the prescribed medication.
19. When choosing a nursing school in the United States that awards an associate degree, a future student nurse should consider schools that have met the standards of nursing education established by which organization?
  1. National League for Nursing Accrediting Commission
  2. North American Nursing Diagnosis Association
  3. Sigma Theta Tau International
  4. American Nurses Association
20. A patient's diet order is "clear liquids to regular as tolerated." How is the nurse functioning when progressing the patient's diet to full liquid?
  1. Dependently
  2. Independently
  3. Collaboratively
  4. Interdependently
21. Who is primarily protected by the licensure of Registered Professional Nurses?
  1. Nurses
  2. Patients
  3. Common law
  4. Health-care agencies
22. Which factor is unique to malpractice when comparing negligence and malpractice?
  1. The action did not meet standards of care.
  2. The inappropriate care is an act of commission.
  3. There is harm to the patient as a result of the care.
  4. There is a contractual relationship between the nurse and patient.
23. A nurse completes an Incident Report after a patient falls while getting out of bed unassisted. Which is the purpose of this report?
  1. Ensure that all parties have an opportunity to document what happened.
  2. Help establish who is responsible for the incident.
  3. Make data available for quality-control analysis.
  4. Document the incident on the patient's chart.
24. How is the nurse functioning when administering a drug that has prn as part of the prescription?
  1. Collegially
  2. Dependently
  3. Independently
  4. Interdependently

25. Which is the main role of the American Nurses Association?
1. Establish standards of nursing practice.
  2. Recognize academic achievement in nursing.
  3. Monitor educational institutions granting degrees in nursing.
  4. Prepare nurses to become members of the nursing profession.
26. A nurse says, "If you do not let me do this dressing change, I will not let you eat dinner with the other residents in the dining room." Which legal term is related to this statement?
1. Battery
  2. Assault
  3. Negligence
  4. Malpractice
27. For which are state legislatures responsible?
1. Standardized care plans
  2. Enactment of Nurse Practice Acts
  3. Accreditation of educational nursing programs
  4. Certification in specialty areas of nursing practice
28. Nursing practice is influenced by the doctrine of *respondeat superior*. Which is the basic concept related to this theory of liability?
1. Nurses must respond to the Supreme Court when they commit acts of malpractice.
  2. Health-care facilities are responsible for the negligent actions of the nurses whom they employ.
  3. Nurses are responsible for their actions when they have contractual relationships with patients.
  4. The laws absolve nurses from being sued for negligence if they provide inappropriate care at the scene of an accident.
29. When attempting to administer a 10 p.m. sleeping medication, the nurse assesses that the patient appears to be asleep. Which should the nurse do?
1. Withhold the drug
  2. Notify the primary health-care provider
  3. Awaken the patient to administer the drug
  4. Administer it later if the patient awakens during the night
30. Which is the primary purpose of the American Nurses Association (ANA) Standards of Clinical Nursing Practice?
1. Establish criteria for quality practice.
  2. Define the philosophy of nursing practice.
  3. Identify the legal definition of nursing practice.
  4. Determine educational standards for nursing practice.
31. Which of the following patients requires a co-signature for a valid consent for surgery?
1. 15-year-old mother whose infant requires exploratory surgery
  2. 40-year-old resident in a home for developmentally disabled adults
  3. 90-year-old adult who wants more information about the risks of surgery
  4. 50-year-old unconscious trauma victim who needs insertion of a chest tube
32. A patient living in Oregon has been receiving hospice care in the home. One day the patient tells the nurse, "Dying takes forever. I hate it that I am a burden to my family. I can't stand this anymore. Can you help me end my life?" The nurse's personal ethical values do not include complying with this patient's request. Which is the nurse's **best** response?
1. "I will inform your primary health-care provider of your desire to die."
  2. "Your family members probably do not consider you a burden."
  3. "I can't help you because I do not believe in assisted suicide."
  4. "Let's talk a little more about your wanting to die."



33. A nurse working in a hospital administers a medication to the wrong patient and is sued by the patient. Under contract law which liability occurs when the hospital is additionally identified as a defendant in the legal action? **Select all that apply.**
1.  Vicarious liability
  2.  Borrowed servant
  3.  Captain of the ship
  4.  Respondeat superior
  5.  Quasi-intentional tort
34. A student nurse about to graduate is actively developing a personal ethical foundation for nursing practice. Place the following actions in the order in which they should progress.
1. Clarify personal values and beliefs.
  2. Identify ethical issues when working.
  3. Identify a personal ethical foundation.
  4. Work continuously to improve ethical decision-making abilities.
  5. Integrate one's personal ethical foundation within the ethics of the profession.
- Answer: \_\_\_\_\_
35. A patient sustained a serious injury as a result of malpractice by a nurse. Several legal elements must be met to prove the nurse committed malpractice in a civil suit. Which statements are associated with the element of causation? **Select all that apply.**
1.  A nurse-patient relationship existed between the nurse and the patient.
  2.  A nurse's omission or commission of an act failed to meet standards of care.
  3.  A nurse's action or inaction was the immediate reason for the plaintiff's injury.
  4.  A nurse should have known that the action or inaction could result in harm or injury to the patient.
  5.  A nurse's action or inaction that did not meet a standard of care resulted in a patient experiencing pain, suffering, and disability.
36. A patient is scheduled to have surgery, and informed consent is to be obtained. Place the following steps in the order in which they should be performed.
1. The patient is willing to sign the consent voluntarily.
  2. The patient signs the consent in the presence of the nurse.
  3. The nurse determines that the patient is alert and competent to give consent.
  4. The primary health-care provider informs the patient of the risks and benefits of the procedure.
- Answer: \_\_\_\_\_
37. Identify the actions that are examples of slander. **Select all that apply.**
1.  Volunteer telling another volunteer a patient's age
  2.  Nurse explaining to a patient that another nurse is incompetent
  3.  Personal care assistant sharing information about a patient with another patient
  4.  Unit manager documenting a nurse's medication error in a performance appraisal
  5.  Housekeeper who is angry at a nurse falsely telling another staff member that the nurse uses cocaine

38. An older adult male is admitted to the hospital after sustaining a brain attack (cerebrovascular accident, stroke). Intravenous fluids, resuscitative medications, and mechanical ventilation are instituted in the emergency department. Eventually, testing indicates absence of brain functions. A nurse interviews the patient's son and daughter and reviews the patient's advanced directives. Legally, which is the **most** likely outcome in this scenario?
1. The son will request that life-sustaining interventions be stopped.
  2. The daughter will legally be able prevent the withdrawal of medical interventions.
  3. The nurse should refer this situation to the agency's ethics committee for consideration.
  4. The primary health-care provider should concur with another health-care provider to arrive at a course of action.

#### Interview With Patient's Daughter

Patient's daughter stated "I love my dad and I don't want him to die." Daughter indicated that she has been the person caring for her father when he is ill and stated that she will do everything she can to keep her dad alive.

#### Interview With Patient's Son

Patient's son stated "I love my dad too but if there is no hope for recovery why are we doing all these things? What is the point?" Son indicated that he knows that he and his sister disagree on what should be done.

#### Patient's Advance Directives

The patient's Health Care Proxy identifies the son as his representative.

39. A student nurse is about to graduate from an accredited nursing program. Which does the student nurse understand are actions **unrelated** to a state Nurse Practice Act? **Select all that apply.**
1.  Setting guidelines for nurses' salaries in the state
  2.  Establishing reciprocity for licensure between states
  3.  Determining minimum requirements to be licensed as a nurse
  4.  Maintaining a list of nurses who can legally practice in the state
  5.  Providing legal counsel for a nurse who is being sued for malpractice
40. A primary health-care provider asks a nurse to witness informed consents by several patients. Which patients identified by the nurse are **unable** to give an informed consent for surgery? **Select all that apply.**
1.  16-year-old boy who is married
  2.  50-year-old woman who is confused
  3.  35-year-old woman who is depressed
  4.  50-year-old woman who does not speak English
  5.  65-year-old man who has received a narcotic for pain

## LEGAL AND ETHICAL ISSUES: ANSWERS AND RATIONALES

1. This action by itself is unsafe because the patient is confused and the information obtained may be inaccurate.
  2. This intervention ignores the patient's concern. Although this ultimately may be done, it is not the priority action.
  - 3. This is the safest intervention because it goes to the original source of the prescription.**
  4. This action ignores the patient's statement and is unsafe without first obtaining additional information.
1. Although documentation of an incident may be used in a court of law, it is not the primary reason for an Incident Report.
  2. Providing a basis for designing new policies is not the primary reason for Incident Reports. New policies may or may not have to be written and implemented.
  - 3. Risk-management committees use statistical data about accidents and incidents to identify patterns of risk and prevent future accidents and incidents.**
  4. Although nurses are always accountable for their actions, accountability for the cause of an incidence is the role of the courts.
1. It is unnecessary to call the supervisor in this situation.
  2. Giving the drug as prescribed may be unsafe for the patient and may result in malpractice.
  3. Changing a medication prescription is not within the scope of nursing practice.
  - 4. Nurses have a professional responsibility to know or investigate the standard dose for medications being administered. In addition, nurses are responsible for their own actions regardless of whether there is a written prescription. The nurse has a responsibility to question and/or refuse to administer a prescription that appears unreasonable.**
1. **Withholding the medication and documenting the patient's refusal are the appropriate interventions. Patients have a right to refuse care.**
  2. Discussing the situation with a family member without the patient's consent is a violation of confidentiality.
  3. The patient has been taught about the medication and adamantly refuses the medication. Further teaching at this time may be viewed by the patient as badgering.
  4. Notifying the primary health-care provider eventually should be done, but it is not the priority at this time.
- 1. Nursing actions must comply with the law, and the law states that euthanasia is legally wrong. Euthanasia can lead to criminal charges of homicide or civil lawsuits for providing an unacceptable standard of care.**
  2. A nurse's beliefs, values, or moral convictions should not be imposed on patients.
  3. Compassion and good intentions are not an acceptable basis for actions beyond the scope of nursing practice.
  4. Nurses as well as other health-care providers cannot legally be involved with euthanasia. In some states in the United States a primary health-care provider can prescribe a medication that can be taken by a patient to cause death. The American Nurses Association, according to its Code for Nurses with Interpretive Statement, indicates that nurses should not participate in active euthanasia or assistive suicide.
- 1. The National Council of State Boards of Nursing is responsible for the NCLEX examinations; however, the licensing authority in the jurisdiction in which the graduate takes the examination verifies the acceptable score on the examination.**
  2. The American Nurses Association (ANA) is the national professional organization for nursing in the United States. It fosters high standards of nursing practice; it does not grant licensure.
  3. Sigma Theta Tau International, Honor Society of Nursing, recognizes academic achievement and leadership qualities, encourages high professional standards, fosters creative endeavors, and supports excellence in the profession of nursing. This organization does not grant licensure.

4. The National League for Nursing (NLN) is committed to promoting and improving nursing service and nursing education; it does not grant licensure.
7.
    1. A nurse expert can testify for either the defense or the prosecution.
    2. A nurse expert can testify for either the prosecution or the defense.
    3. **The American Nurses Association Standards of Clinical Nursing Practice are authoritative statements by which the national organization for nursing describes the responsibilities for which nurses are accountable. An expert nurse is capable of explaining these standards as they apply to the situation under litigation. These professional standards are criteria that help a judge or jury determine if a nurse committed malpractice or negligence.**
    4. An expert nurse is not an expert in the law. The expert nurse's role is not to make judgments about the laws as they apply to the practice of nursing.
  8.
    1. A nurse does not need a primary health-care provider's order to make a referral to a member of the clergy. An interdependent intervention requires a primary health-care provider's order associated with a parameter.
    2. **When a nurse initiates a referral to a member of the clergy the nurse is working independently. Nurses are legally permitted to diagnose and treat human responses to actual or potential health problems.**
    3. A nurse can make a referral to a member of the clergy. This action is within the scope of nursing practice.
    4. The nurse can make a referral to a member of the clergy without collaborating with another professional health-care team member.
  9.
    1. A code of ethics is the official statement of a group's ideals and values. It includes broad statements that provide a basis for professional actions.
    2. **Informed consent is an agreement by a person to accept a course of treatment or a procedure after receiving complete information necessary to make a knowledgeable decision.**
    3. Nurse Practice Acts define the scope of nursing practice; they are unrelated to participation in research studies.
  4. The Constitution of the United States addresses broad individual rights and responsibilities. The rights related to nursing practice and patients include the rights of privacy, freedom of speech, and due process.
10.
    1. **Justice refers to fairness and that all patients should be treated equally, impartially, and without prejudice regardless of individual factors.**
    2. The scenario in the stem does not reflect fidelity. *Fidelity* refers to making only promises or commitments that can be kept.
    3. The scenario in the stem does not reflect veracity. *Veracity* refers to being truthful, which is essential to a trusting nurse-patient relationship.
    4. The scenario in the stem does not reflect nonmaleficence. *Nonmaleficence* refers to preventing harm, avoiding actions that can cause harm, or removing a patient from harm.
  11.
    1. The nurse is following the primary health-care provider's order to get the patient out of bed. There are no restrictions or parameters in relation to the order. However, the nurse must use judgment before, during, and after a transfer if a patient's condition changes.
    2. A nurse does not work collaboratively when moving this patient out of bed.
    3. The responsibility to determine a patient's activity level is not within the legal scope of nursing practice.
    4. **Determining the extent of activity desirable for a patient is within the primary health-care provider's, not a nurse's, scope of practice. Following activity orders is a dependent function of the nurse.**
  12.
    1. Depending on the injured person's physical and emotional status, the person may or may not be able to consent to care.
    2. When a nurse helps in an emergency, the nurse is required to render care that is consistent with care that any reasonably prudent nurse would provide under similar circumstances. The nurse should not attempt interventions that are beyond the scope of nursing practice.
    3. **When a nurse renders emergency care, the nurse has an ethical responsibility not to abandon the injured person. The nurse should not leave the scene until the injured person leaves or**

**another qualified person assumes responsibility.**

4. A nurse should offer assistance, not insist on assisting, at the scene of an emergency.
- 13.**
1. The American Nurses Association (ANA) Standards of Clinical Nursing Practice do not address licensure.
  2. When a person graduates from a school of nursing, the individual receives a diploma that indicates completion of a course of study; the diploma is not a license to practice nursing.
  3. The National League for Nursing (NLN) promotes nursing service and nursing education; it is not involved with licensure.
- 4. The Nurse Practice Act in a state stipulates the requirements for licensure within the state.**
- 14.**
1. Although patients have a right to receive care that meets appropriate standards, the word *right* does not have the same relationship to the word *standard* as the relationship between the words *contract* and *liable*.
  2. The words *standard* and *negligence* do not have the same relationship as the words *contract* and *liable*. Negligence involves an act of commission or omission that a reasonably prudent person would not do.
  3. The words *standard* and *malpractice* do not have the same relationship as the words *contract* and *liable*. Malpractice is negligence by a professional person.
- 4. Liable means a person is accountable for fulfilling a contract that is enforceable by law. Accountable means a person is responsible (liable) for meeting standards, which are expectations established for making judgments or comparisons.**
- 15.**
1. This is not an example of slander, which is a false spoken statement resulting in damage to a person's character or reputation.
  2. This is not an example of battery, which is the unlawful touching of a person's body without consent.
  3. **This is an example of assault. Assault is a verbal attack or unlawful threat causing a fear of harm. No actual contact is necessary for a threat to be an assault.**
  4. This is not an example of libel, which is a false printed statement resulting in damage to a person's character or reputation.

**16. 1. The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) evaluates health-care organizations' compliance with The Joint Commission standards. Accreditation indicates that the organization has the capabilities to provide quality care. In addition, federal and state regulatory agencies and insurance companies require Joint Commission accreditation.**

2. The National League for Nursing (NLN) fosters the development and improvement of nursing education and nursing service.
3. The American Nurses Association (ANA) is the national professional organization for nursing in the United States. Its purposes are to promote high standards of nursing practice and to support the educational and professional advancement of nurses.
4. In the United States, graduates of educational programs that prepare students to become Licensed Practical Nurses or Registered Professional Nurses must successfully complete the National Council Licensure Examination-PN (NCLEX-PN) and the National Council Licensure Examination-RN (NCLEX-RN), respectively, as part of the criteria for licensure.

**17. 1.** The changing of a dry sterile dressing is an interdependent action by the nurse when the primary health-care provider's order for wound care states: Dry Sterile Dressing prn.

2. In this situation, the nurse is not working with other health-care professionals to implement a primary health-care provider's order.
3. This intervention is not within the scope of nursing practice without a primary health-care provider's order.

**4. A nurse is not permitted legally to prescribe wound care. The nurse needs an order from a primary health-care provider to implement wound care.**

**18. 1. The administration of medications is a dependent function of the nurse. The primary health-care provider's prescription should be verified for accuracy. The prescription must include the name of the patient, the name of the drug, the size of the dose, the route of administration, the number**

- of times per day to be administered, and any related parameters.**
2. Although this action is essential for the safe administration of a medication to a patient, it is not the first step of this procedure.
  3. Although this may be done as a time-management practice, it is not the first step when preparing to administer a medication to a patient.
  4. A nurse is legally responsible for the safe administration of medications; therefore, the nurse should assess if a medication prescription is reasonable. However, this is not the first step when preparing to administer a medication to a patient.
- 19. 1. The National League for Nursing Accrediting Commission (NLNAC) is an organization that appraises and grants accreditation status to nursing programs that meet predetermined structure, process, and outcome criteria.**
2. The North American Nursing Diagnosis Association (NANDA) developed a constantly evolving taxonomy of nursing diagnoses to provide a standardized language that focuses on patients and related nursing care.
  3. Sigma Theta Tau International, Honor Society of Nursing, recognizes academic achievement. It does not accredit schools of nursing.
  4. The American Nurses Association (ANA) is the national professional organization for nursing in the United States. It does not accredit schools of nursing.
- 20. 1. This dietary order has parameters that exceed a simple dependent function of the nurse.**
2. Prescribing a dietary order for a patient is outside the scope of nursing practice.
  3. Collaborative or collegial interventions are actions the nurse carries out in conjunction with other health-care team members.
  4. **The primary health-care provider's order implies a progression in the diet as tolerated. The nurse uses judgment to determine the time of this progression, which is an interdependent action.**
- 21. 1. Licensure does not protect the nurse. Licensure grants an individual the legal right to practice as a Registered Nurse.**
- 2. Licensure indicates that a person has met minimal standards of competency, thus protecting the public's safety.**
3. Licensure does not protect common law. Common law comprises standards and rules based on the principles established in prior judicial decisions.
  4. Licensure does not protect health-care agencies. The Joint Commission determines if agencies meet minimal standards of health-care delivery, thus protecting the public.
- 22. 1. There is a violation of standards of care with both negligence and malpractice.**
2. Negligence and malpractice both involve acts of either commission or omission.
  3. The patient must have sustained injury, damage, or harm with both negligence and malpractice.
  4. **Only malpractice is misconduct performed in professional practice, where there is a contractual relationship between the patient and nurse that results in harm to the patient.**
- 23. 1. The nurse who identified or created the potential or actual harm completes the Incident Report. The report identifies the people involved in the incident, describes the incident, and records the date, time, location, actions taken, and other relevant information.**
2. Documentation should be as factual as possible and avoid accusations. Questions of liability are the responsibility of the courts.
  3. **Incident Reports help to identify patterns of risk so that corrective action plans can take place.**
  4. An Incident Report is not part of the patient's medical record, and reference to the report should not be made in the patient's medical record.
- 24. 1. Collegial or collaborative interventions are actions the nurse performs in conjunction with other health-care team members.**
2. Dependent interventions are those activities performed under a primary health-care provider's direction and supervision.
  3. Independent interventions are those activities the nurse is licensed to initiate based on knowledge and expertise.
  4. **An interdependent intervention requires a primary health-care provider's order associated with a set**

parameter. The parameter, whenever necessary (prn), requires that the nurse use judgment in implementing the order.

- 25. 1. The American Nurses Association has established Standards of Care and Standards of Professional Performance. These standards reflect the values of the nursing profession, provide expectations for nursing practice, facilitate the evaluation of nursing practice, and define the profession's accountability to the public.**
2. Sigma Theta Tau International, Honor Society of Nursing, recognizes academic achievement.
  3. The National League for Nursing Accrediting Commission, the Commission on Collegiate Nursing Education, and state education departments monitor educational institutions granting degrees in nursing.
  4. Schools of nursing (e.g., diploma, associate degree, and baccalaureate degree) educate individuals for entry into the practice of nursing.
- 26. 1.** This statement is not an example of battery. Battery is the actual willful touching of another person that may or may not cause harm.
- 2. This statement is an unjust threat. Assault is the threat to harm another person without cause.**
3. This statement is not an example of negligence. Negligence occurs when harm or injury is caused by an act of either commission or omission.
  4. This statement is not an example of malpractice. Malpractice is negligence by a professional person as compared with the actions of another professional person in a similar circumstance when a contract exists between the patient and nurse.
- 27. 1.** Nursing team members or an interdisciplinary team of health-care providers write standardized care plans.
- 2. Every state has its own Nurse Practice Act that describes and defines the legal boundaries of nursing practice within the state.**
3. The National League for Nursing Accrediting Commission, the Commission on Collegiate Nursing Education, and state education departments are the major organizations accrediting nursing education programs in the United States.
  4. The American Nurses Association and other specialty organizations offer certification in specialty areas in nursing practice.
- 28. 1.** This is unrelated to *respondeat superior*. Negligence and malpractice, which are unintentional torts, are litigated in local courts by civil actions between individuals.
- 2. The ancient legal doctrine *respondeat superior* means "let the master answer." By virtue of the employer-employee relationship, the employer is responsible for the conduct of its employees.**
3. Individual responsibility is unrelated to *respondeat superior*. A nurse can have an independent contractual relationship with a patient. When a nurse works for an agency, the contract between the nurse and patient is implied. In both instances the nurse is responsible for the care provided.
  4. This is unrelated to *respondeat superior*. Good Samaritan laws do not provide absolute immunity.
- 29. 1.** This is a violation of the primary health-care provider's order. Drug administration is a dependent nursing function.
2. Notifying the primary health-care provider is unnecessary.
  - 3. Administering a medication is a dependent function of the nurse. The prescription should be followed as written if the prescription is reasonable and prudent. This medication was not a prn medication but rather a standing order.**
  4. The drug should be administered as prescribed not at a later time.
- 30. 1. The ANA Standards of Clinical Nursing Practice describe the nature and scope of nursing practice and the responsibilities for which nurses are accountable.**
2. A philosophy incorporates the values and beliefs about the phenomena of concern to a discipline. The ANA Standards of Clinical Nursing Practice reflect, not define, a philosophy of nursing. Each nurse and nursing organization should define its own philosophy of nursing.
  3. The laws of each state define the practice of nursing within the state.

4. Educational standards are established by accrediting bodies, such as the National League for Nursing Accrediting Commission, the Commission on Collegiate Nursing Education, and state education departments.
- 31.** 1. A mother may legally make medical decisions for her children even if the mother is younger than 18 years of age.
- 2. A person living in a protected environment such as a home for developmentally disabled adults may not have the mental capacity to make medical decisions and requires the signature of a court-appointed legal representative. This person could be a parent, sibling, relative, or unrelated individual.**
3. Older adults can make decisions for themselves as long as they understand the risks and benefits of the surgery and are not receiving medication that may interfere with cognitive ability.
4. The insertion of a chest tube to inflate a lung is an emergency intervention to facilitate respiration and oxygenation. This emergency procedure is implemented to sustain life and does not require a signed consent if the patient is incapacitated.
- 32.** 1. This statement eventually may be made, but at this time it is not the priority. By this response the nurse is functioning as a patient advocate without violating personal values against assisted suicide. In states such as Oregon, Washington, and Vermont primary health-care providers can order medications that may be used by patients to cause their own deaths; this is called assisted suicide. Certain criteria must be met depending on the state such as 18 years of age or older, a terminal illness with fewer than 6 months to live, capability of self-administering the medication, and specific psychiatric criteria (e.g., counseling, no psychiatric diagnosis, exploration of palliative options). Nurses do not have the legal or ethical right or obligation to help patients die. The American Nurses Association believes that nurses should not participate in assisted suicide or euthanasia.
2. This minimizes the patient's concerns. Also, the nurse may or may not know if this is a true statement; the family members may believe that caring for a dying family member is a burden.
3. Although this may be a true statement, it does not meet the patient's physical or emotional needs. This statement focuses on the nurse rather than the patient.
- 4. This statement is an open-ended question that encourages the patient to discuss feelings and explore future options including assisted suicide.**
- 33.** 1. Vicarious liability applies in this situation. Vicarious liability applies when accountability for a wrong is assigned to a person or entity that did not directly cause an injury, but has a contractual relationship with the person who did cause the wrong. The nurse is still liable for his or her own actions.
2. A *borrowed servant* does not apply to this situation. A *borrowed servant* applies when an employer directs a nurse to work for a second employer (e.g., agency nurse); the second employer is held accountable for the nurse's actions.
- 3. The liability of *Captain of the ship* applies in this situation. The liability of *Captain of the ship* occurs when a health-care provider is held liable for a nurse who is working under the direction of the health-care provider. The nurse is still liable for his or her own actions.**
- 4. *Respondeat superior* refers to "Let the master answer" and applies in this situation. When an agency hires a nurse, the nurse functions as a representative of the institution and must perform within its policies and procedures; the hospital is responsible for the actions of the nurse. The nurse is still liable for his or her own actions.**
5. A quasi-intentional tort is not related to this situation. A quasi-intentional tort is making false statements, verbally (slander) or in writing (libel), about another person that harm the person's reputation or hold the person up to ridicule or contempt.
- 34.** 1. A nurse must know oneself before helping others. The first step is to identify and explore personal values and beliefs.
- 3. Once values and beliefs are explored, then a basis for an ethical foundation of nursing practice can be identified for oneself.**



5. After a nurse identifies a personal ethical foundation, it should be compared to the ethics of the nursing profession (American Nurses Association Code of Ethics). This ensures that the nurse works within the standards of the nursing profession.
  2. Identifying ethical issues when working in the nursing profession facilitates nursing actions that preserve personal integrity while meeting the needs of patients without imposing personal values or beliefs onto patients or their family members.
  4. A nurse's ethical decision-making abilities should never remain static. These abilities grow as one matures within the profession and as a variety of factors (e.g., new technology, evolving social policy) influence one's ethical foundation.
- 35.**
1. This statement reflects the element of *duty*, not *causation*. The element of duty is met when a nurse has a legal obligation to provide nursing care to the patient.
  2. This statement reflects the element of *breach of duty*, not *causation*. The element of breach of duty is met when a nurse's action or inaction fails to meet standards of care established by a job description, agency policy or procedures, the state nurse practice act, and standards established by professional organizations.
  3. **Causation relates to malpractice when a patient's injury is directly the result of a nurse's action or inaction (proximate cause).**
  4. **Causation relates to malpractice when a nurse should have known that an action or inaction that is a breach of a nursing standard could result in harm or injury to a patient (foreseeability).**
  5. This statement reflects the element of *damages*, not *causation*. The element of damages is met when the plaintiff proves that physical, emotional, or financial harm or injury was the result of a standard of care not being met.
- 36.**
4. **It is the responsibility of the primary health-care provider to include all the information necessary to make a knowledgeable decision. Patients have a legal right to have adequate and accurate information to make informed decisions.**
- 3.** Patients must be competent to sign a consent form. The patient must be alert, competent, and in touch with reality. Confused, sedated, unconscious, or minor patients may not give consent. Minor patients who are married, parents, emancipated, or serving in the United States military can provide a legal consent.
1. Patients must give their consent voluntarily and without coercion.
  2. The health-care provider witnessing the signing of the consent must ensure that the signature is genuine.
- 37.**
1. This is a violation of the patient's right to confidentiality, not slander.
  2. **This is an example of slander. Slander is a false spoken statement resulting in damage to a person's character or reputation.**
  3. This is a violation of the patient's right to confidentiality, not slander.
  4. This is not slander because it is a written, not spoken, statement and it documents true, not false, information.
  5. **This is an example of slander. It is a malicious, false statement that may damage the nurse's reputation.**
- 38.**
1. **The son by law, as a result of the patient's Health Care Proxy, can make health-care decisions for his father, including withdrawing all life-sustaining interventions.**
  2. The daughter lacks legal authority to act on behalf of her father.
  3. This is unnecessary. Legally, this situation is not an ethical dilemma.
  4. This is unnecessary. There are legal documents that will dictate the future course of action.
- 39.**
1. **The salary of nurses is determined through negotiations between nurses or their representatives, such as a union or a professional nursing organization, and the representatives of the agency for which they work.**
  2. A state's Nurse Practice Act determines the criteria for reciprocity for licensure.
  3. A state's Nurse Practice Act stipulates minimum requirements required for a person to be licensed as a Registered Professional Nurse or Licensed Practical Nurse within the state.

4. A state's Nurse Practice Act defines the criteria for licensure within the state. However, actual functions, such as maintaining a list of nurses who can legally practice in the state, usually are delegated to another official body such as a State Board of Nursing or State Education Department.
  5. State Nurse Practice Acts do not provide legal counsel for a nurse who is sued for malpractice. A nurse should purchase malpractice insurance upon graduation from a nursing program or may be provided legal counsel by an employer.
40. 1. Legally, individuals younger than 18 years old can provide informed consent if they are married, pregnant, parents, members of the military, or emancipated.
2. A person who is confused is unable to understand the risks and benefits associated with making an informed decision. In this situation a person designated as a health-care proxy or legal guardian has to make decisions for the confused individual.
  3. A depressed person is capable of making health-care decisions until proven to be mentally incompetent.
  4. This person can provide informed consent after interventions ensure that the person understands the facts and risks concerning the treatment.
  5. Narcotics depress the central nervous system, including decision-making abilities. This person is considered functionally incompetent.

F.A. DAVIS

COMPANY

# Leadership and Management

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Accountable, accountability  
Case management  
Change theory  
Consensus  
Controlling  
Cooperation  
Creative  
Delegate  
Directing  
Documentation  
Efficiency  
Empower  
Feedback  
Five Rights of Delegation:  
    Right Task  
    Right Person  
    Right Communication  
    Right Time  
    Right Supervision  
Flexible  
Human resource management  
Incentives  
Job description  
Leadership  
Leadership styles—classic:  
    Autocratic—directive  
    Democratic—participative, consultative  
    Laissez-faire—nondirective, permissive  
Leadership styles—contemporary:  
    Charismatic leadership  
    Connective leadership  
Transactional leadership  
Transformational leadership  
Shared leadership  
Managers:  
    First-line managers  
    Unit managers  
    Middle managers  
    Nurse executives  
Motivation  
Network  
Organization  
Performance evaluation  
Power types:  
    Expert  
    Influence  
    Legitimate  
    Referent  
    Reward  
Preceptor  
Primary nursing  
Problem solving  
Productivity  
Resistance to change  
Resource management  
Role model  
Subordinate  
Systems theory  
Table of Organization  
Time management

## LEADERSHIP AND MANAGEMENT: QUESTIONS

1. An accurate assessment drives the rest of the steps of the nursing process. Which management function drives effective management?
  1. Planning
  2. Directing
  3. Organizing
  4. Controlling

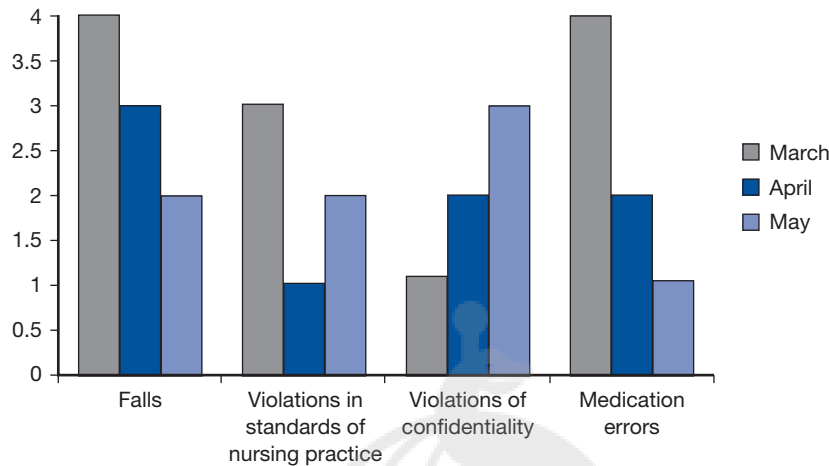
2. Which is **most** basic for a nurse to have when working in a management position?
  1. Strong interpersonal communication skills
  2. Awareness of when to be confrontational
  3. Knowledge of the role of a change agent
  4. Recognition by peers as a leader
3. A unit manager mentors a new unit manager as part of orientation to the position. Which type of power is being used by the unit manager mentor?
  1. Influence
  2. Coercive
  3. Referent
  4. Expert
4. A nurse manager considers that there are “Five Rights of Delegation.” Which is a right of delegation in addition to *right task*, *right person*, *right communication*, and *right time*?
  1. Place
  2. Route
  3. Feedback
  4. Supervision
5. Which should the manager do **first** to overcome resistance to change?
  1. Ensure that the planned change is within the current beliefs and values of the group.
  2. Provide incentives to encourage commitment of participants to the change.
  3. Implement change by employing small steps rather than large steps.
  4. Use informational power to ensure that goals of change are met.
6. When considering the autocratic leadership style, an “autocratic” leader is to an “authoritarian” leader as a “democratic” leader is to which type of leader?
  1. Directive
  2. Permissive
  3. Oppressive
  4. Consultative
7. Which nursing-care delivery model is based on case management?
  1. Patient classification system
  2. Diagnosis Related Groups
  3. Critical pathways
  4. Primary nursing
8. Which statement is **most** significant in relation to the concept of change theory in the health-care environment?
  1. Stages of change are predictable.
  2. Risks and benefits must be weighed.
  3. Change in activity results in positive outcomes.
  4. Large change is easier to adapt to than multiple smaller changes.
9. Several nurses complain to the nurse manager that one of the patient care aides constantly takes extensive lunch breaks. Which should the nurse manager do?
  1. Convene a group meeting of all the patient care aides to review their responsibilities related to time management.
  2. Talk with the patient care aide to explore the reasons for the behavior and review expectations.
  3. Arrange a meeting with the nurses so that they can confront the patient care aide as a group.
  4. Document the patient care aide’s behavior and place it in the aide’s personnel file.

10. Which should the nurse do to ensure efficiency when managing a daily assignment?
  1. Give care to a patient in isolation first.
  2. Plan activities to promote nursing convenience.
  3. Organize care around legally required activities.
  4. Perform routine bed baths between breakfast and lunch.
11. A supervisor communicates expectations about a task to be completed and then delegates the task. Which management function is being implemented by the supervisor?
  1. Planning
  2. Directing
  3. Organizing
  4. Controlling
12. A student nurse in the clinical area is given an appropriate patient assignment by the instructor. Which should the student nurse do?
  1. Complete the care indicated on the patient's plan of care.
  2. Accept the role of leader of the patient's health-care team.
  3. Assume accountability for the tasks that are assigned by the instructor.
  4. Help other students to complete their assigned tasks whenever necessary.
13. Which statement is significant in relation to the concept of change theory in the health-care environment?
  1. Barriers to change can be overcome by embracing new ideas uncritically.
  2. Change generates anxiety by moving away from the comfortable.
  3. Behaviors are easy to change when change is supported.
  4. Change is effective when spontaneous.
14. Which is the major task of a nurse manager?
  1. Accomplishing an objective
  2. Empowering others
  3. Problem solving
  4. Planning
15. A staff nurse must solve a complex problem. Which is the nurse's **most** effective resource?
  1. Organizational chart of the institution
  2. Nursing procedure manual
  3. Unit's nurse manager
  4. Nursing supervisor
16. When delegating a specific procedure to a patient care aide, the aide refuses to perform the procedure. Which should the nurse do **first**?
  1. Assign the procedure to another patient care aide.
  2. Explain that it is part of the patient care aide's job description.
  3. Explore why the patient care aide refused to perform the procedure.
  4. Send the patient care aide to the procedure manual to review the procedure.
17. Which is the **first** thing the nurse should do when planning to apply for a new position within an agency?
  1. Review the job description.
  2. Provide at least several positive references.
  3. Identify if power is associated with the position.
  4. Locate the position on the agency's Table of Organization.
18. Which is the **most** important reason why a nurse aide must fully understand how to implement a delegated procedure?
  1. Be capable of completing the procedure safely.
  2. Be proficient enough to perform the procedure quickly.
  3. Have the knowledge to explain the procedure to a patient.
  4. Have the correct information when teaching the procedure to another nurse aide.

19. A nursing team leader delegates a wound irrigation to a Licensed Practical Nurse (LPN). It has been a long time since the LPN performed this procedure. Which should the nursing team leader do to ensure patient safety?
1. Verbally describe how to perform the procedure to the LPN.
  2. Have the LPN demonstrate how to perform the procedure.
  3. Assign another LPN to assist with the procedure.
  4. Delegate the procedure to another LPN.
20. A nurse manager is informed that a large number of patients will be admitted in response to a terrorist attack. Which type of leadership style is appropriate to use in this situation?
1. Collaborative
  2. Authoritarian
  3. Laissez-faire
  4. Democratic
21. A nurse manager is experiencing staff resistance when implementing change. Which is the **most** important action by the nurse manager to overcome resistance to change?
1. Identify the reason for the resistance.
  2. Restate the purpose of the change concisely.
  3. Modify the objectives to appeal to more key people.
  4. Emphasize the positive consequences of the planned change.
22. Which is the major focus of leadership?
1. Inspiring people
  2. Initiating change
  3. Controlling others
  4. Producing a product
23. Which factor associated with a manager differentiates the role of a manager from a leader?
1. Vision
  2. Charisma
  3. Confidence
  4. Responsibility
24. Which situation is reflective of the saying “A stitch in time saves nine”?
1. Obtaining the vital signs of patients on the unit during a specified time frame
  2. Collecting equipment for a procedure before entering the room
  3. Delegating some interventions to the Licensed Practical Nurse
  4. Documenting the nursing care given every few hours
25. A Registered Nurse delegates a procedure to a Licensed Practical Nurse. Which is the purpose for delegating the procedure to the Licensed Practical Nurse?
1. Create change.
  2. Establish a network.
  3. Improve productivity.
  4. Transfer accountability.
26. A nurse manager plans to provide feedback to a subordinate who needs a change in behavior. Which is the **first** intervention by the nurse manager?
1. Be assertive.
  2. Explore alternatives.
  3. Identify the unacceptable behavior.
  4. Document the content of the counselling session.

27. Which is the main reason a nurse manager achieves a consensus when making a decision within a group?
1. Explore possible alternative solutions.
  2. Demonstrate that staff members are flexible.
  3. Facilitate cooperative effort toward goal achievement.
  4. Ensure the use of effective autocratic decision making.
28. A nurse manager evaluates the performance of a subordinate. Which management function is being implemented by the nurse manager?
1. Planning
  2. Directing
  3. Organizing
  4. Controlling
29. Which of the following is related to systems theory?
1. End result
  2. Linear format
  3. Trial and error
  4. Cyclical process
30. Which activities does a nurse manager engage in who values the importance of positive role modeling? **Select all that apply.**
1.  Counseling subordinates who fail to meet expectations
  2.  Holding team meetings to review rules of the agency
  3.  Engaging in ongoing quality improvement activities
  4.  Reviewing job descriptions with employees
  5.  Following the policies of the agency
31. Which premises are basic to the motivation climate of the Theory Y management style associated with human relations-oriented management? **Select all that apply.**
1.  Employees will exercise self-direction when committed to organizational goals.
  2.  Employees pursue security above other elements related to work.
  3.  Employees generally will accept and even request responsibility.
  4.  Employees must be pressured with discipline to achieve goals.
  5.  Employees seek direction whenever possible.
32. Lewin's planned change theory progresses through phases. Place these statements by the nurse manager in order as change moves through the process.
1. "Let's implement a pilot project next week."
  2. "This is a new venture that should be exciting."
  3. "I know it may be difficult but you are doing a great job."
- Answer: \_\_\_\_\_
33. Which actions are examples of a nurse working independently? **Select all that apply.**
1.  Giving a bed bath to a patient who is experiencing profuse diaphoresis
  2.  Limiting fluids when a patient is on a 1,000 mL fluid restriction diet
  3.  Assigning another nurse to administer medications
  4.  Irrigating a patient's wound with normal saline
  5.  Applying a warm soak on an infiltrated IV site
  6.  Obtaining a patient's vital signs

34. A nurse who is a member of a quality improvement committee reviews a chart detailing trends of 4 problem categories identified in Incident Reports over a 3-month period of time. Corrective action plans were implemented to address each problem category. After analyzing the chart documenting trends over the successive months of March, April, and May, which problem category demonstrated the most improvement?
1. Falls
  2. Medication errors
  3. Violations of confidentiality
  4. Violations in standards of practice



35. A patient is to be discharged from the hospital. Which discharge tasks can be delegated to a nursing assistant? **Select all that apply.**
1.  Teaching the patient how to measure weight using a standing scale
  2.  Obtaining the patient's temperature, pulse, and respiratory rate
  3.  Determining if the patient knows how to measure fluid intake
  4.  Demonstrating to the patient how to use a walker
  5.  Transporting the patient to an exit of the facility
36. Place the following steps of the decision-making process in the order in which they should be implemented by a nurse.
1. Identify possible solutions to the problem.
  2. Gather relevant information.
  3. Identify the problem.
  4. Evaluate the result.
  5. Test a solution.
- Answer: \_\_\_\_\_
37. A nurse and a nursing assistant (unlicensed assistive personnel) are working together on a surgical unit. Which activities should the nurse assign to the nursing assistant? **Select all that apply.**
1.  Assessing the results of blood glucose monitoring
  2.  Delivering meal trays to patients who are in isolation
  3.  Explaining to a patient how to use an incentive spirometer
  4.  Changing the linens on beds that are occupied by patients who are on bed rest
  5.  Emptying a urine collection bag that is attached to continuous bladder irrigation
  6.  Assisting the postanesthesia care unit nurse to help transition a patient to a surgical unit



38. The department of outpatient services of an agency is converting from paper charting to electronic charting. The nurse in charge of one of the clinics is responsible for implementing the change on the unit. Identify the **most** significant barrier to change based on the statements by upper-level managers, the nurse in charge, and staff nurses.
1. The upper-level managers have given an ultimatum about the change.
  2. The nurse in charge has a negative attitude toward the change.
  3. A staff nurse does not know how to use a computer.
  4. A staff nurse is anxious about the change.

#### Nurse in Charge

"Come to me if you have concerns about this change."

"I don't think that this is the way to go but it is something we have to do."

#### Staff Nurses

"I don't know how to use a computer."

"I feel uncomfortable trying something new."

"Maybe in the long run it will make our job easier."

#### Upper-level Managers

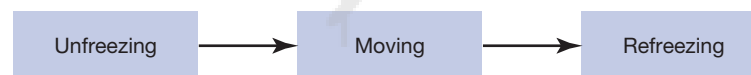
"The nursing education department will provide classes on how to use a computer."

"We must switch to electronic records because it is a requirement of our regulating agencies."

39. Which tasks should be delegated to a Registered Nurse? **Select all that apply.**

1.  Obtaining routine vital signs
2.  Providing discharge teaching
3.  Evaluating a patient's response to morphine
4.  Administering a cleansing enema to a patient
5.  Transporting a patient to the operating room for surgery

40. Based on Kurt Lewin's Change Theory, place an X on the box in which change takes place.



## LEADERSHIP AND MANAGEMENT: ANSWERS AND RATIONALES

- 1. Effective management depends on careful planning. Planning activities include deciding what is to be done, when to do it, where and how to do it, and who will do it and with what level of assistance. Planning is multifaceted and involves establishing goals, identifying interventions based on priorities, and determining how outcomes will be evaluated. What occurs during planning affects all subsequent steps of management activities.**
  - Getting the work accomplished (directing) is associated with just one step in the management process and does not drive the process of effective management.
  - Managing human and economic resources to achieve organizational goals (organizing) is associated with just one step in the management process and does not drive the process of effective management.
  - Measuring goal achievement, ensuring ongoing evaluation, and implementing corrective action when necessary (controlling) are associated with just one step in the management process and do not drive the process of effective management.
- 1. Strong communication skills are an essential competency of a nurse manager. Research demonstrates that 80% to 90% of a manager's day is spent communicating verbally and in writing. Managers must express their thoughts clearly, concisely, and accurately.**
  - Although confrontation may be used occasionally, it is not as important as a competency identified in another option.
  - Although knowledge of the role of change agent is important, it is not as important as a competency identified in another option.
  - Recognition by peers as a leader is not as important as a competency identified in another option. A person generally is promoted to a management position because upper management recognizes leadership qualities. As a nurse manager grows into the role, peers will recognize the leadership ability of the nurse manager.
- This is not an example of influence power. Influence power is the use of persuasion and communication skills to exercise power informally without using the power associated with formal authority.
  - This is not an example of coercive power. The leader bases coercive power on the fear of retribution or the punitive withholding of rewards.
  - This is not an example of referent power. Referent power is associated with respect for the leader because of the leader's charisma and prior successes.
  - This is an example of expert power. Expert power is the respect one receives based on one's ability, skills, knowledge, and experience.**
- The right place is not one of the Five Rights of Delegation.
  - The right route refers to the Five Rights of Medication Administration, not the Five Rights of Delegation.
  - Feedback is part of communication, which is one of the Five Rights of Delegation already cited in the stem of the question.
  - The one who delegates a task is responsible for ensuring that the task is performed safely and according to standards of practice.**
- Change that is consistent with current values and beliefs is easier to implement than change that is inconsistent with current values and beliefs. Values and beliefs are difficult to change.**
  - This is not the priority intervention. Although incentives might motivate some individuals, they do not motivate all because some people have an internal rather than an external locus of control.
  - Although small steps are more effective than large steps because they are easier to achieve and once achieved are motivating, this approach is not the first thing the nurse should do to overcome resistance to change.
  - Although one person sharing explanations with another (informational power) is helpful when trying to change behavior, it is not the most effective type of power to

use when trying to effect change. Another option identifies an action that the nurse should do first.

6. 1. The word *directive* refers to the autocratic, not democratic, leadership style.
  2. The word *permissive* refers to the laissez-faire, not democratic, leadership style.
  3. *Oppressive* is the way some people refer to the autocratic, not democratic, leadership style. There is little freedom and a large degree of control by the autocratic leader, which frustrates motivated, professionally mature staff members.
  4. **The word *consultative* is the word most closely related to the democratic leadership style. Democratic leaders encourage discussion and decision making within the group. The leader facilitates the work of the group by making suggestions, offering constructive criticism, and providing information.**
7. 1. Patient classification systems are not a nursing-care delivery model based on case management. Patient classification systems are designed to assign an acuity level to patients based on their needs for the purpose of determining the number of nursing care hours required to provide care.
  2. Diagnosis Related Groups (DRGs) are not a nursing-care delivery model based on case management. Diagnosis Related Groups are a prospective reimbursement plan in which patients are grouped based on medical diagnoses for the purposes of reimbursing the cost of hospitalization.
  3. Critical pathways are not just a nursing-care delivery model based on case management but are tools used in managed care that are sets of concurrent and sequential actions by nurses as well as other health-care professionals to achieve a specific outcome. They represent specific practice patterns in relation to specific medical/surgical populations.
  4. **Primary nursing is a case management approach in which one nurse is responsible for a number of patients 24 hours a day, 7 days a week. It is a way of providing comprehensive, individualized, and consistent nursing care.**
8. 1. The stages of change are not always predictable. Although effective change moves through three zones according to Lewin's Change Theory (unfreezing [comfort], moving [discomfort], and refreezing [new comfort]), what happens in each zone is not always predictable and change is not always successfully achieved. Change is dynamic and the stages are not rigid.
  2. **Risks and benefits must be carefully analyzed before initiating change. Some change is not worth the risk, because the consequences of failure are greater than the benefits.**
  3. Outcomes of change can be positive or negative. Sometimes well-planned change meets with resistance and the effort to change can result in a loss of credibility, lack of achieving the goal, and confusion.
  4. Small goals are easier to achieve than large goals. Small goals generally are designed to ensure achievement, which is motivating.
9. 1. It is the patient care aide who is late and takes extensive lunch breaks who needs to review the responsibilities related to time, not the patient care aides who follow the rules.
  2. **Recognition of a problem is the first step in the problem-solving process. Once the unacceptable behavior is identified and acknowledged, then the reasons for the problem can be explored, solutions suggested, and expectations reinforced.**
  3. It is not the responsibility of others to confront the employee who is late for work and takes extensive lunch breaks. The employee reports to the nurse manager who is superior in the chain of command of the organization. The nurse manager should meet with the employee. In addition, counseling sessions with employees should be confidential and conducted in private.
  4. This is premature. The nurse manager first should implement an action identified in another option.
10. 1. This may not be possible depending on the needs of patients.
  2. Patient needs are the priority, not the convenience of the nurse.
  3. **Legally required activities must be accomplished because they are dependent functions that support the**

medical regimen of care. Although legally required activities should be accomplished first, many independent actions by the nurse also must be implemented to maintain a basic standard of care and patient safety. Some nursing interventions, which are not essential, can be implemented after the required activities.

4. This may not be possible depending on the needs of patients.
- 11.**
1. This scenario is not an example of the planning function of management. Planning involves establishing goals, designing interventions based on the priority identified, and determining how outcomes will be evaluated.
  2. **This scenario is an example of the directing function of management. Directing involves getting the work accomplished; it includes activities such as assigning and communicating tasks and expectations and guiding, teaching, and motivating staff members in meeting organizational goals.**
  3. This scenario is not an example of the organizing function of management. Organizing activities include obtaining and managing human and economic resources and includes identifying the chain of command, determining responsibilities, and ensuring that policies and procedures clearly describe standards of care and expected outcomes.
  4. This scenario is not an example of the controlling function of management. Controlling activities use outcome criteria to measure the performance of staff members, identify effectiveness in goal achievement, ensure ongoing evaluation, and implement corrective action when necessary.
- 12.**
1. Although students are expected to complete all planned care, the patient's condition can change or some unforeseen event may interfere with the plan. The student must keep the instructor or preceptor informed about the patient's condition and use the instructor or preceptor as a resource person when the unexpected occurs or guidance is needed.
  2. Students are assigned to care for patients for a specific time period and generally are included as members, not leaders, of the nursing team.
  3. **Students are accountable for the tasks assigned by the instructor or preceptor. As part of accountability, students are obligated to keep the instructor or preceptor informed about the status of the patient, how the assignment is progressing, and whether all interventions are implemented as planned.**
  4. Students should not help other students unless specifically assigned to do so by the instructor or preceptor. An exception occurs when assistance is needed to ensure patient safety in an emergency.
- 13.**
1. All barriers to change may not be overcome, for example, financial limitations. Before initiating change, barriers should be anticipated and addressed. All aspects of the new idea are best accomplished when critically analyzed.
  2. **Change causes one to move from the comfortable to the uncomfortable and is known as unfreezing in Lewin's Change Model. It involves moving away from that which is known to the unknown, from the routine to the new, and from the expected to the unexpected. The unknown, new, and unexpected can be threatening, which can increase anxiety.**
  3. Behaviors are not easy to change even when supported. Most people do not like to function in an unfamiliar environment. In addition, change challenges one's comfort zone in each level of Maslow's Hierarchy of Needs.
  4. Planned, not spontaneous, change is most effective because it is organized, systematic, and purposeful.
- 14.**
1. **Although planning, problem solving, and empowering others are tasks of a manager, the bottom line is for the manager to accomplish the work of the organization.**
  2. Although empowering others is one of the tasks of a manager, the major task is identified in another option.
  3. Although problem solving is one of the tasks of a manager, the major task is identified in another option.
  4. Although planning is one of the tasks of a manager, the major task is identified in another option.

15. 1. The organizational chart schematically plots the reporting relationship of every position within the organization. It does not help a staff nurse identify a solution to a complex problem.
  2. The nursing procedure manual is not designed to help a staff nurse identify a solution to a complex problem. The nursing procedure manual contains details of policies relative to nursing practice and nursing procedures along with the purpose and all the steps that one must follow to implement the procedure safely.
  3. **Generally, in the chain of command of an organization, the staff nurse works under the direction of and reports to the unit's nurse manager. The nurse manager generally is an experienced nurse and is the primary resource person for the staff nurse. The staff nurse should seek guidance from the nurse manager when assistance is needed to solve a complex problem.**
  4. The nursing supervisor is higher up the chain of command in a Table of Organization than another employee who is the best person for the staff nurse to seek assistance from when needing help to solve a complex problem.
16. 1. Assigning the procedure to another staff member is premature. Another option has priority.
  2. The employee may be fully aware of the requirements of the job description and not need to have them described. Even though a task is within one's job description, a person can refuse to perform a procedure because of a reason that is considered acceptable.
  3. **The nurse must first explore the reason for the nurse aide's refusal to perform the procedure. The employee may have an acceptable reason for refusing to comply. When the reason is identified, then the nurse manager can take an informed action.**
  4. The reason for refusal may have nothing to do with the lack of understanding of the procedure.
17. 1. **This is one of the most important actions by the nurse seeking a new position. The job description provides an overview of the requirements and responsibilities of the role. Job descriptions include factors such as educational and experiential requirements, job responsibilities, subordinates to be supervised, and to whom one reports in the chain of command.**
  2. Requesting references protects the hiring agency, not the nurse. This is not the most important thing the nurse should do when applying for a new position within an agency.
  3. Although understanding the power of the position may help a person meet the responsibilities associated with the job description, it is not the priority when applying for a new position.
  4. Although it is important to recognize where the new position fits into the organization's Table of Organization, it is not the priority when applying for a new position. A Table of Organization schematically plots the reporting relationship of every position within the organization.
18. 1. **Safety of the patient is the priority. The nurse aide must perform only the skills that are within the legal role of the nurse aide, understood, and practiced and have been performed correctly on a return demonstration.**
  2. Although this may be desirable, it is not the priority.
  3. Although this is important, it is not the priority.
  4. Nurse aides are trained and supervised by the nurse, not other nurse aides.
19. 1. Providing just a verbal description is unsafe. This does not ensure that cognitive information can be converted to a psychomotor skill.
  2. **Demonstration is the safest way to assess whether a person has the knowledge and skill to perform a procedure safely. A superior delegating care is responsible for ensuring that the person implementing the care is legally qualified and competent.**
  3. A peer should not be held responsible for the care assigned to another team member. The Registered Nurse who delegates a procedure to a subordinate is directly responsible for ensuring that the care is safely delivered to patients.
  4. This intervention does not address the original Licensed Practical Nurse's need to know how to perform the procedure

safely. This procedure is within the legal scope of practice of a Licensed Practical Nurse.

20. 1. Collaborative is not a classic leadership style. Collaborative refers to the democratic leadership style. Democratic leaders encourage discussion and decision making within the group, which requires collaboration, coordination, and communication among group members.
2. **The Authoritarian leadership style is the appropriate style to use in a crisis when urgent decisions are necessary. In a crisis, one person must assume the responsibility for decisions. Autocratic leaders give orders and directions and make decisions for the group.**
3. The Laissez-faire leadership style is not the appropriate style to use in a crisis when urgent decisions are necessary. Laissez-faire leaders are nondirective and permissive, which allows for self-regulation, creativity, and autonomy but limits fast-acting efficiency.
4. The Democratic leadership style is not the appropriate style to use in a crisis when urgent decisions are necessary. Democratic leaders encourage discussion and decision making within the group, which takes time.
21. 1. **This is essential to overcome resistance to change. There are many different reasons people resist change. Each person will respond to different strategies. There are four different types of interventions to overcome resistance: providing information, disproving currently held beliefs, maintaining psychological safety, and administering an order or command.**
2. Although it is important to state the purpose of the change clearly and concisely, another option is a more important action that can be implemented by the nurse manager to overcome resistance to change.
3. Modifying a goal compromises the integrity of the planned change. All ramifications associated with the change should be explored before beginning and all contingencies planned for so that modifying a goal will be unnecessary.
4. Although emphasizing the positive consequences of the planned change might be done, another option is a more important action that can be implemented by the nurse manager to overcome resistance to change.
22. 1. **Leaders can inspire others with their vision and gain cooperation through their persuasion and communication skills (influence power), the respect others have for their knowledge and abilities (expert power), and their charisma and prior success (referent power).**
2. Initiating change is the major function of a change agent, not a leader. Change agents are often managers rather than leaders because managers have responsibility for ensuring that the work of the organization is done.
3. Controlling others is a function of a manager, not a leader.
4. Producing a product is a function of a manager, not a leader. A manager is responsible for ensuring that the work of the organization is done, and this often requires the development of such things as a policy or procedure, management reports, and work schedules.
23. 1. Effective leaders and managers both should have vision.
2. Effective leaders and managers both should have charisma.
3. Effective leaders and managers both should have confidence.
4. **Managers, not leaders, have organizational responsibility because of their job description. Leaders are not assigned to direct others. They are viewed as leaders by the members of the group because of their experience, vision, charisma, confidence, expertise, or age.**
24. 1. Taking the vital signs of all the patients on the unit at the same time is called functional nursing and is unrelated to the adage in the question.
2. **This action is an appropriate example of the adage “A stitch in time saves nine.” It means that if you sew a tear when it is small, you need fewer stitches and time to repair it than when it is large. The same adage can be applied to the collection of equipment before a procedure. If the nurse has all the equipment that is needed before**

**beginning a procedure, less time is used than when forgotten equipment is obtained later. Every time the nurse leaves the room for forgotten equipment, the patient is inconvenienced and time is wasted.**

3. Delegation is related to the efficient use of staff and is unrelated to the adage in the question.
  4. This example is unrelated to the adage in the question.
- 25.**
1. Delegation is unrelated to creating change. Delegation is the transfer of responsibility for the performance of a task to another while remaining accountable for the actions of the person to whom the task was delegated. Creating change is associated with responding to a stressor that is either planned or unplanned, which results in change that is positive or negative.
  2. Delegation is unrelated to networking. Networking occurs when a person makes connections with others for sharing ideas, knowledge, information, and professional support.
  3. **Delegation allows the Registered Nurse to assign tasks to various individuals on the nursing team who are best qualified to complete them. In today's health-care environment, nursing team members have different levels of educational preparation. The Registered Nurse must take into account the qualifications and scope of practice of each professional and nonprofessional nursing team member and assign tasks accordingly. When this is done, each person's skills and abilities are used most appropriately and productivity increases.**
  4. The person who is assigned a task is responsible for the outcome of the assigned task. However, the Registered Nurse delegating the task is not relieved of accountability but is responsible for the actions of the person to whom the task was delegated as well as the outcome of the intervention.
- 26.**
1. The nurse manager can provide negative feedback in a manner that is firm without being assertive. Not yielding under pressure (firm) is less confrontational than being confident in a persistent way (assertive).
  2. When providing negative feedback, the exploration of alternative solutions is performed later in the counseling session.
  3. **Problem recognition is the first step in the problem-solving process. Once the unacceptable behavior is identified and acknowledged, then the reasons for the problem can be explored, solutions suggested, and expectations reinforced.**
  4. Although this should be done, it is not feedback. Feedback is necessary for the nurse to recognize one's offending behavior. In addition, documentation is the last, not the first, step in the counseling process.
- 27.**
1. Exploring possible alternative solutions occurs before achieving a consensus. A consensus is achieved when all, or most, agree or have the same opinion.
  2. Consensus, not flexibility, is the goal. However, some members of the group may be flexible and change their opinion to ensure the achievement of a consensus.
  3. **Cooperation and teamwork are essential for the achievement of any goal. If a consensus is achieved about the value of the expected outcome, people are more likely to work together constructively.**
  4. Autocratic decision making does not seek a consensus when making a decision within a group. Autocratic leaders give orders and directions and make decisions for the group. There is little freedom within the group.
- 28.**
1. Evaluating the performance of a subordinate does not fall under the planning function of management. Planning involves establishing goals, designing interventions based on the priority identified, and determining how outcomes will be evaluated.
  2. Evaluating the performance of a subordinate does not fall under the directing function of management. Directing involves getting the work accomplished; it includes activities such as assigning and communicating tasks and expectations and guiding, teaching, and motivating staff members in meeting organizational goals.
  3. Evaluating the performance of a subordinate does not fall under the organizing function of management. Organizing activities include obtaining and

managing human and economic resources and include identifying the chain of command, determining responsibilities, and ensuring that policies and procedures clearly describe standards of care and expected outcomes.

**4. The controlling function of management includes the evaluation of staff members. Controlling activities also include measuring effectiveness of goal achievement, ensuring ongoing evaluation, and implementing corrective action when necessary.**

- 29.** 1. There is no end to a system. Individual parts of a system are interrelated and the whole system responds in an integrated way to changes within a part.
2. Systems do not function in a linear (straight-line) format. Systems are complex.
3. The trial and error method is unrelated to systems theory. It is a problem-solving method in which a number of solutions are tried until one is found that solves the problem.
- 4. Systems theory is a cyclical process in which a whole is broken down into parts and the parts are studied individually as well as how they work together within the system. Every system consists of matter, energy, and communication. Because each part of a system is interconnected, the whole system reacts to changes in one of its parts. The concept of treating a patient holistically is based on an understanding of systems theory.**
- 30.** 1. Counseling subordinates who fail to meet expectations is not an example of role modeling from among the options offered.
2. Holding team meetings to review rules of the agency is not an example of role modeling from among the options offered.
- 3. When a nurse manager engages in ongoing quality improvement activities, the manager is demonstrating behavior that is expected. The nurse manager also should encourage nursing team members to participate in quality improvement activities.**
4. Reviewing job descriptions with employees is not an example of role modeling from among the options offered.
- 5. When a nurse manager follows policies and procedures, the manager is demonstrating behavior that is**

**expected. Role modeling is more effective than telling as a teaching strategy.**

- 31.** 1. **This statement is associated with the motivational climate of the Theory Y management style. Managers who adopt premises associated with Theory Y believe that workers are responsible and accountable and strive to achieve organizational objectives to which they are committed.**
2. Employees who pursue security above other elements related to work are associated with the climate of the Theory X management style. Managers who adopt premises associated with Theory X believe that workers generally display little ambition and mainly are interested in the security provided with employment.
- 3. This statement is associated with the motivational climate of the Theory Y management style. Managers who adopt premises associated with Theory Y believe that workers will be self-directed when a manager assists, supports, and rewards inspired workers.**
4. Employees who require the pressure of discipline to achieve goals are associated with the motivational climate of the Theory X management style. Managers who adopt premises associated with Theory X believe that workers will generally evade work and must be controlled with the threat of punishment to achieve organizational goals.
5. Employees who seek constant direction are associated with the motivational climate of the Theory X management style. Managers who adopt premises associated with Theory X believe that workers will generally evade work and therefore constant supervision is essential for productive workers.
- 32.** 2. **The first phase is called “unfreezing” and is concerned with identifying the need for change, exploring alternative solutions, and stimulating enthusiasm.**
1. **The second phase is called “moving/changing” and is concerned with creating actual visible change.**
3. **The third phase is called “refreezing” and is concerned with providing feedback, encouragement, and constructive criticism to reinforce new behavior.**



- 33. 1. Providing hygiene (e.g., bathing, grooming, and oral care) is an independent function of the nurse that does not require an order from a primary health-care provider.**
2. Providing fluids based on a primary health-care provider's order is a dependent, not independent, function of the nurse.
  - 3. Delegating tasks within the scope of nursing practice is an independent function of the nurse and does not require a primary health-care provider's order.**
  4. Wound care is a dependent function of the nurse and requires a primary health-care provider's order.
  5. Applying heat requires a primary health-care provider's order and is a dependent function of the nurse.
  - 6. Collecting data about patients is part of the assessment step of the nursing process and is an independent function of the nurse.**
- 34. 1.** Although *Falls* demonstrate a downward trend of the number of falls from 4 in March, to 3 in April, and to 2 in May, another category demonstrates a greater degree of improvement.
- 2. Medication errors demonstrate the most improvement in decreasing errors from 4 in March, to 2 in April, and to 1 in May. This demonstrates the most significant downward trend of the number of events for all 4 categories.**
3. *Violations of confidentiality* demonstrate an increase in the number of events from 1 in March, to 2 in April, and 3 in May. This is a serious concern because the number of events progressively increased in spite of the implementation of a corrective action plan.
  4. *Violations in standards of nursing practice* initially demonstrate an improvement in the number of violations from 3 in March to 1 in April; however, the number increased to 2 in May. This demonstrates a lesser degree of improvement than another category.
- 35. 1.** Teaching a patient how to obtain a body weight requires the knowledge and judgment of a Registered Nurse. Teaching requires a complex level of interaction with the patient, problem solving, and innovation in the form of an individually

designed teaching plan of care that addresses the specific learning needs of the patient. In addition, the outcome is unpredictable and it has the potential to cause harm if the skill is taught incorrectly.

- 2. Obtaining vital signs can be delegated to a nursing assistant because it is not a complex task. It requires simple problem-solving skills and a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented appropriately, it is within the scope of practice of an unlicensed nursing assistant. It does not require the more advanced competencies of a Registered Nurse.**
  3. Assessing a patient's level of understanding is a complex task that requires knowledge and judgment and is within the scope of practice of a Registered Nurse. This task requires a complex level of interaction with the patient, problem solving, and innovation in the form of an individually designed teaching plan of care that addresses the specific learning needs of the patient.
  4. Teaching a patient how to use a walker requires the knowledge and judgment of a Registered Nurse. Teaching requires a complex level of interaction with the patient, problem solving, and innovation in the form of an individually designed teaching plan of care that addresses the specific learning needs of the patient. In addition, the outcome is unpredictable and it has the potential to cause harm if the skill is taught incorrectly.
  - 5. Transporting a patient to the exit of the facility is within the scope of practice of a nursing assistant. Nursing assistants are taught how to transport and ambulate patients safely.**
- 36. 3. The first step in the decision-making process is defining and describing the problem.**
- 2. The second step in the decision-making process is gathering significant information associated with the problem.**
  - 1. The third step of the decision-making process is identifying promising strategies to resolve the problem.**

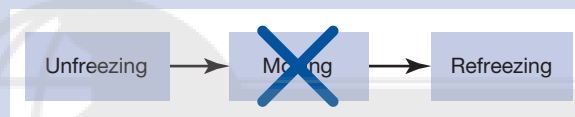
5. The fourth step of the decision-making process is implementing an action to address the problem.
  4. The fifth step of the decision-making process is evaluating the results by comparing the actual outcomes to the expected outcomes of the employed solution to the problems.
- 37.
1. Monitoring a blood glucose level is a procedure that requires the skill of a licensed nurse.
  2. **Delivering meal trays to patients who are in isolation is within the scope of practice of unlicensed assistive personnel. Unlicensed assistive personnel are taught how to use personal protective equipment.**
  3. Patient teaching is within the legal scope of a licensed nurse, not unlicensed assistive personnel.
  4. **Changing the linens on beds that are occupied by patients who are on bed rest is within the scope of practice of unlicensed assistive personnel. The activity is simple and repetitive.**
  5. **Emptying and recording the volume of output collected from a urine collection bag is within the legal role of unlicensed assistive personnel. The nurse will then calculate the volume of urine by deducting the volume of irrigating solution instilled from the total output. Calculating the actual urine output is an assessment that requires the skill of a licensed nurse.**
  6. The postanesthesia care unit (PACU) nurse should be assisted by the primary nurse responsible for the care of the patient. In addition, the PACU nurse must provide a thorough report of the patient's status and important information that the primary nurse should know to care for the patient safely and adequately.
- 38.
1. An ultimatum can be viewed as a challenge, requirement, stipulation, or demand. The need to convert from paper charting to electronic charting is a requirement of the facility's regulating agencies. The upper-level managers identified the change that must be made and the purpose for the change, which is reasonable. The upper-level managers will be providing classes to assist the nurses in achieving this change, which demonstrates support for the nurses.
  2. **Although the nurse in charge appears to be supportive in stating "Come to me if you have concerns about this change," it is better to discuss initial concerns as a group. Specific concerns can be addressed individually later. The statement "I don't think that this is the way to go but it is something we have to do" is a personal attitude that sets a negative tone regarding the change that ultimately may be destructive to achieving the goal of converting from paper charting to electronic charting.**
  3. Change may require the learning of new skills. The staff nurse's statement "I don't know how to use a computer" is an issue that must be addressed. The upper-level managers have indicated that the nursing education department will provide classes on how to use a computer.
  4. Change can precipitate anxiety because it involves the process of transforming, modifying, or doing something different. Anxiety is related to that which is unknown. Therefore, goals and objectives must be identified and educational classes provided to help the staff nurses achieve the conversion from paper charting to electronic charting. The upper-level managers will be providing classes to assist the nurses in achieving this change, which demonstrates support for the nurses.
- 39.
1. Taking routine vital signs is not complex, has little potential for harm, requires only simple problem-solving skills, involves a simple level of interaction with the patient, and is within the scope of practice of an unlicensed nursing assistant. It requires the more advanced competencies of a Registered Nurse only when previous vital signs have been outside the expected range, the patient is unstable, or the patient is transferred from one service/unit to another.
  2. **Discharge teaching requires the knowledge and judgment of a Registered Nurse. It requires synthesizing and summarizing information as well as coordinating a variety of community health-care services to meet patient needs.**
  3. **Evaluation requires the knowledge and judgment of a Registered Nurse. The skill of evaluation requires reassessing, synthesizing and analyzing data,**

**determining significance of data, and diagnosing and responding to the data. In addition, it involves an unpredictable outcome and requires problem solving that may call for innovation in the form of an individually designed plan of care to address the patient's need for pain relief if pain is still being experienced.**

4. Administering an enema is not a complex task. It requires simple problem-solving skills, involves a predictable outcome, and employs a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented, it is within the scope of practice of an unlicensed nursing assistant. It does not require the more advanced competencies of a Registered Nurse.
5. Transporting a patient is not a complex task. It requires simple problem-solving skills and involves a predictable outcome and a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented,

it is within the scope of practice of an unlicensed nursing assistant. It does not require the more advanced competencies of a Registered Nurse.

40. **Change takes place when one is moved out of one's comfort zone and into a discomfort zone. The moving stage causes discomfort as goals and objectives are developed and solutions are implemented. Unfreezing occurs before one enters into the moving stage. Unfreezing is the stage where one is aware of a problem and deciding whether or not improvement is possible. During unfreezing one is still within one's comfort zone. Refreezing is the stage where the change becomes a part of the work setting and environment. A new comfort zone is developed as one becomes familiar with the change and incorporates the change into daily practice.**



F.A. DAVIS

COMPANY

# Health-Care Delivery

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Acuity  
Advocate  
Baby boomers  
Burnout  
Career ladder  
Case management, case manager  
Continuity of care  
Cost containment  
Counselor  
Critical pathways  
Demographics  
Diagnosis Related Groups (DRGs)  
Functional nursing  
Health-care team members:  
    Activity Therapist  
    Certified Social Worker  
    Clinical Nurse Specialist  
    Licensed Practical Nurse  
    Nurse Anesthetist  
    Nurse Assistant  
    Nurse Midwife  
    Nurse Practitioner  
    Occupational Therapist  
    Pastoral care provider, clergy  
    Patient  
    Patient's family members  
    Physical Therapist  
    Physician  
    Physician's Assistant  
    Registered Dietitian  
    Registered Nurse  
    Speech Therapist  
Health-care settings:  
    Acute care hospitals  
    Adult day care  
    Ambulatory care centers  
    Assisted-living residence  
    Clinics  
    Extended care  
    Home health services  
    Hospice (inpatient, residential, in the home)  
    Industrial or occupation settings  
    Life-care community  
    Long-term care nursing homes  
    Neighborhood community health center  
    Physicians' offices  
    Psychiatric facilities  
    Rehabilitation centers  
    School settings  
    Urgent visit centers  
Health Maintenance Organization  
Levels of health care:  
    Primary health care  
    Secondary health care  
    Tertiary health care  
Levels of prevention:  
    Primary prevention  
    Health promotion  
    Health protection  
    Preventive health services  
    Secondary prevention  
    Tertiary prevention  
Managed care  
Medicaid  
Medicare  
Multidisciplinary  
Patient classification system  
Preauthorization  
Preferred Provider Organization  
Primary nursing  
Prospective payment system  
Reengineering  
Reimbursement  
Resource Utilization Groups (RUGs)  
Sandwich generation  
Third-party payers  
Types of agencies:  
    Official—governmental  
    Proprietary—for profit  
    Voluntary—not for profit  
Undocumented immigrants

F.A. COMPANY

## HEALTH-CARE DELIVERY: QUESTIONS

1. Which health-care team member can provide independent health care with third-party reimbursement in the emerging health-care delivery system in the United States?
  1. Licensed Registered Nurse
  2. Clinical Nurse Specialist
  3. Physician's Assistant
  4. Nurse Practitioner
2. Which does critical pathways in health care refer to?
  1. Educational career ladders for health-care professionals
  2. Multidisciplinary plans with predetermined patient outcomes
  3. Times during life when certain health problems are more likely to occur
  4. Organizations that provide services that progress from acute care to long-term care
3. Which setting is the organizational center of the United States health-care system?
  1. Clinic setting
  2. Acute care setting
  3. Community setting
  4. Long-term care setting
4. A nurse is explaining mammography screening to a patient. Which level of health-care delivery service does this diagnostic test reflect?
  1. Secondary
  2. Tertiary
  3. Primary
  4. Acute
5. When should a nurse begin a patient's rehabilitative care?
  1. When the patient is conscious
  2. Once the patient begins walking
  3. After the medical diagnosis is made
  4. Just before discharge from the hospital
6. A nurse case manager is counselling an older adult patient about resources available to assist with the cost of health care. The nurse should inform the patient which organization provides the majority of the health-care costs for people older than 65 years of age?
  1. Medicare
  2. Medicaid
  3. Blue Cross
  4. Blue Shield
7. Which result of reengineering in hospital settings has raised the greatest concerns for patient safety?
  1. Decreased hospital occupancy rates
  2. Increased acuity of hospitalized patients
  3. Hospitals merging with larger institutions
  4. Substitution of less skilled workers for nurses
8. A patient is discharged from the hospital 3 days after abdominal surgery because of the influence of Diagnosis Related Groups (DRGs). Which should the nurse performing the discharge teaching be **most** concerned about?
  1. Providing for continuity of care
  2. Ordering equipment to be used in the home
  3. Accepting discharge by the patient and family
  4. Ensuring hospital reimbursement for services rendered

9. Together the nurse and patient are setting a goal during health-care planning. Which factor generates the **most** anxiety for a patient with this process?
  1. Role
  2. Values
  3. Beliefs
  4. Change
10. Three hospitals agree to work collectively to provide a full range of health-care services in their neighborhoods. Which type of relationship has been entered into by these hospitals?
  1. Integrated health-care service network
  2. Third-party reimbursement system
  3. Health Maintenance Organization
  4. Diagnosis Related Groups
11. A nurse is planning actions that address a patient's health-care needs. Which statement is important for the nurse to consider?
  1. Health and illness clearly are separated at the middle of the health-illness continuum.
  2. Demographics of the population of the United States are changing drastically.
  3. External factors mainly are the cause of most illnesses.
  4. Most people view health as the absence of disease.
12. Which action is common to the majority of Registered Nurse positions in different settings in which nurses work?
  1. Assisting a primary health-care provider
  2. Serving in an administrative capacity
  3. Developing patient plans of care
  4. Providing direct physical care
13. A nurse is planning a community outreach program about the variety of health-care professionals and the services they provide. Which members of the health-care team should the nurse indicate are the largest group of health-care personnel in the United States?
  1. Social workers
  2. Nurse aides
  3. Physicians
  4. Nurses
14. Which is the **major** factor that limits the overhaul of the health-care delivery system of the United States?
  1. Elected officials who do not respond to the pressure of their political constituencies
  2. Explosion of technical advances within the profession of medicine
  3. Complexity of the problems associated with health-care reform
  4. Resistance of physicians to reform
15. Which is emphasized in the traditional health-care delivery system in the United States?
  1. Health promotion
  2. Illness prevention
  3. Diagnosis and treatment
  4. Rehabilitation and long-term care
16. At the end of a shift the nurse in charge must evaluate each patient in relation to the agency's patient classification system. Which is the purpose of this patient classification system?
  1. Document resource needs for the purpose of establishing reimbursement.
  2. Provide data about patient acuity to help assign nursing staff.
  3. Establish that quality standards have been met.
  4. Identify standardized expected outcomes.

17. Which health-care professional is **best** prepared to track a patient's progress through the health-care system?
1. Case manager
  2. Primary nurse
  3. Nurse manager
  4. Home-care nurse
18. A nurse is reviewing a variety of surveys regarding the delivery of health care within the United States. Which statement reflects a significant change in the thinking of the general public about concepts related to health-care delivery?
1. "Institutional-based care will have to be increased as baby boomers age."
  2. "More services must address the secondary health-care needs of the community."
  3. "Individuals can influence their own health through behavior and lifestyle changes."
  4. "Health-care providers should be primarily responsible to provide appropriate health-care services."
19. Which group is the greatest challenge to the financing of health care in the United States?
1. Undocumented immigrants
  2. Medically uninsured
  3. Preterm infants
  4. Older adults
20. A patient asks the nurse, "What is the difference between Medicare and Medicaid?" Which response by the nurse describes the Medicaid program?
1. "A retrospective health-care reimbursement program that pays for costs incurred by health-care agencies for the care of the indigent"
  2. "A state program requiring primary health-care providers to deliver care to people living below the designated poverty level"
  3. "A federally funded health insurance program for individuals with minimal incomes"
  4. "A federally funded health insurance program for people aged 65 years or older"
21. A patient is told that preauthorization is required before surgery can be performed. The patient asks the nurse, "What does preauthorization mean?" Which is an accurate response to the patient's question?
1. "Third-party payers have approved the surgery and the facility will be reimbursed for costs."
  2. "The preoperative checklist has been completed and verified by a nurse."
  3. "Required preoperative diagnostic tests have been performed."
  4. "You have signed the legal consent form for the surgery."
22. A patient is to return from the postanesthesia care unit to a semiprivate room. Which is the **most** significant factor concerning the postoperative patient's potential roommate that will influence the nurse's decision to transfer the postoperative patient to this room?
1. Emotionally fragile
  2. Able to communicate
  3. In the bed by the window
  4. Physiologically compatible
23. A nurse assists a family to explore the options available to help them cope with an older adult family member who cannot live alone because of progressing cognitive difficulties. Which word **best** describes this role of the nurse?
1. Teacher
  2. Advocate
  3. Surrogate
  4. Counselor

24. A nurse is examining research results regarding receipt of health-care benefits in the United States. Which group of people who were the most underserved before the Affordable Care Act of 2010 now have the opportunity to receive health-care benefits?
1. Children
  2. Older adults
  3. Pregnant women
  4. Middle-aged men
25. A patient with an infection receives medical intervention and nursing care in a hospital setting. Which level health-care service has been provided in this situation?
1. Emergency
  2. Secondary
  3. Tertiary
  4. Primary
26. Which is the cornerstone of *Nursing's Agenda for Health Care Reform*?
1. A standardized package of health-care services must be provided by organizations within the federal government.
  2. Health-care services should be provided in environments that are accessible, familiar, and friendly.
  3. Advanced practice nurses should play a prominent role in the provision of primary health care.
  4. Nursing must provide for the central focus of the health-care delivery system.
27. A home health-care nurse is functioning as a case manager for a patient recently discharged from the hospital. Which is the **primary** role of the nurse when functioning as a case manager?
1. Coordinator
  2. Counselor
  3. Provider
  4. Teacher
28. Which is the **best** example of an inpatient care setting where nursing care is delivered?
1. Ambulatory care center
  2. Extended-care facility
  3. Day-care center
  4. Hospice
29. Which change identified by the nurse will **most** affect health-care delivery in the United States in the future?
1. Less emphasis will be placed on prolonging life.
  2. The proportion of older adults in society will increase.
  3. More people will seek health care in an acute care setting.
  4. Genetic counseling will dramatically decrease the number of ill infants born.
30. Diagnosis Related Groups (DRGs) were instituted by the federal government mainly to reduce which of the following?
1. Number of professionals working in hospitals
  2. Focus on illness and place it on prevention
  3. Fragmentation of care
  4. Cost of health care
31. Which characteristic is unique to the nurse-patient relationship?
1. Patient's needs are satisfied.
  2. There is a social component.
  3. Both are working toward a common goal.
  4. The nurse is the leader of the health team.



32. A recently licensed Registered Nurse is working the night shift on an active medical unit in a hospital. Which is the **best** way that this nurse can prevent professional burnout?
1. Challenge the how and why of one's role.
  2. Get adequate sleep and exercise each day.
  3. Clarify expectations, strengths, and limitations.
  4. Seek a balance among seriousness, humor, and aloofness.
33. Which intervention is **most** likely to have the greatest impact on decreasing the nursing shortage?
1. Providing stress reduction programs to address needs of nurses experiencing burnout
  2. Offering bonuses to entice nurses close to retirement to work longer
  3. Developing initiatives to fund the education of nursing faculty
  4. Increasing the recruitment of foreign registered nurses
34. A patient receiving a special diet is given a meal tray that does not contain a food requested by the patient. Place the following interventions in the order that they should be implemented by the nurse.
1. Check the dietary manual.
  2. Schedule a conference with the dietitian.
  3. Verify the primary health-care provider's dietary order.
  4. Explore with the primary health-care provider the possibility of including this food preference in the diet.
- Answer: \_\_\_\_\_
35. Which are examples of an official agency? **Select all that apply.**
1.  Department of Health
  2.  Veterans Affairs Hospital
  3.  American Heart Association
  4.  National League for Nursing
  5.  Nonprofit community hospital
36. A nurse is functioning as a direct caregiver for a patient with multiple health problems. Which words are **most** associated with the caregiver role of the nurse? **Select all that apply.**
1.  Implement
  2.  Facilitate
  3.  Evaluate
  4.  Counsel
  5.  Teach
37. An older adult woman, who was incoherent, wandering, and wearing inadequate clothing for the cold weather, was found by a police officer at night. The woman was admitted to the hospital for dehydration and mild hypothermia. The next afternoon a nurse assesses the patient, interviews the patient's daughter, and considers the health-care services within the community. Which health-care service should the nurse explore with the daughter?
1. Respite care center
  2. Home health aide several hours a day
  3. Full day older adult day-care program
  4. Long-term care facility with assistive living services

## PATIENT'S CLINICAL RECORD

### Patient's Recent History

Patient lives with daughter and attends a half-day older adult day-care program. She experiences episodes of confusion, generally recognizes her family members, but has issues with judgment. She has not attended the day-care program for the past month.

### Patient Assessment

Vital signs are all within expected limits including the temperature, which is 97.8°F; knows her name but does not recognize her daughter or grandchildren; moved to room across from the nurses' station for constant observation because patient has attempted to wander off the unit.

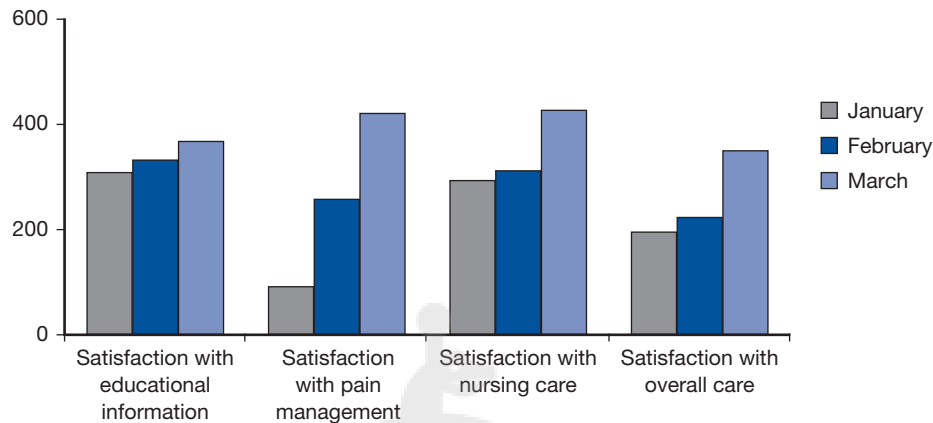
### Interview With Daughter

Daughter states her mother's abilities have progressively declined the last several months. "My mother doesn't know who we are most of the time. I am a single mom of three kids ages 5, 8, and 10 and I work full time. Lately she has episodes of not knowing who we are. I was shocked when the police called and said they found her last night. I am exhausted. I don't think that I can keep doing this much longer."

38. Which major trends in health care are occurring in the United States? **Select all that apply.**
1.  Ever yone should have access to quality health care.
  2.  Social issues are taking a back seat as a result of the advances in technology.
  3.  Striving for longevity will take on greater concern than quality-of-life issues.
  4.  Health-care providers control the direction and development of health-care services.
  5.  Individuals and families have primary responsibility for making health-care decisions.
39. A home-care nurse is coordinating the delivery of health-care services for adults 65 years of age and older who live in homes within the community. Which factors about older adults have the greatest impact on the delivery of health care to this population within the United States? **Select all that apply.**
1.  Live below the economic poverty level, necessitating financial assistance
  2.  Number living long enough to become older adults is increasing
  3.  Suffer from significant cognitive deficits as they age
  4.  Tend to fall, requiring expensive hospital services
  5.  Need the services of long-term care institutions

40. A nurse is a member of an agency's Health Care Research and Quality Committee. The nurse reviews the following bar graph regarding patient satisfaction with the hospital experience after implementation of a 3-month initiative to improve patient satisfaction related to four quality indicators. Identify which quality indicator related to patient satisfaction exhibits the **most** significant improvement between January and March.

1. Satisfaction with educational information
2. Satisfaction with pain management
3. Satisfaction with nursing care
4. Satisfaction with overall care



41. Which nursing activities reflect care on the primary level of health-care delivery? **Select all that apply.**

1.  Arranging for hospice services
2.  Delivering care in a coronary care unit
3.  Providing emergency care at a local hospital
4.  Encouraging attendance at a Smoke Enders' meeting
5.  Administering immunizations to prevent childhood diseases

42. A nurse is considering the services within the community that can meet patients' activities of daily living and health-care needs. Place these services in order beginning with the one in which the patient requires the **least** amount of assistance to the one in which the patient receives the **most** assistance.

1. An intermediate care setting that provides health-care services to individuals who are not acutely ill
2. An assisted living setting that provides meals and minimal help with activities of daily living
3. An independent care setting that provides meals and housekeeping services
4. A long-term care facility that provides skilled nursing care
5. A subacute unit in a skilled nursing facility

Answer: \_\_\_\_\_

43. A nurse is functioning as a patient advocate. Which words **best** describe this nursing role? **Select all that apply.**

1.  Provider
2.  Nurture
3.  Protector
4.  Evaluator
5.  Supporter

44. A nurse reviews the statistics regarding U.S. health-care expenditures published by the Agency for Healthcare Research and Quality, an agency of the U.S. Department of Health and Human Services. Which statistics are accurate and important for the nurse to understand because health-care initiatives must address these concerns?

**Select all that apply.**

1.  Seventy-five percent of the population spends little on health care.
  2.  Five percent of the population incurs approximately 75% of the cost of health care.
  3.  Cancer is the most expensive health condition regarding per-person costs of health care.
  4.  Twenty-five percent of the population has one or more of the five most common chronic illnesses.
  5.  Older adults and disabled individuals who are 25% of the Medicaid population are responsible for 70% of Medicaid spending.
45. Identify which of the following individuals are nursing team members. **Select all that apply.**
1.  Patient
  2.  Unit secretary
  3.  Registered Nurse
  4.  Licensed Practical Nurse
  5.  Primary health-care provider
  6.  Unlicensed nursing personnel



## HEALTH-CARE DELIVERY: ANSWERS AND RATIONALES

1. Licensed Registered Nurses do not receive third-party reimbursement for their services.
  2. Clinical Nurse Specialists are not health-care professionals who receive third-party reimbursement. Clinical Nurse Specialists have been involved in health-care delivery since the 1960s. They are master's-prepared nurses with a specialty in certain areas (e.g., medical-surgical nursing, pediatrics, psychiatry), or they may have advanced education and experience in caring for individuals with special needs (e.g., wound care, enterostomal care, or care of the patient with diabetes).
  3. Physician's Assistants are not health-care professionals who receive third-party reimbursement directly. They work under the supervision of a physician in many different settings and are paid by the physician in private practice or by the organization that hired them. They assist physicians by carrying out common, routine medical treatments, and they have prescriptive authority.
  4. **This is a relatively new trend in health-care delivery. Nurse Practitioners generally are master's-prepared individuals who work independently or collaboratively with physicians to provide primary health-care services. Nurse Practitioners work independently under their own license, are accountable for their own practice, have prescriptive authority, and receive third-party reimbursement, depending on the state in which they work. In the states that do not permit this level of health-care delivery, Nurse Practitioners work under the license of a physician who supervises their practice.**
2. 1. Critical pathways are not an educational career ladder for health-care professionals. A career ladder is the organization of educational experiences so that professional growth progresses in a planned manner.
  2. **Critical pathways are a case management system that identifies specific protocols and timetables for care and treatment by various disciplines designed to achieve expected patient outcomes within a specific time frame.**
3. 1. This statement is a definition of critical time, not critical pathways.
  4. This statement is unrelated to critical pathways.
3. 1. The clinic setting is not the organizational center of the United States health-care system.
  2. **The acute care setting is the organizational center of the United States health-care system today. Specialized services (tertiary level of care) and emergency, critical care, and intense diagnosis and treatment (secondary level of care) of illness and disease are provided for in hospitals (acute care setting). In 1991, the American Nurses Association published *Nursing's Agenda for Health Care Reform*, which made recommendations for health-care reform in many areas. The major trend identified as a result of implementation of the recommendations is a shift of the focus of health care from illness and cure to one of wellness and care. If this occurs, the health-care system of the United States will shift from the acute care setting to the home and community.**
  3. The community setting is not the organizational center of the United States health-care system at this time.
  4. The long-term care setting is not the organizational center of the United States health-care system.
4. 1. **Screening surveys and diagnostic procedures are examples of secondary prevention. Secondary prevention is associated with early detection, early and quick intervention, health maintenance, and prevention of complications. The levels of prevention identify three types of prevention that focus on health-care activities, such as primary prevention (avoiding disease through health promotion and disease prevention), secondary prevention (early detection and treatment), and tertiary prevention (reducing complications, rehabilitation, and restoration and maintenance of optimal function).**

2. This scenario is not an example of tertiary prevention. Tertiary prevention begins after a situation is stabilized and the focus is on rehabilitation and restoration within the limits of the disability.
  3. This scenario is not an example of primary prevention. Primary prevention is associated with activities that promote health and protect against disease.
  4. Acute is not one of the levels of prevention. The word *acute* refers to the type of care that is provided on the secondary care level of the health-care delivery system.
5. 1. Rehabilitation interventions begin whether the patient is conscious or unconscious.
2. Rehabilitation interventions begin whether the patient is ambulatory or nonambulatory.
3. **As soon as a patient is diagnosed with a problem, rehabilitation interventions begin. Care should be present and future oriented.**
4. This is too late to begin rehabilitation interventions.
6. 1. **Medicare has two parts, Part A and Part B. Most people are enrolled automatically in Part A when they reach 65 years of age. It covers costs if one is admitted to a hospital, hospice, or skilled nursing facility for other than custodial care. Individuals must pay a deductible each year, and those who worked less than 10 years in the United States must pay a monthly fee. Part B covers outpatient care including primary-care provider visits, physical therapy, diagnostic tests, vaccines, and some medical supplies. Individuals pay a monthly fee, a deductible, and 20% of the Medicare-approved amount for some types of care.**
2. Medicaid is not a program that pays for the majority of health-care costs of people older than 65 years of age. Medicaid is a United States federal program that is state operated and provides medical assistance for people with low incomes.
3. Blue Cross is a not-for-profit medical insurance plan that pays for hospital services for people of all ages, not just people older than 65 years of age.
4. Blue Shield is a not-for-profit medical insurance plan that pays for care provided by health-care professionals for all age groups, not just for people older than 65 years of age.
7. 1. Reengineering has not reduced hospital occupancy rates. Decreased hospital occupancy rates are related directly to Diagnosis Related Groups and the resultant decrease in lengths of stay. The concerns about a decrease in occupancy rates are not related to patient safety but rather fiscal issues.
2. Reengineering has not increased patient acuity in the hospital setting. Although the increased acuity of hospitalized patients is a real concern when providing for patient safety, safety should not be an issue if a unit is adequately staffed with the appropriate mix of nurses to ancillary staff.
3. Reengineering does not precipitate hospital mergers. Hospital mergers and the resulting reengineering should not impact patient safety if professional practice standards are maintained.
4. **Reengineering is concerned with training a less educationally prepared nursing assistant to implement nursing tasks that were formerly associated with the practice of nursing. This trend poses a serious threat to the safety and welfare of patients because tasks requiring the complex skills of a nurse are being delegated to minimally prepared individuals. This is dangerous in the present health-care environment in which hospitalized patients are more acutely ill than ever before.**
8. 1. **Providing for continuity of care is the major concern with early discharge as a result of DRGs. It requires careful planning to ensure that services, personnel, and equipment are provided in a timely and comprehensive manner and care is not fragmented and disorganized.**
2. Although this is a concern for some individuals, if the discharge planner plans early for the patient's discharge, all equipment should be in place before the patient is discharged.
3. Although this is a concern for some individuals, if patients receive supportive emotional intervention and are prepared for discharge from the first day of admission, patients will generally rather be at home than in the hospital.

4. Hospitals are pleased when they are able to discharge a person earlier than the designated length of stay indicated by the DRGs because the hospital keeps the unused portion of the DRG reimbursement.
9. 1. A role is a set of expectations about how one should behave. Although a health-care goal may conflict with a role one sets for oneself, another option has greater ability to contribute to anxiety than one's role.
    2. A value is an enduring attitude about something that is cherished and held dear to one's heart and should not generate anxiety. People generally set health-care goals that do not conflict with their values.
    3. A belief is an opinion or a conclusion that one accepts as true and may be based on either faith and/or facts and should not generate anxiety. People generally set health-care goals that do not conflict with their beliefs.
  4. **Change almost always causes anxiety because it requires one to move from that which is comfortable and familiar to that which is uncomfortable, unfamiliar, unpredictable, and threatening.**
10. 1. **This is an example of an integrated health-care service network. Hospitals are joining networks to decrease costs and increase reimbursement. This is accomplished by expanding the breadth of services while avoiding duplication of services, keeping people within the network, negotiating the price of supplies and equipment, and centralizing departments (e.g., administration, staff education, and human resources), which results in fewer personnel.**
    2. This is not an example of a third-party reimbursement system. Third-party reimbursement refers to when someone other than the receiver of health care (generally an insurance company) pays for the services provided.
    3. This is not an example of a health maintenance organization (HMO). An HMO is an organization that provides primary health care for a preset fee.
    4. Diagnosis Related Groups (DRGs) are pretreatment diagnoses reimbursement categories designed to decrease the average length of a hospital stay, reducing costs.
11. 1. There is no clear separation between health and illness on the health-illness continuum. Each individual's personal perceptions of multiple factors determine where a person places himself or herself on the health-illness continuum.
    2. **Demographics are changing rapidly in the United States as we become a more heterogeneous, multicultural, multiethnic society. Because of the increasing diversity of the population of the United States, nurses must use transcultural knowledge in a skillful way to provide culturally appropriate, competent care.**
    3. Internal as well as external factors are the cause of illness.
    4. Most people do not view health as the absence of disease. There is no one definition of health because there are so many different factors that impact one's definition of health. Therefore, a definition of health depends on each individual person's own perspective.
  12. 1. The majority of nurses' time is concerned with implementing independent and dependent functions within the scope of nursing practice, not spent assisting a primary health-care provider. In most settings, the nurse and primary health-care provider work in a collaborative relationship to help patients cope with human responses to illness and disease.
    2. Only nursing management positions contain an administrative component.
    3. **Nurses work in a variety of settings; however, a component that is common to all settings is the use of critical thinking to develop patient plans of care.**
    4. Not all Registered Nurse positions include direct physical care of patients. For example, many positions in home care, clinics, industry, and schools focus on case finding, ongoing monitoring of progress, and teaching rather than direct physical care.
  13. 1. Social workers are not the largest group of health-care professionals in the United States.
    2. Nurse aides are not health-care professionals.
    3. Physicians are not the largest group of health-care professionals in the United States.

- 4. Nurses comprise the largest group of health-care professionals in the United States. There are not enough Registered Nurses to meet the present demand. The Bureau of Labor Statistics Employment Projections 2010 to 2020 released in February 2012 identified the need for 1.2 million more nurses by 2020 to replace retiring nurses and meet the number of new job openings resulting from growth in and aging of the population.**
- 14.** 1. Most elected officials recognize the need for health-care reform but generally want to support reform that reflects the desires of their political constituencies. This requires negotiations within the political system that can be prolonged and contentious.
2. This is not the major factor that limits the overhaul of the health-care delivery system of the United States.
- 3. Health-care delivery in the United States is an extremely complex service industry consisting of public, voluntary, and proprietary businesses with multiple disciplines of health-care workers represented. The system is influenced by federal, state, and local social, economic, ethical, and consumer-driven issues.**
4. Physician input is only one factor that may prevent an overhaul of the health-care delivery system of the United States. Although the American Medical Association has a strong political action committee, it was unable to prevent the institution of prospective reimbursement systems that in many ways dramatically changed the work world of the physician as well as placing limits on financial compensation for medical services provided.
- 15.** 1. Health promotion is not emphasized in the traditional health-care delivery system in the United States. However, in 1992, the National League for Nursing predicted that, in the future, health care in the United States will move from the traditional hospital setting to the community with an emphasis on health promotion.
2. Illness prevention is not emphasized in the traditional health-care delivery system in the United States. In 1992, the National League for Nursing predicted that in the future health care in the United States will move from the traditional hospital setting to the community with an emphasis on illness prevention.
- 3. Traditional health-care delivery has centered on activities associated with diagnosing, treating, and curing illness and disease. In addition, hospitals account for the largest proportion of money spent on health care and employ the largest number of health-care workers.**
4. Rehabilitation and long-term care are not emphasized in the traditional health-care delivery system in the United States.
- 16.** 1. This statement does not reflect the purpose of a patient classification system.
- 2. A patient classification system, or acuity report, is designed to rate patients in terms of high or low acuity; the level of acuity is based on the amount of time and nursing resources that are needed to care for the patient. A patient who is unstable and requires constant monitoring and nursing intervention will be rated a higher acuity score than a patient who is stable and relatively self-sufficient in activities of daily living.**
3. Ongoing quality improvement programs are designed to establish whether standards of care have been met and are not a patient classification system.
4. Standardized expected outcomes are established by professional educational and practice organizations, credentialing bodies, and critical pathways, not by a patient classification system.
- 17.** 1. **A case manager coordinates and links health-care services to patients and their families at single levels of care (e.g., during hospitalization) and across levels of care (e.g., progression through hospitalization, extended-care facilities, and home care).**
2. A primary nurse has total responsibility for the planning and delivery of nursing care to a specific patient for the duration of the patient's hospitalization. Primary nursing is a nursing care delivery system that attempts to prevent fragmentation of care and ensure a comprehensive, consistent approach to meeting a patient's needs while in the hospital.



3. A nurse manager's job is to ensure that the objectives and goals of the organization are met appropriately, efficiently, and in a cost-effective manner.
  4. A home-care nurse provides and coordinates health services in the home.
- 18.**
1. Studies and position papers from all segments of the health-care industry indicate the need to provide more health-care services in the community and not the institutional setting. To meet the health-care needs of older adults in the future, efforts have to begin now to provide more community-based support services so that people can remain in their own homes and not have to move to an institutional setting.
  2. More services need to address the primary, not secondary, health-care needs of the community. Secondary health-care services include emergency care, acute care, diagnosis, and complex treatment. The present health-care system has an infrastructure that supports the delivery of secondary health-care services. More emphasis must be placed on providing services that meet the primary health-care needs of society, which include health promotion, illness prevention, health education, and environmental protection.
  3. **Consumers are more aware than ever before that change in their own behavior and lifestyle will have a major influence on their own health status. Public health service announcements, community health education programs, and even television programs and media print materials (e.g., newspapers and magazines) have improved consumer awareness.**
  4. Consumers, not health-care providers, should be charged with the primary responsibility for providing appropriate health-care services. As individuals or as groups, consumer demands and expectations will have the greatest impact on the delivery of health care.
- 19.**
1. Although undocumented immigrants are increasing in numbers, it is not the group posing the greatest challenge to financing health care in the United States.
  2. People who are medically uninsured are not members of the group posing the greatest challenge to financing health care in the United States. There is an increase in the number of individuals who have health insurance as a result of legislation related to the Affordable Care Act of 2010.
- 3.** The March of Dimes identified that 12.8% of live births in the United States in 2005 were premature births. Since then there has been a steady decline to 11.5% as recorded in a preliminary report documenting statistics for 2013. The March of Dimes' goal is to achieve a 9.6% rate in the United States by 2020.
- 4.** **The percentage of older adults in the United States is expected to increase to 21% of the population by the year 2040. Because chronic illness is more prevalent among older adults, additional health-care services will be needed in the future. The need for increased services will increase costs.**
- 20.**
1. Health-care reimbursement in the hospital setting in the United States is based on a prospective, not retrospective, reimbursement formula. Diagnosis Related Groups is a predetermined hospital reimbursement rate based on a medical problem.
  2. Participation in programs providing care to people living below the designated poverty level is voluntary, not mandatory.
  3. **Medicaid is a federally funded, but state-regulated, health insurance program for individuals with low incomes.**
  4. This statement describes Medicare, not Medicaid.
- 21.**
1. **To maintain quality control and cost containment, third-party payers have preauthorization criteria for surgery that may include requirements, such as second opinions and initial conservative therapies.**
  2. A preoperative checklist is unrelated to preauthorization. A checklist summarizes the patient's preoperative preparation to ensure that all significant activities and safety precautions have been completed.
  3. Diagnostic tests are not related to the concept of preauthorization. Diagnostic tests are performed to identify actual or potential health problems that may influence, or be affected by, the surgery.
  4. An Informed Consent is unrelated to preauthorization. Informed Consent is a legal document giving permission for surgery including the procedure, surgical site, and surgeons.

22. 1. Many hospitalized patients may be emotionally fragile because of the stress of the experience. It is only when patients are a threat to themselves or others that they should not be placed with another patient and should be under constant supervision.
2. The ability to communicate is not a requirement for roommates. A patient does not have to converse with, or be responsible for, another patient.
3. The location of a bed within a room is insignificant. When two beds are available, the choice may be left to patient preference.
4. **One patient's physical condition should not interfere with another patient's physical condition. For example, a patient with a communicable disease should be in a private room, whereas a patient with an incision or an open wound should not be in a room with a patient with an infection.**
23. 1. The role of teacher is related to helping patients learn about their health and health-care practices.
2. The role of advocate is related to protecting and supporting patient rights.
3. The surrogate role is not a professional role of the nurse. A surrogate role is assigned to a nurse when a patient believes that the nurse reminds the patient of another person and projects that role and the feelings for the other person onto the nurse.
4. **The role of counselor is associated with helping patients and their family members to recognize and cope with physical and emotional stressors and explore options for meeting health-care needs. In this role the nurse must use attentive listening to help patients and family members to make personal decisions.**
24. 1. **Before the Affordable Care Act of 2010 one in five children lived in poverty and did not have health insurance, and more than 35% of preschool children were not immunized. In 2010 the Affordable Care Act was passed by Congress to address some of these concerns. In 2014 the Affordable Care Act provides for a health insurance marketplace that offers health insurance at a lower cost and with tax credit for families who are economically eligible for assistance. In addition, families can identify if they qualify for Medicaid or the Children's Health Insurance Program (CHIP). CHIP provides comprehensive health coverage based on the state's plan so that parents will not be required to buy a marketplace plan for their children if they earn more than the limit to be eligible for Medicaid benefits.**
2. Although older adults are a vulnerable population, they are not as underserved as a group in another option because of the availability of Medicare.
3. Although pregnant women are a vulnerable population, they are not as underserved as a group in another option.
4. Middle-aged men are the least underserved population of the options offered.
25. 1. Emergency care is a type of health-care service, not a level of care in the health-care system. Emergency care is a description of one type of service provided on the secondary health-care level in the health-care system.
2. **This scenario is an example of the secondary health-care level of the health-care system. Secondary health care is associated with intense and elaborate diagnosis and treatment of disease or trauma and includes critical care and emergency treatment. The levels of health care should not be confused with levels of prevention. The health-care system has three levels of health care that describe the scope of services and settings where health care is provided: primary, secondary, and tertiary. The levels of prevention identify three levels of prevention that focus on health-care activities, such as primary prevention (avoiding disease through health promotion and disease prevention), secondary prevention (early detection and treatment), and tertiary prevention (reducing complications, rehabilitation, restoration, and maintenance of optimal function).**
3. This scenario is not an example of the tertiary health-care level of the health-care system. Tertiary health care is associated with the provision of specialized services.

4. This scenario is not an example of the primary health-care level of the health-care system. Primary health care is associated with early detection and routine care.
- 26.** 1. Although a standardized package of health-care services is a component of *Nursing's Agenda for Health Care Reform*, it is not the cornerstone of the document.
- 2. This statement reflects the cornerstone of Nursing's Agenda for Health Care Reform. All people have a right to receive health care, but this right is useless unless the care is easily reached and used.**
3. Although a prominent role for advanced practice nurses is a component of *Nursing's Agenda for Health Care Reform*, it is not the cornerstone of the document.
4. Although this is a component of *Nursing's Agenda for Health Care Reform*, it is not the cornerstone of the document.
- 27. 1. The primary role of a case manager is to coordinate the activities of all the other members of the health-care team and ensure that the patient is receiving care in the most appropriate setting.**
2. Counseling is not the primary role of a case manager. When counseling, the nurse helps a patient recognize and cope with emotional stressors, improve relationships, and/or promote personal growth.
3. Providing care is not the primary role of a case manager. When providing care, the nurse is in the direct caregiver role. Caregiving involves identifying and meeting the patient's needs by helping the patient regain health through the caring process.
4. Teaching is not the primary role of a case manager. When teaching, the nurse helps the patient learn about health and health-care practices.
- 28.** 1. Ambulatory care centers are not an inpatient care setting. Although some may be located in a hospital, they are more often in convenient locations, such as a shopping mall or storefront. They provide services such as emergency walk-in care, ambulatory surgery, and health prevention and health promotion interventions.
- 2. An extended-care facility is an inpatient setting where a patient/resident lives while receiving subacute medical, nursing, or custodial care. It includes facilities, such as intermediate care and skilled nursing facilities (nursing homes), assisted living centers, rehabilitation centers, and residential facilities for the mentally or developmentally disabled.**
3. Day-care centers are not examples of inpatient care settings. Day-care centers provide care for people who arrive in the morning and go home at the end of the day. They provide care for healthy children or older adults so that significant others can work, or they provide specialized services to specific populations, such as individuals with cerebral palsy or mental health problems.
4. Although hospice services may be provided in a hospital, a nursing home, or a residential hospice setting, the majority of hospice services are provided in the home. Hospice agencies provide multiple specialized services to support the dignity and quality of life of individuals who are dying and their family members.
- 29.** 1. Although this remains to be seen, the explosion in knowledge and technology usually results in treatments that prolong life.
- 2. The percentage of older adults in the United States is expected to increase to 20% by the year 2050. Because chronic illness is more prevalent among older adults, additional health-care services will be needed in the future, raising costs.**
3. More people will seek health care in the home and community, not the acute care setting. In 1992 the National League for Nursing predicted that home care will become the center of health care and that community nursing centers and community health programs will focus on illness prevention and health promotion.
4. This may or may not occur because of a multiplicity of factors, such as religious beliefs, unplanned pregnancies, and a lack of seeking genetic counseling.
- 30.** 1. This is not the reason why DRGs were instituted. In addition, the DRGs have increased the acuity of hospitalized patients requiring a lower ratio of nurses to patients, which necessitates the need to hire more nurses. However, many hospitals have not increased the number of nurses because of reengineering and the lack of available qualified nurses.

2. This is not the reason why DRGs were instituted. Although there is a current trend in the United States with more people focusing on health promotion and illness prevention, it is unrelated to DRGs.
  3. DRGs were not instituted to solve fragmentation of care. Fragmentation of care generally is caused by overspecialization and caregivers failing to address patients' needs holistically and comprehensively.
  4. **The DRGs, pretreatment diagnoses reimbursement categories, were designed to decrease the average length of a hospital stay, reducing costs.**
- 31.**
1. Because of circumstances, a nurse's intervention may not always be able to meet a patient's perceived needs.
  2. The nurse-patient relationship is a therapeutic, not social, relationship.
  3. **When planning patient care, the nurse and patient work together to identify appropriate goals and interventions to facilitate goal achievement.**
  4. The patient, not the nurse, is the leader of the health-care team.
- 32.**
1. How one practices nursing and why one is a nurse are based on enduring values and beliefs. Although it is important to be aware of how one practices nursing and why one is a nurse, confronting, taking exception to, and calling into question one's enduring values are not where the problem of burnout lies.
  2. Although it is important to reduce the effects of stress, these approaches do not reduce the contributing factors that cause stress.
  3. **When faced with any stressful situation that can lead to feelings of burnout, the nurse must begin with self-awareness and identify personal expectations, strengths, and limitations associated with the job. After the assessment is complete and problems are identified, the nurse can explore options to reduce factors contributing to job-related stress. Burnout generally occurs because nurses are unable to practice nursing as they were taught based on principles and standards of practice. Nurses experience stress because of such factors as understaffing, increased patient care assignments, shift work, excessive mandatory overtime, inadequate support, and caring for more patients who are critically ill and dying. The nurse must employ strategies to manage stress to prevent the physical and emotional exhaustion associated with burnout and not wait until these responses occur.**
- 33.**
1. Although humor may temporarily defuse a stressful situation, it is not an effective strategy to cope with the major issues that contribute to burnout. The nurse should not be distant from the patient.
  2. A bonus to entice nurses close to retirement age to work longer is a short-term and limited response to the need for more nurses. Retirement of nurses is not the major cause of the nursing shortage.
  3. **Programs to fund the education of nursing educators will most likely have the greatest impact on reducing the nursing shortage. Many nursing schools are unable to accept eligible applicants to nursing programs each year because of the shortage of faculty. The American Association of Colleges of Nursing report on 2012–2013 Enrollment and Graduation in Baccalaureate and Graduate Programs of Nursing indicated that nursing schools turned away over 78,089 eligible candidates to baccalaureate and graduate nursing programs mainly as a result of insufficient faculty in addition to other constraints such as insufficient clinical sites, classrooms, and preceptors as well as budget constraints.**
  4. Hiring foreign nurses is not a long-term strategy to increase the number of nurses. It will worsen the shortage in their own countries, because the nursing shortage is a global problem, and it will raise concerns regarding effects on salaries, adequacy of education, and quality care here in the United States.
- 34.**
3. **Providing a special diet is a dependent function of the nurse. The primary health-care provider's order should be verified first.**

1. The dietary manual should be reviewed to determine if the requested food is permitted on the ordered diet.
  2. If the requested food is not indicated on the diet in the dietary manual, the nurse should collaborate with appropriate dietary resources (e.g., nutritionist, dietitian).
  4. If the food is not permitted on the diet, the nurse can function as a patient advocate by collaborating with the primary health-care provider to determine if an occasional concession can be made regarding a patient's food preference.
- 35.**
1. Departments of health (state, county, city, or other local government units) are considered official agencies because primarily they are funded by tax money. They are concerned with health promotion and disease prevention.
  2. A Veterans Affairs Hospital is an official organization because it is a part of the Department of Veterans Affairs, which is under the umbrella of federally supported/operated facilities and is financed by taxation.
  3. The American Heart Association is a voluntary not-for-profit organization, not an official organization.
  4. The National League for Nursing (NLN) is a not-for-profit organization founded in 1952 to foster the development and improvement of nursing education and services. It is not an official organization.
  5. Nonprofit community hospitals are voluntary, not official, organizations.
- 36.**
1. The caregiver role is associated with the performance of interventions that will help a patient achieve identified goals.
  2. The caregiver role is associated with facilitating the achievement of goals identified in the patient's plan of care.
  3. Of the options offered, the word *evaluate* is not the word most associated with the nurse functioning as a caregiver. Although evaluation is important in relation to the nursing process and caregiving, it is only one aspect of caregiving.
  4. Of the options offered, the word *counsel* is not the word most associated with the nurse functioning as a caregiver. When counseling, the nurse helps a patient recognize and cope with emotional stressors, improve relationships, and/or promote personal growth; it is only one aspect of caregiving.
- 37.**
1. The daughter needs more than a brief period of relief from caring for her mother. She is a single mother working full time and caring for three small children.
  2. A home health aide several hours a day is an inadequate level of care to keep the patient safe.
  3. A full-day older adult day-care program may be capable of meeting the patient's needs during the day. However, the patient also needs supervision during the night, which may be beyond what the daughter can provide.
  4. The patient requires assistance with the activities of daily living and supervision 24 hours a day to prevent wandering and promote safety.
- 38.**
1. The Affordable Care Act is a movement in the United States to ensure access to quality health care for all.
  2. Social issues are taking a front, not back, seat as a result of advances in technology. Technological advances and specialized treatments are extremely expensive. Social issues include who will pay for health-care costs, who has access to health care, and who will care for older adults and the uninsured (both of whom are increasing in numbers). In addition, ethical issues are becoming prominent in response to advances in areas such as organ transplantation and beginning of life technology.
  3. Although some people strive to sustain life at any cost, most people prefer to seek ways to support and maintain quality, over longevity, of life. The hospice movement, which is increasing, is based on the concept of maintaining quality of life by caring for dying people in their homes surrounded by family and friends and making remaining days as comfortable and meaningful as possible.
  4. Educated consumers, not health-care providers, control the direction and development of health-care services.

Citizens are active members of the boards of trustees of health-care agencies in all settings, community organizations have political action committees that lobby government representatives to shape the political agenda, and the consumer movement has demands and expectations; all of these impact the direction of health-care reform.

5. **The patient is the center of the health-care team and has primary responsibility for making health-care decisions. Consumers are more knowledgeable than ever before, have a greater awareness of health issues, and have a desire to be responsible for health-care decisions. In addition, more knowledgeable consumers (patients and families) have made a major impact on the delivery of health-care services in the United States because they have made their opinions and preferences known.**
  39. 1. The percentage of older adults below the designated poverty level has continued to decline as reported by the United States Census Bureau. The poverty rate for older adults dropped significantly in the 1970s and has continued to decline to 9.7% in 2012 and to 9.5% in 2013 in spite of the recent recession. Poverty does not have a significant impact on the delivery of health care to people 65 years of age and older living in the community. In 2013, the poverty rate for adults 18 to 64 years of age was 13.6%.
  2. **Thirteen percent of the population was 65 years of age and older in 2010 (40.3 million people). The United States Census Bureau predicts that in 2050 there will be an increase to 80 million older adults, accounting for 20% of the population. This is a major factor that has significant impact on the delivery of health care within the United States as the number of individuals 65 years of age and older increases as baby boomers age.**
  3. **The percentage of older adults experiencing cognitive deficits varies depending on the agency compiling the research. The Centers for Disease Control and Prevention identified that in 2013, 5 million Americans aged 65 years or older have Alzheimer's disease. It is predicted that this number may increase to 13.8 million individuals by 2050. This is a major factor that has significant impact on the delivery of health care within the United States as the number of individuals 65 years of age and older increases as baby boomers age.**
  4. **The Centers for Disease Control and Prevention reported in 2012 that one-third of older adults 65 years of age and older experience at least one fall each year. Falls have become the leading cause of fatal and nonfatal injuries for older adults. In 2012 the cost of medical care for individuals experiencing falls was 30 billion dollars. This is a major factor that has significant impact on the delivery of health care within the United States as the number of individuals 65 years of age and older increases as baby boomers age.**
  5. **The United States Census Bureau reported that the percentage of individuals 65 years of age and older residing in a nursing home declined from 5.1% in 1990 to 4.5% in 2000 and to 3.1% in 2010. Although this number declined between 1990 and 2010, the overall number of persons 65 years of age and older living in a nursing home will increase in the future because the population in this age group will increase as baby boomers age. The Census Bureau predicts that by 2050, people 65 years of age and older will double to 80 million and be 20% of the population.**
    40. 1. Although satisfaction with educational information improved between January and March, the improvement was not as significant as improvement in another option.
    2. **Although all four quality indicators related to patient satisfaction demonstrated a positive trend toward greater satisfaction, satisfaction with pain management increased most dramatically from January to March.**
    3. Although satisfaction with nursing care improved between January and March, the improvement was not as significant as improvement in another option.
    4. Although satisfaction with overall care improved between January and March, the improvement was not as significant as improvement in another option.

41. 1. This action is an example of care associated with the tertiary level of health-care delivery. Tertiary care is associated with long-term, chronic, and hospice care and specialized services.
2. This action is an example of care on the secondary level of health-care delivery. Secondary care (acute care) includes emergency treatment, critical care, and care associated with intensive and elaborate diagnosis and treatment.
3. This action is an example of care on the secondary level of health-care delivery. Secondary care (acute care) includes emergency treatment, critical care, and care associated with intensive and elaborate diagnosis and treatment.
4. **This action is an example of the primary level of health-care delivery. Primary care is associated with activities that promote health and protect against disease. The health-care system has three levels of health-care delivery that describe the scope of services and settings: primary, secondary, and tertiary.**
5. **This action is an example of the primary level of health-care delivery. Primary care includes activities that protect a person from contracting a disease.**
42. 3. **An independent care setting provides personal space (e.g., one-bedroom apartment, studio apartment) as well as services such meals, housekeeping, and van rides to stores or appointments. Individuals living in this type of setting must be self-sufficient, cognitively competent, and capable of meeting their own physical needs.**
2. **In addition to the services provided in an independent care setting, an assisted living setting provides help with some of the activities of daily living such as dressing, bathing, and ambulating.**
1. **An intermediate care setting provides health-care services to individuals who require lifelong assistance with the activities of daily living such as individuals who are cognitively impaired or disabled. These settings provide custodial care and function as the individual's home.**
5. **A subacute unit in a skilled nursing facility provides care to individuals with an acute illness, injury, or exacerbation of a disease process that requires skilled health-care services but does not require hospitalization to an acute care facility. The services include activities such as occupational therapy, physical therapy, and learning self-care of a newly created colostomy.**
4. **Skilled nursing care that must be provided for an extended period of time, frequently for the rest of the person's life, is often provided in a long-term care facility. Examples of patients residing in this type of long-term care setting include people with spinal cord injuries, patients in a coma, patients on mechanical ventilation, and people receiving enteral nutrition via a surgically implanted GI tube.**
43. 1. When functioning as a *provider*, the nurse is in the caregiver, not advocate, role. Caregiving involves identifying and meeting the patient's needs by helping the patient regain health through the caring process.
2. When functioning as a *nurturer*, the nurse is in the caregiver, not advocate, role. Nurture means to encourage, foster, and promote, all of which are components of caregiving.
3. **The word *protector* describes the role of the nurse when functioning as the patient's advocate. In the role of advocate, the nurse supports patients' rights and assists in asserting those rights when patients are unable to defend themselves.**
4. Evaluation is the last step in the nursing process; it involves a determination of whether the patient's goals are achieved. The word *evaluator* is not synonymous with the word *advocate*.
5. **The word *supporter* describes the role of the nurse when functioning as the patient's advocate. In the role of advocate, the nurse protects patients' rights and assists in asserting those rights when patients are unable to defend themselves.**
44. 1. Fifty percent of the population spends little on health care.
2. Five percent of the population incurs approximately 50% of the cost of health care.
3. **This is a true statement about the cost of cancer care per person.**

4. This is a true statement about the percentage of people in the population with one or more chronic illnesses.
  5. This is a true statement regarding the population responsible for 70% of Medicaid spending.
45. 1. **The patient is the center of the health team as well as the nursing team. The patient is the most important member of these teams.**
2. The unit secretary is not a member of the nursing team but is a supportive health-team member.
  3. **A Registered Nurse is a member of the nursing team. A Registered Nurse provides direct nursing care and supervises other members of the nursing team such as Licensed Practical Nurses and unlicensed assistive nursing personnel.**
4. **A Licensed Practical Nurse provides uncomplicated direct patient care and works in a structured environment under the direction of a Registered Nurse.**
  5. Primary health-care providers are not members of the nursing team. They are professional health-team members who have a prescriptive license such as a medical doctor (MD), nurse practitioner (NP), and physician's assistant (PA).
  6. **Unlicensed assistive nursing personnel (e.g., nursing associate, nursing assistant, nurse's aide) are members of the nursing team who provide uncomplicated direct care to patients such as bathing, feeding, dressing, and ambulating.**

F.A. DAVIS

COMPANY



# Community-Based Nursing

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Case management	Levels of health-care delivery:
Community	Primary
Demographics	Secondary
Epidemiology	Tertiary
Health-care reform	Levels of prevention:
Health-care settings:	Primary prevention
Acute care hospitals	Health promotion
Adult day-care centers	Health protection
Ambulatory care centers	Preventive health services
Assisted-living residences	Secondary prevention
Clinics	Tertiary prevention
Extended care facilities	Managed care
Home health services	Metropolitan
Hospice (inpatient, residential, in the home)	<i>Nursing's Agenda for Health Care Reform</i>
Industrial or occupation settings	Occupational nurse
Life-care communities	Outreach
Long-term care nursing homes	Population
Neighborhood community health centers	Primary care
Physicians' offices	Public health nurse
Psychiatric facilities	Quality improvement, quality management
Rehabilitation centers	Respite care
School settings	Rural
Urgent visit centers	Self-help group
<i>Healthy People 2020</i>	Suburban
Holistic	Urban
	Vulnerable populations
	Wellness

## COMMUNITY-BASED NURSING: QUESTIONS

1. A family member requests relief from caring for a relative who has a rapidly debilitating malignancy. To which resource should the nurse refer the family member for respite care?
  1. Hospice
  2. Meals on Wheels
  3. Ambulatory care center
  4. Alcohol treatment center
2. Which role of the nurse takes on more emphasis in the delivery of health care in the home than in acute care?
  1. Coordinating the efforts of the health-care team
  2. Delivering skilled nursing care
  3. Providing for healthy meals
  4. Modifying the environment

3. Which is unique to the home-care setting that is different in the acute care setting?
  1. Patient is the center of the health-care team.
  2. Nurse functions as an advocate for the patient.
  3. Nurse is responsible for coordinating the efforts of the patient's health-care team.
  4. Patient is not discharged until teaching regarding self-care activities is completed.
4. Which action reflects the nurse's attempt to work with family members to explore the nature and consequences of their choices?
  1. Affirming
  2. Mediating
  3. Informing
  4. Interviewing
5. When do nursing activities related to community nursing begin?
  1. On the first contact with the patient
  2. After the patient is admitted to the hospital
  3. At the time referrals are made to community resources
  4. When the primary health-care provider writes discharge orders
6. A nurse must collect information about a community to identify its needs. Which is the **most** significant assessment by the nurse?
  1. The demographics of the community
  2. What the community thinks is important
  3. How many support services are available
  4. Environmental data as they relate to public safety
7. A home-care nurse is caring for a variety of patients in their homes. Which individual identified by the nurse will have the **most** difficult time adjusting to a prescribed regimen of long-term home health care?
  1. Middle school-aged child
  2. Preschool-aged child
  3. Adolescent
  4. Older adult
8. Which is unique to the home-care setting that is different in the acute care setting?
  1. Nurses work more independently.
  2. Nurses require excellent communication skills.
  3. Patients must be taught how to care for themselves.
  4. Patients have needs that require less technical nursing skills.
9. A woman is concerned about her children accidentally ingesting her husband's prescription medications. Where should the home-care nurse teach the mother to keep medications?
  1. On a high shelf
  2. In a locked cabinet
  3. In a medicine cabinet in the bathroom
  4. On a shelf in the back of the refrigerator
10. Who is the **most** important health-care team member in an assisted-living facility?
  1. Occupational Therapist
  2. Nurse Aide
  3. Patient
  4. Nurse
11. A patient's contract for home-care services is about to end but the patient still requires care. On which factor will the continuation of services **initially** depend?
  1. Nursing documentation of the need for care
  2. Retrospective audits of quality management
  3. Patient satisfaction with the care being provided
  4. Presence of a primary health-care provider's order

12. Which factor is essential to the health of a community?
  1. Availability of medical specialists
  2. Individuals having health insurance
  3. Everyone having access to health care
  4. Public Health Nurses working in the community
13. A nurse identifies the health-care needs of the members of a community. Which is the nurse's **most** efficient initial approach to meet these needs?
  1. Involve community leaders to work within the political arena to obtain funding for programs.
  2. Write research grants to explore the community's health needs in more detail.
  3. Design educational programs that address the identified community needs.
  4. Make residents aware of the resources in the community.
14. A home-care nurse is performing an initial patient and home assessment. Which is the **most** essential assessment that must be made by the nurse?
  1. Can the home environment support the safety of the patient?
  2. Is the family willing to participate in the patient's recovery?
  3. Does the patient have the potential for self-care?
  4. Can the patient participate in the plan of care?
15. During the process of performing a community assessment, the nurse invites members of the community to come to a meeting and share opinions and concerns about a particular issue. Which is this method of data collection?
  1. An opinion survey
  2. A community forum
  3. A demographic assessment
  4. An observation of participants
16. Which is **most** important when a nurse works in the home-care setting?
  1. Case management
  2. Discharge planning
  3. Enlisting family support
  4. Modifying patient values
17. A nurse is preparing a patient for discharge from the hospital. Which is designed primarily to provide for a continuum of comprehensive health care after discharge?
  1. Primary health-care providers' offices
  2. Home-care agencies
  3. Urgent visit centers
  4. Respite programs
18. A nurse must conduct a community assessment. Which information should the nurse collect **first**?
  1. General health of community members
  2. Characteristics of community members
  3. Physical environment of the community
  4. Social services available in the community
19. A nurse in a home-care agency is providing an orientation program to a group of newly hired patient companions. Which should the nurse teach them about families in the United States?
  1. Families are groups of people related by blood, marriage, adoption, or birth.
  2. Families are made up of fathers, mothers, and their children.
  3. Families vary based on their structural composition.
  4. Families live in the same household.

20. A home-care nurse is providing care for a family supporting a patient with a chronic illness. Which is the **most** important factor the nurse should teach caregivers who care for a family member who has a stable but chronic illness and is living in the home?
1. Have extra equipment and supplies for emergencies.
  2. Plan a daily and monthly schedule of activities.
  3. Keep a daily journal of the patient's status.
  4. Tend to themselves as well as the patient.
21. Which is a need that falls within the category of tertiary health-care services?
1. Critical care
  2. Long-term care
  3. Diagnostic care
  4. Preventive care
22. A person at home is recovering from an illness that has caused functional deficits. Which support service identified by the nurse will provide the **most** benefit for this person?
1. Hospice services
  2. Church outreach program
  3. Home health-care agency
  4. Meals on Wheels program
23. A nurse is providing information about taking medication in the home. Which is a feature common to **most** containers for prescription medications that should be discussed?
1. Drip-proof tops
  2. Unit dose packages
  3. Sun-repellent plastic
  4. Child-resistant covers
24. A nurse must initiate nursing services in the home setting. Which is an important factor that the nurse must consider to ensure third-party reimbursement?
1. The patient must be able to perform some self-care.
  2. The family has the financial resources to pay for the care.
  3. Additional family members need to be available for support.
  4. Intervention must be ordered by a provider with a license to prescribe.
25. A home-care nurse is assessing a patient and family members from a cultural perspective. Which is **most** important for the nurse to do?
1. Recall experiences of caring for patients with a similar background.
  2. Recognize beliefs common to the patient's ethnic group.
  3. Interview the members of the patient's family.
  4. Use the patient as the main source of data.
26. In which setting is it **most** essential for the nurse to assume multiple roles?
1. Rehabilitation facilities
  2. Acute care hospitals
  3. Rural communities
  4. Urban centers
27. Which factor is essential to promote healthy lifestyles and behaviors within the community setting?
1. An entire family must be committed to making changes.
  2. There must be resources available to support the desired changes.
  3. The focus must be on the community as a whole, not on individuals.
  4. A primary health-care provider's order is necessary before care can be provided.

28. A group of nurses is discussing various concerns about health care in the community setting in the United States. Which of the following should they include in the discussion because it has demonstrated a noticeable decline?
1. Public health organizations
  2. At-risk patient groups
  3. Cost of health care
  4. Self-help groups
29. A community health nurse is to care for a patient who was just discharged from an acute care facility after receiving initial medical care for tuberculosis. The family recently immigrated to the United States from another country. Place the following interventions in the order in which they should be performed by the nurse.
1. Explore community resources that can help support the patient and family.
  2. Perform an assessment of the patient and home environment.
  3. Meet with the patient and family in their home.
  4. Review the patient's medical record.
  5. Identify patient and family needs.
- Answer: \_\_\_\_\_
30. Which statements reflect hospice care in the health-care delivery system? **Select all that apply.**
1.  P atients must have less than half a year to live to receive services.
  2.  It assists families to care for their dying relatives at home.
  3.  C are is more expensive than in the acute care setting.
  4.  It provides mainly physical care to the dying person.
  5.  Ho spice is a method of care rather than a location.
31. Identify the nursing interventions that reflect tertiary health-care services. **Select all that apply.**
1.  Providing emotional support to family members after the death of a relative
  2.  T eaching a patient how to use a wheelchair after a stroke
  3.  C onducting a smoking cessation class
  4.  A dministering an influenza vaccine
  5.  C hanging a dressing after surgery
32. Which activities are examples of interventions associated with secondary health-care services? **Select all that apply.**
1.  C onducting a cardiac risk assessment for middle-aged adults
  2.  T eaching a low-fat diet to a person with high cholesterol
  3.  Immu nization of a child during the first year of life
  4.  Enc ouraging regular dental checkups
  5.  Mo nthly self-breast examinations
33. Which statements accurately reflect a concept about a healthy community? **Select all that apply.**
1.  Health of a community is based on the sum of the health of its people.
  2.  The main focus in community health is on the health of each member of society.
  3.  A healthy community seeks to make community resources available to all members.
  4.  The focus of community health mainly is on healing the sick and preventing disease.
  5.  Promotion of health is one of the most important components of community health practice.

34. Which indicators are among the 10 leading health indicators identified by *Healthy People 2010*? **Select all that apply.**
1.  Over weight and obesity
  2.  Substance abuse
  3.  Older adults
  4.  Diabetes
  5.  Vision
35. An older adult woman who has left-sided paralysis because of a brain attack is being cared for by a daughter in the home in which the daughter lives with her husband. The home-care nurse interviews each member of the family separately. Based on the significant information in each interview, which is the **most** important initial nursing intervention?
1. Be sensitive to the patient's cultural beliefs.
  2. Arrange respite care for the patient's daughter.
  3. Reinforce the daughter's responsibility to care for her mother.
  4. Encourage the husband to help his wife with the care of his mother-in-law.

#### Interview With the Patient

"I am thankful that my daughter is caring for me. I took care of my parents and now it is my daughter's turn. Someday my daughter's children will be responsible for caring for her. I want to start acupuncture because I think it will help."

#### Interview With the Daughter

"Initially I took several months off from work to care for my mother. I know it is my responsibility to care for her but it is difficult because I work full time. She has me doing old-fashioned Asian remedies that take time and I don't even know if they will help."

#### Interview With the Daughter's Husband

"My mother-in-law came to live with us from Asia after her husband died. Since her recent discharge from the hospital my wife has been giving her heat and cold applications to promote harmony of yin and yang. It doesn't make any sense to me but my mother-in-law believes it works. I worry about my wife doing too much."

## COMMUNITY-BASED NURSING: ANSWERS AND RATIONALES

- 1. A hospice program is an example of an agency that may provide or arrange for respite care in an inpatient setting or in the home. The caregiving role is physically and emotionally grueling, and family members may need relief from the caregiving role or a break to attend a family function or go on vacation.**
  - Meals on Wheels does not provide respite care. It provides nutritious, low-cost meals for homebound people so that they can remain in their own homes.
  - Ambulatory care centers do not provide respite care. Ambulatory care centers provide care for people with conditions that do not require hospitalization. Services may include diagnosis and treatment of disease and illness, as well as simple surgical procedures in which the patient returns home the same day.
  - An alcohol treatment center does not provide respite care. It provides a specialized service in the care and treatment of individuals who abuse alcohol.
- Coordinating the efforts of the health-care team is an important responsibility of the nurse in all settings in which nurses work.
  - Delivering skilled nursing care is an important responsibility of the nurse in all settings in which nurses work.
  - Ensuring that patients receive healthy meals is an important responsibility of the nurse in all settings in which nurses work.
  - The hospital environment rarely requires modification because it is designed to provide for the safety needs of patients. However, in the home setting a home hazard assessment must be implemented to identify potential problems with walkways, stairways, floors, furniture, bathrooms, kitchens, electrical and fire protection, toxic substances, communication devices, and issues associated with medications and asepsis. Although the nurse may not be able to change a patient's living space and lifestyle, recommendations can be made that will minimize or eliminate risks.**
- The patient is the center of the health-care team in all settings.
  - The nurse functions as an advocate for the patient in both the acute care and home-care settings. The role of advocate is important in all settings because in this role the nurse protects and supports patients' rights.
  - The nurse is responsible for coordinating the efforts of the members of the health-care team in both the acute care and home-care settings.
  - Because of the shorter length of hospital stays, patients are being discharged before all teaching and counseling are completed. However, in the home-care setting, patients are provided with appropriate care until they are able to care for themselves.**
- Affirm means to state positively, to declare firmly, to ratify, and to assert. Exploring the nature and consequences of choices is not affirming.
  - Mediate means to negotiate or intercede. Exploring the nature and consequences of choices is not mediating.
  - Inform means to give information, to enlighten, and to give knowledge. When working with families to explore the nature and consequences of their choices, the nurse can provide information so that people understand the ramifications of their choices. An informed decision is a decision based on an understanding of the facts and ramifications associated with the choice.**
  - Interview means to meet and talk for the purpose of collecting information. Exploring the nature and consequences of choices is not interviewing. However, interviewing skills may be employed when the nurse explores with the patient the nature and consequences of choices.
- As soon as contact with the patient is made, planning and teaching should begin so the patient is prepared to provide self-care in the home.**
  - The nurse does not have to wait until the patient is admitted to the hospital to begin preparing for the patient's return to the community.

3. This is too late. The need for referrals to community agencies can be anticipated in most situations.
  4. This is too late to prepare the patient for self-care in the community.
- 6.**
1. This is not as important as an assessment presented in another option. The demographics of a community are only one component of a community assessment.
  - 2. The members in the community are the primary source of data about the community and its needs. Just as the patient is the center of the health-care team when caring for an individual, the collective membership of a community is the center of the health-care team when caring for the health-care needs of a community.**
  3. This does not help to identify the needs of a community. After the needs of the community are identified, then the ability of the health-care system to deliver the necessary services is assessed.
  4. This is not as important as an assessment presented in another option. Environmental data make up only one component of a community assessment.
- 7.**
1. A middle school-aged child has to cope with the developmental conflict of Industry versus Inferiority. Tasks associated with this age such as deriving pleasure from accomplishments and developing a sense of competence can be facilitated in the home setting. Although a middle school-aged child will have to adjust to the need for long-term home health care, there are fewer crises occurring during the middle school years that impact on development than the number of crises occurring in a group in another option.
  2. A preschool-aged child is dependent on a parent to provide for basic human needs and coping with the developmental conflict of Initiative versus Guilt. Tasks associated with this age, such as the development of confidence in ability and having direction and purpose, can be facilitated in the home setting. Although a preschool-aged child will have to adjust to the need for long-term home health care, there are fewer crises occurring during the preschool years that impact on development than the number of crises occurring in a group in another option.
- 3. Adolescents struggle with the developmental conflict of Identity versus Role Confusion. The adolescent generally will have the hardest time adjusting to the need for long-term home health care than any other stage of development. Adolescents experience multiple and complex physiological, psychological, and social developmental milestones. Adolescents want to be attractive to others, similar to their peers, and accepted within a group. It is common for adolescents to experience mood swings, make decisions without having all the facts, challenge authority, and assert the self. Being relatively isolated in the home for an extended period will pose serious stressors associated with adjustment, which can dramatically influence the outcome of the developmental tasks of adolescence.**
4. The developmental conflict of Ego Integrity versus Despair challenges older adults to understand their worth and accept the approaching end of life. Although older adults will have the second-hardest time adjusting to the need for long-term home health care of the options offered, there are fewer crises occurring during the older adult years that impact development than the number of crises occurring in a group in another option.
- 8. 1. In the home setting, patients tend to have fewer health-care providers' orders and therefore nurses work more independently. In addition, the roles of the nurse in community-based practice today are expanding dramatically. In 1991, the American Nurses Association published *Nursing's Agenda for Health Care Reform*, which made recommendations for health-care reform. The major predictions influencing nurse accountability included: nurses will become community leaders; community-nursing centers will expand and focus on preventing disease and promoting health; and the center of health care will shift to the home setting. Nurses already work independently in such programs as community outreach, nursing centers, nurse-sponsored**



**wellness and health promotion programs, and independent practice. These roles require the nurse to utilize nursing theory and skills that are in the scope of the legal definition of nursing practice and do not require dependence on a primary health-care provider's orders.**

2. Excellent communication skills are essential in both the acute care and community-based settings.
  3. Teaching occurs in both the acute care and community-based settings. In addition, some patients may never be able to care for themselves.
  4. Excellent technical skills are essential in both the acute care and community-based settings. Patients at home receive highly technical therapy such as hemodialysis, intravenous therapy, wound care, and ventilator support.
- 9. 1. This is not a safe place to keep medications. Children have natural curiosity, problem-solving abilities, and the agility to climb to a top shelf.**
- 2. A locked area is the safest place to store prescription as well as over-the-counter medications to prevent accidental ingestion by children.**
3. This is not a safe place to keep medications. Children have natural curiosity, problem-solving abilities, and the agility to climb up to a medicine cabinet.
  4. This is not a safe place to keep medications. Children have natural curiosity and problem-solving abilities and could get to the back of a shelf in a refrigerator.
- 10. 1. The Occupational Therapist (OT) is not the most important member of the health-care team. An Occupational Therapist generally is not a member of the health-care team in an assisted-living residence. On occasion, a primary health-care provider may order occupational therapy, and either the resident will go to an Occupational Therapist to receive therapy or one will come to the resident and provide therapy.**
2. Although Nurse Aides are the people who provide care related to activities of daily living needed by residents in an assisted-living residence, they are not as important as another member of the health-care team.
- 3. The patient is always the center of the health-care team in every setting and is the most important member of the team.**
4. The nurse is not the most important health-care team member in an assisted-living facility. An assisted-living residence (i.e., apartment, villa, or condominium) provides limited assistance with activities of daily living, meal preparation, laundry services, transportation, and opportunities for socialization, not extensive nursing services.
- 11. 1. Case management by the nurse in the home-care setting includes determining whether a patient is ready for discharge or requires a continuation of services. The nurse must document objectively the status of the patient to convince those making the decision (e.g., primary health-care provider, insurer, agency manager) that the patient requires a continuation of services. Nursing documentation supports the decision.**
2. Quality management activities are unrelated to whether a patient is to receive a continuation of services or is to be discharged from a home health-care program. Ongoing quality management programs are designed to monitor the quality of care being delivered and identify problem areas so that efforts can be employed to improve care.
  3. Dissatisfaction with the services of a home health agency may influence whether or not the patient and/or family wants a continuation of services. However, satisfaction or dissatisfaction should not influence whether the patient still needs the services of the home health-care agency.
  4. The primary health-care provider generally is not the only person making the decision of whether a patient is eligible for continuation of services or is ready for discharge from the home-care program. Agency managers and the insurer also may be involved in this decision. However, in the home-care setting a primary health-care provider's order is necessary to initiate home-care services as well as orders directing the nurse in the dependent functions of the nurse.

- 12.** 1. Although it is important to have access to medical specialists, another option has priority. In addition, the availability of primary health-care providers, not specialists, is more essential because primary health care addresses health promotion, illness prevention, and entry into secondary health care (diagnosis and treatment of illness and disease).
2. Although individuals with health insurance have better access to health-care services, it is not essential to have health insurance to receive health care. People can pay privately or, if indigent, they can apply for various government and nonprofit-supported programs that provide basic care. In addition, hospital emergency departments, by law, cannot turn away patients who need emergency care.
- 3. For a healthy community, all members of the community must have access to health care. The health of a community depends on each member of the community having appropriate and comprehensive health care.**
4. Public Health Nurses work for only the federal, state, or local governments implementing programs supported by taxes. These programs are only a small percentage of the multitude of programs and services that are designed to support community health.
- 13.** 1. This is not the most efficient approach. This may be necessary if present resources are not available to meet the needs of the community.
2. The health needs of the members of the community are identified already. Further study at this time does not appear to be appropriate.
3. Designing educational approaches is not the most efficient approach. This may eventually be done after an action in another option is implemented first.
- 4. This is the most efficient initial approach to meeting the identified needs of the members of the community. The use of currently available resources is more efficient than the other options presented.**
- 14.** 1. **The first and most important assessment made by the home-care nurse focuses on determining whether the patient's home environment is safe. Safety and security are basic needs identified by Maslow's Hierarchy of Needs.**
2. Although it is often helpful when family members participate in a home-care patient's recovery, it is not necessary.
3. A patient's potential for self-care is not a criterion for receiving home-care services. Patients who have little or no potential for self-care receive home-care services.
4. Patients who are unable to participate in the plan of care because they are mentally, emotionally, or physically disabled are still eligible for home care.
- 15.** 1. This scenario is not an example of an opinion survey. An opinion survey is designed to collect each individual person's perspective about the problem being studied. Results are tallied to identify the major concerns. Opinion surveys generally are questionnaires.
- 2. A forum is defined as an opportunity for open discussion. Inviting people from the community to share opinions and concerns about a particular issue for the purpose of collecting data is called a community forum.**
3. This scenario is not an example of a demographic assessment. A demographic assessment is the quantitative study of the characteristics of a population. A demographic assessment might include information such as distribution of the population by gender, size, growth, density, and ethnicity.
4. This scenario is not an example of an observation of participants. Direct observation is a method of data collection that may be used to determine whether individuals follow a specific procedure or behave in an expected manner.
- 16.** 1. **Case management is a major role of the nurse in the home-care setting. The nurse engages in activities such as assessing, planning, coordinating nursing care and professional services, making referrals, monitoring medical progress, maintaining documentation, evaluating and monitoring outcomes, determining closure, and facilitating discharge of the patient after goal achievement.**
2. Although discharge planning is a component of the role of the nurse in the home-care setting, it is not the role with the highest priority. Traditionally,

discharge planning was focused on moving a person from the hospital to the home. However, in the present health-care environment discharge planning is conducted when moving a patient from one level of care to another, which occurs in many settings.

3. Although family support is helpful, the patient's interest and motivation in achieving expected outcomes are the most important contributing factors to success.
  4. The role of the nurse is to help the patient achieve expected outcomes that are within the patient's present value and belief systems. Although a patient might be healthier if other behaviors were adopted, it is difficult, and sometimes impossible, to change or modify a person's values and beliefs.
- 17.**
1. Primary health-care providers' offices are the traditional primary care setting for ambulatory care. Patients go to primary health-care providers' offices for routine physicals and the diagnosis and treatment of routine illnesses or diseases. Follow-up visits to primary health-care providers are only one aspect of comprehensive health care.
  2. **Home-care agencies are responsible for coordinating and providing for a continuum of comprehensive health-care services after a patient is discharged from the hospital. Because of the decreased length of stay in the hospital setting, patients are being discharged sooner than ever before and are in need of home-care services.**
  3. Urgent visit centers are designed to diagnose and treat noncritical health problems, such as infections, minor injuries, and physical responses to disease or illness as well as primary care services.
  4. Respite programs provide for short-stay, intermittent, inpatient, or day-care services to patients who generally are cared for at home. This service provides a rest period for family members who have the responsibility of sustained caregiving.
- 18.**
1. Although the general health of members of a community is important, it is not the first information that the nurse should collect when assessing a community.
  2. **Acquiring core information about the people in the community is the first stage in assessing a community. Core**

**characteristics about the members of a community include information such as vital statistics, values and beliefs, demographics, religious groups, and so on.**

3. Although a community's physical environment (e.g., information such as whether it is rural, suburban, or urban, physical boundaries, density, size, types of lodgings, and incidence of crime) is important to know, it is not the first information that the nurse should collect when assessing a community.
  4. Although it is important to know information such as agencies and services available, the accessibility to health-care services, sources of health information, transportation services, routine caseloads, and so on, it is not the first information that the nurse should collect when assessing a community.
- 19.**
1. Families are not limited to individuals who are related by blood, marriage, adoption, or birth.
  2. This is an example of a nuclear family and is only one example of a family structure.
  3. **A family is defined as a social group whose members are closely related by blood, marriage, or friendship. Today, family structure is diverse and includes types such as traditional nuclear families, single-parent families, blended families, cohabitating families, families with gay and lesbian members, families with foster children, and single people living alone but who are part of an extended family.**
  4. Family members remain connected by their relationships, not because they all live in the same household.
- 20.**
1. Although this is a good idea, it is not the most important factor a home-care nurse can convey to a person caring for a family member in the home.
  2. Although this might contribute to efficiency as well as gaining a feeling of control over the activities that must be accomplished, it is not the most important factor a home-care nurse can convey to a person caring for a family member in the home.
  3. A daily journal of the patient's status is unnecessary when a patient is in stable condition. If the patient experiences an

acute episode, then a record of the patient's daily status could be helpful in monitoring progress or lack of progress.

4. **Caregiver role strain experienced by a family member is a serious concern of home-care nurses. Caregivers often fail to address their own health needs because of the extraordinary burden of the caregiver role, which can jeopardize their own health and well-being. Caregivers should be encouraged to delegate responsibilities to other family members; get adequate sleep, rest, and nutritional intake; seek assistance from agencies that provide respite services; take time for leisure activities and a vacation; and join a caregiver support group.**
  21. 1. Critical care lies in the category of secondary, not tertiary, level of health-care services. The secondary level of health-care services is associated with acute care, complex diagnosis, treatment of disease and illness, and emergency care.
  2. **Long-term care lies in the category of tertiary level of health-care services. The tertiary level of health-care services is associated with rehabilitation, care of the dying, and long-term care.**
  3. Diagnostic care lies in the category of secondary, not tertiary, level of health-care services.
  4. Preventive care lies in the category of primary, not tertiary, level of health-care services. Primary health-care services are concerned with promoting health and preventing disease.
22. 1. Hospice services are designed to assist patients who have less than 6 months to live and who have chosen to forego additional curative treatment for palliative care and support of quality of life. Hospice programs also provide support services to members of the patient's family as well as bereavement care for significant others after the death of the patient.
2. Although church outreach programs may be able to provide some support services, generally they are not able to provide the multiple services needed or to coordinate the continuum of comprehensive services that a person with functional deficits will require. Many church outreach programs generally serve as a source of information about services and programs available in the community, and they provide additional support that augments home-care services.
3. **A home health-care agency is designed to coordinate the comprehensive services that a patient may need to recover from an illness that has caused functional deficits. This person may require help in areas such as assistance with activities of daily living, physical and occupational rehabilitation, direct nursing care, counseling, and so on.**
  4. Meals on Wheels provides for only the nutritional needs of a patient.
23. 1. This is not common to all medication containers. Only medications in liquid form should have drip-proof tops.
2. Most prescriptions filled for home use are in multidose containers.
3. Not all medications must be protected from the sun.
4. **All prescriptions filled for home use are dispensed in containers with child-resistant tops, as required by law. If a person has a physical limitation, such as arthritis, that interferes with his or her ability to open a medication container, the person can request that a nonsafety top be provided. The pharmacy generally will document the request in its computer and may even require that a waiver be signed and witnessed for the record.**
24. 1. The ability to provide some self-care is not necessary. In some instances, family members provide total care with no help from the patient.
2. A person does not have to have adequate financial resources to receive nursing services in the home. For example, Medicare, Medicaid, or private health-care insurance plans assume some of the costs of care provided in the home.
3. The presence of family members is not a requirement for home-care services. However, if it is unsafe for the patient to be home alone or unattended for long periods, the home may not be the most appropriate setting. In addition, patients who have no family support may rely on a friend, neighbor, or volunteers from a neighborhood outreach group to help in a supportive way.

- 4. Health-care professionals who have prescriptive licenses (e.g., physicians, nurse practitioners, physician's assistants) must order home-care nursing services. An order from a provider with a prescriptive license is required if a home-care agency is to receive reimbursement from third-party sources (e.g., government, medical insurance plans). Orders written by these professionals direct the medical plan of care.**
- 25.** 1. This denies the individuality of the patient. The nurse's experiential background may be limited and is influenced by personal views that may not be accurate.
2. Each patient is an individual, and generalizations should not be made based on a person's ethnic or cultural group. Generalizations often are based on stereotypes that are preconceived and untested beliefs about people based on their culture, race, and/or ethnic backgrounds.
3. Family members provide only their own views, which are not the most important when assessing variables that affect a patient from a cultural perspective.
- 4. The patient is the center of the health-care team and is the most important source of information about his or her perspective.**
- 26.** 1. Of the options presented, nurses working in a rehabilitation setting are less likely to assume multiple roles. Generally, nurses working in a rehabilitation setting have specific roles and responsibilities.
2. Of the options presented, nurses working in the acute care setting are less likely to assume multiple roles. Generally, nurses working in acute care settings have specific roles and responsibilities.
- 3. Nurses working in rural communities wear many hats. The adage "wear many hats" refers to someone with many different roles and responsibilities. Rural refers to the country or the farm, where communities are less populated and are a great distance from primary health-care providers and health-care services. Because of the uneven distribution of health-care professionals and services in rural areas versus urban areas, nurses working in a rural area will assume many different roles and perform a variety of tasks.**
4. Of the options presented, nurses working in urban centers are less likely to assume multiple roles. Urban centers refer to cities with a population of more than 50,000 individuals, and they tend to have a concentration of specialized services where nurses have specific roles and responsibilities.
- 27.** 1. Each individual person is responsible for his or her own health-seeking actions and behavior. It is ideal if all members of a family are interested and motivated to promote a healthy lifestyle; however, not all members of a family are committed to this value.
- 2. Resources that support health promotion, health protection, and preventive health services are essential if one expects members of the community to engage in healthy lifestyles and behaviors. Resources, such as availability of health professionals, sites for primary health prevention programs for meetings and provision of services, consumables in the form of equipment and medications (e.g., immunizations), and so on, must be available to promote and support health.**
3. Although programs are designed to meet the needs of groups in a community, each individual must be reached and influenced when promoting healthy lifestyles and behaviors.
4. Education is the key in relation to recognizing and understanding the importance of behaviors that support a healthy lifestyle. Educational intervention is an independent function of the nurse and does not require a primary health-care provider's order.
- 28.** 1. **Public health agencies established at the federal, state, and local levels to safeguard and improve the physical, mental, and social well-being of an entire community are on the decline. In an effort to reduce the escalating rise in the budgets of public health agencies, programs and services have been reduced or terminated.**
2. The number of patient groups at risk is increasing, not declining; for example, groups such as older adults, the homeless,

the uninsured, people living below the poverty level, single-parent families, and immigrants.

3. The cost of health care in the United States is dramatically increasing, not declining. In 2011 17.9% of the gross domestic product was spent on health-care costs. It is predicted that by 2021 health-care costs will be 19.9% of the gross domestic product and they will be 26% to 30% by 2040.
4. The number of self-help groups is increasing, not declining. More than 500 self-help groups represent almost all the major health problems, life events, or crises. The National Self-Help Clearinghouse provides information about existing groups and guidelines on how to begin a new group. Consumer access to the World Wide Web and the Internet has disseminated information about self-help groups.

**29. 4. Before meeting with the patient and family the nurse should obtain as much information about the patient as possible.**

3. An assessment of the home environment can be performed only in the home. The patient's family members should be included when feasible because they may provide emotional support and/or be involved with physical care of the patient.
2. A health history and physical assessment of the patient should be performed by the community health nurse. The information on the patient's clinical record may not reflect the patient's current status. The home must be assessed to ensure that it is a safe environment for the patient and that care can be delivered adequately to meet the patient's needs.
5. The nurse, in conjunction with the patient (and family members when appropriate), must identify present needs. Once this is accomplished then goals and objectives can be identified and a plan of care formulated.
1. Once a plan of care is formulated then the nurse, in conjunction with the patient (and family members when appropriate), can identify community resources that may assist them in attaining the goals and objectives of the plan of care.

30. 1. To be eligible for hospice services, an individual must be diagnosed as having less than 6 months to live. It is a service to support patients and their families through the process of dying.
  2. Most hospice care is delivered in patients' homes supported by a team of health-care providers and volunteers. However, there are inpatient hospice programs, palliative care units in hospitals, and residential hospice settings.
  3. The home is a less expensive setting than other health-care settings because family members provide most of the care supported by a team of professionals, nonprofessionals, and volunteers.
  4. Hospice services include not only palliative physical care and support of quality of life for the terminally ill patient but also emotional support to patients and family members. In addition, they include services that assist family members with bereavement and adjustment after the death of the patient.
  5. Hospice is not a location but a concept. It provides supportive, palliative services that focus on managing pain, treatment of symptoms, and helping patients maintain their quality of life so they can live the remainder of their lives to the fullest.
31. 1. Providing bereavement services is an example of a tertiary health-care service. Tertiary care is associated with rehabilitation, long-term care, and care of the dying. Health-care services, which describe the scope of services and settings where health care is provided, include primary, secondary, and tertiary levels. The levels of health-care services should not be confused with levels of prevention.
  2. Teaching a patient how to use a wheelchair after a stroke is an example of a tertiary health-care service. Tertiary services provide care related to rehabilitation.
  3. A smoking cessation class is an example of a service provided on the primary, not tertiary, level of health-care services. Primary health care is associated with illness prevention, health promotion, environmental protection, and health education.

4. Immunizations are an example of primary, not tertiary, health-care services. Primary health care is concerned with promoting health, preventing disease, environmental protection, and health education.
  5. Changing a dressing after surgery is care associated with the secondary, not tertiary, level of health-care services. Secondary health care is associated with acute care, complex diagnosis and treatment of disease and illness, and emergency care.
- 32.**
1. This is a primary, not secondary, health-care service. Risk assessments for specific diseases are included in primary health-care services. Primary health-care services are concerned with generalized health promotion and specific protection against disease.
  2. A low-fat diet generally is part of a medical management program for a person who is overweight or who has high cholesterol. This is a tertiary, not secondary, health-care service. Tertiary health-care services are associated with attempts to reduce the extent and severity of a health problem in an effort to limit disability as well as restore and maintain function.
  3. Administering an immunization is a primary, not secondary, health-care service. Primary health-care services include protecting people from disease.
  4. **Encouraging regular dental checkups is a secondary health-care service that is associated with early detection of disease and prompt intervention.**
  5. **Monthly self-breast examinations are associated with secondary health-care services because they are concerned with detection of breast cancer.**
- 33.**
1. This statement does not accurately reflect a concept about a healthy community. A healthy community seeks to provide infrastructure, resources, and activities that support a healthy community and is not just reflective of the health of its members.
  2. This is not an accurate statement. Community health focuses on families, groups, and the community, not just individuals.
  3. **A healthy community is concerned about all members of the community and works to ensure that all members have access to all of the system's resources.**
4. This statement focuses on illness and is too limited in relation to community health.
  5. **Health promotion has taken on new meaning as consumers take more responsibility for their health status. Teaching about promoting health is a more positive perspective than teaching about preventing illness, which is a negative perspective.**
- 34.**
1. **Overweight and obesity is one of the 10 leading health indicators identified by *Healthy People 2020*. The other nine topics are physical activity, substance abuse, tobacco use, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care.**
  2. **Substance abuse is one of the 10 leading health indicators identified by *Healthy People 2020*. The other nine topics are physical activity, overweight and obesity, tobacco use, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care.**
  3. Older adults is not one of the 10 leading health indicators, but it is one of the 42 topic areas.
  4. Diabetes is not one of the 10 leading health indicators, but it is one of the 42 topic areas.
  5. Vision is not one of the 10 leading health indicators, but it is one of the 42 topic areas.
- 35.**
1. **Beliefs and values usually are held long term and are engrained within one's view of self. It is essential that nurses respect a patient's beliefs and values, particularly for nontraditional healing practices as long as they are not harmful to the patient. Demonstrating respect and a nonjudgmental attitude will help promote a trusting nurse-patient relationship.**
  2. Arranging respite care for the daughter is premature at this time. This may eventually become necessary.
  3. This is an inappropriate intervention by the nurse. Only the daughter can come to the conclusion that it is her responsibility to care for her mother.
  4. This is not the priority. This intervention may be done after a discussion with the patient, daughter, and husband.

# Psychosociocultural Nursing Care

# 3

## Nursing Care Across the Life Span

### KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Adolescent (teenager)  
Agism  
Attachment, bonding  
Brazelton, Berry—Neonatal Behavioral Assessment Scale  
Cephalocaudal  
Congenital anomalies  
Critical time  
Developmental:  
    Milestones  
    Stressor  
    Task  
Egocentrism  
Erikson, Erik—Theory of Personality Development  
Failure to thrive  
Fetus  
Fowler, James—Theory of Faith Development  
Freud, Sigmund—Psychoanalytical Theory  
Genetics  
Havighurst, Robert—Developmental Task Theory of Development  
Infancy, infant, neonate, newborn  
Kohlberg, Lawrence—Theory of Moral Development  
Life cycle  
Life events  
Low birth weight  
Maslow, Abraham—Hierarchy of Basic Human Needs  
Menarche  
Menopause  
Middle adulthood  
Midlife crisis  
Moral reasoning  
Older adult  
Organogenesis  
Physique  
Piaget, Jean—Cognitive Development Theory  
Premenopausal, postmenopausal  
Preschool-aged child  
Preterm  
Proximodistal  
Psychosocial development  
Puberty  
Regression  
Retirement  
Role reversal  
Sandwich generation  
School-aged child  
Senescence  
Sibling rivalry  
Teratogenic  
Toddler  
Young adulthood

F.A. CAVIS

COMPANY



## NURSING CARE ACROSS THE LIFE SPAN: QUESTIONS

1. A nurse is administering medication to an older adult. For which response to medication that occurs **most** frequently in older adults should the nurse assess the patient?
  1. Toxicity
  2. Side effects
  3. Hypersensitivity
  4. Idiosyncratic effects
2. A nurse in a clinic is caring for patients in a variety of age groups. Which age group should the nurse anticipate will have the greatest potential to demonstrate regression when ill?
  1. Infants
  2. Toddlers
  3. Adolescents
  4. Young adults
3. When the nurse assesses an adult patient, which patient behavior may indicate an unresolved developmental task of infancy?
  1. Avoiding assistance from others
  2. Rationalizing unacceptable behaviors
  3. Being overly concerned about cleanliness
  4. Apologizing constantly for small mistakes
4. Which patient should the nurse identify is at the **greatest** risk when taking a drug that has a high teratogenic potential?
  1. Older adult man
  2. Pregnant woman
  3. Four-year-old child
  4. One-month-old infant
5. A nurse in the emergency department is assessing patients of various ages. Which age group should the nurse anticipate will have the **greatest** individual differences in appearance and behavior?
  1. Children
  2. Adolescents
  3. Older adults
  4. Middle-aged adults
6. A 70-year-old patient tells the nurse about experiencing problems with sleep and requests sleeping medication. Which concept associated with drug therapy and quality of sleep is important for the nurse to explain when providing nursing care for this patient?
  1. Sedatives are not well tolerated by older adults.
  2. Antianxiety drugs are the least helpful to support sleep.
  3. Effectiveness of hypnotics increases with prolonged use.
  4. Melatonin is the drug of choice for long-term use in sleep disorders.
7. Which concept is reflective of Erik Erikson's Theory of Personality Development?
  1. Defense mechanisms help people to cope with anxiety.
  2. Moral maturity is a central theme in all stages of development.
  3. Achievement of developmental goals is affected by the social environment.
  4. Two continual processes, assimilation and accommodation, stimulate intellectual growth.

8. A nurse in the clinic is monitoring patients for iron deficiency anemia. Which group of individuals should the nurse anticipate to be at the **greatest** risk?
  1. Postmenopausal women
  2. Older adults
  3. Teenagers
  4. Infants
9. Which group of individuals should the nurse anticipate is at the **greatest** risk for constipation?
  1. Inactive school-aged children
  2. Middle-aged adults
  3. Older-aged adults
  4. Bottle-fed infants
10. A parent tells the nurse in the well-child clinic that the 2-year-old is trying to eat with a spoon and is making a mess. Which should the nurse encourage the parent to do?
  1. Praise and encourage the child while eating.
  2. Provide finger foods until the child is older.
  3. Feed the child along with the child's attempts at eating.
  4. Take the spoon and feed the child until the child is more capable.
11. One of the participants attending a parenting seminar asks the nurse teaching the class, "What is the leading cause of death during the first year of life?" Besides exploring the person's concerns, what should the nurse respond?
  1. Sudden infant death syndrome
  2. Congenital malformations
  3. Unintentional injuries
  4. Short gestation
12. Which individual does the nurse anticipate has the **greatest** risk for problems with regulating body temperature?
  1. Toddler
  2. Teenager
  3. Older adult
  4. School-aged child
13. A pediatric nurse is caring for children of a variety of ages. Which group should the nurse anticipate will have the **most** problems sleeping as a result of multiple complex developmental factors?
  1. Infants
  2. Toddlers
  3. Adolescents
  4. Preschoolers
14. Which is a person referring to when during an interview the person says, "I am a member of the *sandwich generation*"?
  1. Cares for children and aging parents at the same time
  2. Has reversed roles between parents and self
  3. Assists own parents and spouse's parents
  4. Has both older and younger siblings
15. A nurse is planning a teaching session for an older adult about a prescribed medication regimen. Which is a major concern about older adults that the nurse should consider?
  1. They experience an increase in absorption of drugs from the gastrointestinal tract.
  2. They are less motivated to follow a prescribed drug regimen.
  3. They often use alcohol to cope with the stressors of aging.
  4. They have a decreased risk for adverse reactions to drugs.

16. A nurse is caring for several children on a pediatric unit. Children in which age group should the nurse expect will be **most** unstable and challenging with regard to the development of a personal identity?
1. Toddlerhood
  2. Adolescence
  3. Childhood
  4. Infancy
17. A nurse in the operating room cares for patients of a variety of ages. Which individual should the nurse anticipate will have the **greatest** risk for complications during surgery?
1. Middle-aged adult
  2. Pregnant woman
  3. Adolescent
  4. Infant
18. Which word describes the process of growth and development?
1. Fast
  2. Simple
  3. Limiting
  4. Individual
19. A hospice nurse is providing emotional support for eight young children of a dying mother. At which age do children first recognize that death is irreversible, universal, and natural?
1. 9 years of age
  2. 6 years of age
  3. 15 years of age
  4. 12 years of age
20. A school nurse is teaching a class of adolescents about nutrition. Which age group should the nurse identify as having the **highest** energy expenditure and nutrient requirements?
1. End of the life cycle
  2. Middle adult years
  3. Early adult years
  4. First year of life
21. A nurse determines that according to Erikson, establishing relationships based on commitment mainly occurs in which stage of psychosocial development?
1. Middle-aged adulthood
  2. Young adulthood
  3. Adolescence
  4. Infancy
22. Which age group should the nurse identify as being reflected in the following statement? "More time is spent in bed but less time is spent asleep."
1. Two-year-olds
  2. Forty-year-olds
  3. Seventy-year-olds
  4. Fourteen-year-olds
23. A nurse is teaching a parenting class at a local community health center. Which common stressor associated with the developmental stage of early childhood (1 to 3 years) should the nurse include?
1. Accepting limited dietary choices
  2. Adjusting to a change in physique
  3. Responding to life-threatening illness
  4. Resolving conflicts associated with independence

24. A nurse is providing dietary teaching to a group of adolescents recently diagnosed with diabetes mellitus. Which factor should the nurse consider that frequently influences food choices by adolescents?
1. Taste
  2. Routine
  3. Pressure
  4. Preference
25. Which common physiological changes associated with aging should the nurse assess for in an older adult? **Select all that apply.**
1.  Increase in sebaceous gland activity
  2.  Detrioration of joint cartilage
  3.  Loss of social support system
  4.  Decreased hearing acuity
  5.  Increased need for sleep
26. A nurse is facilitating a mothers' class, and the women begin discussing experiences that reflect the intellectual development of their children. Each woman describes a situation that reflects one of the stages of Jean Piaget's theory about logical thinking. Place the situations described in order beginning with the sensorimotor stage and ending with formal operations.
1. "My son touched the radiator and got burned. He'll never do that again."
  2. "My son is learning math and is getting 100s on his tests. He is so smart."
  3. "My daughter is on the debating team in school. We go to interschool meets."
  4. "My daughter asked an obese lady if she had a baby in her stomach. I was so embarrassed."
- Answer: \_\_\_\_\_
27. A nurse identifies that an older adult has successfully resolved the developmental conflict associated with aging. Which of the person's abilities **most** support this conclusion? **Select all that apply.**
1.  Accepting social isolation
  2.  Reminiscing about past life events
  3.  Managing the change in social roles
  4.  Associating with members of every age group
  5.  Increasing the number of meaningful relationships
28. An older adult is admitted to the intensive care unit. For which common adaptations to sensory overload should the nurse monitor the patient? **Select all that apply.**
1.  Tachycardia
  2.  Drowsiness
  3.  Confusion
  4.  Irritability
  5.  Dementia
29. A nurse identifies which words as being **unrelated** to principles of growth and development? **Select all that apply.**
1.  Unpredictable
  2.  Sequential
  3.  Integrated
  4.  Simple
  5.  Static
30. A nurse identifies that a patient in middle adulthood is experiencing a developmental crisis. Which of the person's behaviors support this conclusion? **Select all that apply.**
1.  Unable to mentor children in the next generation
  2.  Difficulty in developing peer relationships
  3.  Inability to achieve feelings of success
  4.  Incapable of delaying satisfaction
  5.  Failure to face eventual death

31. A school nurse is assessing several school-aged children between the ages of 6 and 12 years. Which assessment of a child requires a further assessment?
1. 7-year-old boy
  2. 9-year-old girl
  3. 11-year-old boy
  4. 12-year-old girl

**7-Year-Old Boy**

Grew 1 inch in the last year  
Gained 15 pounds in the last year

**9-Year-Old Girl**

Concerned about achieving acceptable grades in school  
Identifies with other girls in her grade

**11-Year-Old Boy**

Appears clumsy  
Is tall and thin

**12-Year-Old Girl**

Concerned about her physical appearance  
Interested in boys

32. A nurse is caring for a variety of individuals across the life span. Which age groups generally demonstrate an inefficiency of adaptation? **Select all that apply.**

1.  More than 60 years
2.  40 to 60 years
3.  12 to 19 years
4.  3 to 11 years
5.  0 to 1 year

33. A nurse identifies that an adult has an unresolved developmental conflict associated with adolescence. Which behaviors support this conclusion? **Select all that apply.**

1.  Being overly concerned about following daily routines
2.  Requiring excessive attention from others
3.  Relying on oneself rather than others
4.  Failing to verbalize a sense of self
5.  Lacking goals in life

34. Which family members comments about an older adult member of the family demonstrates agism? **Select all that apply.**

1.  “ She has outlived her usefulness.”
2.  “ She is elderly but she is so cute.”
3.  “ She reads the newspaper with difficulty.”
4.  “ He reminisces about his past work experience.”
5.  “ He is most happy when working in his home workshop.”

35. A nurse is assessing a 4-year-old child’s growth and development. Which activities should the nurse expect the child to be capable of performing? **Select all that apply.**

1.  Dresses self
2.  Uses toy tools
3.  Hops on one foot
4.  Rides a two-wheel bicycle
5.  Swims using the freestyle stroke

## NURSING CARE ACROSS THE LIFE SPAN: ANSWERS AND RATIONALES

- 1. This is a serious concern because of a decrease in efficiency of hepatic metabolism and renal excretion of drugs in older adults; as a result, accumulation of the drug occurs, resulting in toxicity.**
  - Although side effects are a concern in older adults, another option is a greater concern.
  - Although hypersensitivity is a concern in older adults, another option is a greater concern.
  - Although idiosyncratic effects are a concern in older adults, another option is a greater concern.
1. Infants already demonstrate behavior on the most basic level.
  - 2. Toddlers are less able to understand and interpret what is happening to them when ill; therefore, they commonly regress to a previous level of development in an attempt to reduce anxiety.**
  - Adolescents generally want to behave in an adult manner and therefore demonstrate a controlled behavioral response to illness.
  - Although some young adults may regress to an earlier level of development as a coping strategy, regression commonly is not used as a defense mechanism when coping with illness.
- 1. People who avoid help from others and who would rather do things themselves generally have not completely resolved the developmental task of Trust versus Mistrust during infancy.**
  - Rationalizing unacceptable behaviors is a defense mechanism, not an indication of an unresolved developmental task of infancy. Rationalization is used to justify in some socially acceptable way ideas, feelings, or behavior through explanations that appear to be logical.
  - This behavior relates more to the Anal Stage of Freud's Psychosexual Theory of Development. Freud believed that when toilet training is approached in a rigid and demanding manner, a child develops into an adult who is overly concerned with orderliness and cleanliness.
- This may indicate an unresolved conflict of Autonomy versus Shame and Doubt associated with the 18-month- to 3-year-old age group. One of the developmental tasks of this age group is learning right from wrong. When parents are overly critical and controlling, a child may be overly self-judgmental and become an adult who feels the need to apologize for small mistakes constantly.
1. An older adult man is not at risk when receiving a medication that has a teratogenic effect.
  - 2. A pregnant woman is at risk. Teratogenic refers to a substance that can cross the placental barrier and interfere with growth and development of the fetus.**
  - A 4-year-old child is not at risk when receiving a medication that has a teratogenic effect.
  - A newborn is not at risk when receiving a medication that has a teratogenic effect.
1. School-aged children (6 to 12 years) tend to have fewer differences in appearance and behavior from their peers. These children begin to be involved with formalized groups where conformity is expected.
  - Although adolescents (12 to 20 years) may be viewed as different from the norms of their parents, they are similar to their peers. In their search for self-identity, adolescents experience role confusion. To control anxiety with role confusion, they are attracted to and conform to peer groups, which provide a sense of security.
  - Although there is diversity in the older adult group (65 years or older) individuals have to adjust to common experiences such as physical decline, retirement, multiple losses, and changes in social roles. Older adults commonly seek out people of the same age to share similar interests and find status among their peers.
  - 4. Middle-aged adults (40 to 60 years) are in a time of transition between young adulthood and older adulthood. Therefore, individuals in this group, more so than in any other age group, have the greatest individual differences**

in appearance and behavior as they span the norms seen in young adulthood, middle adulthood, and older adulthood.

- 6. 1. Sedatives are not well tolerated by older adults because a decrease in the metabolism and excretion of the drug can result in toxicity. In addition, older adults may experience idiosyncratic (e.g., unexpected or opposite) effects.**
2. Antianxiety drugs depress the central nervous system and therefore are helpful in supporting sleep.
  3. The effectiveness of hypnotics decreases, not increases, with prolonged use. They should be used only as a short-term intervention because tolerance and rebound insomnia occur in approximately four weeks.
  4. Although melatonin demonstrates promise as a drug to support sleep, it is not the drug of choice because its safety and efficacy are not yet established.
- 7. 1. Sigmund Freud, not Erik Erikson, identified that defense mechanisms are used to reduce anxiety by preventing conscious awareness of threatening thoughts or feelings.**
2. Lawrence Kohlberg, not Erik Erikson, established a framework for understanding the development of moral maturity, which is the ability to recognize independently what is right and what is wrong.
- 3. Erik Erikson expanded on Freud's Theory of Personality Development by giving equal emphasis to the influence of a person's social and cultural environment. He stressed that psychosocial development depends on an interactive process between the physical and emotional variables during a person's life at eight distinct stages. Each stage requires resolution of a developmental conflict that has opposite outcomes and that requires interaction within the self and with others in the environment.**
4. Assimilation and accommodation of new information necessary to stimulate intellectual growth comprise a concept basic to Jean Piaget's Theory of Cognitive Development, not Erikson's Theory of Personality Development. Assimilation involves the process of organizing new information into one's present body of

knowledge, and accommodation involves rearranging and restructuring thought processes to deal with the imbalance caused by new information and thereby increase understanding.

- 8. 1. Cessation of estrogen and progesterone production during menopause does not contribute to iron deficiency anemia.**
2. Although older adults are at risk for iron deficiency anemia because of decreased intake and less efficient absorption of nutrients, they are not at as high a risk as an age group in another option.
  3. Although teenagers are at risk for iron deficiency anemia because of rapid growth and diets high in fat and low in vitamins, they are not at as high a risk as an age group in another option.
- 4. Infants are at the highest risk for iron deficiency anemia because of the increased physiological demand for blood production during growth, inadequate solid food intake after 6 months of age, and formula not fortified with iron. In addition, premature or multiple-birth infants are at special risk because of inadequate stores of iron during the end of fetal development.**
- 9. 1. Although inactivity may promote constipation, there are no physiological changes in school-aged children that will compound the risk for constipation.**
2. Although middle-aged adults experience slower gastrointestinal motility than when they were younger, they are not at as great a risk for constipation as an age group in another option.
- 3. Older adults are at the greatest risk for constipation because of decreases in activity levels, in intake of high-fiber foods, in peristalsis, in digestive enzymes, and in fluid intake.**
4. Constipation in infants is uncommon except when they are weaned from formula to cow's milk or when their diet is mismanaged.
- 10. 1. From 18 months to 3 years of age (Autonomy versus Shame and Doubt), the child strives for independence. Attempts to self-feed should be encouraged and enthusiastically praised even though the child may make a mess. They allow the child to practice**

- and perfect new skills, help to develop fine motor skills, and support control of the self and the environment.**
2. Although finger foods help to avoid a mess during mealtime, the child must learn how to use utensils when eating. This intervention interferes with the achievement of the task associated with this age group.
  3. This should be avoided. When children are made to feel that the job they are doing is not good enough, it conveys a sense of shame and doubt and will make them feel inadequate.
  4. This is discouraging to the child and may precipitate feelings of inadequacy, shame, and doubt. When caregivers always do what children should be learning, children are not permitted to learn for themselves.
- 11.**
1. The most recent statistics from the National Center for Health Statistics indicate that sudden infant death syndrome (SIDS) is ranked as the third leading cause of all infant deaths.
  2. **The most recent statistics from the National Center for Health Statistics indicate that congenital malformations are ranked first as the leading cause of all infant deaths.**
  3. The most recent statistics from the National Center for Health Statistics indicate that unintentional injuries are ranked as the fifth leading cause of all infant deaths. Maternal complications associated with pregnancy are ranked as the fourth leading cause of all infant deaths.
  4. The most recent statistics from the National Center for Health Statistics indicate that short gestation and low birth weight are ranked as the second leading cause of all infant deaths.
- 12.**
1. Toddlers generally are able to regulate body temperature as long as they are basically healthy.
  2. Adolescents generally are able to regulate body temperature as long as there are no coexisting health problems.
  3. **Regulation of body temperature depends on the ability to dilate or constrict blood vessels and control the activity of sweat glands. In the older adult, the production of sweat glands decreases, reducing a person's ability to perspire and resulting in risk for heat exhaustion; there are decreased amounts of muscle mass and subcutaneous fat, which lead to increased susceptibility to cold; there are inefficient vasoconstriction in response to cold and inefficient vasodilation in response to heat; and there is a diminished ability to shiver.**
4. School-aged children generally are able to regulate temperature as long as there are no other underlying medical conditions.
- 13.**
1. Infants initially sleep 17 to 20 hours a day and by the end of the first year are sleeping 12 to 16 hours a day. Frequent awakening for feeding is expected and is not a sleep problem for the infant.
  2. Toddlers (18 months to 3 years) generally sleep 12 to 15 hours a day with one or two naps. Toddlers occasionally will awaken during the night because of teething pains, illness, separation anxiety, and loneliness; awakening during the night is not unusual in the toddler. If caregivers establish regular bedtime routines and provide emotional comfort, sleep problems are minimal during this age group.
  3. **Adolescents (12 to 20 years) have more multiple and complex physiological (e.g., puberty), psychological (e.g., self-identity and independence issues), and social (e.g., peer pressure, altered roles, and maturing relationships) milestones than any other stage of development. Anxiety associated with all of these stressors contributes to altered sleep patterns and sleep deprivation. Adolescents generally need 8 to 10 hours of sleep a day; however, adolescents' sleep needs vary widely.**
  4. Preschoolers (3 to 5 years) have well-established sleep-wake cycles, they sleep 10 to 12 hours a day, and daytime napping decreases. Dreams and nightmares, which can awaken the child, are common but are not considered abnormal. Establishing consistent rituals that include quiet time helps to minimize nighttime awakening.
- 14.**
1. **When middle-aged adults are caring for their children and their aging, dependent parents at the same time, they are referred to as the sandwich generation. Their parents and children represent the bread, and they are the meat in between.**



2. Role reversal is not a definition of the sandwich generation.
  3. Assisting both sets of parents is not a definition of the sandwich generation.
  4. Being a middle child between older and younger siblings is not the definition of the sandwich generation.
- 15.**
1. Older adults experience decreased, not increased, absorption of drugs from the gastrointestinal tract.
  2. **The literature documents that older adults are at high risk for nonadherence to a medication regimen because of its complexity. The larger the number of medications and the larger the number of doses per day, the higher the risk of nonadherence. One study indicated that the adherence rate was 87% for daily dosing, 81% for doses twice a day, 77% for doses three times a day, and 39% for doses four times a day. Other reasons for not fully adhering to a drug regimen include inconvenience, side effects, financial limitations, and/or perceived ineffectiveness of the drugs.**
  3. Although approximately 10% to 15% of older adults have some problem with alcohol use late in life, the literature supports the fact that there is a decrease, not increase, in the incidence of alcoholism with the aged.
  4. Older adults have an increased, not decreased, risk for adverse reactions to drugs. Adverse effects are any effects that are not therapeutic. Adverse effects can be side effects that are minor and tolerable or serious, requiring discontinuation of the drug.
- 16.**
1. Although toddlers (18 months to 3 years; early childhood—Autonomy versus Shame and Doubt) experience a number of developmental milestones, toddlerhood is not as unstable or complex as another stage of development. Toddlers explore and test the environment, develop independence, and have a beginning ability to control the self.
  2. **Adolescents (12 to 20 years—Identity versus Role Confusion) have more multiple and complex physiological (e.g., puberty), psychological (e.g., self-identity and independence), and social (e.g., peer pressure, altered roles, and maturing relationships) milestones than any other stage of development. The multiplicity of these stressors can have a major impact on the development of the adolescent's personal identity and sense of self.**
3. Although children in early childhood or toddlerhood (18 months to 3 years—Autonomy versus Shame and Doubt) and late childhood (3 to 6 years—Initiative versus Guilt) experience a number of developmental milestones, they are not as unstable or complex as another age group. The main tasks of childhood are achievement of self-control, initiation of one's own activities, and development of purpose and competence.
  4. Although infants (birth to 18 months—Trust versus Mistrust) experience a number of developmental milestones, their development is not as unstable or complex as that of another age group. The main tasks of infancy are to adjust to living in and responding to the environment and the development of trust.
- 17.**
1. Middle-aged adults usually are safe candidates for surgery.
  2. Although a pregnant woman has unique needs during surgery, as long as the mother's cardiovascular and fluid and electrolyte statuses are maintained, the fetus is supported and safe.
  3. Although the adolescent has needs related to body image and separation from friends, the physiological risk of surgery is not increased.
  4. **Infants are at risk for fluid volume depletion because of a small blood volume and limited fluid reserves. In addition, immature liver and kidneys affect the ability to metabolize and eliminate drugs, an undeveloped immune system increases the risk of infection, and immature temperature regulating mechanisms increase the risk of hyperthermia and hypothermia.**
- 18.**
1. Some stages are faster and some are slower, depending on the person and the developmental level.
  2. The growth and development process is complex and influenced by many different factors.
  3. Just the opposite is true; the growth and development process helps people to extend themselves to be the most that they can be.

4. Although people follow a general pattern, they do not grow and develop at exactly the same rate or extent.
19. 1. **A 9-year-old child has a more realistic understanding of death than a younger child and recognizes that death is universal, irreversible, and natural. A 9-year-old child has a beginning knowledge of his or her own mortality and may fear death.**
2. A 6-year-old child is developing an understanding of the differences among the concepts of past, present, and future. A 6-year-old child believes that death is temporary, can be caused by bad thoughts, and may be a punishment and that magic can make the dead person alive.
3. Recognizing that death is irreversible, universal, and natural occurs at an earlier age than 15 years.
4. Recognizing that death is irreversible, universal, and natural occurs at an earlier age than 12 years.
20. 1. Older adults experience decreases in basal metabolic rate, lean body mass, and physical activity that contribute to a decrease in caloric needs.
2. During the middle adult years, energy expenditure decreases and nutritional needs stabilize. People in other age groups have greater needs for nutrients to meet physiological demands than do those in the middle adult years.
3. Although young adults tend to be active and require nutrients adequate to meet high energy expenditure, physical growth slows and the basal metabolic rate begins to stabilize, so they require fewer calories than do other age groups.
4. **During the first year of life, nutritional needs per unit of body weight are the greatest in comparison to any other time during the life span. Birth weight generally doubles in 4 to 6 months and triples by the end of the first year.**
21. 1. Middle-aged adults (25 to 45 years—Generativity versus Stagnation) strive to fulfill life goals associated with family, career, and society, as well as to give to and care for others.
2. **Young adults (18 to 25 years—Intimacy versus Isolation) strive to establish mature relationships, commit to suitable partners, and develop social and work roles acceptable to society.**
- Unsuccessful resolution results in self-absorption, egocentricity, and emotional isolation.**
3. Adolescents (12 to 20 years—Identity versus Role Confusion) strive to make the transition from childhood to adulthood with a sense of personal self.
4. Infants (newborn to 18 months—Trust versus Mistrust) strive to have their needs met through interacting with others. When their needs are consistently met they develop a sense of trust in their caregivers.
22. 1. Toddlers are active once awake and rarely spend much time in bed when not sleeping. Toddlers sleep 12 to 14 hours a day, including one or two daytime naps.
2. Middle-aged adults sleep 6 to 8 hours a day. Although middle-aged adults spend more time in bed awake than when they were younger, they spend less time in bed awake than an age group in another option.
3. **Older adults still need 7 to 9 hours of sleep daily but often receive less because of difficulty falling asleep and more frequent awakening. They often go to bed earlier in an effort to get more sleep and end up spending more time in bed awake. Sleeping difficulties are attributed to a decrease in melatonin, less deep sleep, a decrease in exercise, more naps, movement disorders, sleep apnea, and medical and psychological problems.**
4. Adolescents sleep 8 to 10 hours a day. Adolescents generally have high activity levels and stay up late. It may seem as though adolescents are always sleeping because they sleep later in the morning, but generally they go to bed much later at night.
23. 1. This might be required of an older adult who is learning to adjust to a therapeutic diet. More often people in the older age group need to adapt to the stress of a declining ability to ingest, digest, and/or absorb particular food.
2. This is an expected developmental task of adolescence, not early childhood. Many bodily changes occur in this transitional period, such as a growth spurt and sexual maturity.
3. This is not an expected developmental stressor of this age group. Only a small

percentage of the population of 18-month-old to 3-year-old children faces the challenge of a life-threatening illness.

4. **During early childhood, the child gains independence through learning right from wrong. Independence occurs with guidance from parents as the child learns self-control without feeling shame and doubt. When parents are overly protective or critical, feelings of inferiority will develop.**
24. 1. Although taste influences choices of foods ingested by adolescents, a factor identified in another option generally has more influence over what adolescents eat.
  2. Adolescents tend to have few rigid routines because of their busy schedules. A factor identified in another option generally has more influence over what adolescents eat than do routines.
  3. **Peers often dictate the dietary choices of adolescents. Fad dieting and demands of socialization that generally involve fast food are common among adolescents.**
  4. Although personal preferences may influence choices of foods ingested by adolescents, a factor identified in another option generally has more influence over what adolescents eat.
25. 1. Although sebaceous glands increase in size with age, the amount of sebum produced decreases, hastening the evaporation of water from the stratum corneum and resulting in cracked, dry skin.
  2. **Older adults generally experience a deterioration of the hyaline cartilage surface of joints, which tears, allowing bones to be in direct contact with each other. Often this results in the formation of spurs or projecting points that limit joint motion.**
  3. Loss of a social support system is a psychosocial, not physiological, change commonly experienced by older adults.
  4. **Hearing acuity decreases, particularly in relation to high-pitched sounds, because of atrophy in the organ of Corti and cochlear neurons, loss of sensory hair cells, and degeneration of the stria vascularis.**
  5. Older adults have the same need for sleep as younger individuals. However, it is more difficult for older adults to obtain the quality and quantity of sleep desired.

Chemical, structural, and functional changes in the nervous system disrupt circadian rhythms and sleep.

26. 1. The sensorimotor stage (birth to 2 years) is governed by sensations in which simple learning takes place. It progresses from reflex activity, through repetitive behaviors, to imitative behavior. These children are curious, experiment, and learn primarily through trial and error.
  4. The preoperational stage (2 to 7 years) involves thinking that is concrete and tangible; these children cannot reason beyond the observable. Also, their thinking is transductive; that is, knowledge of one characteristic is transferred to another.
  2. The concrete-operational stage (7 to 11 years) reflects an increasing ability to use symbols and understand relationships between things and ideas. Judgments are made based on what they reason (conceptual thinking) rather than just what they see (preoperational thinking). Also, they develop the concept of conservation; that is, physical factors (e.g., volume, weight, and number) remain the same even though outward appearances may change.
  3. The formal operational stage (11 to 15 years) involves thinking that is abstract, theoretical, philosophical, and hypothetical. Thinking is characterized by flexibility, adaptability, and drawing logical conclusions.
27. 1. Although social isolation is a risk for some older adults because of declining health, death of family members and friends, fear of crime, or injury precipitating a desire not to leave the house, most older adults seek opportunities to maintain and build social contacts via the telephone, Internet, community groups, senior centers, life-care communities, and so on.
  2. **Older adults review life experiences and put them all in perspective. With a successful life review, the individual views life as meaningful, respects the self, and feels respect from others.**
  3. **The older adult needs to adjust to multiple changes in social roles to emerge emotionally integrated with an intact ego and sense of wholeness.**

**Changes in social roles are often dramatic as the result of retirement, death of significant others, changing responsibilities within the extended family structure, moving to different living quarters, and decreasing finances.**

4. Although older adults associate with members of all age groups, they generally establish an explicit affiliation with members of their own age group. This supports a sharing of common interests and concerns, as well as meeting belonging and self-esteem needs as older adults seek status among their peers.
  5. Older adults do not always have the energy or stamina needed to invest in increasing the number of new meaningful relationships. In addition, they tend to experience a decrease, not increase, in meaningful relationships because of the death of members of their circle of friends and relatives.
- 28. 1. If sensory overload precipitates anxiety and the autonomic nervous system is stimulated by the fight or flight mechanism, tachycardia will occur.**
2. Sensory overload generally precipitates anxiety, agitation, and restlessness, not drowsiness.
  3. **Confusion is a common response to sensory overload. Because of excessive sensory stimulation, a person is unable to perceive the environment accurately or respond appropriately.**
  4. **Excessive sensory stimulation from the environment can overwhelm an individual's nervous system resulting in irritability.**
  5. Dementia is a progressive irreversible decline in mental function that is not caused by sensory overload.
- 29. 1. Growth and development comprise an orderly process that follows a predictable, not unpredictable, path. There are three predictable patterns: cephalocaudal—proceeding from head to toe; proximodistal—progressing from gross motor to fine motor movements; and symmetrical—both sides developing equally. Growth is marked by measurable changes in the physical aspects of the life cycle, and development is marked by behavioral**
- changes that occur because of achievement of developmental tasks and their resulting functional abilities and skills.**
2. Growth and development follow a sequential timetable whereby multiple dynamic changes occur in a systematic and orderly manner.
  3. Individuals grow and develop in the physiological, cognitive, psychosocial, moral, and spiritual realms in an integrated way, with each one influencing the others.
  4. **Growth and development comprise a complex, not simple, process that involves multiple influencing variables, such as genetics, experience, health, culture, and environment.**
  5. **The word *static* means stationary, stagnant, or fixed. Growth and development are dynamic and progressive.**
- 30. 1. A task associated with middle adulthood is sharing of self and performing activities that promote the growth of others, particularly those in the next generation.**
2. Developing peer relationships is one of the developmental tasks of the 6- to 12-year-old child and adolescent, not the middle-aged adult.
  3. **A major task of middle adulthood is successfully fulfilling lifelong goals that involve family, career, and society. If these goals are not achieved, a crisis is often precipitated.**
  4. Delaying satisfaction is one of the developmental tasks of the 18-month- to 3-year-old child, not the middle-aged adult.
  5. Facing death is one of the developmental tasks of the 65-year-old and older adult, not the middle-aged adult.
- 31. 1. During the school-aged years, children usually grow approximately 2 inches a year and gain 4.5 to 6 lb a year. This child should be assessed further because of the potential for obesity. Obesity in children is increasing in the United States.**
2. Age-appropriate psychosocial development in school-aged children includes associating with peers of the same gender and desiring peer approval. This age group also is developing personal and

interpersonal competence; they are conscientious and industrious.

3. Children approaching 10 to 12 years of age often appear awkward and lanky. They tend to be uncoordinated as muscle and bone growth advances; they are adjusting to these physical changes.
  4. Children approaching 10 to 12 years begin to develop a self-image and body image. They have increasing concerns about their appearance and begin to become interested in children of the opposite gender.
- 32. 1. When a person reaches 60 years of age and older, all physiological systems are less efficient, which reduces compensatory reserve.**
2. In the 40- to 60-year-old age group, a person will begin to see the earliest signs of aging. Changes are gradual and insidious and generally do not have an impact on function.
  3. In the 12- to 19-year-old age group, the adolescent is experiencing rapid growth and a beginning transition to adulthood, not a decline in the ability to adapt.
  4. In the 3- to 11-year-old age group, children are growing at a continuous pace in their ability to adapt to the world around them, not declining in their ability to adapt.
- 5. Infants have immature immune systems and body systems that are still developing. Also, their body's physiological processes have a limited experiential background on which to draw responses to new stressors. These issues result in an inefficiency of adaptation.**
- 33. 1.** This relates to Freud's Anal Stage of development (1 to 3 years). According to Freud, if a parent is strict, overbearing, and oppressive during toilet training, the child may develop traits of an anal retentive personality (e.g., obsessive-compulsive tendencies, rigid thought patterns, stinginess, and/or stubbornness).
2. Seeking excessive attention from others is most likely the result of an unresolved task of the 6- to 12-year-old age group (school age), Industry versus Inferiority. Seeking attention often is an attempt to increase self-esteem.
  3. People who have difficulty accepting help from others or who would rather do things themselves generally have not completely resolved the developmental task of infancy, Trust versus Mistrust.
- 4. A main developmental task of adolescence is being capable of determining "who you are." An inability to verbalize a sense of self later in life reflects an unresolved conflict of Identity versus Role Confusion.**
- 5. A main developmental task of adolescence is forming a sense of personal identity as a foundation for the tasks of young adulthood, making decisions regarding career choices, and selecting a mate. An adult who has difficulty setting goals in life indicates an unresolved conflict of Identity versus Role Confusion.**
- 34. 1.** This statement is a clear example of agism whereby older adults are systematically stereotyped and discriminated against because they are old. This is a form of prejudice, an unfavorable opinion without concrete information about the individual. Agism is based on the misconceptions that older adults are no longer productive, are narrow minded, are unable to learn, are dependent, experience memory loss, live in a nursing home, are ill, are boring, and so on.
2. The word *elderly* has a negative connotation. It implies that the person is different from other human beings and is frail, weak, or disabled. To call an adult *cute* is demeaning because it may imply that the person is childlike.
  3. This is not a discriminatory statement indicative of agism.
  4. This is not a discriminatory statement indicative of agism.
  5. This is not a discriminatory statement indicative of agism.
- 35. 1. Preschool-aged children have the fine motor skills to open and close zippers and buttons.**
- 2. Preschool-aged children have the motor skills necessary to manipulate a toy tool such as a hammer.**

3. **Preschool-aged children have the gross motor skills and balance to be able to hop and skip on one foot, balance on one foot, and perform a broad jump.**
4. Preschool-aged children do not have the strength and balance to ride a two-wheel bicycle. A preschooler usually can ride a tricycle. School-aged children, not preschool-aged children, usually are able to ride a two-wheel bicycle.
5. Preschool-aged children do not have the strength and coordination to swim using the freestyle stroke. Some preschool-aged children are able to do the “doggie paddle.” School-aged children, not preschool-aged children, usually are able to swim using the freestyle stroke.



# Communication

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, or information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Assertive skills

Barriers to communication:

Advising

Direct questions

Disapproving

False reassurance

Moralizing

Patronizing

Probing

Body language

Communication process:

Encoding by sender

Message

Channels of communication:

Auditory

Kinesthetic

Visual

Decoding by receiver

Feedback

Confidential, confidentiality

Confrontation

Congruence

Content themes

Conversation

Empathy, empathetic, empathic

Exploring

Group dynamics

Interaction

Interpersonal communication

Interview:

Formal

Informal

Intrapersonal communication

Nonverbal

Rapport

Space:

Intimate

Personal

Social

Public

Territoriality

Therapeutic communication skills:

Active listening

Clarifying

Focusing

Indirect question

Open-ended question

Paraphrasing

Reflection

Responding

Silence

Summarizing

Touching

Validating

Therapeutic relationship, phases:

Orientation

Working

Termination

Verbal, verbalization

F.A. DAVIS

COMPANY

## COMMUNICATION: QUESTIONS

1. A nurse is collecting data for an admission nursing history. Which question by the nurse is **best** to open the discussion?
  1. "What brought you to the hospital?"
  2. "Would it help to discuss your feelings?"
  3. "Do you want to talk about your concerns?"
  4. "Would you like to talk about why you are here?"

2. A nurse must conduct a focused interview to complete an admission history. Which interviewing technique should the nurse use?
  1. Probing
  2. Clarification
  3. Direct questions
  4. Paraphrasing statements
3. Which statement about communication should the nurse consider to be accurate?
  1. Verbal communication is essential for human relationships.
  2. Hands are the most expressive part of the body.
  3. Behavior clearly reflects feelings.
  4. Communication is inevitable.
4. A patient is extremely upset and mentions something about a work-related issue that the nurse cannot understand. Which is the nurse's **best** response?
  1. "It's natural to worry about your job."
  2. "Your job must be very important to you."
  3. "Calm down so that I can understand what you are saying."
  4. "I'm not quite sure I heard what you were saying about your work."
5. Which is the purpose of the use of humor by a nurse when interacting with a patient?
  1. Diminish feelings of anger
  2. Refocus the patient's attention
  3. Maintain a balanced perspective
  4. Delay dealing with the inevitable
6. A nurse is caring for a patient who is blind in the left eye and visually impaired in the right eye. Which actions should the nurse employ to promote communication with this patient?
  1. Touch the patient's left arm before initiating a conversation
  2. Ensure that the door to the patient's room is on the patient's left side
  3. Close the window curtains and dim the lights before speaking with the patient
  4. Knock on the door and request permission to enter before approaching the patient
7. A patient is admitted to the hospital with cirrhosis of the liver caused by long-term alcohol abuse. Which is the **best** response by the nurse when the patient says, "I really don't believe that my drinking a couple of beers a day has anything to do with my liver problem?"
  1. "You find it hard to believe that beer can hurt the liver."
  2. "How long is it that you have been drinking several beers a day?"
  3. "Each beer is equivalent to one shot of liquor so it's just as damaging to the liver as hard liquor."
  4. "Do you believe that beer is not harmful even though research shows that it is just as bad for you as hard liquor?"
8. Which is being communicated when the nurse leans forward during a patient interview?
  1. Aggression
  2. Anxiety
  3. Interest
  4. Privacy
9. Which statement describes the following proverb? *Wat you do speaks so loudly I cannot hear what you say.*
  1. Hearing ability is an important factor in communicating.
  2. Nonverbal messages are often more meaningful than words.
  3. Listening to what people say requires attention to what is being said.
  4. When people talk too loudly it is hard to understand what is being said.



10. A mother whose young daughter has died of leukemia is crying and is unable to talk about her feelings. Which is the **best** response by the nurse?
1. "Everyone will remember her because she was so cute. She was one of our favorites."
  2. "As hard as this is, it is probably for the best because she was in a lot of pain."
  3. "She put up the good fight but now she is out of pain and in heaven."
  4. "It must be hard to deal with such a precious loss."
11. A young adult who had a leg amputated because of trauma says, "No one will ever choose to love a person with one leg." Which is the **best** response by the nurse?
1. "You are a good-looking person, and you will have no trouble meeting someone who cares."
  2. "You may feel that way now, but you will feel differently as time passes."
  3. "Do you feel that no one will marry you because you have one leg?"
  4. "How do you see your situation at this point?"
12. A nurse is changing a patient's dressing over an abdominal wound. Which level of space around the patient is entered during the dressing change?
1. Public
  2. Social
  3. Intimate
  4. Personal
13. Which stage of an interview establishes the relationship between the nurse and the patient?
1. Preinteraction stage
  2. Orientation stage
  3. Examining stage
  4. Working stage
14. A patient is exhibiting anxious behavior and states, "I just found out that I have cancer everywhere and I don't have very long to live. My life is over." Which is the **best** response by the nurse?
1. "It might be good if your family were here right now. Shall I call them?"
  2. "What might be the best way to approach this terrible news?"
  3. "That is so sad. You must feel like crying."
  4. "It sounds like you feel hopeless."
15. Which interviewing skill is used when the nurse says, "You mentioned before that you are having a problem with your colostomy."
1. Focusing
  2. Clarifying
  3. Paraphrasing
  4. Acknowledging
16. A patient says, "I am really nervous about having a spinal tap tomorrow." Which is the **best** response by the nurse?
1. "I'll ask the doctor for a little medication to help you relax."
  2. "Patients who have had a spinal tap say it is not that uncomfortable."
  3. "It's all right to be nervous, and I don't remember anyone who wasn't."
  4. "Your physician is excellent and is very careful when spinal taps are done."
17. A patient with chest pain is being admitted to the emergency department. When asked about next of kin the patient states, "Don't bother calling my daughter; she is always too busy." Which is the **best** response by the nurse?
1. "She might be upset if you don't call her."
  2. "What does your daughter do that makes her so busy?"
  3. "Is there someone else that you would like me to call for you?"
  4. "I can't imagine that your daughter wouldn't want to know that you are sick."

18. Which is the nurse doing when using the interviewing technique of *attentive listening*?
1. Identifying the patient's concerns and exploring them with why questions
  2. Determining the content and feeling of the patient's message
  3. Employing silence to encourage the patient to talk
  4. Using nonverbal skills to display interest
19. A patient who has had a number of postoperative complications appears upset and agitated, yet withdrawn. Which is the **most** appropriate statement by the nurse?
1. "You seem distressed. Tell me why you are upset."
  2. "You've been having a pretty rough time of it since surgery."
  3. "It's not uncommon to have complications after the kind of surgery that you had."
  4. "I'm not sure that I know everything that has been happening. Tell me what has happened to you since surgery."
20. A nurse is admitting a patient to the unit who was transferred from the emergency department. Which should the nurse do to facilitate communication?
1. Ensure that the patient has an effective way to communicate with health-care team members.
  2. Use interviewing techniques to control the direction of the patient's communication.
  3. Minimize energy spent by the patient on negative feelings and concerns.
  4. Refocus to the positive aspects of the patient's situation and prognosis.
21. A nurse is caring for a confused patient with a diagnosis of dementia of the Alzheimer's type. Which should the nurse say when assisting the patient to eat?
1. "Please eat your meat."
  2. "It's important that you eat."
  3. "What would you like to eat?"
  4. "If you don't eat, you can't have dessert."
22. A patient states, "Do you think I could have cancer?" The nurse responds, "What did the doctor tell you?" Which interviewing approach did the nurse use?
1. Paraphrasing
  2. Confrontation
  3. Reflective technique
  4. Open-ended question
23. A nurse is developing a therapeutic relationship with a patient with emotional needs. Which nursing interventions are essential during the working stage of the relationship?
1. Establish a formal or informal contract that addresses the patient's problems.
  2. Implement nursing actions that are designed to achieve expected patient outcomes.
  3. Develop rapport and trust so the patient feels protected and an initial plan can be identified.
  4. Clearly identify the role of the nurse and establish the parameters of the professional relationship.
24. A nurse uses reflective technique when communicating with an anxious patient. On which does the nurse focus when using reflective technique in this situation?
1. Feelings
  2. Content themes
  3. Clarification of information
  4. Summarization of the topics discussed

25. A patient states, "My wife is going to be very upset that my prostate surgery probably is going to leave me impotent." Which is the **best** response by the nurse?
1. "I'm sure your wife will be willing to make this sacrifice in exchange for your well-being."
  2. "The surgeons are getting great results with nerve-sparing surgery today."
  3. "Your wife may not put as much emphasis on sex as you think."
  4. "Let's talk about how you feel about this surgery."
26. A patient states, "I think that I am dying." The nurse responds, "You believe that you are dying?" Which interviewing approach did the nurse use?
1. Focusing
  2. Reflecting
  3. Validating
  4. Paraphrasing
27. A nurse plans to foster a therapeutic relationship with a patient. Which is important for the nurse to do?
1. Work on establishing a friendship with the patient.
  2. Use humor to defuse emotionally charged topics of discussion.
  3. Sympathize with the patient when the patient shares sad feelings.
  4. Demonstrate respect when discussing emotionally charged subjects.
28. A patient appears tearful and is quiet and withdrawn. The nurse says, "You seem very sad today." Which interviewing approach did the nurse use?
1. Examining
  2. Reflecting
  3. Clarifying
  4. Orienting
29. A patient is admitted to the hospital with a tentative medical diagnosis and multiple diagnostic tests are performed. Where in the patient's chart can the nurse find documentation about the current medical diagnosis after the diagnostic test results are reviewed by the primary health-care provider?
1. Progress Notes
  2. Admission Sheet
  3. History and Physical
  4. Social Service Record
30. Which nursing actions should the nurse implement when speaking with an older adult whose hearing is impaired? **Select all that apply.**
1.  Limit background noise.
  2.  Exaggerate lip movements.
  3.  Lower the pitch of your voice.
  4.  Stand directly in front of the patient when speaking.
  5.  Raise the volume of your voice while speaking directly toward the patient's good ear.
31. A patient with a colostomy wants to learn how to irrigate a newly created colostomy. The nurse provides this teaching by developing a therapeutic nurse-patient relationship and implementing teaching strategies. Identify the statements that are included in the working stage of this therapeutic relationship. **Select all that apply.**
1.  "How do you feel about doing this procedure?"
  2.  "Would you like to try to insert the cone yourself today?"
  3.  "You did a great job managing the instillation of fluid today."
  4.  "I am here to help you learn how to irrigate your colostomy."
  5.  "I'll arrange for a home care nurse to visit you in your home when you are discharged."

32. A risk manager is conducting a retrospective audit of a patient's clinical record to identify the use of unacceptable abbreviations. Which abbreviations did the risk manager identify that are on The Joint Commission's official *Do Not Use List*?

Select all that apply.

1.  U
2.  c c
3.  mg
4.  MS
5.  Q OD
6.  0800 hour

#### Medication Administration Record

MS 4 mg subcutaneous at 1400 hour and patient verbalized relief within 15 minutes. Patient serum glucose was 180 at 1700 hour; 4 U regular insulin administered subcutaneously as prescribed.

#### Intake and Output Record

0800 Hour: Milk 60 cc, orange juice 120 cc; coffee 120 cc

#### Progress Note

Patient to be discharged in a.m. and will receive physical therapy QOD.

33. A nurse is attempting to develop a helping relationship with a patient who was recently diagnosed with cancer. Which factors are unique to this helping relationship? Select all that apply.

1.  The patient is permitted to assume the dominant role.
2.  The nurse and the patient equally share information.
3.  The interaction is specific to the patient.
4.  The interaction is guided by a purpose.
5.  The needs of both participants are met.

34. A nurse is using military time when entering information into a patient's clinical record. For example, the clock below indicates that the time is 0708 a.m. Which number in military time should the nurse enter to document a wound irrigation that was implemented at 9 p.m.?

1. 0900
2. 1900
3. 2100
4. 2300



35. An agitated 80-year-old patient states, "I'm having trouble with my bowels." Which responses by the nurse incorporate the interviewing skill of paraphrasing? **Select all that apply.**
1.  " You're having trouble with your bowels?"
  2.  " It sounds like your bowels are causing you problems."
  3.  " You sound upset that your bowels are causing difficulties."
  4.  " It's common to have problems with the bowels at your age."
  5.  " When did you first notice having trouble with your bowels?"
36. A patient states, "I can't believe that I couldn't even eat half my breakfast." Which statements by the nurse use the interviewing skill of reflection? **Select all that apply.**
1.  " Let's talk about your inability to eat."
  2.  " What part of your breakfast were you able to eat?"
  3.  " You appear startled that you did not finish your tray of food."
  4.  " How long have you been unable to eat most of your breakfast?"
  5.  " You seem surprised that you were unable to eat all your breakfast."
37. A nurse in a sub-acute unit in a skilled nursing facility is caring for a patient who recently had the surgical creation of a colostomy. Place the following nursing actions in the order that reflects the nurse-patient communication process, beginning with the first stage and progressing to the last stage.
1. Provide positive feedback to the patient for successful performance of a colostomy irrigation.
  2. Assist the patient to learn how to perform colostomy self-care.
  3. Review all the information on the patient's clinical record.
  4. Explore the reasons for the nurse-patient interaction.
  5. Summarize the goals and objectives achieved.
  6. Introduce self to the patient.
- Answer: \_\_\_\_\_
38. Which abilities of the nurse are important to achieve effective therapeutic communication? **Select all that apply.**
1.  Using interviewing skills
  2.  Remaining nonjudgmental
  3.  Sending just verbal messages
  4.  Being assertive when collecting data
  5.  Displaying sympathy when communicating
39. A patient is to have arthroscopic surgery of the knee to repair a torn tendon. The patient says, "I don't know if I'll make it through this surgery." Which responses by the nurse may block further communication by the patient? **Select all that apply.**
1.  " The type of surgery you are having is minor."
  2.  " Surgery often can be frightening."
  3.  " Everything will be all right."
  4.  " You are not going to die."
  5.  " You sound scared."
40. Which should a nurse never do when documenting information on a patient's electronic medical record? **Select all that apply.**
1.  Leave the patient's medical record open on the computer screen when entering the patient's room to administer a medication.
  2.  Share information verbally about a patient with another nurse who is also caring for the patient.
  3.  Document nursing care administered to a patient immediately after it is completed.
  4.  Give a personal access code to another member of the health-care team.
  5.  Document exact quotes of a patient's subjective information.

## COMMUNICATION: ANSWERS AND RATIONALES

1. 1. **This is a focused open-ended statement that invites the patient to communicate while centering on the reason for seeking health care.**
  2. This direct question can be answered with a “yes” or “no” response. If the response is “no,” then communication will be cut off.
  3. This direct question can be answered with a “yes” or “no” response, which may limit communication.
  4. This direct question can be answered with a “yes” or “no” response. The patient may not like to talk but the patient may need to talk.
2. 1. Probing questions violate the patient’s privacy, may cut off communication, and are inappropriate even in a focused interview. Probing interviewing occurs when the nurse persistently attempts to obtain information even after the patient indicates an unwillingness to discuss the topic or the nurse pursues information out of curiosity, rather than because the information is significant.
  2. Although clarification may be used during a focused interview to understand what the patient is saying, it is not the primary technique used for seeking specific information.
  3. **A focused interview explores a particular topic or obtains specific information. Direct questions meet these objectives and avoid extraneous information.**
  4. Paraphrasing may be used during a focused interview to redirect ideas back to the patient so that the patient can verify that the nurse received the message accurately or to allow the patient to hear what was said. However, it is not a technique that obtains specific information quickly.
3. 1. All communication, not just verbal communication, is essential for human relationships.
  2. The face, not the hands, is the most expressive part of the body.
  3. Behavior may imply, not clearly reflect, feelings. The nurse should obtain verbal feedback from the patient regarding assumptions about behavior.
  4. **Theory indicates that all behavior has meaning, people are always behaving, and we cannot stop behaving or communicating; therefore, communication is inevitable.**
4. 1. This may or may not be an accurate assumption.
  2. This makes an assumption that may be erroneous.
  3. This patronizing response treats the patient in a condescending manner. The patient cannot calm down.
  4. **This response requests additional information in an attempt to clarify an unclear message.**
5. 1. Humor used inappropriately can cause anger to be increased, suppressed, or repressed. Anger should be expressed safely, not diminished.
  2. The focus should be on the patient’s concerns.
  3. **Humor is an interpersonal tool and a healing strategy. It releases physical and psychic energy, enhances well-being, reduces anxiety, increases pain tolerance, and places experiences within the context of life.**
  4. Coping strategies should not be delayed because delay increases stress and anxiety and prolongs the process.
6. 1. Touching a patient with a visual impairment before speaking is an intrusive action and may startle the patient.
  2. A door to the room on the patient’s left side will require the patient to completely turn the head to the left so that the patient can use the right eye to view a person entering the room. The door should be on the patient’s right side.
  3. Patients with visual impairments may still have some sight. Adequate lighting facilitates nonverbal communication.
  4. **Knocking on the door before entering the room alerts the patient to the fact that someone is at the door and requesting permission to enter the room demonstrates respect and provides for privacy.**
7. 1. **This is an example of paraphrasing. It repeats the content in the patient’s message in similar words to provide feedback to let the patient know whether the message was understood and to prompt further communication.**

2. This response does not address the content or emotional theme of the patient's statement. In addition, this probing question may be a barrier to further communication.
  3. Although factual, this response is confrontational. This nurse's statement may put the patient on the defensive and inhibit further communication.
  4. This assertive, confronting, judgmental response may put the patient on the defensive and cut off communication.
- 8.**
1. Piercing eye contact, increased voice volume, challenging or confrontational conversation, invasion of personal space, and inappropriate touching convey aggression, which is a hostile, injurious, or destructive action or manner.
  2. A closed posture, avoidance of eye contact, increased muscle tension, and increased motor activity convey anxiety.
  3. **Leaning forward is a nonverbal behavior that conveys involvement. It is a form of physical attending, which is being present to another.**
  4. Privacy is not reflected by leaning forward during an interview. Privacy is facilitated by pulling a patient's curtain or finding a separate room or quiet space to talk.
- 9.**
1. Although hearing, one aspect of decoding a message, is an important factor in the communication process, it is unrelated to the stated proverb.
  2. **Nonverbal communication (e.g., body language) conveys messages without words and is under less conscious control than verbal statements. When a person's words and behavior are incongruent, nonverbal behavior most likely reflects the person's true feelings.**
  3. Although this true statement reflects active listening, it is unrelated to the stated proverb.
  4. This statement is unrelated to the stated proverb. The volume of a message may or may not influence understanding of the message. The volume of a message occurs on the physiological level, whereas understanding a message occurs on the cognitive level.
- 10.**
1. This response is not therapeutic because it focuses on the nurse rather than on the mother.
  2. The first part of this response minimizes the loss. The second part of the response focuses on the pain experienced by the child, which may increase the mother's grief.
  3. This response minimizes the loss and focuses on the pain experienced by the child, which may increase the mother's grief. Also, the mother may not believe in heaven.
  4. **The nurse's response is empathetic. The response focuses on the feelings surrounding the loss and provides an opportunity for the mother to verbalize.**
- 11.**
1. This negates the patient's concerns and provides false reassurance. The patient needs to focus on the "negative" before focusing on the "positive." In addition, only the future will tell if the patient meets someone who cares.
  2. This is false reassurance. There is no way the nurse can ensure that this belief will change.
  3. **This is an example of paraphrasing, which restates the patient's message in similar words. It promotes communication.**
  4. This statement is unnecessary. The patient has already stated a point of view.
- 12.**
1. Touching is not used with public distance. Public space (12 feet and beyond) is effective for communicating with groups or the community. Individuality is lost.
  2. Invasive touching does not occur with social distance. Social space (4 to 12 feet) is effective for more formal interactions or group conversations.
  3. **Physically caring for a patient involves inspection and touch that invades the instinctual, protective distance immediately surrounding an individual. Intimate space (physical contact to 1½ feet) is characterized by body contact and visual exposure.**
  4. "Laying on of the hands" does not occur with personal distance. Personal space (1½ to 4 feet) is effective for communicating with another. It is close enough to imply caring and is not extended to the distance that implies lack of involvement.
- 13.**
1. The preinteraction stage occurs before the nurse meets the patient. During this stage the nurse gathers information about the patient.
  2. **The purposes of the orientation stage of an interview are to establish rapport and orient the interviewee. A relationship is**

**established through a process of creating goodwill and trust. The orientation stage focuses on explaining the purpose and nature of the interview and what is expected of the patient.**

3. There is no stage called the examining stage in an interview. Examining takes place during a physical assessment, when specific skills are used to collect data systematically to identify health problems.
  4. This is not the purpose of the working stage. In the working stage, also called the body stage, of an interview patients communicate how they think, feel, know, and perceive in response to questions by the nurse.
- 14.**
1. This response abdicates the nurse's responsibility to explore the patient's concerns immediately. In addition, it could be an erroneous assumption.
  2. The patient is in the shock and disbelief mode of coping and will not be able to explore approaches to coping. In addition, using the words "terrible news" may increase anxiety and hopelessness.
  3. This response imposes the nurse's feelings and own coping skills into the situation.
  4. **This is an example of reflective technique because the nurse incorporated the patient's feelings into the response. When no solutions to a problem are evident, a person becomes hopeless (i.e., despairing, despondent).**
- 15.**
1. **This example of focusing helps the patient explore a topic of importance. The nurse selects one topic for further discussion from among several topics presented by the patient.**
  2. This is not an example of clarifying, which lets the patient know that a message was unclear and seeks specific information to make the message clearer.
  3. This is not an example of paraphrasing, which is restating the patient's message in similar words.
  4. This is not an example of acknowledging, which is providing nonjudgmental recognition for a contribution to the conversation, a change in behavior, or an effort by the patient.
- 16.**
1. This statement avoids the patient's feelings and fails to respond to the patient's need to talk about concerns. It cuts off communication.
  2. This is a generalization that minimizes the patient's concern and should be avoided.
  3. **This statement is therapeutic. It recognizes the patient's feelings, gives the patient permission to feel nervous, and reassures the patient that one's behavior is not unusual. This statement sets the groundwork for the next statement, such as, "Let's talk a little bit about the spinal tap and the concerns you may have."**
  4. This is false reassurance, which discourages discussion of feelings and should be avoided.
- 17.**
1. This response will put the patient on the defensive and jeopardize the nurse-patient relationship.
  2. This response requires the patient to rationalize the daughter's behavior and focuses on information that is not significant at this time.
  3. **This response lets the patient know that the message has been heard and moves forward to meet the need to notify a significant other of the patient's situation.**
  4. This provides false reassurance. Only the daughter can convey this message.
- 18.**
1. "Why" statements are direct questions that tend to put the patient on the defensive and cut off communication.
  2. **Attentive listening is the active use of all the senses to comprehend and appreciate the patient's verbal and nonverbal thoughts and feelings.**
  3. Silence is a passive interaction. Silence allows the patient time for quiet contemplation of what has been discussed.
  4. When talking with patients, verbal and nonverbal cues are used to indicate care and concern, which promote communication.
- 19.**
1. The first part of this statement uses the therapeutic interviewing technique of reflection, which identifies the underlying feelings of the patient and is appropriate. However, the second half of the statement is asking for an explanation, which is inappropriate. Patients often interpret "why" questions as accusations, which can cause resentment and mistrust and should be avoided.
  2. **This is an example of the therapeutic interviewing skill of an open-ended statement. It demonstrates that the nurse recognizes what the patient is**



going through, and the statement encourages free verbalization by the patient. At the very least it demonstrates caring and concern.

3. This statement minimizes the patient's feelings and is not supportive.
  4. This statement will not inspire confidence in the nurse. Nurses should know what is happening if care is to be comprehensive and patient centered.
- 20. 1. Communication between the patient and health-care providers is essential, particularly for obtaining subjective data and feedback. Speech, pantomime, writing, touch, and picture boards are examples of channels of transmission (i.e., media used to convey a message).**
2. The patient, not the nurse, should direct the flow of communication.
  3. Negative feelings or concerns must be addressed. Both physical and psychic energy are used when coping with stress.
  4. The focus must be on the patient's present concerns before refocusing to other issues because anxiety increases if immediate concerns are not addressed. Focusing on the negative sometimes is necessary before focusing on the positive.
- 21. 1. Confused patients more easily understand simple words and sentences.**
2. This may not be understood by the confused patient because the word "important" involves a conceptual thought. These patients respond better to concrete communication.
  3. A confused patient may not be able to make a decision.
  4. This is a threat and should be avoided when talking with patients. Also, it involves interpreting a "cause and effect" relationship.
- 22. 1.** The nurse's response is not an example of paraphrasing, which is restating the patient's basic message in similar words.
2. This is not an example of confrontation. A confronting or challenging statement fails to consider feelings, puts the patient on the defensive, and is a barrier to communication.
  3. The nurse's response is not an example of reflective technique, which is referring back the basic feelings underlying the patient's statement.
  4. **This open-ended statement invites the patient to elaborate on the expressed**
- thought with more than a one- or two-word response.**
- 23. 1.** Formal or informal contracts are established during the introductory (orientation), not working, stage of a therapeutic relationship.
- 2. During the working stage of the therapeutic relationship, nursing interventions have a twofold purpose: assisting patients to explore and understand their thoughts and feelings and facilitating and supporting patients' decisions and actions.**
3. The development of trust is the primary goal of the introductory (orientation), not working, stage of a therapeutic relationship. Trust is achieved through respect, concern, credibility, and reliability.
  4. These tasks are achieved during the introductory (orientation), not working, stage of a therapeutic relationship.
- 24. 1. Reflective technique requires active listening to identify the underlying emotional concerns or feelings contained in patients' messages. These feelings are then referred back to patients to promote a clearer understanding of what they have said.**
2. Content themes are referred back to patients through paraphrasing, which is a restatement of what was said in similar words.
  3. When seeking clarification, the nurse can indicate confusion, restate the message, or ask the patient to elaborate in an attempt to make the patient's message more clearly understood.
  4. Summarization is not reflective technique. Summarization reviews the significant points of the discussion to reiterate or clarify information.
- 25. 1.** This response is false reassurance. Only the wife can make this statement.
2. Although a true statement, this response negates the patient's concerns and cuts off communication.
  3. This may or may not be a true statement. Only the wife can make this statement.
  4. **The patient may be using projection to cope with the potential for impotence. This response indicates that it is acceptable to talk about sexuality and invites the patient to verbalize concerns.**

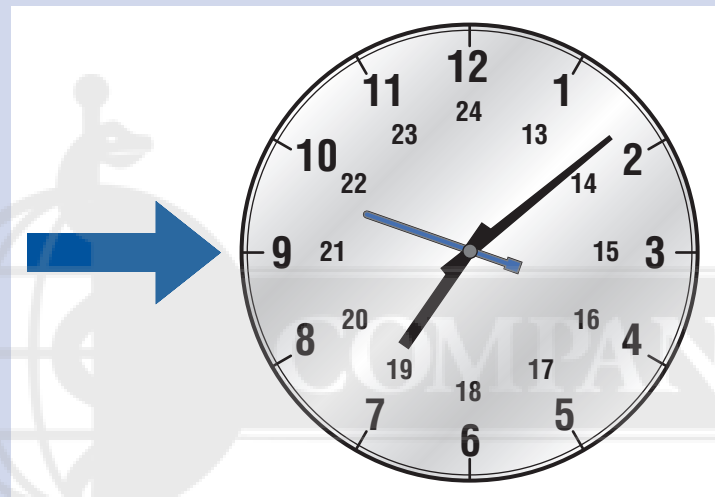
- 26.** 1. This is not an example of focusing, which centers on the key elements of the patient's message in an attempt to eliminate vagueness. It keeps a rambling conversation on target to explore the major concern. The patient was not rambling.
2. This is not an example of reflecting, which focuses on feelings.
3. This is not an example of validating. Consensual validation, a form of clarification, verifies the meaning of specific words rather than the overall meaning of the message. This ensures that both patient and nurse agree on the meaning of the words used.
- 4. The nurse's response is an example of paraphrasing because it uses similar words to restate the patient's message.**
- 27.** 1. The nurse should maintain a professional relationship with the patient. Nurses may be "friendly" toward patients but should not establish a "friendship" with a patient.
2. Humor with emotionally charged issues may be viewed as minimizing concerns or being frivolous and could be a barrier to communication.
3. Sympathy denotes pity, which should be avoided. The nurse should empathize, not sympathize, with the patient.
- 4. Emotionally charged topics should be approached with respectful, sincere interactions that are accepting and nonjudgmental and that will promote further verbalizations.**
- 28.** 1. Examining is not an interviewing technique.
- 2. Reflective technique refers to feelings implied in the content of verbal communication or in exhibited nonverbal behaviors. Patients who are crying, quiet, and withdrawn often are sad.**
3. This is not an example of clarifying, which is the use of a statement to understand a message better when communication is unclear, rambling, or garbled.
4. This is not an example of orienting. Reality orientation is a nursing technique used to assist patients in restoring an awareness of what is actual, authentic, or real.
- 29.** 1. **Generally, the Progress Notes contain documentation by all members of the health-care team. After a patient is admitted and diagnostic tests are completed, the patient's medical diagnosis may change. The ongoing changes and current status of the patient are documented in the Progress Notes.**
2. The Admission Sheet is the best source for identifying the patient's admitting medical diagnosis, but it will not contain the current medical diagnosis if the diagnosis changed after completion of diagnostic tests.
3. The History and Physical Examination contain a history of the patient, results of the physical examination, and a list of the medical problems on the day of admission to the hospital. The admission medical diagnosis may be different after diagnostic tests are completed.
4. Although the patient's medical diagnosis might be documented on the patient's Social Service Record, it is not the major source for this information.
- 30.** 1. **Limiting competing stimuli promotes reception of verbal messages.**
2. Exaggerating lip movements may be demeaning and ineffective because the patient may not be able to read lips.
- 3. Lowering the pitch of the voice may be helpful. Hearing loss in the older adult typically involves a decreased perception of high-pitched sounds.**
- 4. Standing directly in front of the patient when speaking focuses the patient's attention on the nurse. A hearing-impaired receiver must be aware that a message is being sent before the message can be received and decoded.**
5. Raising the volume of the voice is demeaning and may be viewed by the patient as aggressive behavior.
- 31.** 1. This statement reflects the orientation stages of a therapeutic relationship. Although exploration of feelings is done throughout the stages, the primary goal of the orientation stage is the establishment of trust. Trust is promoted when the nurse focuses on the patient's emotional needs, is respectful, and individualizes care.
- 2. This statement reflects the working stage of a therapeutic relationship. It involves completing interventions that address expected outcomes, such as learning how to perform a colostomy irrigation.**
- 3. This statement reflects the working stage of a therapeutic relationship. It**

includes providing feedback and encouragement.

4. This statement reflects the orientation stage of a therapeutic relationship. The nurse and patient make a verbal agreement to work together to assist the patient to achieve a goal.
  5. This statement reflects the termination stage of a therapeutic relationship. It focuses on summarizing what has transpired and been accomplished and looks to the future.
- 32. 1. The abbreviations U and u for units are on The Joint Commission's official Do Not Use List. These abbreviations may be mistaken for the number 0, the number 4, or cc. The word unit should be written out in full.**
2. An abbreviation for *cubic centimeters* is cc. The abbreviation cc is not on The Joint Commission's official *Do Not Use List*. However, it is being considered for future inclusion because it can be confused with the word *units* when written poorly. The use of milliliters in place of cc is preferred by The Joint Commission.
  3. The use of the abbreviation mg for *milligram* is not on The Joint Commission's official *Do Not Use List*.
  4. **The abbreviation MS for *morphine sulfate* is on The Joint Commission's official Do Not Use List. MS can be mistaken for *morphine sulfate* or *magnesium sulfate*. The name of the medication should be spelled out in full.**
  5. **The use of the abbreviation QOD for every other day is on The Joint Commission's official Do Not Use List. Other abbreviations for every other day include qod, q.o.d., and QOD, and they are also on The Joint Commission's official Do Not Use List. "Every other day" should be written out in full.**
  6. The use of 0800 represents 8 a.m. in military time. This reflects acceptable documentation.
- 33. 1. There are times that the nurse, not the patient, must assume a dominant role; examples include when the patient is unconscious, out of touch with reality, in a crisis, or experiencing panic.**
2. In a therapeutic relationship, the focus is on the patient, not the nurse.
  3. **The helping relationship (interpersonal relationship, therapeutic relationship) is a personal, patient-focused, process.**

The patient is the center of the health team and therefore the focus of any nurse-patient interaction.

4. **Nursing interventions should be designed to achieve desirable patient outcomes. Nursing care is purposeful and goal directed.**
  5. The purpose of a therapeutic relationship is to focus on and meet the needs of the patient, not the nurse.
- 34. 1. 0900 is 9 a.m.**
2. 1900 is 7 p.m.
  3. **2100 is 9 p.m. The large font numbers reflect a.m. The small font numbers reflect p.m.**
  4. 2300 is 11 p.m.



- 35. 1. A nurse uses the technique of paraphrasing when restating a patient's comment or using similar words to rephrase what the patient has said.**
2. **The nurse's statement substitutes the word *problems* for *trouble*, which paraphrases the patient's comment.**
  3. This is not an example of paraphrasing. This statement uses the interviewing technique of reflection because it focuses on feelings rather than words.
  4. This negates the patient's concern and shuts off communication.
  5. This is not an example of paraphrasing; it is a direct question that collects specific information.
- 36. 1. The nurse's response does not employ reflective technique. This open-ended statement invites the patient to explore factors that may be influencing eating.**
2. This response is an example of a direct question, not the use of reflective technique. It elicits a minimal amount of

- information about only one aspect of eating.
3. **This statement is an example of reflective technique because it focuses on the feeling of being startled.**
  4. This response is an example of a direct question, not the use of reflective technique.
  5. **This statement is an example of reflective technique because it focuses on the feeling of surprise.**
37. 3. **During the *preinteraction stage* of the communication process, the nurse gathers information about the patient. This stage occurs before meeting the patient.**
6. **During the *orientation stage* of the communication process, the nurse introduces himself or herself to the patient and begins to establish a rapport with the patient.**
  4. **During the *orientation stage* of the communication process, the nurse and patient exchange information, clarify roles, and identify goals and objectives of the interaction.**
  2. **During the *working stage* of the communication process, the nurse and patient work toward meeting the patient's needs. The nurse may function as a caregiver, counselor, teacher, resource person, etc.**
  1. **During the *working stage* of the communication process, the nurse provides feedback about the patient's performance.**
  5. **During the *termination stage* of the communication process, the nurse summarizes what has been accomplished, reinforces past learning, arranges for available resources, and concludes the interpersonal relationship.**
38. 1. **Communication is facilitated by interviewing techniques that involve attitudes, behaviors, and verbal messages. Interviewing skills promote therapeutic communication because they are patient centered and goal directed.**
2. **A nonjudgmental attitude communicates acceptance to the patient, which provides emotional support and precipitates further communication.**
  3. Communication involves both verbal and nonverbal messages. Often nonverbal messages carry more meaning than verbal messages because actions speak louder than words.
  4. Assertiveness when collecting data may be perceived by the patient as aggression, which is a barrier to communication.
  5. A therapeutic relationship should avoid sympathy because it implies pity. The nurse should empathize, not sympathize, with patients.
39. 1. **This response minimizes the patient's concerns. It is not minor surgery for this patient.**
2. This example of reflective technique focuses on feelings, which promotes communication.
  3. **This response is false reassurance. It denies the patient's concerns about survival and does not invite the patient to elaborate.**
  4. **This response denies the patient's feelings and is false reassurance. Also, it closes communication and does not provide the patient with an opportunity to discuss concerns.**
  5. This example of reflective technique identifies feelings, which promotes communication.
40. 1. **Leaving the patient's medical record open on the computer screen violates patient confidentiality as well as leaves the file vulnerable to another person contaminating the information in the file.**
2. A nurse should communicate, verbally and in writing, important information to other members of the health-care team responsible for caring for the patient. Valuable time may lapse before other members of the team read the patient's electronic medical record.
  3. Documenting care immediately after it is administered ensures that the information is in the patient's medical record. Also, delaying documentation may result in the nurse's forgetting to include pertinent information.
  4. **This ensures that only the nurse assigned the code can insert information into the electronic medical record via that code. This protects the nurse who has the code.**
  5. Inclusion of exact patient statements prevents the nurse from including personal interpretations that may not be accurate.

# Psychological Support

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

### Anxiety:

- Mild
- Moderate
- Severe
- Panic, panic attack

### Behavior modification

### Beliefs

### Bereavement

### Body image

### Confusion

### Conscious, unconscious, subconscious

### Coping

### Crisis:

- Adventitious/unpredictable events
- Developmental/maturational
- Situational

### Crisis intervention

### Defense mechanisms:

- Compensation
- Conversion
- Denial
- Depersonalization
- Dissociation
- Identification
- Intellectualization
- Introjection
- Minimization
- Projection
- Rationalization
- Reaction formation
- Regression
- Repression
- Sublimation
- Substitution
- Suppression

### Delirium

### Delusions

### Dementia

### Dependence

### Depression

### Desensitization

### Ego integrity

### Egocentric

### Empathy, empathetic, empathic

### Freudian terms:

- Ego
- Id
- Superego

### Grieving:

- Anticipatory
- Dysfunctional

### Stages of grieving (Kübler-Ross):

- Denial
- Anger
- Bargaining
- Depression
- Acceptance

### Guided imagery

### Hallucinations

### Hopelessness

### Meditation

### Memory

### Midlife crisis

### Personal identity

### Positive mental attitude

### Powerlessness

### Progressive relaxation

### Psychodynamic

### Psychosocial development

### Psychotherapy

### Role:

- Role ambiguity
- Role conflict
- Role strain

### Self-concept

### Self-esteem

### Social isolation

### Spirituality, spiritual distress

### Suicide, suicidal

### Sympathy

### Transference/countertransference

### Trust

### Values

F.A. I T S

COMPANY

## PSYCHOLOGICAL SUPPORT: QUESTIONS

1. A patient with a terminal illness tells the nurse, "I have lived a long life. I am ready to go." Which is the nurse's **best** response?
  1. Offer the patient a back rub.
  2. Sit quietly by the patient's bedside.
  3. Tell the family about the patient's statement.
  4. Discuss with the patient how dying is part of the life cycle.
2. A man with a heart condition continues to perform strenuous sports against medical advice. Which defense mechanism does the nurse identify the patient is using?
  1. Denial
  2. Repression
  3. Introjection
  4. Dissociation
3. Which is an important concept to consider about anxiety to provide appropriate nursing care?
  1. Panic attacks generally have a slow onset that can be prevented if identified early.
  2. One can conceptualize anxiety as being similar to the health-illness continuum.
  3. People who lead healthy lifestyles rarely experience anxiety.
  4. Anxiety is an abnormal reaction to realistic danger.
4. Which word reflects the ability of a person to perceive another person's emotions accurately?
  1. Trust
  2. Empathy
  3. Sympathy
  4. Autonomy
5. What is the consequence when the nurse denies a patient the use of a defense mechanism?
  1. Causes more anxiety
  2. Precipitates withdrawal
  3. Facilitates effective coping
  4. Encourages emotional growth
6. Which defense mechanism is being used when a patient who has just been diagnosed with terminal cancer calmly says to the nurse, "I'll have to get on the Internet to assess my options"?
  1. Intellectualization
  2. Introjection
  3. Depression
  4. Denial
7. A patient is told that surgery is necessary and the patient begins to experience elevations in pulse, respirations, and blood pressure. Which stage of anxiety is indicated by these nursing assessments?
  1. Mild
  2. Moderate
  3. Severe
  4. Panic
8. A nurse concludes that a woman is remembering only the good times after the death of her husband. Which defense mechanism is the woman using?
  1. Compensation
  2. Minimization
  3. Repression
  4. Regression

9. A patient strongly states the desire to go to the hospital coffee shop for lunch regardless of hospital policy. Which does the nurse conclude that this behavior **most** likely reflects?
1. Anger with the policies of the hospital
  2. Dissatisfaction with hospital meals
  3. The need to regain a little control
  4. A desire for a change of scenery
10. A nurse is teaching a patient about the positive effects of exercise to reduce anxiety. Which patient comment about how exercise reduces anxiety indicates that the patient understands the nurse's teaching?
1. "It stimulates the production of endorphins."
  2. "It interferes with the ability to concentrate."
  3. "It reduces the metabolism of epinephrine."
  4. "It decreases the acidity of blood."
11. A primary health-care provider informs a patient that the diagnosis is inoperable cancer and the prognosis is poor. After the primary health-care provider leaves the room, the patient begins to cry. Which should the nurse do?
1. Touch the patient's hand to provide support.
  2. Leave the room to give the patient privacy to cry.
  3. Telephone the patient's family to inform them of the diagnosis.
  4. Ask the patient questions to encourage a ventilation of feelings.
12. A nurse is caring for a patient who is scheduled for intravenous chemotherapy for cancer. Which defense mechanism is being used when the patient says to the daughter, "Be brave"?
1. Rationalization
  2. Minimization
  3. Substitution
  4. Projection
13. A patient says to a nurse, "I'm the same age as my father when he died. Am I going to die of my cancer?" Which is the appropriate inference about what the patient is experiencing?
1. Grieving associated with the potential for death
  2. Powerlessness associated with feelings of being out of control
  3. Fear associated with the perceived threat to biological integrity
  4. Impaired coping associated with inadequate psychological resources
14. A patient who is withdrawn says, "When I have the opportunity, I am going to commit suicide." Which is the **best** response by the nurse?
1. "You have a lovely family. They need you."
  2. "You must feel overwhelmed to want to kill yourself."
  3. "Let's explore the reasons you have for wanting to live."
  4. "Suicide does not solve problems. Tell me what is wrong."
15. Which situation identified by the nurse reflects the defense mechanism of displacement?
1. A woman is very nice to her mother-in-law whom she secretly dislikes.
  2. A man says that he is not so bad, so don't believe what they say about him.
  3. An adolescent puts a poor grade on a test out of her mind when at her after-school job.
  4. An older man gets angry with friends after family members attempt to talk with him about his illness.

16. Which is the **best** way for the nurse to support patients' self-esteem needs across the life span?
1. Employing a positive mental attitude
  2. Providing a nonjudgmental environment
  3. Encouraging social interaction with others
  4. Supporting the use of defense mechanisms
17. A nurse identifies that a patient is mildly anxious. Which assessment of the patient supports this conclusion?
1. Preoccupied
  2. Forgetful
  3. Fearful
  4. Alert
18. A patient expresses a sense of hopelessness. Which concern identified by the nurse is the priority?
1. Risk for self-harm
  2. Inability to cope
  3. Powerlessness
  4. Fatigue
19. When assessing a patient for anxiety, which characteristic about anxiety should the nurse consider?
1. It is triggered by a known stressor.
  2. It occurs simultaneously with fear.
  3. It is a response that is avoidable.
  4. It is a universal experience.
20. A woman with diabetes does not follow her prescribed diet and states, "Everyone with diabetes cheats on their diet." Which defense mechanism does the nurse identify this patient is using?
1. Rationalization
  2. Sublimation
  3. Undoing
  4. Denial
21. A nurse is interviewing a patient who is a devout Jehovah's Witness. Which nursing statement reflects ethnocentrism?
1. "Tell me more about your food preferences."
  2. "One of your options is that you can have a kidney transplant."
  3. "You should have a blood transfusion because it is the best way to treat your anemia."
  4. "There is birth control available since you have said you do not want to get pregnant."
22. A neonate is born with a life-threatening anomaly to parents who are Roman Catholic. The primary health-care provider discusses the need for immediate surgery with the parents and they sign an Informed Consent. Which should a culturally competent nurse say to the parents?
1. "Shall I call a priest so that your baby can receive the Sacrament of the Anointing of the Sick?"
  2. "I will take you to the chapel so that you can pray for your baby during the surgery."
  3. "I will arrange for a Eucharistic minister to give your baby Holy Communion."
  4. "Would you like a nurse who is Roman Catholic to baptize your baby?"



23. A female patient of Arab descent is admitted to the hospital for emergency surgery for an injury sustained in an automobile collision. Considering the Arab culture, which person will be making health-care decisions?
1. The matriarch of the family
  2. The woman's oldest son
  3. The patient's husband
  4. The patient
24. A 4-year-old boy is admitted to the emergency department and diagnosed with leukemia. The parents are informed that their child has an excellent prognosis if treated with chemotherapy. The parents are practicing Christian Scientists and adamantly refuse drug therapy. Which should the nurse do?
1. Encourage the parents to seek the prayers of one of the church's practitioners.
  2. Explain to the parents how the chemotherapeutic regimen will cure the leukemia.
  3. Talk with the nursing supervisor about referring this situation to the ethics committee.
  4. Accept the decision based on the first amendment of the Constitution of the United States.
25. A home care nurse provides nursing services for a community of people who practice the Amish religion and follow a simple lifestyle. Which statement is **unrelated** to the beliefs and values of Amish people?
1. "I am going to have my baby at home rather than in a hospital."
  2. "I need permission from my church before I can have surgery."
  3. "Please find a nursing home for my father who has dementia."
  4. "I do not want anything done to me to prolong my life."
26. A nurse is caring for a patient who is Native American. Which is essential for the nurse to do to provide culturally competent nursing care that is **unique** to Native Americans?
1. Treat the body of a deceased person with respect.
  2. Limit access to the patient to just immediate family members.
  3. Support hot and cold remedies as long as they do not harm the patient.
  4. Provide privacy when family members perform rituals that involve chanting.
27. A primary health-care provider orders a regular diet for a patient of the Jewish faith who follows a kosher diet. Which meals arranged by the nurse are culturally appropriate? **Select all that apply.**
1.  Chicken lo mein, fried rice, pineapple chunks, and tea
  2.  Sliced beef, mixed vegetables, baked potato, and cola
  3.  Hamburger on a bun, potato chips, and milk
  4.  Curried shrimp, egg noodles, and coffee
  5.  Eggs, buttered roll, and orange juice
  6.  Oatmeal, toast, and hot chocolate
28. A family from Asia immigrates to the United States. Which of the following reflect the concept of acculturation? **Select all that apply.**
1.  Family members take several herbs daily.
  2.  Husband is attending school to learn English.
  3.  Wife prepared a meal with turkey on Thanksgiving.
  4.  Grandparents live in the same house as the rest of the family.
  5.  The children demonstrate respect for their parents and grandparents.
29. A nurse must provide culturally competent nursing care to a patient. Place the following in the order in which they should be performed.
1. Provide care that incorporates the patient's specific beliefs, values, and health-care practices.
  2. Recall the beliefs, values, and health-care practices associated with the patient's culture.
  3. Explore the patient's specific beliefs, values, and health-care practices.
  4. Explore own beliefs, values, and health-care practices.

Answer: \_\_\_\_\_

- 30.** A nurse is caring for a woman who is hospitalized because of severe burns to the right hand as a result of a stove-top fire. The patient follows Hinduism. Which should the nurse do to meet the patient's spiritual/cultural needs? **Select all that apply.**
- Provide privacy when the husband visits the patient.
  - Assign a nursing assistant to assist the patient with meals.
  - Recognize that pain may be stoically accepted by the patient.
  - Ensure that a female nurse aid helps the patient with hygienic practices.
  - Give her sacred gold necklace to her husband to be taken home for safe-keeping.
- 31.** A nurse is caring for a patient who is a member of the Church of Jesus Christ of Latter-day Saints. Which questions by the nurse are culturally sensitive? **Select all that apply.**
- "Which is the best way for me to care for your sacred undergarment while you are in surgery?"
  - "Shall I call a priest to bring you the Eucharist in the morning before your surgery?"
  - "Would you like orange juice to be included with your breakfast?"
  - "Do you want me to place the head of your bed toward Mecca?"
  - "Should I tell the dietitian that you want a vegetarian diet?"
- 32.** A woman who is a member of the Seventh-day Adventist Church is pregnant and considering an abortion. According to her religious beliefs, in which circumstances can this woman decide to have an abortion? **Select all that apply.**
- Form of birth control
  - Mother's life is in jeopardy
  - Gender selection of the fetus
  - Pregnancy resulted from rape
  - Congenital anomaly in the fetus
- 33.** A male patient with Latino heritage is diagnosed with hypertension. The nurse reviews the primary health-care provider's orders, obtains the patient's vital signs, and interviews the patient and patient's wife. Which should the nurse do?
- Obtain the patient's vital signs again in one hour.
  - Explain to the wife that garlic will not help lower her husband's blood pressure.
  - Explore with the couple the fact that prayer will not lower a person's blood pressure.
  - Accept the couple's decision about consuming a clove of garlic and the juice of a lemon daily.

### PATIENT'S CLINICAL RECORD

#### Primary Health-Care Provider's Orders

2-gram sodium diet  
 Vital signs every 4 hours  
 Hydrochlorothiazide (HCTZ) 25 mg by mouth once a day  
 Furosemide 20 mg by mouth once a day

#### Patient's Vital Signs

Temperature: 98.8°F, orally  
 Pulse: 88 beats per minute, bounding  
 Respirations: 22 breaths per minute, unlabored  
 Blood pressure: 160/94 mm Hg

#### Patient and Spouse Interview

*Patient:* "I am going to pray because God has kept me healthy up to now."

*Patient's Wife:* "We decided that my husband will eat a clove of garlic and drink the juice from a lemon every day."

34. When the nurse analyzes a patient's statements, which statements **best** reflect the dimension of self-esteem? **Select all that apply.**
1.  " I really like the me that I see."
  2.  " What do I want to achieve?"
  3.  " How do I appear to others?"
  4.  " I like things my way."
  5.  " I'm OK, you're OK."
35. Anxiety can progress through levels of severity from mild to panic. The patient's level of anxiety will influence how the nurse approaches the patient situation. Place these patient statements in order as anxiety progresses from mild, to moderate, to severe, and finally to panic.
1. "I want to know more about the surgery I am having tomorrow."
  2. "I don't think I am going to make it through the surgery tomorrow."
  3. "I can't concentrate and all I think about is the pain I may have tomorrow."
  4. "I get butterflies in my stomach when I think about the surgery tomorrow."
- Answer: \_\_\_\_\_
36. A nurse is caring for a patient with a comprehension deficit. Which should the nurse do to **best** support this patient? **Select all that apply.**
1.  **A** sk that unclear words be repeated.
  2.  **S** peak directly in front of the patient.
  3.  **M** a ke a referral for a hearing evaluation.
  4.  **E** sta blish structured activities of daily living.
  5.  **P** araphrase statements when they are not understood.
37. Which nursing actions demonstrate support of human dignity in the practice of nursing? **Select all that apply.**
1.  **M** a intaining confidentiality of information about patients
  2.  **S** u pporting the rights of others to refuse treatment
  3.  **O** b taining sufficient data to make inferences
  4.  **C** alling patients by their preferred name
  5.  **S** ta ying at the scene of an accident
38. A preoperative patient is anxious about pending elective surgery. Which are the **best** ways for the nurse to help the patient reduce the anxiety? **Select all that apply.**
1.  **I** nvo lve significant others.
  2.  **U** se distraction techniques.
  3.  **E** x plore identified concerns.
  4.  **F** o ster verbalization of feelings.
  5.  **U** se progressive desensitization strategies.
39. Which might a patient be at risk for in the psychosocial domain when the nursing assessment indicates that the patient is almost completely paralyzed? **Select all that apply.**
1.  **I** n f ection
  2.  **S** e l f -harm
  3.  **C** o nstipation
  4.  **H** o p elessness
  5.  **P** o w erlessness
40. A dying patient is withdrawn and depressed. Which nursing actions are therapeutic? **Select all that apply.**
1.  **A** s sisting the patient to focus on positive thoughts daily
  2.  **E** x p laining that the patient should focus on future goals
  3.  **R** e m a i n i n g available in case the patient wants to talk
  4.  **A** c c e p t i n g the patient's behavioral adaptation
  5.  **O** f f e r i n g the patient advice when appropriate

## PSYCHOLOGICAL SUPPORT: ANSWERS AND RATIONALES

1. Although a back rub may provide physical comfort, at this time the patient requires psychosocial comfort. Offering to provide a back rub changes the subject and may cut off further communication.
  - 2. Sitting quietly by the patient's bedside conveys nonjudgmental acceptance of the statement and provides emotional support. Silence may precipitate further communication.**
  - Telling the family about the patient's statement is a violation of confidentiality.
  - This is not an appropriate time to initiate an intellectual discussion. The patient's needs are in the psychosocial domain (affective domain).
- 2. 1. This scenario is an example of denial. Denial is being used when a person ignores or refuses to acknowledge something unacceptable or unpleasant.**
  - This scenario is not an example of repression. Repression is an unconscious mechanism whereby painful or unpleasant ideas are kept from conscious awareness.
  - This scenario is not an example of introjection. Introjection is the taking into one's personality the norms and values of another as a means of reducing anxiety.
  - This scenario is not an example of dissociation. Dissociation occurs when a person segregates a group of thoughts from consciousness or when an object or idea is segregated from its emotional significance in an effort to avoid emotional distress.
1. Panic attacks cannot be prevented if identified early, and they do not have a slow onset. Panic attacks usually occur suddenly and spontaneously, build to a peak in 10 minutes or less, and last from several minutes to as long as an hour.
  - 2. People can experience anxiety along a continuum from no anxiety to mild, moderate, severe, or panic, just as health is viewed along a continuum from illness to health.**
  - Healthy people experience anxiety when physically or emotionally threatened. Anxiety is a universal response to a threat. People will feel anxious when exposed to something new that is a threat to self-identity or self-esteem.
  - A realistic danger triggers fear, not anxiety.
1. Trust is not the nurse's perceiving the patient's emotions accurately. Trust is established when a patient has confidence in the nurse because the nurse demonstrates competence and respect for the patient and behaves in a predictable way.
  - 2. Empathy is the nurse's ability to have insight into the feelings, emotions, and behavior of the patient.**
  - Sympathy is more than expressing concern and sorrow for a patient but also contains an element of pity. When sympathetic, the nurse may let personal feelings interfere with the therapeutic relationship, which can impair judgment and limit the ability to identify realistic solutions to problems. Although sympathy is a caring response, it is not therapeutic, as is empathy.
  - Autonomy is being self-directed, not being able to perceive another person's emotions.
- 1. Defense mechanisms are used to reduce anxiety and achieve or maintain emotional balance. If a nurse identifies reality and does not recognize the patient's need to use defense mechanisms, the patient will become more anxious, even to the point of panic.**
  - Denying the use of a defense mechanism usually does not precipitate withdrawal. Behavioral responses usually include irritability, increased motor activity, and even anger.
  - Denying a patient the use of a defense mechanism will contribute to ineffective coping, not facilitate effective coping.
  - Denying the use of a defense mechanism will not encourage emotional growth. Emotional growth develops as a result of gaining insight into behavior, recognizing reality, and addressing problems constructively.
- 1. This scenario is an example of intellectualization. Intellectualization is the use of reasoning to avoid facing unacceptable stimuli in an effort to protect the self from anxiety.**
  - This scenario is not an example of introjection. Introjection is the taking into one's personality the norms and values of another as a means of reducing anxiety.

3. This scenario is not an example of depression. Depression is not a defense mechanism; it is an altered mood indicated by feelings of sadness, discouragement, and loss of interest in usual pleasurable activities.
  4. This scenario is not an example of denial. Denial is ignoring or refusing to acknowledge something unacceptable or unpleasant.
7. 1. During mild anxiety, the pulse, respirations, and blood pressure remain at the resting rate.
  2. **During moderate anxiety, the pulse, respirations, and blood pressure are slightly elevated in response to the stimulation of the autonomic nervous system.**
  3. During severe anxiety, the pulse, respirations, and blood pressure are more than just slightly elevated. The pulse and respirations are rapid and may be irregular, and the blood pressure is high, not just slightly elevated.
  4. During a panic attack, the pulse and respirations are very rapid and may be irregular, the blood pressure will be high, and the patient may hyperventilate. If a panic attack is extreme, the blood pressure may suddenly drop and cause fainting.
8. 1. This scenario is not an example of compensation. Compensation is making an attempt to achieve respect in one area as a substitute for a weakness in another area.
  2. This scenario not an example of minimization. Minimization is not admitting to the significance of one's own behavior, thereby reducing one's responsibility.
  3. **This scenario is an example of repression. Repression is an unconscious mechanism in which painful or unpleasant ideas are kept from conscious awareness.**
  4. This scenario is not an example of regression. Regression is resorting to an earlier, more comfortable pattern of behavior that was successful in earlier years but is now inappropriate.
9. 1. Patients generally follow hospital policies because they recognize that they are designed to keep patients safe. When they do not follow rules, usually it is for a reason other than because they are angry.
  2. Patients have an opportunity to choose foods they like from the menu, to request alternative meals if they are unhappy with the food that arrives, and to ask family members to bring in food as long as the food is permitted on the ordered diet.
  3. **All behavior has meaning. Acting-out behaviors that reflect attempts to control events often are covert expressions of feeling powerless.**
  4. Most hospital units have a lounge that supports patients' needs to have a change of scenery from their rooms.
10. 1. **Exercise stimulates endorphin production, which promotes a sense of well-being and euphoria. Also, endorphins act as opiates and produce analgesia by modulating the transmission of pain perception.**
  2. Exercise improves, not interferes with, one's ability to concentrate and solve problems by increasing circulation, which facilitates oxygenation of brain cells.
  3. Exercise promotes, not reduces, metabolism of epinephrine, thereby minimizing autonomic arousal and decreasing vigilance associated with the anxious response.
  4. The acidity of blood is increased, not decreased, by exercise. This improves digestion and metabolism and thereby increases one's energy level.
11. 1. **Touching the patient conveys concern and caring and is supportive. Quiet support provides a nonjudgmental environment in which the patient is allowed to cry, which is the expression of a feeling.**
  2. Leaving abandons the patient at a time when the patient needs emotional support.
  3. Conveying this information to the patient's family is a violation of confidentiality.
  4. Exploring the patient's feelings is premature. The patient requires time to cry as a way to express sad feelings.
12. 1. This scenario is not an example of rationalization. Rationalization is used to justify in some socially acceptable way ideas, feelings, or behavior through explanations that appear to be logical.
  2. This scenario is not an example of minimization. Minimization is not admitting to the significance of one's own behavior, thereby reducing one's responsibility.

3. This scenario is not an example of substitution. Substitution is replacement of an unattainable, unavailable, or unacceptable goal, emotion, or motive with one that is attainable, available, or acceptable in an effort to reduce anxiety, frustration or disappointment.
  4. **This scenario is an example of projection. Projection is attributing thoughts, emotions, motives, or characteristics within oneself to others.**
13. 1. A characteristic of grieving is that the person must express distress regarding a loss or potential loss. This patient is asking questions, not displaying distress related to a perceived impending death.
  2. This statement does not reflect powerlessness. People who are powerless usually do not ask questions.
  3. **This statement supports the fact that the patient is experiencing fear. A characteristic of fear is the verbalization of feelings of apprehension and alarm related to an identifiable source.**
  4. This statement does not indicate that the patient is coping ineffectively or has inadequate psychological resources. The patient is gathering data by appropriately asking questions, which is an effective, task-oriented action in the coping process.
14. 1. This statement is inappropriate; the patient is unable to cope, is selecting the ultimate escape, and is not capable of meeting the needs of others; this response also may precipitate feelings such as guilt.
  2. **This statement identifies feelings and invites further communication; it uses the interviewing technique of reflection.**
  3. This denies the patient's feelings; the patient must focus on the negatives before exploring the positives.
  4. This is a judgmental response that may cut off communication. This response is too direct, and the patient may not consciously know what is wrong.
15. 1. This scenario is an example of reaction formation, not displacement. Reaction formation is when a person develops conscious attitudes, behaviors, interests, and feelings that are the exact opposite to unconscious attitudes, interests, and feelings.
  2. This scenario is an example of minimization. Minimization allows a person to decrease responsibility for one's own behavior.
  3. This scenario is an example of suppression, not displacement. Suppression is a conscious attempt to put unpleasant thoughts out of the conscious mind to be dealt with at a later time.
  4. **This scenario is an example of displacement. Displacement is the transfer of emotion from one person or object to a person or an object that is more acceptable and less threatening.**
16. 1. The nurse's personal attitudes should not be imposed on the patient. An attitude is a mental position or feeling toward a person, an object, or an idea.
  2. **When the nurse establishes a nonjudgmental environment and functions without biases, preconceptions, or stereotypes and avoids challenging a patient's values and beliefs, a patient's self-esteem is supported.**
  3. This may or may not support self-esteem needs. The benefit of this intervention depends on the relationships that develop and whether they promote self-worth.
  4. The support of a defense mechanism results in reality distortion. The use of defense mechanisms should be accepted, not supported. The nurse just should recognize when defense mechanisms are being used because all behavior has meaning.
17. 1. Preoccupation reflects moderate, not mild, anxiety. People with moderate anxiety tend to focus on one issue and use selective attention.
  2. Forgetfulness reflects moderate, not mild, anxiety. With mild anxiety, the person increases arousal and perceptual fields and is motivated to learn. With moderate anxiety, the person has a narrowed focus of attention and may become forgetful because of an inability to focus attention.
  3. Fearfulness is not a response to anxiety. Fearfulness is a response to an identifiable source, whereas anxiety is caused by an unidentifiable source.
  4. **Increased alertness occurs when one is mildly anxious. Alertness and vigilance are the result of an increase in one's**

perceptual field and state of arousal in response to the stimulation of the autonomic nervous system when one feels threatened.

**18. 1. Risk for self-harm takes priority over the other three concerns because of the potential for suicide.**

2. Although a person who expresses hopelessness may also demonstrate an inability to manage stressors because of inadequate physical, psychological, behavioral, or cognitive resources, another option identifies a concern that has a higher priority.
3. Although a person who expresses hopelessness may also perceive a lack of personal control over events or situations, another option identifies a concern that has a higher priority.
4. Although a person who expresses hopelessness may also experience an overwhelming sense of exhaustion unrelieved by rest, another option identifies a concern that has a higher priority.

- 19. 1. Anxiety is triggered by an unknown, not known, stressor.**
2. Anxiety and fear do not occur simultaneously. Anxiety is precipitated by an unknown stressor, while fear is precipitated by a known stressor.
  3. Anxiety cannot be avoided. It is an expected aspect of everyday living. Every time someone experiences something new, it is a threat to the identity or self-esteem; therefore, people feel anxious.
  4. **Anxiety is a common and universal response to a threat. Every time people experience something new that is a threat to the identity or self-esteem, they may feel anxious. Anxiety is a psychosocial response to an unknown stress; it may be a vague sense of apprehension at one extreme to impending doom at the other extreme.**

**20. 1. This is an example of rationalization. Rationalization is used to justify in some socially acceptable way ideas, feelings, or behavior through explanations that appear to be logical.**

2. This is not an example of sublimation. Sublimation is the channeling of primitive sexual or aggressive drives into activities or behaviors that are more socially acceptable, such as sports or creative work.

3. This is not an example of undoing. Undoing is use of actions or words in an attempt to cancel unacceptable thoughts, impulses, or acts. This reduces feelings of guilt through atonement or retribution.
4. This is not an example of denial. Denial is an unconscious protective response that involves a person's ignoring or refusing to acknowledge something unacceptable or unpleasant to reduce anxiety.

**21. 1. This statement reflects culturally sensitive, appropriate, and competent nursing care. The nurse is collecting information to individualize nursing care.**

2. This statement does not impose the nurse's values, beliefs, and practices onto the patient (cultural imposition) because it is just providing the patient with an additional option; however, it is culturally insensitive. A person who is a devout Jehovah's Witness does not believe in organ transplantation, abortion, or sterilization. Jehovah's Witnesses do allow birth control, autopsy, and cremation.

**3. This is an example of ethnocentrism. Ethnocentrism is viewing one's own values, beliefs, and practices as being superior or more acceptable or best in comparison to the patient's values, beliefs, and practices. A person who is a devout Jehovah's Witness does not believe in the use of blood or blood products even in a life-threatening situation. Jehovah's Witnesses do believe in the use of artificial blood expanders.**

4. This statement does not reflect ethnocentrism. The patient has stated a need and the nurse is providing information regarding how to meet that need.

**22. 1. The infant should be baptized before receiving the Sacrament of the Anointing of the Sick.**

2. This is presumptuous, inappropriate, and authoritative. The parents may not have the energy, focus, or desire to pray.
3. Individuals must be baptized before they can receive Holy Communion. Holy Communion usually is administered after studying the scriptures and basics of the Roman Catholic religion and reaching the age of reason (usually 7 years of age). Nothing should be put into the mouth of an individual being prepared for surgery, to prevent aspiration.

- 4. A member of the Roman Catholic faith can baptize in an emergency if a priest is unavailable. The surgery is imminent.**
- 23.** 1. Women are not the decision makers in families of Arab heritage regardless of their age or status.  
 2. This is not the role of the oldest son while the patient's husband is still alive.  
**3. In Arab heritage, women do not make autonomous health-care decisions; husbands are the decision makers for their wives.**  
 4. Women are not the decision makers in families of Arab heritage.
- 24.** 1. While prayer can be powerful, it alone will not cure leukemia. Church practitioners are trained by the church to pray for members. Church members believe that physical illness and sin are states of mind, correctable through properly applied prayer.  
 2. This is an inappropriate intervention at this time. The parents are steadfastly and obstinately refusing drug therapy. It also provides false reassurance because not all children with leukemia experience a cure after undergoing chemotherapy.  
**3. This is an ethical dilemma. An ethics committee is an advisory body with a multidisciplinary composition that facilitates the exploration and resolution of ethical issues that occur within the facility.**  
 4. The United States court system can intervene on the behalf of infants and children when parents refuse life-saving treatments. The nurse is not being an advocate for the child in this situation.
- 25.** 1. Amish people believe that birth and death are phases of life and should occur in the home.  
 2. Amish people need permission from their church before receiving care in a hospital. They accept anesthesia, surgery, blood transfusions, blood products, dental care, and organ transplants other than the heart (the heart is considered the soul of the body).  
**3. It is unlikely that an Amish person would place a family member in a nursing home. Amish people believe in caring for ill family members in their home and prefer to die in the home with family members by the bedside. They have a strong commitment to family members and members of the community.**
4. Amish people believe that end of life care be limited so that assets are used for the living.
- 26.** 1. Everyone, dead or alive, should be treated with respect at all times.  
 2. Native Americans believe illness is a concern of the family, extended family, and tribe. The nurse should support visits from those people who are desired by the patient.  
 3. People with Hispanic and Latino heritage, not Native Americans, believe in the use of "hot" and "cold" remedies to heal illnesses.  
**4. Native Americans engage in rituals, ceremonies, and exorcisms that may involve chanting, dancing, and the wearing of amulets. Privacy should be provided.**
- 27.** 1. **All the foods and fluid in this meal are permitted on a kosher diet. Meat from animals that are cloven footed, cud chewing, and slaughtered and prepared following strict laws of Kashrut (kosher diet) are permitted.**  
 2. **All of the foods and fluid in this meal are permitted together on a kosher diet. Beef is from a cow, a cud-chewing animal, which is permitted on a kosher diet as long as it is not served at the same meal as a dairy product.**  
 3. Hamburger is ground beef and milk is a dairy product. Meat and dairy products cannot be served at the same meal. Each requires separate sets of dishes, pots, pans, and utensils to ensure that they remain separate and do not contaminate each other. Potato chips are permitted with meals that contain meat or dairy products.  
 4. Only fish that have scales and fins are permitted on a kosher diet. Shellfish such as shrimp, crab, and lobster are not permitted on a kosher diet.  
**5. All of the foods and this fluid in this meal are permitted together on a kosher diet. This meal does not contain both dairy and meat products and does not contain pork.**  
**6. All these foods and fluid are permitted at the same meal when a person is following a kosher diet. This meal does not contain both dairy and meat products and does not contain pork.**



28. 1. This is not an example of acculturation. Asian cultures have a rich history of Eastern medicine including the use of herbs, applications of hot and cold, and acupuncture to reestablish balance within the body.
2. **Acculturation is the process of adapting to a new environment or situation that is different from one's own. Currently, the dominant language in the United States is English. The husband is attempting to adapt to the United States.**
3. **Eating turkey on Thanksgiving is a tradition in the United States. The wife's making a turkey on Thanksgiving is incorporating a tradition associated with their new country into the family's practices.**
4. This is not an example of acculturation. Several generations of family members living in the same household is an accepted practice within an Asian family, not something that generally is practiced in the United States. However, this may become more prevalent in the United States as the economy continues to decline and young adults and retired individuals do not have the economic resources to maintain a separate home.
5. This does not necessarily reflect acculturation. Individuals from Asian cultures value respect for elders and are subordinate to authority. This may or may not reflect the attitude of all individuals living in the United States. Some believe older adults no longer have the same value as when they were younger because they do not contribute to society.
29. 4. **A nurse must know herself or himself before caring for others. Personal values, beliefs, practices, biases, and prejudices must be identified to ensure that they are not imposed on patients.**
2. **Often there are commonalities in the values, beliefs, and practices within a culture. It is important for the nurse to be aware of these commonalities to promote culturally competent nursing care.**
3. **Individuals within a culture do not always ascribe to the beliefs, values, and practices of the collective culture. Preferences must be explored with patients to ensure that nursing care is individualized.**
1. **Knowing about the beliefs, values, and practices within a culture and specific to an individual is not enough. A nurse must respect and provide care that adheres to the beliefs, values, and practices of each individual to provide culturally appropriate and competent nursing care.**
30. 1. **Public displays of affection are prohibited. Touching, hugging, and kissing are considered strictly private matters.**
2. **Individuals who practice Hinduism eat with only the right hand because the left hand is used for toileting activities.**
3. **Followers of Hinduism believe that pain is caused by the anger of a higher power and therefore one must bear the condition and situation.**
4. **Women are modest and prefer female direct patient caregivers. Patient privacy is a priority.**
5. **Wearing a sacred gold necklace should be permitted. It can be removed only with consent from the patient when it will interfere with a necessary procedure.**
31. 1. **This question is culturally sensitive. The sacred undergarment worn by a member of the Church of Jesus Christ of Latter-day Saints is removed only for bathing. It can be removed for surgery but must be treated with respect.**
2. This question is culturally insensitive. Receiving the Eucharist (Holy Communion) is a practice of religions such as Roman Catholic and Episcopalian.
3. **This question is culturally sensitive. Dietary practices prohibit the intake of coffee and tea, not orange juice.**
4. This question is culturally insensitive. Positioning the head of the bed toward Mecca meets the spiritual needs of those who follow the Islamic faith.
5. This question is culturally insensitive. Members of the Church of Jesus Christ of Latter-day Saints are permitted to eat a moderate amount of meat.
32. 1. **The Seventh-day Adventist Church, a Protestant denomination, opposes abortion for convenience. Abortion as a form of birth control is unacceptable.**
2. **The Seventh-day Adventist Church, a Protestant denomination, permits abortion in extreme situations such as when the life of the mother is in**

**jeopardy. The life of the mother becomes the priority.**

3. The Seventh-day Adventist Church, a Protestant denomination, does not condone abortion as an intervention of convenience. Abortion to prevent the birth of an infant with an undesirable gender is not condoned.
  4. **The Seventh-day Adventist Church, a Protestant denomination, permits abortion in extreme situations such as when the pregnancy resulted from rape or incest.**
  5. **The Seventh-day Adventist Church, a Protestant denomination, permits abortion in extreme situations such as when a fetus has a severe congenital anomaly.**
- 33.**
1. It is unnecessary to obtain the patient's vital signs in one hour. Although the blood pressure is increased, it is not at a dangerous level. The primary health-care provider ordered that vital signs be obtained every 4 hours.
  2. Garlic has hypolipemic and antiplatelet properties that can help lower blood pressure.
  3. Prayer, meditation, and biofeedback exercises can help lower the vital signs, especially heart rate and blood pressure.
  4. **Latino and Hispanic individuals believe illness is caused by an imbalance in hot and cold principles. Hypertension is considered a "hot" illness and therefore should be treated with "cold" therapies. Cold therapies include the ingestion of foods such as citrus fruits, garlic, and bananas.**
- 34.**
1. **This statement best reflects the dimension of self-esteem. Self-esteem is a person's self-evaluation of one's own worth or value. A person whose self-concept comes close to one's ideal self generally will have a high self-esteem.**
  2. This statement reflects one's self-expectations, not self-esteem. Establishing expectations contributes to the composition of the ideal self.
  3. This statement reflects self-concept, not self-esteem. Self-concept is an individual's knowledge about oneself. Self-concept is derived from all the collective beliefs and images about oneself as a result of interaction with the environment, society, and feedback from others.
  4. This statement is a reflection of a patient's need to be autonomous and self-reliant. Having confidence in one's ability to complete a task is only one component of self-concept.
  5. **This statement reflects the dimension of self-esteem. By stating "I'm OK," the person demonstrates self-acceptance.**
- 35.**
1. **Mild anxiety is a slightly aroused state that enhances perception, learning, and performance of activities.**
  4. **Moderate anxiety increases the arousal state that precipitates feelings of tension and nervousness. The heart and respiratory rates increase, and the person may have mild gastrointestinal symptoms, such as a feeling of butterflies in the stomach.**
  3. **Severe anxiety consumes the person's physical and emotional energy. Perceptions are decreased, and the person focuses on limited aspects of what is precipitating the anxiety.**
  2. **Panic is an overwhelming state where the person feels out of control. Perceptions may be distorted and exaggerated, and the person may have feelings of impending doom.**
- 36.**
1. **To best support a patient the nurse must understand what the patient is communicating. When a patient's message is unclear the nurse must obtain clarification.**
  2. This action does not facilitate comprehension. It helps a patient with a hearing deficit recognize that someone is speaking, and it facilitates lip reading if the patient has the ability to read lips.
  3. The patient's problem is a decreased ability to process and understand information, not a hearing loss.
  4. **New experiences require a person to process information and problem solve, which is difficult to do for the person with a comprehension deficit. Lack of understanding is threatening to feelings of safety and security. Structure and routines provide predictability, which limits confusion, disorientation, and anxiety.**
  5. **Paraphrasing a message uses different words that the patient may understand, promoting decoding of the message and communication.**

- 37. 1. Confidentiality respects the patient's right to privacy, which is a component of human dignity.**
2. This supports the right of a patient to self-determination, which is based on the concept of freedom, not human dignity.
  3. This reflects the nurse's attempt to seek the truth, not support human dignity.
  - 4. Calling patients by their given name demonstrates respect for the individual. Avoid names such as "dear," "sweetie," "honey," and "grandma," or "grandpa," because they are demeaning and disrespectful.**
  5. This reflects a nurse's attempt to be responsible and accountable, not support human dignity.
- 38. 1. Significant others generally are as anxious as the patient because anxiety is contagious. Anxious significant others bring to the discussion their own emotional problems that can misdirect the focus from the patient as well as compound the problem.**
2. Although distraction techniques, such as guided imagery, can help manage stress, other options offer a more effective interventions to reduce anxiety.
  - 3. Exploring identified concerns individualizes the nurse's interventions. Specific issues can be addressed and knowledge deficits corrected.**
  - 4. Using interviewing techniques encourages the patient to verbalize feelings and explore concerns, which reduce anxiety. Verbalization uses energy, makes concerns recognizable, and promotes problem solving.**
  5. Anxiety is not something one can desensitize oneself to by increasing exposure to the stressor. With anxiety, the stressor is unknown.
- 39. 1. The risk for infection is a concern in the physiological, not the psychosocial, domain.**
2. Data do not support the concern that the patient will cause self-harm. The data related to the risk for self-harm are an expression of a desire to harm oneself, commit suicide, or die.
  3. The risk for constipation is a concern in the physiological, not the psychosocial, domain.
  - 4. A person who feels hopeless sees no solution to the problem. A person who is almost completely paralyzed may not be able to mobilize energy on his or her own behalf to move forward and achieve goals.**
  - 5. People who are unable to care for themselves independently often perceive a lack of control over events. The nurse should be alert to the presence of data that support powerlessness.**
- 40. 1. Focusing on positive thoughts is inappropriate because it denies the patient's feelings; the patient needs to focus on the future loss.**
2. Focusing on future goals is inappropriate because it denies the patient's feelings; the patient needs to focus on the impending death. The nurse should not be telling the patient what should be the focus of care.
  - 3. Remaining available to the patient indicates that the nurse is not abandoning the patient. The nurse's presence provides quiet support without intruding on the patient's coping.**
  - 4. Depression is the fourth stage of grieving according to Kübler-Ross; patients become withdrawn and noncommunicative when feeling a loss of control and recognizing future losses. The nurse should accept the behavior and be available if the patient wants to verbalize feelings.**
  5. It is never appropriate to offer advice; people must explore their alternatives and come to their own conclusions.

# Teaching and Learning

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Behavior modification  
Continuing education program  
Feedback  
Focus group  
Inservice education program  
Learning domains:  
  Affective:  
    Receiving  
    Responding  
    Valuing  
    Organizing  
    Characterizing  
  Cognitive:  
    Acquisition  
    Comprehension  
    Application  
    Analysis  
    Synthesis  
    Evaluation  
  Psychomotor:  
    Set  
    Guided response  
    Mechanism  
    Complex overt response  
    Adaptation  
    Origination

Locus of control:  
  External  
  Internal  
Motivation  
Orientation program  
Pre-test, post-test  
Readiness  
Reading level  
Reinforcement  
Teaching:  
  Formal  
  Informal  
Teaching methods:  
  Active learning  
  Audiovisual aids  
  Case study  
  Computer-assisted instruction  
  Demonstration  
  Discussion  
  Lecture  
  Programmed instruction  
  Return demonstration  
  Role-playing  
  Simulation  
  Written material

F.A. AVIS COMPANY

## TEACHING AND LEARNING: QUESTIONS

1. A nurse is caring for a patient who has type 1 diabetes and an ulcer on the big toe of the right foot. The nurse plans to review how to perform self-blood glucose monitoring, self-administer an injection, and apply a sterile dressing to the ulcer on the toe. The nurse identifies that the patient is a kinesthetic learner. Which teaching strategy is **most** appropriate for the nurse to use with this patient?
  1. Give verbal instructions and encourage a discussion
  2. Provide occasions to touch and handle equipment
  3. Present pictures and illustrations
  4. Use models and videos

2. A nurse is assessing a patient to determine educational needs. Which is **most** important for the nurse to consider?
  1. Make no assumptions about the patient.
  2. Teaching may be informal or formal in nature.
  3. The teaching plan should be documented on appropriate records.
  4. A copy of the teaching-learning contract should be given to the patient.
3. Which is the **primary** reason why nurses attend continuing education programs?
  1. Update professional knowledge.
  2. Network within the nursing profession.
  3. Fulfill requirements for an advanced degree.
  4. Graduate from an accredited nursing program.
4. A nurse is designing a teaching-learning program for a patient who is to be discharged from the hospital. After developing a nurse-patient relationship, which should the nurse do **next**?
  1. Identify the patient's locus of control.
  2. Use a variety of teaching methods appropriate for the patient.
  3. Formulate an achievable, measurable, and realistic patient goal.
  4. Assess the patient's current understanding of the content to be taught.
5. A nurse is teaching an older adult how to perform a dressing change. Which nursing action is **most** important to address a developmental stress of older adults?
  1. Speak louder when talking to the patient.
  2. Use terminology understandable to the patient.
  3. Have the patient provide a return demonstration.
  4. Allow more time for the patient to process information.
6. A nurse is planning a weight-reduction program with an obese patient. Which should the nurse anticipate will be the **most** important component that will determine the success or failure of this program?
  1. Rewarding compliant behavior with favorite foods
  2. Encouraging at least 1 hour of exercise daily
  3. Using an 800-calorie daily dietary regimen
  4. Setting realistic goals
7. A nurse is teaching a patient recently diagnosed with diabetes mellitus the step-by-step procedure of administering an insulin injection by using an orange. However, after two sessions of practice the patient is still reluctant to self-administer the insulin. Which should the nurse do?
  1. Keep reinforcing the principles that have been presented.
  2. Have the patient administer the injection to an orange again.
  3. Give the patient an opportunity to explore concerns about the injection.
  4. Determine if a member of the family is willing to administer the insulin.
8. Every person who attended a smoking cessation educational program completed a questionnaire. Which is this type of evaluation called?
  1. Survey
  2. Post-test
  3. Case study
  4. Focus group
9. A nurse educator designed various educational programs that employ role-playing as a teaching strategy. Which group of people should the nurse anticipate will benefit the **most** from role-playing?
  1. Older adults preparing to retire from the workforce
  2. Men unwilling to admit that they have a drinking problem
  3. Adolescents learning to abstain from recreational drug use
  4. Middle-aged adults preparing for total-knee replacement surgery

10. To be **most** effective, at which grade reading level should the nurse prepare written educational medical material?
  1. Fourth-grade
  2. Eighth-grade
  3. Tenth-grade
  4. Sixth-grade
11. A nurse uses computer-assisted instruction as a strategy when providing preoperative teaching. Which should the nurse explain to preoperative patients is the **greatest** advantage of computer-assisted instruction?
  1. Learners can progress at their own rate.
  2. It is the least expensive teaching strategy.
  3. There are opportunities for pre- and post-testing.
  4. Information is presented in a well-organized format.
12. A nurse is teaching a preschool-aged child. Which teaching method is **most** appropriate for the nurse to use when teaching a child in this age group?
  1. Demonstrations
  2. Coloring books
  3. Small groups
  4. Videos
13. A nurse is attending a class about a new intravenous pump presented by the hospital staff education department. Which is this type of educational program?
  1. Continuing education program
  2. Inservice education program
  3. Certification program
  4. Orientation program
14. A nurse is planning teaching about weight-reduction strategies to an obese patient. Which should the nurse assess **first** before implementing the teaching plan?
  1. Intelligence
  2. Experience
  3. Motivation
  4. Strengths
15. A nurse is planning to engage a patient in a program to learn about a newly diagnosed illness. Which psychosocial response to the illness will have the **greatest** impact on the patient's future success of learning?
  1. Fear
  2. Denial
  3. Fatigue
  4. Anxiety
16. A nurse must implement a teaching plan for a patient recently diagnosed with heart failure. Which should the nurse do **first**?
  1. Identify the patient's level of recognition of the need for learning.
  2. Frame the goal within the patient's value system.
  3. Determine the patient's preferred learning style.
  4. Assess the patient's personal support system.
17. Which of the following teaching-learning concepts that moves from one extreme to the other is basic to all teaching plans?
  1. Cognitive to the affective domain
  2. Formal to the informal
  3. Simple to the complex
  4. Broad to the specific

18. A nurse is teaching a postoperative patient deep breathing and coughing exercises. Which method of instruction is **most** appropriate in this situation?
1. Explanation
  2. Demonstration
  3. Video presentation
  4. Brochure with pictures
19. A nurse is teaching a patient colostomy care in relation to the affective domain. Which teaching method is **most** effective for this situation?
1. Discussing a pamphlet about colostomy care from the American Cancer Society
  2. Exploring how the patient feels about having a colostomy
  3. Providing a demonstration on how to do colostomy care
  4. Showing a videotape demonstrating colostomy care
20. A school nurse is teaching a class of adolescents about avoiding smoking and includes role-playing as a creative learning activity. Which is the **primary** reason for using role-playing?
1. Provides more fun than other methods
  2. Eliminates the need for media equipment
  3. Requires active participation by the learner
  4. Gives the learner the opportunity to be another person
21. A culturally competent nurse is planning to teach a patient about a new regimen of self-care. Which must the nurse assess **first** about the patient before implementing the teaching plan?
1. Religious affiliation
  2. Support system
  3. National origin
  4. Health beliefs
22. A nurse is planning to teach the patient how to self-administer a colostomy irrigation. Place the following actions that the nurse should employ in the order in which they should be implemented.
1. Identify the patient's readiness to learn.
  2. Involve the patient in learning activities.
  3. Identify the patient's motivation to learn.
  4. Repeat essential concepts to reinforce learning.
  5. Evaluate the patient's learning versus desired outcomes.
- Answer: \_\_\_\_\_
23. A nursing instructor is evaluating a student nurse's knowledge. Which student behaviors indicate that learning has occurred in the highest level of learning in the cognitive domain? **Select all that apply.**
1. Identifies the expected properties of urine
  2. Explains the importance of producing urine
  3. Recognizes when something is contaminated
  4. Comparates achieved outcomes with planned outcomes
  5. Contrasts laboratory results of urine testing against the expected range
24. A nurse is to teach a patient how to change a dressing and irrigate a wound that resulted from the separation of wound edges of an incision and that is healing by secondary intention. The nurse reviews the primary health-care provider's orders, obtains the patient's vital signs, and assesses the patient. Which should the nurse do **next**?
1. Administer the prescribed pain medication and reassess the patient in 30 minutes.
  2. Teach the patient how to irrigate the wound and change the dressing.
  3. Notify the primary health-care provider of the patient's status.
  4. Wait 15 minutes and retake the patient's vital signs.

## PATIENT'S CLINICAL RECORD

### Primary Health-Care Provider's Orders

Irrigate abdominal wound with 0.9% sodium chloride and apply a wet to damp dressing twice a day.

Oxycodone 7.5 mg every 6 hours prn for incisional pain

### Patient's Vital Signs

Temperature: 100.2°F, orally

Pulse: 98 beats per minute

Respirations: 20 breaths per minute

Blood pressure: 140/90 mm Hg

### Patient Interview

Patient is quiet and responding with one-phrase answers. States pain is 7 on a scale of 0 to 10. Transferred from chair to bed while bent over and holding abdomen. Patient states, "I can't wait to learn how to do this dressing so that I can go home."

25. A nurse is providing health teaching for a patient with a cognitive deficit. Which interventions by the nurse will support this patient's learning? **Select all that apply.**

1.  Using simple vocabulary and syntax
2.  Establishing a structured environment
3.  Asking that unclear words be repeated
4.  Speaking directly in front of the patient
5.  Making a referral for a hearing evaluation

26. A unit secretary tells the nurse that the primary health-care provider has just ordered a low-calorie diet for a patient who is overweight. Place these nursing interventions in the order in which they should be implemented.

1. Verify the dietary order.
2. Determine food preferences.
3. Teach specifics about a low-calorie diet.
4. Review a meal plan designed by the patient.
5. Assess the patient's motivation to follow the diet.

Answer: \_\_\_\_\_

27. Which describe a patient with an external locus of control? **Select all that apply.**

1.  Behaving appropriately to obtain the right to watch a television program
2.  Is self-motivated when implementing health promotion behaviors
3.  Wants to please family members with efforts to get well
4.  Understands the expected outcome of therapy
5.  Is a self-actualized adult

28. A nurse is teaching a patient with a hearing impairment. Which should the nurse do to facilitate the teaching-learning process? **Select all that apply.**

1.  Limit educational sessions to 10 minutes.
2.  Provide information in written format.
3.  Use at least 2 teaching methods.
4.  Face the patient when talking.
5.  Teach in group settings.

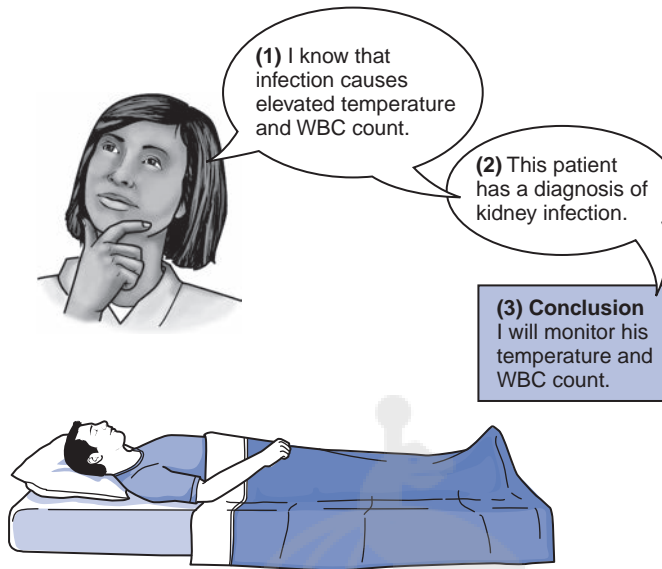
29. A nurse formulates teaching goals using action verbs. Which words are examples of verbs employed in learning outcomes in the psychomotor domain? **Select all that apply.**

1.  Accepts
2.  Explains
3.  Performs
4.  Assembles
5.  Demonstrates



30. A nurse is assessing the results of dietary teaching for a patient with diabetes mellitus. Which patient behaviors indicate that learning occurred in the affective domain? **Select all that apply.**
- Discusses which food on the ordered diet must be avoided
  - Eats only food approved on the prescribed special diet
  - Lists foods that are permitted on the diet
  - Asks about which foods can be eaten
  - Avoids food that is high in sugar
31. A community health nurse is caring for a patient who has a pressure ulcer and requires assistance with bathing, grooming, and toileting. Docusate sodium, daily weights, and a dressing change of the wound twice a day are ordered. When performing which nursing interventions should the nurse educate the patient about docusate sodium? **Select all that apply.**
- Bathing
  - Toileting
  - Daily weights
  - Wound treatment
  - Medication administration
32. After assessing a patient's learning needs, abilities, and motivation and identifying patient goals, the nurse must formulate a teaching plan. Place the following steps in the order in which they should be implemented.
- Choose teaching strategies to be employed.
  - Evaluate the effectiveness of the teaching plan.
  - Identify the information that the learner must learn.
  - Organize the information in the sequence that information is to be presented.
  - Develop instructional materials that will reinforce and supplement information provided in the class.
- Answer: \_\_\_\_\_
33. A nurse is planning a teaching plan for an older adult. Which common factors among older adult patients must be considered? **Select all that apply.**
- Sensory decline occurs as one ages.
  - Learning may require more energy.
  - Intelligence decreases as people age.
  - Older adults rely more on visual rather than auditory learning.
  - Older adult patients are more resistant to change that accompanies new learning.
34. A nurse is teaching a patient who has impaired vision to self-inject insulin. Which should the nurse do to facilitate the teaching-learning process? **Select all that apply.**
- Obtain an order for automatic-stop syringes.
  - Provide written information in large print.
  - Use audio learning materials.
  - Enunciate each word clearly.
  - Speak slowly.

35. A nurse educator is teaching a class on problem solving and reinforced the concepts of inductive and deductive reasoning using the attached illustration. Which is the **most** important reason why the nurse educator presented this illustration?
1. It appeals to students who are visual learners.
  2. It employs the concept of positive reinforcement.
  3. It stimulates learning in students with an internal locus of control.
  4. It improves students' conceptual understanding of complex content.



Deductive reasoning

F.A. DAVIS

COMPANY

## TEACHING AND LEARNING: ANSWERS AND RATIONALES

1. Verbal instructions and discussions are most appropriate to use with patients who are auditory, not kinesthetic, learners. Auditory learners learn best by processing information by listening to words.
  2. **Kinesthetic learners learn best when processing information by doing. Kinesthetic learners should be engaged in physical activities that allow them to touch and handle equipment.**
  3. Pictures and illustrations are most appropriate to use with patients who are visual, not kinesthetic, learners. Visual learners learn best by processing information with the eyes.
  4. Models and videos are most appropriate to use with patients who are visual, not kinesthetic, learners. Visual learners learn best by processing information with the eyes.
2. **1. Many variables influence an individual's willingness and ability to learn (e.g., readiness, motivation, physical and emotional abilities, education, age, cultural and health beliefs, cognitive abilities). Because everyone is unique with individual needs, the nurse must avoid making assumptions and generalizations.**
    2. The patient's needs must be identified before teaching formats and strategies are designed.
    3. The patient's needs must be identified before the teaching plan is designed, implemented, and documented.
    4. The patient's needs must be identified before a plan is designed and a contract is written.
  3. **1. Continuing education programs are formal learning experiences designed to update and enhance professional knowledge or skills. This is necessary because of the explosion in information and technology within health care. Some states require evidence of continuing education units (CEUs) for license renewal.**
    2. Although nurses who attend continuing education programs have the opportunity to network professionally with other nurses, it is not the main purpose of attending a continuing education program.
    3. Continuing education programs do not fulfill requirements for an advanced degree. Master's and doctoral programs grant advanced degrees in specialty areas (e.g., parent-child health, mental health, medical-surgical nursing, and gerontology) and practice roles (e.g., nurse practitioner, education, and administration).
    4. Continuing education programs do not prepare a person to graduate from an accredited nursing degree program. Associate degree programs, baccalaureate degree programs, and diploma schools of nursing prepare graduates to take the NCLEX-RN examination.
  4. **1. Determining the patient's locus of control will influence whether the patient will be motivated by rewards from outside the self (external locus of control) or by personally identified rewards within the self (internal locus of control). This information should influence the nurse's teaching-learning plan. However, it is not the first thing the nurse should do of the options offered.**
    2. Although a variety of teaching methods should be used so that all the senses are engaged in learning, it is not the first thing the nurse should do of the options offered.
    3. Goal setting is accomplished after the nurse gathers essential information that will influence the goal, particularly in relation to the achievable and realistic factors of a goal.
    4. **Learners bring their own lifetimes of learning to the learning situation. The nurse must customize each teaching plan, capitalize on the patient's previous experience and knowledge, and identify what the patient still needs to know before teaching can begin.**
  5.
    1. Speaking loudly could be demeaning. A normal volume of speaking is appropriate.
    2. Using understandable terminology is a teaching principle common to all age groups, not just older adults.
    3. Obtaining a return demonstration is a teaching principle common to all age groups, not just older adults. This ensures that the learner has learned all the critical elements associated with the skill.**4. Reaction time will slow as one ages; therefore, older adults need more time**

**to process and respond to information or perform a skill. In addition, some older adults may have less energy, experience more fatigue, and may need shorter, frequent learning sessions.**

6. 1. Learning is encouraged when positive behaviors are reinforced with a reward. However, food as a reward should be avoided in this scenario because it may foster old habits that contributed to the original weight gain. For people with an internal locus of control, rewards should center on recognition of personal achievement, such as pleasing oneself, returning to a usual lifestyle, avoiding complications, and, in this scenario, losing weight. For the person with an external locus of control, rewards might center on privileges or praise received from pleasing significant others or members of the health-care team.
2. Although exercise is an important component of any weight-loss program, exercise alone will not determine the success or failure of a weight-loss program.
3. This is a dependent function of the nurse and requires a primary health-care provider's order. In addition, an 800-calorie diet is too few calories to acquire basic nutrients to maintain adequate health. Weight-loss diets should be between 1200 and 1500 calories for women and between 1500 and 1800 calories for men.
4. **Setting realistic goals is important to the success of a weight-loss program. Because achieving success is dependent largely on motivation, the teacher and patient should design goals that demonstrate immediate progress or growth. One strategy is to design numerous realistic short-term intermediary goals that are achieved more easily than one long-term goal.**
7. 1. The nurse has been doing this and it has not been effective. A reassessment is necessary.
2. The patient already knows the technique of how to administer the injection. The issue is the patient is reluctant to self-administer the injection.
3. **When a teaching plan is ineffective, the nurse must gather more data and revise the teaching plan to achieve the desired goal.**
4. This promotes dependency and prevents the patient from becoming self-sufficient.
8. 1. **The terms questionnaire and survey are used interchangeably to describe a type of evaluation tool designed to gather data about a topic. This method is used to obtain information, such as feedback regarding an educational program.**
2. A post-test is not a questionnaire. A post-test is an examination given to assess cognitive learning after an educational program is completed.
3. A case study is not a questionnaire. A case study is a teaching tool that presents a scenario and a sequence of data to which the learner is required to analyze and respond.
4. A focus group is not a questionnaire. A focus group is designed to gather opinions and suggestions from a group of people about a particular topic using a discussion, not survey, format.
9. 1. The role-playing technique is unlikely to be used by adults preparing to retire. Role-playing is most often used when learning parenting and other interpersonal skills.
2. Men who are unwilling to admit that they have a drinking problem are not demonstrating readiness to learn. In addition, role-playing requires a person to assume a role for the purpose of learning a new behavior. These men are demonstrating an unwillingness to learn a new behavior.
3. **A group of adolescents should benefit most from role-playing. Role-playing provides a safe environment in which to practice interpersonal skills. It enables individuals to rehearse what should be said, learn to respond to the emotional environment, and experience the pressures of the person playing the peer using drugs.**
4. The role-playing technique is unlikely to be used by adults preparing for knee replacement surgery. Role-playing is most often used when learning parenting and other interpersonal skills.
10. 1. The fourth-grade reading level is too low for medical material. Research demonstrates that the average reading level is higher than fourth grade.

2. The eighth-grade reading level is too high a reading level for educational medical material. Randomized studies demonstrate that only 22% of individuals requiring health teaching are able to profit from written health materials on the eighth-grade reading level.
  3. The 10th-grade reading level is too high a reading level for educational medical material. Twenty percent of Americans read at or below the fifth-grade reading level and are considered functionally illiterate.
  4. **Randomized studies demonstrate that the average reading level of individuals who need health teaching is 6.8 grades of schooling.**
11. 1. **Learners progress through a program at their own pace viewing informational material, answering questions, and receiving immediate feedback. Some programs feature simulated situations that require critical thinking and a response. Correct responses are rationalized, praise is offered, and incorrect responses trigger an explanation of why the wrong answer is wrong and offer encouragement to try again. This is a superior teaching strategy for the learner who may find that group lessons are paced either too fast or too slowly for effective learning.**
2. Computer-assisted instruction (CAI) is not the least inexpensive teaching strategy. CAI requires a computer, keyboard, and station; software; technical support to install, maintain, and repair equipment; and a computer-literate teaching staff to preview, select, and implement CAI programs.
  3. Although individual CAI programs often include pre- and post-testing components, this is not the greatest advantage of CAI as a teaching strategy.
  4. Although CAI programs generally are well organized in a programmed instruction (step-by-step) format, this is not the greatest advantage of using CAI as a teaching strategy.
12. 1. Demonstrations generally are used for teaching a skill. Skills involve learning about equipment, rationales, and sequencing multiple steps and are too cognitively complex for the developmental abilities of a preschooler. A teaching method in another option is more age appropriate for a preschooler.
2. **Coloring books are the best approach because they require preschoolers to be active participants in their own learning. In addition, the child has a product to keep and be proud of, it reduces anxiety associated with learning because coloring is an activity most preschoolers are familiar with, and it is within a preschooler's cognitive level.**
  3. Preschoolers are just beginning to interact with peers, have a short attention span, and get distracted easily, and therefore need a one-on-one relationship with the teacher. The teacher facilitates the learning specifically for the individual, keeps the learner focused, and provides reinforcement on the learner's cognitive level. Other age-specific strategies include games; storybooks; the use of dolls, puppets, or toys; and role-playing.
  4. A video requires concentration and an attention span that may be beyond the developmental abilities of a preschooler.
13. 1. This scenario is not an example of a continuing education (CE) program. Continuing education refers to formal professional development experiences designed to enhance the knowledge or skills of the learner.
2. **Inservice programs generally are provided by health-care agencies to reinforce current knowledge and skills or provide new information about such issues as policies, theory, skills, practice, or equipment.**
  3. This scenario is not an example of a certification program. The American Nurses Association has a certification program in which nurses can demonstrate minimum competence in specialty areas. Achievement of certification demonstrates advanced expertise and a commitment to ensuring competence.
  4. This scenario is not an example of an orientation program. An orientation program is provided by a health-care agency to introduce new employees to the policies, procedures, departments, services, table of organization, expectations, equipment, and so on, within the agency.
14. 1. Assessing intelligence by a nurse is a subjective assessment that is difficult to perform. Declining functional abilities,

debilitating diseases, pain, and stress may impair the intellectual functioning of some individuals.

2. Although it is important to assess a patient's experience before implementing a teaching plan, of the options offered it is not the first thing the nurse should do.
  3. **If the patient does not recognize the need to learn or value the information to be learned, the patient will not be ready to learn.**
  4. Although it is important to assess a patient's strengths before implementing a teaching plan, of the options offered, it is not the first thing the nurse should do.
15. 1. Although fear will affect the success of a teaching program and will need to be assessed and modifications employed, it is not the factor that will have the greatest impact on the future success of a teaching program. Fear initially causes change; however, as fear subsides a person often returns to the previous behavior.
2. **Of all the options presented, the patient in denial is the person least ready and motivated to learn. The patient in denial is unable to recognize the need for the learning.**
  3. Fatigue is a physiological, not psychosocial, response to an illness. When teaching, the nurse must assess the patient's stamina and modify the teaching program so as not to unduly strain the patient and yet meet the objectives.
  4. Although assessing for anxiety is important, it is not the factor that has the greatest impact on the future success of a teaching program. Mild anxiety is motivating. Moderate anxiety will motivate a patient to learn but may require the nurse to keep concepts and approaches simple. The person with moderate anxiety may need to be refocused and have distractions minimized to facilitate learning. If severe anxiety or panic is present, the teaching program will have to be postponed until the patient is less anxious.
16. 1. **The learner must recognize that the need exists and that the material to be learned is valuable. Motivation is the most important factor influencing learning.**
2. Although setting goals within the patient's value system is important, it is not the first thing the nurse should do before implementing a teaching plan.
  3. Although the teacher should identify a patient's learning style, a variety of teaching methods, not just the patient's preference, should be used. This ensures that as many senses as possible are stimulated when learning, thereby increasing the probability of a successful outcome to the learning.
  4. Although supportive individuals (e.g., family members and friends) can assist in helping the patient maintain a positive mental attitude and reinforce learning, another option has a higher priority.
17. 1. Teaching and learning involve one or all domains of learning (e.g., cognitive, affective, and psychomotor) and do not move from one to the other in progressive order.
2. Teaching methods that are formal or informal are equally effective. The key is to select the approach that is most likely to be effective for the individual learner. This depends on a variety of factors, such as intelligence, content to be taught, learning style preferences, available resources, reading level, and so on.
  3. **When moving from the simple to the complex, a person works at integrating and incorporating the less complex, new learning into one's body of knowledge and understanding before moving on to more complex information. Complex material is best learned when easily understood aspects of the topic are presented first as a foundation for the more complex aspects.**
  4. There is no documented principle that supports the need to present content in the direction of broad to specific rather than specific to broad. Each individual patient and the information to be taught will influence the direction in which content is taught.
18. 1. An explanation is not the best approach to teach a psychomotor skill. An explanation uses words to describe a behavior that the learner then has to attempt to perform.
2. **A demonstration is the best strategy for teaching a psychomotor skill. A demonstration is an actual performance of the skill by the teacher who is acting as a role model. A demonstration**

usually is followed by a return demonstration. The learner can imitate the teacher during a return demonstration, ask questions, and receive feedback from the instructor.

3. Although a video provides a realistic performance of the skill, it does not allow for questions or feedback.
  4. A brochure with pictures is too static and one-dimensional for teaching a psychomotor skill.
- 19.**
1. This option reflects learning in the cognitive domain. Cognitive learning involves the intellect and requires thinking.
  2. **This option reflects learning in the affective domain. Affective learning is concerned with feelings, emotions, values, beliefs, and attitudes about the colostomy.**
  3. Providing a demonstration on colostomy care is an example of a teaching strategy in the psychomotor domain. The psychomotor domain is related to mastering a skill and requires the use of physical and motor activity.
  4. Showing a videotape demonstrating colostomy care is an example of a teaching strategy in the psychomotor domain. It reflects a beginning awareness of the objects needed and steps to be implemented in a skill.
- 20.**
1. Role-playing is no more or less fun than many other active and creative learning strategies.
  2. This is not the reason for using role-playing. Media equipment can be used with role-playing.
  3. **Learning activities that actively engage the learner have been shown to be more effective as well as more fun than methods that do not actively engage the learner. When learners are actively involved, they assume more responsibility for their own learning and develop more self-interest in learning the content.**
  4. Role-playing is designed to support rehearsing a desired behavior in a safe environment. Although it may involve an opportunity to play another person, which allows one to view a situation from another vantage point, it is not the most important reason why role-playing is effective.
- 21.**
1. Although religious affiliation may be important to know, it is only one part of a patient's sociocultural makeup. Another option has a higher priority.
  2. Although the level of support is important to know, it is only one part of a patient's sociocultural makeup. Another option has a higher priority.
  3. Although national origin is important to know, it is only one part of a patient's sociocultural makeup. In addition, nurses have to be careful not to make generalizations and stereotype an individual because of national origin, because each person is an individual.
  4. **Individuals have their own beliefs associated with cultural health practices, faith, diet, illness, death and dying, and lifestyle, which all have a major impact on health beliefs. Not all members of a culture have the same beliefs.**
- 22.**
3. **The first step of the options presented involves determining the patient's desire to learn. If the patient does not recognize that the learning is important, the patient will not be invested in the learning process.**
    1. The second step of the options presented is determining if the patient is ready to learn. The patient may be motivated to learn, but if the patient is in pain or fatigued, the patient may not be able to focus on the learning.
    2. The third step of the options presented is to implement a teaching plan by engaging the patient in planned learning activities.
    4. The fourth step of the options presented is related to the concept of repetition of essential concepts to facilitate retention of learned information. Practice of psychomotor skills along with feedback from the nurse strengthens the learning and encourages independence.
    5. The fifth step of the options presented is the evaluation of the patient's performance in light of stated goals. When evaluating a psychomotor skill the nurse observes the patient's implementation of the skill to ensure that steps in the skill (e.g., collects necessary equipment, follows standards of asepsis and safety, and recognizes

and responds to problems associated with the procedure) are implemented according to principles.

23. 1. Identifying the expected properties of urine reflects learning on the knowledge level, which is the first of six levels of complexity in the cognitive domain.
  2. Explaining the importance of producing urine reflects learning on the comprehension level, which is the second of six levels of complexity in the cognitive domain.
  3. Recognizing when something is contaminated reflects learning on the application level, which is the third level of six levels of complexity within the cognitive domain.
  4. **When a learner compares achieved outcomes with planned outcomes, the learner is evaluating the effectiveness of the learning. This activity is evaluation, which is the highest level of the cognitive domain. It requires the nurse to compare, contrast, and differentiate information.**
  5. **This is the highest level of learning in the cognitive domain. Contrasting laboratory results of urine testing with the expected range reflects learning on the evaluation level, which is the sixth and highest level of learning in the cognitive domain.**
24. 1. The patient's pulse, respirations, and blood pressure are all slightly increased. These adaptations probably are being caused by the release of catecholamines resulting from the pain the patient is experiencing. Moderate to severe pain will interfere with learning. The patient will have difficulty concentrating on the task at hand. The nurse should postpone the teaching session, administer the prescribed pain medication, and reassess the patient in 30 minutes. The teaching session can be reinstated after the pain is reduced.
  2. Teaching at this time is an inappropriate intervention.
  3. Notifying the primary health-care provider is unnecessary. The patient's adaptations are common responses to the patient's physical status.
  4. Waiting will delay meeting the patient's physical needs.
25. 1. Simple vocabulary with as few syllables as possible along with short simple sentences is less confusing for a patient with a comprehension deficit.
  2. For people who have a cognitive deficit, participating in a learning program often makes them feel overwhelmed and threatened. The teacher should provide a structured environment in which variables are controlled to reduce anxiety and support comprehension. The nurse should minimize ambiguity, provide a familiar environment, teach at the same time each day, limit environmental distractions, and provide simple learning materials.
  3. Clarifying unclear words stated by the patient helps the nurse understand what the patient is saying. Patient concerns and questions must be addressed by the nurse.
  4. Speaking directly in front of the patient helps the patient with impaired hearing, not the patient who has a cognitive deficit.
  5. The patient does not need a hearing evaluation. The patient's problem is a cognitive deficit, not a hearing loss.
26. 1. Verifying the order should be done first because a diet requires a primary health-care provider's order; following a specific diet is a dependent function of the nurse.
  5. Assessing motivation is one of the most important factors influencing learning. The learner must recognize that the need exists and that the need will be addressed through the learning.
  2. Determining food preferences is part of nursing assessment. Food preferences can then be included in the teaching plan about the low-calorie diet.
  3. Details of the diet can be taught after the order is verified, motivation is determined, and preferences are identified.
  4. Evaluation is the final step of teaching. A meal plan designed by the patient requires not just an understanding of the information but an ability to apply the information.
27. 1. The person with an external locus of control is motivated by rewards that center on privileges, incentives, or



**praise received from pleasing significant others or members of the health-care team. Watching television is a privilege in this situation.**

2. Self-motivated behavior indicates an internal, not external, locus of control. People with an internal locus of control are motivated by personal internal rewards such as achieving a personal goal, pleasing oneself, returning to a usual lifestyle, and avoiding complications.
  3. **Pleasing others precipitates feedback that is often viewed as positive by the recipient. Positive verbal or nonverbal communication from another is an external reward.**
  4. Understanding the expected outcome of therapy is associated with recognizing the goal one is working to achieve; it does not describe an external locus of control.
  5. A self-actualized adult is motivated by an internal locus of control. According to Maslow, the self-actualized person is an individual who has a need to develop to one's maximum potential and personally realize one's qualities and abilities.
- 28.**
1. Limiting the length of sessions is unnecessary. Hearing is the problem, not fatigue.
  2. **Written materials augment verbal teaching. The patient can review the written materials during and after the teaching session.**
  3. **Varieties of teaching methods facilitate learning because multiple senses are stimulated. When we see, hear, and touch, learning is more effective than when we see or hear alone. In addition, research demonstrates that we remember only 10% of what we read, 20% of what we hear, 30% of what we see, 50% of what we see and hear, and 80% of what we say and do.**
  4. Some patients who are hearing impaired lip-read. Facing the patient enables the patient to see the nurse's lips clearly.
  5. A group setting is the least desirable teaching format for hearing-impaired individuals. One-on-one learning sessions limit background noise and distractions that hinder learning. In addition, a one-on-one session allows for individual feedback that ensures that the message is received as intended.
- 29.**
1. Accepting something indicates learning in the affective, not psychomotor, domain. Learning in the affective domain includes things such as feelings, emotions, and attitudes.
  2. Explaining something indicates learning in the cognitive, not psychomotor, domain. Learning in the cognitive domain is reflected in the ability to understand the meaning of learned content.
  3. **Performing an activity indicates learning in the psychomotor domain. Learning in the psychomotor domain is related to mastering a skill and requires motor activity.**
  4. **Assembling something indicates learning in the psychomotor domain. Learning in the psychomotor domain is related to mastering a skill and requires motor activity.**
  5. **Demonstrating something indicates learning in the psychomotor domain. Learning in the psychomotor domain is related to mastering a skill and requires motor activity.**
- 30.**
1. This behavior is an example of learning in the cognitive, not affective, domain. Cognitive learning involves the intellect and requires thinking.
  2. **Eating food on the ordered diet is an example of learning in the affective domain. When learning is incorporated into the learner's behavior because it is perceived as important, learning has occurred in the affective domain. Affective learning involves the expression of feelings and the changing of beliefs, attitudes, or values.**
  3. Compiling a list of permitted foods is an example of learning in the cognitive, not affective, domain. Cognitive learning involves the intellect and requires thinking.
  4. Asking questions is not an outcome demonstrating learning. This is an example of a question a learner might ask when learning content in the cognitive domain. Cognitive learning involves the intellect and requires thinking.
  5. **Avoiding foods high in sugar is an example of learning in the affective domain. When learning is incorporated into the learner's behavior because it is perceived as important, learning has occurred in the affective domain. Affective learning involves the**

expression of feelings and the changing of beliefs, attitudes, or values.

31. 1. Docusate sodium is a stool softener and is unrelated to the activity of bathing. Teaching the patient about skin assessment and skin care is best performed during a bath.
  2. **An excellent time for the nurse to teach the patient about docusate sodium, a medication that promotes bowel elimination, is when the patient is being assisted to the toilet.**
  3. Docusate sodium is a stool softener and is unrelated to the activity of monitoring a patient's daily weight. Daily weights are taken to assess fluid balance.
  4. Docusate sodium is a stool softener and is unrelated to a dressing change of a pressure ulcer.
  5. **During medication administration is a perfect time for the nurse to educate a patient about the medications that the patient is receiving.**
32. 3. **The first step in planning a teaching plan is to identify the information that the learner must acquire. This step is accomplished by formulating realistic, measurable learning goals.**
  4. **The second step in planning a teaching plan is organizing the information in an appropriate sequence to be presented.**
  1. **The third step in planning a teaching plan is the selection of the teaching strategies to be employed based on the advantages and disadvantages of each strategy and which is best to achieve the learning goals.**
  5. **The fourth step in planning a teaching plan is to develop instructional materials that will reinforce and supplement information provided in the class.**
  2. **The teacher should develop a method to evaluate whether learning goals are met. Post-tests, written exercises, questionnaires, surveys, and direct observation of performance are some examples of evaluation methods.**
33. 1. **Sensory impairment results from the aging process, which must be considered when planning a teaching plan for an older adult. Aging causes such changes as: a reduced ability to focus or accommodate because of reduced elasticity of the lens of the eye; a narrowing of the visual field; increased opacification of the lens that causes cataracts with accompanying blurring of vision and increased sensitivity to glare; a decrease in the ability to hear high-frequency sounds; and an increase in the keratin content of cerumen that causes an accumulation of cerumen in the middle ear and thus endangers hearing.**
  2. **Various physiological changes of aging have an impact on the rate of learning (e.g., declines in sensory perception and speed of mental processing and more time needed for recall), requiring the use of multisensory teaching strategies and a repetitive approach. In addition, older adults may have less physical and emotional stamina because of more chronic illnesses, so they may require shorter and more frequent learning sessions.**
  3. Although some older adults may experience a decline in short-term memory, they are not less intelligent. When older adults experience a decline in sensory function (e.g., vision, hearing), they may feel ashamed or frustrated, causing withdrawal. Behaviors reflective of withdrawal may be misperceived as a decline in intelligence.
  4. This is not necessarily true. Individuals usually have learning preferences that persist throughout life.
  5. Older adults generally are not resistant to change. Some older adults may be less motivated to learn if they believe that death is near. However, in this situation when older adults are shown how learning will improve their quality of life and independence, they are motivated to learn.
34. 1. **An automatic-stop syringe ensures that an appropriate dose of insulin can be prepared despite a patient's vision impairment.**
  2. **Large print magnifies the written information to a size that may facilitate reading by the patient who is vision impaired.**
  3. **Audio learning materials use the sense of hearing rather than sight to promote the teaching-learning process.**
  4. Enunciating each word clearly is an appropriate intervention for a patient who has a hearing, not a vision, impairment.

5. Speaking slowly is an appropriate intervention for a patient who has a hearing, not a vision, impairment.
- 35.**
1. Although an illustration appeals to visual learners, this is not the primary reason why the nurse educator decided to present this illustration to reinforce content presented in the lecture.
  2. The concept of positive reinforcement is not associated with presenting an illustration to reinforce learning. Positive reinforcement is associated with using praise and encouragement to enhance motivation. Research by Ivan Pavlov and B. F. Skinner presented the theory of positive reinforcement.
  3. An internal or external locus of control is associated with motivational theory and is unrelated to the rationale for using graphics to explain complex information.
  4. **Research demonstrates that when illustrations are used in conjunction with reading content, learners outperform students who just read the content. Illustrations attract attention, facilitate retention of information, and improve understanding of complex content by creating a context.**



# Essential Components of Nursing Care

# 4

## Nursing Process

### KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

#### Care plan, types:

- Case management
- Clinical pathway
- Computerized
- Individualized
- Standardized

#### Clinical record, parts of:

- Admission sheet
- Consents
- Flow sheets
- History and physical
- Laboratory/diagnostic test results
- Medication administration record
- Health-care provider's orders
- Progress notes

#### Data, sources of:

- Primary
- Secondary

#### Data, types:

- Objective
- Subjective

#### Data collection methods:

- Auscultation
- Examination
- Inspection
- Interview
- Observation
- Palpation
- Percussion

#### Functions of the nurse:

- Dependent
- Independent
- Interdependent

#### Goal, components of:

- Achievable
- Measurable
- Realistic
- Time frame

#### Inference

#### Intervention skills:

- Assisting
- Collaborating
- Coordinating
- Managing
- Monitoring
- Protecting
- Supporting
- Sustaining
- Teaching

#### Nursing diagnosis:

- Diagnostic label
- Related to factors: contributing factors, etiology
- As evidenced by: signs and symptoms, defining characteristics

#### Nursing process:

- Assessment
- Analysis
- Planning
- Implementation
- Evaluation

#### Outcomes:

- Actual
- Expected

#### Reasoning:

- Deductive
- Inductive

F.A. DAVIS

COMPANY

## NURSING PROCESS: QUESTIONS

1. During which of the five steps in the nursing process does the nurse determine whether outcomes of care are achieved?
  1. Implementation
  2. Evaluation
  3. Planning
  4. Analysis
2. When considering the nursing process, the word “observe” is to “assess” as the word “explore” is to which of the following words?
  1. Plan
  2. Analyze
  3. Evaluate
  4. Implement
3. Which statement is related to the concept that is central to the nursing process?
  1. It is dynamic rather than static.
  2. It focuses on the role of the nurse.
  3. It moves from the simple to the complex.
  4. It is based on the patient’s medical problem.
4. Which word **best** describes the role of the nurse when using the nursing process to meet the needs of the patient holistically?
  1. Teacher
  2. Advocate
  3. Surrogate
  4. Counselor
5. Which word is **most** closely associated with scientific principles?
  1. Data
  2. Problem
  3. Rationale
  4. Evaluation
6. A pebble dropped into a pond causes ripples on the surface of the water. Which part of the nursing diagnosis is directly related to this concept?
  1. Defining characteristics
  2. Outcome criteria
  3. Etiology
  4. Goal
7. A nurse teaches a patient to use visualization to cope with chronic pain. Which step of the nursing process is associated with this nursing intervention?
  1. Planning
  2. Analysis
  3. Evaluation
  4. Implementation
8. Which action reflects the assessment step of the nursing process?
  1. Taking a patient’s apical pulse rate every 2 hours after being admitted for an episode of chest pain
  2. Scheduling a patient’s fluid intake over 12 hours when the patient has a fluid restriction
  3. Examining a patient for injury after a patient falls in the bathroom
  4. Obtaining a patient’s respiratory rate after a nebulizer treatment

9. A nurse is caring for a patient with a fever. Which is a well-designed goal for this patient?
  1. “The patient will have a lower temperature.”
  2. “The patient will be taught how to take an accurate temperature.”
  3. “The patient will maintain fluid intake adequate to prevent dehydration.”
  4. “The patient will be given aspirin every eight hours whenever necessary.”
10. Which should the nurse do during the evaluation step of the nursing process?
  1. Set the time frames for goals.
  2. Revise a plan of care.
  3. Determine priorities.
  4. Establish outcomes.
11. During which step of the nursing process does determining which actions will be employed to meet the needs of a patient occur?
  1. Implementation
  2. Assessment
  3. Planning
  4. Analysis
12. Which information supports the appropriateness of a nursing diagnosis?
  1. Defining characteristics
  2. Planned interventions
  3. Diagnostic statement
  4. Related risk factors
13. Which is the primary goal of the assessment phase of the nursing process?
  1. Build trust
  2. Collect data
  3. Establish goals
  4. Validate the medical diagnosis
14. Which **most** directly influences the planning step of the nursing process?
  1. Related factors
  2. Diagnostic label
  3. Secondary factors
  4. Medical diagnosis
15. A nurse collects information about a patient. Which should the nurse do next?
  1. Plan nursing interventions.
  2. Write patient-centered goals.
  3. Formulate nursing diagnoses.
  4. Determine significance of the data.
16. When two nursing diagnoses appear closely related, which should the nurse do **first** to determine which diagnosis most accurately reflects the needs of the patient?
  1. Reassess the patient.
  2. Examine the *related to* factors.
  3. Analyze the *secondary to* factors.
  4. Review the defining characteristics.
17. Which is the **primary** reason why a nurse performs a physical assessment of a newly admitted patient?
  1. Identify if the patient is at risk for falls.
  2. Ensure that the patient’s skin is totally intact.
  3. Identify important information about the patient.
  4. Establish a therapeutic relationship with the patient.

18. A nurse evaluates a patient's response to a nursing intervention. To which aspect of the nursing process is this evaluation **most** directly related?
1. Goal
  2. Problem
  3. Etiology
  4. Implementation
19. A nurse concludes that a patient's elevated temperature, pulse, and respirations are significant. Which step of the nursing process is being used when the nurse comes to this conclusion?
1. Implementation
  2. Assessment
  3. Evaluation
  4. Analysis
20. When the nurse considers the nursing process, the word "identify" is to "recognize" as the word "do" is to which of the following words?
1. Plan
  2. Analyze
  3. Evaluate
  4. Implement
21. A nurse is collecting subjective data associated with a patient's anxiety. Which assessment method should be used to collect this information?
1. Observing
  2. Inspecting
  3. Auscultation
  4. Interviewing
22. A nurse assesses that a patient has slurred speech and a retained bolus of food in the mouth. The presence of which additional patient assessments should be clustered with this group of signs and symptoms? **Select all that apply.**
1.  Dy spepsia
  2.  C oughing
  3.  Dr ooling
  4.  Gu rgling
  5.  P laque
23. Nurses use the nursing process to provide nursing care. These statements reflect nursing care being provided to a variety of patients. Place the statements in order as the nurse progresses through the steps of the nursing process, starting with assessment and ending with evaluation.
1. "Did you sleep last night after I gave you the sleeping medication?"
  2. "The patient's clinical manifestations indicate dehydration."
  3. "The patient will have a bowel movement in the morning."
  4. "What brought you to the hospital today?"
  5. "I am going to give you an enema."
- Answer: \_\_\_\_\_
24. A nurse is caring for a patient with a urinary elimination problem. Which are accurately stated goals? **Select all that apply.**
1.  " The patient will be taught how to use a bedpan while on bedrest."
  2.  " The patient will experience fewer incontinence episodes at night."
  3.  "The patient will transfer independently and safely to a toilet before discharge."
  4.  "The patient will be assisted to the commode every two hours and whenever necessary."
  5.  "The patient will experience one or less events of urinary incontinence daily within 6 weeks."

25. Which human responses identified by the nurse are examples of objective data? **Select all that apply.**
- Irregular radial pulse of 50 beats per minute
  - Wheezing on expiration
  - Temperature of 99 F
  - Shortness of breath
  - Dizziness
26. Place the following statements that reflect the analysis step of the nursing process in the order in which they should be implemented.
- Cluster data.
  - Identify conclusions.
  - Interpret clustered data.
  - Communicate conclusion to other health team members.
  - Identify when additional data are needed to further validate clustered data.
- Answer: \_\_\_\_\_
27. Which patient statements provide subjective data? **Select all that apply.**
- "I'm not sure that I am going to be able to manage at home by myself."
  - "I can call a home-care agency if I feel I need help at home."
  - "What should I do if I have uncontrollable pain at home?"
  - "Will a home health aide help me with my care at home?"
  - "I'm afraid because I live alone and I'm on my own."
28. Which nursing action reflects an activity associated with the analysis step of the nursing process? **Select all that apply.**
- Formulating a plan of care
  - Identifying the patient's potential risks
  - Categorizing data into meaningful relationships
  - Designing ways to minimize a patient's stressors
  - Making decisions about the effectiveness of patient care
29. A nurse is interviewing a patient. Which patient statements are examples of objective data? **Select all that apply.**
- "I am hungry."
  - "I feel very warm."
  - "I ate half my lunch."
  - "I have a rash on my arm."
  - "I have the urge to urinate."
  - "I vomit every time I eat something."
30. Which statement indicates that the nurse is using inductive reasoning? **Select all that apply.**
- A patient is admitted with a diagnosis of dehydration and the nurse assesses the patient's skin for tenting.
  - A nurse observes a patient falling out of bed on the right hip and immediately assesses the patient for pain in the right hip.
  - A patient has an elevated white blood cell count and a fever. The nurse concludes that the patient may have an infection.
  - A patient is scheduled for surgery and is crying, trembling, and has a rapid pulse. The nurse makes the inference that the patient is anxious.
  - A nurse receives a call from the admission department that a patient with hypoglycemia is being admitted to the unit. The nurse plans to assess the patient for pale, cool, clammy skin and a low blood glucose level.
- Answer: \_\_\_\_\_



31. The following statements reflect steps in the nursing process. Place the statements in order as the nurse advances through the steps of the nursing process, beginning with assessment and ending with evaluation.

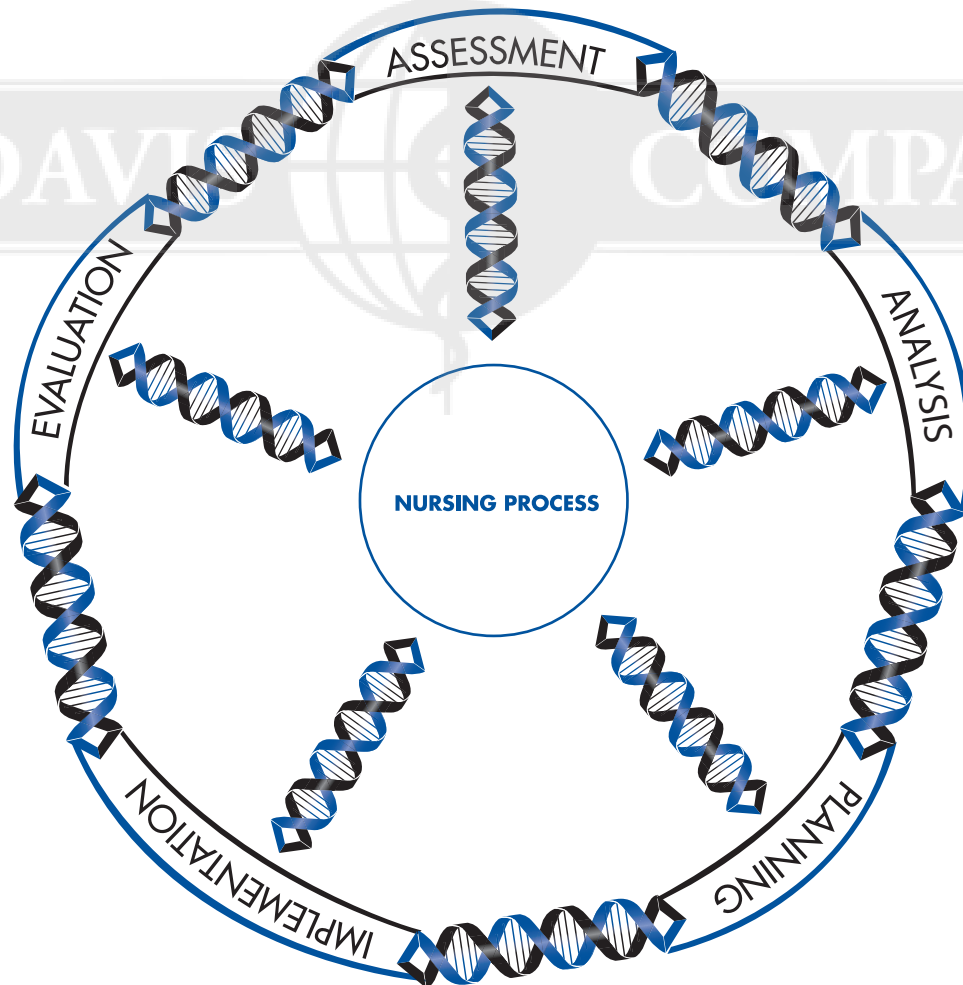
1. "The patient is encouraged to attempt to defecate after meals."
2. "The patient reports not having had a bowel movement for 8 days."
3. "The patient has constipation related to limited mobility and inadequate fluid intake."
4. "The patient will have a bowel movement within 2 days that is of normal consistency."
5. "The patient's stool is still hard and dry 2 days after initiating an increase in fluids and activity."

Answer: \_\_\_\_\_

32. A nurse is interviewing a patient at the change of shift. Which patient statements reflect subjective data? **Select all that apply.**

1. \_\_\_ " When I lift my head up off the bed I feel like vomiting."
2. \_\_\_ " I just went in the urinal and it needs to be emptied."
3. \_\_\_ " My pain feels like a 5 on a scale of 0 to 5."
4. \_\_\_ " The physician said I can go home today."
5. \_\_\_ " I ate only 50% of my breakfast."

33. A nurse identifies that the patient's report of decreased activity and intake of fluids may be the underlying cause of the patient's constipation. Place an X over the word that reflects the step of the nursing process that is functioning.



34. A patient is transferred from the emergency department to a medical-surgical unit at 6:30 p.m. The nurse arriving on duty at 8 p.m. reviews the patient's clinical record. Which information documented in the clinical record reflects the evaluation step of the nursing process?
1. Productive cough
  2. Seek order for chest physiotherapy
  3. No dizziness reported by the patient
  4. Acetaminophen 650 mg administered at 5 p.m.

### PATIENT'S CLINICAL RECORD

#### Nurse's Transfer Note From the Emergency Department

Patient admitted to the emergency department at 3 p.m. complaining of shortness of breath, which patient reported became worse over the last few days. Sputum culture and metabolic panel and complete blood count drawn and sent to laboratory. Oxygen ordered at 2 L via nasal cannula, acetaminophen 650 mg PO administered at 5 p.m. Patient transferred to 5 South with a diagnosis of R/O pneumonia at 6 p.m.

#### Vital Signs Sheet

Oxygen saturation: 85%  
 Temperature: 102.4°F, temporal  
 Pulse: 92 beats per minute, regular rate  
 Respirations: 28 breaths per minute  
 Blood pressure: 160/90 mm Hg

#### Nurse's Progress Note

7 p.m.: IV 0.45% sodium chloride running at 100 mL per hour. IV site is clean, dry, and intact. Patient has a productive cough, and respirations are 28 breaths per minute related to excessive respiratory secretions. Called primary health-care provider for an order for chest physiotherapy. Patient states feeling tired and nauseated. Patient had 4 ounces of soup and 3 ounces of water and refused rest of dinner. Patient assisted to the bathroom to void; no dizziness reported by the patient.

35. The nurse assesses a patient and collects a variety of data. Identify the human responses that are subjective data. **Select all that apply.**
1.  Na usea
  2.  Ja undice
  3.  Diz ziness
  4.  Dia phoresis
  5.  Hy potension

## NURSING PROCESS: ANSWERS AND RATIONALES

1. During the implementation step of the nursing process, outcomes are not determined, but rather planned nursing care is delivered.
  2. **Evaluation occurs when actual outcomes are compared with expected outcomes that reflect goal achievement. If the goal is achieved, the patient's needs are met.**
  3. During the planning step of the nursing process, expected outcomes are determined, but their achievement is measured in another step of the nursing process.
  4. During the analysis step of the nursing process, outcomes are not determined; rather, the nurse identifies human responses to actual or potential health problems.
1. The definitions of the words “observe” and “assess” are similar. Observe means to view something scientifically, and assess means to collect information. The word “plan” does not fit the analogy because the definitions of the words “plan” and “explore” are not similar. Explore means to examine. Plan means to design an intention.
  2. **The definitions of the words “observe” and “assess” are similar. Observe means to view something scientifically, and assess means to collect information. The word “analyze” fits the analogy. Explore means to examine. Analysis means to investigate.**
  3. The definitions of the words “observe” and “assess” are similar. Observe means to view something scientifically, and assess means to collect information. The word “evaluation” does not fit the analogy because the definitions of explore and evaluate are not similar. Explore means to examine. Evaluation within the concept of the nursing process means to come to a conclusion about a patient's response to a nursing intervention.
  4. The definitions of the words “observe” and “assess” are similar. Observe means to examine something scientifically, and assess means to collect information. The word “implement” does not fit the analogy because the definitions of explore and implement are not similar. Explore means to examine. Implement means to carry out an action.
1. **The nursing process is a dynamic five-step problem-solving process (assessment, analysis, planning, implementation, and evaluation) designed to diagnose and treat human responses to health problems.**
  2. The nursing process focuses on the needs of the patient, not the role of the nurse.
  3. Moving from the simple to the complex is a principle of teaching, not the nursing process. The nursing process is a complex interactive five-step problem-solving process designed to meet a patient's needs. It requires an understanding of systems and information-processing theory and the critical-thinking, problem-solving, decision-making, and diagnostic-reasoning processes.
  4. The nursing process is concerned with a person's human responses to actual or potential health problems, not the patient's medical problem.
1. Although functioning as a teacher is an important role of the nurse, it is a limited role compared with another option. As a teacher, the nurse helps the patient gain new knowledge about health and health care to maintain or restore health.
  2. **When the nurse supports, protects, and defends a patient from a holistic perspective, the nurse functions as an advocate. Advocacy includes exploring, informing, mediating, and affirming in all areas to help a patient navigate the health-care system, maintain autonomy, and achieve the best possible health outcomes.**
  3. The word surrogate is not the word that best describes the role of the nurse providing holistic care. The nurse is placed in the surrogate role when a patient projects onto the nurse the image of another and then responds to the nurse with the feelings for the other person's image.
  4. Although functioning as a counselor is an important role of the nurse, it is a limited role compared with another option. As

counselor, the nurse helps the patient improve interpersonal relationships, recognize and deal with stressful psychosocial problems, and promote achievement of self-actualization.

5. 1. The word “data” (information) is not associated with the term “scientific principles” (established rules of action).
  2. The word “problem” (difficulty) is not associated with the term “scientific principles” (established rules of action).
  3. **The word “rationale” (justification based on reasoning) is closely associated with the term “scientific principles” (established rules of action). Scientific principles are based on rationales.**
  4. The word “evaluation” (determining the value or worth of something) is not associated with the term “scientific principles” (established rules of action).
6. 1. Defining characteristics do not contribute to the problem statement but support or indicate the presence of the nursing diagnosis. Defining characteristics are the major and minor signs and symptoms that support the presence of a nursing diagnosis.
  2. Outcome criteria are not a part of the nursing diagnosis. Outcome criteria (goals) are part of the planning step of the nursing process.
  3. **The etiology (also known as related to or contributing factors) are the conditions, situations, or circumstances that cause the development of the human response identified in the problem statement of the nursing diagnosis. The etiology precipitates the human response just as a pebble dropped in a pond causes ripples on the surface of water.**
  4. Goals are not part of the nursing diagnosis. Goals are the expected outcomes or what is anticipated that the patient will achieve in response to nursing intervention.
7. 1. This is not an example of the planning step of the nursing process. During the planning step the nurse identifies the nursing interventions that are most likely to be effective.
  2. This is not an example of the analysis step of the nursing process. During the analysis step data are critically explored and interpreted, significance of data is determined, inferences are made and validated, signs and symptoms and clusters of signs and symptoms are compared with the defining characteristics of nursing diagnoses, contributing factors are identified, and nursing diagnoses are identified and organized in order of priority.
3. This is not an example of the evaluation step of the nursing process. Evaluation occurs when actual outcomes are compared with expected outcomes that reflect goal achievement.
  4. **This is an example of the implementation step of the nursing process. It is during the implementation step that planned nursing care is delivered.**
8. 1. This action reflects the step of implementation. The nurse puts into action the plan to monitor the patient’s vital signs after a cardiac event is suspected.
  2. This action reflects the planning step of the nursing process.
  3. **This action reflects the assessment step of the nursing process. Assessment involves collecting data via observation, physical examination, and interviewing.**
  4. This action reflects the evaluation step of the nursing process. The nurse assesses the patient’s respiratory rate and effort after a nebulizer treatment to determine if the treatment was effective in reducing airway resistance, thereby improving the patient’s respiratory rate and reducing respiratory effort.
9. 1. This goal is inappropriate because the word “lower” is not specific, measurable, or objective.
  2. This is not a goal. This is an action the nurse plans to implement to help a patient achieve a goal.
  3. **This is a well-written goal. Goals must be patient centered, specific, measurable, and realistic and have a time frame in which the expected outcome is to be achieved. The words “adequate” and “dehydration” are based on generally accepted criteria against which to measure the patient’s actual outcome. The word “maintain” connotes continuously, which is a time frame.**

4. This is not a goal. This is an action the nurse plans to implement to help a patient achieve a goal.
- 10.** 1. Setting time frames for goals to be achieved is part of the planning, not evaluation, step of the nursing process.
- 2. Revising a plan of care takes place in the evaluation step of the nursing process. If during evaluation it is determined that the goal was not met, the reasons for failure have to be identified and the plan modified.**
3. Determining priorities is part of the planning, not evaluation, step of the nursing process. Priority setting is a decision-making process that ranks a patient's nursing needs and nursing interventions in order of importance.
4. Establishing outcomes is part of the planning, not evaluation, step of the nursing process.
- 11.** 1. This does not occur during the implementation step of the nursing process. During the implementation step the nurse puts the plan of care into action. Nursing interventions include actions that are dependent (requiring a primary health-care provider's order), independent (autonomous actions within the nurse's scope of practice), and interdependent (interventions that require a primary health-care provider's order but that permit the nurse to use clinical judgment in their implementation).
2. This does not occur during the assessment step of the nursing process. During the assessment step the nurse uses various skills such as observation, interviewing, and physical examination to collect data from various sources.
- 3. The identification of nursing actions designed to help a patient achieve a goal occurs during the planning step of the nursing process.**
4. This does not occur during the analysis step of the nursing process. The nurse identifies the patient's human responses to actual or potential health problems during the analysis step of the nursing process.
- 12.** 1. **The defining characteristics are the major and minor cues that form a cluster that support or validate the presence of a nursing diagnosis. At least one major defining characteristic must be present for a nursing diagnosis to be considered appropriate for the patient.**
2. Planned interventions do not support the nursing diagnosis. They are the nursing actions designed to help resolve the "related to" or "contributing to" factors and achieve expected patient outcomes that reflect goal achievement.
3. The diagnostic statement cannot support the nursing diagnosis because it is the first part of the nursing diagnosis. A nursing diagnosis is made up of two parts, the diagnostic statement (also known as the problem statement) and the "related to" factors (also known as factors that contribute to the problem or the etiology).
4. Related risk factors cannot support the nursing diagnosis because they are the second part of the nursing diagnosis. A nursing diagnosis is made up of two parts, the diagnostic statement (also known as the problem statement) and the "related to" factors (also known as factors that contribute to the problem or the etiology).
- 13.** 1. Although trust may be established during the assessment phase of the nursing process, it is not the purpose of this step of the nursing process. The development of trust generally takes time.
- 2. The primary purpose of the assessment step of the nursing process is to collect data (information) from various sources using a variety of approaches.**
3. When a five-step nursing process is followed, formulating goals occurs during the planning, not assessment, step of the nursing process.
4. Validating the medical diagnosis is not within a nurse's legal scope of practice.
- 14.** 1. **Related factors (i.e., "contributing to" factors, etiology) contribute to the problem statement of the nursing diagnosis and directly impact on the planning step of the nursing process. Nursing interventions are selected to minimize or relieve the effects of the related factors. If nursing interventions are appropriate and effective, the human response identified in the problem statement part of the nursing diagnosis will resolve.**

2. The planning step of the nursing process includes setting a goal, identifying the outcomes that will reflect goal achievement, and planning nursing interventions. Although the wording of the goal is directly influenced by the diagnostic label (problem statement of the nursing diagnosis), the selection of nursing interventions is not.
  3. Secondary factors generally have only a minor influence on the planning step of the nursing process.
  4. The medical diagnosis does not influence the planning step of the nursing process. The nurse is concerned with human responses to actual or potential health problems, not the medical diagnosis.
- 15.**
1. Nursing care is planned after nursing diagnoses and goals are identified, not immediately after data are collected.
  2. Goals are designed after a nursing diagnosis is identified, not after data are collected.
  3. Once data are collected, the nurse must first organize and cluster the data to determine significance and make inferences. After all this is accomplished, then the nurse can formulate a nursing diagnosis.
  4. **After data are collected, they are clustered to determine their significance.**
- 16.**
1. If a thorough assessment was completed initially, a reassessment should not be necessary.
  2. To establish which of two nursing diagnoses is most appropriate is not dependent upon identifying the factors that *contributed to* (also known as *related to* or *etiology of*) the nursing diagnosis. These factors are identified after the problem statement is identified.
  3. To establish which of two nursing diagnoses is more appropriate is not dependent upon analyzing the *secondary to* factors. *Secondary to* factors generally are medical conditions that precipitate the *related to* factors. The *secondary to* factors are identified after the *related to* factors of the problem are identified.
  4. **The first thing the nurse should do to differentiate between two closely associated nursing diagnoses is to compare the data collected to the major and minor defining characteristics of each of the nursing diagnoses being considered.**
- 17.**
1. Although completing a nursing physical assessment includes an assessment of the risk for falls, it is only one component of the assessment.
  2. Although completing a nursing physical admission assessment includes an assessment of the skin, it is only one component of the assessment.
  3. **This is the primary purpose of a nursing physical assessment. Data must be collected and then analyzed to determine significance and grouped in meaningful clusters before a nursing diagnosis or plan of care can be made.**
  4. Although completing a nursing physical assessment helps to initiate the nurse-patient relationship, it is not the primary purpose of completing a nursing admission assessment.
- 18.**
1. **To evaluate the effectiveness of a nursing action the nurse must compare the actual patient outcome with the expected patient outcome. The expected outcomes are the measurable data that reflect goal achievement, and the actual outcomes are what really happened.**
  2. The problem is associated with the first half (problem statement) of the nursing diagnosis, not the evaluation step of the nursing process.
  3. Etiology is a term used to identify the factors that relate to or contribute to the problem statement of the nursing diagnosis, not the evaluation step of the nursing process.
  4. Implementation is a step separate from evaluation in the nursing process. Nursing care must be performed before it can be evaluated.
- 19.**
1. This is not an example of the implementation step of the nursing process. It is during the implementation step that planned nursing care is delivered.
  2. This is not an example of the assessment step of the nursing process. Although data may be gathered during the assessment step, the manipulation of the data is conducted in a different step of the nursing process.

3. This is not an example of the evaluation step of the nursing process. Evaluation occurs when actual outcomes are compared with expected outcomes, which reflect attainment or nonattainment of the goal.
  4. **During the analysis step of the nursing process, data are critically explored and interpreted, significance of data is determined, inferences are made and validated, cues and clusters of cues are compared with the defining characteristics of nursing diagnoses, contributing factors are identified, and nursing diagnoses are identified and organized in order of priority.**
20. 1. The words “identify” and “recognize” have the same definition. They both mean the same as that which is known. The word “plan” does not fit the analogy because the definitions of plan and do are different. The word “plan” means a method of proceeding. The word “do” means to carry into effect or to accomplish.
2. The words “identify” and “recognize” have the same definition. They both mean the same as that which is known. The word “analyze” does not fit the analogy because the definitions of analyze and do are different. The word “analyze” means to investigate the patient’s human response to an actual or potential health problem. The word “do” means to carry into effect or to accomplish.
3. The words “identify” and “recognize” have the same definition. They both mean the same as that which is known. The word “evaluate” does not fit the analogy because the definitions of evaluate and do are different. The word “evaluate” means to determine the worth of something, whereas the word “do” means to carry into effect or to accomplish.
4. **This is the correct analogy. The words “identify” and “recognize” have the same definition. They both mean the same as that which is known. The words “do” and “implement” both have the same definition. They both mean to carry out some action.**
21. 1. Observation is the deliberate use of all the senses and involves more than just inspection and examination. It includes surveying, looking, scanning, scrutinizing, and appraising. Although the nurse makes inferences based on data collected by observation, this is not as effective as another data collection method to identify subjective data associated with a patient’s anxiety.
2. Inspection involves the act of making observations of physical features and behavior. Although the nurse observes behaviors and makes inferences based on their perceived meaning, another data collection method is more effective in identifying subjective data associated with a patient’s anxiety.
3. Auscultation is listening for sounds within the body. This collects objective, not subjective, data, which are measurable.
4. **Interviewing a patient is the most effective data collection method when collecting subjective data associated with a patient’s anxiety. The patient is the primary source for subjective data about beliefs, values, feelings, perceptions, fears, and concerns.**
22. 1. Epigastric discomfort after eating (dyspepsia) may be sign of a gastrointestinal problem. Dyspepsia is unrelated to the patient’s other clinical manifestations.
2. **The body continuously secretes saliva (approximately 1,000 mL/day) that usually is swallowed. If a patient is having difficulty swallowing, the patient may aspirate saliva, which can cause coughing.**
3. **The body continuously secretes saliva (approximately 1,000 mL/day) that usually is swallowed. When saliva accumulates and is not swallowed it dribbles out of the mouth (drooling). Drooling in addition to the patient’s other clinical manifestations indicates that the patient may have impaired swallowing.**
4. **The body continuously secretes saliva (approximately 1,000 mL/day) that usually is swallowed. When saliva accumulates and is not swallowed it makes a bubbling or gurgling sound in the posterior oropharynx as air is inhaled and exhaled.**
5. A thin film of mucin, food debris, and dead epithelial cells on the teeth (plaque) is not related to the patient’s other clinical

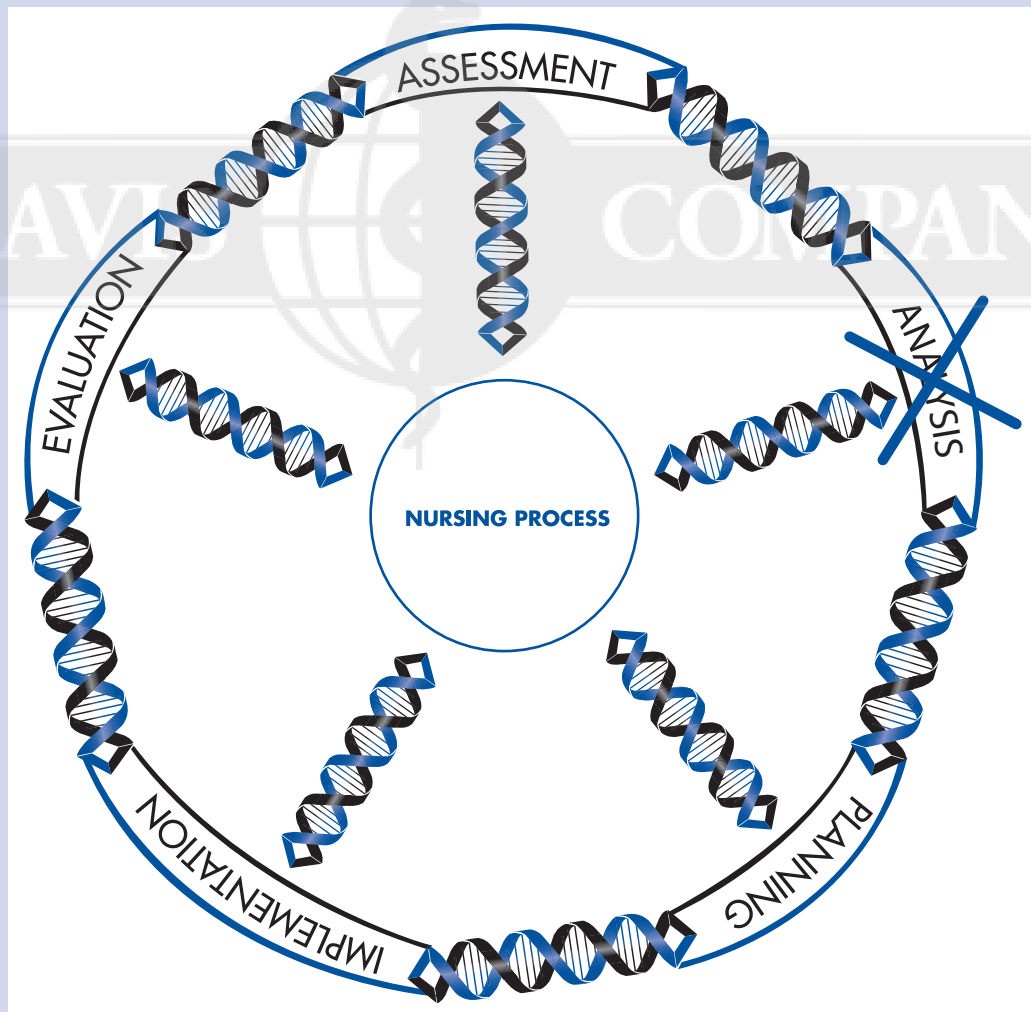
manifestations. Plaque is related to the development of dental caries.

23. 4. **Objective and subjective data must be collected, verified, and communicated during the assessment step of the nursing process.**
  2. Data are clustered and analyzed, and their significance is determined, leading to a conclusion about the patient's condition, during the analysis step of the nursing process.
  3. Identifying goals, projecting outcomes, setting priorities, and identifying interventions are all part of the planning step of the nursing process.
  5. Planned actions are initiated and completed during the implementation step of the nursing process.
  1. Identifying responses to care, comparing actual outcomes with expected outcomes, analyzing factors that affected outcomes, and modifying the plan of care if necessary are all part of the evaluation step of the nursing process.
24. 1. This statement is not a goal. This is an action the nurse plans to implement to help a patient achieve a goal.
  2. This goal is inappropriate because the word "fewer" is not specific, measurable, or objective.
  3. This is a correctly worded goal. Goals must be patient-centered, measurable, realistic, and include the time frame in which the expected goal is to be achieved. The word "independently" indicates that no help is needed, and the word "safely" indicates that no injury will occur. The time frame is "before discharge."
  4. This statement is not a goal. This is an action the nurse plans to implement to help a patient achieve a goal.
  5. This is a correctly worded goal. Goals must be patient-centered, measurable, realistic, and include the time frame in which the expected goal is to be achieved. The words "one or less event . . . daily" comprise a measurable statement and the words "within 6 weeks" establish a time frame.
25. 1. A radial pulse is objective information. Objective data are measurable and checkable.
  2. The sound of wheezing is objective data because it can be heard by others. Air becomes turbulent when it moves through narrow passages that cause vibration of airway walls, resulting in high-pitched whistling sounds (wheezing).
  3. A temperature of 99°F is objective information. Objective data are measurable and can be verified.
  4. A patient's report about shortness of breath is an example of subjective, not objective, data. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.
  5. A patient's report about dizziness is an example of subjective, not objective, data. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.
26. 1. The first step in the analysis phase of the nursing process is to group and cluster data that appear to have a relationship. The nurse uses inductive reasoning, moving from the specific to the general.
  5. The second step in analysis involves gathering additional data to corroborate, substantiate, support, and validate clustered data further.
  3. The third step in analysis involves interpreting the data. The nurse uses reasoning based on knowing commonalities and differences and a scientific foundation of knowledge and experiential background to determine if the data cluster is significant.
  2. The fourth step in analysis involves the nurse making a conclusion about the clustered and validated data.
  4. The fifth step in analysis involves communicating conclusions to other health team members such as a nursing diagnosis in a nursing plan of care.
27. 1. Knowing one's own abilities is subjective information because it is the patient's perception and can be verified only by the patient. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.



2. This statement is neither subjective nor objective data. It is a statement indicating an understanding of how to seek home-care services after discharge.
  3. This statement is neither subjective nor objective data. It is a question indicating that the patient wants more information about how to control pain when at home.
  4. This statement is neither subjective nor objective data. It is a statement exploring who will provide assistance with care once the patient goes home.
  5. **Fear is subjective information because it is the patient's perception and can be verified only by the patient. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.**
- 28.
1. This occurs during the planning, not analysis, step of the nursing process.
  2. **Potential risk factors are identified during the analysis step of the nursing process. Risk diagnoses are designed to address situations in which patients have a particular vulnerability to health problems.**
  3. **Determining which data are significant or insignificant and then categorizing the meaningful data into clusters of data that are related are parts of the analysis step of the nursing process.**
  4. This occurs during the planning, not analysis, step of the nursing process.
  5. This occurs during the evaluation, not analysis, step of the nursing process.
- 29.
1. Hunger is an example of subjective, not objective, data. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.
  2. Feeling warm is an example of subjective, not objective, data. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.
  3. **The amount of food eaten by a patient can be objectively verified. The nurse measures and documents the percentage of a meal ingested by a patient to quantify the amount of food consumed.**
  4. **A rash on a patient's arm can be objectively verified via inspection.**
  5. Having the urge to void is an example of subjective, not objective, data. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.
  6. **Vomiting is a human response that is observable and the amount vomited can be measured. Vomiting is objective information.**
- 30.
1. This statement reflects the nurse using deductive reasoning. It moves from a general premise (the patient is dehydrated) to a specific deduction (the patient will probably have tenting of the skin, which is a sign of dehydration).
  2. This statement reflects the nurse using deductive reasoning. It moves from a general premise (the patient may have fractured the head of the femur in the fall) to a specific deduction (the patient will probably have pain in the hip if it is fractured).
  3. **This statement reflects the nurse using inductive reasoning. It moves from the specific to the general. A pattern of information (an elevated white blood cell count and elevated temperature) leads to a generalization (the patient may have an infection).**
  4. **This statement reflects the nurse using inductive reasoning. It moves from the specific to the general. A pattern of information (crying, trembling, and a rapid pulse) leads to a generalization (the patient may be anxious).**
  5. This statement reflects the nurse using deductive reasoning. It moves from a general premise (the patient is experiencing hypoglycemia) to a specific deduction (the patient will probably have pale, cool, clammy skin and a low blood glucose level).
- 31.
2. **This statement reflects data collection that occurs in the assessment phase of the nursing process, which is the first step.**
  3. **This statement reflects etiological factors contributing to the nursing diagnosis problem statement, which is "constipation." This step analyzes the data collected in the assessment phase of the nursing process.**

4. This statement is a measurable goal. Identifying goals occurs after the nursing diagnosis is identified.
  1. This statement indicates implementation of a planned action that is designed to address the problem statement.
  5. Information about a patient's response to nursing care can be used to compare the patient's actual outcome with the expect outcome, which is the evaluation phase of the nursing process.
32. 1. Feeling like vomiting is something that only the patient can perceive. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.
2. This statement reflects objective, not subjective, information. The urine is observable and measurable. Objective data can be verified.
  3. A patient's perception about a level of pain is subjective information. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.
  4. This information reflects objective, not subjective, data. The statement can be verified.
  5. This information reflects objective, not subjective, data. The statement can be verified.
33. Determining relationships of data and their significance are associated with the analysis phase of the nursing process.



- 34.** 1. A productive cough is information collected during the assessment phase of the nursing process.
2. Seeking an order for chest physiotherapy reflects the planning phase of the nursing process.
- 3. This statement reflects an evaluation of the patient's response to ambulation.**
4. Administering an ordered medication reflects the implementation phase of the nursing process.
- 35. 1. Nausea is an unpleasant, wave-like sensation in the back of the throat, epigastrium, or abdomen that may lead to vomiting. It is considered subjective data because it cannot be measured by the nurse objectively. It is experienced only by the patient.**
2. A yellow color of the skin, whites of the eyes, and mucous membranes (jaundice) because of deposition of bile pigments from excess bilirubin in the blood is objective, not subjective, information. Objective data are measurable and checkable.
- 3. This is subjective information because it is the patient's perception and can be verified only by the patient. Subjective data are those responses, feelings, beliefs, preferences, and information that only the patient can confirm.**
4. Excessive sweating (diaphoresis) is objective, not subjective, information. Objective data are measurable and checkable.
5. Abnormally low systolic and diastolic blood pressure levels (hypotension) can be measured and verified and therefore are objective data.

F.A. DAVIS

COMPANY

# Physical Assessment

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Afebrile	Data:
Asymptomatic	Objective, subjective
Autonomic nervous system	Primary source of
Barrel chest	Secondary source of
Blood pressure:	Ecchymosis
Auscultatory gap	Edema:
Korotkoff's sounds	Dependent
Pulse pressure	Sacral
Systolic/diastolic	Erythema
Body weight	Exacerbation
Borborygmi (bowel sounds)	Fever (pyrexia), stages of:
Breathing:	Onset (cold or chill phase)
Costal (thoracic)	Course (plateau phase)
Diaphragmatic (abdominal)	Defervescence (fever abatement, flush phase)
Patterns:	General adaptation syndrome
Biot	Heart rate:
Cheyne-Stokes	Bradycardia
Eupnea	Irregular rhythm (dysrhythmia)
Kussmaul	Pulse deficit
Rate:	Tachycardia
Apnea	Hirsutism
Bradypnea	Hyperemia
Tachypnea	Hypertension
Breath sounds:	Hypotension
Adventitious:	Hypovolemic shock
Crackles (rales)	Jaundice
Gurgles (rhonchi)	Lesions
Pleural friction rub	Lethargy
Stridor	Level of consciousness
Wheeze	Local adaptation syndrome
Expected:	Malaise
Bronchial	Memory:
Bronchovesicular	Long term
Vesicular	Short term
Capillary refill	Mental status
Circadian rhythms, diurnal variations	Mobility:
Clubbing	Balance
Cognitive impairment:	Gait
Confusion	Posture
Delirium	Strength
Dementia	

Mood	Carotid
Neuro-checks	Femoral
Neurovascular assessment	Pedal
Orientation to time, place, person	Popliteal
Orthostatic hypotension	Posterior tibial
Pain assessment scales:	Temporal
FLACC pain rating scale	Tibial
Numerical scales	Remission
Wong-Baker FACES Rating Scale	Shivering
Parasympathetic nervous system	Sympathetic nervous system
Physical assessment:	Temperature sites:
Auscultation	Axillary
Inspection	Oral
Palpation	Rectal
Percussion	Tympanic
Pruritus	Tremor
Pulse sites:	Turgor
Apical	Urticaria
Brachial	

## PHYSICAL ASSESSMENT: QUESTIONS

1. A nurse is assessing a patient's bilateral pulses for symmetry. Which pulse site should not be assessed on both sides of the body at the same time?
  1. Radial
  2. Carotid
  3. Femoral
  4. Brachial
2. A nurse is caring for a patient who is experiencing an increase in signs and symptoms associated with multiple sclerosis. Which term describes a recurrence of signs and symptoms associated with a chronic disease?
  1. Variance
  2. Remission
  3. Adaptation
  4. Exacerbation
3. When evaluating the vital signs of a group of patients the nurse takes into consideration the circadian rhythm of body temperature. At which time of day is body temperature usually at its lowest?
  1. 4 p.m. to 6 p.m.
  2. 4 a.m. to 6 a.m.
  3. 8 p.m. to 10 p.m.
  4. 8 a.m. to 10 a.m.
4. Which method of examination is being used when the nurse's hands are used to assess the temperature of a patient's skin?
  1. Palpation
  2. Inspection
  3. Percussion
  4. Observation

5. A nurse must assess for the presence of bowel sounds in a postoperative patient. Which technique should the nurse employ to obtain accurate results when auscultating the patient's abdomen?
  1. Listen for several minutes in each quadrant of the abdomen.
  2. Place a warmed stethoscope on the surface of the abdomen.
  3. Perform auscultation before palpation of the abdomen.
  4. Start at the left lower quadrant of the abdomen.
6. Which assessment requires the nurse to assess the patient further?
  1. 18-year-old woman with a pulse rate of 140 after riding 2 miles on an exercise bike
  2. 50-year-old man with a BP of 112/60 mm Hg on awakening in the morning
  3. 65-year-old man with a respiratory rate of 10
  4. 40-year-old woman with a pulse of 88
7. A nurse is monitoring the status of postoperative patients. Which vital sign will change **first** when a postoperative patient has internal bleeding?
  1. Body temperature
  2. Blood pressure
  3. Pulse pressure
  4. Heart rate
8. A patient has had a 101 F fever for the past 24 hours. How often should the nurse monitor this patient's temperature?
  1. Every 2 hours
  2. Every 4 hours
  3. Every 6 hours
  4. Every 8 hours
9. A nurse is unable to palpate a patient's brachial pulse. Which pulse should the nurse assess to determine adequate brachial blood flow in this patient?
  1. Radial
  2. Carotid
  3. Femoral
  4. Popliteal
10. Which of the following can cause urine to appear red?
  1. Beets
  2. Strawberries
  3. Red food dye
  4. Cherry gelatine
11. A nurse is assessing a patient's heart rate by palpating the carotid artery. Which action should the nurse implement when assessing a pulse at this site?
  1. Monitor for a full minute.
  2. Palpate just below the ear.
  3. Press gently when palpating the site.
  4. Massage the site before assessing for rate.
12. A nurse obtains the blood pressure of several adults. Which blood pressure result should cause the **most** concern?
  1. 102/70 mm Hg
  2. 140/90 mm Hg
  3. 125/85 mm Hg
  4. 118/75 mm Hg
13. A nurse is planning care for a patient who has intolerance to activity. Which is the **first** assessment that should be made by the nurse?
  1. Range of motion
  2. Pattern of vital signs
  3. Impact on functional health patterns
  4. Influence on the other family members

14. The nurse must take a patient's rectal temperature. Which should the nurse do?
  1. Take the temperature for 5 minutes.
  2. Wear gloves throughout the procedure.
  3. Place the patient in the right lateral position.
  4. Insert the thermometer 2 inches into the patient's anus.
15. Which usually is **unrelated** to a nursing physical assessment?
  1. Posture and gait
  2. Balance and strength
  3. Hygiene and grooming
  4. Blood and urine values
16. A nurse is performing a psychosocial assessment. Which assessment should be identified as a subtle indicator of depression?
  1. Unkempt appearance
  2. Anxious behavior
  3. Tense posture
  4. Crying
17. A nurse in the emergency department is caring for a patient who is diagnosed with hypothermia. The presence of which factor in the patient's history may have precipitated this condition?
  1. Heat stroke
  2. Inability to sweat
  3. Excessive exercise
  4. High alcohol intake
18. Which is common to the collection of specimens for culture and sensitivity tests regardless of their source?
  1. Preservative media must be used.
  2. Two specimens should be obtained.
  3. Surgical asepsis must be maintained.
  4. A morning specimen should be collected.
19. An adult patient's vital signs are: oral temperature 99 F, pulse 88 beats per minute with a regular rhythm, respirations 16 breaths per minute and deep, and blood pressure 180/110 mm Hg. Which sign should cause concern?
  1. Pulse
  2. Respirations
  3. Temperature
  4. Blood pressure
20. A patient is admitted to the emergency department with difficulty breathing. Which patient response identified by the nurse causes the **most** concern?
  1. Low pulse oximetry
  2. Wheezing on expiration
  3. Shortness of breath on exertion
  4. Using accessory muscles of respiration
21. When evaluating the vital signs of a group of patients the nurse takes into consideration the circadian rhythm of body temperature. At which time of day is body temperature usually at its highest?
  1. 12 a.m. to 2 a.m.
  2. 6 a.m. to 8 a.m.
  3. 4 p.m. to 6 p.m.
  4. 8 p.m. to 10 p.m.

22. Which physical examination method should a nurse use when assessing for borborygmi?
1. Palpation
  2. Inspection
  3. Percussion
  4. Auscultation
23. Which nursing action is common to all instruments when taking a temperature?
1. Ensure that the instrument is clean.
  2. Place a disposable sheath over the probe.
  3. Wash with cool soap and water after use.
  4. Check that it is below ninety six degrees before insertion.
24. A nurse concludes that a patient is experiencing pyrexia. Which assessment precipitated this conclusion?
1. Mental confusion
  2. Increased appetite
  3. Rectal temperature of 101 F
  4. Heart rate of 50 beats per minute
25. A nurse in the emergency department is engaging in an initial assessment of a patient. Which assessment takes priority?
1. Blood pressure
  2. Airway clearance
  3. Breathing pattern
  4. Circulatory status
26. A nurse plans to take a patient's radial pulse. Which method of examination should be used by the nurse?
1. Palpation
  2. Inspection
  3. Percussion
  4. Auscultation
27. The nurse is obtaining a patient's blood pressure. Which information is **most** important for the nurse to document?
1. Staff member who took the blood pressure
  2. Patient's tolerance to having the blood pressure taken
  3. Position of the patient if the patient is not in a sitting position
  4. Difference between the palpated and auscultated systolic readings
28. A nurse is teaching a cancer prevention community health class. Which recommended cancer screening guideline for asymptomatic people not at risk for cancer should the nurse include?
1. Pap smear annually for females 13 years of age and older
  2. Mammogram annually for women 30 years of age and older
  3. Colonoscopy at 50 years of age and every 10 years thereafter
  4. Prostate-specific antigen yearly for men 30 years of age and older
29. A nurse is assessing a patient who states "I feel cold." Which mechanism that helps regulate body temperature will increase body heat?
1. Vasodilation
  2. Evaporation
  3. Shivering
  4. Radiation



30. Edrophonium IV is administered to a patient suspected of having myasthenia gravis. Within 30 seconds after administration of the edrophonium, the patient experiences a cholinergic reaction with increased muscle weakness, bradycardia, diaphoresis, and hypotension. The primary health-care provider prescribes atropine sulfate 1 mg IV STAT. The vial of atropine sulfate indicates 0.5 mg/mL. Calculate how many milliliters of atropine sulfate the nurse should administer. **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ mL.
31. A nurse in the clinic must obtain the vital signs of each patient via an electronic thermometer before patients are assessed by the primary health-care provider. Which patient characteristics indicate that the nurse should take the patient's temperature via the rectal, rather than the oral, route? **Select all that apply.**
1.  Mouth breather
  2.  History of vomiting
  3.  Presence of confusion
  4.  Intolerance of the semi-Fowler position
  5.  Seven-year-old child level of intelligence
32. A patient with hypertension is given discharge instructions to take the blood pressure every day. A nurse is evaluating a family member taking the patient's blood pressure as part of the patient's discharge teaching plan. Which behaviors indicate that the family member needs additional teaching? **Select all that apply.**
1.  Positions the arm higher than the level of the heart
  2.  Places the diaphragm of the stethoscope over the brachial artery
  3.  Applies the center of the bladder of the cuff directly over an artery
  4.  Releases the valve on the manometer so that the gauge drops 10 mm Hg per heartbeat
  5.  Inserts the earpieces of the stethoscope into the ears so that they tilt slightly backward
33. A nurse is caring for a patient who sustained trauma in an automobile collision. The nurse makes the following assessments: Does not open the eyes when asked a question but opens eyes and withdraws from painful stimulus when turned and positioned; makes sounds but does not speak words. The nurse uses the Glasgow Coma Scale (GCS) to rate the patient's level of consciousness. Which point total on the Glasgow Coma Scale should the nurse document in the patient's clinical record indicating the patient's level of consciousness?
1. 4
  2. 6
  3. 8
  4. 10

**GLASGOW COMA SCALE****Eye Opening Points**

Eyes open spontaneously 4  
 Eyes open in response to voice 3  
 Eyes open in response to pain 2  
 No eye opening response 1

**Best Verbal Response Points**

Oriented (e.g., to person, place, time) 5  
 Confused, speaks but is disoriented 4  
 Inappropriate, but comprehensible words 3  
 Incomprehensible sounds, but no words are spoken 2  
 None 1

**Best Motor Response Points**

Obeys command to move 6  
 Localizes painful stimulus 5  
 Withdraws from painful stimulus 4  
 Flexion, abnormal decorticate posturing 3  
 Extension, abnormal decerebrate posturing 2  
 No movement or posturing 1

**Total Points ?**

34. A patient has a serious vitamin K deficiency. For which clinical manifestations should the nurse assess this patient? **Select all that apply.**
1.  Bone pain
  2.  Skin lesions
  3.  Bleeding gums
  4.  Ecchymotic area
  5.  Muscle weakness
35. A patient has lost approximately 2 units of blood during a vaginal delivery. For which responses to this blood loss should the nurse assess this patient? **Select all that apply.**
1.  Increased urinary output
  2.  Rapid, shallow breathing
  3.  Hypertension
  4.  Tachycardia
  5.  Bradypnea
36. A nurse identifies that a patient with a fever has cool skin. Which additional signs confirm the onset (cold or chill phase) of a fever? **Select all that apply.**
1.  Goose bumps on the skin
  2.  Decreased shivering
  3.  Cyanotic nail beds
  4.  Flushed skin
  5.  Sweating
37. A nurse is interviewing a newly admitted patient. Which words used by the patient describe data associated with the defervescence phase (fever abatement, flush phase) of a fever? **Select all that apply.**
1.  Cold
  2.  Achy
  3.  Warm
  4.  Sweaty
  5.  Thirsty

38. A nurse is caring for a patient who had surgery for a hysterectomy 2 days ago. After reviewing the patient's medical record, which piece of data should cause the nurse the most concern?
1. Respirations: 10 breaths per minute
  2. Vomited after eating 6 ounces of soup
  3. IV infiltration in left hand
  4. Temperature: 99.4°F

### PATIENT'S CLINICAL RECORD

#### Primary Health-Care Provider's Orders

Hydromorphone 6 mg PO every 4 hours for severe incisional pain  
 Acetaminophen 325 mg PO every 4 hours prn for mild incisional pain or 650 mg PO every 4 hours prn for moderate incisional pain  
 Diet: Clear liquids, progress to regular as tolerated  
 Activity: OOB 3 times a day, ambulate in hallway  
 Vital signs every 4 hours

#### Nurse's Progress Notes

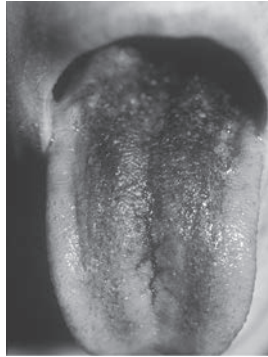
Patient progressed to full liquids; full liquids not well tolerated, vomited after eating 6 ounces of soup; ambulated in hallway 30 feet, tolerated well without signs of activity intolerance. Administered hydromorphone 6 mg at 4 p.m. for incisional pain reported at level 7 out of 10. Abdominal dressing dry and intact. IV 0.9% sodium chloride at 100 mL per hour infiltration in left hand, discontinued and moved to right hand. Warm soak applied 20 minutes to left hand as per protocol.

#### Vital Signs Sheet 6 p.m.

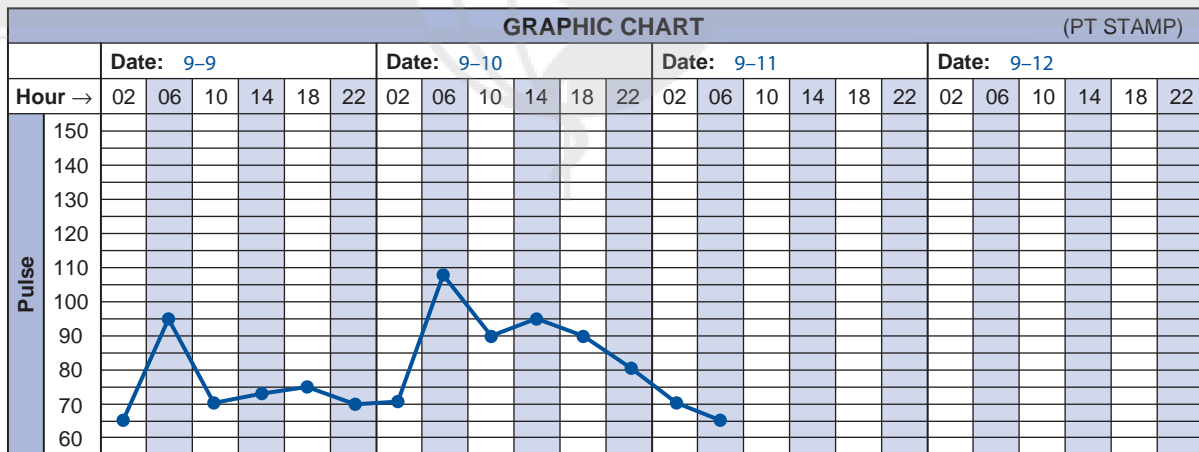
Temperature: 99.4°F, orally  
 Pulse: 68 beats per minute, regular  
 Respirations: 10 breaths per minute  
 Blood pressure: 110/68 mm Hg

39. A nurse concludes that a patient has inadequate nutrition. Which patient adaptations support this conclusion? **Select all that apply.**
1.  P resence of surface papillae on the tongue
  2.  Red dish-pink mucous membranes
  3.  C achectic appearance
  4.  Sp oon-shaped nails
  5.  Shiny eyes

40. A nurse is performing a physical assessment on a newly admitted patient. The photograph reflects the condition of the patient's tongue. Which nursing intervention should the nurse anticipate will address the origin of this patient's problem?

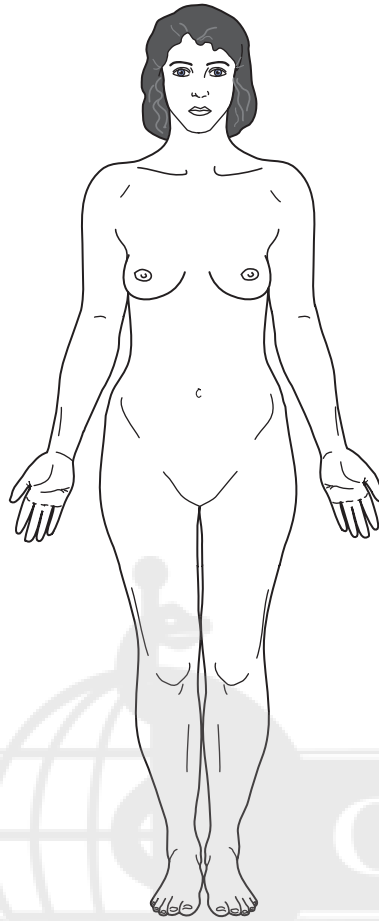


1. Administering prescribed B vitamins
  2. Providing oral hygiene 4 times a day
  3. Administering prescribed antifungal medication
  4. Encouraging the intake of 3,000 mL of oral fluid daily
41. A patient has an elevated temperature and reports feeling cold. Which additional physical changes should the nurse expect during the onset phase (cold or chill phase) of a fever? **Select all that apply.**
1.  Restlessness with confusion
  2.  Decreased respiratory rate
  3.  Profuse perspiration
  4.  Pale, cold skin
  5.  Shivering
42. At which day and time did the patient have a pulse rate of 75 beats per minute?



1. 9-9 at 0002
  2. 9-9 at 1800
  3. 9-11 at 0006
  4. 9-10 at 1000
43. A nurse is assessing a postoperative patient for signs of hemorrhage. Which clinical manifestations are indicative of shock? **Select all that apply.**
1.  Hypertension
  2.  Hypotension
  3.  Irregular pulse
  4.  Fast respirations
  5.  Cold, clammy skin

44. Place an X over the site in the illustration that is used **most** often by nurses for assessing a patient's heart rate.



45. A nurse refers to the Glasgow Coma Scale when assessing a patient's level of consciousness. Place the following statements related to verbal response in the Glasgow Coma Scale in order from behaviors that support alertness to those that support unresponsiveness.

1. No response
2. Oriented, converses
3. Disoriented, converses
4. Uses inappropriate words
5. Makes incomprehensible sounds

Answer: \_\_\_\_\_

## PHYSICAL ASSESSMENT: ANSWERS AND RATIONALES

1. There are no contraindications for palpating both radial arteries at the same time.
  - 2. It is unsafe to palpate both carotid arteries at the same time. Slight compression of both carotid arteries can interfere with blood flow to the brain. In addition, excessive compression of the carotid arteries can stimulate the carotid sinuses, which causes a reflex drop in the heart rate.**
  3. There are no contraindications for palpating both femoral arteries at the same time.
  4. There are no contraindications for palpating both brachial arteries at the same time.
1. The word “variance” is not a term that describes recurrence of signs and symptoms of a chronic illness. Variance occurs when there is a deviation from a critical pathway. This occurs when goals are not met or interventions are not performed according to the stipulated time period.
  2. The word “remission” is not a term that describes recurrence of signs and symptoms of a chronic illness. A remission is a period during a chronic illness of lessened severity or cessation of symptoms.
  3. The word “adaptation” is not a term that describes recurrence of signs and symptoms of a chronic illness. An adaptation is a physical or emotional response to an internal or external stimulus.
  - 4. An exacerbation is the period during a chronic illness when signs and symptoms reappear after a remission or absence of symptoms.**
1. Body temperature is rising between 4 p.m. and 6 p.m.
  - 2. Diurnal variations (circadian rhythms) vary throughout the day with the lowest body temperature usually occurring between 4 a.m. and 6 a.m. The metabolic rate is at its lowest while the person is sleeping.**
  3. Body temperature is at its highest between 8 p.m. and 10 p.m.
  4. Body temperature is rising between 8 a.m. and 10 a.m.
- 1. Gross temperature assessments (e.g., cold, cool, warm, hot) can be obtained by palpation. Palpation is the examination of the body using the sense of touch. Sensory nerves in the fingers transmit messages through the spinal cord to the cerebral cortex, where they are interpreted by the nurse.**
  2. Inspection cannot assess skin temperature. Inspection uses the naked eye to perform a visual assessment of the body.
  3. Percussion cannot assess skin temperature. Percussion is the act of striking the body's surface to elicit sounds that provide information about the size and shape of internal organs or whether tissue is air filled, fluid filled, or solid.
  4. Observation cannot assess skin temperature. Observation uses the naked eye to perform a visual assessment of the body.
1. This is unnecessary. Bowel sounds may be hyperactive (1 every 3 seconds) or hypoactive (1 every minute). After a sound is heard, the stethoscope is moved to the next site. For sounds to be considered absent there must be no sounds for 3 to 5 minutes.
  2. This is done for patient comfort, not to influence the accuracy of the assessment.
  - 3. Bowel sounds are auscultated before palpation and percussion because these techniques stimulate the intestines and thus cause an increase in peristalsis and a false increase in bowel sounds.**
  4. This is not necessary. However, many people do begin the systematic four-quadrant assessment in the lower right quadrant over the ileocecal valve, where the digestive contents from the small intestine empty through a valve into the large intestine.
1. This is an acceptable increase in heart rate with strenuous aerobic exercise.
  2. This is an acceptable blood pressure with the body at rest. The expected blood pressure in an adult is a systolic value of 90 to 119 mm Hg and a diastolic value of 60 to 79 mm Hg.
  - 3. A respiratory rate of 10 is below the expected respiratory rate for an adult and should be assessed further. The**

**expected respiratory rate for an adult is 12 to 20 breaths per minute.**

4. This is within the expected range of 60 to 100 beats per minute.
7.
  1. Although the body temperature decreases as shock progresses because of a decreased metabolic rate, it is not one of the first signs of shock.
  2. Two other vital signs will alter before blood pressure as the heart attempts to compensate for decreased circulating blood volume.
  3. Although during shock the pulse pressure will narrow, other vital signs will change first. Pulse pressure is the difference between the systolic and diastolic pressures.
  4. **The initial stage of shock begins when baroreceptors in the aortic arch and the carotid sinuses detect a drop in the mean arterial pressure. The sympathetic nervous system responds by constricting peripheral vessels and increasing the heart and respiratory rates. During the compensatory stage of shock, the effects of epinephrine and norepinephrine continue with stimulation of alpha-adrenergic fibers causing vasoconstriction of vessels supplying the skin and abdominal viscera and beta-adrenergic fibers causing vasodilation of vessels supplying the heart, skeletal muscles, and respiratory system.**
8.
  1. This is too frequent for routine monitoring of body temperature. Although the set point for body temperature changes rapidly, it takes several hours for the core body temperature to change.
  2. **This is an appropriate interval of time for routine monitoring of body temperature. It is frequent enough to identify trends in changes in body temperature while limiting unnecessary assessments.**
  3. Every 6 hours is too long an interval for monitoring a patient with a fever and is unsafe.
  4. Every 8 hours is too long an interval for monitoring a patient with a fever and is unsafe.
9.
  1. **The brachial artery splits (bifurcates) into the radial and ulnar arteries. When there is an adequate radial pulse, the brachial artery must be patent.**
  2. This information will not provide information about brachial artery blood flow. The carotid arteries are in the neck, whereas the brachial arteries are in the arms. A carotid pulse site is located on the neck at the side of the larynx, between the trachea and the sternomastoid muscle.
  3. This information will not provide information about brachial artery blood flow. The femoral arteries are in the legs, whereas the brachial arteries are in the arms. A femoral pulse site is in the groin in the femoral triangle. It is in the anterior, medial aspect of the thigh, just below the inguinal ligament, halfway between the anterior superior iliac spine and the symphysis pubis.
  4. This information will not provide information about brachial artery blood flow. The popliteal arteries are in the legs, whereas the brachial arteries are in the arms. A popliteal pulse site is in the lateral aspect of the hollow area at the back of the knee (popliteal fossa).
10.
  1. **Betacyanin, a pigment that gives beets their purplish red color, is excreted in the urine and feces of some people when it is nonmetabolized (a genetically determined trait). This bright red pigment turns the urine and feces red for several days after eating beets.**
  2. Strawberries will not turn the urine red. However, they can cause an allergic reaction (reason is unknown), producing the cellular release of histamine and hives.
  3. Red food dye does not turn the urine red. Red dye No. 3, found in foods such as maraschino cherries, is a suspected carcinogen.
  4. Red food dye does not turn the urine red. However, red dye No. 3, found in foods such as gelatine desserts and maraschino cherries, is a suspected carcinogen.
11.
  1. This is unnecessarily long, and even slight compression can interfere with blood flow to the brain.
  2. This is not the site to access the carotid artery. A carotid pulse site is located on the neck at the side of the larynx, between the trachea and the sternomastoid muscle.
  3. **The carotid artery should be palpated with a light touch to prevent interference to blood flow to the brain and stimulation of the carotid sinus**

that can cause a reflex drop in the heart rate.

4. This is contraindicated. Massage can stimulate the carotid sinus located at the level of the bifurcation of the carotid artery, and this results in a reflex drop in the heart rate.
- 12.**
1. This blood pressure reading is within the acceptable ranges for an adult, which are a systolic value of 90 to 119 mm Hg and a diastolic value of 60 to 79 mm Hg.
  2. **This blood pressure is within the parameters of stage I hypertension and is the blood pressure that should cause the most concern. A systolic reading of 140 to 159 mm Hg or a diastolic reading of 90 to 99 mm Hg indicates stage I hypertension.**
  3. Although this blood pressure is within the parameters of pre-hypertension and should cause concern, it is not the highest blood pressure of the options offered. Pre-hypertension is indicated by a systolic reading in the range of 120 to 139 mm Hg or a diastolic reading in the range of 80 to 89 mm Hg.
  4. This blood pressure reading is within the expected range for an adult, which is a systolic value of 90 to 119 mm Hg and a diastolic value of 60 to 79 mm Hg.
- 13.**
1. Activity intolerance is related to the cardiovascular and respiratory systems, not the nervous and musculoskeletal systems.
  2. **Activity intolerance is related to the inability to maintain adequate oxygenation to body cells, which is associated with respiratory and cardiovascular problems. Obtaining the vital signs (e.g., pulse, respirations, and blood pressure) will provide valuable information about these systems.**
  3. Although the impact on functional health patterns might eventually be assessed, it is not the priority.
  4. Although the influence on the other family members might eventually be assessed, it is not the priority.
- 14.**
1. A plastic rectal thermometer must remain in place 2 to 4, not 5, minutes to obtain an accurate reading. An electronic thermometer usually will obtain a reading within several seconds.
  2. **Gloves, personal protective pieces of equipment, are the best way the nurse is protected from contracting or transmitting a pathogen.**
3. The left, not right, lateral position is the best position to place a patient when obtaining a rectal temperature because it utilizes the anatomical position of the anus and rectum for safe, easy insertion of the thermometer.
  4. Inserting the thermometer 2 inches into the anus can cause damage to the mucous membranes. A lubricated thermometer should be inserted 1.5 inches into the anus to ensure a safe, accurate reading.
- 15.**
1. Assessing posture and gait is within the scope of nursing practice because posture and gait reflect human responses.
  2. Assessing balance and strength is within the scope of nursing practice because balance and strength reflect human responses.
  3. Assessing hygiene and grooming is within the scope of nursing practice because hygiene and good grooming reflect human responses.
- 4. Ordering and assessing urine and blood values are not in the independent practice of nursing. These assessments are dependent or interdependent functions of the nurse and are covered by specific orders or standing orders, respectively.**
- 16.**
1. **When people are depressed they frequently do not have the physical or psychic energy to perform the activities of daily living and often exhibit an unkempt appearance. A dishevelled, untidy appearance is a covert, subtle indication of depression.**
  2. Anxious behavior is overt, not covert and subtle.
  3. Tense posture is overt, not covert and subtle.
  4. Crying is overt, not covert and subtle.
- 17.**
1. Hyperthermia, not hypothermia, is associated with this condition. Heat stroke (heat hyperpyrexia) is failure of the heat-regulating capacity of the body that results in extremely high body temperatures (105 F).
  2. Hyperthermia, not hypothermia, can result from the lack of sweat. The inability to perspire does not allow the body to cool by the evaporation of sweat (vaporization).
  3. Hyperthermia, not hypothermia, can result from excessive exercise. Exercise increases



heat production as carbohydrates and fats break down to provide energy. Body temperature temporarily can increase as high as 104 F.

4. **Excessive alcohol intake interferes with thermoregulation by providing a false sense of warmth, inhibiting shivering and causing vasodilation, which promotes heat loss. In addition, it impairs judgment, which increases the risk of making inappropriate self-care decisions.**
18.
    1. This is not necessary for all specimens.
    2. Generally, if a specimen is collected using proper technique, one specimen is sufficient for testing for culture and sensitivity.
    3. **The results of culture and sensitivity tests are faulty and erroneous if the collection container or inappropriate collection technique introduces extraneous microorganisms that falsify and misrepresent results. Surgical asepsis (sterile technique) must be maintained.**
    4. This is not necessary for any culture and sensitivity specimen.
  19.
    1. This is within the expected adult pulse range of 60 to 100 beats per minute and the rhythm is regular; the patient should be assessed further and the information compared with the patient's baseline data.
    2. This is within the expected adult respiratory range of 14 to 20 breaths per minute.
    3. This is within the expected adult temperature range of 97.6 F to 99.6 F for an oral temperature.
    4. **The blood pressure is more than the expected systolic value of less than 120 mm Hg and a diastolic value less than 80 mm Hg and, of the options presented, should cause the most concern. A blood pressure with a systolic reading more than 160 or a diastolic reading more than 100 indicates stage II hypertension.**
  20.
    1. Pulse oximetry is a noninvasive procedure to measure the oxygen saturation of the blood. The expected value is 95% or more. If a patient's pulse oximetry result is low, the patient is hypoxic and needs medical intervention.
    2. Although wheezing on expiration, which is associated with bronchial constriction, requires continuous monitoring, it is not as critical an assessment as a low pulse oximetry. Wheezing on exhalation that increases in severity or wheezing on both inhalation and exhalation becomes a priority in relation to the situation presented.
    3. Shortness of breath is an expected response to exertion and is not a cause for concern.
    4. Although using accessory muscles of respiration requires monitoring, it is not as critical an assessment as low pulse oximetry. Some people with chronic respiratory problems always use accessory muscles of respiration when breathing.
  21.
    1. The body temperature is on the decline during this time.
    2. The body temperature is just beginning to rise from its lowest level, which occurs between 4 a.m. and 6 a.m.
    3. Although the body temperature is rising, it has not reached its peak at this time.
    4. **Diurnal variations (circadian rhythms) vary throughout the day, with the highest body temperature usually occurring between 8 p.m. and midnight.**
  22.
    1. Palpation may stimulate intestinal motility, which increases bowel sounds, but it is not the assessment method used to hear bowel sounds. Palpation is the examination of the body using the sense of touch.
    2. Inspection cannot assess bowel sounds. Inspection uses the naked eye to perform a visual assessment of the body.
    3. Percussion may stimulate intestinal motility, which increases bowel sounds, but it is not the assessment method used to hear bowel sounds. Percussion is the act of striking the body's surface to elicit sounds that provide information about the size and shape of internal organs or whether tissue is air filled, fluid filled, or solid.
    4. **Auscultation is the process of listening to sounds produced in the body. It is performed directly by just listening with the ears or indirectly by using a stethoscope that amplifies the sounds and conveys them to the nurse's ears. Active intestinal peristalsis causes rumbling, gurgling, and tinkling abdominal sounds known as bowel sounds (borborygmi).**

- 23. 1. This is an acceptable medical asepsis practice. All instruments, regardless of their type, must be clean before and after use.**
2. This is true only for electronic thermometers and sometimes used for plastic thermometers.
  3. This is true only for plastic thermometers.
  4. This is not true for all thermometers, such as chemical disposable thermometers, temperature-sensitive tape, and electronic thermometers. This is true for plastic thermometers.
- 24. 1. Mental confusion is a not a common human response to pyrexia.**
2. Loss of appetite (anorexia), not an increased appetite, is a common human response to pyrexia.
  - 3. A rectal temperature of 101°F (38.3°C) or oral temperature of 100°F (37.8°C) is a common human response that indicates pyrexia (fever).**
  4. An increased heart rate (tachycardia), not a decreased heart rate (bradycardia), is a common human response to pyrexia.
- 25. 1. Although important, blood pressure is related to circulation which is not the priority.**
- 2. Patient assessment must always be conducted in order of priority of needs. In an emergency, the ABCs of assessment are airway, breathing, and circulation. A clear airway is essential for life and therefore has priority.**
  3. Although important, assessment of a breathing pattern is not the priority.
  4. Although important, circulation is not the priority.
- 26. 1. Palpation, the examination of the body using the sense of touch, is used to obtain the heart rate at a pulse site. When measuring a pulse, an artery is compressed slightly by the fingers so that the pulsating artery is held between the fingers and a bone or firm structure.**
2. A pulse is not measured by using the sense of sight. Inspection uses the naked eye to perform a visual assessment of the body.
  3. Percussion cannot measure a pulse. Percussion is the act of striking the body's surface to elicit sounds that provide information about the size and shape of internal organs or whether tissue is air filled, fluid filled, or solid.
4. Auscultation is used to obtain an apical, not radial, pulse. Auscultation is the process of listening to sounds produced in the body. It is performed directly by just listening with the ears or indirectly by using a stethoscope that amplifies the sounds and conveys them to the nurse's ears.
- 27. 1. Although this should be done, it is not the most important information that should be documented.**
2. This is necessary only if the patient did not tolerate the procedure.
  - 3. The patient's position when the blood pressure is measured may influence results. Generally, systolic and diastolic readings are lower in the horizontal than in the sitting position. There is a lower reading in the uppermost arm when a person is in a lateral recumbent position. A change from the horizontal to an upright position may result in a temporary decrease (5 to 10 mm Hg) in blood pressure; when this decrease exceeds 25 mm Hg systolic or 10 mm Hg diastolic, it is called orthostatic hypotension.**
  4. This is unnecessary because they are approximately the same.
- 28. 1. The American Cancer Society recommends that women should not have a Pap test before age 21.**
2. The American Cancer Society recommends that women receive yearly mammograms at 40 years of age.
  - 3. A colonoscopy should be performed at age 50 and every 10 years thereafter. This is the age when the risk for colon cancer increases.**
  4. The American Cancer Society recommends that screening for cancer of the prostate be conducted on an individual basis. Individuals who are African American or have a family member with the disease before the age of 65 should discuss the need for screening with a primary health-care provider starting at age 45.
- 29. 1. Vasodilation brings warm blood to the peripheral circulation where it is lost through the skin via radiation; this produces heat loss.**
2. Evaporation (vaporization) is the conversion of a liquid into a vapor. When perspiration on the skin evaporates, it promotes heat loss.

3. Shivering generates heat by causing muscle contraction, which increases the metabolic rate by 100% to 200%.
4. Radiation is the transfer of heat from the surface of one object to the surface of another without direct contact; this produces heat loss.

30. Answer: 2 mL. Solve the question by using ratio and proportion.

$$\frac{\text{Desired}}{\text{Have}} = \frac{1 \text{ mg}}{0.5 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$

$$\begin{aligned} 0.5x &= 1 \text{ mL} \\ x &= 1 \div 0.5 \\ x &= 2 \text{ mL} \end{aligned}$$

31. 1. Mouth breathing allows environmental air to enter the mouth, which may result in an inaccurately low reading. To take an oral temperature the instrument must remain under the tongue of a closed mouth until the reading is obtained. This can take as little as several seconds (electronic thermometers) or as long as 3 to 4 minutes (plastic thermometers).
  2. A history of vomiting does not negate the use of an oral thermometer. If the patient should begin to vomit, the nurse can remove the thermometer.
  3. Taking an oral temperature when a patient is confused is unsafe. A patient who is confused may bite down on an oral thermometer and cause injury to the mouth.
  4. An oral thermometer can be used with a patient maintained in any position.
  5. A 7-year-old child understands cause and effect and can follow directions regarding the use of an oral thermometer.
32. 1. A blood pressure should be taken with the arm supported at the level of the heart. If the arm is above the level of the heart, the blood pressure reading will be inaccurately decreased, and if the arm is below the level of the heart or not supported, the blood pressure reading will be inaccurately increased.
  2. This is a correct action when obtaining a blood pressure reading. The brachial artery is close to the skin's surface, and the diaphragm of the stethoscope is used for

low-pitched sounds of a blood pressure reading.

3. This ensures an accurate reading because it provides uniform and complete compression of the brachial artery.
4. This may result in an inaccurate reading. The valve on the manometer should be opened to allow the gauge to drop 2 to 3 mm Hg per heartbeat.
5. The earpieces of the stethoscope should be placed into the ears so that they tilt slightly forward, not backward. This ensures that the openings in the earpieces of the stethoscope are facing toward the ear canal for uninterrupted transmission of sounds.

33. 1. The number 4 does not reflect the patient's total points on the Glasgow Coma Scale.
2. The number 6 does not reflect the patient's total points on the Glasgow Coma Scale.
3. The number 8 reflects the patient's total points on the Glasgow Coma Scale as demonstrated in the scale below.
4. The number 10 does not reflect the patient's total points on the Glasgow Coma Scale.

### GLASGOW COMA SCALE

#### Eye Opening Points

Eyes open spontaneously 4  
Eyes open in response to voice 3

#### Eyes open in response to pain 2

No eye opening response 1

#### Best Verbal Response Points

Oriented (e.g., to person, place, time) 5  
Confused, speaks but is disoriented 4  
Inappropriate, but comprehensible words 3

#### Incomprehensible sounds but no words are spoken 2

None 1

#### Best Motor Response Points

Obeys command to move 6  
Localizes painful stimulus 5

#### Withdraws from painful stimulus 4

Flexion, abnormal decorticate posturing 3  
Extension, abnormal decerebrate posturing 2  
No movement or posturing 1

#### Total Points 8

Major Head Injury 8

Moderate Head Injury 9–12

Minor Head Injury 13–15

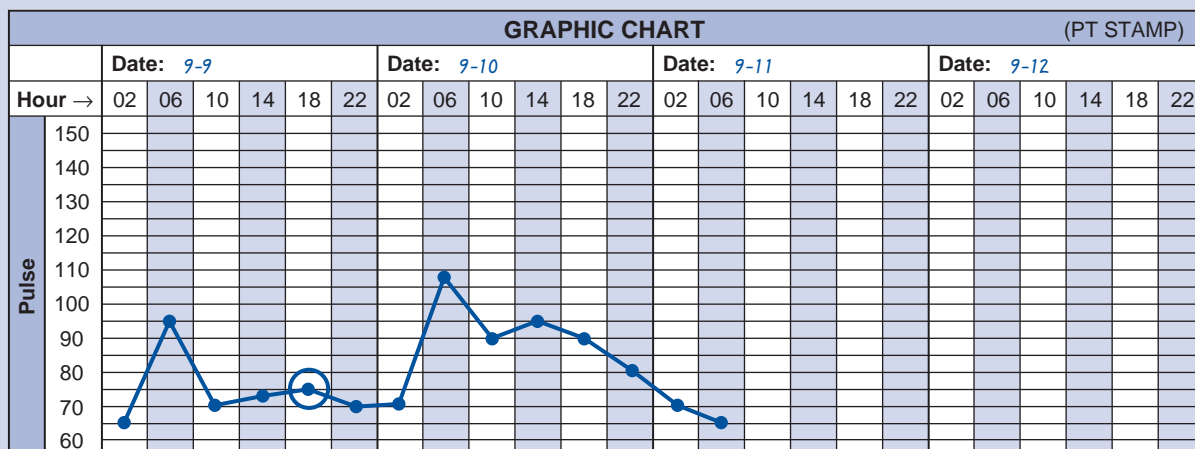
- 34.** 1. A deficiency in vitamin D, not vitamin K, causes bone pain associated with osteoporosis.
2. Vitamin K deficiency is not associated with skin lesions. Ascorbic acid (vitamin C) deficiency causes small skin hemorrhages and delays wound healing. Riboflavin (vitamin B<sub>2</sub>) deficiency causes lip lesions, seborrheic dermatitis, and scrotal and vulval skin changes.
- 3. A disruption in the clotting mechanism of the body can result in bleeding. Vitamin K plays an essential role in the production of the clotting factors II (prothrombin), VII, IX, and X.**
- 4. An ecchymotic area is caused by extravasation of blood into skin or mucous membranes. In this patient's situation, it is caused by a disruption in the clotting mechanism of the body as a result of a vitamin K deficiency.**
5. A deficiency in thiamine (vitamin B<sub>1</sub>), not vitamin K, causes muscle weakness.
- 35.** 1. With a reduction in blood volume there will be less blood circulating through the kidneys, resulting in a decreased, not increased, urinary output.
- 2. With a decrease in circulating red blood cells, the respiratory rate will increase to meet oxygen needs.**
3. With a reduction in blood volume, the blood pressure will be decreased, not increased.
- 4. Tachycardia occurs with hemorrhage as the body attempts to bring more oxygen to cells via the circulation.**
- 5. Rapid breathing, not bradypnea, occurs with hemorrhage as the respiratory rate increases to meet oxygen needs.**
- 36.** 1. **Contraction of the *arrector pili* muscles (goose bumps), an attempt by the body to trap air around body hairs, is associated with the onset phase (cold or chill phase) of a fever. During this phase, the body responds to pyrogens by conserving heat to raise the body's temperature and reset the body's thermostat.**
2. Decreased shivering is a response associated with the defervescence phase (fever abatement, flush phase) of a fever. During this stage the hypothalamus attempts to lower the body's temperature and heat loss responses occur. Shivering, which increases the body's temperature, occurs during the onset phase (cold or chill phase) of a fever.
- 3. Cyanosis of the nail beds occurs during the onset phase (cold or chill phase) of a fever. Vasoconstriction and shivering are the body's attempt to conserve heat.**
4. Flushed skin occurs during the defervescence phase (fever abatement, flush phase) of a fever as the hypothalamus attempts to lower the body's temperature. Quick vasodilation occurs, which helps to cool the body.
5. Profuse diaphoresis (sweating) occurs during the defervescence phase (fever abatement, flush phase) of a fever as the hypothalamus attempts to lower the body's temperature. During this phase, the fever abates and the body's temperature returns to the expected range.
- 37.** 1. Feeling cold occurs during the onset phase (cold or chill phase) of a fever because of vasoconstriction, cool skin, and shivering.
2. Feeling achy occurs during the course phase (plateau phase) of a fever. Generally this is the result of extra energy being exerted by the body fighting the infection, as well as a response to activation of the immune system.
- 3. Feeling warm is associated with the defervescence phase (fever abatement, flush phase) of a fever because of sudden vasodilation.**
- 4. Feeling sweaty occurs during the defervescence phase (fever abatement, flush phase) of a fever because of the body's heat loss response.**
5. Feeling thirsty is associated with the course phase (plateau phase) of a fever because of mild to severe dehydration.
- 38.** 1. **A respiratory rate of 10 or below is a concern. The patient is receiving hydromorphone, an opioid, which depresses the central nervous system. A respiratory rate is depressed when an opioid medication is excessive. The dose of hydromorphone may need to be reduced.**
2. Although vomiting is a concern, it is not as important as data presented in another option. The patient is receiving 100 mL of fluid hourly; therefore, the patient is most likely well hydrated.
3. Although an IV infiltration is a concern, it is not as important as data presented in

another option. The IV was discontinued and replaced in the other hand and a warm soak was applied.

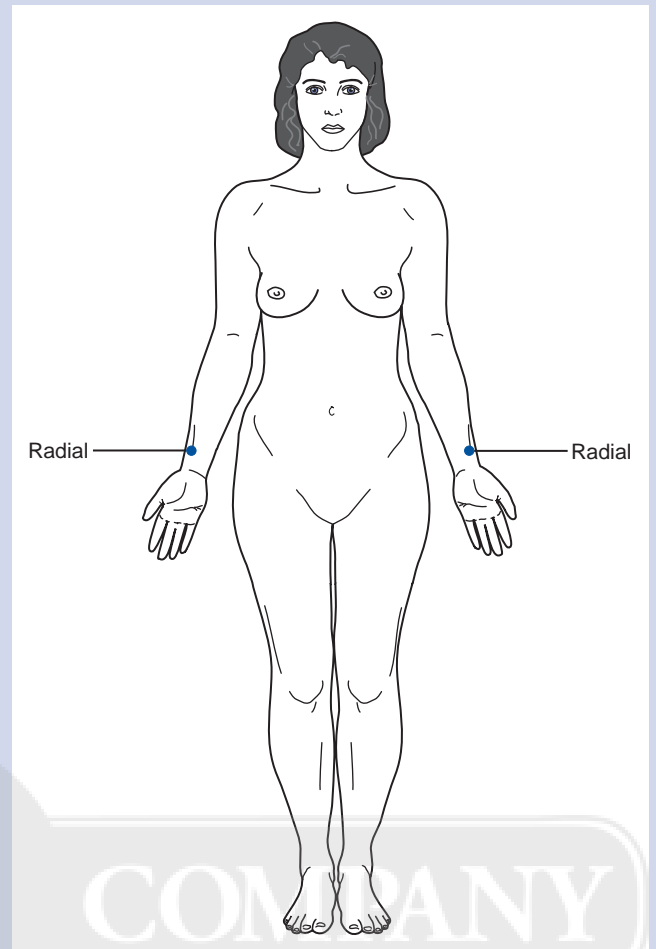
4. Although an increase in temperature after surgery is a concern, an oral temperature of 99.4°F is within the normal range of 97.6°F to 99.6°F.
- 39.**
1. The tongue usually is pink, moist, and smooth, with papillae and fissures present. A beefy red or magenta color, smooth appearance, and increase or decrease in size indicates nutritional problems.
  2. This is the usual color of mucous membranes because of their rich vascular supply. Pale mucous membranes or the presence of lesions indicates nutritional problems.
  3. **Cachexia is general ill health and malnutrition marked by weakness and excessive leanness (emaciation).**
  4. **Fingernails that curve inward like spoons can be caused by iron deficiency, vitamin B<sub>12</sub> deficiency, or anemia.**
  5. The eyes are always moist and shiny because lacrimal fluid continually washes the eyes. Pale or red conjunctivae, dryness, and soft or dull corneas are signs of nutritional problems.
- 40.**
1. The patient is not exhibiting the signs of a vitamin B deficiency. B vitamins treat fissures and cracking at the corners of the mouth (cheilosis) caused by a deficiency of B vitamins.
  2. Providing oral hygiene 4 times a day will not address the origin of this patient's problem.
  3. **The photograph demonstrates a human response to a fungal infection in the oral cavity. When documenting this assessment the nurse should describe this patient's tongue as a "black, hairy**

**tongue," which is characteristic of an oral fungal infection.**

4. Encouraging an increase in the intake of oral fluids does not address the origin of this patient's problem.
- 41.**
1. Restlessness with confusion may indicate the beginning of delirium associated with high fevers that alter cerebral functioning. Delirium is associated with the course phase (plateau phase) of a fever.
  2. During the course phase (plateau phase) of a fever, the pulse and respiratory rates will increase because of an increase in the basal metabolic rate, in an attempt to pump oxygenated blood to the tissues.
  3. Profuse diaphoresis (sweating) occurs during the defervescence phase (fever abatement, flush phase) of a fever.
  4. **Pale, cold skin occurs during the onset phase (cold or chill phase) of a fever because of vasoconstriction, which is an attempt to conserve body heat.**
  5. **Shivering occurs during the onset phase (cold or chill phase) of a fever. Fever is caused by the release of inflammatory mediators (pyrogens) that cause the hypothalamus to reset the set point of temperature. When this happens the body feels cold and shivering occurs. Shivering involves muscle contraction that produces heat, which increases the temperature to the new hypothalamic set point.**
- 42.**
1. On 9-9 at 0002 the patient's pulse rate was 65 beats per minute.
  2. **On 9-9 at 1800 the patient's pulse rate was 75 beats per minute.**
  3. On 9-11 at 0006 the patient's pulse rate was 65 beats per minute.
  4. On 9-10 at 1000 the patient's pulse rate was 90 beats per minute.



43. 1. During the compensatory stage of shock, blood is shunted away from, not toward, the periphery. Hyperemia is an increase in blood flow to an area where the overlying skin becomes reddened and warm.
2. The circulating blood volume is reduced by 25% to 35% during the compensatory stage of shock and by 35% to 50% during the progressive stage of shock as the peripheral vessels constrict to increase blood flow to vital organs. This shunting of blood causes hypotension.
3. With shock the heart rate increases (tachycardia); it is not irregular. The heart rate increases during the compensatory stage of shock to maintain adequate blood flow to body tissues.
4. During the compensatory stage of shock, the respiratory rate increases, not decreases, to maintain adequate oxygenation of body cells.
5. With hemorrhage there is a decrease in blood pressure as a result of hypovolemia, which in turn stimulates the sympathetic nervous system. The sympathetic nervous system stimulates vasoconstriction, which moves blood from the periphery of the body to vital organs. The decrease in circulation to the skin causes it to become cold and clammy.
44. The radial pulse is the most easily found and accessible site for routine monitoring of the pulse, and it provides accurate information when the heart rate is regular. The radial pulse site is where the radial artery runs along the radial bone, on the thumb side of the inner aspect of the wrist.



45. 2. *Oriented and converses* is rated 5, the highest level of functioning of the 5 levels in the Verbal Response category of the Glasgow Coma Scale.
3. *Disoriented and converses* is rated 4 out of 5 levels of functioning and is after *oriented and converses* level 5 in the Verbal Response category of the Glasgow Coma Scale.
4. *Uses inappropriate words* is rated 3 out of 5 levels of functioning and is after *disoriented and converses* level 4 in the Verbal Response category of the Glasgow Coma Scale.
5. *Makes incomprehensible sounds* is rated 2 out of 5 levels of functioning and is after *uses inappropriate words* level 3 in the Verbal Response category of the Glasgow Coma Scale.
1. *No response* is rated 1, the lowest level of the 5 levels of functioning and is after *makes incomprehensible sounds* level 2 in the Verbal Response category of the Glasgow Coma Scale.

# Infection Control

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Afebrile	Immune response
Antibiotics	Immune system
Antibody	Immunity
Antigen	Immunization
Antimicrobial	Immunocompromised
Antipyretic	Immunosuppression
Asepsis:	Inflammatory response
Medical	Infection, types:
Surgical	Iatrogenic
Biohazardous	Health-care-associated infection (HAI) (formerly called nosocomial infection)
Chain of infection:	Local
Characteristics of the pathogen	Opportunistic
Portal of entry	Systemic
Reservoir	Leukocytosis
Portal of exit	Local adaptation syndrome (LAS)
Mode of transmission	Microorganisms:
Characteristics of the host	Bacteria
Culture and sensitivity	Fungi
Débridement	Viruses
Drainage, exudate:	Neutropenia
Purulent, pus	Ova and parasites
Sanguineous	Pediculosis
Serosanguineous	Phagocytosis
Serous	Pyrogens
Erythema	Standard precautions
Fever (febrile, pyrexia)	Transmission-based precautions:
General adaptation syndrome (GAS)	Airborne precautions
Healing:	Contact precautions
Primary intention	Droplet precautions
Secondary intention	White blood cell count
Hyperthermia	

## INFECTION CONTROL: QUESTIONS

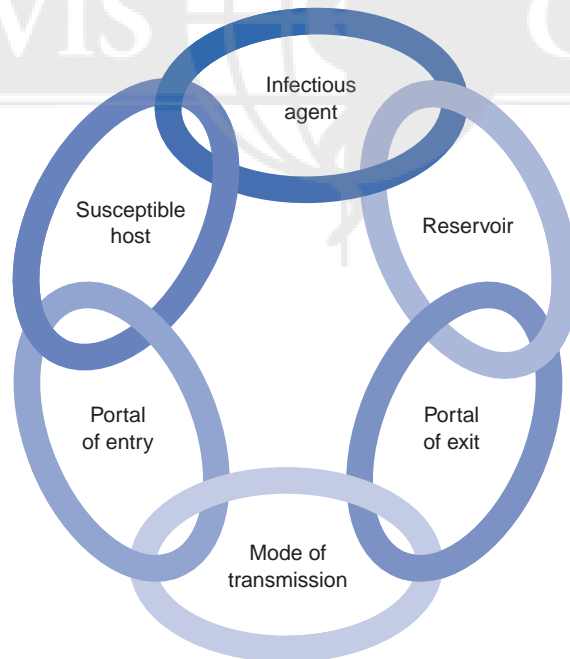
1. Which is the **primary** reason why the nurse should avoid glued-on artificial nails?
  1. They interfere with dexterity of the fingers.
  2. They could fall off in a patient's bed.
  3. They harbor microorganisms.
  4. They can scratch a patient.

2. A nurse working in a clinic is assessing patients of a variety of ages. People within which age group should the nurse particularly assess for subtle signs and symptoms of subclinical infections?
  1. Children of school age
  2. Older adults
  3. Adolescents
  4. Infants
3. Which condition places a patient at the **greatest** risk for developing an infection?
  1. Implantation of a prosthetic device
  2. Burns over more than 20% of the body
  3. Presence of an indwelling urinary catheter
  4. More than 2 puncture sites from laparoscopic surgery
4. Which does the nurse determine is a secondary line of defense against infection?
  1. Mucous membrane of the respiratory tract
  2. Urinary tract environment
  3. Integumentary system
  4. Immune response
5. A nurse is concerned about a patient's ability to withstand exposure to pathogens. Which blood component should the nurse monitor?
  1. Platelets
  2. Hemoglobin
  3. Neutrophils
  4. Erythrocytes
6. When brushing a patient's hair, the nurse identifies white oval particles attached to the hair behind the ears. For which should the nurse assess the patient?
  1. Pediculosis
  2. Hirsutism
  3. Dandruff
  4. Scabies
7. A nurse educator is evaluating whether a new staff nurse understands the relationship between a fever and an infection. Which statement by the new staff nurse indicates an understanding of this relationship?
  1. "Phagocytic cells release pyrogens that stimulate the hypothalamus."
  2. "Leukocyte migration precipitates the inflammatory response."
  3. "Erythema increases the flow of blood throughout the body."
  4. "Pain activates the sympathetic nervous system."
8. A nurse is caring for the following group of patients with infections. Which infection is classified as a hospital-acquired infection?
  1. Respiratory infection contracted from a visitor
  2. Vaginal canal infection in a postmenopausal woman
  3. Urinary tract infection in a patient who is sedentary
  4. Wound infection caused by unwashed hands of a caregiver
9. A nurse is caring for a patient with a high fever secondary to septicemia. The primary health-care provider orders a cooling blanket (hypothermia blanket). Through which mechanism does the hypothermia blanket achieve heat loss?
  1. Radiation
  2. Convection
  3. Conduction
  4. Evaporation
10. Which patient condition identified by a nurse is unrelated to infection?
  1. Catabolism
  2. Hyperglycemia
  3. Ketones in the urine
  4. Decreased metabolic activity



11. A nurse is caring for a group of hospitalized patients. Which should the nurse do **first** to prevent patient infections?
  1. Provide small bedside bags to dispose of used tissues.
  2. Encourage staff to avoid coughing near patients.
  3. Administer antibiotics as prescribed.
  4. Identify patients at risk.
12. A patient has a wound that is healing by secondary intention. Which solution to cleanse the wound and dressing should the nurse expect will be ordered to support wound healing?
  1. Normal saline and a gauze dressing.
  2. Normal saline and a wet-to-damp dressing.
  3. Povidone-iodine and a dry sterile dressing.
  4. Half peroxide and half normal saline and a wet-to-dry dressing.
13. A nurse is caring for a group of patients experiencing various medical conditions. The patient with which condition is at the **greatest** risk for a wound infection?
  1. Surgical creation of a colostomy
  2. First-degree burn on the back
  3. Puncture of the foot by a nail
  4. Paper cut on the finger
14. A school nurse is teaching a class of adolescents about the function of the integumentary system. Which fact about how the skin protects the body against infection is important to include in this discussion?
  1. Cells of the skin are constantly being replaced, thereby eliminating external pathogens.
  2. Epithelial cells are loosely compacted on skin, providing a barrier against pathogens.
  3. Moisture on the skin surface prevents colonization of pathogens.
  4. Alkalinity of the skin limits the growth of pathogens.
15. A patient's stool specimen is positive for *Clostridium difficile*. Which isolation precautions should the nurse institute for this patient?
  1. Droplet
  2. Contact
  3. Reverse
  4. Airborne
16. Which should the nurse do to interrupt the transmission link in the chain of infection?
  1. Wash the hands before providing care to a patient.
  2. Position a commode next to a patient's bed.
  3. Provide education about a balanced diet.
  4. Change a dressing when it is soiled.
17. Which patient statements indicate that further teaching by the nurse is necessary regarding how to ensure protection from food contamination?  
**Select all that apply.**
  1. \_\_\_ " I should stuff a turkey an hour before putting it in the oven."
  2. \_\_\_ " I love juicy rare hamburgers with onion and tomato."
  3. \_\_\_ " I prefer chicken salad sandwiches with mayonnaise."
  4. \_\_\_ " I know to spit out food that does not taste good."
  5. \_\_\_ " I should defrost frozen food in the refrigerator."

18. A patient is admitted to the ambulatory surgery unit for an elective procedure. When performing a physical assessment the nurse identifies that the patient has *Pediculus capitis* (head lice). Place the nurse's interventions in the order in which they should be implemented.
1. Establish contact isolation.
  2. Comb the hair with a fine-toothed comb.
  3. Notify the provider of the patient's condition.
  4. Obtain a prescription for a pediculicidal shampoo.
  5. Wash the patient's hair with a pediculicidal shampoo.
- Answer: \_\_\_\_\_
19. Which primary defenses protect the body from infection? **Select all that apply.**
1.  Tears in the eyes
  2.  Healthy intact skin
  3.  Cilia of respiratory passages
  4.  Alkalinity of gastric secretions
  5.  Bile in the gastrointestinal system
  6.  Moist environment of the epidermis
20. A nurse is caring for patients with a variety of wounds. Which wounds will likely heal by primary intention? **Select all that apply.**
1.  Cut in the skin from a kitchen knife
  2.  Excoriated perianal area
  3.  Abrasion of the skin
  4.  Surgical incision
  5.  Pressure ulcer
21. A nurse changes a patient's dressing when it is soiled. Place an X in the center of the step where this nursing action breaks the chain of infection.



F.A. DAVIS

COMPANY

22. A patient has a wound infection. Which local human responses should the nurse expect to identify? **Select all that apply.**
1.  Neutropenia
  2.  Malaise
  3.  Edema
  4.  Fever
  5.  Pain
23. Which nursing actions protect patients as susceptible hosts in the chain of infection? **Select all that apply.**
1.  Wearing personal protective equipment
  2.  Administering childhood immunizations
  3.  Recapping a used needle before discarding
  4.  Instituting prescribed immunoglobulin therapy
  5.  Disposing of soiled gloves in a waste container
24. From which type of isolation precaution is this mask designed to protect the nurse?



1. Contact
  2. Airborne
  3. Standard
  4. Protective
25. A patient tells the nurse, "I think I have an ear infection." The nurse should assess this patient for which objective human responses to an ear infection? **Select all that apply.**
1.  Throbbing pain
  2.  Purulent drainage
  3.  Elevated temperature
  4.  Dizziness when moving
  5.  Hearing a buzzing sound
26. Which are examples of primary defenses that protect the body from infection? **Select all that apply.**
1.  Antibiotic therapy
  2.  Lysozymes in saliva
  3.  The low pH of the skin
  4.  The alkaline environment of the vagina
  5.  Production of mucus by cells in the genitourinary tract

27. A nurse is caring for a patient who has an order for shortening a Penrose drain 1 inch daily. The nurse washes the hands, removes the soiled dressing, sets a sterile field, dons sterile gloves, and cleans around the drain with sterile saline solution as ordered. Place the following steps in the order in which they should be implemented by the nurse.
1. Complete dressing the wound.
  2. Pull the drain out 1 inch gently and steadily.
  3. Grip the Penrose drain with a pair of sterile forceps.
  4. Remove the pin and replace it at the surface of the wound.
  5. Cut off the excess drain using sterile scissors, ensuring that 2 inches remain outside the wound.
- Answer: \_\_\_\_\_
28. Which nursing actions protect patients from infection at the portal of entry portion of the chain of infection? **Select all that apply.**
1.  Positioning an indwelling urine collection bag below the level of the patient's pelvis
  2.  Using sterile technique when administering an intramuscular injection
  3.  Enclosing a urine specimen in a biohazardous transport bag
  4.  Wearing clean gloves when handling a patient's excretions
  5.  Washing the hands after removal of soiled gloves
  6.  Maintaining a dressing over a surgical incision
29. The nurse is reviewing the clinical record of a newly admitted older adult male patient. Which piece of data should cause the **most** concern?
1. WBC 30,000 mm<sup>3</sup>
  2. Temperature 103°F
  3. Abdominal cramping
  4. Blood pressure 110/86 mm Hg

F.A. DAVIS COMPANY

#### PATIENT'S CLINICAL RECORD

##### Laboratory Results

WBC: 30,000 mm<sup>3</sup>

Hct: 52%

Hb: 13 g/dL

##### Emergency Department Nurse's Admission Note

Patient reports feeling overwhelming fatigue, anorexia, "high" fevers, burning on urination, "frequently urinating small amounts," and abdominal cramping. States that these signs and symptoms have progressively worsened over the last few days.

##### Vital Signs Sheet

Pulse: 100 beats per minute, regular

Temperature (oral): 103°F

Respirations: 24 breaths per minute

Blood pressure: 110/86 mm Hg

30. A nurse identifies that a patient has an inflammatory response. Which localized patient responses support this conclusion? **Select all that apply.**
1.  Fever
  2.  Swelling
  3.  Erythema
  4.  Bradypnea
  5.  Tachycardia

31. A nurse must collect the following specimens. Which specimens do not require the use of surgical aseptic technique? **Select all that apply.**
1.  Stool for occult blood
  2.  Stool for ova and parasites
  3.  Oropharyngeal mucus for a culture
  4.  Urine from a retention catheter for a urinalysis
  5.  Exudate from a wound for culture and sensitivity
32. A nurse plans to remove a patient's wound dressing. The nurse identifies the patient, explains what is going to be done and why, washes the hands, collects equipment, provides for the patient's privacy, and places the patient in an appropriate and comfortable position. Place the following steps in the order in which they should be implemented when removing the soiled dressing.
1. Don clean gloves.
  2. Pull the tape away from the skin gently.
  3. Assess the volume, color, and odor of exudate.
  4. Place the soiled dressing and gloves in a biohazardous waste receptacle.
  5. Remove the dressing by lifting the edge of the dressing upward and toward the center of the wound.
  6. Loosen the edges of the tape around the dressing starting from the outside and moving toward the center of the dressing.
- Answer: \_\_\_\_\_
33. Which patient information collected by the nurse reflects a systemic response to a wound infection? **Select all that apply.**
1.  Increased body temperature
  2.  Increased heart rate
  3.  Leukocytosis
  4.  Exudate
  5.  Edema
  6.  Pain
34. A nurse is caring for a patient who has an order for a vacuum-assisted closure device using black foam to facilitate wound healing. The nurse verifies the order, explains to the patient what is to be done and why, gathers equipment, washes the hands, sets a sterile field, and dons sterile gloves. Place the following steps in the order in which they should be implemented.
1. Trim the black foam to the size of the wound cavity.
  2. Pinch and cut a 2-cm round hole in the center of the transparent film.
  3. Connect the suction device tubing to the collection canister tubing and pump.
  4. Place the foam in the wound cavity without overlapping onto the surrounding skin.
  5. Place the suction device over the hole in the film and apply gentle pressure to secure in place.
  6. Apply the transparent film 1 to 2 inches beyond wound edges without stretching or wrinkling the film.
- Answer: \_\_\_\_\_
35. A primary health-care provider prescribes azithromycin "Z Pak" for a patient with a diagnosis of chronic bronchitis. Which should the nurse teach the patient that is important to know about taking azithromycin? **Select all that apply.**
1.  "Take this medication with food."
  2.  "You can discontinue the medication as soon as you feel better."
  3.  "Take 500 mg on the first day and then 250 mg for 4 more days, for a total of 1.5 g."
  4.  "The first dose should be taken after we notify you of the results of the culture and sensitivity."
  5.  "Avoid taking an antacid containing aluminum or magnesium within 2 hours of taking this medication."

## INFECTION CONTROL: ANSWERS AND RATIONALES

1. Artificial nails do not interfere with finger dexterity if kept at a reasonable length (not longer than 1/4 inch beyond the end of the finger).
  2. Although this is a concern, it is not the main reason they should be avoided.
  3. **Studies have demonstrated that artificial nails, especially when cracked, broken, or split, provide crevices in which microorganisms can grow and multiply and therefore should be avoided by direct care providers.**
  4. When artificial nails are cared for so that they remain intact and free of cracks or breaks, they should not scratch the skin.
1. School-aged children generally respond to infections with acute signs and symptoms that are identified easier and earlier than in an age group in another option.
  2. **Infections are more difficult to identify in the older adult because the signs and symptoms are not as acute and obvious as in other age groups, as a result of the decline in all body systems related to aging.**
  3. Adolescents generally respond to infections with acute signs and symptoms that are identified more easily and earlier than in an age group in another option.
  4. Infants generally respond to infections with acute signs and symptoms that are identified more easily and earlier than in an age group in another option.
1. Although wound infections can occur when prosthetic devices are implanted, they are surgically implanted under sterile conditions to minimize this risk.
  2. **Burns more than 20% of a person's total body surface generally are considered major burn injuries. When the skin is damaged by a burn, the underlying tissue is left unprotected and the individual is at risk for infection. The greater the extent and the deeper the depth of the burn, the higher is the risk for infection.**
  3. Although urinary tract infections can occur with an indwelling urinary catheter, these catheters are closed systems in which sterile technique is maintained; this minimizes the risk for infection.
  4. Laparoscopic surgery is performed using sterile technique to minimize the risk of infection.
1. Protective mechanisms in the respiratory tract provide a primary, not secondary, line of defense against pathogenic microorganisms. Primary defenses are nonspecific immune defenses that are anatomical, mechanical, or chemical barriers. In the respiratory tract they include intact mucous membranes, mucus, bactericidal enzymes, cilia, sneezing, and coughing.
  2. Protective mechanisms in the urinary tract environment provide a primary, not secondary, line of defense against pathogenic microorganisms. These defenses include intact mucous membranes, urine flowing out of the body, and urine acidity.
  3. Skin provides a primary, not secondary, line of defense against pathogenic microorganisms. These defenses include intact skin, surface acidity, and the usual flora that is found on the skin.
  4. **The immune response is a specific, secondary line of defense against pathogenic microorganisms. The production of antibodies to neutralize and eliminate pathogens and their toxins (immune response) is activated when phagocytes fail to destroy invading microorganisms completely. The primary, nonspecific defenses (e.g., anatomical, mechanical, chemical, and inflammatory) work in harmony with the secondary defense (immune response) to defend the body from pathogenic microorganisms.**
1. Platelets are essential for blood clotting and are unrelated to an individual's ability to withstand exposure to pathogens.
  2. Hemoglobin is the part of the red blood cell that carries oxygen from the lungs to the tissues and is unrelated to the assessment of an individual's ability to withstand exposure to pathogens.
  3. **Neutrophils, the most numerous leukocytes (white blood cells), are a primary defense against infection because they ingest and destroy microorganisms (phagocytosis). When the leukocyte count is low, it indicates**

**a compromised ability to fight infection.**

4. Red blood cells (erythrocytes) do not reflect an individual's ability to withstand exposure to pathogens. Erythrocytes transport oxygen via hemoglobin molecules.
- 6. 1. Pediculosis (*Pediculus humanus capitis*) is characterized by white oval particles attached to the hair. When identified, the nurse should assess the patient further for the presence of scratch marks on the scalp and by asking the patient if the head feels itchy. Also, the nurse must assess the extent of infestation and if any other areas of the body are infested with other types of lice (*P. humanus corporis* [body hair] and *Phthirus pubis* [pubic and axillary hair]). A patient with this infestation should be on contact isolation to prevent spread of the infestation to others.**
2. White oval particles attached to hair are not indicative of hirsutism. Hirsutism is the excessive growth of hair or hair growth in unusual places, particularly in female patients. In female patients usually it is caused by excessive androgen production or metabolic abnormalities.
  3. White oval particles attached to hair are not indicative of dandruff. Dandruff is the excessive shedding of dry white scales as a result of the expected exfoliation of the epidermis of the scalp. Dandruff scales do not attach to the hair and are easily brushed away from the hair shaft.
  4. White oval particles attached to hair are not indicative of scabies. Scabies is a communicable skin disease caused by an itch mite (*Sarcoptes scabiei*) and is characterized by skin lesions (e.g., small papules, pustules, excoriations, and burrows ending in a vesicle) with intense itching.
- 7. 1. Microorganisms or endotoxins stimulate phagocytic cells, which release pyrogens that stimulate the hypothalamic thermoregulatory center, causing fever.**
2. Leukocyte migration does not precipitate the inflammatory response but is a phase of the inflammatory response. White blood cells reach a wound within a few hours after the injury to ingest bacteria and clean a wound of debris through the process of phagocytosis.
  3. Erythema does not increase the flow of blood throughout the body. Increased blood flow to a localized area causes erythema.
  4. Pain does not cause an increase in body temperature directly.
- 8. 1. A respiratory infection contracted from a visitor is not an example of an infection that directly resulted from a diagnostic or therapeutic procedure.**
2. A vaginal infection in a postmenopausal woman is not an example of an infection that directly resulted from a diagnostic or therapeutic procedure.
  3. A urinary tract infection in a patient who is sedentary is not an example of an infection that directly resulted from a diagnostic or therapeutic procedure.
- 4. A hospital-acquired infection directly results from a diagnostic or therapeutic procedure. When a caregiver does not wash his/her hands, thereby transmitting a pathogen that causes a wound infection, the result is an iatrogenic infection.**
- 9. 1. Radiation is not related to heat loss via a cooling (hypothermia) blanket. Radiation is heat loss from one surface to another surface without direct contact.**
2. Convection is not related to heat loss via a cooling (hypothermia) blanket. Convection is the loss of heat as a result of the motion of cool air flowing over a warm body. The heat is carried away by air currents that are cooler than the warm body.
- 3. Conduction is the transfer of heat from a warm object (skin) to a cooler object (hypothermia blanket) during direct contact.**
4. Evaporation is unrelated to heat loss via a cooling (hypothermia) blanket. Evaporation is the conversion of a liquid to a vapor, which occurs when perspiration on the skin is vaporized. For each gram of water that evaporates from the skin, approximately 0.6 of a calorie of heat is lost.
- 10. 1. Catabolism, the destructive phase of metabolism with its resultant release of energy, is related to infection.**
2. Serum glucose is increased (hyperglycemia) in the presence of an infection because of the release of glucocorticoids in the general adaptation syndrome.
  3. The presence of ketones in the urine, a sign that the body is using fat as a source

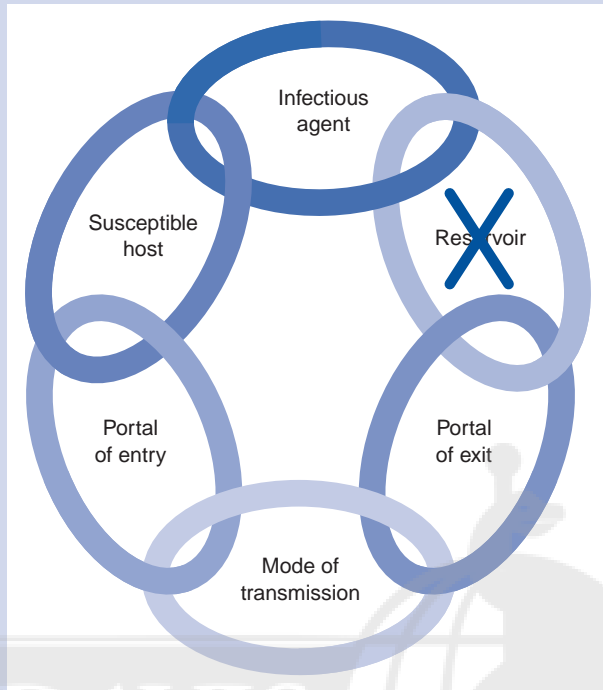
of energy, is related to infection because of the associated increased need for calories for fighting the infection.

4. **Metabolic activity increases, not decreases, with an infection as the body mounts a defense to fight invading pathogenic microorganisms.**
11. 1. Although this is something the nurse may provide to contain soiled tissues, it is not the first action the nurse should implement to prevent infection.
  2. Although this is something the nurse may do to limit airborne or droplet transmission of microorganisms, it is not the first action the nurse should implement to prevent infection.
  3. Antibiotics generally are prescribed for patients who have infections. Antibiotics rarely are prescribed prophylactically to prevent the development of resistant strains of microorganisms.
  4. **This is the most important first step in the prevention of infection. A patient who is at risk to transmit an infection or at risk to be physiologically unable to protect the self from infection may require the institution of special precautions (e.g., transmission-based precautions, protective isolation).**
12. 1. Although normal saline is appropriate for cleansing a wound, a moist, not dry, environment facilitates epithelialization and minimizes scar formation.
  2. **Cleaning with normal saline will not damage fibroblasts. Wet-to-damp dressings allow epidermal cells to migrate more rapidly across the wound surface than dry dressings, thereby facilitating wound healing.**
  3. Povidone-iodine is cytotoxic and should not be used on clean granulating wounds.
  4. Hydrogen peroxide is cytotoxic and should not be used on clean granulating wounds. Removal of a dressing that has dried on a wound will pull recently granulated tissue off of the wound bed.
13. 1. Surgery is conducted using sterile technique. In addition, preoperative preparation of the bowel helps to reduce the presence of organisms that have the potential to cause infection.
  2. There is no break in the skin in a first-degree burn; therefore, there is less of a risk for a wound infection than an example in another option.
3. **Of all the options, puncture of the foot by a nail has the greatest risk for a wound infection. A nail is a soiled object that has the potential of introducing pathogens into a deep wound that can trap them under the surface of the skin, a favorable environment for multiplication.**
  4. Paper generally is not heavily soiled, and the wound edges are approximated. This is less of a risk than an example in another option.
14. 1. **Epithelial cells of the skin are regularly shed along with potentially dangerous microorganisms that adhere to the skin's outer layers, thereby reducing the risk of infection.**
  2. Epithelial cells on the skin are closely, not loosely, compacted, providing a barrier against pathogens.
  3. Moisture on the skin surface facilitates, not prevents, colonization of pathogens.
  4. Acidity, not alkalinity, of the skin limits the growth of pathogens.
15. 1. Droplet precautions are used for patients who have an illness transmitted by particle droplets larger than 5  $\mu$ m (micrometers) (e.g., mumps, rubella, pharyngeal diphtheria, *Mycoplasma pneumoniae*, pertussis, streptococcal pharyngitis, and pneumonic plague).
  2. **Contact precautions are used for patients who have an illness transmitted by direct contact or with items contaminated by the patient, for example, gastrointestinal, respiratory, skin, or wound infections or colonization with drug-resistant bacteria including *Clostridium difficile*, *Escherichia coli*, *Shigella*, as well as other infections/infestations, such as hepatitis A, herpes simplex virus, impetigo, pediculosis, scabies, syncytial virus, and parainfluenza.**
  3. Reverse precautions, also known as neutropenic precautions or protective isolation, are used for patients who are immunocompromised; isolation practices are employed, and personal protective equipment is worn by the caregiver to protect the patient from the caregiver.
  4. Airborne precautions are used for patients who have an illness transmitted by airborne droplet nuclei smaller than 5  $\mu$ m (micrometers), for example, varicella, rubeola, and tuberculosis.



16. 1. This is an example of controlling the mode of transmission. Direct transmission of microorganisms from one person to another is interrupted when microorganisms are removed from the skin surface by hand washing. Hand washing is part of hand hygiene, which also includes nail care, skin lubrication, and wearing of minimal jewelry in a health-care environment. Hand hygiene should be performed before and after patient care and whenever contamination has occurred.
2. The use of a commode is an example of controlling the reservoir and the portal of exit from the reservoir links in the chain of infection.
3. Ingesting a balanced diet is an example of reducing the susceptibility of the host link in the chain of infection.
4. Changing a soiled dressing is an example of controlling the reservoir and portal of exit from the reservoir links in the chain of infection.
17. 1. **The practice of placing stuffing inside a turkey and letting it stand at room temperature is not advisable because it promotes the multiplication of microorganisms.**
2. **Hamburger meat should be thoroughly cooked so that disease-producing microorganisms within the meat are destroyed.**
3. This statement does not indicate a lack of knowledge about the use or storage of mayonnaise.
4. This statement does not indicate a lack of knowledge about what to do when it is determined that something does not taste right.
5. This is the correct way to defrost frozen food. Food should not be defrosted in an environment between 45 F and 140 F because bacteria will rapidly grow in this temperature range.
18. 1. **Medical aseptic techniques must be instituted to protect others from being exposed to the infestation.**
3. **The primary health-care provider must be notified because the surgery must be cancelled and treatment instituted.**
4. **Treatment with a pediculicidal shampoo requires a prescription; it is a dependent function of the nurse.**
5. **The patient's hair should be washed as soon as possible with a medicated shampoo (e.g., permethrin, crotamiton).**
2. **After the hair is washed with a pediculicidal shampoo, it should be combed with a fine-toothed comb to remove the nits (eggs).**
19. 1. **Tears flush the eyes of microorganisms and debris and are a primary defense that protects the body from infection.**
2. **Healthy, intact skin prevents entry of many pathogens. In addition, the normal flora of the skin hinders growth of disease-causing microorganisms that settle on the skin.**
3. **Cilia line the nasal passages, sinuses, trachea, and larger bronchi and are tiny hair-like cells that sweep microorganisms up from the lower airways. These microorganisms are then expelled from the body by coughing and sneezing.**
4. Acidity, not alkalinity, of gastric secretions is a primary defense mechanism that protects the body from infection.
5. Bile helps emulsify fats; it does not protect the body from infection.
6. A dry, not moist, epidermis is a primary defense mechanism that protects the body from infection.
20. 1. **A cut in the skin caused by a sharp instrument with minimal tissue loss can heal by primary intention when the wound edges are lightly pulled together (approximated).**
2. Excoriation heals by secondary, not primary, intention. Excoriation is an injury to the surface of the skin. It can be caused by friction, scratching, and chemical or thermal burns.
3. An abrasion heals by secondary, not primary, intention. With an abrasion, friction scrapes away the epithelial layer, exposing the underlying tissue.
4. **A surgical incision is caused by a scalpel, which is a sharp instrument. This type of wound can heal by primary intention when the wound edges are lightly pulled together (approximated) with sutures.**
5. A pressure ulcer heals by secondary, not primary, intention. Secondary intention healing occurs when wound edges are not approximated because of full-thickness tissue loss; the wound is left open until it fills with new tissue.

21. Changing a soiled dressing breaks the chain of infection at the *Reservoir* (source) step. Soiled or wet dressings are a perfect environment for pathogens to proliferate.



22. 1. An increase in white blood cells (leukocytosis), not a decrease in white blood cells (neutropenia), occurs in response to both local and systemic infections.
2. Discomfort, uneasiness, or indisposition (malaise) is a systemic, not local, response to infection.
3. **Chemical mediators increase the permeability of small blood vessels, thereby causing fluid to move into the interstitial compartment, with resulting local edema.**
4. Fever is a systemic, not local, response to a wound infection. Microorganisms, or endotoxins, stimulate phagocytic cells that release pyrogens, which stimulate the hypothalamic thermoregulatory center to produce an increased temperature (fever, pyrexia).
5. **Pain is caused by localized edema that puts pressure on the surrounding nerves; this is associated with the local adaptation syndrome.**
23. 1. This is an example of controlling the mode of transmission, not the susceptible host, link in the chain of infection.
2. **This is an example of an action designed to interrupt the susceptible**
- host link in the chain of infection by increasing the resistance of the host to an infectious agent.**
3. Discarding uncapped, used syringes in a sharps container disrupts the chain of infection at the reservoir link in the chain of infection. The nurse should never recap a used needle because of the risk of a needle-stick injury.
4. **Immunoglobulins are a group of related proteins able to act as antibodies. Immunoglobulin therapy helps defend a susceptible host against infection.**
5. This is an example of controlling the mode of transmission, not the susceptible host, link in the chain of infection.
24. 1. An N95 respirator mask is not necessary when caring for a patient receiving contact precautions. Patients receiving contact precautions have infections that are transmitted by contact with wounds, dressings, contaminated supplies, or patients' secretions or excretions. A regular mask with an eye shield is necessary when providing care when splashing of blood, body fluids, or secretions is likely, such as when irrigating a wound.
2. **This mask is an N95 respirator mask, which should be worn when entering the room of a patient receiving airborne precautions. The National Institute for Occupational Safety and Health tests and certifies special fitted masks such as the N95 respirator mask for use when maintaining airborne precautions. Infections such as tuberculosis, severe acute respiratory syndrome (SARS), rubeola (measles), and varicella (chickenpox) are considered airborne infections whereby microorganisms are transmitted via air currents. Patients with these infections receive airborne precautions.**
3. An N95 respirator mask is not necessary when implementing standard precautions. Standard precautions are actions implemented by the nurse in the care of all persons regardless of their diagnosis.
4. An N95 respirator mask is not necessary when implementing protective precautions. Protective precautions (reverse isolation, neutropenic precautions) include actions designed to protect the immunocompromised patient from

infection. The nurse wears a mask so as not to introduce microorganisms into the air, thereby protecting the patient from the nurse. Additional actions include such actions as restricting fresh fruit, vegetables, and flowers. Depending on the degree of immunosuppression, the patient may be placed in a room with positive airflow, have water purity monitored, and have air conduits in the room checked for the presence of microorganisms.

25. 1. Throbbing pain is subjective, not objective, information because pain cannot be observed; it is felt and described only by the patient.
2. **Purulent drainage from the ear is objective information because it can be observed and measured.**
3. **An elevated temperature is a cardinal sign of infection and is objective data because it is measured with a thermometer. A fever is a secondary defense against infection. An increase in core body temperature increases metabolism, impedes growth of pathogens, and activates specific immune responses to protect the body.**
4. Dizziness is subjective, not objective, information because it cannot be measured; dizziness is experienced and described only by the patient.
5. Hearing a buzzing sound (tinnitus) is subjective, not objective, information because it cannot be observed; a buzzing sound is perceived and described only by the patient.
26. 1. Antibiotic therapy is the use of chemotherapeutic agents to control or eliminate bacterial infections. It is not a primary defense that protects the body from infection. The inappropriate use of antibiotics destroys the usual flora of the body and can predispose an individual to additional infections.
2. **Lysozymes in saliva help wash microorganisms from the teeth and gums.**
3. **The low pH of the skin is caused by phospholipids that help prevent the development of bacterial infections.**
4. The acidic, not alkaline, environment of the vagina protects it from the growth of pathogens.
5. **Mucus produced by epithelial cells in the genitourinary tract adheres to pathogens to facilitate their elimination through urination.**
27. 3. **Using sterile forceps maintains sterility of the drain.**
2. **Gentle, steady pulling on the drain avoids accidental withdrawal of the drain farther than intended.**
4. **Removing and reattaching the pin at the surface of the wound prevent the drain from sliding back into the wound where it could become inaccessible. If this were to occur, a surgical procedure would be required to access the drain.**
5. **Cutting off the excess drain by using sterile scissors maintains sterility of the drain. Leaving 2 inches to the length of the drain allows an adequate length of drain to grasp when shortening or removing the drain in the future.**
1. **Completing the dressing protects the wound and provides an environment conducive for wound healing.**
28. 1. **This is an action designed to interrupt the portal of entry link in the chain of infection. By keeping the collection bag below the level of the patient's pelvis, backflow is prevented, which reduces the risk of introducing pathogens into the bladder.**
2. **Using sterile technique when administering medication parenterally helps to reduce the risk of introducing a pathogen into the body.**
3. **Using a biohazardous transport bag is an example of controlling the reservoir and mode of transmission links in the chain of infection.**
4. **Wearing clean gloves is an example of controlling the mode of transmission, not the portal of entry, link in the chain of infection.**
5. **Hand washing is an example of controlling the mode of transmission, not the portal of entry, link in the chain of infection.**
6. **A dressing over a surgical incision provides a barrier between the healing incision and the environment. The dressing protects the patient from potential invading microorganisms at the portal of entry portion of the chain of infection.**
29. 1. **A white blood cell count of 30,000 mm<sup>3</sup> or higher is a critical**

**finding indicating a potential life-threatening health situation. The clinical indicators support a medical diagnosis of urosepsis—septicemia from bacteria entering the bloodstream from a urinary cause.**

2. Although a temperature of 103°F is higher than the expected range of 96.8°F to 100.4°F, it is not as critical as data in another option.
  3. Although abdominal cramping is an important piece of data, it is not as critical as data in another option.
  4. A blood pressure of 110/86 mm Hg is low for an older adult man and probably is low because of dehydration associated with “high” fevers of a few days’ duration. Although the blood pressure indicates a need for fluid replacement, it is not as critical as data in another option.
- 30.**
1. A fever is a systemic, not local, response to inflammation.
  2. **Chemical mediators released at the site of an injury increase capillary permeability, causing excessive interstitial fluid that results in swelling (edema).**
  3. **Local trauma or infection stimulates the release of kinins, which increase capillary permeability and blood flow to the local area. The increase of blood flow to the area causes erythema (redness).**
  4. Bradypnea is a regular but excessively slow rate of breathing (less than 12 breaths per minute) and is not a response associated with the local adaptation syndromes.
  5. Tachycardia is an elevated heart rate more than 100 beats per minute and is unrelated to the local adaptation syndrome.
- 31.**
1. **Stool for occult blood does not have to be sterile because test results for the presence of blood are not altered if the specimen is contaminated with exogenous organisms.**
  2. **Stool for ova and parasites does not have to be sterile because test results for the presence of parasitic eggs and parasites are not altered if the specimen is contaminated with exogenous microorganisms.**
  3. Sterile technique is used to collect a throat culture, to avoid contaminating the specimen with exogenous organisms that may alter the accuracy of test results.
  4. The bladder is a sterile cavity, and the nurse must use sterile technique to collect urine from the port of a retention catheter (Foley) so as not to introduce any pathogens. In addition, it is important not to introduce exogenous organisms that may contaminate the specimen and alter the accuracy of test results.
  5. Sterile technique is used to collect exudate from a wound to avoid contaminating the specimen with exogenous organisms that may alter the accuracy of test results.
- 32.**
1. **Clean gloves protect the nurse from the patient’s blood and body fluids.**
  6. **Loosening the edges of the tape around the entire dressing prepares the tape to be removed by the nurse. Moving from the edge toward the center of the wound avoids pulling on the wound.**
  2. **Pulling the tape away from the skin gently reduces discomfort and skin trauma during tape removal.**
  5. **Gently lifting the dressing upward and toward the center of the wound avoids dragging the edges of the dressing into the center of the wound contaminating the wound.**
  3. **Assessing the status of the wound provides data for evaluating the progress of wound healing.**
  4. **Placing soiled dressings and contaminated gloves in a biohazardous waste receptacle breaks the chain of infection at the transmission link.**
- 33.**
1. **Fever is a common systemic response to infection. Microorganisms or endotoxins stimulate phagocytic cells that release pyrogens, which stimulate the hypothalamic thermoregulatory center, resulting in fever.**
  2. **An increased heart rate (tachycardia) occurs in response to the increase in the metabolic rate associated with an infection. In addition, blood volume increases as peripheral and visceral vasoconstriction enhances blood flow to the heart and lungs as the body prepares to fight the infection.**
  3. **The number of white blood cells increases above the expected range (leukocytosis) to help fight the infection.**
  4. Exudate is a local, not systemic, response to an injury or inflammation. Exudate is

cleared away through lymphatic drainage or exits from the body via a wound.

5. Edema is a local, not systemic, response to infection. Chemical mediators increase the permeability of small blood vessels, thereby causing fluid to enter the interstitial compartment, resulting in local edema.
  6. Pain is a local, not systemic, response to inflammation because swelling of inflamed tissue exerts pressure on nerve endings.
- 34. 1. The black foam is cut to the exact size of the cavity of the wound so that suction is applied to the full surface of the wound cavity.**
4. **Avoiding overlapping surrounding intact skin with the foam prevents skin from becoming macerated as the foam becomes wet during therapy.**
  6. **The transparent film creates a seal so that negative pressure can be created by the device. Avoiding stretching the film during application prevents excess tension when negative pressure is established, which can cause tissue injury.**
2. **Creating a 2-cm hole in the transparent film provides a port over which the suction device is applied.**
  5. **The suction device placed over the 2-cm hole in the transparent film once connected to the pump draws excess**

**exudate away from the wound and into the tubing.**

3. **Connecting the suction device tubing to the collection canister and pump establishes negative pressure, which draws excess exudate from the wound. Suctioned exudate exits the wound via the suction device that is secured to the transparent film, is drawn into the tubing, and is collected in the collection canister.**
- 35. 1.** Azithromycin should be taken 1 hour before or 2 hours after meals because food can decrease the amount of medication absorbed by as much as 50%.
2. The entire regimen should be completed, not discontinued once the patient feels better. Taking the entire regimen of an antibiotic eradicates the pathogens that have invaded the body. Stopping an antibiotic early promotes the development of resistant bacteria and a return of the infection.
3. **This is the dose and administration regimen for azithromycin “Z-Pak.”**
  4. The first dose can be administered once the specimen for culture and sensitivity is collected. The patient does not have to wait for the results of the culture and sensitivity test to initiate therapy. Waiting will only prolong the infection.
  5. **Antacids may decrease the peak level of azithromycin and decrease its effectiveness.**

# Safety

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or usually associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Abdominal thrust (Heimlich maneuver)	Functional alignment
Allergies:	Incident report
Food	Knots:
Latex	Clove hitch
Medication	Half bow
Aspiration	Slip
Call bell	Restraints:
Cardiopulmonary resuscitation (CPR)	Belt
Child-proof devices	Elbow
Dysphagia	Jacket
Electrical:	Mitt
Grounding	Mummy
Hazards	Poncho
Surge	Vest
Falls	Side rails
Fire safety:	
Fire extinguishers—A, B, C	
RACE model (Rescue, Alarm, Confine, Extinguish)	

## SAFETY: QUESTIONS

1. A resident brings several electronic devices to a nursing home. One of the devices has a two-pronged plug. Which rationale should the nurse provide when explaining why an electrical device must have a three-pronged plug?
  1. Controls stray electrical currents
  2. Promotes efficient use of electricity
  3. Shuts off the appliance if there is an electrical surge
  4. Divides the electricity among the appliances in the room
2. A nurse is caring for a patient with Parkinson disease who is experiencing difficulty swallowing. Which potential problem associated with dysphagia has the **greatest** influence on the plan of care?
  1. Anorexia
  2. Aspiration
  3. Self-care deficit
  4. Inadequate intake
3. A nurse is caring for a confused patient. Which should the nurse do to prevent this patient from falling?
  1. Encourage the patient to use the corridor handrails.
  2. Place the patient in a room near the nurses' station.
  3. Reinforce how to use the call bell.
  4. Maintain close supervision.

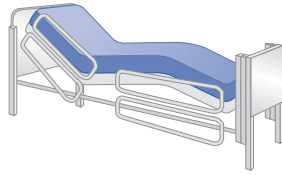
4. A school nurse is teaching children about fire safety procedures. Which is the **first** thing they should be taught to do if their clothes catch on fire?
  1. Yell for help.
  2. Roll on the ground.
  3. Take their clothes off.
  4. Pour water on their clothes.
5. A primary health-care provider orders a vest restraint for a patient. Which should the nurse do **first** when applying this restraint?
  1. Perform an inspection of the patient's skin where the restraint is to be placed.
  2. Ensure that the back of the vest is positioned on the patient's back.
  3. Permit four fingers to slide between the patient and the restraint.
  4. Secure the restraint to the bed frame using a slipknot.
6. An unconscious patient begins vomiting. In which position should the nurse place the patient?
  1. Supine
  2. Side-lying
  3. Orthopneic
  4. Low-Fowler
7. A toaster is on fire in the pantry of a hospital unit. Which should the nurse do **first**?
  1. Activate the fire alarm.
  2. Unplug the toaster from the wall.
  3. Put out the fire with an extinguisher.
  4. Evacuate the patients from the room next to the kitchen.
8. The risk management coordinator is preparing a program on the factors that contribute to falls in a hospital setting. Which factor that **most** often contributes to falls should be included in this program?
  1. Wet floors
  2. Frequent seizures
  3. Advanced age of patients
  4. Misuse of equipment by nurses
9. A nurse is assessing a patient who is being admitted to the hospital. Which is the **most** important information that indicates whether the patient is at risk for physical injury?
  1. Weakness experienced during a prior admission
  2. Medication that increases intestinal motility
  3. Two recent falls that occurred at home
  4. The need for corrective eyeglasses
10. Which should the nurse do to **best** prevent a patient from falling?
  1. Provide a cane.
  2. Keep walkways clear of obstacles.
  3. Assist the patient with ambulation.
  4. Encourage the patient to use hallway handrails.
11. Which is the **last** step in making an occupied bed that the nurse should teach a nursing assistant?
  1. Elevating the head of the bed to a semi-Fowler position
  2. Ensuring that the patient is in a comfortable position
  3. Lowering the height of the bed toward the floor
  4. Raising both the side rails on the bed
12. A nurse is caring for a patient with a nasogastric tube for gastric decompression. Which nursing action takes priority?
  1. Discontinuing the wall suction when providing nursing care
  2. Positioning the patient in the semi-Fowler position
  3. Instilling the tube with 30 mL of air every 2 hours
  4. Caring for the nares at least every 8 hours

13. A patient states that when turning on an electric radio a strong electrical shock was felt. Which should the nurse do **first**?
  1. Arrange for the maintenance department to examine the radio.
  2. Disconnect the radio from the source of energy.
  3. Check the patient's skin for electrical burns.
  4. Take the patient's apical pulse.
14. A nurse educator is teaching a group of newly hired nursing assistants. Which hospitalized patient should they be taught is at the **greatest** risk for injury?
  1. School-aged child
  2. Comatose teenager
  3. Postmenopausal woman
  4. Confused middle-aged man
15. A nurse in the nursing education department of a community hospital is planning an inservice education class about injury prevention. Which factor that **most** commonly causes physical injuries in hospitalized patients should be included in the teaching plan?
  1. Malfunctioning equipment
  2. Failure to use restraints
  3. Visitors
  4. Falls
16. Which is the **priority** nursing intervention to prevent patient problems associated with latex allergies?
  1. Use nonlatex gloves.
  2. Identify persons at risk.
  3. Keep a latex-safe supply cart available.
  4. Administer an antihistamine prophylactically.
17. Which nursing intervention enhances an older adult's sensory perception and thereby helps prevent injury when walking from the bed to the bathroom?
  1. Providing adequate lighting
  2. Raising the pitch of the voice
  3. Holding onto the patient's arm
  4. Removing environmental hazards
18. A nurse is preparing a patient for a physical examination. Which is **most** important for the nurse to do in this situation?
  1. Identify the positions contraindicated for the patient during the examination.
  2. Explore the patient's attitude toward health-care providers.
  3. Inquire about other professionals caring for the patient.
  4. Ask when the patient last had a physical examination.
19. A patient has dysphagia. Which nursing action takes priority when feeding this patient?
  1. Ensuring that dentures are in place
  2. Medicating for pain before providing meals
  3. Providing verbal cueing to swallow each bite
  4. Checking the mouth for emptying between every bite
20. A 3-year-old child is admitted to the pediatric unit. Which should the nurse do to maintain the safety of this preschool-aged child?
  1. Teach the child how to use the call bell.
  2. Put the child in a crib with high side rails.
  3. Ensure the child is under continuous supervision.
  4. Have the child stay in the playroom most of the day.



21. Which time of day is of **most** concern for the nurse when trying to protect a patient with dementia from injury?
1. Afternoon
  2. Morning
  3. Evening
  4. Night
22. A nurse is orienting a newly admitted patient to the hospital. Which is **most** important for the nurse to teach the patient how to do?
1. Notify the nurse when help is needed.
  2. Get out of the bed to use the bathroom.
  3. Raise and lower the head and foot of the bed.
  4. Use the telephone system to call family members.
23. Profuse smoke is coming out of the heating unit in a patient's room. Which should the nurse do **first**?
1. Open the window.
  2. Activate the fire alarm.
  3. Move the patient out of the room.
  4. Close the door to the patient's room.
24. A nurse must apply a hospital gown that does not have snaps on the shoulders to a patient receiving an intravenous infusion in the forearm. Which should the nurse do?
1. Insert the IV bag and tubing through the sleeve from inside of the gown first.
  2. Disconnect the IV at the insertion site, apply the gown, and then reconnect the IV.
  3. Close the clamp on the IV tubing no more than 15 seconds while putting on the gown.
  4. Don the gown on the arm without the IV, drape the gown over the other shoulder, and adjust the closure behind the neck.
25. A nurse is providing care for a patient with a wrist restraint. How often should a restraint be removed, the area massaged, and the joints moved through their full range?
1. Once a shift
  2. Once an hour
  3. Every 2 hours
  4. Every 4 hours
26. Which is the **first** action the home-care nurse should employ to prevent falls by an older adult living at home?
1. Conduct a comprehensive risk assessment.
  2. Encourage the patient to remove throw rugs in the home.
  3. Suggest installation of adequate lighting throughout the home.
  4. Discuss with the patient the expected changes of aging that place one at risk.
27. A nurse is preparing a bed to receive a newly admitted patient. Which action is **most** important?
1. Placing the patient's name on the end of the bed
  2. Ensuring that the bed wheels are locked
  3. Positioning the call bell in reach
  4. Raising one side rail
28. Which are appropriately worded goals for a patient who is at risk for falling? **Select all that apply.**
1. \_\_\_ "The patient will be able to walk from a bed to a chair safely while hospitalized."
  2. \_\_\_ "The patient will be taught how to call for help to ambulate."
  3. \_\_\_ "The patient will be kept on bedrest when dizzy."
  4. \_\_\_ "The patient will be restrained when agitated."
  5. \_\_\_ "The patient will be free from trauma."

29. A nurse is caring for a patient who has an order for a mitt restraint. Place an X where the mitt restraint strap should be secured with a quick-release knot.



30. Which interventions should a nurse implement when assisting a patient to use a bedpan? **Select all that apply.**
- Dust powder on the rim before placing the bedpan under the patient.
  - Ensure that the bed rails are raised once the patient is on the bedpan.
  - Position the rounded rim of the bedpan toward the front of the patient.
  - Encourage the patient to help as much as possible when using the bedpan.
  - Raise to the semi-Fowler position once the patient is placed on the bedpan.
31. A nurse identifies the presence of smoke exiting the door to the dirty utility room. Place the nurse's actions in order of priority using the RACE model.
- Pull the fire alarm.
  - Close unit doors and windows.
  - Shut the door to the utility room.
  - Provide emotional support to agitated patients.
- Answer: \_\_\_\_\_
32. Which clinical manifestation indicates that a further nursing assessment is necessary to determine if the patient is having difficulty swallowing? **Select all that apply.**
- Debilis in the buccal cavity
  - Abdominal cramping
  - Epigastric pain
  - Slurred speech
  - Constipation
  - Drooling
33. A male patient is admitted to ambulatory care for a bilateral herniorrhaphy. A nurse on the unit interviews the patient, obtains the patient's vital signs, and reviews the primary health-care provider's orders. Which should the nurse do **first**?
- Contact the operating suite and inform them of the patient's latex allergy.
  - Ensure the patient's allergy band includes the patient's identified allergies.
  - Notify the primary health-care provider of the patient's elevated vital signs.
  - Share the information about the patient's anxiety with health team members.

### PATIENT'S CLINICAL RECORD

#### Primary Health-Care Provider's Orders

Nothing by mouth  
 IVF: 0.9% sodium chloride at 125 mL/hour  
 Midazolam 5 mg, IM on call to preoperative suite

#### Vital Signs

Temperature: 99.2°F, orally  
 Pulse: 96 beats per minute  
 Respirations: 22 breaths per minute  
 Blood pressure: 124/82 mm Hg

#### Patient Interview

Patient states "I am a little nervous because I have never had surgery before." During preoperative testing patient indicated an allergy to oxycodone/acetaminophen but forgot to include allergies to latex and peanuts.

34. A nurse is planning care for a patient who requires bilateral arm restraints because the patient is delirious and attempting to pull out a urinary retention catheter. Which information is important to consider when planning care for this patient?

**Select all that apply.**

1.  Use of restraints adequately prevents injuries.
  2.  Reasons for use of restraints must be clearly documented.
  3.  Most patients recognize that restraints contribute to their safety.
  4.  Restraints need a primary health-care provider order before application.
  5.  Laws permit the use of restraints when specific guidelines are followed.
35. A nurse is implementing the action demonstrated in the illustration. Which is the nurse doing?
1. Transferring a patient into a wheelchair
  2. Teaching abdominal breathing to a patient
  3. Dislodging an object from a patient's airway
  4. Holding a patient up after the patient became dizzy when walking



36. An adult patient consistently tries to pull out a urinary retention catheter. As a last resort to maintain integrity of the catheter and patient safety, the nurse obtains an order for a restraint. Which types of restraints are most appropriate in this situation? **Select all that apply.**

1.  Mummy restraint
  2.  Elbow restraint
  3.  Jacket restraint
  4.  Wrist restraint
  5.  Mitt restraint
37. A nurse uses the *Get Up and Go* test to assess a patient for weakness, poor balance, and decreased flexibility. Place the following actions in the order in which they should be implemented when employing the *Get Up and Go* test.
1. Ask the patient to walk 10 feet and then to return to the chair.
  2. Ask the patient to close the eyes.
  3. Ask the patient to open the eyes.
  4. Ask the patient to sit in a chair.
  5. Ask the patient to stand.
- Answer: \_\_\_\_\_

38. Which actions are important when the nurse uses a stretcher? **Select all that apply.**

1.  Lowering the bed below the level of the stretcher when transferring a patient from the stretcher to a bed
2.  Guiding the stretcher around a turn leading with the end with the patient's head
3.  Ensuring the patient's head is at the end with the swivel wheels
4.  Pulling the stretcher on the elevator with the patient's feet first
5.  Pushing the stretcher from the end with the patient's head

39. Which human responses to illness alert the nurse that a patient is at risk for aspiration during meals? **Select all that apply.**

1.  Bulimia
2.  Lethargy
3.  Anorexia
4.  Stomatitis
5.  Dysphagia

40. A nurse is caring for a patient with a moderate problem with balance. Place an X over the cane that is most appropriate for this patient.



F.A. DAVIS

COMPANY

## SAFETY: ANSWERS AND RATIONALES

- 1. A three-pronged plug functions as a ground to dissipate stray electrical currents.**
  - The purpose of a three-pronged plug is not to promote efficient use of electricity.
  - A surge protector shuts off the appliance.
  - A multiple outlet plug divides the electricity among appliances in the room.
1. Although lack of an appetite (anorexia) can occur with dysphagia, it is not the most serious associated risk.
  - 2. When a person has difficulty with swallowing (dysphagia), food or fluid can pass into the trachea and be inhaled into the lungs (aspiration), rather than swallowed down the esophagus. This can result in choking, partial or total airway obstruction, or aspiration pneumonia.**
  - Dysphagia is unrelated to self-care deficit. Feeding self-care deficit occurs when a person is unable to cut food, open food packages, or bring food to the mouth.
  - Inadequate intake of food and fluid can result with dysphagia because of fear of choking. However, it is not the most serious associated risk.
1. A confused patient may not be able to follow directions or understand how to use corridor handrails.
  - Moving the patient near the nurses' station may be impossible and impractical.
  - A confused patient may not be able to follow directions or understand how to use a call bell.
  - 4. Maintaining safety of the confused patient is best accomplished through close or direct supervision. Confused patients cannot be left on their own because they may not have the cognitive ability to understand cause and effect, and therefore their actions can result in harm.**
1. This eventually may be done, but the child must do something immediately before waiting for help to arrive.
  - 2. Rolling on the ground will smother the flames and put the fire out. Children should be taught to: "Stop, drop, and roll."**
3. Taking off their clothes may be impossible. In addition, it will take time, and the clothing and skin will continue to burn.
  4. Finding and obtaining water will take too much time, and the clothing and skin will continue to burn. Something must be done immediately.
- 1. Even when applied correctly, restraints can cause pressure and friction. A baseline assessment of the skin under the restraint should be made. In addition, the presence of a dressing, pacemaker, subcutaneous infusion port, or subclavian catheter may influence the type of restraint to use.**
  - Although the back of the vest should be positioned on the patient's back, it is not the first intervention.
  - The jacket may be too loose if four fingers are used. The jacket should be applied so that two, not four, fingers can slide between the patient and the restraint.
  - Securing the restraint to the bed frame using a slipknot should be done; however, it is the last, not the first, intervention associated with the application of a vest restraint.
1. The supine position will promote aspiration and should be avoided in this situation.
  - 2. The side-lying position prevents the tongue from falling to the back of the oropharynx, thus allowing the vomitus to flow out of the mouth by gravity and preventing aspiration.**
  - The orthopneic position is an unsafe, impossible position in which to maintain an unconscious patient.
  - The low-Fowler position will allow the tongue to fall to the back of the oropharynx, promoting aspiration. This position should be avoided in this situation.
- 1. Because no patient is in jeopardy, the nurse's initial action should be to activate the fire alarm. The sooner the alarm is set, the sooner professional firefighters will reach the scene of the fire.**
  - Unplugging the toaster is unsafe because it places the nurse in jeopardy. The nurse

- may be exposed to an electrical charge or become burned.
3. This is an inappropriate intervention because the nurse may not be capable of containing or fighting the fire. Not calling for professional firefighting help first places the nurse, staff, and patients in jeopardy.
  4. Evacuating patients is premature at this time, but it may become necessary eventually.
- 8.**
1. Although wet floors can contribute to falls, they are not the most common factor that contributes to falls in the hospital setting.
  2. Although seizures can contribute to falls, most patients do not experience seizures.
  3. **Older adults who are hospitalized frequently have multiple health problems, are frail, and lack stamina. All of these factors contribute to the inability to maintain balance and ambulate safely.**
  4. Although this occasionally happens and is negligence, it is not the most common factor that contributes to falls in the hospital setting.
- 9.**
1. Although this is important information, it is not the most important factor of the options offered in this question. In addition, the prior admission may have been too long ago to have any current relevance.
  2. A patient with increased intestinal motility may experience diarrhea, which may place the patient at risk for a fluid and electrolyte imbalance, not a physical injury. Although a person with diarrhea may need to use the toilet more frequently, a bedside commode or bedpan can be used to reduce the risk of falls.
  3. **This is significant information that must be considered because if falls occurred before, then they are likely to occur again. When a risk is identified, additional injury prevention precautions can be implemented.**
  4. Although this is important information, it is not the most important factor of the options offered in this question.
- 10.**
1. The patient may or may not need a cane. An unnecessary cane may actually increase the risk of a fall.
  2. Although this should be done, it is not the best intervention of the options presented.
  3. **This widens the patient's base of support, which improves balance and decreases the risk of a fall.**
  4. Although this should be done, it is not the best intervention of the options presented.
- 11.**
1. Elevating the head of the bed may not be necessary. This action should be based on the individual needs of the patient.
  2. Assisting the patient to a comfortable position should be done while the bed is at an effective working height for the caregiver.
  3. **It is safer if the bed is in the lowest position because a greater risk for injury to a patient occurs when the mattress of the bed is farther from the floor.**
  4. Raising the side rails on the bed may not be necessary. This action should be based on the individual needs of the patient.
- 12.**
1. Discontinuing the wall suction is unnecessary and can result in vomiting and aspiration.
  2. **A nasogastric (NG) tube for gastric decompression passes down the esophagus, through the cardiac sphincter, and into the stomach. The cardiac sphincter remains slightly open because of the presence of the NG tube. The semi-Fowler position keeps gastric secretions in the stomach via gravity (preventing reflux and aspiration) and allows the gastric contents to be suctioned out by the NG tube.**
  3. Instilling the NG tube with air is not done routinely every 2 hours. This may be done to identify the presence of the tube in the stomach or help re-establish patency of the tube when it is clogged.
  4. Caring for the nares should be done more frequently than every 8 hours to prevent irritation and pressure.
- 13.**
1. Having the radio examined may be done eventually; it is not the priority at this time.
  2. Disconnecting the radio is contraindicated because it may place the nurse in jeopardy.
  3. Inspecting the patient's skin is not the priority, and electrical burns may or may not be evident.
  4. **An electric shock can interfere with the electrical conduction system within the heart and result in dysrhythmias. An**

**electric shock can be transmitted through the body because body fluids (consisting of sodium chloride) are an excellent conductor of electricity.**

14. 1. Although a school-aged child is at risk for injury in a hospital setting, age-related precautions are always instituted. More nurses generally are assigned to pediatric units and frequently family members are at the bedside.
  2. A patient in a coma is not at as high a risk for injury as a patient in another option. A patient in a coma demonstrates less response to painful stimuli, generally has an absence of muscle tone and reflexes in the extremities, and appears to be in a deep sleep.
  3. A woman after menopause is not at a high risk for injury.
  4. **A confused patient is at an increased risk for injury because of the inability to comprehend cause and effect and therefore lacks the ability to make safe decisions.**
15. 1. Malfunctioning equipment is not a common cause of injuries in a hospital.
  2. The use of restraints has declined dramatically, and now they are used only when patients may harm themselves or others.
  3. Visitors are not the main cause of injuries in a hospital.
  4. **Research demonstrates that most physical injuries experienced by hospitalized patients occur from falls. Failing to call for assistance, inadequate lighting, and the altered health status of patients all contribute to falls.**
16. 1. This may or may not be necessary depending on the needs of the patient.
  2. **Patient allergies must be identified (e.g., latex, food, and medication) before any care is provided, be documented in the patient's clinical record, and appear on an allergy-alert wristband. After a risk is identified, additional safety precautions can be implemented to prevent exposure to the offending allergen. Assessment is the first step of the nursing process.**
  3. Keeping a latex-safe supply cart available may be useless unless the supplies are used appropriately.
  4. Administering an antihistamine is unnecessary. A person with a latex allergy should not be exposed to products with latex.
17. 1. **Adequate lighting provides for the safety of patients, staff, and visitors within a hospital. Inadequate lighting causes shadows, a dark environment, and the potential for misinterpreting stimuli (illusions) and is a contributing cause of accidents in the hospital setting. This intervention maximizes a patient's sense of sight.**
  2. When talking with older adults it is better to lower, not raise, the pitch of the voice. As people age they are more likely to have impaired hearing with higher-pitch sounds.
  3. Holding the patient's arm does not enhance a patient's sensory perception. Holding a patient's arm is not always necessary and therefore could be degrading or promote regression.
  4. Although this should be done, removing environmental hazards will not enhance a patient's sensory perception.
18. 1. **A physical examination requires a patient to assume a variety of positions such as supine, side-lying, sitting, and standing. The nurse should inquire about any positions that are uncomfortable or contraindicated because of past or current medical conditions to prevent complications.**
  2. Although the patient's attitude toward health-care providers may be obtained before a physical examination, it is not the priority.
  3. Inquiring about other professionals caring for the patient is not the priority before a physical examination. This might be done later to prevent fragmentation of care and ensure continuity of care.
  4. Although identifying when the last physical examination was performed may be done, it is not a priority before a physical examination.
19. 1. Although this should be done if a patient has dentures, it is not the priority.
  2. Although an analgesic may be administered, it can cause drowsiness that may increase the potential for aspiration in a patient with dysphagia.
  3. Although this should be done, the patient may be physically incapable of following this direction.
  4. **This is the safest way to ensure that a bolus of food is not left in the mouth**

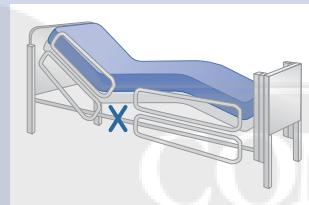
where it can be aspirated and cause an airway obstruction.

20. 1. A preschool-aged child does not have the cognitive and emotional maturity to use a call bell.
  2. A preschool-aged child might attempt to climb over the side rails. A crib with high side rails is more appropriate for an infant.
  3. **Constant supervision ensures that an adult can monitor the preschool-aged child's activity and environment so that safety needs are met. Preschool-aged children are active, curious, and fearless and have immature musculoskeletal and neurological systems, narrow life experiences, and a limited ability to understand cause and effect. All of these factors place preschool-aged children at risk for injury unless supervised.**
  4. This is inappropriate because most preschoolers still take one or two naps daily, the child may be on bedrest, and periods of activity and rest should be alternated to conserve the child's energy.
21. 1. The sunlight and usual afternoon activities generally help keep patients with dementia more oriented and safe.
  2. The sunlight and the routine morning activities of hygiene, grooming, dressing, and eating generally help keep patients with dementia more oriented and safe.
  3. As the day progresses and the sun sets, the concern for safety increases because of altered cognition (sundowner syndrome). However, in the evening there are activities of daily living and available caregivers to distract the patient and provide for safety.
  4. **At night, patients with dementia often continue to experience confusion and agitation. At night there is less light, less activity, and fewer caregivers, so there are fewer orienting stimuli. Patients who are confused or agitated are at an increased risk for injury because they may not comprehend cause and effect and therefore lack the ability to make safe judgments.**
22. 1. **Explaining how to use a call bell meets safety and security needs. It reinforces that help is immediately available at a time when the patient may feel physically or emotionally vulnerable in an unfamiliar environment.**
  2. Patients generally do not need teaching about how to get out of bed to go to the bathroom. This instruction depends on the individual needs of a patient.
  3. How to manipulate the bed is part of orienting a patient to the hospital environment; however, it is not the most important point to emphasize with a patient.
  4. Use of the telephone is part of orienting a patient to the hospital environment; however, it is not the most important point to emphasize with a patient.
23. 1. Opening a window is contraindicated because environmental air will feed the fire and cause it to increase in severity.
  2. Although activating the alarm will be done, it is not the priority at this point in time.
  3. **The patient's physical safety is the priority. The patient must be removed from direct danger before the alarm is activated and the fire contained.**
  4. Although closing the door will be done eventually, it is not the priority at this point in time.
24. 1. **This ensures that the IV bag and tubing are safely passed through the armhole of the gown before the patient puts the arm with the insertion site through the gown. This prevents tension on the tubing and insertion site, which limits the possibility of the catheter dislodging from the vein.**
  2. Disconnecting the IV tubing at the catheter insertion site is unnecessary. This increases the risk of contaminating the equipment and the potential for infection.
  3. Stopping the flow of the IV solution can result in blood coagulating at the end of the catheter in the vein, compromising the patency of the IV tubing.
  4. Draping the gown over the shoulder leaves the patient exposed unnecessarily. It interferes with privacy, and the patient may feel cold.
25. 1. Once a shift is too long a period; it promotes the development of injuries (e.g., contractures, pressure ulcers).
  2. Once an hour generally is too often and unnecessary.
  3. **Restraints should be removed every 2 hours. The extremities must be moved through their full range of**



**motion to prevent muscle shortening and contractures. The area must be massaged to promote circulation and prevent pressure injuries.**

4. Four hours is too long a period between activities and promotes the development of injuries.
- 26. 1. Assessment is the first step of the nursing process. The best way to prevent falls is by identifying those at risk and instituting multiple interventions that prevent falls.**
2. This is inadequate. Removing throw rugs is just one strategy.
  3. This is inadequate. Ensuring adequate lighting is just one strategy.
  4. This is inadequate. Exploring the issues of aging with a patient is just one strategy.
- 27. 1. Placing patients' names on the end of their beds violates the patient's right to privacy. An identification wristband must be worn for patient identification.**
- 2. Locked bed wheels are an important safety precaution. The bed must be an immovable object because the patient may touch the bed for support, lean against it when getting in or out of bed, or move around when in bed. If bed wheels are unlocked during these maneuvers, the bed may move and the patient can fall.**
3. The call bell cord may become an obstacle when moving the patient into the bed. This should be done after the patient is in the bed.
  4. The side rail may become an obstacle when moving the patient into the bed. This should be done after the patient is in the bed.
- 28. 1. This is an appropriate goal. It is realistic, specific, measurable, and has a time frame. It is realistic to expect that all patients be safe. It is specific and measurable because safety from trauma can be compared with standards of care within the profession of nursing. It has a time frame because the words "while hospitalized" reflect the time frames of always, constantly, and continuously while directly under the care of a health team.**
2. Being taught how to call for help is a planned intervention, not a goal.
  3. Maintaining a patient on bedrest is a planned intervention, not a goal.
- 29. A restraint strap should always be tied with a quick-release knot to the frame of the bed. Tying a restraint strap to the side rail is contraindicated because when the side rail is lowered it may become too tight, causing an injury.**



- 30. 1. The use of powder should be avoided because it is a respiratory irritant.**
- 2. Patient safety is a priority. A bedpan is not a stable base of support, and the effort of elimination may require movements that alter balance. Side rails provide a solid object to hold while balancing on the bedpan and supply a barrier to prevent falling out of bed.**
3. The rounded rim of a bedpan should be placed under the patient's buttocks, not toward the front of the patient.
  4. Encouraging the patient to help promotes the patient's independence and limits strain on the nurse.
  5. The semi-Fowler position is comfortable and provides a more normal position for defecation that helps prevent straining.
- 31. 1. Pulling the fire alarm ensures that appropriate hospital personnel and the fire department are notified of the fire. Trained individuals will arrive to contain and extinguish the fire and help move patients if necessary. The RACE model should be followed in a**

- fire emergency: rescue, alarm, confine, and extinguish).
3. Closing the door to the dirty utility room protects the patients and staff members in the immediate vicinity of the fire.
  2. Closing unit doors and windows provides a barrier between the patients and the fire and limits drafts that could exacerbate the fire.
  4. Patients should be supported emotionally during a crisis because anxiety can be contagious.
32. 1. Retention of food in the oral cavity indicates that the patient is not swallowing ingested food completely. Food collects in the buccal cavity because the area between the teeth and cheek forms a pocket that traps food.
2. Abdominal cramping is related to problems such as flatus, malabsorption, and increased intestinal motility, not difficulty swallowing.
  3. Epigastric pain is related to problems such as gastritis, cholecystitis, and angina, not difficulty swallowing.
  4. Slurred speech reflects an inability of the tongue and muscles of the face to form words. Dysfunction of the muscles of the face and tongue will interfere with the ability to chew and swallow food.
  5. Constipation is not related to difficulty swallowing.
  6. Drooling indicates that oral secretions are accumulating in the mouth. This may occur when a person has difficulty swallowing.
33. 1. This intervention should be performed immediately after the priority intervention. Patients with latex allergies require special precautions to be taken in the operating suite. The use of latex products can be life-threatening for the patient if appropriate precautions are not taken. All equipment, such as gloves and tubes, must be latex free to protect the patient from experiencing an allergy that can progress to anaphylaxis.
2. Protecting the patient is the priority, and a red allergy band is the first line of defense. In addition, the patient's allergies must be included on other designated places on the patient's medical record.
3. Although the patient's vital signs are on the high side of normal or slightly elevated, their elevations probably are related to the patient's anxiety. These elevations should be documented and reported but they are not the priority at this time. Normal ranges for vital signs include: temperature, 98.6 F to 99.8 F; pulse, 60 to 100 beats per minute; respirations, 12 to 20 breaths per minute; blood pressure: systolic pressure, 90 to 120 mm Hg, and diastolic pressure 60 to 80 mm Hg.
  4. Although this should be done, this is not the priority at this time. Mild to moderate anxiety is a common response when anticipating surgery, especially when being experienced for the first time. The patient's anxiety should be documented and communicated to other members of the health team, but it is not the priority at this time. However, when a patient has a sense of impending doom, the surgeon should be notified immediately because the patient may not be in the right frame of mind for surgery; if surgery is performed, it can be a self-fulfilling prophesy.
34. 1. This statement is not true. Injuries and falls can occur if restraints are not applied appropriately. In addition, research indicates that patients incur less severe injuries if they are left unrestrained.
2. The reason for the use of restraints must adhere to standards of care and be documented on the patient's clinical record to create a legal document that protects the patient as well as health-care providers.
  3. The opposite is true. Patients resist the use of restraints and usually are mentally or emotionally incompetent to understand their necessity or benefits.
  4. Restraints can be applied by nurses in emergencies without a primary health-care provider order to protect patients from harming themselves or others. Restraints can be used for nonviolent patients who are at risk for harming themselves (level 1 restraint) or violent patients who are at risk for harming themselves or others (level 2 restraint). A primary health-care provider must assess the patient and document the need for the original application of the restraint and its

continued use within specified time frames. For example, for a level 1 restraint, a primary health-care provider's order must be obtained within 12 hours after its application and daily thereafter, whereas for a level 2 restraint, a primary health-care provider must evaluate the patient within 1 hour after its application and every 4 hours thereafter.

- 5. Federal and state laws provide specific guidelines regarding patients' rights and responsibilities of caregivers associated with the use of restraints. In addition, The Joint Commission has specific guidelines that require documentation of: previous restraint-free interventions that have failed to protect the patient; a description of the situation indicating a need for the restraint; the least restrictive restraint that has been selected; and assessments and orders by a primary health-care provider within specified time frames.**

- 35.** 1. A nurse stands in front of a patient when transferring the patient from a bed to a wheelchair.
2. Abdominal breathing is best taught when the nurse demonstrates placement of the hands on one's own abdomen. The nurse teaches the patient to contract and relax the diaphragm when inhaling and exhaling. With the patient's hands resting on his or her own abdomen, the abdomen will rise on inspiration and relax on exhalation when abdominal breathing is implemented correctly.
- 3. This is an illustration of the abdominal thrust maneuver (Heimlich maneuver) used to dislodge a foreign object from a person's airway. An abdominal thrust applies pressure up against the diaphragm that forces air out the lungs, exerting pressure behind the obstruction, thus dislodging the foreign object from the airway.**
4. When a patient becomes dizzy and begins to fall, the nurse should not try to keep the patient in the standing position because this can cause injury to the patient and/or nurse. The nurse should project one hip forward and with a wide base of support guide the patient down along that leg until the patient reaches the floor. Once the patient is on the floor, the nurse protects the patient's head to prevent a head injury.
- 36.** 1. A mummy restraint usually is used to immobilize an infant or very young child during a procedure.
- 2. A soft limb splint that extends from the mid-forearm to the mid-upper arm can be applied to inhibit flexion of the elbow, which can prevent the pulling out of tubes.**
3. A jacket restraint usually is used to keep a person from falling out of bed while not immobilizing the extremities.
- 4. A wrist restraint encircles the wrist and has ties that are secured with a slipknot to the bed frame so that a patient is unable to reach tubes.**
- 5. A mitt restraint covers the hand to prevent the fingers from grasping and pulling out tubes.**
- 37.** 4. The first step involves asking the patient to sit in a chair. This allows the nurse time to observe the patient's posture while sitting in a straight-backed chair before any other activity.
- 5. The second step involves asking the patient to stand. This allows the nurse to observe the patient's use of the leg muscles to stand or whether the patient has to push up and off the seat with the hands to stand. This helps to assess leg strength when moving to a standing position.**
- 2. The third step involves asking the patient to close the eyes. This allows the nurse to observe if the patient sways to maintain balance when the eyes are closed.**
- 3. The fourth step involves asking the patient open the eyes. This prepares the patient for the next step in the procedure.**
- 1. The fifth step involves asking the patient to walk 10 feet, turn around, and return to the chair. This allows the nurse to observe the patient's gait, posture, stability, pace, and balance when ambulating.**
- 38.** 1. **Keeping a bed lower than a stretcher when transferring a patient from the stretcher to a bed uses gravity, which places less stress and strain on both the patient and nurses.**
2. It is too difficult and unsafe to maneuver a stretcher with the nonswivel wheels on the leading end of the stretcher. The end of

the stretcher with the patient's head does not have swivel wheels.

3. The swivel-wheeled end of the stretcher should be the leading end of the stretcher, and it is unsafe to lead with the patient's head. In addition, the end of the stretcher with the swivel wheels moves through greater arcs; this can cause dizziness. The swivel wheels of a stretcher should be at the end under the patient's feet, not the head.
4. This is unsafe and places the patient in physical jeopardy. The elevator doors may inadvertently close by the patient's head while the nurse is pulling the feet end of the stretcher into the elevator. The patient should be moved into an elevator head, not feet, first.
5. **A stretcher should always be pushed, not pulled, so that the transporter stays at the patient's head for protection. The swivel wheels must be under the patient's feet on the leading end of the stretcher for safe maneuverability.**

39. 1. The risk for aspiration in a patient with bulimia occurs after, not during, meals. Bulimia is characterized by episodes of binge eating followed by purging, depression, and self-deprecation.
2. **When a person is sleepy, sluggish, or stuporous (lethargic), there may be a reduced level of consciousness and diminished reflexes, including the gag and swallowing reflexes. This condition can result in aspiration of food or fluids that can compromise the person's airway and respiratory status.**
3. A lack of appetite (anorexia) is unrelated to aspiration. The less food or fluid that is placed in the mouth, the less the risk is for aspiration.
4. **An inflammation of the mucous membranes of the mouth (stomatitis) may result in dysphagia and increase the risk of aspiration.**

**5. Dysphasia, difficulty swallowing, places a patient at risk for aspiration generally because of impaired innervation of the tongue and muscles used for swallowing.**

40. 1. This is a single-ended cane with a half circle handle. It is used by patients who can navigate stairs and need minimal support.
2. This is a single-ended cane with a straight handle. It is used by patients who need minimal support but have hand weakness.
3. **This is a quad cane and is the most appropriate cane to meet this patient's needs. It has four prongs that provide a wide base of support and it has a straight handle. It is used by patients with moderate balance problems.**
4. This is a Lofstrand (forearm support) crutch, not a cane. It is used by patients who need to limit or eliminate weight-bearing on a lower extremity. The patient relies on the strength in the arms and shoulders when walking. The Lofstrand crutch supports the wrist, thus making walking safer.



# Medication Administration

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Air-lock (air-bubble) technique

Bevel

Bolus

Canthus, inner/outer

Diluent

Drug levels:

Therapeutic

Peak

Toxic

Trough

Filtered needle

Five Rights:

Right patient

Right medication

Right route

Right dose

Right frequency

Gauge

Injection sites:

Abdomen

Deltoid

Dorsogluteal

“Love handles”

Rectus femoris

Vastus lateralis

Ventrogluteal

Instillation

Interaction:

Drug

Food

Medication-dispensing systems

Medication prescriptions:

prn orders

Single orders

Standing orders

STAT orders

Stop orders

Telephone orders

Metered-dose inhaler

Over-the-counter drugs (OTCs)

Parenteral

Reconstitution

Routes of administration:

Buccal

Ear (otic)

Epidural

Eye (ophthalmic)

Intradermal

Intramuscular

Intrathecal

Intravenous:

Intravenous piggyback infusion (IVPB), intermittent infusion

IV push

Nasal cavity

Rectal

Subcutaneous

Sublingual

Topical

Transdermal

Urinary bladder

Vaginal

Substance abuse

Systemic/local effects

Titrate

Troche

Tuberculin syringe

Unit-dose system

Z-track

F.A. DAVIS



COMPANY

## MEDICATION ADMINISTRATION: QUESTIONS

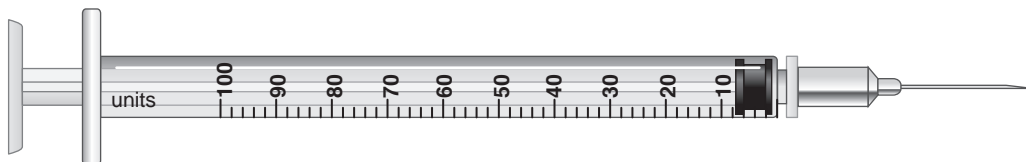
1. A nurse instructs a patient to close the eyes after the administration of eye drops. Which rationale for this instruction should the nurse explain to the patient?
  1. Limits corneal irritation
  2. Squeezes excess medication from the eyes
  3. Disperses the medication over the eyeballs
  4. Prevents medication from entering the lacrimal duct
2. How often should “docusate sodium 100 mg PO bid” be given?
  1. Three times a day
  2. Two times a day
  3. Every other day
  4. At bedtime
3. A nurse is preparing to reconstitute a medication in a multiple-dose vial. Which is the **most** essential step in the preparation of this medication?
  1. Instilling an accurate amount of diluent into the vial
  2. Using a filtered needle when drawing up the medication from the vial
  3. Instilling air into the vial before withdrawing the reconstituted solution
  4. Wiping the rubber seal of the vial with alcohol before and after each needle insertion
4. Which characteristic is associated with a subcutaneous injection of 5,000 units of heparin?
  1. 3-mL syringe
  2. 22-gauge needle
  3. 1½-inch needle length
  4. 90-degree angle of insertion
5. A home-care nurse observes the spouse of a patient inserting a rectal suppository. Which behavior indicates that the nurse must provide further teaching about suppository administration?
  1. Lubricates the tip of the suppository
  2. Inserts the suppository while wearing a glove
  3. Inserts the suppository while the patient bears down
  4. Places the suppository a finger length into the rectum
6. A primary health-care provider prescribes a medication that must be administered via the intramuscular route. Which site should the nurse eliminate from consideration because it has the **highest** potential for injury when administering an intramuscular injection?
  1. Vastus lateralis
  2. Rectus femoris
  3. Ventrogluteal
  4. Dorsogluteal
7. Which information about a parenteral medication indicates that the nurse should use a filtered needle when preparing the medication?
  1. Has to be reconstituted
  2. Is supplied in an ampule
  3. Appears cloudy in the vial
  4. Is to be mixed with another medication
8. Which should the nurse use when administering a subcutaneous injection?
  1. 5-mL syringe
  2. 25-gauge needle
  3. Tuberculin syringe
  4. 1½-inch-long needle

9. When the nurse brings pills to a patient, the patient is unable to hold the paper cup with the medications. Which should the nurse do?
  1. Crush the pills and mix them with applesauce.
  2. Use the paper cup to introduce the pills into the patient's mouth.
  3. Have the primary health-care provider prescribe the liquid form of the drug.
  4. Put the pills into the patient's hand and have the patient self-administer the pills.
10. Which route is inappropriate for a topical medication?
  1. Intradermal
  2. Bladder
  3. Rectum
  4. Vagina
11. A nurse holds a bottle with the label next to the palm of the hand when pouring a liquid medication. Which is the rationale for this action?
  1. Prevent soiling of the label by spilled liquid.
  2. Conceal the label from the curiosity of others.
  3. Ensure accuracy of the measurement of the dose.
  4. Guarantee the label is read before pouring the liquid.
12. A primary health-care provider prescribes a medicated powder to be applied to a patient's lower leg. Which is **most** essential for the nurse to do when applying the medicated powder?
  1. Apply a thin layer in the direction of hair growth.
  2. Protect the patient's face with a towel.
  3. Dress the area with dry sterile gauze.
  4. Ensure that the skin surface is dry.
13. A nurse must administer a medication that is supplied in an ampule. Which should the nurse do **first** to access the ampule?
  1. Inject the same amount of air as the fluid to be removed.
  2. Wipe the constricted neck with an alcohol swab.
  3. Break the constricted neck using a barrier.
  4. Insert the needle into the rubber seal.
14. A nurse must administer a medication into the ear of an adult. Which should the nurse do to limit patient discomfort when administering ear drops?
  1. Warm the solution to body temperature.
  2. Place the patient in a comfortable position.
  3. Pull the pinna of the ear upward and backward.
  4. Instill the fluid in the center of the auditory canal.
15. A nurse instructs a patient to inhale deeply and hold each breath for a second when using a hand-held nebulizer. The patient asks, "Why do I have to hold my breath?" Which information should the nurse include in the response to the patient's question?
  1. "It prolongs treatment."
  2. "It limits hyperventilation."
  3. "It disperses the medication."
  4. "It prevents bronchial spasms."
16. Which abbreviation indicates that the primary health-care provider wants a medication administered before meals?
  1. pc
  2. OD
  3. PO
  4. ac

17. A home-care nurse is helping a patient with short-term memory loss with how to remember to take multiple drugs throughout the day. Which should the nurse do when teaching this patient?
  1. Suggest that the patient wear a watch with an alarm.
  2. Ask a family member to call the patient when medications are to be taken.
  3. Design a chart of the medications the patient takes each day during the week.
  4. Instruct the patient to put medications in a weekly organizational pill container.
18. Which action should be implemented by the nurse when a medication is delivered by the Z-track method?
  1. Use a special syringe designed for Z track injections.
  2. Pull the skin laterally away from the injection site before inserting the needle.
  3. Administer the injection in the muscle on the anterolateral aspect of the thigh.
  4. Insert the needle in a separate spot for each dose on a Z shaped grid on the abdomen.
19. A nurse must reconstitute a powdered medication. Which action should the nurse implement?
  1. Keep the needle below the initial fluid level as the rest of the fluid is injected.
  2. Instill the solvent that is consistent with the manufacturer's directions.
  3. Score the neck of the ampule before breaking it.
  4. Shake the vial to dissolve the powder.
20. A nurse is preparing to administer a tablet to a patient. When should the nurse remove the medication from its unit dose package?
  1. Outside the door to the patient's room
  2. At the patient's bedside
  3. In the medication room
  4. At the medication cart
21. Which nursing action is appropriate when administering an analgesic?
  1. Reassess drug effectiveness every eight hours.
  2. Follow the prescription exactly for the first twenty-four hours.
  3. Seek a new prescription after two doses that do not achieve a tolerable level of relief.
  4. Ask the primary health-care provider to prescribe another medication for breakthrough pain.
22. The primary health-care provider prescribes a troche. In which part of the body should the nurse administer the troche?
  1. Ear
  2. Eye
  3. Mouth
  4. Rectum
23. A nurse teaches a patient about taking a sublingual nitroglycerin tablet. Which part of the body identified by the patient indicates that the patient understands the teaching?
  1. "On my skin."
  2. "Inside my cheek."
  3. "Under my tongue."
  4. "In my eye on the lower lid."
24. A nurse plans to administer a bolus dose of a medication via a currently running intravenous infusion. Which should the nurse do **first**?
  1. Use a volume-control infusion set with microdrip tubing.
  2. Ensure that it is compatible with the IV solution being infused.
  3. Pinch the tubing above the infusion port while instilling the bolus.
  4. Instill it into a 50-mL bag of normal saline and infuse it via a secondary line.



25. A nurse is administering an intradermal injection. At which angle should the nurse insert the needle?
1. 90-degree angle
  2. 45-degree angle
  3. 30-degree angle
  4. 15-degree angle
26. A nurse plans to administer a 3-mL intramuscular injection. Which muscle is the **least** desirable to use for the administration of this medication?
1. Deltoid
  2. Dorsogluteal
  3. Ventrogluteal
  4. Vastus lateralis
27. A nurse is preparing to administer a subcutaneous injection of insulin. Which site should the nurse use to **best** promote its absorption?
1. Upper lateral arms
  2. Anterior thighs
  3. Upper chest
  4. Abdomen
28. Which should a nurse use when placing a cream into a patient's vaginal canal?
1. A finger
  2. A gauze pad
  3. An applicator
  4. An irrigation kit
29. A primary health-care provider prescribes a medication that must be administered transdermally. Which information about the route of administration does the nurse understand is related to a drug prescribed to be administered transdermally?
1. Inhaled into the respiratory tract
  2. Dissolved under the tongue
  3. Absorbed through the skin
  4. Inserted into the rectum
30. Which should the nurse do to limit discomfort when administering an injection to an adult?
1. Pull back on the plunger before injecting the medication.
  2. Apply ice to the area before the injection.
  3. Pinch the area while inserting the needle.
  4. Inject the medication slowly.
31. A nurse is preparing to draw up medication from a vial. Which action should the nurse implement **first**?
1. Ensure that the needle is firmly attached to the syringe.
  2. Rub vigorously back and forth over the rubber cap with an alcohol swab.
  3. Inject air into the vial with the needle bevel below the surface of the medication.
  4. Draw up slightly more air than the volume of medication to be withdrawn from the vial.
32. A primary health-care provider prescribes 18 units of regular insulin and 26 units of NPH insulin to be given at 0730 a.m. in the same syringe. Indicate on the syringe, by shading in the appropriate area, how many total units of regular and NPH insulin are to be drawn into the syringe.



33. A primary health-care provider prescribes a topical medication to be administered to a patient with an area of excoriated skin. Place the following steps in the order in which they should be implemented.

1. Don clean gloves.
2. Evaluate the results of the lotion on the skin.
3. Warm the tube of medication before application.
4. Cleanse the skin gently with soap and water and pat dry.
5. Don sterile gloves and apply a thin layer of lotion to the desired area.

Answer: \_\_\_\_\_

34. The instructions with a medication states to use the Z track method. Which actions should the nurse implement that are specific to this procedure? **Select all that apply.**

1.  P inch the site throughout the procedure.
2.  Massage the site after the needle is removed.
3.  Add 0.3 to 0.5 mL of air after drawing up the correct dosage.
4.  Remove the needle immediately after the medication is injected.
5.  Change the needle after the medication is drawn into the syringe.

35. A health-care provider prescribes benztropine 1.5 mg PO STAT. Benztropine is available in 0.5 mg scored tablets. How many tablets should the nurse administer?

**Record your answer using a whole number.**

Answer: \_\_\_\_\_ tablets.

36. Which routes are **unrelated** to the parenteral administration of medications? **Select all that apply.**

1.  Buccal
2.  Z track
3.  Sublingual
4.  Intravenous
5.  Intradermal

37. Which interventions are uniquely related to the administration of an intradermal injection? **Select all that apply.**

1.  Using the air-bubble technique
2.  Circling the injection site with a pen
3.  Pinching the skin during needle insertion
4.  Inserting the needle with the bevel upward
5.  Massaging the area after the fluid is instilled

38. A primary health-care provider prescribes an intravenous antibiotic to be administered 4 times a day. The patient has a primary infusion of 0.9% sodium chloride infusing. The medication is compatible with the sodium chloride. Place an X over the port that should be used when administering this drug as an IVPB infusion.



39. A nurse is assessing a patient to determine if it is appropriate to administer a prescribed medication via the oral route. Which information indicates that the nurse should ask the primary health-care provider for a change in route? **Select all that apply.**

1.  Nausea
2.  Unconsciousness
3.  Gastric suctioning
4.  Emergency situation
5.  Difficulty swallowing

40. A primary health-care provider prescribes a medication via a transdermal patch. Place the following steps in the order in which they should be implemented when administering this medication.
1. Remove the previous patch.
  2. Contain and dispose of the used patch.
  3. Wear clean gloves throughout the procedure.
  4. Write the date, time, and your initials on the patch.
  5. Apply a new patch to a different section of the skin.
  6. Wash and dry the skin after removal of the used patch.
- Answer: \_\_\_\_\_
41. A primary health-care provider prescribes an oral medication for a patient. The nurse identifies that the patient is having some difficulty swallowing. What should the nurse plan to do? **Select all that apply.**
1.  Crush tablets that are crushable and mix with a small amount of applesauce.
  2.  Have the patient hyperextend the neck slightly when swallowing.
  3.  Give water before, during, and after medication administration.
  4.  Stroke under the chin over the larynx.
  5.  Have the patient use a straw.
42. The primary health-care provider prescribes 500 mL of D<sub>5</sub>W with 10 mEq of KCl to be administered over 10 hours. The intravenous tubing states that each mL delivers 60 gtts. At what rate per minute should the nurse adjust the flow rate of the intravenous solution? **Record your answer using a whole number.**
- Answer: \_\_\_\_\_gtts/min
43. A primary health-care provider prescribes nose drops to be administered twice a day. Which should the nurse do when instilling the nose drops? **Select all that apply.**
1.  Tell the patient not to sniff the medication once administered.
  2.  Place the patient in the supine position with the head tilted backward.
  3.  Pinch the nares of the nose together briefly after the drops are instilled.
  4.  Instruct the patient to blow the nose 5 minutes after the drops are instilled.
  5.  Insert the drop applicator ½ inch into the nose toward the base of the nasal cavity.
44. Which routes are associated with the administration of a suppository? **Select all that apply.**
1.  Ear
  2.  Nose
  3.  Mouth
  4.  Vagina
  5.  Rectum
45. A primary health-care provider prescribes a monthly intramuscular injection of fluphenazine 37.5 mg. The medication is available as 25 mg/mL. How much solution of fluphenazine should the nurse administer? **Record your answer using one decimal place.**
- Answer: \_\_\_\_\_mL.
46. A nurse is to administer an eye irrigation to a patient's right eye. Which should the nurse do? **Select all that apply.**
1.  Direct the flow of solution from the inner to the outer canthus.
  2.  Irrigate with a bulb syringe held several inches above the eye.
  3.  Expose the conjunctival sac and hold open the upper lid.
  4.  Don sterile gloves before beginning the procedure.
  5.  Position the patient in a right lateral position.

47. A primary health-care provider prescribes medicated ear drops for a patient. Place the following steps in the order in which they should be implemented after cleaning the patient's ear.
1. Release the pinna and gently press on the tragus several times.
  2. Pull up and back on the cartilaginous part of the pinna gently.
  3. Place the drops on the side of the ear canal without touching the canal with the dropper.
  4. Position the patient in the side-lying position with the affected ear facing toward the ceiling.
  5. Warm the refrigerated ear drops to room temperature by holding the container in the palm of a hand for several minutes.

Answer: \_\_\_\_\_

48. A primary health-care provider prescribes a rectal suppository for an adult patient. Which actions should the nurse implement when administering the rectal suppository? **Select all that apply.**
1.  Lubricate the medication before insertion.
  2.  Warm the medication equal to body temperature.
  3.  Instruct the patient to take deep breaths through the mouth.
  4.  Insert the medication just inside the rectum's external sphincter.
  5.  Place the patient in the prone position to administer the medication.

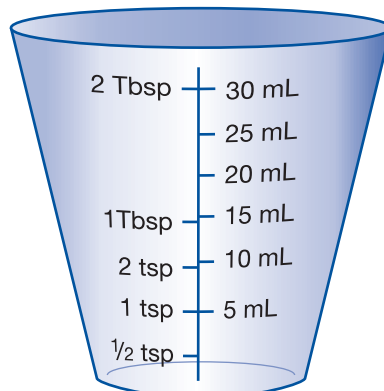
49. A primary health-care provider orders an IV infusion of 1,000 mL 0.9% sodium chloride to be followed by 1,000 mL D<sub>5</sub>W with 20 mEq of potassium chloride. The infusion is to be administered at 125 mL/hour. The drop factor of the IV tubing states 10 drops/mL. At how many drops per minute should the nurse set the IV infusion? **Record your answer using a whole number.**

Answer: \_\_\_\_\_gtts/min

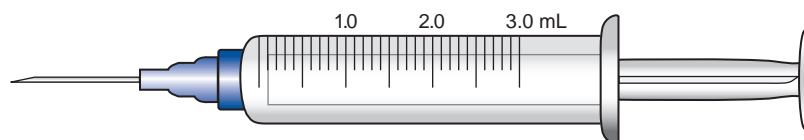
50. A primary health-care provider prescribes a liquid medication that has an unpleasant taste for a school-aged child. What should the nurse do to facilitate administration of this medication? **Select all that apply.**

1.  Mix it with the child's favorite food.
2.  Teach that the taste only lasts a short time.
3.  Give an ice pop just before giving the medication.
4.  Have a parent administer the medication if present.
5.  Offer the child the choice of a spoon, needleless syringe, or dropper.

51. A primary health-care provider prescribes acetaminophen 320 mg PO every 6 hours prn for pain for a 12-year-old child. The child has difficulty swallowing pills and the nurse obtains a liquid form of the drug. The bottle of acetaminophen states that there are 160 mg/5 mL. Put an X at the point on the graduated medicine cup that indicates how much solution of acetaminophen should be administered.



52. A nurse is interviewing a newly admitted patient in the process of completing a nursing admission history and physical. Which information should be included in a medication reconciliation form? **Select all that apply.**
- Vitamins
  - Drug allergies
  - Food supplements
  - Over-the-counter herbs
  - Prescribed medications
53. Which equipment and technique should the nurse use to administer most intramuscular injections? **Select all that apply.**
- Use a 1-inch needle.
  - Use a 25-gauge needle.
  - Insert the needle at a 45-degree angle.
  - Aspirate before instilling the medication.
  - Massage the insertion site after needle removal.
54. A primary health-care provider prescribes a vaginal suppository for a patient. The nurse obtains the suppository, pulls the curtain around the patient's bed, encourages the patient to void, provides perineal care, and then dons a new pair of clean gloves. Place the following steps in the order in which they should now progress to complete the administration of the vaginal suppository.
- Drape the patient exposing only the vaginal area.
  - Position the patient in the dorsal recumbent position.
  - Encourage the patient to remain in the supine position for 10 to 20 minutes.
  - Lubricate the suppository and the nurse's index finger with a water-soluble jelly.
  - Insert the suppository downward and backward using the full length of the index finger.
- Answer: \_\_\_\_\_
55. A primary health-care provider prescribes a liquid oral medication for a patient. Which actions should the nurse implement when administering this medication? **Select all that apply.**
- Vigorously shake the liquid before pouring a dose.
  - Measure oral liquids in a calibrated medication cup at eye level.
  - Pour liquids with the label facing away from the palm of the hand.
  - Place an opened top of a container on a surface with the inside lid facing up.
  - Use a needleless syringe to measure an oral liquid less than 5 mL and transfer it to a medication cup.
56. A patient in the emergency department becomes agitated, and limit setting by the nurse is ineffective. The patient's behavior escalates, and the patient attempts to punch the nurse. The primary health-care provider prescribes a STAT dose of haloperidol 2.5 mg IM. The haloperidol available states that there is 5 mg/mL. Indicate on the syringe, by shading in the appropriate area, how much solution of haloperidol should be administered.



57. A primary health-care provider prescribes an oral medication for a patient with a nasogastric tube on low continuous suction. Which actions should the nurse implement when administering this medication? **Select all that apply.**
- Give each medication separately.
  - Follow medication administration with 100 mL of free water.
  - Crush crushable tablets into a fine powder and mix with 30 mL of warm water.
  - Shut off nasogastric tube suctioning for 30 minutes after medication administration.
  - Ensure nasogastric tube placement by instilling 30 mL of air while auscultating over the epigastric area for a “whooshing” sound.
58. An older adult is transported via ambulance to the emergency department of the hospital after being found unconscious on the living room floor by a family member. The patient regains consciousness and tells the nurse that everything went blank after standing up abruptly from a lounge chair. The patient is diagnosed with dehydration and is admitted for observation and rehydration therapy. The nurse performs a routine patient assessment 18 hours after initiation of the IV therapy. What should the nurse do **first** after reviewing the patient’s clinical record and assessing the patient?
- Administer oxygen via a nasal cannula.
  - Slow the rate of the intravenous fluid infusion.
  - Elevate the head of the bed to the semi-Fowler position.
  - Notify the primary health-care provider of the patient’s status.

### PATIENT’S CLINICAL RECORD

#### Vital Signs on Admission

Temperature: 99.6°F

Pulse: 96 beats per minute

Respirations: 22 breaths per minute, regular rhythm

Blood pressure: 100/60 mm Hg

#### Primary Health-Care Provider Orders

IVF: 0.9% sodium chloride at 125 mL/hour for 24 hours

Docusate sodium 100 mg PO once a day

#### Nurse’s Physical Assessment of the Patient

Temperature: 99.8°F

Pulse: 112 beats per minute

Respirations: 26 breaths per minute, labored

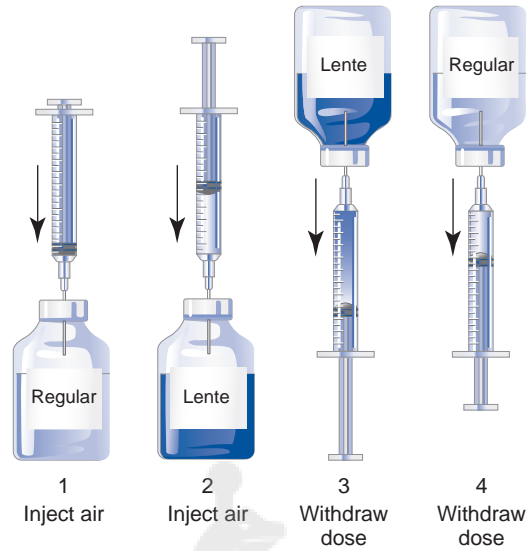
Blood pressure: 150/98 mm Hg

Breath sounds: Fine rales at base of lungs

59. A primary health-care provider orders a unit of packed red blood cells for a patient with a low hemoglobin level. Which actions should be implemented by the nurse when administering this transfusion? **Select all that apply.**
- Adjust the flow rate to 20 drops per minute for the first 15 minutes.
  - After 15 minutes with no reaction, assess the vital signs every 45 minutes.
  - Administer 100 mL of 0.9% sodium chloride before administering the transfusion.
  - Discontinue the blood transfusion if it extends beyond 4 hours after its initiation.
  - Stay with the patient for 15 minutes after initiating the blood transfusion while taking vital signs every 5 minutes.

60. A primary health-care provider orders NPH and regular insulin to be administered to a patient with diabetes. Place the following illustrations in the order in which they should be implemented when mixing NPH and regular insulin in the same syringe.

Answer: \_\_\_\_\_



F.A. DAVIS

COMPANY

## MEDICATION ADMINISTRATION: ANSWERS AND RATIONALES

1. Instilling medication into the conjunctival sac prevents the trauma of drops falling on the cornea.
  2. Closing the eyes gently, rather than squeezing the lids shut, prevents the loss of medication from the conjunctival sac.
  - 3. Closing the eyes moves the medication over the conjunctiva and eyeball and helps ensure an even distribution of medication.**
  4. Gentle pressure over the inner canthus for 1 minute after administration prevents medication from entering the lacrimal duct.
1. The abbreviation for three times a day is tid (ter in die).
  - 2. The abbreviation bid (bis in die) represents twice a day.**
  3. Bid does not mean every other day. Every other day must be written out. The abbreviation for every other day QOD (quaque altera die) should not be used.
  4. Bid does not mean at bedtime. Formerly the abbreviation for bedtime (hour of sleep) was hs (hora somni); however, The Joint Commission disallows the use of the abbreviation of hs because of the frequency of errors with its use.
- 1. The required amount of diluent must be followed exactly in a multiple-dose formulation to ensure accurate dosage preparation. The diluent for a single-dose formulation also must be exact so that the medication is diluted enough not to injure body tissues.**
  2. A filtered needle should be used when drawing up fluid from an ampule, not a vial. A filter prevents shards of glass from entering the syringe.
  3. Although this is an advisable practice, it is not as important as administering an accurate dose.
  4. The rubber seal must be wiped with alcohol before, not after, needle insertion.
1. Most doses of heparin are less than 1 mL. Three milliliters of heparin is excessive and may result in bleeding.
  2. A 22-gauge needle is too large and can cause unnecessary trauma and bleeding at the insertion site. A 25- or 26-gauge needle is adequate.
  3. A 1½-inch length needle is unnecessarily long and may enter a muscle rather than subcutaneous tissue.
  - 4. A ½-inch-length needle inserted at a 90-degree angle will ensure that the heparin is inserted into subcutaneous tissue.**
1. Lubrication is required to limit tissue trauma and ease insertion.
  2. Standard precautions should be employed when there is exposure to patients' body fluids.
  - 3. Bearing down increases intra-abdominal pressure, which impedes the insertion of the suppository. The patient should be instructed to relax and breathe deeply and slowly while the suppository is inserted.**
  4. In an adult, a suppository should be inserted 4 inches to ensure it is beyond the internal sphincter.
1. The vastus lateralis site is not near large nerves or blood vessels, and the muscle does not lie over a joint. It is a preferred site for infants 7 months of age and younger.
  2. The rectus femoris site is not near major nerves, blood vessels, or bones. It is a preferred site for adults.
  3. The ventrogluteal site is not near large nerves or blood vessels. It is a preferred site in adults and children.
  - 4. The dorsogluteal site has the highest risk for injury because of the close proximity of the sciatic nerve, blood vessels, and bone.**
1. Reconstitution occurs within a closed vial and does not require a filtered needle.
  - 2. The top of an ampule must be snapped off at its neck to access the fluid. A filtered needle prevents glass particles from being drawn into the syringe.**
  3. The majority of medications in vials are clear solutions. Cloudy fluid usually indicates contamination. Additional information from a drug guide or pharmacist is necessary to determine if the cloudiness is an expected characteristic of the drug or it indicates contamination.
  4. It is not necessary to use a filtered needle when mixing medications.



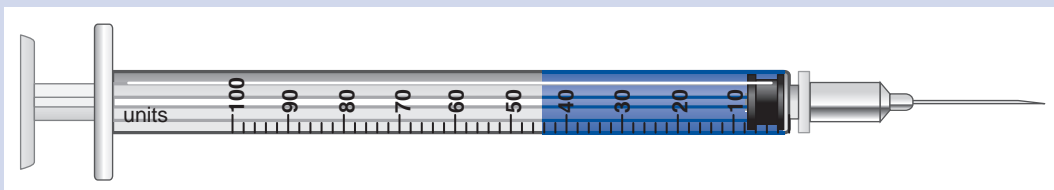
8. 1. A subcutaneous injection should not exceed 1 mL. A 3-mL, not a 5-mL, syringe is acceptable for a subcutaneous injection.
2. **A subcutaneous injection should use a 25- to 29-gauge needle, which minimizes tissue trauma. The diameter of a needle is referred to as its gauge, which ranges from 28 (small) to 14 (large).**
3. The volume of a tuberculin syringe is only 1 mL. For most subcutaneous injections, a syringe that can accommodate up to 3 mL is preferred to facilitate handling of the syringe.
4. A 1½-inch length is appropriate for an intramuscular, not subcutaneous, injection.
9. 1. Mixing medication with applesauce is done if the patient has dysphagia.
2. **The patient needs assistance. Keeping medication in the cup, rather than touching it with the hands, maintains medical asepsis.**
3. It is not necessary to obtain an order for the liquid form of the medication. An order is required if a route other than oral is necessary.
4. This action is unrealistic and unsafe. The patient has demonstrated the need for assistance.
10. 1. **An intradermal injection is inserted below, not on top of, the epidermis.**
2. Medications in the form of solutions can be instilled into the bladder. They are designed to work locally and are considered topical medications.
3. Medications in the form of a suppository can be inserted into the rectum and are considered topical medications. Most are designed to work locally, although some are absorbed systemically.
4. Medications in the form of a suppository, tablet, cream, foam, or jelly can be instilled into the vagina. They are designed to work locally and are considered topical medications.
11. 1. **Liquid medication may drip down the side of the bottle and soil the label, which may interfere with the ability to read the label accurately.**
2. Although patient confidentiality should always be maintained, this is not the reason for holding the label toward the palm of the hand.
3. Accuracy of the dose is ensured by using a calibrated cup and measuring the liquid at the base of the meniscus while positioning the cup at eye level.
4. The label should be read before holding it against the palm of the hand.
12. 1. This action is done with lotions, creams, or ointments.
2. It is unnecessary to protect the patient's face. When the powder is sprinkled gently on the site, the powder should not become aerosolized.
3. A dressing is not a universal requirement. When necessary, a dressing is applied with a primary health-care provider's order.
4. **Moisture harbors microorganisms and when mixed with a powder will result in a paste-like substance. The site should be clean and dry before medication administration to ensure effective action of the drug.**
13. 1. Injecting air is done with a vial, not an ampule.
2. The rubber seal of a vial, not the neck of an ampule, should be wiped with alcohol.
3. **A barrier, such as a commercially manufactured ampule opener, gauze, or an alcohol swab, should be used to protect the hands from broken glass.**
4. Piercing a rubber seal is done with a vial, not an ampule.
14. 1. **Instilling cold medication into the ear canal is uncomfortable and can cause vertigo and nausea. Holding the bottle of medication in the hand for several minutes warms the solution to body temperature.**
2. The side-lying position with the involved ear upward must be maintained for 2 to 3 minutes while the instilled medication disperses throughout the ear canal.
3. These actions straighten the ear canal and facilitate the flow of medication toward the eardrum in an adult; it does not limit discomfort.
4. This action is contraindicated because the force of the fluid may injure the eardrum. The drops should be directed along the side of the ear canal.
15. 1. There is no advantage in prolonging the treatment.
2. Slow, deep breathing will limit hyperventilation.
3. **A pause at the height of inspiration will promote distribution and absorption of the medication before exhalation begins.**

4. Slow inhalations and exhalations with pursed lips help prevent bronchial spasms.
16.
    1. The abbreviation for after meals is pc (post cibum).
    2. The abbreviation for right eye is OD. However, this abbreviation should be spelled out because there is confusion among the following abbreviations: right eye—OD (oculus dexter), left eye—OS (oculus sinister), and both eyes—OU (oculus utro).
    3. The abbreviation for by mouth is PO (per os).
    4. **The abbreviation for before meals is ac (ante cibum).**
  17.
    1. This suggestion is unrealistic. When the alarm goes off, the patient may not remember why it is ringing.
    2. This suggestion is unrealistic and puts an excessive burden on family members.
    3. A chart is unrealistic. The chart may be complex, confusing, and require repeated cognitive decisions throughout the day that may be beyond the patient's ability.
    4. **Pill distribution can be set up once a week. After the medication is taken, the empty section reminds the patient that the medication was taken, which prevents excessive doses. This is a major issue for patients with short-term memory loss.**
  18.
    1. A special syringe is not needed for administering a medication via Z track. The barrel of the syringe must be large enough to accommodate the volume of solution to be injected (usually 1 to 3 mL) and the needle long enough to enter a muscle (usually 1½ inches).
    2. **This action creates a zigzag track through the various tissue layers. The track prevents backflow of medication up the needle track when simultaneously removing the needle and releasing the traction on the skin after the medication is injected.**
    3. The use of the vastus lateralis muscle for a Z track injection may cause discomfort for the patient. Z track injections are tolerated more when the well-developed gluteal muscles are used.
    4. The needle is inserted into the muscle once for a Z track injection. The Z represents the zigzag pattern of the needle track that results when the skin traction and the needle are simultaneously removed.
  19.
    1. This will create excessive bubbles that can interfere with complete reconstitution or result in bubbles being drawn into the syringe. Both occurrences can result in an inaccurate dose.
    2. **Compatibility is necessary so that a compound or precipitate that is harmful to a patient does not result.**
    3. Reconstitution occurs in a vial (a closed system), not an ampule (an open system).
    4. Shaking the vial will create excessive bubbles. The vial should be rotated between the hands to facilitate reconstitution.
  20.
    1. Opening the package outside the room exposes the medication to the environment, where it may become contaminated or grouped with other medications being administered to the patient, thus interfering with safe administration of one or more of the medications.
    2. **The medication should be opened and administered immediately to the patient, thereby limiting the potential for contamination. Reading the label immediately before opening the package is an additional safety check. Immediate administration prevents accidental disarrangement of medications that may result in a medication error.**
    3. Opening the package in the medication room exposes the medication to the environment because it requires the nurse to carry the medication through the unit to the patient's room. In addition, it can become confused with the medications for other patients.
    4. Opening the package at the medication cart exposes the medication unnecessarily to the environment, and it can be inadvertently confused with the medications for other patients.
  21.
    1. The patient should be assessed every 1 to 2 hours to ensure effectiveness of the drug.
    2. The prescription should be followed exactly if it is a safe dose; however, if the medication is not effective, 24 hours is too long a period not to intervene.
    3. **Two doses provide enough time to evaluate the effectiveness of a medication for pain. Patients should not have to endure intolerable levels of pain.**
    4. Requesting additional medication is unnecessary if the drug is the appropriate dose.

22.
  1. Medications in the form of a solution are instilled into the ear.
  2. Ophthalmic medications in the form of a solution or an ointment are administered in the eye.
  3. **A troche, a lozenge-like tablet, dissolves slowly in the mouth in the buccal cavity to provide a localized effect.**
  4. Medications in the form of suppositories are inserted through the anus into the rectum.
23.
  1. Topical medications are applied on the skin.
  2. A troche or lozenge given by the buccal route is placed between the cheek and gums.
  3. **A sublingual medication is placed under the tongue. It is absorbed quickly through the mucous membranes into the systemic circulation.**
  4. A medication placed in the lower conjunctival sac of the eye is administered for its local effect and is considered a topical medication.
24.
  1. The volume of fluid of a bolus dose is too small to necessitate a volume-control infusion set.
  2. **An incompatible solution can increase, decrease, or neutralize the effects of the medication. In addition, an incompatibility may result in a compound or cause a precipitate that is harmful to the patient.**
  3. Pinching the tubing is not done first. Pinching is done immediately before and while instilling the medication to ensure that the medication flows toward the patient, rather than in the opposite direction up the tubing.
  4. This is done for a medication administered via an intermittent intravenous infusion over a 30- to 90-minute period rather than an intravenous bolus (IV push) dose that is administered over 1 to 5 minutes.
25.
  1. A 90-degree angle is appropriate for an intramuscular, not an intradermal, injection.
  2. A 45-degree angle is appropriate for a subcutaneous, not an intradermal, injection.
  3. A 30-degree angle is too steep an angle for an intradermal injection, and a wheal will not form.
  4. **An intradermal injection is administered by inserting a needle at a 10- to 15-degree angle through the skin with the bevel of the needle facing upward toward the skin. The small volume of medication instilled just below the epidermis causes the formation of a wheal (localized area of swelling that appears like a small bubble).**
26.
  1. **The deltoid muscle, on the lateral aspect of the upper arm, is a small muscle that is incapable of absorbing a large medication volume. This site is more appropriate for 1 mL of solution.**
  2. The dorsogluteal site uses the gluteus maximus muscles in the buttocks, which can absorb larger medication volumes.
  3. The ventrogluteal site uses the gluteus medius and minimus muscles in the area of the hip, which can absorb larger medication volumes.
  4. The vastus lateralis muscles are located on the anterolateral aspect of the thighs, which can absorb larger medication volumes.
27.
  1. Although insulin can be administered at the deltoid site, it is a small area that is not conducive to injection rotation within the site. The rate of absorption at this site is slower than at the preferred site for insulin administration.
  2. Although insulin can be administered in this site, tissues of the thighs and buttocks have the slowest absorption rate.
  3. The chest is not an acceptable site for the administration of insulin because of the lack of adequate subcutaneous tissue.
  4. **The abdomen is the preferred site for administration of insulin because it is a large area that promotes a systematic rotation of injections, and it has the fastest rate of absorption.**
28.
  1. Either a gloved finger or an applicator is used to insert a vaginal suppository, not a cream.
  2. It is impossible to insert a cream into the vaginal canal with a gauze pad. If attempted, it will traumatize the mucous membranes of the vagina.
  3. **The consistency of a cream requires that an applicator be used to ensure that the medication is deposited along the full length of the vaginal canal.**
  4. The consistency of a cream is too thick to be inserted into the vagina with an irrigating kit.
29.
  1. A medication that is aerosolized is inhaled.
  2. A tablet, such as nitroglycerin, is dissolved under the tongue.
  3. **A medicated patch or disk can be applied directly to the skin, where the**

medication is released and absorbed over time. This method ensures a continuous therapeutic drug level and reduces fluctuations in circulating drug levels.

4. Medications in the form of a suppository are inserted into the rectum.
- 30.**
1. Testing for a blood return prevents injecting medication directly into the circulatory system, rather than limiting the discomfort of an injection.
  2. Applying ice is contraindicated because it causes vasoconstriction, which limits absorption of the medication.
  3. Pinching the skin aids in needle insertion when administering a subcutaneous injection. It does not limit the discomfort of an injection.
  4. **Injecting slowly allows the fluid to be dispersed gradually, which limits tissue trauma and discomfort.**
- 31.**
1. **This will ensure a tight seal and a closed system. If not firmly connected, the hub of the needle may disengage from the barrel of the syringe during preparation or administration of the medication when internal and external pressures are exerted on the needle and syringe.**
  2. The top just needs to be swiped. Rubbing back and forth is a violation of surgical asepsis because it reintroduces microorganisms to the area being cleaned.
  3. Injecting air below the surface of the solution should be avoided because it causes bubbles that may interfere with the drawing up of an accurate volume of solution.
  4. Excess air in the closed system raises pressure in the vial that may cause bubbles when withdrawing the fluid and result in an inaccurate volume of solution.
- 32.** **Answer: 44 units total.**  
**A total of 44 units of insulin should be drawn into the syringe. Eighteen units of regular insulin are drawn into the syringe first and then the 26 units of NPH insulin are drawn into the syringe. It is done in this order to ensure that the NPH insulin, which is longer acting, does not dilute the regular insulin in the vial, which is fast acting.**
- 33.**
1. Using clean gloves conforms to standard precautions; they protect the nurse from the patient's body fluids.
  4. Cleansing the area removes debris and previously applied topical medication; doing so allows the skin to be accessible to the lotion. Patting the skin dry is less irritating to the skin than rubbing, and the dry surface facilitates adherence of the lotion.
  3. Warming the medication promotes comfort for the patient when it is applied.
  5. Sterile gloves maintain sterility of the procedure and prevent the nurse from contacting and absorbing the medication. Excessive lotion can irritate the skin.
  2. Evaluating the results of the lotion on the skin ensures that therapeutic and nontherapeutic responses to the medication are identified. These responses must be documented and communicated to other members of the health-care team.
- 34.**
1. When the Z track method is used during an intramuscular injection, the skin and subcutaneous tissue are pulled laterally 1 to 1½ inches away from the injection site, not pinched.
  2. Massage is contraindicated because it will force medication back up the needle track, which may result in tissue irritation or staining.
  3. **The injection of a small amount of air after the medication is administered instills air into the Z track, and this helps to keep the medication deeply seated in the muscle.**
  4. Removal of the needle should be delayed 10 seconds to allow the medication to begin to be dispersed and absorbed.
  5. **The Z-track method is used with viscid or caustic solutions. Changing the needle ensures that medication is not on the outside of the needle, which prevents tracking of the medication into subcutaneous tissue during needle insertion.**



35. Solve the problem using the “Desire Over Have” formula.

$$\frac{\text{Desire } 1.5 \text{ mg}}{\text{Have } 0.5 \text{ mg}} = \frac{x \text{ tablets}}{1 \text{ tablet}}$$

$$0.5x = 1 \times 1.5$$

$$x = 1.5 \div 0.5$$

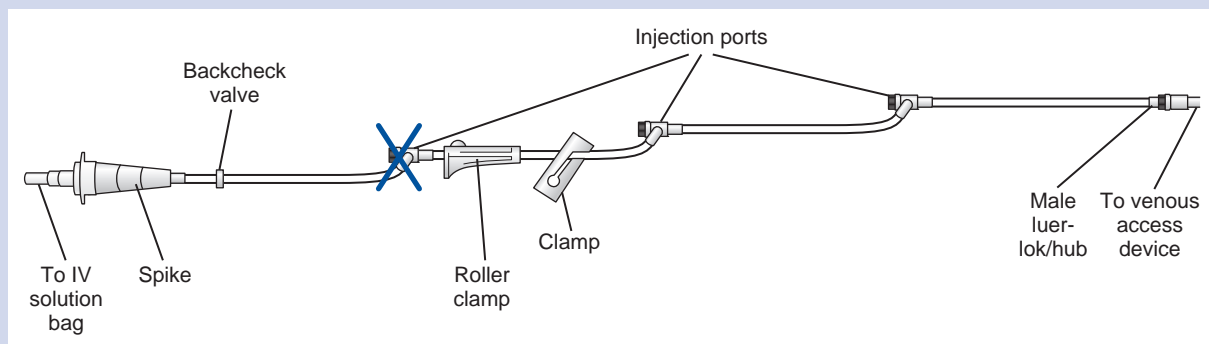
$$x = 3 \text{ tablets}$$

36. 1. A parenteral route is outside the gastrointestinal tract. A medication administered by the buccal route dissolves between the cheeks and gums, where it acts on the oral mucous membranes or is swallowed with saliva. Most troches are used for their local effect. The mucosal route of administration includes the nasal mucosa, the buccal mucosa, sublingually, and the bronchioles.
2. Z track is a method of administering an intramuscular injection. The intramuscular route is a parenteral route.
3. A parenteral route is outside the gastrointestinal tract. With the sublingual route medication dissolves under the tongue, where it is rapidly absorbed. The sublingual route is a mucosal route of administration.
4. The intravenous route, a parenteral route, instills medication directly into the venous circulation.
5. The intradermal route, a parenteral route, injects medication just under the epidermis.
37. 1. The air-bubble or air-lock technique can be used with intramuscular, not intradermal, injections. Its use is controversial, particularly with disposable plastic syringes.
2. Circling the injection site with a pen indicates the area that must be evaluated; generally the site is assessed 72 hours after the intradermal injection.

3. Pinching or bunching up tissue is appropriate with subcutaneous, not intradermal, injections.
4. When medication is injected with the bevel up, a small wheal will form under the skin. This technique is used only with intradermal injections.
5. Massaging the site of an intradermal injection will disperse the medication beyond the intended injection site and is contraindicated.

38. This port is accessible to the short length of a secondary administration set tubing. The port is above the roller set tubing. The port is above the roller clamp on the primary tubing. When the bag of medication is hung higher than the primary solution bag, the back check valve on the primary tubing will shut off the flow of the primary infusion until the secondary infusion is almost complete. See figure below.

39. 1. Vomiting, not nausea, is a contraindication for oral medications.
2. Nothing that requires swallowing should ever be placed into the mouth of an unconscious patient because of the risk for aspiration.
3. Gastric suctioning can be interrupted for 20 to 30 minutes after medication has been instilled via a nasogastric tube.
4. In an emergency a drug is best administered intravenously, rather than orally, because it is faster acting.
5. Nursing interventions, such as positioning, mixing a crushed medication in applesauce, and dissolving a medication in a small amount of fluid, can be employed to facilitate the ingestion of medication.
40. 3. Wearing clean gloves protects the nurse from contact with the medication.
1. Removing the previous patch reduces the risk of an overdose of the medication.



2. Containing and disposing of the used patch protect others from contact with the active substance still on the patch.
  6. Washing and drying the skin after removing a used patch eliminate lingering medication from the skin and minimize the risk of overdose.
  5. Applying a patch to a different surface of the skin avoids irritation to a surface that is used excessively.
  4. Writing the date, time, and your initials on the patch allows for accountability and helps minimize the risk of a medication error.
41. 1. Reducing the size of a tablet and mixing it with a food the consistency of applesauce facilitate ingestion and minimize the risk of aspiration. The thickness of applesauce is easier to control in the mouth than water for a person who has difficulty swallowing.
2. Hyperextending the neck when swallowing facilitates entry of the substance ingested into the trachea; this action is unsafe. Slightly flexing, not hyperextending, the neck helps to open the esophagus and bypass the trachea when swallowing.
  3. Giving fluid before, during, and after medication administration lubricates the oral cavity and facilitates movement of medication toward the esophagus and stomach.
  4. Stroking under the chin over the larynx encourages laryngeal elevation, which facilitates swallowing.
  5. A straw deposits fluid in the back of the mouth and does not allow time for a coordinated approach to swallowing. The use of a straw increases the risk of aspiration.
42. Solve the problem by using the following formula.

$$\frac{\text{Total volume to be infused} \times \text{drop factor}}{\text{Total time in minutes}}$$

$$\frac{500 \text{ (total volume ordered)} \times 60 \text{ (drop factor of the IV tubing)}}{60 \text{ (minutes within an hour)} \times 10 \text{ (number of hours ordered)}}$$

$$\frac{500 \times 60 = 30,000}{60 \times 10 = 600}$$

$$30,000 \div 600 = 50 \text{ drops per minute (gtts/min)}$$

43. 1. Avoiding sniffing the nose drops after administration allows the medication to reach desired areas (ethmoid and sphenoid sinuses) via gravity.
  2. This position ensures that gravity will promote the flow of medication to the nasopharynx. Five minutes is the length of time the patient should remain in the supine position with the head tilted backward.
  3. Pinching the nose is unnecessary and can frighten the patient, who already may be having difficulty breathing.
  4. Blowing the nose should be avoided because it may remove medication from the nose.
  5. Nose drops should be directed toward the midline of the ethmoid bone with the dropper held  $\frac{1}{2}$  inch above the nares. Holding the dropper  $\frac{1}{2}$  inch above the nares prevents contamination of the dropper.
44. 1. Medicated solutions are administered via drops in the ear.
2. Medicated solutions are dropped or sprayed in the nose.
  3. Tablets, lozenges, and troches are administered in the mouth.
  4. Semisolid cone-shaped or oval suppositories that melt at body temperature can be inserted into the vagina.
  5. Semisolid cone-shaped or oval suppositories that melt at body temperature can be inserted into the rectum.
45. Solve the problem using the “Desire Over Have” formula.

$$\frac{\text{Desire } 37.5 \text{ mg}}{\text{Have } 25 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$

$$25x = 37.5$$

$$x = 37.5 \div 25$$

$$x = 1.5 \text{ mL}$$

46. 1. This action prevents secretions and fluid from entering and irritating the lacrimal ducts.
2. A bulb syringe produces a flow of fluid that is forceful and difficult to control. An IV bag of solution is preferred to provide a flow of fluid by gravity that is gentle and controllable.

3. These actions provide access to the eye.
  4. Medical, not surgical, asepsis is required for this procedure.
  5. The patient should be placed in a sitting or back-lying position with the head tilted toward the affected eye.
47. 5. Warming the medication to room temperature minimizes discomfort when the medication enters the external ear canal.
4. The side-lying position helps to retain the drops in the external ear canal via gravity.
  2. Gently pulling up and back on the pinna for an adult helps to straighten the ear canal, and this promotes the flow of drops toward the tympanic membrane.
  3. Placing the drops on the side of the ear canal allows the fluid to flow down the wall of the external ear canal and avoid injury to the tympanic membrane.
  1. Pressing gently on the tragus several times moves the medication along the external ear canal toward the tympanic membrane.
48. 1. Lubrication eases insertion by reducing friction, which limits tissue trauma and discomfort.
2. Warming the medication causes it to melt, making it impossible to insert. Most rectal suppositories are kept refrigerated until used.
  3. Taking deep breaths relaxes the rectal sphincters.
  4. Rectal suppositories should be inserted 3 inches into the rectal canal of an adult. This can be accomplished by using the full length of a lubricated, gloved index finger to place the suppository.
  5. The patient should be placed in the left-lateral or left-Sims position to take advantage of the anatomical curve of the rectum and sigmoid colon.
49. Solve the problem by using the following formula.

$$\frac{\text{Total volume to be infused} \times \text{drop factor}}{\text{Total time in minutes}}$$

$$\frac{125 \text{ (ordered mL/hr)} \times 10 \text{ (drop factor of the IV tubing)}}{60 \text{ (number of minutes in 1 hour)}}$$

$$125 \times 10 = 1,250$$

$$1,250 \div 60 = 20.8$$

Because 0.8 is greater than 0.5, round the answer up to 21 drops/minute.

50. 1. Using a favorite food or liquid to mask the taste of a medication may promote a negative association with and subsequent refusal of the favorite food or liquid. This practice should be avoided.
2. Although this may be a true statement, it denies the child's dislike of the medication's unpleasant taste.
3. An ice pop just before administration may numb the taste buds and minimize the unpleasant taste of the medication.
4. A parent should not be asked to administer unpleasant tasting medication to avoid the child associating the parent with the unpleasant medication.
5. Offering the child a choice supports a sense of control. Involvement in decisions limits resistance.
51. Solve the problem using the "Desire Over Have" formula.

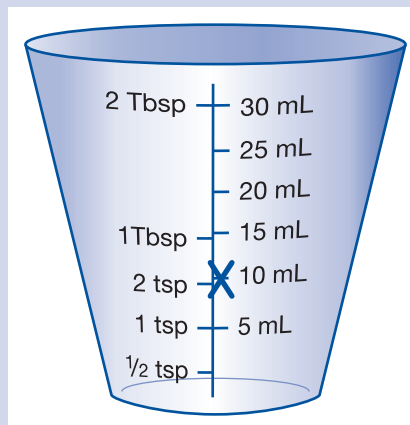
$$\frac{\text{Desire } 320 \text{ mg}}{\text{Have } 160 \text{ mg}} = \frac{x \text{ mL}}{5 \text{ mL}}$$

$$160x = 320 \times 5$$

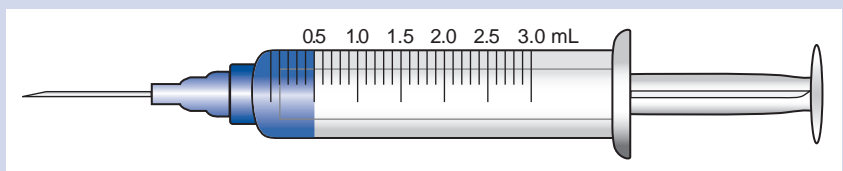
$$160x = 1,600$$

$$x = 1,600 \div 160$$

$$x = 10 \text{ mL}$$



52. 1. Vitamins are a medication and should be included on a medication reconciliation form. An accurate list of all the drugs that a patient is taking (e.g., name, dose, route, and frequency) should be reconciled on admission and during transitions (e.g., transfer between units, shift reports, when new medication administration records are implemented, and at discharge). This list needs to be compared with new medications prescribed and education provided to the patient about each medication.
2. Generally drug allergies are documented on a health history, not the drug reconciliation form.
3. Food supplements are considered medications because they often contain ingredients that may interact with medicinal products.
4. Over-the-counter herbs are considered medications because they contain ingredients that may unfavorably interact with medicinal products.
5. Prescribed medications should be included on a medication reconciliation form.
53. 1. A 1½-inch needle is required to reach muscular tissue.
2. A 22-gauge needle usually is used for an intramuscular injection; a 25-gauge needle usually is used for a subcutaneous injection.
3. The needle should be inserted at a 90-degree angle; a 45-degree angle is used for a subcutaneous injection.
4. Aspiration is done before instilling the medication to ensure that a blood return does not occur, which indicates that the needle is in a blood vessel.
5. Massage promotes dispersion of the medication.
54. 2. Positioning the patient in the dorsal recumbent position provides access to the vaginal area and is a comfortable position for the patient during the procedure.
1. Exposing only the vaginal area provides for privacy and supports dignity.
4. Lubricating the suppository and the nurse's gloved index finger facilitates insertion and limits tissue trauma.
5. Directing insertion downward and backward using the full length of the nurse's index finger follows the contour of the vaginal anatomy and ensures that the medication is inserted deep in the vaginal canal.
3. Encouraging the patient to remain in the supine position for 10 to 20 minutes after insertion allows time for the suppository to melt and to keep it in contact with vaginal tissue, which facilitates absorption.
55. 1. Not all liquids should be vigorously shaken. Only liquids that contain constituents that must be evenly distributed need to be vigorously shaken; the nurse should follow the manufacturer's directions.
2. Measuring oral liquids in a calibrated medication cup at eye level ensures accuracy.
3. Liquids should be poured with the label against the palm of the hand to allow a view of the label to facilitate the three checks of medication administration and prevent the liquid from dripping on and obscuring the label.
4. Placing an opened top of a container on a surface with the inside lid facing up prevents contamination of the inside of the lid and subsequent contamination of the bottle when the lid is returned and closed.
5. Using a needleless syringe to measure an oral liquid volume less than 5 mL and transferring it to a medication cup are acceptable practices because they ensure accuracy.
56. Solve the problem using the "Desire Over Have" formula.
- $$\frac{\text{Desire } 2.5 \text{ mg}}{\text{Have } 5 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$
- $$5x = 2.5$$
- $$x = 2.5 \div 5$$
- $$x = 0.5 \text{ mL}$$





57.
  1. **If the tube used to administer a medication via a nasogastric tube becomes accidentally disconnected during administration, the nurse can identify the approximate volume of the one medication that was lost when reporting the event to the primary health-care provider.**
  2. Oral medication via a nasogastric tube should be followed by 30 mL, not 100 mL, of tap water to ensure tube patency. Free water refers to larger volumes of water administered at routine intervals as per orders by a primary health-care provider.
  3. **Crushing crushable tablets into a fine powder and mixing it with 30 mL of warm water dissolve the medication and prevent clogging the enteral tube.**
  4. **Shutting off nasogastric tube suctioning for 30 minutes after medication administration enhances medication absorption in the stomach.**
  5. This method is the most unreliable method of assessing placement of a nasogastric tube. Measuring the pH of gastric aspirate is more accurate. A low pH (1 to 5; acidic) indicates the tube probably is in the stomach; a high pH (more than 6; alkaline) indicates the tube probably is in the intestine or respiratory tract.
58.
  1. Although this should be done to increase the amount of oxygen reaching body cells, it is not the priority.
  2. **The patient is exhibiting signs of fluid volume overload and pulmonary edema. The intravenous fluid infusion rate should be slowed to 15 to 30 mL per hour to decrease the amount of fluid entering the patient's intravenous compartment while maintaining the integrity of the intravenous access site until the rapid response team is notified and arrives.**
  3. Although elevating the head of the bed should be done because it will promote respirations and reduce the amount of blood returning from the lower extremities, it is not the priority.
  4. Notifying the primary health-care provider should be done eventually. However, the patient requires immediate intervention.
59.
  1. **This is the recommended initial flow rate. It delivers a small amount of blood that allows the nurse to evaluate the patient's response to the blood. If the patient does not experience a reaction within the first 15 minutes, then the remainder of the packed red blood cells can be administered over 2 to 4 hours.**
  2. Vital signs should be taken every 15 to 30 minutes depending on the agency's policy; this supports early detection of a transfusion reaction or fluid overload, which enables early intervention.
  3. Administering 100 mL of 0.9% sodium chloride before administering a blood transfusion is unnecessary; 0.9% sodium chloride solution is used to prime the tubing, and a small amount may be infused to assess patency of the venipuncture site.
  4. **Blood transfusions that extend to 4 hours are discontinued because bacterial growth may occur in the product.**
  5. **The majority of severe transfusion reactions occur during the first 15 minutes of the procedure. Identifying a reaction early minimizes consequences. Clinical indicators of a transfusion reaction include back pain, chills, itching, or shortness of breath.**
60.
  2. **First: The nurse should use an insulin syringe to draw up environmental air equal to the combined volume of both insulins. While keeping the NPH vial right-side up, the nurse should inject air equal to the prescribed amount of NPH into the air pocket at the top of the vial. This air prevents negative pressure inside the NPH vial when the NPH solution is withdrawn later in the procedure. Injecting air into the air pocket at the top of the vial avoids needle exposure to the NPH insulin and prevents bubbles that later can cause an inaccurate dose when the NPH insulin is withdrawn.**
    1. **Second: The nurse should inject the remaining air into the air pocket of the regular insulin vial while the vial is right-side up. Keeping the needle in the air pocket avoids causing bubbles in the solution. Bubbles displace solution, increasing the risk of an incorrect dose. Also, the injected air prevents negative pressure inside the regular insulin vial later when withdrawing the regular insulin.**

4. **Third:** The nurse should invert the regular insulin vial and draw up the prescribed amount of regular insulin. By drawing up the regular insulin first, it prevents contamination of the regular insulin vial with NPH insulin, which is slower acting.
3. **Fourth:** The nurse should reinsert the needle into the NPH vial, invert the vial, and withdraw the prescribed amount of NPH insulin. The mixed insulin is now ready to be administered.



# Pharmacology

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

- Adverse effect
  - Allergic/allergy
  - Blood level
  - Controlled substance
  - Dependence
  - Drug effect:
    - Adverse
    - Anaphylaxis, anaphylactic
    - Idiosyncratic
    - Local
    - Side
    - Synergistic
    - Systemic
    - Therapeutic
    - Topical
    - Toxic, toxicity
  - Drug levels, terms related to:
    - Duration
    - Peak
    - Onset
    - Therapeutic range
    - Trough
  - Drug names:
    - Generic
    - Trade
  - Food and Drug Administration (FDA)
  - Half-life
  - Hypersensitivity
  - Interaction
  - Prophylactic
  - Teratogenic
  - Tolerance/threshold
- ### CLASSIFICATIONS OF DRUGS
- Analgesic
  - Antacid
  - Antianxiety agent
  - Antiarrhythmic, antidysrhythmic
  - Antibacterial
  - Antibiotic
  - Anticholinergic
  - Anticoagulant
  - Anticonvulsant/antiepileptic
  - Antidepressant
  - Antidiabetic
  - Antidiarrheal
  - Antiemetic
  - Antifungal
  - Antihistamine
  - Antihypertensive
  - Anti-inflammatory
  - Antineoplastic
  - Antiparkinson
  - Antipsychotic
  - Antipyretic
  - Antiretroviral
  - Antitussive
  - Antiulcer
  - Bronchodilator
  - Cathartic
  - Diuretic
  - Emetic
  - Expectorant
  - Hypnotic
  - Laxative
  - Lipid-lowering agent
  - Mucolytic
  - Narcotic
  - Opioid
  - Skeletal muscle relaxant
  - Thyroid agent
  - Vasodilator
  - Vitamins and minerals
- ### DRUG FORMS
- Caplet
  - Capsule
  - Elixir
  - Emulsion
  - Enteric-coated
  - Extract
  - Liniment
  - Lotion
  - Metered-dose inhaler (MDI)
  - Ointment
  - Paste
  - Pill
  - Powder

F.A. DAVIS

COMPANY

Solution	Tablet
Suppository	Tincture
Suspension	Transdermal
Syrup	Troche, lozenge

## PHARMACOLOGY: QUESTIONS

1. Which effect on the body does the nurse understand is the reason for the need to discontinue a medication when the patient's liver function tests become elevated as a result of the medication?
  1. Side effect
  2. Toxic effect
  3. Adverse effect
  4. Synergistic effect
2. Which nursing action is important in relation to the administration of most antibiotics?
  1. Assessing for constipation
  2. Administering between meals
  3. Encouraging foods high in vitamin K
  4. Monitoring the volume of urinary output
3. A nurse is preparing to administer an injection of heparin. Which is the preferred site for this injection?
  1. Leg
  2. Arm
  3. Buttock
  4. Abdomen
4. Which concept associated with drug therapy and quality of sleep is important for a nurse to consider when planning nursing care?
  1. Aggressive pain management will reduce pain but increase insomnia.
  2. Abrupt discontinuation of hypnotic drugs can lead to withdrawal.
  3. Sedatives support restful sleep for people experiencing hypoxia.
  4. Barbiturates are the drugs of choice for insomnia.
5. A primary health-care provider prescribes a medication that is known to cause nephrotoxicity. Which element of pharmacokinetics does the nurse understand is critical when assessing this patient's response to this medication?
  1. Excretion
  2. Absorption
  3. Distribution
  4. Biotransformation
6. After administering a drug, the nurse monitors the patient for reactions. Which reaction has the **greatest** potential to be life-threatening?
  1. Toxicity
  2. Habituation
  3. Anaphylaxis
  4. Idiosyncratic
7. A nurse is assessing patients' responses to medications received. Which must the nurse know about these drugs to **best** evaluate whether the expected outcomes of the drug therapy have been achieved?
  1. Side effects
  2. Therapeutic effect
  3. Mechanism of action
  4. Chemical composition

8. A nurse is to administer a variety of analgesics. For which medication is it **most** important that the nurse know its daily dose limit?
  1. Meperidine
  2. Ibuprofen
  3. Morphine
  4. Codeine
9. A patient in pain requests the prescribed pain medication, which is an opioid. Which nursing assessment is essential before administering the opioid?
  1. Blood pressure
  2. Respirations
  3. Temperature
  4. Pulse
10. A primary health-care provider prescribes an antihypertensive medication to be administered twice a day. Which is essential for the nurse to assess before administering the antihypertensive agent?
  1. Level of consciousness
  2. Apical heart rate
  3. Blood pressure
  4. Respirations
11. Which is a common concern of the nurse when caring for patients taking drugs that depress the immune system?
  1. Inability to follow the therapeutic regimen
  2. Sensory perceptual alterations
  3. Constipation
  4. Infection
12. After the nurse administers an opioid, the patient becomes excitable. Which response should the nurse identify as being experienced by the patient?
  1. Toxic
  2. Allergic
  3. Synergistic
  4. Idiosyncratic
13. A patient experiences unrelenting neuropathic pain. Which classification of drug should the nurse anticipate will be prescribed for this patient?
  1. Anticonvulsant
  2. Antidepressant
  3. Antihistamine
  4. Anesthetic
14. A nurse is administering 10 a.m. medications to several patients on a hospital unit. The nurse anticipates that a patient with which condition is at the **greatest** risk for toxicity associated with most drugs?
  1. Liver disease
  2. Kidney insufficiency
  3. Respiratory difficulty
  4. Malabsorption syndrome
15. A nurse is discussing with a patient the variety of routes that medications can be administered. The nurse explains that medications are absorbed **most** efficiently through which route?
  1. Orally
  2. Rectally
  3. Intravenously
  4. Intramuscularly

16. A patient has been taking an antianxiety medication for a prolonged period of time. Which information is helpful to the nurse when attempting to determine if the patient has developed a physiological dependence on the drug?
1. Degree of tolerance
  2. Strength of the dose
  3. Perceived need by the patient
  4. Time it takes to achieve the therapeutic effect
17. A patient has a prescription for an antiemetic as an adjunct to antineoplastic therapy. Which dosing schedule should the nurse anticipate that the primary health-care provider will prescribe?
1. After the patient vomits
  2. Thirty minutes before meals
  3. When the patient reports nausea
  4. Four and eight hours after the initial dose
18. After the ingestion of a new medication the patient develops a rash, urticaria, and pruritus. Which should the nurse conclude that the patient is experiencing?
1. Allergic response
  2. Idiosyncratic effect
  3. Anaphylactic reaction
  4. Synergistic interaction
19. A patient is taking hydrochlorothiazide (HCTZ) once a day. Which fruit should the nurse encourage the patient to eat because it contains the **highest** amount of potassium?
1. Plum
  2. Orange
  3. Banana
  4. Tangerine
20. A nurse must administer a medication that is a digitalis derivative. Which nursing assessment is essential before administering this medication?
1. Pulse rate
  2. Blood pressure
  3. Respiratory rate
  4. Level of consciousness
21. A nurse teaches a patient to use a metered-dose inhaler (MDI). The patient asks, "Why do I need this instead of just taking a pill?" Which should the nurse respond is the primary purpose of a metered-dose inhaler?
1. "It provides you with a sense of control."
  2. "It directs the medication into your upper respiratory tract."
  3. "It delivers medication via positive pressure into your lungs."
  4. "It releases the medication in small particles that you can inhale deeply."
22. Patients with multiple health problems often go to a variety of medical specialists. Which response to medication occurs more frequently in patients who go to several medical specialists?
1. Interactions
  2. Habituation
  3. Tolerance
  4. Allergies
23. A nurse is responsible for administering medications via various routes to a group of patients. Which route of administration is the **most** effective way to achieve and maintain a drug's therapeutic level?
1. IV push
  2. Sublingual route
  3. Oral administration
  4. Large-volume infusion

24. A nurse is administering a variety of medications via the following routes. Which of these routes is the **fastest** acting?
1. Buccal
  2. Transdermal
  3. Subcutaneous
  4. Intramuscular
25. A patient asks the nurse why a lipid-lowering drug was prescribed. Before formulating a response, which should the nurse consider is the reason why primary health-care providers generally prescribe a hyperlipidemic drug?
1. After failure of diet therapy
  2. For those who are unable to exercise
  3. For patients older than 60 years of age
  4. After 2 consecutive months of elevated serum lipid levels
26. A nurse administers a prescribed antiemetic. A reduction in which clinical manifestation indicates that the patient is experiencing a therapeutic response?
1. Fever
  2. Anxiety
  3. Vomiting
  4. Coughing
27. A nurse is contrasting prefilled, disposable unit-dose intramuscular drug cartridges versus multidose vials. Which does the nurse conclude is the **primary** purpose of unit-dose cartridges?
1. Ensure that the appropriate-length needle is attached.
  2. Reduce the incidence of drug interactions.
  3. Limit preparation time in emergencies.
  4. Ensure purity of the drugs.
28. Which human response does the nurse understand is prevented by weaning a patient from a long-term prescribed corticosteroid rather than experiencing a sudden discontinuance of the corticosteroid?
1. Shock
  2. Seizures
  3. Bleeding
  4. Hypothermia
29. The nurse is administering an antihypertensive medication to a patient. Which clinical manifestation should the nurse identify as an excessive response to the antihypertensive agent?
1. Respirations of 24 breaths per minute
  2. Heart rate of 60 beats per minute
  3. Blood pressure of 80/60 mm Hg
  4. Oral temperature of 98 F
30. A patient has a prescription for sertraline, an antidepressant. Which is **most** important for the nurse to do?
1. Monitor the patient for suicidal tendencies.
  2. Advise the patient to engage in psychotherapy.
  3. Teach the patient to limit alcohol intake to one drink per day.
  4. Encourage the patient to diet because weight gain is common with this drug.
31. A patient is receiving an antipyretic agent. Which patient assessment should be performed to determine if the medication has achieved a therapeutic response?
1. Urine output
  2. Pain tolerance
  3. Respiratory rate
  4. Body temperature

32. Which is the **most** important action by the nurse before instituting patient-controlled analgesia (PCA) via a continuous intravenous route for the relief of pain?
1. Identify the patient's pain tolerance.
  2. Assess the patient's respiratory status.
  3. Determine the patient's pain threshold.
  4. Monitor the patient's analgesic blood levels.
33. Identify the drug classifications that are correctly associated with their expected therapeutic outcomes. **Select all that apply.**
1.  Bronchodilators: relieve dyspnea
  2.  Diuretics: increase urinary output
  3.  Antitussives: prevent or relieve coughing
  4.  Expectorants: decrease mucus production
  5.  Antiemetics: prevent or treat nausea and vomiting
34. A primary health-care provider prescribes aluminum hydroxide/magnesium hydroxide tablets, an antacid agent, for a patient with symptoms of indigestion. Which are the important things the nurse should teach this patient to do? **Select all that apply.**
1.  Document the characteristics of gastric discomfort in a log.
  2.  Notify the health team if coffee-ground vomitus occurs.
  3.  Monitor for the presence of diarrhea.
  4.  Take the drug an hour before meals.
  5.  Swallow the tablets whole.
35. A nurse in the hospital is evaluating patient responses to medications. Which classifications of drugs commonly precipitate diarrhea? **Select all that apply.**
1.  Sedatives
  2.  Narcotics
  3.  Laxatives
  4.  Antibiotics
  5.  Antiemetics
36. A public health nurse is planning a health class about herbal remedies for a group of older adults at the community center. Which information about herbal remedies should the nurse include in the class? **Select all that apply.**
1.  Can cause serious herbal-to-drug interactions with prescribed medications
  2.  Required to be labeled with information about their structure
  3.  Approved by the Food and Drug Administration
  4.  Natural because they are botanical in origin
  5.  Safe because they are organic
37. A primary health-care provider tells a patient who is receiving an antibiotic that several blood specimens will be taken to evaluate the effectiveness of the antibiotic therapy. The patient asks the nurse, "Why do these tests have to be done?" Which information included in a response by the nurse answers this patient's question? **Select all that apply.**
1.  Maintain constant drug levels in the body.
  2.  Determine the half-life of a drug in the body.
  3.  Identify whether the dose of the drug is adequate.
  4.  Establish where biotransformation occurs in the body.
  5.  Monitor the rate of absorption of the drug in the body.
38. The primary health-care provider prescribes cefaclor 1.5 g IVPB 30 minutes before surgery to prevent infection. The medication is supplied in a 10-g vial that states that after reconstitution there will be 500 mg/mL. How much solution should the nurse administer? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ mL.



39. A patient with a severe upper respiratory tract infection is being treated with a bronchodilator. Which patient responses indicate that the therapeutic effect has been achieved? **Select all that apply.**
- Oxygen saturation of 95%
  - Presence of viscous secretions
  - Experiencing no difficulty breathing
  - Exhibiting a decrease in respiratory excursion
  - Decrease in bronchovesicular breath sounds on auscultation
40. A patient admits to taking magnesium hydroxide for its laxative effect several times a week. Which information should the nurse teach the patient about this medication? **Select all that apply.**
- It can cause dependence and dehydration if taken for more than 2 weeks.
  - It can cause an accumulation of sodium and potassium ions in the body.
  - It should be discontinued if you experience watery diarrhea.
  - It should be accompanied by 2 to 3 glasses of fluid.
  - It should be taken at bedtime.
41. While the nurse is applying a transdermal patch, the patient asks the nurse, “Why can’t I just take a pill?” Which should the nurse explain are the advantages of administering a medication via a transdermal patch? **Select all that apply.**
- “It limits allergic responses.”
  - “It prevents drug interactions.”
  - “It delivers the drug over a period of time.”
  - “It bypasses the harsh acidic digestive system.”
  - “It provides a local rather than a systemic effect.”
42. A patient has a prescription for diphenoxylate/atropine, an antidiarrheal agent. Which should the nurse teach the patient about this medication? **Select all that apply.**
- Report the occurrence of decreased urination, muscle cramps, weakness, or fainting.
  - Inform the primary health-care provider if diarrhea persists for more than 2 days.
  - Be alert to the fact that the medication may cause hyperactivity.
  - Limit fluid intake to 2,000 mL/day.
  - Avoid crushing the tablets.
43. A primary health-care provider prescribes famotidine 20 mg PO bid to inhibit gastric acid secretion for a patient reporting epigastric discomfort. What should the nurse do when caring for this patient? **Select all that apply.**
- Assess for constipation.
  - Evaluate the oral cavity for stomatitis.
  - Check for a decreased serum creatinine.
  - Monitor a complete blood count with differential.
  - Encourage the intake of the full course of therapy as prescribed.
44. A primary health-care provider prescribes zolpidem, an extended-release tablet, 12.5 mg PO at hour of sleep for a patient experiencing insomnia. What is important for the nurse to teach the patient about this medication? **Select all that apply.**
- Avoid drinking alcohol.
  - Swallow the tablet whole.
  - Take it with food for best results.
  - Repeat the dose if not asleep in 3 hours.
  - Take it when you are able to stay in bed for at least 6 hours.

45. Place the elements of pharmacokinetics in order from the first step to the last step as a medication moves from its entry to its exit from the body.
1. Excretion
  2. Absorption
  3. Distribution
  4. Biotransformation
- Answer: \_\_\_\_\_
46. A patient at the outpatient clinic reports increasing joint pain caused by arthritis associated with the aging process. The primary health-care provider prescribes ibuprofen 600 mg PO qid for joint pain. What should the nurse teach the patient about this medication? **Select all that apply.**
1.  T ake it with a full glass of water.
  2.  D o not exceed 4,000 mg of this drug daily.
  3.  D o uble a dose if a previous dose is forgotten.
  4.  R eport the intake of the drug if dental treatment or surgery is necessary.
  5.  U se an oatmeal bath for a mild skin rash because it is a common side effect.
47. A primary health-care provider prescribes nitrofurantoin 100 mg PO every 6 hours for a patient who reports signs and symptoms of a urinary tract infection. What should the nurse teach the patient to do when taking nitrofurantoin? **Select all that apply.**
1.  T ake this drug on an empty stomach.
  2.  U se a straw to take the medication and rinse the mouth afterward.
  3.  N o te that urine will be reddish/orange in color but do not be alarmed.
  4.  R eport diarrhea, abdominal cramping, fever, and bloody stools if they occur.
  5.  I nform the primary health-care provider if signs and symptoms do not resolve within a week of therapy.
48. An active older adult female patient reports episodes of urinary urgency and frequency, urge incontinence, and bladder spasms. The primary health-care provider diagnoses an overactive bladder and prescribes oxybutynin 2.5 mg PO tid. What should the nurse teach this patient? **Select all that apply.**
1.  C atheterize yourself periodically after urinating to determine the presence of residual urine.
  2.  S ed ation and weakness may occur when taking this medication.
  3.  R efr ain from activities requiring alertness when drowsy.
  4.  R eport an inability to pass urine if it should occur.
  5.  A void strenuous activity in a warm environment.
49. A nurse is caring for a patient who is receiving 2 types of analgesics. Which effects does the nurse understand occur when these medications are administered together? **Select all that apply.**
1.  C urative
  2.  P alliative
  3.  S y nergistic
  4.  P otentiation
  5.  A ntagonistic
50. A primary health-care provider prescribes the corticosteroid budesonide 180 mcg, 2 inhalations, bid, along with a bronchodilator. What should the nurse teach the patient about these medications? **Select all that apply.**
1.  “ Let the health team know if you have a lactose intolerance.”
  2.  “ Take your budesonide first and the bronchodilator 5 minutes later.”
  3.  “ You can expect an improvement in your symptoms within 2 weeks of use.”
  4.  “Use tap water to rinse and spit after each time you use your budesonide inhaler.”
  5.  “If you experience an acute bronchospasm between doses, you can take an additional dose of budesonide.”

51. Dextromethorphan 30 mg and guaifenesin 600 mg PO every 4 hours prn is prescribed for a patient with a cough and respiratory tract infection. What should the nurse teach the patient who is taking this medication? **Select all that apply.**
- “ Increase your fluid intake to a minimum of 2 quarts of fluid daily.”
  - “ Report if signs and symptoms do not improve after 2 weeks of therapy.”
  - “Talk with the primary health-care provider before taking another over-the-counter cold remedy.”
  - “Avoid diet and caffeine pills or stimulants prescribed for attention deficit hyperactivity disorder.”
  - “Tell your primary health-care provider if severe dizziness, anxiety, confusion, or slow or shallow breathing occur.”
52. Which information documented in the clinical record of an adult male patient should the nurse consider problematic?
- Calcium: 5.4 mEq/L
  - Temperature: 97.8°F
  - Docusate sodium: 1,000 mg, PO, daily
  - Respirations: 14 breaths per minute, unlabored

### PATIENT'S CLINICAL RECORD

#### Laboratory Results

Calcium: 5.4 mEq/L  
Sodium: 137 mEq/L  
Potassium: 4.2 mEq/L

#### Physical Assessment

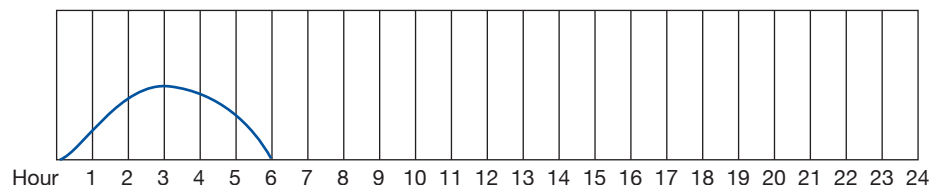
Temperature (oral): 97.8°F  
Pulse: 62 beats per minute  
Respirations: 14 breaths per minute, unlabored  
Blood pressure: 128/84 mm Hg

#### Medication Reconciliation Form

Aspirin 81 mg, PO, daily  
Docusate sodium 1,000 mg, PO, daily  
Alprazolam 2 mg, PO, qid

53. A primary health-care provider prescribes simvastatin 20 mg PO daily, a lipid lowering agent for a patient with an elevated cholesterol level. What should the nurse teach the patient receiving this medication? **Select all that apply.**
- Exchange vegetable oils containing monounsaturated fatty acids with vegetable oils containing polyunsaturated fatty acids.
  - Report the presence of muscle aches, pains, stiffness, or weakness to the primary health-care provider immediately.
  - Consume 2 to 3 servings of fish high in omega-3 fatty acids weekly.
  - Monitor for is cola-colored urine or if output is reduced or absent.
  - Take the medication in the morning.
54. A primary health-care provider prescribes esomeprazole 20 mg PO daily for a patient reporting gastroesophageal reflux at night. What should the nurse teach the patient receiving this medication? **Select all that apply.**
- Take the drug one hour after meals.
  - Do not to crush or chew the medication.
  - Taking antacids and esomeprazole concurrently is acceptable.
  - Avoid nonsteroidal anti-inflammatory drugs while on this medication.
  - Mix the capsule contents with applesauce if having difficulty swallowing.

55. A primary health-care provider prescribes acetylsalicylic acid (aspirin) for a patient experiencing body aches and fever associated with an upper respiratory tract infection. Which nontherapeutic responses related to acetylsalicylic acid should the nurse teach the patient to report to the primary health-care provider? **Select all that apply.**
- Rash
  - Tinnitus
  - Bleeding
  - Dizziness
  - Constipation
56. A nurse is caring for a patient receiving morphine for intractable pain associated with cancer. For what nontherapeutic effects should the nurse monitor the patient? **Select all that apply.**
- Sedation
  - Confusion
  - Tachypnea
  - Constipation
  - Hypertension
57. Which words are associated with the medication levothyroxine. **Select all that apply.**
- Trade
  - Generic
  - Curative
  - Antidote
  - Substitutive
58. A primary health-care provider prescribes a medication that must maintain effective blood concentrations of the drug to be effective. Which information is essential for the nurse to know about this medication to ensure its effectiveness? **Select all that apply.**
- Therapeutic range
  - Trough level
  - Peak level
  - Half-life
  - Onset
59. A primary health-care provider prescribes medication for a hospitalized older adult patient with a diagnosis of the flu, an oral candida infection, and a history of hypothyroidism and moderate dementia. Which prescriptions should the nurse discuss with the primary health-care provider before administering medications? **Select all that apply.**
- Nystatin 1 lozenge 200,000 units, via buccal cavity, four times a day for 14 days
  - Acetaminophen 1,000 mg, PO, every 6 hours prn for headache
  - Levothyroxine 100 mcg PO once a day
  - Simvastatin 20 mg PO hour of sleep
  - Doxycycline sodium 100 mg PO bid
60. Which type of insulin is reflected by the illustration regarding its length of action?
- Glargine
  - Regular
  - Lispro
  - NPH



## PHARMACOLOGY: ANSWERS AND RATIONALES

1. A side effect is an unintended response that generally is predictable and well tolerated. It usually does not require discontinuation of the drug because the drug's benefit outweighs the discomfort. Dry mouth and nausea are examples of side effects that do not require discontinuation of the drug, and they usually respond to palliative interventions.
  2. **Liver impairment is an example of a toxic effect that requires discontinuation of a medication. Toxic effects are dangerous and harmful responses to a medication that are often predictable. When a patient exhibits a toxic effect to a medication, the nurse should hold the medication and notify the primary health-care provider immediately. The only time holding a dose would not apply is if the drug dose must be tapered to discontinue the drug safely.**
  3. An adverse effect is an unintended, usually unpredictable response to a medication that is more severe than a side effect. When an adverse effect occurs, the medication may or may not be discontinued, depending on its severity.
  4. A synergistic effect does not apply in this situation. A synergistic effect occurs when the combined effect of two medications is greater than when the effects of each are just added together.
1. Most antibiotics tend to cause diarrhea, not constipation.
  2. **Food often interferes with the dissolution and absorption of antibiotics and delays their action. Also, food can combine with molecules of certain drugs and can change their molecular structure and ultimately inhibit or prevent their absorption.**
  3. Yogurt, not foods high in vitamin K, is encouraged for a patient receiving antibiotics. Yogurt helps to recolonize the endogenous flora of the gastrointestinal tract that can be eradicated by antibiotics.
  4. Antibiotics do not affect the volume of urinary output.
1. The tissues in the legs are not preferred for the administration of heparin (Hep-Lock) because muscle activity associated with walking increases the risk of hematoma formation.
  2. The tissues in the arms are not preferred for the administration of heparin because muscle activity associated with movement of the arms increases the risk of hematoma formation.
  3. The tissues associated with walking are not preferred for the administration of heparin because muscle activity increases the risk of hematoma formation.
  4. **The abdomen is a preferred site for the administration of heparin because it lacks major muscles and muscle activity. This site has the least risk for hematoma formation.**
1. Effective pain management will facilitate rest and sleep, not promote insomnia.
  2. **Barbiturate sedative-hypnotics depress the central nervous system and when withdrawn abruptly can cause withdrawal symptoms such as restlessness, tremors, weakness, and insomnia. Long-term use should be tapered by 25% to 30% weekly.**
  3. Sedatives, central nervous system depressants, are not advocated for patients with hypoxia because they depress respirations, which may exacerbate the hypoxia.
  4. Barbiturates depress the central nervous system, alter REM and NREM sleep, result in daytime drowsiness, and cause rebound insomnia. For this reason, antianxiety drugs or tranquilizers are preferred.
1. **Medication elimination occurs primarily via urine produced by the nephrons of the kidneys (*excretion*). If a medication is toxic to nephrons, damage to nephrons can result. A drug that can cause damage to nephrons is known as nephrotoxic. A nurse must assess the patient for a decrease in urine production and identify laboratory results that indicate impairment of the kidneys, such as elevated creatinine and blood urea nitrogen levels.**
  2. Nephrotoxicity is unrelated to the process of movement of a medication into the bloodstream (*absorption*).
  3. Nephrotoxicity is unrelated to the transport of a medication from the site of absorption to the site of medication action (*distribution*).

4. Nephrotoxicity is unrelated to the process of biotransformation. Biotransformation is the conversion of a medication to a less active form (*detoxification*) in preparation for excretion.
- 6.** 1. Medication toxicity results from excessive amounts of the drug in the body because of overdosage or impaired metabolism or excretion. Most drug toxicity that occurs immediately after administration is preventable through accurate prescribing and administering of the medication. Toxicity that occurs through the cumulative effect occurs over time and, if recognized early, is not life-threatening.
2. Drug habituation is a mild form of psychological dependence that occurs over time and is not life-threatening.
- 3. Anaphylaxis, a severe allergic reaction, requires immediate intervention (e.g., epinephrine, IV fluids, corticosteroids, and antihistamines) because it can be fatal.**
4. An idiosyncratic effect is an unexpected, individualized response to a drug. The response can be an underresponse or an overresponse, or it can cause unpredictable, unexplainable symptoms. Usually, it is not life-threatening.
- 7.** 1. Side effects are unintended effects other than the therapeutic effect.
- 2. Therapeutic effects are the desired, intended effects of the drug. They are the reason for which the drug is prescribed.**
3. Although it is important to know the mechanism of action of a drug (pharmacodynamics), this knowledge is not as important as knowing the physical, mental, behavioral, or emotional responses indicating that a drug is having the desired impact on the patient.
4. Although it is important to know the chemical composition of a drug, this is not as significant as knowing the desired response to the medication.
- 8.** 1. When administered to an adult under the supervision of a primary health-care provider, meperidine may exceed the recommended oral dosage of 1,200 mg/day or the IV dose of 15 to 35 mg/hr.
- 2. In adults, ibuprofen should not exceed 3,600 mg/day when used as an anti-inflammatory agent or 1,200 mg/day when used as an analgesic or antipyretic. Higher doses do not increase effectiveness and may cause major gastrointestinal and central nervous system adverse effects. Ibuprofen is an over-the-counter medication which increases the risk for an overdose as a result of self-medication by an uninformed consumer.**
3. Recommended daily doses for morphine vary based on weight of the patient and route of administration. Recommended dosages routinely are exceeded in pain management of patients with chronic, intractable (malignant) pain when prescribed by a primary health-care provider.
4. When administered to an adult under the supervision of a primary health-care provider, codeine may exceed the recommended daily dosage of 120 mg.
- 9.** 1. An opioid can cause the side effect of hypotension. However, assessment of blood pressure is not as essential as another vital sign.
- 2. An opioid depresses the respiratory center in the medulla, which results in a decrease in the rate and depth of respirations. When a patient's respiratory rate is less than 10 breaths per minute the drug should be withheld and the primary health-care provider notified.**
3. The side effects and adverse reactions to opioids do not include alterations in temperature.
4. An opioid analgesic can cause the side effect of bradycardia, so the pulse should be assessed before administration. However, assessment of heart rate is not as essential as another vital sign.
- 10.** 1. This is unnecessary because antihypertensives do not alter the level of consciousness.
2. The apical heart rate should be assessed before administering cardiac glycosides and antidysrhythmics, not antihypertensives.
- 3. Antihypertensives, such as beta-adrenergic blockers, calcium channel blockers, vasodilators, and angiotensin-converting enzyme (ACE) inhibitors, all act to reduce blood pressure; therefore, the blood pressure should be obtained before and monitored after administration.**

4. Respirations and breath sounds should be assessed before administering bronchodilators and expectorants, not antihypertensive agents.
11. 1. Although this is a concern for any patient who must follow a pharmacological regimen, it is not the most common risk associated with drugs that suppress the immune system.
    2. Medications that depress the immune system usually do not cause sensory problems. Although some antineoplastic drugs can cause peripheral neuropathy, this response is not as common as gastrointestinal, hematological, integumentary, and immune system adverse effects.
    3. Medications that depress the immune system are more likely to cause gastrointestinal disturbances such as anorexia, nausea, vomiting, and diarrhea, not constipation.
  4. **Medications that suppress the immune system, such as antineoplastics (destroy stem cells that are precursors to white blood cells), corticosteroids (suppress function and numbers of eosinophils and monocytes), and antibiotics (destroy body flora), lower the body's ability to fight microorganisms that can cause infection.**
12. 1. Toxicity is manifested by sedation, respiratory depression, and coma. The antidote naloxone may be necessary.
    2. Allergic responses frequently manifest as a rash, urticaria, and pruritus.
    3. A synergistic response associated with an opioid is reflected by a lowered level of consciousness and sedation.
  4. **Excitability is an unexpected, unexplainable response to an opioid. Opioids are central nervous system depressants that relieve pain and promote sedation, not cause excitability.**
13. 1. Anticonvulsants do not relieve pain. Anticonvulsants depress abnormal neuronal discharges in the central nervous system and limit or prevent seizures.
    2. **Antidepressants, particularly amitriptyline, potentiate the effects of opioids and have innate analgesic properties.**
    3. Antihistamines do not relieve pain. Antihistamines block the effects of histamine at the H<sub>1</sub> receptor.
  4. Although anesthetics do block pain, they generally are not used to relieve neuropathic pain. General anesthetics depress the central nervous system sufficiently to allow pain-free invasive procedures (e.g., surgery), and local anesthetics produce brief episodes of decreased nerve transmission when general anesthesia is not warranted.
14. 1. **Drug-metabolizing enzymes in the liver detoxify drugs to a less active form (biotransformation). With liver dysfunction, biotransformation is impaired and drugs accumulate, ultimately reaching toxic levels.**
    2. Although decreased kidney function will adversely affect drug excretion, it does not pose the greatest risk for toxicity.
    3. Most drugs are degraded in the liver and excreted through the kidneys, not the lungs.
    4. Most drugs are degraded in the liver and excreted through the kidneys, not the intestines.
15. 1. Food, fluid, and gastric acidity can influence the dissolution and absorption of medications.
    2. The absorption of rectal medications is influenced by the presence of fecal material and is unpredictable.
  3. **Intravenous medications enter the bloodstream directly by way of a vein. Intravenous administration offers the quickest rate of absorption, and it is within the circulatory system for easy distribution.**
  4. The intramuscular route is not the most efficient route for absorption of medication.
16. 1. Tolerance is not a reliable indicator of dependence. Tolerance to a drug has occurred when increasing amounts of the drug must be administered to achieve the therapeutic effect.
    2. Strength of a dose is not a reliable indicator of dependence. Factors such as age, weight, gender, and drug tolerance also influence the strength of a dose.
  3. **Drug dependence, a form of drug abuse, occurs when a person has an emotional reliance on a drug because there is a craving for the effect or response that the drug produces.**
  4. The length of time a drug takes to achieve its therapeutic effect is unrelated to the

development of physiological dependence on the drug.

17. 1. This is too late. When an antiemetic is administered as an adjunctive to chemotherapy, vomiting should not occur.
  2. This is inappropriate. When an antiemetic is given prophylactically for a chemotherapeutic regimen, it is administered in relation to when the chemotherapeutic agent is given, not meals.
  3. This is too late. Prophylactic administration of an antiemetic will prevent nausea and vomiting.
  4. **Antiemetics should be administered 30 minutes before initiation of chemotherapy and then 4 and 8 hours after the initial dose of the antiemetic.**
18. 1. **A drug allergy is an immunological response to a drug. In addition to integumentary responses, the patient may develop angioedema, rhinitis, lacrimal tearing, nausea, vomiting, wheezing, dyspnea, and diarrhea.**
  2. An idiosyncratic effect is an unexpected, individualized response to a drug. The response can be an underresponse or an overresponse, or it may cause unpredictable, unexplainable signs or symptoms.
  3. The early signs of anaphylaxis are shortness of breath, acute hypotension, and tachycardia.
  4. When a drug interaction occurs where the action of one or both drugs is potentiated, it is called a synergistic effect.
19. 1. One medium-size plum contains approximately 114 mg of potassium.
  2. One medium-size orange contains approximately 237 mg of potassium.
  3. **One medium-size banana contains approximately 450 mg of potassium. Hydrochlorothiazide (HCTZ), by its action in the distal convoluted tubule, promotes the excretion of potassium. Potassium must be replenished because of its vital role in the sodium-potassium pump.**
  4. One medium-size tangerine contains approximately 132 mg of potassium.
20. 1. **A medication that is a digitalis derivative such as digoxin decreases conduction through the sinoatrial (SA) and atrioventricular (AV) nodes and**
    - prolongs the refractory period of the AV node, resulting in a slowing of the heart rate (negative chronotropic effect). When the heart rate is less than preset parameters (e.g., 60 beats per minute) or higher than preset parameters (e.g., 100 beats per minute), the medication should be held and a serum digoxin level assessed for exceeding its therapeutic range of 0.5 to 2 ng/mL. It is important to remember that the heart rate may exceed a rate of 100 beats per minute with toxicity.
  2. Dysrhythmias, not alterations in blood pressure, are cardiovascular signs of toxicity.
  3. This assessment is unnecessary because a change in respiratory status is not a symptom of toxicity.
  4. Toxicity may cause confusion and disorientation, not an altered level of consciousness.
21. 1. Although this may be a secondary benefit for some patients, it is not the reason for using a metered-dose inhaler (MDI).
  2. The medication from an MDI is delivered to the lungs, which comprise the lower, not upper, respiratory tract.
  3. Although an MDI delivers the medication via pressure to the patient's mouth, it is the act of the patient's inhalation that delivers the medication to its site of action.
  4. **An MDI aerosolizes the medication so that the suspension of microscopic liquid droplets can be inhaled deep into the lung.**
22. 1. **A drug interaction occurs when one drug affects the action of another drug. The effect of one or both drugs increases, decreases, or is negated. The risk for drug interactions increases when multiple drugs are prescribed by several primary health-care providers with inadequate communication among the providers.**
    2. Drug habituation is a mild form of psychological dependence.
    3. Tolerance occurs when a patient develops a decreased response to a medication and therefore requires an increased dose to achieve the therapeutic response.
    4. An allergic reaction results from an immunological response to a medication to which the patient has been sensitized.



- 23.** 1. An IV push (bolus) is the administration of a drug directly into the systemic circulation. Usually, it is administered as a single dose in an emergency. It achieves the desired level quickly but does not maintain it.
2. The sublingual route is used intermittently and only when necessary. It is not used to maintain constant therapeutic drug levels.
3. Although the oral route is the safest, easiest, and most desirable way to administer medications, there are fluctuations in serum blood levels because the medication is administered intermittently one or more times throughout the day.
- 4. With a large-volume infusion, a drug is added to an IV container (usually 250 mL, 500 mL, or 1,000 mL), and the resulting solution is administered over time. This approach maintains a constant serum drug level.**
- 24.** 1. Medications administered via the buccal route dissolve between the teeth and gums, mix with saliva, and are swallowed. This route has a slow onset of action.
2. The transdermal route is noted for its ability to sustain the absorption of medication, not because it produces a rapid response. The absorption of medications administered via the transdermal route is influenced by the condition of the skin, the presence of interstitial fluid, and the adequacy of circulation to the area.
3. The subcutaneous route is faster-acting than some routes because it is a parenteral route but slower-acting than other parenteral routes because subcutaneous tissue does not have a large blood supply.
- 4. Of the options offered, the intramuscular route is the fastest-acting route because muscles have a large vascular network that ensures rapid absorption into the bloodstream.**
- 25.** 1. **Generally, conservative management of hyperlipidemia through dietary modifications and exercise is attempted before resorting to a medication. Lipid-lowering agents have side effects and adverse effects and may interact with other drugs.**
2. Exercise is only one factor that influences the patient's lipid status. Factors such as diet, cigarette smoking, stress, concurrent diseases, and family history are additional factors that must be considered when a pharmacological regimen is prescribed.
3. Lipid-lowering agents are prescribed for patients who are older than 60 years old only when necessary, not because they are older than 60 years old.
4. Only people with chronically elevated lipid levels receive antilipidemics because of their significant side effects. Lifestyle modifications are attempted first.
- 26.** 1. Antipyretics, not antiemetics, reduce fever.
2. Anxiolytics, not antiemetics, reduce anxiety.
- 3. Antiemetics block the emetogenic receptors to prevent or treat nausea or vomiting.**
4. Antitussives, not antiemetics, reduce the frequency and intensity of coughing.
- 27.** 1. Although generally this is true, there are times the attached needle is inappropriate for a particular patient and the nurse must change the needle or transfer the medication into a standard syringe.
2. Drug interactions can still occur with prefilled, disposable cartridges because the drug within the cartridge may alter or be altered by the concurrent presence of another medication in the patient's body.
3. Although prefilled cartridges are convenient in an emergency, it is not the primary purpose of having prefilled cartridges.
- 4. Single-dose cartridges prepared by a medication manufacturer or pharmacy ensure the purity of the drug. Multiple-dose vials can be contaminated by rubber debris and microorganisms.**
- 28.** 1. **Exogenous glucocorticoids cause adrenal suppression. When exogenous corticosteroids are withdrawn abruptly, the adrenal glands are unable to produce adequate amounts of glucocorticoids, thus causing acute adrenal insufficiency and shock.**
2. Acute adrenal insufficiency may cause dizziness and syncope, not seizures.
3. Acute adrenal insufficiency is unrelated to hemorrhage.
4. Acute adrenal insufficiency may cause hyperthermia, not hypothermia.
- 29.** 1. Antihypertensive agents do not directly affect respirations. Respirations may return to the expected range of 12 to

- 20 breaths per minute when cardiac output improves.
- This heart rate is within the expected range of 60 to 100 beats per minute.
  - The acceptable range for the systolic pressure is 90 to less than 120 mm Hg. This patient's systolic reading is outside the expected range, which is an excessive decrease when receiving an antihypertensive agent.**
  - Antihypertensive agents do not influence body temperature. Expected adult oral temperatures range between 97.5 F and 99.5 F.
- 30. 1. When depression lifts during the early stages of antidepressant therapy, the individual has renewed energy that may support the implementation of suicidal ideation. Patient safety is the priority.**
- Although this should be done, it is not the priority.
  - Alcohol should be avoided because it potentiates the central nervous system depressive effects of sertraline.
  - A person will more likely lose, not gain, weight when taking sertraline because its side effects include anorexia, nausea, and vomiting.
- 31. 1.** Intake and output are monitored when a patient is taking a diuretic, not an antipyretic.
- Pain tolerance is monitored when a patient is taking an analgesic, not an antipyretic.
  - Respirations are monitored when a patient is taking a central nervous system depressant or bronchodilator, not an antipyretic.
  - Antipyretics lower fever by affecting thermoregulation in the central nervous system and/or inhibiting the action of prostaglandins peripherally.**
- 32. 1.** Although this may be done, it is not the priority. Pain tolerance is the highest intensity of pain that the person is willing to endure.
- 2. Analgesics depress the central nervous system; therefore, the respiratory status must be monitored before and routinely throughout administration for signs of respiratory depression.**
- Although this may be done, it is not the priority. Pain threshold is the amount of pain stimulation a person requires before pain is felt.
  - Monitoring analgesic blood levels is unnecessary.
- 33. 1. Bronchodilators relax smooth muscles of the bronchi and bronchioles, thus increasing the diameter of their lumens (bronchodilation) and resulting in a decrease in airway resistance.**
- Diuretics increase the urinary excretion of water and electrolytes such as sodium, potassium, calcium, and chloride.
  - Antitussives prevent or relieve coughing by depressing the cough center in the medulla.**
  - Expectorants increase, not decrease, the flow of respiratory secretions; they decrease the viscosity of secretions and promote the coughing up and removal of mucus from the lungs.
  - Antiemetics, depending on the agent (e.g., antihistamines, anticholinergics, neuroleptic agents, prokinetic agents, serotonin antagonists, and substance P neurokinin-1 receptor antagonist), act in a variety of ways to prevent, limit, or treat nausea and vomiting.**
- 34. 1. A log will help evaluate the patient's response to the aluminum and magnesium hydroxide regimen. Characteristics include location, duration, intensity, and description of the discomfort.**
- These are symptoms of gastric bleeding, and the primary health-care provider should be notified immediately. Enzymes act on blood to produce coffee-ground emesis and tarry stools.**
  - The magnesium in the aluminum and magnesium hydroxide preparation can cause diarrhea in some people.**
  - This medication should be taken 1 to 3 hours after a meal and at bedtime to neutralize gastric acid.
  - This medication should be thoroughly chewed and taken with at least a half glass of water to prevent the tablet from entering the intestine undissolved.
- 35. 1.** Sedatives, used to promote sleep, depress the central nervous system, which may cause constipation, not diarrhea.
- Narcotics, opium derivatives used to relieve pain, depress the central nervous system, which may cause constipation, not diarrhea.

3. **Diarrhea is an adverse reaction to a laxative. Laxatives are agents that increase evacuation of the bowel via various mechanisms. An excessive dose or taking a laxative when it is not necessary can cause diarrhea.**
  4. **Antibiotics can alter the flora of the body, with resulting superinfections. Opportunistic fungal infections of the gastrointestinal system may cause a black, furred tongue, nausea, and diarrhea.**
  5. **Antiemetics, used to prevent or alleviate nausea and vomiting, may cause constipation, not diarrhea.**
- 36. 1. Some herbal supplements can cause dangerous herbal-to-drug interactions or nontherapeutic responses when taken concurrently with over-the-counter or prescribed medication.**
2. **The Dietary Supplement Health and Education Act of 1994 stipulated that herbs must be labeled with information about their effects on the structure and function of the body. Herbal substances officially are considered food supplements.**
  3. **The Food and Drug Administration (FDA), a division of the U.S. Department of Health and Human Services, regulates the manufacture, sale, and effectiveness of prescription and nonprescription medications, not herbal remedies.**
  4. **Herbs, considered by some to be “natural,” are plants that are valued for their medicinal properties. As medicinal substances, they should be viewed by the consumer as drugs.**
  5. **Just because herbs are organic does not ensure that they are safe. Many herbs even though organic can be toxic if ingested in unsafe amounts.**
- 37. 1. Drug levels are maintained within a therapeutic range that is less than the peak level and more than the trough level. The peak serum level of a drug is the maximum concentration of a drug in the blood (occurs when the elimination rate equals the absorption rate). Trough levels indicate the serum level of a drug just before the next dose is to be administered. The results of these two values determine the dose and time a drug should be administered to maintain a serum level of a drug within its therapeutic range.**
2. **Although a drug’s half-life, the usual amount of time needed by the body to reduce the concentration of the drug by one half, is helpful in determining how frequently a drug should be given initially, it does not reflect an individual patient’s response to the drug.**
  3. **Based on peak and trough levels of a drug, the dosage is adjusted to ensure that the concentration of the drug in the blood remains in the therapeutic range over a 24-hour period.**
  4. **Biotransformation, the process of inactivating and breaking down a drug, takes place primarily in the liver. Peak and trough levels may indirectly reflect the rate of biotransformation, not the place where it occurs.**
  5. **This is not the purpose of peak and trough levels, although peak and trough levels indirectly measure both the absorption and the inactivation and elimination of a drug from the body.**
- 38. Answer: 3 mL. Use ratio and proportion to convert grams to milligrams first and then perform a calculation to determine the dose.**
- $$\frac{\text{Desired } 1.5 \text{ g}}{\text{Have } 1 \text{ g}} = \frac{x \text{ mg}}{1,000 \text{ mg}}$$
- $$1x = 1.5 \times 1,000$$
- $$x = 1,500 \text{ mg; therefore, 1,500 mg is equal to 1.5 g}$$
- $$\frac{\text{Desired } 1,500 \text{ mg}}{\text{Have } 500 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$
- $$500x = 1,500$$
- $$x = 1,500 \div 500$$
- $$x = 3 \text{ mL}$$
- 39. 1. Oxygen saturation measures the ratio of oxyhemoglobin to the total concentration of hemoglobin in the blood. It indicates how much a person is being oxygenated. An oxygen saturation level of 95% or higher indicates an acceptable range.**
2. **Mucolytic agents, not bronchodilators, liquefy thick, sticky (viscous) secretions.**
  3. **Bronchodilators expand the airways of the respiratory tract, and this promotes air exchange and easier respirations.**
  4. **The ability of the chest to expand (respiratory excursion) increases, not decreases.**

5. Bronchovesicular breath sounds will increase, not decrease, after the administration of a bronchodilator. Bronchovesicular sounds are expected blowing sounds heard over the mainstem bronchi. They are blowing sounds that are moderate in pitch and intensity and equal in length on inspiration and expiration.
- 40. 1. Prolonged laxative use weakens the bowel's natural responses to fecal distention and results in chronic constipation. The osmotic action of magnesium salts in magnesium hydroxide draws water into the intestine, which can cause dehydration and electrolyte imbalances.**
2. Magnesium hydroxide causes sodium and potassium to be lost from, rather than accumulate in, the body. The magnesium in magnesium hydroxide may be absorbed and result in hypermagnesemia.
  - 3. Watery diarrhea is a sign of an overdose of magnesium hydroxide. The drug should be discontinued because watery diarrhea can lead to a serious imbalance in fluid and electrolytes.**
  4. Each dose should be followed by 8 ounces of water to promote a faster effect and help replenish lost fluid. Daily fluid intake should be 2,000 to 3,000 mL.
  5. This will interrupt sleep. Magnesium hydroxide causes bowel elimination 3 to 6 hours after its administration.
- 41. 1. The composition of the drug and the patient's response to the drug, not the route by which it is administered, determine if an allergic response occurs.**
2. The composition of a drug and its molecular reaction with another drug that is concurrently present determine if a drug interaction will occur.
  - 3. A transdermal patch placed on the skin gradually releases a predictable amount of medication that is absorbed into the bloodstream for a prescribed period of time. This approach maintains therapeutic blood levels and reduces fluctuations in circulating drug levels.**
  - 4. A drug administered via a transdermal patch cannot be inactivated by gastric acidity. Drugs taken orally can cause gastric irritation, which can be avoided if the drugs are administered via a transdermal patch.**
  5. Transdermal patches are used for their systemic, not local, effects.
- 42. 1. These are clinical indicators of dehydration and should be reported to the primary health-care provider because rehydration therapy may be necessary.**
- 2. Diphenoxylate/atropine depresses intestinal motility and effectively controls diarrhea within 24 to 36 hours. If diarrhea persists beyond 48 hours, the primary health-care provider should be notified.**
  3. Diphenoxylate/atropine may depress the central nervous system, which causes drowsiness and sedation, not hyperactivity.
  4. When a patient is experiencing diarrhea, fluid should be encouraged, not restricted, to prevent dehydration and electrolyte imbalances.
  5. The tablets for this medication are not enteric coated and do not have extended-release properties; therefore, they may be crushed if necessary.
- 43. 1. Constipation and diarrhea are both side effects of famotidine for which the nurse should assess the patient.**
2. Although administered by mouth, famotidine is not known to cause stomatitis.
  3. An increase, not decrease, in serum creatinine is a side effect associated with famotidine. Seventy percent of famotidine is excreted unchanged via the kidneys, and the drug may cause kidney damage.
  - 4. The nurse should monitor a patient's CBC with differential periodically during famotidine therapy to identify hematological adverse reactions. Serious hematological adverse reactions include agranulocytosis, aplastic anemia, anemia, neutropenia, and thrombocytopenia.**
  - 5. Completing the full course of therapy and not discontinuing the medication when feeling better support the achievement of the maximum therapeutic effect.**
- 44. 1. Mixing alcohol and zolpidem can intensify the effects of both and can precipitate dangerous side effects such as dizziness, shallow breathing, and impaired motor control, judgment, and thinking; it can even cause loss of consciousness or coma.**
- 2. Controlled-release (CR) medications should never be chewed, crushed, divided, or dissolved. A damaged tablet**

alters the process by which the medication is released. Too much medication may be released into the system at once, causing an excessive dose. Zolpidem is a dual-layer tablet: 10.5 mg is released immediately and another 2.5 mg later. The first layer dissolves rapidly to help a person get to sleep, and the second layer dissolves gradually to help a person stay asleep.

3. Zolpidem is better absorbed and therefore more effective when taken when the stomach is empty.
  4. Zolpidem is a central nervous system depressant that has a habit-forming potential if taken in higher doses than prescribed. Excessive doses can lead to tolerance and abuse. Also, a second dose so close to a previous dose can dramatically increase the risk of adverse reactions associated with the central nervous system such as irregular heart rate, impaired breathing, and memory loss.
  5. **Zolpidem is a central nervous system depressant that has a duration of action of approximately 7 to 8 hours. If the person is active before the medication is metabolized, drowsiness, dizziness, light-headedness, and impaired balance may occur, increasing the risk for injury.**
45. 2. The process of movement of a medication into the bloodstream (*absorption*) is the first element of pharmacokinetics as medication moves from its entry to its exit from the body.
3. The transport of a medication from the site of absorption to the site of medication action (*distribution*) is the second element of pharmacokinetics as medication moves from its entry to its exit from the body.
  4. Conversion of a medication to a less active form (*biotransformation*) in preparation for excretion is the third element of pharmacokinetics as medication moves from its entry to its exit from the body.
  1. Elimination of a medication by the body (*excretion*) is the fourth element of pharmacokinetics as medication moves from its entry to its exit from the body.
46. 1. Taking ibuprofen with a full glass of water and maintaining adequate fluid

**intake help to prevent renal adverse reactions.**

2. The patient should not exceed 2,400 mg of ibuprofen daily because this is the total number of milligrams prescribed by the primary health-care provider. However, information from the manufacturer states that patients should not exceed a total daily dose of 3,200 mg, to avoid stomach or intestinal damage.
  3. The patient should avoid taking a double dose. However, if a forgotten dose is remembered, it can be taken as long as it not too close to the next scheduled dose.
  4. **Research demonstrates that bleeding time is increased when taking ibuprofen; therefore, ibuprofen should be discontinued if dental treatment or surgery is scheduled.**
  5. If a skin rash occurs the patient should discontinue taking ibuprofen immediately. A rash may indicate toxic epidermal necrolysis or Stevens-Johnson syndrome, which can be life-threatening.
47. 1. Nitrofurantoin should be administered with food, not on an empty stomach, to minimize gastric irritation.
2. **This helps to prevent staining of the teeth associated with nitrofurantoin.**
  3. The urine is brown or rust colored, not reddish/orange, with nitrofurantoin. Reddish/orange urine is associated with the drug phenazopyridine, a urinary tract analgesic that contains a type of azo dye.
  4. **The patient should monitor for these signs and symptoms because they are indicative of pseudomembranous colitis, a serious adverse reaction to nitrofurantoin.**
  5. A week is too long to wait to report lack of improvement in signs and symptoms of the urinary tract infection. The patient should be instructed to notify the primary health-care provider if signs and symptoms do not resolve within several days.
48. 1. This is a dependent function of the nurse and requires an order by the primary health-care provider.
2. **Sedation and weakness may result from the anticholinergic effects of oxybutynin, especially in older adults.**
  3. **Drowsiness is a side effect of oxybutynin because of its anticholinergic effects. The patient should avoid activities such as driving**

when the level of alertness is diminished.

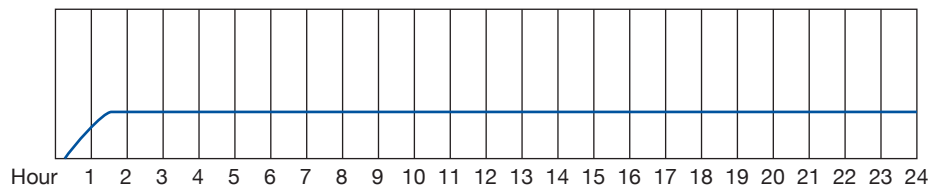
4. Urinary retention requires immediate medical attention to avoid permanent bladder damage resulting from overstretching of the bladder and kidney damage caused by a backup of urine into the kidneys. Oxybutynin exerts an antispasmodic effect on smooth muscle by inhibiting the action of acetylcholine and also relaxes the bladder's detrusor muscle. These actions can lead to urinary retention in some people.
  5. Oxybutynin decreases the ability to perspire because of its anticholinergic effect, which may cause fever and heat stroke if a person engages in strenuous activity in a warm environment.
49. 1. Analgesics do not have a curative action.  
 2. Analgesics decrease the intensity of pain (palliative treatment). Palliative treatments minimize signs and symptoms or promote comfort; palliative treatments do not produce a cure.  
 3. When 2 analgesics are administered together they exert a synergistic effect. A synergistic effect occurs when the combined effect of two medications is greater than when the effects of each are added together.  
 4. When 2 analgesics are given together they potentiate the action of each other. Potentiation occurs when drugs administered together increase the action of one or both drugs.  
 5. Two analgesics will increase, not decrease (antagonize), the action of each other.
50. 1. Budesonide, an inhaled corticosteroid, contains a small amount of milk sugar (lactose) that may cause an allergic reaction in a patient with lactose intolerance.  
 2. The bronchodilator reduces airway resistance, and then the budesonide can be aspirated deeper into the lungs for maximal effect.  
 3. Improvement in asthma control can occur within 24 hours of starting treatment; however, 1 to 2 weeks of treatment may be necessary to achieve a maximum benefit from an inhaled corticosteroid.  
 4. Rinsing the mouth with water and avoiding swallowing after use of budesonide will help to reduce the risk of an oral fungal (candida) infection.
51. 1. Increased fluid intake will help to decrease the viscosity of respiratory secretions and moisten the throat. At least 2,000 mL or more of fluid is suggested when taking dextromethorphan and guaifenesin.  
 2. One week, not 2 weeks, is long enough to wait before informing the primary health-care provider of a lack of improvement in signs and symptoms. Another intervention may be required.  
 3. Dextromethorphan, a cough suppressant, and guaifenesin, an expectorant, are contained in other over-the-counter cough remedies. Taking multiple drugs with the same or similar properties can cause an overdose of these elements.  
 4. Although taking a stimulant concurrently with dextromethorphan and guaifenesin can increase the risk of unpleasant side effects, it is not within the nurse's role to discontinue a medication.  
 5. These are serious side effects of dextromethorphan and guaifenesin; these medications should be discontinued with medical supervision.
52. 1. A calcium level of 5.4 mEq/L is within the expected range of 4.5 to 5.5 mEq/L and is not a cause for concern.  
 2. A temperature of 97.8°F is within the expected range of 97.5°F to 99.5°F for an adult and is not a cause for concern.  
 3. One thousand milligrams of docusate sodium daily exceeds the recommended daily dose of 50 to 500 mg and is a cause for concern.  
 4. A respiratory rate of 14 breaths per minute is within the expected range of 12 to 20 breaths per minute for an adult and is not a cause for concern.
53. 1. The opposite should be encouraged. Vegetable oils with polyunsaturated fatty acids should be exchanged for vegetable oils with monounsaturated fatty acids.

2. These human responses may indicate a serious adverse reaction to simvastatin and must be evaluated. In addition to reducing the liver's production of cholesterol, simvastatin affects several enzymes in muscle cells that are responsible for muscle growth; this may be the cause of muscle symptoms. However, these symptoms may indicate the presence of rhabdomyolysis. Rhabdomyolysis is a condition that breaks down skeletal muscle fibers and myocyte cell membranes which leads to muscle necrosis. Because rhabdomyolysis can be fatal, muscle symptoms must be seriously evaluated.
  3. Research demonstrates that omega-3 fatty acids help limit triglycerides, inflammation, hypertension, and cardiovascular and autoimmune diseases.
  4. Cola-colored urine indicates the presence of myoglobin, which is a skeletal muscle protein involved in metabolism. When skeletal muscles are damaged, they release myoglobin into the bloodstream. The blood is then filtered by the kidneys, thus causing urine to be cola or tea colored. Reduced urine output or absence of urine may indicate kidney damage caused by rhabdomyolysis necessitating immediate medical attention.
  5. Simvastatin should be taken at bedtime or during the evening meal, not in the morning. Research demonstrates that the body makes cholesterol at night and that cholesterol levels are lower when simvastatin is taken in the evening rather than in the morning.
54. 1. Food activates the proton pump mechanism, which releases gastric acid in the stomach. When esomeprazole, a proton pump inhibitor, is taken 30 minutes to 1 hour before a meal, it allows time for esomeprazole to be absorbed into the bloodstream, which then prevents the final transport of hydrogen ions into the gastric lumen.
2. This prevents damage to the delayed-release pellets within the esomeprazole capsule.
  3. Antacids may be used when taking esomeprazole.
  4. NSAIDs may cause an increase in gastrointestinal irritation and should be avoided.
  5. Opening the capsule can be done as long as the pellets are not crushed or chewed.
55. 1. One type of rash is a hypersensitivity (allergic) reaction to a chemical element in a drug. Hypersensitivity reactions can be mild if localized, but if the exposure is systemic, the reaction is on a larger scale and may even be life-threatening.
2. Tinnitus is caused by damage to the eighth cranial nerve, which is a toxic effect of acetylsalicylic acid.
  3. Acetylsalicylic acid has antiplatelet agglutination properties that cause an increase in clotting time.
  4. Dizziness is indicative of hypotension, which is not a common nontherapeutic response to acetylsalicylic acid.
  5. Diarrhea, rather than constipation, is more likely to occur with the intake of acetylsalicylic acid. Aspirin inhibits the COX-1 enzyme and causes a thinning of the stomach lining that increases the prospect of gastrointestinal irritation from digestive juices and contributes to diarrhea, heartburn, abdominal pain, bloating, and bleeding.
56. 1. Morphine, an opioid analgesic, is a central nervous system depressant. A central nervous system depressant reduces the activity and slows down the normal functions of the brain, thus leading to a decreased level of alertness.
2. Morphine, an opioid analgesic, is a central nervous system depressant. A central nervous system depressant has a sedating effect on brain function that can lead to confusion.
  3. Morphine, an opioid analgesic, is a central nervous system depressant. A central nervous system depressant decreases the respiratory center of the brain, thus causing bradypnea, not tachypnea.
  4. Morphine, an opioid analgesic, is a central nervous system depressant. A central nervous system depressant decreases gastrointestinal motility and contributes to constipation.
  5. Morphine, an opioid analgesic, is a central nervous system depressant. A central

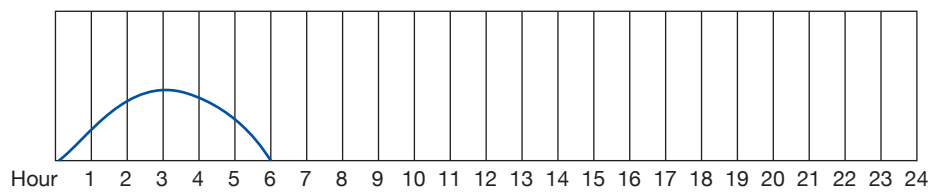
nervous system depressant relaxes the neurovascular system and contributes to hypotension, not hypertension.

- 57.** 1. Synthroid is a proprietary brand (trade) name for levothyroxine. Trade names of drugs are patented by drug companies. They begin with a capital letter and usually are short and easy to recall.
- 2. Levothyroxine is the generic (non-proprietary, official) name for the synthetic thyroid hormone that is chemically identical to thyroxine (T4). It is used to treat thyroid hormone deficiency.**
3. Levothyroxine does not have a curative action. It is a synthetic hormone used to treat a thyroid deficiency.
4. Levothyroxine does not have an antidotal action. An antidote is used to reverse the toxic effect of another medication. An example of a medication that is an antidote is naloxone; it limits central nervous system depression resulting from opioids.
- 5. Levothyroxine is a supportive (substitutive) medication because it maintains health by providing an essential hormone that is deficient in the body.**
- 58.** 1. **Knowing a drug's therapeutic range is essential. It indicates the lowest blood concentration level that is effective and the highest blood concentration level that is effective without causing toxicity.**
- 2. A trough level reflects the lowest plasma concentration of a drug in the patient's body. The nurse must determine if a trough level is within the drug's therapeutic range. A trough plasma level is determined by a blood test that assesses the level of the drug in the patient's body just before the administration of a prescribed dose of the medication.**
- 3. A peak level reflects the highest plasma concentration of a drug in the patient's body. The nurse must determine if a peak level is high enough to be within the therapeutic range yet not too high to be toxic. A peak plasma level is determined by a blood test that assesses the level of the drug in the patient's body 30 minutes to 1 hour after administration of the medication.**
4. Knowing the time needed by the body to metabolize or inactivate one-half the amount of a medication (half-life) will not help the nurse determine if an effective blood concentration level of the drug is being maintained.
5. Knowing the length of time it takes the body to respond to a medication (onset) will not help the nurse determine if an effective blood concentration level of the drug is being maintained.
- 59.** 1. **The prescription for the nystatin lozenges should be discussed with the primary health-care provider. It is unlikely that a patient with moderate dementia will be able to follow directions to keep a lozenge in the mouth for the length of time necessary for it to dissolve without swallowing. Also, it places the patient at risk for aspiration.**
- 2. The prescription for acetaminophen should be discussed with the primary health-care provider. Acetaminophen 1,000 mg administered every 6 hours will deliver 4,000 mg of acetaminophen, which exceeds the recommended maximum daily intake of 3,000. Excessive doses can cause liver damage.**
3. It is not necessary to discuss the prescription for levothyroxine 100 mcg. It is within the appropriate range of dosage for this medication and it will not interact with any of the other prescribed medications.
4. It is not necessary to discuss the prescription for simvastatin with the primary health-care provider. There are no concerns associated with administering simvastatin concurrently with the other prescribed medications and the dose is within the acceptable dosage range for an adult.
5. It is not necessary to discuss the prescription for docusate sodium with the primary health-care provider. There are no concerns associated with administering docusate sodium concurrently with the other prescribed medications and the dose is within the acceptable dosage range for an adult.
- 60.** 1. Glargine is a long-acting insulin with an onset of 1 to 2 hours. It has no pronounced peak and it has a duration of 24 hours or more.

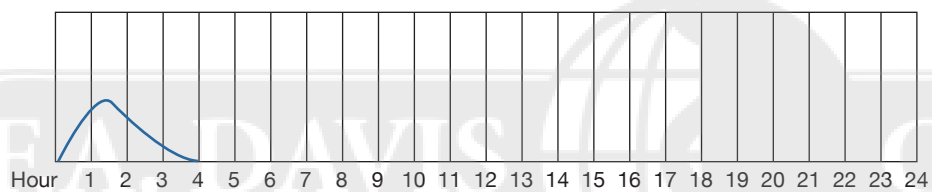




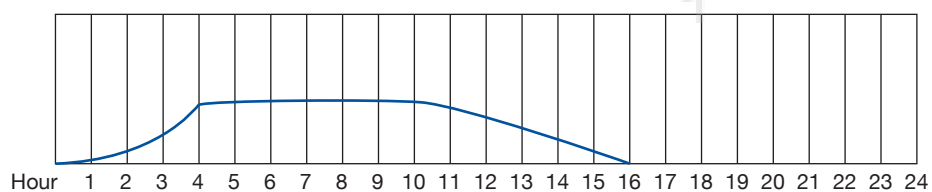
2. The graphic illustrates that regular insulin is short acting, with an onset of  $\frac{1}{2}$  to 1 hour. It has a peak of 2 to 3 hours and a duration of 3 to 6 hours.



3. Lispro is a rapid-acting insulin with an onset of 15 minutes, a peak of 60 to 90 minutes, and a duration of 3 to 4 hours.



4. NPH is an intermediate-acting insulin with an onset of 2 to 4 hours, a peak of 4 to 10 hours, and a duration of 10 to 16 hours.



# Basic Human Needs and Related Nursing Care

# 5

## Hygiene

### KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Activities of daily living

Asepsis

Back massage

Baths:

Bag bath (towel bath)

Bed bath (partial, complete)

Shower (standup, shower chair)

Sitz bath

Tub bath

Canthus, outer and inner

Cerumen

Circumcised, uncircumcised

Cuticles

Dental caries

Dentures

Distal

Effleurage

Flossing

Halitosis

Heat loss, mechanisms of:

Conduction

Convection

Evaporation

Radiation

Hirsutism

Integumentary

Labia, majora and minora

Mucous membrane

Oral hygiene

Orange stick

Pediculosis

Perianal area

Perineal care

Peripheral neuropathy

Plaque

Proximal

Sebaceous glands

Skin, dermis and epidermis

Smegma

Sordes

Toe pleat

F.A. DAVIS

COMPANY

### HYGIENE: QUESTIONS

1. A nurse is bathing a patient who has a fever. Why should the nurse use tepid bath water for this procedure?
  1. Increases heat loss
  2. Removes surface debris
  3. Reduces surface tension of skin
  4. Stimulates peripheral circulation

2. A nurse must make the decision to give a patient a full or partial bed bath. Which criterion is **most** important for the basis of this decision?
  1. Primary health-care provider's order for the patient's activity
  2. Immediate need of the patient
  3. Time of patient's last bath
  4. Patient preference
3. A patient has had a nasogastric tube to decompress the stomach for 3 days and is scheduled for intestinal surgery in the morning. For which of the following is the patient at the **greatest** risk?
  1. Physical injury
  2. Ineffective social interaction
  3. Decreased nutritional intake
  4. Altered oral mucous membranes
4. A patient is incontinent of urine and stool. For which patient response should the nurse be **most** concerned?
  1. Impaired skin integrity
  2. Altered sexuality
  3. Dehydration
  4. Confusion
5. A nurse is giving a patient a bed bath. Which nursing action is **most** important?
  1. Lower the 2 side rails on the working side of the bed.
  2. Ensure that the bath water is at least 110 F.
  3. Fold the washcloth like a mitt on the hand.
  4. Raise the bed to the highest position.
6. A nurse plans to give a patient a back rub. Which is the product the nurse should use for this intervention?
  1. Baby powder
  2. Rubbing alcohol
  3. Moisturizing lotion
  4. Antimicrobial cream
7. A nurse changes the linen of a bed while the patient sits in a chair. Of the options presented, which is the **most** important nursing action when changing bed linens?
  1. Ensuring the hem of the bottom sheet is facing the mattress
  2. Arranging the linen in the order in which it is to be used
  3. Shifting the mattress up to the headboard of the bed
  4. Checking the soiled bed linens for personal items
8. A nurse is responsible for providing hair care for a patient. Which should the nurse do to distribute oil evenly along hair shafts?
  1. Brush from the scalp toward the hair ends
  2. Lift opened fingers through the hair
  3. Apply a conditioner to wet hair
  4. Use a fine-toothed comb
9. Which condition identified by the nurse places a patient at the **greatest** risk for impaired self-care when toileting?
  1. Amputation of a foot
  2. Early dementia
  3. Fractured hip
  4. Pregnancy
10. A patient asks the nurse, "Why do I have to use mouthwash if I brush my teeth?" Which rationale should the nurse include when responding to this question?
  1. Minimizes the formation of cavities
  2. Helps reduce offensive mouth odors
  3. Softens debris that accumulates in the mouth
  4. Destroys pathogens that are found in the oral cavity

11. A nurse is planning to shampoo the hair of a patient who has an order for bedrest. Which should the nurse do **first**?
  1. Wet hair thoroughly before applying shampoo.
  2. Encourage the use of dry shampoo.
  3. Brush the hair to remove tangles.
  4. Tape eye shields over both eyes.
12. A patient has just had perineal surgery. Which type of bath should the nurse expect to be ordered for this patient?
  1. Sponge bath
  2. Sitz bath
  3. Tub bath
  4. Bed bath
13. A nurse plans to assist a patient who has impaired vision with a bed bath. Which is the **most** appropriate nursing intervention to facilitate bathing for this patient?
  1. Providing the patient with a liquid bath gel rather than a bar of soap
  2. Giving the patient an adapted toothbrush to use when brushing the teeth
  3. Checking the patient's ability to give self-care through a crack in the curtain
  4. Ensuring the patient can locate bathing supplies placed on the over-bed table
14. A nurse plans to meet the hygiene needs of a hospitalized patient who is experiencing hemiparesis because of a brain attack (cerebrovascular accident). Which is an appropriate nursing intervention?
  1. Assisting with the bath as needed
  2. Giving total assistance with a complete bath
  3. Providing minimal supervision during the bath
  4. Encouraging a family member to bathe the patient
15. A nurse is making an occupied bed. Which nursing action is **most** important?
  1. Securing top linens under the foot of the mattress and mitering the corners
  2. Ensuring that the patient's head is supported and is in functional alignment
  3. Fan-folding soiled linens as close to the patient's body as possible
  4. Positioning the bed in the horizontal position
16. A nurse must bathe the feet of a patient with diabetes. Which should the nurse do before bathing this patient's feet?
  1. File the nails straight across with an emery board.
  2. Teach that daily foot care is essential to healthy feet.
  3. Ensure a provider's order for hygienic foot care is obtained.
  4. Assess for additional risk factors that may contribute to localized problems.
17. Which should be the nurse's **first** intervention after removing a bedpan from under a debilitated patient who has just had a bowel movement?
  1. Document results.
  2. Provide perineal care.
  3. Reposition the patient.
  4. Cover the patient with the top linens.
18. Which common problem with the hair should the nurse anticipate when patients are on complete bedrest?
  1. Dry hair
  2. Oily hair
  3. Split hair
  4. Matted hair
19. A nurse is helping a patient who has right hemiparesis to get dressed. Which action should the nurse implement?
  1. Put the gown's right sleeve on first.
  2. Keep the patient in an open-backed gown.
  3. Encourage the patient to dress independently.
  4. Leave the right sleeve off while adjusting the tie at the neck.

20. A patient is incontinent of loose stools and is cognitively impaired. Which action should the nurse implement to help the patient prevent skin breakdown?
1. Wash the buttocks with strong soap and water.
  2. Bathe immediately after a bowel movement.
  3. Place the call bell in easy reach.
  4. Put a pad under the buttocks.
21. A nurse covers the patient with a cotton blanket during a bath. Which of the following mechanisms of heat loss is prevented by the nurse's action?
1. Vasodilation
  2. Conduction
  3. Convection
  4. Diffusion
22. Which is the **first** assessment that should be performed by the nurse before planning to meet the hygiene needs of a patient?
1. Recognize the patient's developmental stage.
  2. Collect the patient's toiletries needed for the bath.
  3. Identify the patient's ability to assist in hygiene activities.
  4. Determine the patient's preferences about hygiene practices.
23. A nurse gives a bed-bound patient a bed bath. Which is the **primary** reason why the nurse provides hygiene care to this patient?
1. Support a sense of well-being by increasing self-esteem.
  2. Promote circulation by stimulating peripheral nerve endings.
  3. Remove excess oil, perspiration, and bacteria by mechanical cleansing.
  4. Exercise muscles by contraction and relaxation of muscles when bathing.
24. Which human response, identified by the nurse, **best** supports the concern that a patient has a reduced capacity to provide for activities of daily living?
1. Presence of joint contractures
  2. Inability to wash body parts
  3. Postoperative lethargy
  4. Visual disorders
25. When giving a patient a bed bath, a nurse washes the patient's extremities from distal to proximal. Which is the rationale for this nursing action?
1. Decreases the chance of infection
  2. Facilitates removal of dry skin
  3. Stimulates venous return
  4. Minimizes skin tears
26. During oral care the nurse identifies a patch of dried food and debris adhered to the hard palate of the patient's mouth. Which word should the nurse use when documenting this condition?
1. Sordes
  2. Plaque
  3. Glossitis
  4. Stomatitis
27. A nurse is teaching a patient about how many times a day it is necessary to brush the teeth to achieve effective dental hygiene. According to the American Dental Association, how many times a day should the nurse teach the patient to brush the teeth?
1. 6
  2. 4
  3. 3
  4. 2

28. A nurse is providing hygiene to a patient with peripheral neuropathy. Which action should the nurse implement?
1. Seek an order for foot care.
  2. File the toenails straight across the nail.
  3. Wash the feet with lukewarm water and dry well.
  4. Apply moisturizing lotion to the feet, especially between the toes.
29. Which nursing intervention **most** requires the nurse to consider the concept of personal space?
1. Providing a bed bath
  2. Obtaining the vital signs
  3. Performing a health history
  4. Ambulating the patient down the hall
30. Which nursing actions are common to both a bed bath and a tub bath? **Select all that apply.**
1.  Obtain an order from the primary health-care provider
  2.  Help the patient wash parts that cannot be reached
  3.  Exposing just the part of the body being washed
  4.  Providing for privacy throughout the bath
  5.  Ensuring that the call bell is in reach
31. A nurse plans to provide a patient with a partial bath. Place the steps in the order in which the nurse should proceed.
1. Back
  2. Face
  3. Axilla
  4. Both hands
  5. Genital area
  6. Change water
- Answer: \_\_\_\_\_
32. Which should the nurse implement when caring for a patient who wears eyeglasses? **Select all that apply.**
1.  Encourage use of artificial tears while hospitalized.
  2.  Store eyeglasses in a safe place when not being worn.
  3.  Dry the lenses with a paper towel after they are washed.
  4.  Limit the time that eyeglasses are worn in an effort to rest the eyes.
  5.  Use warm water to clean the lenses of eyeglasses at least once a day.
33. When providing morning care for a patient, the nurse identifies crusty debris around the patient's eyes. Which actions should the nurse implement when cleaning the patient's eyes? **Select all that apply.**
1.  Wear sterile gloves.
  2.  Use a tear-free baby soap.
  3.  Position the patient on the same side as the eye to be cleaned.
  4.  Wash the eyes with cotton balls from the inner to outer canthus.
  5.  Use a separate cotton ball for each stroke when washing the eyes.
34. A nurse must make an unoccupied bed. Which nursing actions are essential? **Select all that apply.**
1.  Position the call bell in reach.
  2.  Place a pull sheet on top of the draw sheet.
  3.  Ensure that the bottom sheet is free of wrinkles.
  4.  Ensure that there is a toe pleat at the foot of the bed.
  5.  Complete one side of the bed before completing the other side.

35. A nurse plans to administer a foot bath to a patient who is sitting in a chair and has no contraindications for this intervention. Place the following steps in the order in which they should be implemented.

Answer: \_\_\_\_\_

1. Soak each foot individually for 5 to 20 minutes subject to the patient's tolerance, condition of the skin, and absence of a history of diabetes or peripheral vascular disease.
  2. Don clean gloves and assist the patient to position one foot in the water, verifying with the patient that the water temperature is comfortable.
  3. Position a waterproof pad on the floor on which to place a basin half-filled with warm water approximately 105 F to 110°F.
  4. Wash each foot with rinse-free soap and clean under the nails with an orange stick.
  5. Apply lotion to each foot, avoiding between the toes.
  6. Dry each foot gently, especially between the toes.
36. A nurse teaches a patient effective oral hygiene practices. Which patient behaviors indicate that the teaching about preventing and removing dental plaque was understood? **Select all that apply.**
1.  Uses an abrasive toothpaste
  2.  Brushes the teeth with a toothbrush
  3.  Gargles with anti-plaque mouthwash
  4.  Flosses the teeth with unwaxed floss
  5.  Has teeth cleaned regularly by a dental hygienist
37. A nurse is providing for the hygiene and grooming needs of an obese patient who easily becomes short of breath when moving about. Which nursing interventions are important? **Select all that apply.**
1.  Administering oxygen during provision of care
  2.  Maintaining the bed in a high-Fowler position
  3.  Assessing the patient's response to the activity
  4.  Bathing areas that the patient cannot reach
  5.  Providing rest periods every ten minutes
38. A nurse plans to shave a male patient's facial hair. Which actions should the nurse implement? **Select all that apply.**
1.  Shave in the direction of hair growth.
  2.  Hold the razor perpendicular to the skin.
  3.  Use long, downward strokes with the razor.
  4.  Ensure that the patient is not receiving an anticoagulant.
  5.  Use a hot, wet washcloth to wrap the face before shaving.
39. A nurse is caring for a patient who was newly admitted to a rehabilitation facility. The nurse reviews the patient's clinical record and chooses which of the following bathing plans to meet the patient's hygiene needs?
1. Complete bath with partial assistance
  2. Towel bath with total assistance
  3. Shower with partial assistance
  4. Tub bath with total assistance

## PATIENT'S CLINICAL RECORD

### History

A 74-year-old woman admitted for rehabilitation after a total hip replacement 6 days ago due to chronic pain from osteoarthritis. Postoperative status was uneventful; suture line intact and free of signs or symptoms of complications. Ingesting a regular diet; fluid and electrolytes in balance. Vital signs stable, although the respiratory rate is slightly elevated and labored due to a history of emphysema.

### Nursing Admission Assessment

Resting in the semi-Fowler position with an abduction pillow in place. Oriented to person but not time and place. Patient keeps saying, "This does not look like my home. I want to go home." Surgical site is dry and intact, wound edges approximated, and is free of any signs or symptoms of complications. Patient is pulling on the linen and appears agitated and is attempting to turn from side to side. Incontinent of urine.

### Vital Signs

Temperature: 99.4°F, temporal

Pulse: 98 beats per minute, regular

Respirations: 28 breaths per minute, pursed-lip breathing

Blood pressure: 150/90 mm Hg

40. A nurse is caring for a patient with an excessively dry mouth. Which nursing actions are important when providing mouth care for this patient? **Select all that apply.**
1.  **W**earing clean gloves
  2.  **P**roviding oral care every 2 hours
  3.  **R**insing frequently with mouthwash
  4.  **C**leansing 4 times a day with a water pick
  5.  **S**wabbing with a sponge-tipped applicator of lemon and glycerin
41. A nurse is providing perineal care to a male patient. Which should the nurse do? **Select all that apply.**
1.  **W**ash the genital area with hot, sudsy water.
  2.  **W**ash the scrotum before washing the glans penis.
  3.  **W**ash the shaft of the penis while moving toward the urinary meatus.
  4.  **W**ash the penis with one hand while holding it firmly with the other hand.
  5.  Wash the glans with a circular motion starting at the tip and then proceeding down the shaft.
42. A school nurse teaches an adolescent who has dry skin and acne about skin care. Which statements by the adolescent indicate that the information is understood? **Select all that apply.**
1.  " I will scrub my face every day with a strong soap."
  2.  " I will carefully break pustules after washing my face."
  3.  " I will apply a water-based emollient after washing my face."
  4.  " I will bathe my face with cool water when I shower in the morning."
  5.  " I will use mild soap to gently cleanse my face thoroughly twice a day."



43. A nurse is observing a nursing assistant in a home care setting administering a bed bath. Which issues apparent in the photograph indicate that the nursing assistant has violated the standards of care for a bed bath? **Select all that apply.**

1.  The pillows behind the patient's body should be removed before the bath.
2.  The nursing assistant's uniform is in contact with the patient's linens.
3.  The nursing assistant should be making eye contact with the patient.
4.  The patient's left leg should be covered with the bath blanket.
5.  The nursing assistant is not wearing clean gloves.



44. Which statements made by an older adult indicate to the nurse that additional teaching about skin care is necessary? **Select all that apply.**

1.  " I limit my baths to twice a week."
2.  " I humidify my home in the winter."
3.  " I apply moisturizing lotion to my body daily."
4.  " I use a bubble-bath product when I take a bath."
5.  " I love to relax in a hot bath before going to bed."

45. Which actions should the nurse implement when providing fingernail care during a patient's bath? **Select all that apply.**

1.  **P**ush cuticles back with the rounded end of a metal nail file.
2.  **F**ile nails straight across, rounding corners slightly.
3.  **A**pply a moisturizing lotion around cuticles.
4.  **C**lean under nails with an orange stick.
5.  **S**oak hands in hot water first.

## HYGIENE: ANSWERS AND RATIONALES

1. Heat is transferred from the warm surface of the skin to the water that is in direct contact with the body, and evaporation of the water promotes cooling. Tepid water is slightly below body temperature, and a person with a fever has an elevated body temperature (febrile).
  2. Friction, not the temperature of the bath water, helps to remove surface debris.
  3. Soap, not the temperature of bath water, reduces the surface tension of water, not the surface tension of skin.
  4. Peripheral circulation is increased by warm water and by rubbing the skin with a washcloth.
1. Full or partial bed baths can be administered regardless of the activity order written by the primary health-care provider because it is an independent function of the nurse.
  2. A total patient assessment with an analysis of the data identifies the needs of the patient and the appropriate intervention to meet those needs.
  3. Time has no relevance in relation to identifying what type of bed bath to administer to a patient.
  4. Although patient preference is a consideration, patient teaching should convince a patient what should be done to meet physical needs.
1. This patient is not at risk for physical injury. A person at risk for physical injury is in jeopardy for harm because of a perceptual or physiological deficit, a lack of awareness of hazards, or maturational age.
  2. This patient is not at risk for ineffective social interaction. A person at risk for ineffective social interaction is in jeopardy of experiencing negative, insufficient, or unsatisfactory interactions with others.
  3. Inadequate nutritional intake generally is not a concern. Most postoperative patients usually progress from a clear liquid to a regular diet in 2 to 3 days once bowel function returns. This is too short a time frame to be concerned about decreased nutritional intake.
  4. Not drinking anything by mouth and having a tube through the nose and posterior pharynx can result in drying of the oral mucous membranes and a coated, furrowed tongue.
1. Fecal material contains enzymes that erode the skin, and urine is an acidic fluid that macerates the skin. As a result, altered skin integrity is a serious concern.
  2. Although incontinence may contribute to low self-esteem, which may impact a person's sexual patterns, it is not the priority.
  3. Incontinence is unrelated to dehydration.
  4. Although confusion may contribute to a patient experiencing incontinence, confusion is not a reaction to incontinence.
1. Although lowering the two side rails on the working side of the bed might be done to promote safe body mechanics of the nurse, it is not a necessity.
  2. The temperature of bath water should be between 110°F and 115°F to promote comfort, dilate blood vessels, and prevent chilling. A lower temperature can cause chilling, and a higher temperature can cause skin trauma.
  3. Although a mitt retains water and heat and prevents loose ends from irritating the skin, it is not as essential as other factors that relate to patient safety.
  4. Although the height of the bed should be adjusted to promote the nurse's body mechanics, it is not as essential as other factors that relate to patient safety.
1. Baby powder mixed with secretions of the skin forms a paste-like substance that supports antimicrobial growth and irritates the skin, promoting skin breakdown. Also, baby powder should be avoided because it is a respiratory irritant.
  2. Rubbing alcohol causes drying of the skin and should not be used.
  3. Moisturizing lotion lubricates the skin and reduces friction between the nurse's hands and the patient's back. Lotion facilitates smooth movement of the hands across the patient's skin, which is relaxing and prevents trauma to the skin. The use of a moisturizing lotion for a back rub does not require a primary health-care provider's order.

4. An antimicrobial cream is inappropriate for a back rub. It can dry the skin and eliminate the integument's natural flora. Use of an antimicrobial cream requires a primary health-care provider's order.
7. 1. Although it is important to provide a smooth surface by placing the seam of a hem facing the mattress, it is not the priority.
    2. Arranging linen in the order in which it is to be used is an efficient approach that permits each sheet to be accessible when needed; however, it is not a priority.
    3. Although shifting the mattress up to the headboard of the bed is important to ensure that the patient is well supported when the head of the bed is elevated or the knee gatch employed, it is not the priority.
  4. **A nurse must take reasonable precautions to ensure that a patient's personal belongings, especially eyeglasses, dentures, and prosthetic devices, are kept safe. Checking for personal belongings before placing soiled linen into a linen hamper is a reasonable, prudent nursing action.**
8. 1. **Brushing the hair from the scalp to the ends of the hair massages the scalp and distributes oils secreted by the scalp down along the length of the hair shaft.**
    2. Lifting opened fingers through the hair to distribute oil evenly along hair shafts is inadequate hair care. It might be done at the completion of hair care to style the hair.
    3. Although a conditioner will make hair more supple, it will not facilitate distribution of oil along the hair shaft.
    4. A fine-toothed comb has pointed ends and should not be used for daily grooming because it can injure the scalp, damage the hair shaft, and split the ends of hair.
  9. 1. A patient with an amputation of a foot can still transfer to a bedside commode or ambulate with crutches to a bathroom.
    2. When a person has early dementia, frequent reminders to perform self-toileting activities or declarative directions about toileting usually are adequate.
  3. **Discomfort resulting from the proximity of the fracture to the pelvic area and the limitations placed on the positioning of, or weight-bearing on, the affected leg impact a patient's ability to use a bedpan or transfer to a commode.**
4. Although the enlarging uterus exerts pressure on the bladder, causing urinary frequency and alteration of the person's center of gravity, self-toileting usually is not impaired.
10. 1. Dental caries are caused by plaque. Therefore, brushing and flossing, not the use of mouthwash, are the most efficient ways to prevent dental caries.
    2. **An offensive odor to the breath (halitosis) can be caused by inadequate oral hygiene, periodontal disease, or systemic disease. Rinsing the mouth with mouthwash will flush the oral cavity of debris and microorganisms, which will reduce halitosis if it is caused by a localized problem.**
  3. Mouthwash flushes debris away from the teeth; it does not soften debris.
  4. Only bactericidal mouthwashes can limit the amount of bacterial flora in the mouth; prolonged or excessive use can result in oral fungal infections.
11. 1. Although wetting the hair thoroughly before applying shampoo is done, it is not the first intervention.
    2. Dry powder shampoos can irritate the scalp and dry the hair.
  3. **It is easier and causes less trauma to the hair to brush out tangles when the hair is dry rather than wet.**
  4. Taping eye shields over both eyes is unnecessary. Appropriate positioning will let the water flow by gravity away from the face, and a washcloth can be placed over the eyes.
12. 1. A sponge bath is given to reduce a patient's fever through heat loss via conduction and vaporization. Giving a sponge bath is an independent function of the nurse and does not require a primary health-care provider's order.
    2. **A sitz bath immerses a patient from the mid-thighs to the iliac crests, or umbilicus, in a special tub, or the patient sits in a basin that fits onto the toilet seat, so the legs and feet remain out of the water. The moist heat to the genital area increases local circulation, cleans the skin, reduces soreness, and promotes relaxation, voiding, drainage, and healing. A sitz bath requires a primary health-care provider's order because it is a method of applying local heat to the perineal area.**

3. Tubs generally are used for therapeutic baths when medications are added to the water to soothe irritated skin.
  4. A bed bath is indicated for patients with restricted mobility or decreased energy. Giving a bed bath is an independent function of the nurse and does not require a primary health-care provider's order.
- 13.**
1. Manipulating a bottle of bath gel may be more difficult than using a bar of soap for a patient who is vision impaired.
  2. Adapted toothbrushes are intended for people who have neuromuscular problems that interfere with grasping and manipulating a toothbrush, not for people with impaired vision.
  3. Monitoring a patient through a crack in the bedside curtain is a violation of patient privacy. Patients have a right to know when they are being assessed.
- 4. Identifying the placement of supplies on the over-bed table facilitates the use of equipment by a person with impaired vision and encourages self-care.**
- 14.**
1. **Hemiparesis is a weakness on one side of the body that can interfere with the performance of activities of daily living. Encouraging the patient to do as much as possible will support self-esteem, and assisting when necessary will ensure that hygiene needs are met.**
  2. Providing total assistance is unnecessary and may lower the patient's self-esteem, precipitate regression, or promote dependence.
  3. Minimal supervision may result in the completion of an inadequate bath.
  4. It is not the responsibility of the family to meet the physical needs of a hospitalized relative.
- 15.**
1. These actions will promote plantar flexion and should not be done without a toe pleat.
  2. **Maintaining functional alignment of a patient's head when making an occupied bed promotes comfort and minimizes stress to the respiratory passages and vital anatomy in the neck.**
  3. Although fan-folding soiled linens as close to the patient's body as possible is done, it is not the priority.
  4. Although positioning the bed in the horizontal position may be done to facilitate tight sheets with minimal wrinkles, it is not the priority. In addition, there are many patients who cannot assume this position.
- 16.**
1. A podiatrist should file or cut the toenails of a patient with diabetes. The toenails usually are thickened and hardened, and an accidental injury can take a long time to heal, become infected, and, if gangrene occurs, can even lead to an amputation.
  2. Although patient teaching about daily foot care is important, it is not the priority.
  3. A primary health-care provider's order is unnecessary. Foot care in relation to hygiene is within the scope of independent nursing practice.
- 4. A thorough assessment of the patient is the first step of the nursing process. People with diabetes frequently have thick, hardened toenails, peripheral neuropathy, impaired arterial and venous circulation in the feet, and foot or leg ulcers.**
- 17.**
1. Documenting results is done after the patient's immediate needs are met.
  2. **When rolling a debilitated patient off a bedpan the perianal area is exposed, which permits the nurse to provide immediate perineal hygiene. A bed-bound, debilitated patient is incapable of providing self-hygiene after having a bowel movement on a bedpan.**
  3. Repositioning the patient is not the priority after removing a debilitated patient from a bedpan.
  4. The top linens should not have been removed during this procedure because they provide privacy and maintain dignity.
- 18.**
1. Bedrest does not cause dry hair. Malnutrition, aging, and excessive shampooing cause dry hair.
  2. Bedrest does not cause oily hair. Infrequent shampooing causes oily hair.
  3. Bedrest does not cause hair to split. Excessive brushing, blow drying, and coloring cause hair to split.
  4. **Bedrest causes matted, tangled hair because of friction and pressure related to the movement of the head on a pillow.**
- 19.**
1. **Putting the right sleeve of the gown on the weak extremity first puts less stress on affected muscles; the stronger side can stretch more easily to dress.**

2. Although dressing the patient in an open-backed gown is helpful, the nurse still needs to put the gown on without stressing the joints, tendons, muscles, and nerves of the weak arm.
  3. Encouraging the patient to dress independently may be frustrating and tiring and may cause further damage to the weak arm.
  4. Leaving the right sleeve off while adjusting the tie at the neck is unnecessary. The patient should be dressed appropriately.
- 20.**
1. Strong soap may further irritate the skin.
  - 2. Loose stool contains digestive enzymes that are irritating to the skin and should be cleaned from the skin as soon as possible after soiling.**
  3. The patient is cognitively impaired and may be unaware of needs or how to use a call bell.
  4. Placing a pad under the buttocks will not keep stool off the skin.
- 21.**
1. Vasodilation increases blood flow to the surface of the skin, which promotes, not prevents, heat loss.
  2. Conduction is the transfer of heat between two objects in physical contact.
  - 3. Convection is the transfer of heat by movement of air along a surface. Using a bath blanket limits the amount of air flowing across the patient, which prevents heat loss.**
  4. Diffusion is the movement of molecules from a solution of higher concentration to a solution of lower concentration.
- 22.**
1. The patient's developmental level will influence how the nurse will proceed, but it is not the first assessment.
  2. Collecting the patient's toiletries is done after several other considerations and just before actually beginning the bath.
  3. Although identifying the patient's ability to assist in hygiene activities is significant in relation to the extent of self-care that may be expected, it is not the first assessment.
  - 4. Hygiene is a personal matter determined by individual beliefs, values, and practices. Hygiene practices are influenced by culture, religion, environment, age, health, and personal preferences. When personal preferences are supported, the patient has a sense of control and usually is more accepting of care.**
- 23.**
1. Although a bath is refreshing and relaxing and may support self-esteem, this is not the primary reason for bathing.
  2. Although friction from rubbing the skin increases surface temperature, which increases circulation to the area, this is not the primary purpose of a bed bath.
  - 3. The removal of accumulated oil, perspiration, dead cells, and bacteria from the skin limits the environment conducive to the growth of bacteria and skin breakdown. Intact, healthy skin is one of the body's first lines of defense.**
  4. Although range-of-motion exercises may be performed while bathing a patient, this is not the purpose of the bath.
- 24.**
1. Although a person may have contractures, a person may still be able to provide self-care.
  - 2. Being unable to wash body parts is a human response indicating that a patient is unable to provide for one's own activities of daily living, such as meeting hygiene and grooming needs.**
  3. People who are lethargic or listless generally are still able to provide for their own basic self-care needs. However, they may require frequent rest periods or more time to complete the task.
  4. People who are legally blind are still able to provide for their own self-care needs.
- 25.**
1. Friction, regardless of the direction of the washing strokes, in conjunction with soap and water, mechanically removes secretions, dirt, and microorganisms that decrease the potential for infection.
  2. Friction, regardless of the direction of the washing strokes, mechanically removes dry, dead skin cells.
  - 3. The pressure exerted on the skin surface by long, smooth strokes moving from distal to proximal areas also presses on the veins, which promotes venous return.**
  4. Long, smooth washing strokes that avoid a shearing force minimize skin tears.
- 26.**
- 1. The accumulation of matter, such as food, epithelial elements, dried secretions, and microorganisms (sordes) eventually can lead to dental caries and periodontal disease and therefore must be removed during oral hygiene.**

2. Plaque is an invisible film composed of secretions, epithelial cells, leukocytes, and bacteria that adheres to the enamel surface of teeth.
  3. Glossitis is an inflammation of the tongue.
  4. Stomatitis is an inflammation of the oral mucosa.
- 27.**
1. Brushing the teeth 6 times a day is more than the number of times a day recommended by the American Dental Association. Brushing the teeth 6 times a day is unnecessary for effective dental hygiene. It may cause gum recession which can lead to dentine hypersensitivity or cause damage to the neck of the teeth.
  2. Brushing the teeth 4 times a day is more than the number of times a day recommended by the American Dental Association. It is important to know that excessive brushing with a soft brush using minimal pressure will not wear away enamel in the absence of an acidic environment. However, brushing the teeth 4 or more times a day may cause problems such as gum recession, which can lead to dentine hypersensitivity or cause damage to the neck of the teeth.
  3. Brushing the teeth 3 times a day is more than the number of times a day recommended by the American Dental Association. However, some reputable Web sites recommend brushing the teeth after each meal. Some sites recommend brushing the teeth upon awakening to facilitate removal of bacteria from the mouth.
- 4. The American Dental Association recommends brushing the teeth for 2 minutes 2 times a day and it should be done at least 30 minutes after consuming acidic food or drinks.**
- 28.**
1. A primary health-care provider's order is unnecessary because providing foot care is within the scope of nursing practice.
  2. When the patient has peripheral neuropathy, cutting or filing toenails should be provided by a podiatrist.
- 3. Lukewarm water is comfortable and limits the potential for burns. Drying the feet limits moisture that promotes bacterial growth.**
4. Lotion between the toes in the dark warm environment of shoes promotes the growth of bacteria and the development of an infection.
- 29.**
- 1. Touching a patient during a bed bath invades the person's intimate space (physical contact to 1½ feet) because of the need to expose and touch personal body parts.**
  2. Although the nurse enters a patient's intimate space when obtaining vital signs, it does not involve touching the intimate parts of a patient's body and is therefore less intrusive than other procedures.
  3. This can be accomplished by remaining in a person's personal space (1%oto 4 feet) or social space (4 to 12 feet).
  4. Although touching a patient while ambulating invades the person's intimate space, it does not involve touching the intimate parts of a patient's body and is therefore less intrusive than other procedures.
- 30.**
- 1. Providing a bed bath is within the scope of nursing practice, so a primary health-care provider's order is unnecessary. An order is necessary for a tub bath or shower because it requires an activity order and is therefore a dependent function of the nurse.**
  - 2. Patients should provide self-care within their abilities. When they have limitations, such as an inability to reach a body area, an activity intolerance, a decreased level of consciousness, or dementia, it is the nurse's responsibility to assist the patient regardless of the type of bath.**
  3. It is impossible to expose just the body parts being washed during a tub bath or shower. During a tub bath or shower the entire body is exposed.
  - 4. Bathing is a private matter and an invasion of personal space. The nurse provides privacy by pulling a curtain, closing a door, and keeping the patient covered as much as possible. These interventions maintain the patient's dignity.**
  5. There is no need for a call bell when a patient is taking a tub bath or a shower because it is unsafe to leave a patient alone.
- 31.**
- 2. The bath should follow a cephalocaudal progression and be based on the principle of from "clean to dirty." The face is washed first before soap is place in the bath water.**

3. The axillae are less soiled than the hands but are more soiled than the face.
  4. The hands are more soiled than the axilla.
  6. The water is changed after washing the soiled hands so as not to contaminate other areas of the body.
  1. The back is less soiled than the genital area.
  5. The genital area is considered the most soiled and should be washed last.
- 32.**
1. Encouraging the use of artificial tears is unnecessary. Not everyone who wears eyeglasses has dry eyes. Also, this intervention requires a health-care provider's order.
  2. Storing eyeglasses in a safe place when not being worn protects them from loss or damage.
  3. A paper towel is coarse and may scratch the lenses of eyeglasses. A soft nonabrasive cloth or chamois should be used.
  4. Patient preference determines how long eyeglasses can be worn.
  5. Eyeglasses should be cleaned at least once a day because dirty lenses impair vision. Warm, not hot, water is used to prevent distortion of the lens or frame, particularly if it is made of a plastic compound.
- 33.**
1. Medical, not surgical, asepsis is necessary. Clean gloves are adequate.
  2. Soap is never used around the eyes. The eyes should be washed only with water.
  3. Tilting the head or turning the patient toward the same side as the eye to be washed facilitates the flow of water from the inner to the outer canthus. This limits secretions from entering the lacrimal ducts.
  4. Washing the eyes from the inner canthus to the outer canthus moves debris away from the lacrimal duct.
  5. Using a new cotton ball for each stroke prevents reintroducing debris removed during the initial stroke.
- 34.**
1. The call bell does not have to be positioned until there is a patient occupying the bed.
  2. A pull sheet is not included in the procedure for an unoccupied bed. In addition, this creates too many layers of linens that may wrinkle under a patient. The draw sheet can be used as a pull sheet.
3. Wrinkles create ridges that exert additional pressure on the skin, promoting discomfort, skin irritation, and the development of pressure ulcers.
  4. A toe pleat is essential because it allows room for movement of the feet and helps to prevent plantar flexion as a result of top sheets that are too tight.
  5. Although this action is advisable to conserve the nurse's time and energy, it is not a priority.
- 35.**
3. The first step involves positioning a waterproof pad on the floor on which to place the foot basin. Warm water promotes circulation. Avoiding hot water protects the patient from sustaining a burn injury.
  2. The second step involves donning clean gloves to protect the nurse from the patient's body fluids. The heel of a foot is a common place for skin cracks and skin breakdown. Ensuring that the water temperature is comfortable helps to prevent a burn injury.
  1. The third step involves soaking a foot for the appropriate length of time considering the patient's condition. A foot bath for a patient with diabetes or peripheral vascular disease may dry the skin, placing the patient at risk for cracks in the skin, and should be conducted over 5 minutes or less.
  4. The fourth step involves washing each foot with rinse-free soap because this avoids the drying effect of soap residue. Cleaning under the nails with an orange stick removes debris and minimize the risk of injury that could occur when using a sharp instrument.
  6. The fifth step involves drying each foot, especially between the toes, because moisture can cause maceration and support the growth of fungal infections.
  5. The sixth step involves applying lotion to each foot while avoiding between the toes. Lotion hydrates the skin and keeps skin supple, reducing the risk of cracks in the skin. Lotion between the toes should be avoided because it can cause skin maceration and support the growth of fungal infections.

- 36.** 1. Abrasive toothpaste (dentifrice) can harm the enamel of teeth. Nonabrasive toothpaste and a soft toothbrush should be used.
- 2. Brushing the teeth involves several techniques: brushing back and forth strokes across the biting surface of teeth; brushing from the gum line to the crown of each tooth; and, with the bristles at a 45-degree angle at the gum line, vibrating the bristles while moving from under the gingival margin to the crown of each tooth.**
- 3. Mouthwash with anti-plaque properties can help prevent plaque buildup.**
- 4. Unwaxed floss is thin, slides between the teeth easily, and is more effective than waxed floss.**
- 5. A dental hygienist is a licensed oral health-care professional educated to provide such services as dental education, dental radiographs, oral prophylaxis, and plaque removal.**
- 37.** 1. Administration of oxygen is a dependent function of the nurse and requires a primary health-care provider's order unless it is needed in an emergency situation. The situation in this question is not an emergency.
2. When an obese patient is in the high-Fowler position the abdominal organs press against the diaphragm, which limits respiratory excursion. The semi-Fowler position is preferred.
- 3. Evaluation of a patient's response to care allows the nurse to alter care to meet the patient's individual needs.**
- 4. Bathing body parts that the patient cannot reach ensures that the patient receives adequate hygiene care.**
5. A rest period every 10 minutes may be inadequate or may unnecessarily prolong the bath. This is not individualized to the patient's needs.
- 38.** 1. **Shaving in the direction of hair growth limits skin irritation and prevents ingrown hairs.**
2. A safety razor should be held at a 45-, not 90-, degree angle to the skin.
3. Short firm but gentle strokes should be used when shaving a patient.
- 4. Ensuring that the patient is not receiving an anticoagulant is essential. A patient receiving an anticoagulant should use an electric razor to avoid the risk of blood loss associated with an accidental cut using a safety razor.**
5. A hot washcloth may cause a burn injury. A warm, not hot, washcloth applied to the face for several minutes before shaving helps to soften the beard.
- 39.** 1. The patient is too confused to provide self-care even with partial assistance.
- 2. A towel bath is the most appropriate bathing plan for this patient. It is quick and easy to administer and is the intervention that is least taxing physically considering the patient's recent surgery, confusion, and respiratory status.**
3. The patient is too confused and physically dependent to participate in a shower even with partial assistance.
4. It is too soon after surgery to submerge the patient's body in a tub bath. Generally a tub bath is contraindicated until a surgical wound is fully healed.
- 40.** 1. **Wearing clean gloves protects the nurse from the blood and body fluids of the patient. This interrupts the chain of infection.**
- 2. Mouth breathing, oxygen use, unconsciousness, and debilitation, among other conditions, can lead to dry oral mucous membranes. The nurse should provide oral hygiene with saline rinses frequently to keep the oral mucosa moist.**
3. Mouthwash contains astringents that can injure sensitive, delicate dry mucous membranes.
4. Oral hygiene four times a day is inadequate for a patient with a dry mouth, and a water pick is contraindicated because the force of the water can injure delicate dry mucous membranes.
5. Lemon and glycerin swabs are counterproductive because their use can lead to further dryness of the mucosa and an alteration in tooth enamel.
- 41.** 1. Warm, not hot, water is used to clean the perineal area because the skin and mucous membranes of the genital area are sensitive, and hot water may cause harm.
2. The glans penis, foreskin, and shaft of the penis are cleaned before the scrotum. The scrotum is considered more soiled than the penis because of its proximity to the rectum.



3. When cleaning the shaft of the penis, bathing should start at the glans penis and then proceed down the shaft toward the scrotum.
  4. **Stabilizing the penis and holding it firmly facilitates the bathing procedure and usually prevents an erection.**
  5. **Washing from the tip of the penis in a circular motion and then down the shaft of the penis follows the principle of “clean to dirty,” the meatus being the cleanest.**
- 42.
1. Strong soap may irritate fragile skin, and washing every other day is inadequate to cleanse the skin.
  2. Breaking pustules should be avoided because it can spread infection and cause skin damage and scarring. Acne with pustules requires the intervention of a dermatologist because topical or oral medications may be necessary to treat the acne.
  3. **A water-based emollient for dry skin is less likely to block sebaceous gland ducts and hair follicles than an oil-based emollient, which will aggravate the condition.**
  4. Washing once a day is inadequate to cleanse the skin. Warm, not cool, water is necessary to remove the oily accumulation on the face.
  5. **Washing the face with mild soap and water twice a day will remove dirt and oil, which helps prevent secondary infection. Washing the face more than twice a day can irritate the skin and make acne worse.**
- 43.
1. The pillows can remain under the patient's head throughout the bath as long as this position is not contraindicated by the patient's condition. A patient does not have to remain in the supine position to receive a bed bath.
  2. **When a nursing care provider's uniform touches a patient's linens the uniform is considered contaminated. Microorganisms from the patient can be carried on the uniform to other patients. This is a violation of medical asepsis.**
  3. The nursing assistant should not be making eye contact with the patient. The nursing assistant should be concentrating on looking at the action being implemented.
- 44.
1. Limiting baths to twice a week is an acceptable practice. Excessive exposure to warm water and soap exacerbates dry skin associated with aging.
  2. A humidified environment limits the amount of insensible loss of moisture through the skin, which helps the skin retain fluid and remain supple.
  3. Applying moisturizing lotion to the body daily is an acceptable practice. Older adults experience less sebum produced by sebaceous glands, causing dry and scaly skin. Moisturizing lotion helps to keep skin supple and less dry.
  4. **Bubble-bath preparations cause irritation and dryness of the skin because they remove essential skin surface oils. Showers are preferable to baths because baths require submersion in warm water, which is detrimental to skin hydration and resiliency.**
  5. **Hot bath water removes essential skin surface oils, causing skin to be dry and scaly, and should be avoided. A short shower with warm water should be encouraged instead.**
- 45.
1. Cuticles should be pushed back with a washcloth or an orange stick.
  2. **Filing nails straight across helps to avoid ingrown nails. Rounding corners slightly reduces sharp edges that may scratch the skin.**
  3. **Applying a moisturizing lotion around cuticles helps to soften cuticles.**
  4. **An orange stick is an implement that is shaped to facilitate removal of debris from under the nails without causing tissue injury. Removal of dirt and debris decreases the risk of infection.**
  5. Hot water can cause tissue injury and should be avoided. Warm, not hot, water should be used.

# Mobility

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Ambulation

Atrophy

Blanchable erythema

Body mechanics

Bony prominence

Contracture

Exercises:

    Aerobic

    Anaerobic

    Isometric

    Isotonic

Flaccidity

Footdrop

Functional alignment

Gait

Hemiparesis

Hemiplegia

Joints:

    Ball and socket

    Condyloid

    Hinge

    Pivot

    Saddle

Mechanical lift, Hoyer lift

Paraplegia

Paresis

Popliteal

Positioning devices:

    Bed cradle

    Hand roll

    Hand-wrist splint

    Heel and elbow protectors

    Pillow

    Side rail

    Trapeze bar

    Trochanter roll

    Turning and pull sheet

Positions:

    Contour

    Dorsal recumbent

    Fowler (low-, semi-, high-)

    Knee-chest

    Lateral

Lithotomy

Orthopneic

Prone

Sims

Supine

Trendelenburg

Posture

Pressure relief, reduction devices:

    Mattresses:

        Air mattress

        Dense foam and gel

        Egg-crate mattress

    Cushions:

        Air

        Gel

        Heel and elbow protectors

        Sheepskin

Pressure ulcer, stages I, II, III, IV

Quadriplegia

Range-of-motion exercises:

    Active

    Active-assistive

    Passive

Range-of-motion movements:

    Abduction

    Adduction

    Circumduction

    Eversion

    Extension

    Flexion:

        Dorsal flexion

        Lateral flexion

        Plantar flexion

        Radial flexion

        Ulnar flexion

    Hyperextension

    Inversion

    Opposition of thumb

    Pronation

    Rotation:

        External

        Internal

        Supination

F.A. DAVIS

COMPANY

Reactive hyperemia	Mitt
Restraints:	Poncho
Belt	Vest
Chest	Wrist
Elbow	Shearing force
Four-point	

## MOBILITY: QUESTIONS

1. A nurse turns a patient's ankle so that the sole of the foot moves medially toward the midline. Which word should the nurse use when documenting exactly what was done during range-of-motion exercises?
  1. Inversion
  2. Adduction
  3. Plantar flexion
  4. Internal rotation
2. A nurse is transferring a patient from a bed to a wheelchair. Which should the nurse do to quickly assess this patient's tolerance to the change in position?
  1. Obtain a blood pressure.
  2. Monitor for bradycardia.
  3. Determine if the patient feels dizzy.
  4. Allow the patient time to adjust to the change in position.
3. A nurse is transferring a patient from the bed to a wheelchair using a mechanical lift. Which is a basic nursing intervention associated with this procedure?
  1. Lock the base lever in the open position when moving the mechanical lift.
  2. Raise the mechanical lift so that the patient is six inches off the mattress.
  3. Keep the wheels of the mechanical lift locked throughout the procedure.
  4. Ensure the patient's feet are guarded when sitting on the mechanical lift.
4. A patient has hemiplegia as a result of a brain attack (cerebrovascular accident). Which complication of immobility is a concern to the nurse?
  1. Dehydration
  2. Contractures
  3. Incontinence
  4. Hypertension
5. Which stage pressure ulcer requires the nurse to measure the extent of undermining?
  1. Stage 0
  2. Stage I
  3. Stage II
  4. Stage III
6. A patient has a cast from the hand to above the elbow because of a fractured ulna and radius. After the cast is removed, the nurse teaches the patient active range-of-motion exercises. Which patient action indicates that further teaching is necessary?
  1. Moves the elbow to the point of resistance
  2. Keeps the elbow flexed at 90° after the procedure
  3. Assesses the elbow's response after this procedure
  4. Puts the elbow through its full range at least 3 times

7. Which word is **most** closely associated with nursing care strategies to maintain functional alignment when patients are bed bound?
  1. Endurance
  2. Strength
  3. Support
  4. Balance
8. A patient with impaired mobility is to be discharged within a week from the hospital. Which is an example of a discharge goal for this patient?
  1. The patient will understand range-of-motion exercises before their initiation.
  2. The patient will be taught range-of-motion exercises after they are ordered.
  3. The patient will transfer independently to a chair by discharge.
  4. The patient will be kept clean and dry at all times.
9. A nurse is performing passive range-of-motion exercises for a patient who is in the supine position. Which motion occurs when the nurse bends the patient's ankle so that the toes are pointed toward the ceiling?
  1. Adduction
  2. Supination
  3. Dorsal flexion
  4. Plantar extension
10. A nurse is caring for a patient with impaired mobility. Which position contributes **most** to the formation of a hip flexion contracture?
  1. Low-Fowler
  2. Orthopneic
  3. Supine
  4. Sims
11. A patient is diagnosed with a stage IV pressure ulcer with eschar. Which medical treatment should the nurse anticipate the primary health-care provider will order for this patient?
  1. Heat lamp treatment three times a day
  2. Application of a topical antibiotic
  3. Cleansing irrigations twice daily
  4. Debridement of the wound
12. A nurse raises a patient's arm forward and upward over the head during range-of-motion exercises. Which word should the nurse use when documenting exactly what was done during this range-of-motion exercise?
  1. Flexion
  2. Supination
  3. Opposition
  4. Hyperextension
13. A patient with a history of thrombophlebitis should not have pressure exerted on the popliteal space. In which position should the nurse **avoid** placing this patient?
  1. Prone
  2. Supine
  3. Contour
  4. Trendelenburg
14. A nurse is caring for a variety of patients, each experiencing one of the following problems. Which health problem places a patient at the **greatest** risk for complications associated with immobility?
  1. Incontinence
  2. Quadriplegia
  3. Hemiparesis
  4. Confusion

15. A nurse in a community center is conversing with a group of older adults who voiced fears about falling. Which is the **most** common consequence associated with older adults' fear of falling that the nurse should discuss with them?
  1. Impaired skin integrity
  2. Occurrence of panic attacks
  3. Self-imposed social isolation
  4. Decreased physical conditioning
16. A nurse is evaluating an ambulating patient's balance. Which factor about the patient is **most** important for the nurse to assess?
  1. Posture
  2. Strength
  3. Energy level
  4. Respiratory rate
17. A patient with an order for bedrest has diaphoresis. Which should the nurse use to **best** limit the negative effects of perspiration on dependent skin surfaces of this patient?
  1. Ventilated heel protectors
  2. Air-filled rings
  3. Air mattress
  4. Sheepskin
18. A nurse is teaching a class to nursing assistants about how to care for patients who are immobile. Which should the nurse include about why immobilized people develop contractures?
  1. Muscles that flex, adduct, and internally rotate are stronger than weaker opposing muscles.
  2. Muscular contractures occur because of excessive muscle flaccidity.
  3. Muscle mass and strength decline at a progressive rate weekly.
  4. Muscle catabolism exceeds muscle anabolism.
19. A nurse turns the palm of a patient's hand downward when performing range-of-motion exercises. Which word should the nurse use when documenting exactly what was done?
  1. Pronation
  2. Lateral flexion
  3. Circumduction
  4. External rotation
20. Which nursing action is **most** effective in relation to the concept *Immobility can lead to occlusion of blood vessels in areas where bony prominences rest on a mattress*?
  1. Encouraging the patient to breathe deeply 10 times per hour
  2. Performing range-of-motion exercises twice a day
  3. Placing a sheepskin pad under the sacrum
  4. Repositioning the patient every 2 hours
21. A nurse plans to use a trochanter roll when repositioning a patient. Where should the nurse place the trochanter roll?
  1. Under the small of the back
  2. Behind the knees when supine
  3. Alongside the ilium to mid-thigh
  4. In the palm of the hand with the fingers flexed
22. Which is the earliest nursing assessment that indicates permanent damage to tissues because of compression of soft tissue between a bony prominence and a mattress?
  1. Nonblanchable erythema
  2. Circumoral cyanosis
  3. Tissue necrosis
  4. Skin abrasion

23. An emaciated patient is at risk for developing a pressure ulcer. In which position should the nurse avoid placing the patient?
1. Thirty-degree lateral position
  2. Side-lying position
  3. Supine position
  4. Prone position
24. A nurse is making an occupied bed. Which should the nurse do to prevent plantar flexion?
1. Tuck in the top linens on just the sides of the bed.
  2. Place a toe pleat in the top linens over the feet.
  3. Let the top linens hang off the end of the bed.
  4. Use trochanter rolls to position the feet.
25. A nurse identifies that a patient's pressure ulcer has just partial-thickness skin loss involving the epidermis and dermis. Which stage pressure ulcer should the nurse document based on this assessment?
1. Stage I
  2. Stage II
  3. Stage III
  4. Stage IV
26. Which nursing action should be implemented when assisting a patient to move from a bed to a wheelchair?
1. Lowering the bed to 2 inches below the height of the patient's wheelchair
  2. Applying pressure under the patient's axillae areas when standing up
  3. Letting the patient help as much as possible when permitted
  4. Keeping the patient's feet within 6 inches of each other
27. A nurse places a patient in the orthopneic position. Which is the **primary** reason for the use of this position?
1. Facilitates breathing
  2. Supports hip extension
  3. Prevents pressure ulcers
  4. Promotes urinary elimination
28. An immobilized bed-bound patient is placed on a 2-hour turning and positioning program. Which should the nurse explain to the patient is the **primary** reason why this program is important?
1. Supports comfort
  2. Promotes elimination
  3. Maintains skin integrity
  4. Facilitates respiratory function
29. Which do nurses sometimes do that increase their risk for injury when moving patients?
1. Use longer, rather than shorter, muscles when moving patients
  2. Place their feet wide apart when transferring patients
  3. Pull rather than push when turning patients
  4. Rotate their backs when moving patients
30. Nurses should monitor for which systemic responses in immobilized patients?  
**Select all that apply.**
1.   P ressure ulcer
  2.   Dep endent edema
  3.   Hy postatic pneumonia
  4.   P lantar flexion contracture
  5.   Inc reased cardiac workload

31. A nurse moves a patient's leg through the range of motion demonstrated in the figure. Which word should the nurse use when documenting exactly what was done during the range-of-motion exercise?
1. Eversion
  2. Circumduction
  3. Plantar flexion
  4. External rotation



32. A nurse is placing a patient in the left lateral position. Which actions should the nurse implement when positioning this patient? **Select all that apply.**
1.  Maintain the left knee flexed at ninety degrees.
  2.  Rest the right leg on top of the left leg.
  3.  Place the ankles in plantar flexion.
  4.  Align the shoulders with the hips.
  5.  Protract the left shoulder.
33. A nurse places a patient with a sacral pressure ulcer in the left Sims position. How should the nurse position the patient's right arm? **Select all that apply.**
1.  On a pillow
  2.  Behind the back
  3.  With the palm up
  4.  In internal rotation
  5.  With the elbow flexed
34. A nurse concludes that a patient has the potential for impaired mobility. Which assessments reflect risk factors that support this conclusion? **Select all that apply.**
1.  Joint pain
  2.  Exertional fatigue
  3.  Sedentary lifestyle
  4.  Limited range of motion
  5.  Increased respiratory rate
35. A nurse enters the room of the patient in the photograph. The patient has right-sided weakness and is attempting to transfer out of bed without the nurse's knowledge. What should the nurse do **first**?
1. Lower the height of the bed to its lowest position to the floor.
  2. Reposition the patient back to the semi-Fowler position.
  3. Move the wheelchair parallel to the foot of the bed.
  4. Put on the patient's slippers.



36. A nurse plans to teach a patient with hemiparesis to use a cane. Which should the nurse teach the patient to do? **Select all that apply.**
1.  Move forward 1 step with the weak leg first followed by the strong leg and cane.
  2.  Adjust the cane height 12 inches lower than the waist.
  3.  Hold the cane in the strong hand when walking.
  4.  Look at the feet when walking with the cane.
  5.  Avoid leaning over onto the cane.
37. A nurse is planning to help move a patient up in bed. Which actions can the nurse implement to reduce the risk of self-strain when performing this action? **Select all that apply.**
1.  Move the patient up against gravity.
  2.  Use the large muscles of the legs.
  3.  Bend the body from the waist.
  4.  Keep the knees slightly bent.
  5.  Raise the bed to waist level.
38. A primary health-care provider orders crutches for a person who has a left lower leg injury. The nurse is teaching the person how to move from a standing to a sitting position in a chair. Place the following steps in the order in which they should be implemented.
1. While standing, back up so that the unaffected leg is against the edge of the center of the chair seat.
  2. Hold the hand bars of both crutches with the left hand.
  3. Lean forward slightly and flex the knees and hips.
  4. Grasp the arm of the chair with the right hand.
  5. Lower the body into the chair.
- Answer: \_\_\_\_\_
39. A patient sits for excessive lengths of time in a wheelchair. Which sites should the nurse assess for skin breakdown in this patient? **Select all that apply.**
1.  Ischial tuberosities
  2.  Bilateral scapulae
  3.  Trochanters
  4.  Malleolus
  5.  Sacrum



40. A patient with limited mobility has an order to be out of bed to a chair for 1 hour daily. The nurse plans to transfer the patient using a mechanical lift. Which actions should the nurse implement? **Select all that apply.**
- Apply gentle pressure against the patient's knees while lowering the patient into the chair.
  - Ensure that there is an order to use this device to transfer the patient out of bed.
  - Hook the longer straps on the end of the sling closest to the patient's feet.
  - Place a sheepskin inside the sling so that it is under the patient.
  - Lead with the patient's feet when exiting the bed.
41. A primary health-care provider orders a standard walker for a patient who has left-sided weakness and requires some assistance with balance, but can bear weight on both legs. Which should the nurse teach the patient about how to use the walker safely? **Select all that apply.**
- Advance the strong leg last by itself.
  - Lift the walker and move it forward twelve inches.
  - Advance the walker and the weak leg ahead together first.
  - Adjust the height of the walker so that it is equal with the hip joint.
  - Roll the walker a comfortable distance ahead before stepping forward.
42. A nurse is to transfer a patient from a bed to a chair. After washing the hands, providing privacy, and explaining the transfer to the patient, the nurse ensures that the wheels on the bed are locked and moves the bed to the lowest position. Place the following steps in the order in which they should be implemented.
- Verify if the patient feels dizzy.
  - Assess the patient's vital signs and strength while in the supine position.
  - Assist the patient to a sitting position on the side of the bed with the feet on the floor.
  - Elevate the head of the bed to the high-Fowler position and put footwear on the patient's feet.
  - Support the patient sitting on the side of the bed for several minutes before transferring to a chair.
- Answer: \_\_\_\_\_
43. Which actions employed by the nurse indicate acceptable body mechanics to avoid self-injury? **Select all that apply.**
- Keep back, neck, pelvis, and feet aligned.
  - Position oneself close to the patient.
  - Keep knees and hips slightly flexed.
  - Arrange for adequate help.
  - Keep feet close together.
44. A nurse is assessing a patient's risk for thrombus formation associated with impaired mobility. Which factors constitute Virchow's triad? **Select all that apply.**
- Compression of small vessels in the legs
  - Orthostatic hypotension
  - Coagulation activation
  - Hypostatic pneumonia
  - Venous stasis
45. A nurse is caring for a male patient who is at risk for a pressure ulcer. After reviewing the patient's clinical record, which area of the body should the nurse identify is **most** at risk for a pressure ulcer?
- Greater trochanters
  - Ischial tuberosities
  - Medial malleolus
  - Spinal processes

**PATIENT'S CLINICAL RECORD****Primary Health-Care Provider Orders**

Oxygen via simple face mask, humidified, 8 L flow rate

Levofloxacin 500 mg, PO, daily for 14 days

Prednisone 30 mg, PO, daily for 2 days; 20 mg, PO, daily for 2 days; 10 mg, PO, daily for 2 days; and 5 mg, PO, daily for 2 days

Position for comfort

OOB to bathroom

Fluid intake, at least 3,000 mL daily, soft diet

**Nurse's Progress Note**

Patient sitting in an upright position leaning on a pillow on the over-bed table, oxygen face mask in place and set at a flow rate of 8 L, patient has a productive cough, expectorating clear-colored mucous. Respirations are 34 and labored, with mild retractions and flaring of nares. Assisted with activities of daily living, shortness of breath on activity.

**Patient Interview**

Patient states that he was fine until he caught his 5-year-old granddaughter's cold. He developed a fever, nasal stuffiness, and a "heavy cough" that got progressively worse. The primary health-care provider admitted him to the hospital with the diagnosis of pneumonia and an oxygen saturation rate of 88%. He said that since he is in the hospital he "feels much better." He stated that he is able to breathe best leaning over the over-bed table, that his cough is improved, and his fever is resolving.

F.A. DAVIS

COMPANY

## MOBILITY: ANSWERS AND RATIONALES

- 1. Inversion, a gliding movement of the foot, occurs by turning the sole of the foot medially toward the midline of the body.**
  2. Adduction occurs when an arm or leg moves toward and/or beyond the midline of the body.
  3. Plantar flexion occurs when the joint of the ankle is in extension by pointing the toes of the foot downward and away from the anterior portion of the lower leg.
  4. Internal rotation of a leg occurs by turning the foot and leg inward so that the toes point toward the other leg.
- 1. Although a blood pressure reading may indicate the presence of hypotension, the blood pressure should be obtained before and after a transfer to allow a comparison to conclude that the hypotension is orthostatic hypotension.**
  2. If the patient is experiencing orthostatic hypotension, the heart rate will increase, not decrease.
  - 3. Feeling dizzy is a subjective response to orthostatic hypotension. Obtaining feedback from the patient provides a quick evaluation of the patient's tolerance of the transfer.**
  4. Allowing the patient time to adjust to the change in position is not an assessment. This is a safe intervention for a patient who is experiencing orthostatic hypotension.
- 1. The width of the base depends on the configuration of the bed, objects in the room, and the ultimate destination. The base usually is locked open when lifting or lowering the patient and locked closed when moving the lift.**
  2. Raising the mechanical lift so that the patient is six inches off the mattress is unsafe. The lift should raise the patient high enough to clear the surface of the bed.
  3. The wheels must be unlocked to move the lift from under the bed to its ultimate destination.
  - 4. The legs dangle from the sling and therefore may drag across the linens or hit other objects if not protected.**
- 1. Dehydration is not a response to immobility.**
  - 2. Contractures result from permanent shortening of muscles, tendons, and ligaments. Routine range-of-motion exercises and maintaining the body in functional alignment can prevent contractures.**
  3. The decreased tone of the urinary bladder and the inability to assume the usual voiding position in bed promote urinary retention, rather than urinary incontinence.
  4. With immobility, the increased heart rate reduces the diastolic pressure. In addition, there is a decrease in blood pressure related to postural changes from lying to sitting or standing (orthostatic hypotension). This situation is manageable with a priority on maintaining patient safety.
- 1. There is no stage 0 in the classification system for staging pressure ulcers.**
  2. The skin is still intact and there is no undermining in a stage I pressure ulcer.
  3. Tissue damage is superficial and there is no undermining in a stage II pressure ulcer.
  - 4. In a stage III pressure ulcer there is full-thickness skin loss involving damage to subcutaneous tissue that may extend to the fascia and there may or may not be undermining, which is tissue destruction underneath intact skin along wound margins.**
- 1. Moving the elbow to the point of resistance is desirable. Performing range of motion beyond resistance may injure muscles and joints and should be avoided.**
  - 2. Keeping the elbow flexed after the procedure is undesirable because it contributes to a flexion contracture. Slight flexion to maintain functional alignment is preferred because it minimizes stress and strain on muscles, tendons, ligaments, and joints.**
  3. Responses to range-of-motion exercises must be evaluated and compared with the assessment performed before the procedure.
  4. Sequential flexion and extension of a hinge joint are efficient in facilitating full range of motion of the joint.

7. 1. Endurance relates to aerobic exercise that improves the body's capacity to consume oxygen for producing energy at the cellular level.
  2. Strength relates to isometric and isotonic exercises, which contract muscles and promote their development.
  3. **The line of gravity passes through the center of gravity when the body is correctly aligned; this results in the least amount of stress on the muscles, joints, and soft tissues. Bed-bound patients often need assistive devices such as pillows, sandbags, bed cradles, wedges, rolls, and splints to support and maintain the vertebral column and extremities in functional alignment.**
  4. Balance relates to body mechanics and is achieved through a wide base of support and a lowered center of gravity.
8. 1. This goal is not measurable as stated. Understanding is not measurable unless parameters are identified.
  2. This statement is a nursing intervention, not a patient goal.
  3. **This is a patient-centered goal that is specific and measurable and has a time frame.**
  4. This statement is a nursing goal, not a patient goal.
9. 1. Adduction occurs when an arm or leg moves toward and/or beyond the midline of the body.
  2. Supination occurs when the hand and forearm rotate so that the palm of the hand is facing upward.
  3. **Dorsal flexion (dorsiflexion) of the joint of the ankle occurs when the toes of the foot point upward and backward toward the anterior portion of the lower leg.**
  4. There is no range of motion called plantar extension. Plantar flexion occurs when the joint of the ankle is in extension by pointing the toes of the foot downward and away from the anterior portion of the lower leg.
10. 1. In the low-Fowler position the hips are slightly flexed.
  2. **While in the high-Fowler position the patient is then positioned leaning forward with arms resting on an over-bed table (orthopneic position). In the orthopneic position, the hips are extensively flexed, creating an angle less than 90 degrees.**
  3. In the supine position the hips are extended (180 degrees), not flexed.
  4. In the Sims position, the hip and knee of the upper leg are just slightly flexed.
11. 1. Heat lamp treatments will further dry out the wound and can cause burns.
  2. Topical antibiotics are used only when the ulcer is infected, not to treat eschar.
  3. Cleansing irrigations are ineffective in removing the thick, fibrin-containing cells of eschar covering the surface of the wound.
  4. **Thick, leather-like, necrotic devitalized tissue (eschar) must be removed surgically or enzymatically before wound healing can occur.**
12. 1. **The shoulder, a ball-and-socket joint, flexes by raising the arm from a position by the side of the body forward and upward to a position beside the head.**
  2. Supination occurs when the hand and forearm rotate so that the palm of the hand is facing upward.
  3. Opposition is the touching of the thumb of the hand to each fingertip of the same hand.
  4. Hyperextension of the arm occurs by moving an arm from a resting position at the side of the body to a position behind the body.
13. 1. In the prone position there is pressure in front of, not behind, the knees.
  2. In the supine position the hips and legs are extended, which does not exert pressure on the popliteal spaces.
  3. **In the contour position the head of the bed and the knee gatch are slightly elevated. The elevated knee gatch puts pressure on the popliteal spaces.**
  4. In the Trendelenburg position the hips and knees are extended, which does not exert pressure on the popliteal spaces.
14. 1. Patients who are incontinent are not necessarily immobile.
  2. **Quadriplegia, paralysis of all four extremities, places the patient at greatest risk for pressure ulcers because the patient has no ability to shift body weight off of bony prominences or change position without total assistance.**

3. Hemiparesis, muscle weakness on one side of the body, does not prevent a person from shifting or changing position to relieve pressure on the skin.
  4. Confused patients can move independently when uncomfortable or when encouraged and assisted to move by the nurse.
- 15.**
1. A person who chooses not to ambulate still has the ability to assume many different sitting or lying-down positions.
  2. The occurrence of panic attacks is not the most common consequence. Anxiety and ultimately panic that is precipitated by a situation can be prevented by avoiding the situation.
  3. A person who chooses not to ambulate because of a fear of falling still can socialize.
  4. **Most falls occur when ambulating. Fear of falling results in the conscious choice not to place oneself in a position where a fall can occur. Disuse and muscle wasting cause a reduction of muscle strength at the rate of 5% to 10% per week so that within 2 months of immobility more than 50% of a muscle's strength can be lost. In addition, there is a decreased cardiac reserve. These responses result in decreased physical conditioning.**
- 16.**
1. **Assessing posture will identify whether the patient's center of gravity is in the midline from the middle of the forehead to a midpoint between the feet and therefore balanced within the patient's base of support.**
  2. Strength has more to do with the exertion of power, not balance.
  3. Energy has more to do with endurance, not balance.
  4. Assessing the respiratory rate before activity establishes a baseline against which to compare the respiratory rate after activity to determine tolerance for activity, not balance.
- 17.**
1. Ventilated heel protectors protect only the heels, not the other dependent areas of the body.
  2. Air-filled rings usually are made of plastic, which tends to promote sweating. Air rings rarely are used because they are designed for just the sacral area and often they increase, not decrease, pressure.
  3. Air mattresses usually are made of plastic, which tends to promote sweating.
- 4.** **The soft tufts of sheepskin allow air to circulate, thereby promoting the evaporation of moisture that can precipitate skin breakdown.**
- 18.**
1. **The state of balance between muscles that serve to contract in opposite directions is impaired with immobility. The fibers of the stronger muscles contract for longer periods than do those of the weaker, opposing muscles. This results in a change in the loose connective tissue to a denser connective tissue and to fibrotic changes that limit range of motion.**
  2. Contractures occur because of muscle spasticity and shortening, not muscle flaccidity.
  3. Disuse and muscle wasting cause a reduction in muscle strength at the rate of 5% to 10% a week so that within 2 months more than 50% of a muscle's strength can be lost. This results in muscle atrophy, not contractures.
  4. Muscle catabolism exceeding muscle anabolism is unrelated to contractures. In unused muscles, catabolism exceeds anabolism and the muscles decrease in size (disuse atrophy).
- 19.**
1. **Pronation of the hand occurs by rotating the hand and arm so that the palm of the hand is facing down toward the floor.**
  2. Lateral flexion of the hand occurs with both abduction (radial flexion) and adduction (ulnar flexion). With the hand supinated, radial flexion occurs by bending the wrist laterally toward the thumb and ulnar flexion occurs by bending the wrist laterally toward the fifth finger.
  3. Circumduction, associated with a ball-and-socket joint, occurs when an extended extremity moves forward, up, back, and down in a full circle.
  4. External rotation is associated with ball-and-socket joints. External rotation of a shoulder occurs when the upper arm is held parallel to the floor, the elbow is at a 90-degree angle, the fingers are pointing toward the floor, and the person moves the arm upward so that the fingers point toward the ceiling. External rotation of the hip occurs when a leg in extension is turned so that the foot points outward from the midline of the body.

- 20.** 1. Deep breathing prevents atelectasis and hypostatic pneumonia, not pressure ulcers, which this question is about.  
 2. Range-of-motion exercises help prevent contractures, not pressure ulcers.  
 3. Although sheepskin reduces friction and limits pressure, its main purpose is to allow air to circulate under the patient to minimize moisture and maceration of skin.  
**4. Turning a patient relieves pressure on the capillary beds of the dependent areas of the body, particularly the skin overlying bony prominences, which reestablishes blood flow to the area. When pressure on a capillary exceeds 15 to 32 mm Hg its lumen is occluded, depriving oxygen to local body cells.**
- 21.** 1. Placing a trochanter roll under the small of the back is unsafe. A trochanter roll placed in the small of the back is uncomfortable and produces an excessive lumbar curvature.  
 2. Placing a trochanter roll behind the knees when supine is contraindicated because it places unnecessary pressure on the popliteal area.  
**3. A trochanter roll is a rolled wedge, pillow, or sandbag placed by the lateral aspect of the leg between the iliac crest and knee to prevent external hip rotation.**  
 4. The diameter of a trochanter roll is too wide to maintain the hand in functional alignment.
- 22.** 1. **Nonblanchable erythema refers to redness of intact skin that persists when finger pressure is applied. This is the classic sign of a stage I pressure ulcer.**  
 2. Circumoral cyanosis is associated with hypoxia, not pressure ulcers.  
 3. With necrosis, death of cells has occurred. Necrosis occurs in stage III and stage IV pressure ulcers.  
 4. With an abrasion, the superficial layers of the skin are scraped away. This stage II, not stage I, pressure ulcer appears reddened and may exhibit localized serous weeping or bleeding.
- 23.** 1. The 30-degree lateral position is the preferred position to prevent pressure ulcers because it limits body weight directly over bony prominences, versus other positions.
- 2. In the side-lying position the majority of the body weight is borne by the greater trochanter. The bone is close to the surface of the skin, with minimal overlying protective tissue.**
3. In the supine position the occiput, scapulae, spine, elbows, sacrum, and heels are at risk for pressure; however, the body weight is distributed more evenly than in some other positions.  
 4. In the prone position the ears, cheeks, acromion process, anterior-superior spinous process, knees, toes, male genitalia, and female breasts are at risk for pressure; however, the body weight is distributed more evenly than in some other positions.
- 24.** 1. Top sheets tucked in along the sides of the bed still exert pressure on the upper surface of the feet, which may promote plantar flexion. The sides of top sheets, mitered at the foot of the bed, hang feely off the side of the bed.  
**2. Making a vertical or horizontal toe pleat in the linen at the foot of the bed over the patient's feet leaves room for the feet to move freely and avoids exerting pressure on the upper surface of the feet, thus minimizing plantar flexion.**  
 3. The weight of the top sheets still exerts pressure on the upper surface of the feet, promoting plantar flexion.  
 4. Trochanter rolls prevent external hip rotation, not plantar flexion.
- 25.** 1. In a stage I pressure ulcer the skin is still intact and manifests clinically as reactive hyperemia.  
**2. In a stage II pressure ulcer the partial-thickness skin loss manifests clinically as an abrasion, blister, or shallow crater.**  
 3. In a stage III pressure ulcer there is full-thickness skin loss involving the subcutaneous tissue that may extend to the underlying fascia. The ulcer manifests clinically as a deep crater with or without undermining.  
 4. In a stage IV pressure ulcer there is full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures.
- 26.** 1. The bed should be higher, not lower, than the wheelchair so that gravity can facilitate the transfer.

2. Applying pressure under the patient's axillae areas when standing up should be avoided because it can injure local nerves and blood vessels.
  - 3. Encouraging the patient to be as self-sufficient as possible ensures that the transfer is conducted at the patient's pace, promotes self-esteem, and decreases the physical effort expended by the nurse.**
  4. Keeping the patient's feet within 6 inches of each other will provide a narrow base of support and is unsafe.
- 27. 1. Sitting in the high-Fowler position and leaning forward (orthopneic position) allow the abdominal organs to drop by gravity, which promotes contraction of the diaphragm. The arms resting on an over-bed table increase thoracic excursion. This position promotes breathing.**
2. The hips will be in extreme flexion, not extension.
  3. Pressure ulcers can still occur on the ischial tuberosities.
  4. Standing (for men) and sitting on a toilet/commode (for women) are superior to any position for promoting urinary elimination.
- 28. 1. Although turning the patient to a new position every 2 hours provides variety and increased comfort, these are not the primary reasons for this intervention.**
2. Although turning frequently promotes elimination, the upright positions, such as high-Fowler and sitting, have a greater influence on elimination because of the effect of gravity.
  - 3. Compression of soft tissue greater than 15 to 32 mm Hg interferes with capillary circulation and compromises tissue oxygenation in the compressed area. Turning the patient relieves the compression of tissue in dependent areas, particularly those tissues overlying bony prominences.**
  4. Although turning and positioning promote respiratory functioning, other interventions, such as sitting, deep breathing, coughing, and incentive spirometry, have a greater influence on respiratory status.
- 29. 1. Nurses should use the longer, stronger muscles of the thighs and buttocks when moving patients to protect their weaker back and arm muscles.**
2. Nurses should have a wide base of support when moving patients to provide better stability.
  3. Nurses should use a pulling motion to turn patients because the muscles that flex, rather than extend, the arm are stronger, and pulling, rather than pushing, creates less friction and therefore less effort.
  - 4. Twisting (rotation) of the thoracolumbar spine and flexion of the back place the line of gravity outside the base of support, which can cause muscle strain and disabling injuries. Misaligning the back when moving patients occurs most often when not facing the direction of the move.**
- 30. 1. Prolonged pressure on skin over a bony prominence interferes with capillary blood flow to the skin, which ultimately can result in the localized response of a pressure ulcer.**
- 2. Decreased calf muscle activity and pressure of the bed on the legs allow blood to accumulate in the distal veins. The resulting increased hydrostatic pressure moves fluid out of the intravascular compartment and into the interstitial compartment, causing edema.**
  - 3. Static respiratory secretions provide an excellent media for bacterial growth that can result in hypostatic pneumonia, which is a systemic response to immobility.**
  4. Plantar flexion contracture (footdrop) is a localized response to prolonged extension of the ankle.
  - 5. An increased cardiac workload results from a decrease in vessel resistance and redistribution of blood in the body with blood pooling in the lower extremities. These are systemic responses to immobility.**
- 31. 1. Eversion, a gliding movement of the foot, occurs by turning the sole of the foot away from the midline of the body.**
2. Circumduction is a range of motion that is performed with a ball-and-socket joint. It occurs when an extended extremity moves forward, up, back, and down in a full circle.
  3. Plantar flexion occurs when the joint of the ankle is in extension by pointing the toes of the foot downward and away from the anterior portion of the lower leg.

4. **External rotation occurs when the entire leg is rolled outward from the body so that the toes point away from the opposite leg.**
32.
    1. This excessive flexion can result in contractures of the hip and knee. The left leg should be slightly flexed or extended.
    2. The right leg should be supported on a pillow in front of the left leg.
    3. The ankles should be maintained at 90 degrees.
    4. **Maintaining alignment of the shoulders and hips avoids stress and strain on the bones, muscles, and joints.**
    5. **In the left lateral (side-lying) position, the left arm is positioned in front of the body with the shoulder pulled forward (protracted). This reduces pressure on the joint in the shoulder and acromial process.**
  33.
    1. **In the left Sims position the patient's right arm and leg are supported on pillows to prevent internal rotation of the shoulder and hip.**
    2. The right arm is positioned in front of, not behind, the back.
    3. The right hand is positioned in pronation, not supination.
    4. The right arm is positioned to maintain the shoulder in functional alignment, not internal rotation.
    5. **The right elbow should be slightly flexed at the elbow; this supports comfort and functional alignment.**
  34.
    1. **Joint pain may prevent the patient from moving about, leading to contractures resulting in impaired mobility.**
    2. Exertional fatigue is associated with activity intolerance. People who are fatigued are still able to move.
    3. People who are sedentary are still able to move.
    4. **Limited range of motion is associated with contracture formation and impaired mobility.**
    5. An increased respiratory rate is a response to activity, not impaired mobility.
  35.
    1. The patient may fall if the bed is lowered while the patient is sitting on the side of the bed. Although lowering the height of the bed closer to the floor should be done, it is not the first thing that the nurse should do in this scenario.
    2. **The patient should be repositioned back in bed. The height of the bed from the floor is in the highest position and must be lowered before the patient can be transferred out of bed. It is unsafe to lower the height of the bed while the patient is sitting on the side of the bed.**
    3. Repositioning the wheelchair is not the first thing that the nurse should do. Also, the wheelchair should be positioned at the head of the left side of the bed. A patient with right-sided weakness should exit the bed leading with the strong left arm and leg.
    4. Putting on the patient's slippers is not the first thing the nurse should do in this scenario. Once the patient is returned to bed then slippers can be placed on the patient's feet and then the patient can be transferred.
  36.
    1. The unaffected leg should be advanced first because the weight of the body is supported by the leg with the greatest strength.
    2. With the tip of the cane placed 6 inches lateral to the foot, the handle should be at the level of the patient's greater trochanter to ensure that the elbow will be flexed 15 to 30 degrees when using the cane.
    3. **A cane is a hand-gripped assistive device; therefore, the hand opposite the hemiparesis should hold the cane. Exercises can strengthen the flexor and extensor muscles of the arms and the muscles that dorsiflex the wrist.**
    4. This will cause flexion of the neck, hips, or waist that will move the center of gravity outside the base of support. Body alignment is essential for balance, stability, and safe ambulation.
    5. **Leaning over onto the cane should be avoided. The patient should distribute weight between the feet and cane while standing in an upright posture. This is the most stable position when using a cane.**
  37.
    1. Muscle strain is reduced when moving patients with gravity, not with the added effort needed to move patients against gravity.
    2. **To exert an upward lift the gluteal and leg muscles should be used, rather than the sacrospinal muscles of the back.**



The gluteal and leg muscles are larger than the sacrospinal muscles and therefore fatigue less quickly, and their use protects the intervertebral disks.

3. Bending from the waist increases the strain on the sacrospinal muscles and intervertebral disks.
  4. The muscles of the legs are most efficient when the knees and hips are slightly bent. This reduces strain on the muscles being used.
  5. Positioning the bed at waist height avoids the need to reach and stretch, which may strain a caregiver's muscles, bones, joints, tendons, or ligaments.
- 38. 1. Being as close as possible to the chair allows a person to use the chair for support when sitting. Also, it supports sitting deeper into the seat of the chair, which is safer than sitting on the edge of the seat.**
2. Holding the hand bars of both crutches with the left hand frees the right hand for the next step in the procedure.
  4. Grasping the arm of the chair with the right hand allows the person to support body weight partially on the right arm and the right leg.
  3. Leaning forward slightly and flexing the knees and hips partially lowers the body and prepares it for the next step in the procedure.
  5. Lowering the body into the chair protects the body from injury.
- 39. 1. When in the sitting position, the hips and knees are flexed at 90 degrees and the body's weight is borne by the pelvis, particularly the ischial tuberosities, which are bony protuberances of the lower portion of the ischium. Using a wheelchair results in prolonged sitting unless interventions are implemented to promote local circulation.**
2. Pressure to the scapulae occurs when in a sitting position as well as when in the supine and Fowler positions.
  3. Pressure to a trochanter occurs in a side-lying, not the sitting, position.
  4. Pressure to the lateral malleolus of an ankle occurs in a side-lying, not a sitting, position.
  5. Pressure to the sacrum occurs when in a sitting position, as well as when in the supine and Fowler positions.
- 40. 1. Applying gentle pressure against the patient's knees while lowering the patient into the chair facilitates an upright sitting position in a chair.**
2. Moving patients with a mechanical lift is within the scope of nursing practice, and a primary health-care provider's order is unnecessary.
  3. The longer straps/chains go in the holes for the seat support, which keep the legs and pelvis below the upper body. Appropriate placement of the upper and lower straps/chains creates a bucket seat in which a patient is moved safely.
  4. Placing a sheepskin inside the sling so that it is under the patient may result in the patient's sliding down and out of the sling during the transfer. Nylon, net, or canvas slings are available.
  5. It does not matter whether the feet or the head exit the bed first as long as functional alignment and safety are maintained.
- 41. 1. Advancing the unaffected leg last by itself allows weight to be borne by the affected leg while both arms are supported on the walker.**
2. Six, not 12, inches is the proper distance to advance a walker. Twelve inches will require the patient to reach too far forward, moving beyond a stable center of gravity.
  3. Advancing the walker and the affected leg together ensures that weight is borne by the unaffected leg.
  4. Adjusting the height of the walker so that it is equal with the hip joint is too low and will require the patient to stoop to reach the hand bar. The hand bar should be at a height just below the patient's waist, allowing the elbows to be slightly flexed. A walker that is the correct height allows a patient to assume a more functional posture.
  5. A standard walker does not have wheels. Directing a person to advance a walker a comfortable distance is unsafe. The word "comfortable" is subjective and unclear. Walkers should be advanced 6 inches at a time to ensure that a person's weight does not extend beyond the center of gravity.
- 42. 2. Assessing vital signs is the first step in the procedure because results provide baseline data against which to compare outcomes when evaluating activity tolerance.**

4. Elevating the head of the bed is the second step in the procedure. It minimizes the effort required by the patient to move to a sitting position in the bed as well as minimizes lifting by the nurse. Footwear protects the patient's feet from physical injury and contamination from pathogens that may be on the floor.
  3. Assisting the patient to a sitting position on the side of the bed with the feet on the floor facilitates pivoting of the trunk of the body perpendicular to the length of the bed. This prepares the body eventually to assume a wide base of support with the greatest mass between the feet.
  1. Verifying if the patient feels dizzy evaluates tolerance to the activity and is the fourth step in the transfer procedure. Dizziness indicates orthostatic hypotension. If this occurs the nurse should support the patient in the sitting position for a few minutes. If dizziness does not resolve, then return the patient to a semi-Fowler position to provide for the safety of the patient.
  5. Supporting the patient in the sitting position for several minutes before transferring to a chair is the fifth step in the transfer procedure. This reduces the possibility of orthostatic hypotension and allows more time for an evaluation of the patient's response to the change in position.
43. 1. Alignment reduces the risk of lumbar vertebrae and muscle group injury resulting from torquing (twisting).
  2. Positioning oneself close to the patient keeps the patient closer to your center of gravity. Increased stability reduces strain on back muscles.
  3. Keeping knees and hips slightly flexed facilitates using the large muscles of the legs rather than the back to move the patient.
  4. Multiple caregivers share the load of moving a patient safely.
  5. Feet should be positioned wide apart, not close together, to provide a wide base of support, which increases stability.
44. 1. **Compression of small vessels in the legs is one of the three factors that make up Virchow's triad. Immobility leads to vessel compression which can cause injury to small vessels.**
  2. Orthostatic hypotension is not one of the three factors that make up Virchow's triad. Orthostatic hypotension occurs when prolonged inactivity deactivates the baroreceptors associated with constriction and distention of blood vessels. When changing position there is a decrease in venous return, followed by a decrease in cardiac output and a decline in blood pressure. It may take several seconds to several minutes for the blood pressure to respond to the change in position.
  3. **Coagulation activation is one of the three factors that make up Virchow's triad. As a result of venous pooling there is a decreased clearance of coagulation factors, resulting in activation of clotting (i.e., the blood clots faster).**
  4. Hypostatic pneumonia is not one of the three factors that make up Virchow's triad. Hypostatic pneumonia is an inflammation of the lung as a result of stasis of respiratory secretions.
  5. **Venous stasis is one of the three factors that make up Virchow's triad. Inactive skeletal muscles of the legs do not adequately compress the peripheral vessels in the legs and therefore do not assist with the return of blood back to the heart; this results in stasis of blood in the lower extremities.**
45. 1. Greater trochanters are at risk when a patient is in the side-lying position.
  2. **Ischial tuberosities are at greatest risk when a patient is in the orthopedic or mid- to high-Fowler positions because the greatest weight of the body is exerted against the genital, perianal, and sacral areas of the body.**
  3. A lateral malleolus is at risk when a patient is in a side-lying position.
  4. Spinal processes are at risk when a patient is in the supine or a Fowler position.

# Nutrition

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

### Amino acids:

- Essential
- Nonessential

### Basal metabolic rate

Calorie, kilocalorie

Calorie count

### Cellular metabolism:

- Anabolism
- Catabolism

### Fiber:

- Insoluble
- Soluble

### Food consistency:

- Chopped
- Liquid
- Pureed
- Regular
- Soft

Ideal body weight

### Laboratory values:

- Blood urea nitrogen
- Serum albumin
- Total cholesterol
- Transferrin level
- Triglycerides

Malnutrition

MyPlate

Nausea

### Nutrients:

- Carbohydrates
- Fats
- Minerals:
  - Fluoride
  - Iodine
  - Iron
  - Potassium
  - Sodium

### Protein:

- Complete
- Incomplete
- Water

Obesity

Recommended dietary allowances

Stomatitis

### Therapeutic diets:

- Clear liquid
- Full liquid
- 2 g sodium
- Low residue
- Mechanical soft
- Protein restricted

### Tube feedings:

- Continuous
- Gastrostomy
- Intermittent
- Jejunostomy
- Nasogastric

Underweight

### Vegetarian:

- Flexitarian
- Lactovegetarian
- Vegan
- Ovolactovegetarian

### Vitamins:

#### Fat soluble:

- A
- D
- E
- K

#### Water soluble:

- C (ascorbic acid)
- B<sub>1</sub> (thiamine)
- B<sub>2</sub> (riboflavin)
- B<sub>3</sub> (niacin)
- B<sub>6</sub> (pyridoxine)
- B<sub>12</sub> (cobalamin)
- Biotin
- Folic acid
- Pantothenic acid

Vomiting

F.A. DAVIS

COMPANY

## NUTRITION: QUESTIONS

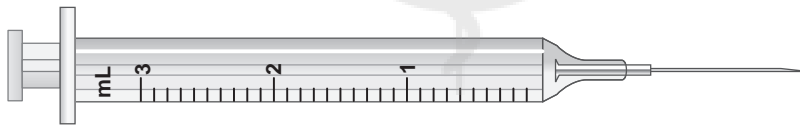
1. A patient is admitted to the hospital with a history of liver dysfunction associated with hepatitis. With which metabolic problem does the nurse anticipate that this patient may have a problem?
  1. Emulsifying fats
  2. Digesting carbohydrates
  3. Manufacturing red blood cells
  4. Reabsorbing water in the intestines
2. A nurse is assessing a patient who is admitted to the hospital with withdrawal from alcohol. Which effect of alcohol on the body will influence the patient's plan of care?
  1. Interferes with the absorption of glucose
  2. Accelerates the absorption of medications
  3. Decreases the absorption of many important nutrients
  4. Lengthens passage time of stool through the intestinal tract
3. An obese resident of a nursing home who is receiving a 1,500-calorie weight reduction diet has not lost weight in the past 2 weeks. Which should the nurse do **first**?
  1. Inform the primary health-care provider of the patient's lack of progress.
  2. Instruct the patient to limit intake to 1,000 calories per day.
  3. Schedule a multidisciplinary team conference.
  4. Keep a log of the oral intake for 3 days.
4. A patient of Latino heritage is prescribed a low-fat diet. The patient tells the nurse, "I am going to have a hard time giving up my favorite family recipes." Which food should the nurse recommend that is low in fat and generally is included in the Latino culture?
  1. Salsa
  2. Pasta
  3. Steamed fish
  4. Refried beans
5. A patient is diagnosed with a vitamin A deficiency. Which type of pie should the nurse encourage the patient to ingest?
  1. Blueberry
  2. Pumpkin
  3. Cherry
  4. Pecan
6. A patient is anorexic because of stomatitis related to chemotherapy. Which should the nurse be **most** concerned about when planning care for this patient?
  1. Aspiration
  2. Dehydration
  3. Malnutrition
  4. Constipation
7. A nurse is counseling a patient with the diagnosis of osteoporosis. In addition to calcium, which vitamin supplement should the nurse anticipate that the primary health-care provider will prescribe for this patient?
  1. B
  2. K
  3. D
  4. E

8. An older adult is admitted to the hospital for multiple health problems. Assessment reveals that the patient has no teeth and is having difficulty eating. Which diet should the nurse encourage the primary health-care provider to order for this patient?
  1. Liquid supplements
  2. Mechanical soft
  3. Pureed
  4. Soft
9. A nurse is caring for patients with a variety of nutrition-related problems. Which problem eventually may require a patient to have a nasogastric feeding tube inserted?
  1. Malabsorption syndrome
  2. Difficulty swallowing
  3. Nausea and vomiting
  4. Stomatitis
10. A nurse is caring for a patient who is confused and disoriented. Which type of food containing chicken is **most** appropriate for this patient?
  1. Soup
  2. Salad
  3. Fingers
  4. Casserole
11. An older adult tends to bruise easily and the primary health-care provider recommends that the patient eat foods high in vitamin K. In addition to teaching the patient about food sources of vitamin K, the nurse should include nutrients that must be ingested for vitamin K to be absorbed. Which foods that increase the absorption of vitamin K should be included in the teaching plan?
  1. Carbohydrates
  2. Starches
  3. Proteins
  4. Fats
12. A school nurse is preparing a health class about vitamins. Which information about vitamins that is based on a scientific principle should the nurse include?
  1. Eating a variety of foods prevents the need for supplements.
  2. Megadoses of vitamins have proved to be most effective in preventing illness.
  3. Taking a prescribed vitamin supplement is the best way to ensure adequate intake.
  4. Vitamins that are more expensive are more pure than those that are less expensive.
13. A patient without any identified current health problems is having a yearly physical examination. The laboratory results indicate the presence of ketosis. Which rationale explains the presence of ketosis in this otherwise healthy adult?
  1. Inadequate intake of carbohydrates
  2. Increased intake of protein
  3. Excessive intake of starch
  4. Decreased intake of fiber
14. Which vitamin should a nurse teach a patient does not require fat in the diet to be absorbed?
  1. Vitamin C
  2. Vitamin A
  3. Vitamin E
  4. Vitamin D

15. An occupational nurse is facilitating a weight reduction group discussion. Which should the nurse explain is the **most** common contributing factor of obesity?
  1. Sedentary lifestyle
  2. Low metabolic rate
  3. Hormonal imbalance
  4. Excessive caloric intake
16. A nurse is evaluating the effectiveness of a nutritional program for a patient with anemia. Which clinical finding is a short-term indicator of an improved nutritional status?
  1. Weight gain of two pounds daily
  2. Increasing transferrin level
  3. Decreasing serum albumin
  4. Appropriate skin turgor
17. A patient is diagnosed with iron deficiency anemia. Which major cause of iron deficiency will influence a focused assessment by the nurse?
  1. Metabolic problems
  2. Inadequate diets
  3. Malabsorption
  4. Hemorrhage
18. A primary health-care provider identifies that a patient may have a fluoride deficiency. Which physical characteristic supports this conclusion?
  1. Stomatitis
  2. Dental caries
  3. Bleeding gums
  4. Mottling of the teeth
19. A nurse identifies that a vegetarian understands the importance of eating kidney beans when the patient indicates that they are essential because they contain which nutrient?
  1. Carbohydrates
  2. Minerals
  3. Protein
  4. Fat
20. Which is the **most** common independent nursing intervention to help a hospitalized debilitated older adult maintain body weight?
  1. Making mealtime a social activity
  2. Taking a thorough nutritional history
  3. Providing assistance with the intake of meals
  4. Encouraging dietary supplements between meals
21. An adult female patient with which total cholesterol level requires health teaching about a low-cholesterol diet?
  1. 210 mg/dL
  2. 190 mg/dL
  3. 150 mg/dL
  4. 100 mg/dL
22. A nurse is caring for a patient who is expending energy that is greater than the patient's caloric intake. Which human response will occur?
  1. Fever
  2. Anorexia
  3. Malnutrition
  4. Hypertension

23. A nurse is reviewing the laboratory findings of a patient to assess the patient's nutritional status. Which laboratory result from among the following tests is an indicator of inadequate protein intake?
1. High hemoglobin
  2. Low serum albumin
  3. Low specific gravity
  4. High blood urea nitrogen
24. A patient of Asian heritage is recommended to follow a low-fat diet to lose weight. Which food low in fat generally is consumed by members of an Asian population?
1. Egg rolls
  2. Spareribs
  3. Crispy noodles
  4. Hot and sour soup
25. A nurse is teaching a patient about the importance of balancing protein, carbohydrates, and fats in the diet. The nurse identifies that the teaching about carbohydrates is understood when the patient states that carbohydrates are known for providing which of the following?
1. Electrolytes
  2. Vitamins
  3. Minerals
  4. Energy
26. A patient has been blind in one eye for several years because of the complications associated with diabetes mellitus. The patient is admitted to the hospital with a detached retina and resulting loss of sight in the other eye. Which should the nurse do to assist this patient with meals?
1. Explain to the patient where items are located on the plate according to the hours of a clock.
  2. Encourage eating one food at a time according to the preference of the patient.
  3. Order finger foods that are permitted on the patient's diet.
  4. Feed the patient the ordered meals.
27. Which is **unrelated** to the balance of calcium in the body?
1. Osteoporosis
  2. Vitamin D
  3. Tetany
  4. Iron
28. A nurse is caring for a patient receiving bolus enteral feedings several times daily. Which nursing intervention is **most** important to help prevent diarrhea?
1. Flush the tube after every feeding.
  2. Check the residual before each feeding.
  3. Elevate the head of the bed 30 degrees continuously.
  4. Discard the refrigerated opened cans of formula after 24 hours.
29. A nurse teaches a patient about the prescribed low-fat diet. Which foods selected by the patient indicate that the teaching was understood? **Select all that apply.**
1. \_\_\_ Eggs
  2. \_\_\_ Liver
  3. \_\_\_ Cheese
  4. \_\_\_ Turkey
  5. \_\_\_ Scallops
  6. \_\_\_ Flounder

30. A patient has a high serum cholesterol level. Which foods should the nurse teach the patient to **avoid**? **Select all that apply.**
- Liver
  - Shrimp
  - Skim milk
  - Turkey burger
  - Sliced bologna
31. A primary health-care provider prescribes folic acid 0.8 mg PO once daily for a patient with anemia. Unit-dose tablets of 0.4 mg/tablet are available. How many tablets should the nurse administer? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ tablets
32. A patient has a decreased hemoglobin level because of a low intake of dietary iron. Which foods should the nurse teach the patient are excellent sources of iron? **Select all that apply.**
- Eggs
  - Fruit
  - Meat
  - Bread
  - Spinach
33. A primary health-care provider orders a low-residue diet for a patient with an inflammatory bowel disease. Which foods should the nurse teach the patient to include in the diet? **Select all that apply.**
- Scrambled eggs
  - Iceberg lettuce
  - Orange juice
  - Green beans
  - Rye bread
34. A patient is admitted to the hospital with a diagnosis of alcoholism. The primary health-care provider prescribes thiamine hydrochloride (vitamin B<sub>1</sub>) 50 mg IM three times a day. The drug is supplied 100 mg/mL. Indicate on the syringe the line to which the nurse should fill the syringe to administer the prescribed dose.



35. A patient has multiple fractures from a skiing accident. To **best** facilitate bone growth the nurse should encourage the patient to eat more foods high in calcium. Which foods selected by the patient indicate an understanding of foods that are high in calcium? **Select all that apply.**
- Orange juice
  - Peanut butter
  - Cottage cheese
  - Baked flounder
  - Low-fat yogurt
  - Cooked spinach
36. A nurse is obtaining a health history from a patient. Which information reflects healthy behaviors? **Select all that apply.**
- Increasing fruits and vegetables to 50% of food intake
  - Substituting fish for meat in the diet
  - Wanting to lose 20 pounds
  - Consuming 4 eggs a week
  - Eating foods low in fat



37. A nurse is caring for a postoperative patient. The nurse reviews the patient's concurrent health problems, checks the medications prescribed by the primary health-care provider, and performs a focused assessment. Which should the nurse do at 12 p.m.?
1. Administer 5 units of regular insulin subcutaneously to the patient.
  2. Notify the primary health-care provider of the patient's status.
  3. Give the oral solution of 15 mg of oxycodone.
  4. Provide an additional dose of ipratropium.

#### Concurrent Health Problems

Diabetes mellitus for 10 years  
Obstructive lung disease (COPD) for 6 years

#### Prescribed Medications

Ipratropium 17 mcg aerosol inhaler, 2 inhalations four times a day  
Oxycodone oral solution 15 mg PO every 6 hours whenever necessary  
NPH insulin 20 units subcutaneously 8 a.m.  
Regular insulin 8 units subcutaneously 8 a.m.  
Regular insulin coverage subcutaneously before meals and at hour of sleep  
<150 mg/dL to 0 units  
151–200 mg/dL to 3 units  
201–250 mg/dL to 5 units  
251–300 mg/dL to 7 units  
301–350 mg/dL to 9 units  
>351: Call provider

#### Physical Assessment

11:50 a.m.: Breath sounds indicate slight wheezing over right sternal border  
Respirations: 22 breaths per minute, unlabored  
Serum glucose finger stick: 235 mg/dL  
Incisional pain of 3 on pain scale of 0 to 10

38. A primary health-care provider orders a clear liquid diet for a patient. Which foods should the nurse teach the patient to **avoid** when following this diet? **Select all that apply.**
1.  Strawberry gelatin
  2.  Decaffeinated tea
  3.  Strong coffee
  4.  Pureed soup
  5.  Ice cream
39. A nurse teaches a postoperative patient about foods high in protein that will promote wound healing. Which food selection by the patient indicates that the teaching was effective? **Select all that apply.**
1.  Milk
  2.  Meat
  3.  Bread
  4.  Cheese
  5.  Vegetables

40. A nurse must obtain the serum glucose level of a patient with diabetes mellitus. The nurse completes all the initial preparations for the procedure including verifying the order, identifying the patient, and washing the hands. Place the following steps in the order in which they should be performed.
1. Don clean gloves.
  2. Wipe away the first drop with sterile gauze.
  3. Hold the patient's finger in a dependent position.
  4. Drop the second drop of blood on the reagent strip.
  5. Puncture the side of the end of a finger with a sterile lancet.
  6. Wipe the intended puncture side with an approved antiseptic.
- Answer: \_\_\_\_\_
41. A patient is scheduled for surgery and the nurse is teaching the patient about the importance of vitamin C in wound healing. Which sources of vitamin C should the nurse include in the teaching plan? **Select all that apply.**
1.  Potatoes
  2.  Papayas
  3.  Yogurt
  4.  Beans
  5.  Milk
42. A nurse is administering enteral nutrition via the method depicted in the photograph. Identify the steps that should be implemented when administering enteral nutrition via this method. **Select all that apply.**
1.  Administer water after the feeding.
  2.  Administer the bolus over 60 minutes.
  3.  Elevate the head of the bed 15 degrees.
  4.  Ensure that the formula is at room temperature.
  5.  Add formula continuously to the syringe just before it empties.



43. A young adult woman tells the nurse that she has been taking St. John's wort for several weeks for depression. Which should the nurse teach the patient that is important to know about taking St. John's wort? **Select all that apply.**
- St. John's wort should not be taken without an evaluation by a primary health-care provider.
  - Use an additional method of birth control if taking an oral contraceptive.
  - Disc ontinue it if there is no improvement in symptoms within 3 months.
  - Disc ontinue it 2 weeks before surgery with general anesthesia.
  - A pply sunscreen to skin exposed to the sun.
44. An older adult states that he is experiencing all the signs and symptoms of an enlarged prostate and is interested in taking the herbal supplement saw palmetto. Which is important for the nurse to teach the patient about treatment with saw palmetto? **Select all that apply.**
- It should not be taken until after a workup by a urologist.
  - T aking saw palmetto is generally safe as a dietary supplement.
  - Sa w palmetto interferes with the measurement of prostate-specific antigen.
  - Some patients report an improvement in erectile dysfunction after taking saw palmetto.
  - The most recent research by reputable institutions indicates that saw palmetto is more effective than a placebo in reducing the symptoms of an enlarged prostate.
45. A nurse is providing for the nutritional needs of several patients. Which problems increase patients' caloric requirements? **Select all that apply.**
- Bu rns
  - Na usea
  - Dy sphagia
  - P neumonia
  - Dep ression

## NUTRITION: ANSWERS AND RATIONALES

- 1. Bile is produced and concentrated in the liver and stored in the gallbladder. As fat enters the duodenum, it precipitates the release of cholecystokinin, which stimulates the gallbladder to release bile. Bile, an emulsifier, enlarges the surface area of fat particles so that enzymes can digest the fat.**
  - The liver is not involved with carbohydrate digestion. Ptyalin (secreted by the parotid glands), amylase (secreted by the pancreas), and sucrase, lactase, and maltase (secreted by the walls of the small intestine) digest carbohydrates.
  - The liver is not involved with red blood cell production. People who are deficient in iron and protein have difficulty with red blood cell production.
  - The large intestine, not the liver, is involved with reabsorbing water. The majority of the water in chyme is reabsorbed in the first half of the colon, leaving the remainder (approximately 100 mL) to form and eliminate feces.
1. Alcohol interferes with the absorption of thiamine, which is essential to oxidize, not absorb, glucose.
  2. The damaging effects of alcohol decrease, not increase, the efficiency of the process of absorption of medications in the stomach and intestines. However, alcohol can potentiate the action of drugs, such as central nervous system depressants.
- 3. Alcohol interferes with vitamin intake, absorption, metabolism, and excretion. It specifically interferes with the absorption of vitamins A, D, K, thiamine, folic acid, pyridoxine, and B<sub>12</sub>.**
  4. Alcohol increases intestinal motility so that it decreases, not increases, the length of time it takes intestinal contents to pass through the body.
1. Informing the primary health-care provider of the patient's status is premature. The nurse is abdicating the responsibility to help the patient.
  2. A change in diet requires a primary health-care provider's order. Generally, calories should not be restricted below 1,200 cal/day for women or 1,500 cal/day for men so that they receive adequate amounts of essential nutrients.
3. Conducting a multidisciplinary team conference may eventually be done, but it is premature at this time.
  - 4. When the expected outcome of an intervention is not attained, the situation must be reassessed to determine the problem and the plan changed appropriately. A record of a dietary intake provides objective information about the amounts and types of food consumed. This information provides data about nutrient deficiencies or excesses, eating patterns, behaviors associated with eating, and potential problems and needs.**
- 1. Salsa predominantly contains tomatoes, onions, and peppers, all which are low in fat.**
  2. Pasta contains predominantly carbohydrates, not fat. In addition, in the Latino culture, rice and beans are preferred over pasta. Pasta is associated with the Italian culture.
  3. Although steamed fish is low in fat, foods in the Latino culture generally are stewed or fried. Vegetables, legumes, and meat usually are preferred over fish.
  4. Refried beans are a fried food that should be avoided on a low-fat diet. Frying involves cooking food with a saturated or unsaturated fat solution, which is composed mostly of fatty acids. Fatty acids combine with glycerol to form triglycerides.
1. One piece of blueberry pie contains only 14 mcg RE of vitamin A.
  - 2. Pumpkin is an excellent source of vitamin A. One piece (one-sixth of a 9-inch diameter pie) contains 3,750 mcg RE (retinol equivalents) of vitamin A.**
  3. One piece of cherry pie contains only 70 mcg RE of vitamin A.
  4. One piece of pecan pie contains only 115 mcg RE of vitamin A.
1. Although in some patients stomatitis may cause difficulty with swallowing (dysphagia), which may contribute to aspiration, a bland diet soft in consistency will help to minimize dysphagia.

2. Ingesting adequate amounts of fluid generally is not a problem as long as acidic fluids are avoided because they irritate the lesions of the mucous membranes.
  - 3. Stomatitis, inflammation of the mucous membranes of the oral cavity, can be painful. Patients with stomatitis frequently avoid eating to limit discomfort, which can lead to inadequate nutritional intake and malnutrition.**
  4. Although a loss of appetite may contribute to constipation, an increase in fluid intake and activity can help prevent constipation.
- 7.**
    1. The B-complex vitamins are related to protein synthesis and cross-linking of collagen fibers, which are essential for integrity of the integumentary system, not strong bones.
    2. Vitamin K promotes blood clotting by increasing the synthesis of prothrombin by the liver; it does not promote strong bones.
    - 3. Vitamin D (also regarded as a hormone) promotes bone mineralization by producing transport proteins that bind calcium and phosphorus, which increases intestinal absorption, stimulates the kidneys to return calcium to the bloodstream, and stimulates bone cells to use calcium and phosphorus to build and maintain bone tissue.**
    4. Vitamin E prevents the oxidation of unsaturated fatty acids and thereby prevents cell damage; it does not promote strong bones.
  - 8.**
    1. A person with few or no teeth, should be able to meet all daily nutrient requirements without liquid supplements.
    - 2. A mechanical soft diet is modified only in texture. It includes moist foods that require minimal chewing and eliminates most raw fruits and vegetables and foods containing seeds, nuts, and dried fruit.**
    3. A person with few or no teeth, can handle a diet with a more solid consistency than pureed foods. A pureed diet is a soft diet processed to a semisolid consistency.
    4. A person with few or no teeth, can handle a diet with a more solid consistency than a soft diet. A soft diet is moderately low in fiber and lightly seasoned. A soft diet usually is ordered for patients who are unable to tolerate a regular diet after surgery as a transition between liquids and a regular diet.
- 9.**
    1. A nasogastric feeding (enteral feeding) enters the stomach and is not an appropriate therapy for a patient with malabsorption syndrome. The formula would still have to be absorbed by the gastrointestinal tract.
    - 2. If a patient with difficulty swallowing (dysphagia) does not respond to a dysphagia diet (mechanical soft, soft, blended or pureed liquids), there may be a need for the insertion of a gastrostomy tube. Gastrostomy feedings can be administered to meet nutritional needs and minimize the risk of aspiration.**
    3. Nasogastric feedings are contraindicated in the presence of vomiting because of the potential for aspiration. The cause of the nausea and vomiting should be identified and treated.
    4. Nasogastric feedings are a drastic measure for stomatitis. Stomatitis, an inflammation of the mouth, usually is a temporary problem that responds to pharmacological therapy and frequent, appropriate oral hygiene.
  - 10.**
    1. A confused patient may not know how to manipulate a spoon to eat soup. This may result in spilling and frustration.
    2. Eating chicken salad requires the use of a utensil that may be beyond the patient's cognitive ability.
    - 3. Chicken fingers are a single food item that usually is familiar to most people in the United States. A single familiar food is an easier symbol to decode cognitively than food mixed together in one dish. Food that the patient can eat with the fingers, rather than a utensil, promotes independence.**
    4. Eating a casserole requires the use of a utensil that may be beyond the patient's ability. In addition, food mixed together is more confusing than food that is presented individually for patients who are confused or disoriented.
  - 11.**
    1. Carbohydrates are not necessary for the absorption of vitamin K.
    2. Starches are not necessary for the absorption of vitamin K.
    3. Proteins are not necessary for the absorption of vitamin K.

- 4. Vitamin K is one of the fat-soluble vitamins (A, D, E, and K) that require the presence of fat to be absorbed. Vitamin K plays an essential role in the production of the clotting factors II (prothrombin), VII, IX, and X.**
- 12. 1. A balanced diet with choices in moderation from a variety of foods will provide the recommended daily allowances of essential nutrients without the need for supplements.**
2. Megadoses of vitamins no longer operate as nutritional agents, and excesses are detrimental to the body, particularly to the liver and brain.
  3. Vitamins by themselves will not ensure an adequate intake. Their action contributes to chemical reactions (i.e., they act as catalysts), and they must have their substrate materials to work on, which are carbohydrates, protein, and fats and their metabolites.
  4. It may or may not be true that expensive vitamins are more pure than inexpensive vitamins.
- 13. 1. When the amount of carbohydrates ingested does not meet the energy requirements of an individual, the body will break down stored fat to meet its energy needs. Ketone bodies are produced during the oxidation of fatty acids.**
2. An increased intake of protein helps meet energy demands because when the energy from carbohydrates is depleted, the body converts protein and fatty acids to glucose (gluconeogenesis).
  3. Starch is the major source of carbohydrates in the diet and it yields simple sugars on digestion. Adequate serum glucose levels provide for energy needs, thus negating the need to break down body fat, resulting in ketosis.
  4. Fiber is unrelated to ketosis.
- 14. 1. Vitamin C (ascorbic acid) is a water-soluble vitamin. The presence of fat or bile salts is unnecessary for its absorption.**
2. Vitamin A is a fat-soluble vitamin that requires fat and bile salts to be absorbed.
  3. Vitamin E is a fat-soluble vitamin that requires fat and bile salts to be absorbed.
  4. Vitamin D is a fat-soluble vitamin that requires fat and bile salts to be absorbed.
- 15. 1. A sedentary lifestyle is only one theory associated with the cause of obesity.**
2. A low metabolic rate is only one theory associated with the cause of obesity.
  3. A hormonal imbalance is only one theory associated with the cause of obesity.
  4. **An excessive caloric intake is the basis of all weight gain regardless of the etiology. Excess ingested nutrients are stored in adipose tissue (fat) and muscle, which increases body weight. Obesity is body weight 20% or greater than ideal body weight. Glucose is stored as glycogen in the liver and muscle with surplus amounts being converted to fat. Glycerol and fatty acids are stored as triglycerides in adipose tissue. Excess amino acids are used for glucose formation or are stored as fat.**
- 16. 1. A rapid weight gain indicates fluid retention, not an improved nutritional status. One liter of fluid weighs 2.2 pounds.**
2. **Transferrin is a glycoprotein formed in the liver. Serum transferrin is a marker for iron metabolism and protein status. Because its half-life is 8 days compared with albumin, which is 20 days, serum transferrin levels will provide earlier objective information concerning a person's increasing or decreasing nutritional status. Serum transferrin ranges between 215 and 380 mg/dL in adults depending on gender.**
  3. A decreasing serum albumin level indicates a deteriorating, not improving, nutritional status. A serum albumin level should range between 3.5 and 5.0 g/dL. Mild depletion values range between 2.8 and 3.4 g/dL. Moderate depletion values range between 2.1 and 2.7 g/dL. In severe depletion, values are less than 2.1 g/dL.
  4. Appropriate skin turgor, fullness, and elasticity that allow the skin to spring back to its previous state after being pinched reflect an adequate fluid, not nutritional, balance.
- 17. 1. Although the inability to form hemoglobin in the absence of other necessary factors, such as vitamin B<sub>12</sub> (pernicious anemia), can result in iron deficiency, it is not the major cause of iron deficiency.**
2. **The most common nutrient deficiency in the United States is that of iron, which results from an inadequate**

**supply of dietary iron. The major condition indicating iron deficiency is anemia because iron is a key component of red blood cells.**

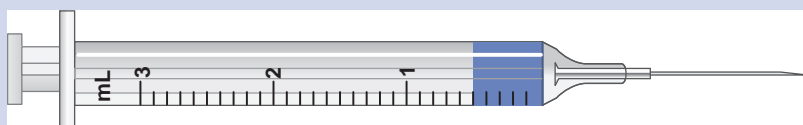
3. Malabsorption of iron is not the major cause of iron deficiency. However, the malabsorption of iron can be caused by a lack of gastric hydrochloric acid, which is necessary to help liberate iron for absorption, and the presence of phosphate or phytate, inhibitors of iron absorption.
  4. Although hemorrhage can precipitate iron deficiency, it is not the major etiological factor.
- 18.**
1. Stomatitis, inflammation of the mucous membranes of the mouth, is most often caused by infectious sources (e.g., herpes simplex virus, *Candida albicans*, and hemolytic streptococci) or chemotherapy, not fluoride deficiency.
  2. **Fluoride strengthens the ability of the tooth structure to withstand the erosive effects of bacterial acids on the teeth. The recommended daily intake of fluoride for adults is 1.5 to 4.0 mg.**
  3. Bleeding gums is caused by inflammation of the gums (gingivitis), not fluoride deficiency.
  4. Mottling of the teeth is related to a fluoride excess, not a fluoride deficiency. Yellow, brown, or black discoloration of teeth may indicate other problems, such as staining, a partial or total nonviable nerve, or tetracycline administration during the prenatal period or early childhood.
- 19.**
1. Although kidney beans are an excellent source of carbohydrates, a vegetarian diet has many other foods that can be selected to provide this nutrient.
  2. Although kidney beans are an excellent source of minerals, especially sodium, potassium, and phosphorus, a vegetarian diet has many other foods that can be selected to provide this nutrient.
  3. **Kidney beans are high in protein. One cup of kidney beans contains 15 g of protein. Complete proteins come from animal sources, such as meat, poultry, and fish, but they are not included on a vegetarian diet. Kidney beans combined with a grain are a substitute for a complete protein.**
  4. One cup of kidney beans contains only 1 g of fat.
- 20.**
1. Although making mealtime a social activity is desirable, it may be impractical or impossible in an acute care facility. Patient rooms may be private or semiprivate, which limits exposure to other patients, and patients often are too sick to socialize.
  2. Although obtaining a nutritional history is done, the information will not necessarily improve intake.
  3. **Sick older adults often are debilitated, lack energy, and do not feel well. Assistance with meals conserves the patient's energy and demonstrates a caring concern, which may increase the intake of food.**
  4. Dietary supplements require a primary health-care provider's order. Providing dietary supplements is a dependent function of the nurse.
- 21.**
1. **A total cholesterol level of 210 mg/dL in a woman is 10 mg more than the acceptable limit of 200 mg/dL. Patients should be taught the foods to avoid that are high in cholesterol to prevent excessive cholesterol levels.**
  2. 190 mg/dL is an acceptable level of cholesterol for an adult woman.
  3. 150 mg/dL is an acceptable level of cholesterol for an adult woman.
  4. 100 mg/dL is an acceptable level of cholesterol for an adult woman.
- 22.**
1. During the states of malnutrition and starvation, the basal metabolic rate (BMR) decreases because the lean body mass decreases. Fever is associated with an increased, not decreased, BMR.
  2. When energy expended is greater than the caloric intake, an individual will experience hunger, not anorexia. Hunger is a dull or acute pain felt around the epigastric area caused by a lack of food. Anorexia is the loss or lack of appetite.
  3. **When energy expenditure exceeds caloric intake, eventually body fat and muscle mass break down to supply the fuel needed for metabolism. Malnutrition results when the body's cells have a deficiency or excess of one or more nutrients.**
  4. When a person is malnourished, eventually the serum protein will be low, which may result in decreased colloid osmotic pressure and then movement of fluid from the intravascular compartment into the

peritoneal cavity. When the circulating blood volume decreases, the blood pressure decreases, not increases.

- 23.** 1. Hemoglobin concentration of the blood correlates closely with the red blood cell count. Elevated hemoglobin suggests hemoconcentration from increased numbers of red blood cells (polycythemia) or dehydration.
2. **Serum proteins, particularly albumin, reflect a person's skeletal muscle and visceral protein status. An expected serum albumin level ranges between 3.5 and 5.0 g/dL. Mild depletion ranges between 2.8 and 3.4 g/dL. Moderate depletion ranges between 2.1 and 2.7 g/dL. Severe depletion is less than 2.1 g/dL.**
3. Specific gravity is a urine test that measures the kidney's ability to concentrate urine. A low specific gravity reflects dilute urine that suggests a high urine volume, diabetes insipidus, kidney infection, or severe renal damage with disturbances in concentrating and diluting abilities.
4. Blood urea nitrogen (BUN) measures the nitrogen fraction of urea, a product of protein metabolism. An elevated BUN suggests renal disease, reduced renal perfusion, urinary tract obstruction, and increased protein metabolism.
- 24.** 1. Egg rolls are a fried food. Frying involves cooking food in a solution consisting of saturated or unsaturated fat, which is composed mostly of fatty acids. Fatty acids combine with glycerol to form triglycerides.
2. Spareribs are high in saturated fat and cooked with sauces that are high in saturated or unsaturated fat.
3. Crispy noodles are a fried food that should be avoided. Frying involves cooking food with a saturated or unsaturated fat solution, which is composed mostly of fatty acids.
4. **Hot and sour soup contains less fat than the other food choices listed.**
- 25.** 1. An electrolyte is a chemical substance that, in solution, dissociates into electrically charged particles. Electrolytes maintain the chemical balance between cations and anions in the body, which is essential for acid-base balance.
2. Vitamins are organic compounds that do not provide energy but are needed for the metabolism of energy.
3. Minerals are inorganic elements or compounds essential for regulating body functions. The major minerals of the body are calcium, phosphorus, sodium, potassium, magnesium, chloride, and sulfur.
4. **Carbohydrates, a group of organic compounds, such as saccharides, starch, cellulose, and gum, are the main fuel sources for energy. Athletes competing in endurance events often adhere to a diet that increases carbohydrates to 70% of the diet for the last 3 days before a race (carbohydrate loading) to maximize muscle glycogen storage.**
- 26.** 1. **The clock system, which identifies where certain foods are on a plate in relation to where numbers are located on a clock, allows the patient to be independent when eating. Independence with activities of daily living supports self-esteem.**
2. Eating one food at a time is unnecessary and may decrease the patient's appetite.
3. Ordering finger foods is unnecessary and limits the patient's food choices.
4. Feeding the patient does not promote independence and may precipitate feelings of low self-esteem.
- 27.** 1. Osteoporosis is a disease characterized by a decrease in total bone mass and deterioration of bone tissue that leads to bone fragility and the risk of fractures. Adequate calcium is necessary for building and strengthening bones and preventing osteoporosis.
2. Vitamin D promotes bone mineralization by producing transport proteins that bind calcium and phosphorus. This increases intestinal absorption, stimulates the kidneys to return calcium to the bloodstream, and stimulates bone cells to use calcium and phosphorus to build and maintain bone tissue.
3. A decrease in calcium in the blood (hypocalcemia) can eventually lead to tetany, which is characterized by muscle spasms, paresthesias, and convulsions.
4. **Iron is unrelated to calcium balance. Iron is essential for hemoglobin formation.**
- 28.** 1. Flushing the tube after every feeding moves the formula into the stomach and helps maintain tube patency; it does not reduce the risk of diarrhea.



2. Checking residual volume informs the nurse about the absorption of the last feeding. This step prevents the addition of more feeding than the patient can digest; it does not prevent diarrhea. Generally feedings are withheld when a certain residual volume is identified. Protocols may include withholding the next feeding when a residual of half the volume of the last feeding is removed just before the next feeding, or the primary health-care provider may give specific instructions if there is a residual volume.
  3. Elevating the head of the bed 30 degrees at all times helps to keep the formula in the stomach via the principle of gravity and helps to prevent aspiration; it does not prevent diarrhea.
  4. **Contaminated formula can cause diarrhea. Opened cans of formula support bacterial growth and must be discarded after 24 hours even when refrigerated.**
29. 1. Eggs should be avoided on a low-fat diet. One egg contains 1.7 g of saturated fat.
2. Liver should be avoided on a low-fat diet. Three ounces of liver contain 2.5 g of saturated fat.
  3. Cheese should be avoided on a low-fat diet. Depending on the cheese, 1 ounce contains 4.4 to 6.2 g of saturated fat.
  4. **Turkey is permitted on a low-fat diet. Three ounces of turkey contain 0.9 g of saturated fat. A low-fat food should contain less than 1.0 g of saturated fat per serving.**
  5. **Scallops are permitted on a low-fat diet. Three ounces of scallops contain 0.1 g of saturated fat.**
  6. **Flounder is permitted on a low-fat diet. Three ounces of flounder contain 0.3 g of saturated fat.**
30. 1. **Liver is high in cholesterol. Three ounces of beef, calf, and chicken liver contain 331, 477, and 537 mg of cholesterol, respectively.**
2. **Shrimp are high in cholesterol. Three ounces of shrimp contain 166 mg of cholesterol.**
  3. One cup of skim milk contains only 18 mg of cholesterol.
  4. Three ounces of turkey contain only 59 mg of cholesterol.
  5. Two slices of bologna contain only 31 mg of cholesterol.
31. **Answer: 2 tablets.**  
Solve the problem by using ratio and proportion.
- $$\frac{\text{Desired } 0.8 \text{ mg}}{\text{Have } 0.4 \text{ mg}} = \frac{x \text{ tab}}{1 \text{ tab}}$$
- $$0.4 x = 0.8$$
- $$x = 0.8 \div 0.4$$
- $$x = 2 \text{ tablets}$$
32. 1. One egg contains only 1.0 mg of iron.
2. One serving of fruit contains less than 1.0 mg of iron.
  3. **Meat, especially liver, is an excellent source of iron. Three ounces of meat contain 1.6 to 5.3 mg of iron depending on the type of meat and whether it is a regular or lean cut.**
  4. One slice of bread contains 0.7 to 1.4 mg of iron depending on the type of bread.
  5. **Spinach is an excellent source of iron. A half cup of boiled spinach contains 3.2 mg of iron.**
33. 1. **All eggs, except fried, are permitted on a low-residue (low-fiber) diet. A low-residue diet is easily digested and absorbed and limits bulk in the intestines after digestion.**
2. **Lettuce is permitted on a low-residue diet. One cup of shredded iceberg lettuce contains 0.8 g of fiber.**
  3. Orange juice contains pulp, a soluble fiber, which is not permitted on a low-residue diet.
  4. Green beans contain polysaccharides that provide structure to plants and result in a residual after digestion that is not permitted on a low-residue diet. One cup of green beans contains 4.19 g of dietary fiber.
  5. Whole-grain breads, breads with seeds or nuts, and breads made with bran consist of insoluble fibers that are not permitted on a low-residue diet. Two slices of whole-wheat bread contain 4 g of fiber.
34. **Solve the problem by using ratio and proportion.**
- $$\frac{\text{Desired } 50 \text{ mg}}{\text{Have } 100 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$
- $$100 x = 50$$
- $$x = 50 \div 100$$
- $$x = 0.5 \text{ mL}$$



- 35.** 1. One cup of orange juice contains only 27 mg of calcium.  
2. One tablespoon of peanut butter contains only 5 mg of calcium.  
3. **Cottage cheese is an excellent source of calcium, which is essential for bone growth. One cup of cottage cheese contains 155 mg of calcium. The NIH Consensus Conference—Optimal Calcium Intake recommends an average intake of 1,000 to 1,500 mg of calcium daily for an adult depending on various factors.**  
4. Three ounces of baked flounder contain only 13 mg of calcium.  
5. **Low-fat yogurt is an excellent source of calcium, which is essential for bone growth. One cup of low-fat yogurt contains 345 mg of calcium.**  
6. **Cooked spinach is an excellent source of calcium, which is essential for bone growth. One cup of cooked spinach contains 276 mg of calcium.**
- 36.** 1. The Center for Nutrition Policy and Promotion advocates in the MyPlate diet that fruits should be 25% of one's diet and vegetables should be 25% of one's diet.  
2. **Fish, such as flounder and haddock, contain extremely low levels of saturated fat compared with meat, which is much higher in saturated fat.**  
3. Wanting to lose 20 pounds reflects cognition, not behavior. Desiring something may or may not progress to action.  
4. **Although eggs are high in cholesterol, they are low in saturated fats, and they can be eaten in moderation (e.g., 4 to 6 eggs or less a week). Recent studies indicate that even 1 egg a day is not associated with an increased risk of coronary heart disease or stroke.**  
5. **Eating foods low in fat is a healthy behavior because it is an action that promotes a healthy lifestyle. Implementing health-promotion behaviors is based on the perceived benefits of the actions.**
- 37.** 1. The patient's serum glucose level is 235. The primary health-care provider wrote a prescription for regular insulin coverage. When the serum glucose level is between 201 and 250 the patient is to receive 5 units of regular insulin subcutaneously.
2. It is unnecessary to notify the primary health-care provider of the patient's status.  
3. The patient's pain is at level 3 on a scale of 0 to 10. The nurse can delay the administration of oxycodone, a potent analgesic, until the patient is experiencing a higher level of pain.  
4. The patient's respiratory status is stable. There is no prescription to administer an additional dose of ipratropium. The administration of medication is a dependent function of the nurse.
- 38.** 1. Gelatin is a clear liquid that is a solid when refrigerated and a liquid at room temperature. It is permitted in either form on a clear liquid diet.  
2. Caffeinated or decaffeinated tea is permitted on a clear liquid diet.  
3. Weak or strong and caffeinated or decaffeinated coffee is permitted on a clear liquid diet.  
4. **Pureed soups are permitted on a full-liquid, not clear liquid, diet. Pureed soups have a high-solute load, including fats and proteins, which stimulates the digestive process.**  
5. **Milk and milk products are not included on a clear liquid diet. Ice cream contains a high-solute load, including fat and proteins, which stimulates the digestive process.**
- 39.** 1. One cup of milk contains only 8 g of protein.  
2. **Food from animal sources (e.g., meat, poultry, fish, and eggs) provides complete proteins and therefore is the best source of protein. Three ounces of meat or poultry contain 19 to 25 g of protein depending on the type of meat or poultry.**  
3. Although a serving of a grain product contains approximately 2 g of protein, it primarily provides carbohydrates and fiber.  
4. **Cheese is a product that is produced from an animal source. It provides a complete protein and promotes wound healing. Cheese, depending on the type, consists of 18 to 30 g of protein per 3 ounces.**  
5. The majority of vegetables provide only 1 to 3 g of protein.
- 40.** 1. **Wearing clean gloves protects the nurse from the patient's blood. This is not a sterile procedure.**

3. Holding the finger in a dependent position allows more blood to enter the distal portion of the finger. Avoid squeezing the finger because it increases the likelihood of an inaccurate low reading.
  6. Wiping the site with an approved antiseptic will remove some surface microorganisms that could enter the skin when punctured. The antiseptic used should not interfere with the reagent on the strip and it should dry on the skin before the puncture occurs. The use of alcohol is controversial because it dries the skin, and if it interacts with the reagent it will give a false low reading.
  5. The side of a finger has fewer nerve endings than the pad of a fingertip and, therefore, during and after the procedure the discomfort will be less. Some advocate using just the two last digits of a hand because they are not used as much as the other fingers.
  2. The first drop of blood should be wiped away with sterile gauze because the first drop contains more serous fluid, which can alter test results. Sterile gauze limits microorganisms from entering the puncture site.
  4. The finger should hover over the reagent strip, and the drop of blood should make minimal contact with the reagent strip. This provides a full drop of blood for testing. A smeared blood sample will provide an inadequate amount of blood resulting in an inaccurate reading.
41. 1. Potatoes are an excellent source of vitamin C (ascorbic acid). One medium potato contains approximately 42 mg of vitamin C.
  2. Papayas are an excellent source of vitamin C. One cup of papayas contains 87 mg of vitamin C.
  3. Eight ounces of yogurt contain only 1 mg of vitamin C.
  4. Dried beans (legumes) contain no vitamin C. One cup of green beans contains only 12 mg of vitamin C.
  5. One cup of milk contains only 2 mg of vitamin C.
42. 1. This is a photograph of a formula being administered via a gastrostomy tube. Thirty to 60 mL of water should be added to the catheter-tip syringe when the syringe is nearly empty of formula. This will clear the tube of formula at the end of the feeding and will prevent occlusion of the tube.
  2. This is a photograph of a formula being administered via a gastrostomy tube. Bolus feedings administered over a 60-minute period generally are controlled by a feeding pump, not administered by gravity, as indicated in the photograph.
  3. This is a photograph of a formula being administered via a gastrostomy tube. The head of the bed should be elevated 30 to 45 degrees during the feeding and for 1 hour after the feeding to minimize the risk of gastroesophageal reflux and aspiration.
  4. This is a photograph of a formula being administered via a gastrostomy tube. A formula at room temperature is less likely to cause gastric discomfort.
  5. This is a photograph of a formula being administered via a gastrostomy tube. Formula is added continuously to the catheter-tip syringe just before it empties until the entire feeding is administered. Just before the final amount of formula exits the syringe, 30 to 60 mL of water is added to the syringe to clear the tubing of formula.
43. 1. A primary health-care provider should assess the patient's level of depression. St. John's wort is not recommended for moderate to severe depression. Other medications may be of greater benefit.
  2. St. John's wort may decrease the effectiveness of oral contraceptives.
  3. A lifting of depression may be identified as early as 2 to 3 weeks after initiation of St. John's wort. If no improvement is identified in 4 to 6 weeks, discontinue the medication.
  4. St. John's wort must be discontinued before surgery because patients exposed to general anesthesia may experience cardiovascular collapse.
  5. A heightened reaction to the sun (photosensitization) is a response that can occur with exposure to sunlight when taking St. John's wort.
44. 1. It is advisable to be evaluated by an urologist because the symptoms that the patient is experiencing may be caused by a serious medical condition

- other than benign enlargement of the prostate.
2. Side effects are not common and generally are mild. Side effects include dizziness, headache, nausea, vomiting, constipation, and diarrhea. Primary health-care providers generally permit a patient to take saw palmetto if the patient is insistent because it has so few side effects.
  3. There is no evidence that saw palmetto interferes with the measurement of prostate-specific antigen (PSA), a protein associated with prostate cancer. However, a primary health-care provider may order a PSA test and implement a rectal examination for baseline data before initiating treatment with saw palmetto.
  4. **Some men do report an enhanced ability to maintain an erection. It is believed that saw palmetto relaxes smooth muscle, allowing blood to flow smoothly and supporting an erection.**
  5. Research supported by the National Institute of Diabetes and Digestive and Kidney Diseases, the National Center for Complementary and Alternative Medicine, and the National Institutes of Health Office of Dietary Supplements indicates that saw palmetto has no greater effect on the signs and symptoms of benign prostatic hypertrophy than treatment with a placebo.
45. 1. Burns interrupt the integrity of the skin and as a result a primary defense against infection is disrupted. The body's metabolic rate increases dramatically in an attempt to repair the skin and protect the body from infection. Nutrients are required to provide the building blocks for skin cells, white blood cells, and immunoglobulins.
  2. Nausea does not precipitate a need for an increase in caloric intake above average requirements. However, frequent small dry feedings and medications to limit nausea may be used.
  3. Difficulty swallowing (dysphagia) does not precipitate a need for an increase in caloric intake above average requirements. However, the texture of foods and the rate of feeding may have to be adjusted.
  4. **An individual with pneumonia requires an increase in caloric requirements because of an increased resting energy expenditure and hypermetabolic state. With an infection, more energy is needed to regulate an elevated body temperature and extra protein is needed to produce antibodies and white blood cells.**
  5. Depression does not precipitate a need for an increase in caloric intake above average requirements. If a depressed patient becomes withdrawn and sedentary, caloric requirements may decrease.

# Oxygenation

## OXYGENATION: KEYWORDS

The following words include English vocabulary, nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

- Abdominal thrust
- Accessory muscles of respiration
- Activity intolerance
- Aerosol therapy
- Airway clearance
- Airway obstruction
- Airway resistance
- Alveoli
- Arterial blood gases
- Aspiration
- Atelectasis
- Auscultation
- Breathing, types of:
  - Abdominal
  - Apnea
  - Bradypnea
  - Deep
  - Diaphragmatic
  - Eupnea
  - Pursed-lip
  - Tachypnea
  - Thoracic
- Breath sounds:
  - Adventitious:
    - Crackles (rales)
    - Gurgles (rhonchi)
    - Pleural friction rub
    - Stridor
    - Wheezes
  - Normal:
    - Bronchial
    - Bronchovesicular
    - Vesicular
- Bronchial spasm
- Bronchoscopy
- Capillary refill
- Cardiac output
- Cardiac workload
- Cardiopulmonary resuscitation
- Cardiovascular
- Chest physiotherapy
- Chest percussion
- Chest vibration
- Postural drainage vibration
- Chest radiograph (x-ray)
- Chest tube
- Choking
- Cilia
- Circumoral cyanosis
- Cough:
  - Nonproductive
  - Productive
- Cyanosis
- Diffusion
- Dyspnea
- Dysrhythmias
- Electrocardiogram
- Endotracheal tube
- Excursion
- Exhale, exhalation
- Expectorate
- Expiration
- Extubation
- Fatigue
- Heimlich maneuver
- Hemoglobin saturation
- Hemoptysis
- Hemorrhage
- Humidify
- Hypercapnia
- Hypertension/hypotension
- Hyperventilation/hypoventilation
- Hypostatic pneumonia
- Hypovolemic shock
- Hypoxia, hypoxemia
- Incentive spirometer
- Inhale, inspiration
- Intrathoracic pressure
- Intubation
- Iron deficiency anemia
- Laryngeal spasm
- Metered-dose inhaler (MDI)
- Mucous membranes
- Mucus

F.A. DAVIS

COMPANY

Nares	Secretions:
Nebulizer	Tenacious
Oropharynx	Viscous
Orthopnea	Sedentary
Orthostatic hypotension	Sputum
Oxygen delivery systems:	Sternum
Face mask	Suctioning:
Nasal cannula	Nasal
Nonrebreather mask	Oropharyngeal
Venturi mask	Tracheal
Oxygen liter-flow gauge	Thoracentesis
Oxygen saturation	Thoracic
Oxygen therapy	Thoracotomy
Pallor	Thrombophlebitis
Palpable	Tidal volume
Patency, patent	Tissue perfusion
Peripheral pulses	Tracheostomy
Pneumothorax	Valsalva maneuver
Positive-pressure ventilation	Vasoconstriction
Postural hypotension	Vasodilation
Pulmonary embolus	Ventilation
Pulmonary function tests	Vital capacity
Pulse oximetry	Xiphoid process

## F.A. DAVIS COMPANY OXYGENATION: QUESTIONS

1. A nurse teaches a patient how to use an incentive spirometer. Which projected patient outcome will support the conclusion that the use of the incentive spirometer was effective?
  1. Supplemental oxygen use will be reduced.
  2. Inspiratory volume will be increased.
  3. Sputum will be expectorated.
  4. Coughing will be stimulated.
2. A primary health-care provider orders chest physiotherapy with percussion and vibration for a newly admitted patient. Which information obtained by the nurse during the health history should alert the nurse to question the provider's order?
  1. Emphysema
  2. Osteoporosis
  3. Cystic fibrosis
  4. Chronic bronchitis
3. Which nursing assessment **best** indicates a patient's ability to tolerate activity?
  1. Vital signs that take three minutes to return to preactivity level
  2. Absence of adventitious breath sounds on auscultation
  3. Flexibility of muscles and joints
  4. Reports of weakness
4. Which should the nurse do if an adult is choking on food?
  1. Apply sharp upward thrusts over the patient's xiphoid process.
  2. Determine if the patient can make any verbal sounds.
  3. Hit the middle of the patient's back firmly.
  4. Sweep the patient's mouth with a finger.

5. A patient has thick tenacious respiratory secretions. Which should the nurse do to liquefy the patient's respiratory secretions?
  1. Change the patient's position every two hours.
  2. Get a prescription for an antitussive agent.
  3. Encourage the patient to drink more fluid.
  4. Teach effective deep breathing.
6. Which action is effective in meeting the needs of a patient experiencing laryngospasm after extubation?
  1. Ensuring hyperextension of the head
  2. Providing positive-pressure ventilation
  3. Instituting cardiopulmonary resuscitation
  4. Administering oxygen by using a face mask
7. A patient's hemoglobin saturation via pulse oximetry indicates inadequate oxygenation. Which should the nurse do **first**?
  1. Notify the primary health-care provider.
  2. Encourage breathing deeply.
  3. Raise the head of the bed.
  4. Administer oxygen.
8. A nurse is reviewing the laboratory results of a patient with the preliminary diagnosis of anemia. An abnormal response of which diagnostic test reflects iron deficiency anemia?
  1. Hemoglobin
  2. Platelet count
  3. Serum albumin
  4. Blood urea nitrogen
9. A patient is admitted with the diagnosis of lower extremity arterial disease (LEAD). Which is a specific desirable outcome for a patient with this diagnosis?
  1. Respirations within the expected range
  2. Oriented to the environment
  3. Palpable peripheral pulses
  4. Prolonged capillary refill
10. A primary health-care provider orders bedrest for a patient. Which should the nurse explain to the patient is the **primary** purpose of bedrest?
  1. Conserve energy.
  2. Maintain strength.
  3. Enhance protein synthesis.
  4. Reduce intestinal peristalsis.
11. A nurse is planning to teach one patient pursed-lip breathing and another patient diaphragmatic breathing. Which technique associated with diaphragmatic breathing is different from pursed-lip breathing that the nurse should include in the teaching plan?
  1. Inhale through the mouth.
  2. Exhale through pursed lips.
  3. Raise both shoulders while breathing deeply.
  4. Tighten the abdominal muscles while exhaling.
12. A meal tray arrives for a patient who is receiving 24% oxygen via a Venturi mask. Which should the nurse do to meet this patient's needs?
  1. Request an order to use a nasal cannula during meals.
  2. Discontinue the oxygen when the patient is eating meals.
  3. Obtain an order to change the mask to a nonrebreather mask during meals.
  4. Arrange for liquid supplements that can be administered via a straw through a valve in the mask.

13. A nurse evaluates that the patient understood teaching about the purpose of pursed-lip breathing when the patient includes which information when explaining its purpose to a relative?
  1. Precipitates coughing
  2. Helps maintain open airways
  3. Decreases intrathoracic pressure
  4. Facilitates expectoration of mucus
14. An unconscious patient who had oral surgery is admitted to the postanesthesia care unit. In which position should the nurse place the patient?
  1. Prone
  2. Supine
  3. Fowler
  4. Lateral
15. A primary health-care provider orders chest physiotherapy with percussion and vibration for a patient. After the primary health-care provider leaves, the patient says, "I still don't understand the purpose of this therapy." Which statement should be included in the nurse's response?
  1. "It eliminates the need to cough."
  2. "It limits the production of bronchial mucus."
  3. "It helps clear the airways of excessive secretions."
  4. "It promotes the flow of secretions to the base of the lungs."
16. A nurse raises the head of the bed for a patient who has difficulty breathing. Which science includes the principle that explains how this intervention facilitates respiration?
  1. Physics
  2. Biology
  3. Anatomy
  4. Chemistry
17. Which clinical manifestation is of **most** concern when the nurse assesses a patient who has impaired mobility?
  1. Shallow respirations
  2. Increased oxygen saturation
  3. Decreased chest wall expansion
  4. Gurgling sounds when breathing
18. A nurse teaches a patient to make a series of short, forceful exhalations (huffing) just before actually coughing. Which information should the nurse include when explaining the purpose of this action?
  1. Conserves energy
  2. Liquefies respiratory secretions
  3. Limits pain precipitated by coughing
  4. Raises sputum to a level where it can be expectorated
19. Which are effective leg exercises the nurse should encourage a patient to perform to prevent circulatory complications during the postoperative period?
  1. Flexing the knees
  2. Isometric exercises
  3. Dorsiflexion exercises
  4. Passive range of motion
20. Which outcome **best** reflects achievement of the goal, "The patient will expectorate lung secretions with no signs of respiratory complications"?
  1. Absence of adventitious breath sounds
  2. Deep breathing and coughing nonproductively
  3. Drinking 3,000 mL of fluid in the last 24 hours
  4. Expectorating sputum three times between 3 p.m. and 11 p.m.



21. Which should the nurse do **first** when caring for a nonverbal patient who is restless, agitated, and irritable?
  1. Administer oxygen.
  2. Suction the oropharynx.
  3. Reduce environmental stimuli.
  4. Determine patency of the airway.
22. Which action should the nurse implement to increase both the respiratory and the circulatory functions of a patient in a coma?
  1. Encourage the patient to cough.
  2. Massage the patient's bony areas.
  3. Assist the patient with breathing exercises.
  4. Change the patient's position every two hours.
23. A patient sucking on a hard candy inhales while laughing and develops a total airway obstruction. Which is the nurse attempting to do when implementing an abdominal thrust?
  1. Produce a burp
  2. Pump the heart
  3. Push air out of the lungs
  4. Put pressure on the stomach
24. A nurse in the postanesthesia care unit is monitoring several patients who received general anesthesia. Which patient response causes the **most** concern?
  1. Pain
  2. Stridor
  3. Lethargy
  4. Diaphoresis
25. A primary health-care provider orders oxygen for a patient to be delivered at a high flow rate. Which additional nursing action is necessary when implementing a high-liter flow as opposed to a low-liter flow?
  1. Attaching a flow meter to the wall outlet
  2. Providing oral hygiene whenever necessary
  3. Using an oil-based lubricant when caring for the nares
  4. Humidifying oxygen before it is delivered to the patient
26. A nurse is teaching a patient how to use an incentive spirometer. Which position should the nurse assist the patient to assume during this procedure?
  1. Sitting
  2. Side-lying
  3. Orthopneic
  4. Low-Fowler
27. Which is the **most** important action by the nurse after a patient has a thoracotomy?
  1. Ensure the patient's intake is at least 3,000 mL of fluid per 24 hours.
  2. Provide the patient with adequate medication for pain relief.
  3. Maintain the integrity of the patient's chest tube.
  4. Reposition the patient every 2 hours.
28. A nurse is assessing a postoperative patient. Which complication has occurred when the patient experiences purulent sputum, dyspnea, and chest pain?
  1. Hypostatic pneumonia
  2. Hypovolemic shock
  3. Thrombophlebitis
  4. Pneumothorax

29. An obese patient has limited mobility after an open reduction and internal fixation of a fractured hip. For which human response related to increased blood coagulability should the nurse monitor this patient?
1. Muscle deterioration
  2. Pain in the calf
  3. Hypotension
  4. Bradypnea
30. For which clinical manifestation should the nurse monitor the patient when concerned about a potential for respiratory distress?
1. Productive cough
  2. Sore throat
  3. Orthopnea
  4. Eupnea
31. A nurse identifies that a patient's hands are edematous when attempting to apply a pulse oximetry probe. Which action should the nurse implement?
1. Attach the probe to one of the patient's toes.
  2. Connect the probe to one of the patient's earlobes.
  3. Wash the patient's hand before attaching the probe to the finger.
  4. Encourage the patient to perform active range-of-motion exercises of the hand.
32. A primary health-care provider's order reads, "6 L oxygen via face mask." The patient, who has been extremely confused since being in the unfamiliar environment of the hospital, becomes agitated and repeatedly pulls off the mask. Which should the nurse do?
1. Tighten the strap around the head.
  2. Reapply the mask every time the patient pulls it off.
  3. Provide an explanation of why the oxygen is necessary.
  4. Request that the order for oxygen be changed to a nasal cannula.
33. A nurse is caring for a male patient. Which laboratory results place this patient at risk for an impaired ability to tolerate activity? **Select all that apply.**
1.  $\text{Hct}$  of 45%
  2.  $\text{Hb}$  of 10 g/dL
  3.  $\text{O}_2$  saturation of 90%
  4.  $\text{RBC}$  count of  $3.8 \times 10^6/\text{mm}^3$
  5.  $\text{WBC}$  count of  $7.5 \times 10^6/\text{mm}^3$
34. A nurse teaches a preoperative patient how to use an incentive spirometer. Place the steps of the use of an incentive spirometer in the order in which they should be performed.
1. Inhale slowly.
  2. Hold the incentive spirometer level.
  3. Remove the mouthpiece and exhale normally.
  4. Keep the visual indicator at the inspiratory goal for several seconds.
  5. Maintain a firm seal with the lips around the mouthpiece during inhalation.
- Answer: \_\_\_\_\_
35. A primary health-care provider orders a loading dose of theophylline 6 mg/kg IV over 30 minutes. The patient weighs 150 pounds. How many milligrams of theophylline should the nurse administer? **Record your answer using a whole number.**
- Answer: \_\_\_\_\_mg

36. A nurse in the operative suite is preparing an older adult for surgery. Which physiological factors place the older adult at **greater** risk of life-threatening complications associated with surgery for which the nurse should be aware?

**Select all that apply.**

1.  Skin elasticity
  2.  Bladder emptying
  3.  Tolerance for pain
  4.  Respiratory excursion
  5.  Cardiovascular capacity
37. Which instructions should the nurse give a patient who is using the device in the illustration?



1. Breathe out normally, seal your mouth around the mouthpiece, breathe in slowly and deeply as possible, hold your breath at least three seconds, and remove the mouthpiece and exhale.
  2. Hold the device, seal your mouth around the mouthpiece, and breathe in and out slowly and deeply.
  3. Seal your mouth around the mouthpiece and breathe in and out normally.
  4. Take a deep breath and forcefully exhale through the mouthpiece.
38. A nurse is caring for a patient who has a chest tube after thoracic surgery. Which actions should the nurse implement when caring for this patient?

**Select all that apply.**

1.  Encourage the patient to cough and deep breathe at regular intervals.
  2.  Clamp the tube when providing for activities of daily living.
  3.  Position the collection device at the same level as the chest.
  4.  Maintain an airtight dressing over the puncture wound.
  5.  Empty chest tube drainage every shift.
  6.  Avoid using pins to secure tubing.
39. A nurse is concerned about the risk for thrombophlebitis when caring for a patient with impaired mobility. For which clinical manifestations associated with thrombophlebitis should the nurse monitor the patient? **Select all that apply.**
1.  Postural hypotension
  2.  Difficulty breathing
  3.  Blanchable erythema
  4.  Dependent edema
  5.  Acute chest pain

40. Which is the nurse preparing to do with the equipment depicted in the photograph?



1. Perform gastric lavage.
  2. Obtain a sputum specimen.
  3. Institute gastric decompression.
  4. Administer a nebulizer treatment.
41. A nurse is caring for a patient receiving oxygen via a nasal cannula. Which actions should the nurse implement? **Select all that apply.**
1.  Adjust the flow meter to the ordered oxygen flow rate.
  2.  Reassess nares, cheeks, and ears for signs of pressure every 2 hours.
  3.  Loop the tubing over the patient's ears and adjust it firmly under the chin.
  4.  Ensure hygiene includes applying an oil-based lubricant to the patient's nares.
  5.  Alternate the position of the prongs curving upward versus downward every 2 hours.
42. A nurse is assessing a patient with a respiratory problem. Which clinical manifestations are **most** reflective of an early response to hypoxia? **Select all that apply.**
1.  Dysrhythmias
  2.  Restlessness
  3.  Irritability
  4.  Cyanosis
  5.  Apnea

43. Which piece of information documented in the clinical record of a male adult should the nurse consider problematic?
1. Simvastatin 20 mg, PO, in the evening
  2. Pulse 100 beats per minute
  3. Oxygen saturation 85%
  4. WBC 8,000/mm<sup>3</sup>

### PATIENT'S CLINICAL RECORD

#### Laboratory Results

WBC 8,000/mm<sup>3</sup>

Hb 17 g/dL

Hct 50%

#### Physical Assessment

BP: 132/70 mm Hg

Pulse: 100 beats per minute

Respirations: 22 breaths per minute

Temperature: 99°F, oral

Oxygen saturation: 85%

#### Medication Reconciliation Form

Levothyroxine 100 mcg, PO, daily

Simvastatin 10 mg, PO, hs

Montelukast 10 mg, PO, hs

44. A primary health-care provider orders oxygen via a simple face mask at a flow rate of six liters for a patient. The nurse explains the procedure to the patient and maintains standard precautions. Place the following steps in the order in which they should be implemented.
1. Place the mask on the patient's face from the bridge of the nose to under the chin.
  2. Secure the elastic bands around the back of the patient's head.
  3. Attach the prefilled humidifier to the flow meter.
  4. Attach the flow meter to the wall oxygen source.
  5. Attach the face mask tubing to the humidifier.
  6. Turn the oxygen flow meter on to six liters.

Answer: \_\_\_\_\_

45. A primary health-care provider prescribes zafirlukast 40 mg daily to be divided into two doses, one in the morning and one in the evening. How many tablets should the nurse administer for each dose? **Record your answer using a whole number.**

Answer: \_\_\_\_\_ta      blets

## OXYGENATION: ANSWERS AND RATIONALES

1. Patients who use an incentive spirometer may or may not be receiving oxygen.
  2. **An incentive spirometer provides a visual goal for and measurement of inspiration. It encourages the patient to execute and maintain a sustained inspiration. A sustained inspiration opens airways, increases the inspiratory volume, and reduces the risk of atelectasis.**
  3. Although sputum may be expectorated after the use of an incentive spirometer, this is not the primary reason for its use.
  4. Although the deep breathing associated with the use of an incentive spirometer may stimulate coughing, this is not the primary reason for its use.
1. These are appropriate interventions for a patient with emphysema. Emphysema is a chronic obstructive pulmonary disease characterized by an abnormal increase in the size of air spaces distal to the terminal bronchioles with destructive changes in their walls.
  2. **Implementing the primary health-care provider's order may compromise patient safety because percussion and vibration in the presence of osteoporosis may cause fractures. Osteoporosis is an abnormal loss of bone mass and strength.**
  3. These are appropriate interventions for a patient with cystic fibrosis. Cystic fibrosis causes widespread dysfunction of the exocrine glands. It is characterized by thick, tenacious secretions in the respiratory system that block the bronchioles, creating breathing difficulties.
  4. These are appropriate interventions for a patient with chronic bronchitis. Bronchitis is an inflammation of the mucous membranes of the bronchial airways.
1. **Vital signs reflect cardiopulmonary functioning of the body. Vital signs obtained before and after activity provide data that can be compared to determine the body's response to the energy demands of ambulation. When the vital signs return to the preactivity level within 3 minutes it indicates that the patient has tolerated the activity.**
  2. The absence of abnormal breath sounds (adventitious sounds) indicates the nonexistence of a respiratory problem. Adventitious breath sounds (e.g., wheezes, rhonchi, rales, pleural friction rub, and stridor) indicate narrowed airways, presence of excessive respiratory secretions, pleural inflammation, or diminished ventilation and are not the best signs to use when assessing a person's tolerance to activity.
  3. Flexibility relates to mobility, not one's physiological capacity to endure activities that require energy.
  4. A report of weakness indicates that the patient has not tolerated the activity.
1. Thrusts to the xiphoid process may cause a fracture that may result in a pneumothorax.
  2. **When a person is choking on food, the first intervention is to determine if the person can speak because the next intervention will depend on if it is a partial or total airway obstruction. Ask the patient "Are you choking?" With a partial airway obstruction, the person will be able to make sounds because some air can pass from the lungs through the vocal cords. In this situation, the person's own efforts (gagging and coughing) should be allowed to clear the airway. With a total airway obstruction, the person will not be able to make a sound because the airway is blocked and the nurse should immediately initiate the abdominal thrust maneuver (Heimlich maneuver).**
  3. Hitting the middle of the patient's back firmly should never be done with an adult because if it is a partial obstruction it interferes with the person's own efforts to clear the airway or can cause the bolus of food to lodge farther down the trachea. If it is a total obstruction, slapping the back will be useless and delay the initiation of the abdominal thrust maneuver.
  4. Sweeping the patient's mouth with a finger can force the bolus of food farther down the trachea and is contraindicated.
1. Changing positions will mobilize, not liquefy, respiratory secretions.
  2. Mucolytics, not antitussives, liquefy respiratory secretions. Antitussives prevent or relieve coughing.

3. **A fluid intake of 2,500 to 3,000 mL is recommended to maintain the moisture of the respiratory mucous membranes. Adequate fluid keeps respiratory secretions thin so that they can be moved by ciliary action or coughed up and spat out (expectorated).**
  4. Deep breathing mobilizes, not liquefies, respiratory secretions.
6. 1. Although tilting the head backward (hyperextension of the head) elongates the pharynx, reducing airway resistance, this will do nothing to correct the obstruction at the glottis (opening through the vocal cords). Also, the tongue will block the airway unless there is forward pressure applied on the lower angle of the jaw (jaw thrust maneuver).
  2. **Positive pressure will push the vocal cords backward toward the wall of the larynx, opening the glottis (space between the vocal cords), which allows ventilation of the lung.**
  3. Instituting cardiopulmonary resuscitation is unnecessary. The patient is having a respiratory, not a cardiac, problem.
  4. Administering oxygen by using a face mask is useless because the glottis is obstructed and the oxygenated air will not enter the lung.
7. 1. Notifying the primary health-care provider is premature. The patient's needs must be met first.
  2. Although encouraging deep breathing might be done eventually, it is not the priority at this time. This may or may not help. Inadequate oxygenation can be caused by a variety of problems other than shallow breathing.
  3. **A nurse can implement this immediate, independent action. Nurses are permitted to treat human responses. Raising the head of the bed facilitates the dropping of the abdominal organs by gravity away from the diaphragm, which permits the greatest lung expansion.**
  4. Obtaining and setting up the equipment take time that can be used for other more appropriate interventions first.
8. 1. **Iron is necessary for hemoglobin synthesis. Therefore, reduced intake of dietary iron results in iron deficiency anemia. Hemoglobin is the main component of red blood cells and transports oxygen and carbon dioxide through the bloodstream.**
  2. Platelets are unrelated to iron deficiency anemia. Platelets (thrombocytes) are nonnucleated, round or oval, flattened, disk-shaped, formed elements in the blood that are necessary for blood clotting.
  3. Albumin is unrelated to iron deficiency anemia. Albumin is a protein in the blood that helps to maintain blood volume and blood pressure.
  4. Blood urea nitrogen (BUN) is unrelated to iron deficiency anemia. BUN is a test that measures the nitrogen portion of urea present in the blood. It is an index of glomerular function in the production and excretion of urea.
9. 1. Respirations within the expected range are unrelated to lower extremity arterial disease (LEAD).
  2. LEAD usually involves inadequate circulation in the lower extremities, not the brain.
  3. **Palpable peripheral pulses are an appropriate expected outcome for a patient with arterial vascular disease, which is a decrease in nutrition and respiration at the peripheral cellular level because of a decrease in capillary blood supply. A physiological response associated with LEAD is diminished or absent arterial pulses.**
  4. A prolonged capillary refill indicates a continued problem with peripheral tissue perfusion. After compression, blanched tissue should return to its original color within 2 seconds (blanch test).
10. 1. **Bedrest reduces cardiopulmonary demands, muscle contraction, and other bodily functions. All of this reduces the basal metabolic rate, which conserves energy.**
  2. Activity, not bedrest, maintains strength.
  3. Protein synthesis is enhanced by the intake of amino acids, not bedrest.
  4. Although bedrest may limit peristalsis, it is not the most common reason bedrest is ordered.
11. 1. Inhalation is through the nose for both diaphragmatic and pursed-lip breathing.
  2. Exhalation through pursed lips is performed only with pursed-lip breathing.
  3. Raising both shoulders while breathing deeply is not part of diaphragmatic or pursed-lip breathing. The use of these

accessory muscles of respiration is a compensatory mechanism that helps to increase thoracic excursion when inhaling.

4. **With diaphragmatic breathing the contraction of abdominal muscles at the end of expiration helps to reduce the amount of air left in the lungs (residual volume).**
12. 1. **A Venturi mask interferes with eating because it covers the nose and mouth. Using a nasal cannula during meals will help meet both the nutritional and oxygen needs of the patient. A nasal cannula delivers oxygen via prongs placed in the patient's nares, leaving the mouth unobstructed, which promotes talking and eating. Specific oxygen delivery systems require an order and are a dependent function of the nurse, except in emergency situations.**
    2. Discontinuing oxygen when the patient is eating is unsafe because it can compromise the patient's respiratory status while the oxygen is disconnected.
    3. A Venturi mask and a nonrebreather mask are both masks that cover the mouth, which interferes with eating.
    4. Liquid supplements are unnecessary. The patient should eat the diet ordered by the primary health-care provider.
  13. 1. Deep breathing and huff coughing, not pursed-lip breathing, stimulate effective coughing.
    2. **Pursed-lip breathing involves deep inspiration and prolonged expiration against slightly closed lips. The pursed lips create a resistance to the air flowing out of the lungs, which prolongs exhalation and maintains positive airway pressure, thereby maintaining an open airway and preventing airway collapse.**
    3. Pursed-lip breathing increases, not decreases, intrathoracic pressure.
    4. The huff cough stimulates the natural cough reflex and is effective for clearing the central airways of sputum. Saying the word huff with short, forceful exhalations keeps the glottis open, mobilizes sputum, and stimulates a cough.
  14. 1. Although the prone position allows for drainage from the mouth, it is contraindicated because lying on the side of the face compresses oral tissues, impedes assessment, complicates oral suctioning, and may compromise the airway.
    2. The supine position is unsafe. In an unconscious patient, the gag and swallowing reflexes may be impaired, which increases the risk for aspiration as the tongue falls to the back of the oropharynx, occluding the airway.
    3. The Fowler position is unsafe. An unconscious patient is unable to maintain an upright position.
    4. **The lateral position facilitates the flow of secretions out of the mouth by gravity, keeps the tongue to the side of the mouth, maintaining the airway, and permits effective assessment of the oropharynx and respiratory status.**
  15. 1. Chest physiotherapy promotes, not eliminates, the need for coughing.
    2. Chest physiotherapy promotes the expectoration of, not limits the production of, bronchial mucus.
    3. **The forceful striking of the skin over the lung (percussion, clapping) and fine, vigorous, shaking pressure with the hands on the chest wall during exhalation (vibration) mobilize secretions so that they can be coughed up and expectorated.**
    4. Chest physiotherapy mobilizes secretions, thus facilitating expectoration and interfering with the flow of secretions to the base of the lungs.
  16. 1. **Raising the head of the bed drops the abdominal organs away from the diaphragm via the principle of gravity, facilitating breathing. Gravity, the tendency of weight to be pulled toward the center of the earth, is a physics principle.**
    2. Raising the head of the bed is not related to biology. Biology is the study of living organisms.
    3. Raising the head of the bed is not related to anatomy. Anatomy is the study of the form and structure of living organisms.
    4. Raising the head of the bed is not related to chemistry. Chemistry is the study of elements, compounds, and atomic relations of matter.
  17. 1. Although shallow respirations are a concern, they are not as serious as a clinical manifestation in another option.
    2. Oxygen saturation may be decreased, not increased, with immobility.



3. Although decreased chest wall expansion is a concern, it is not as serious as a clinical manifestation in another option.
- 4. Respirations that sound gurgling (gurgles, rhonchi) indicate air passing through narrowed air passages because of secretions, swelling, or a tumor. A partial or total obstruction of the airway can occur, which is life-threatening.**
- 18.** 1. Regardless of the type of cough, coughing uses, not conserves, energy. However, after the airway is cleared of sputum, the patient's oxygen demands will be met more effectively.
2. An increased fluid intake, not coughing, liquefies respiratory secretions.
3. Limiting pain precipitated by coughing is not the purpose of huff coughing. Coughing usually is not painful unless the thoracic muscles are strained or the patient has had abdominal or pelvic surgery.
- 4. The huff cough stimulates the natural cough reflex and is effective for clearing the central airways of sputum. Saying the word huff with short, forceful exhalations keeps the glottis open and raises sputum to a level where it can be coughed up and expectorated.**
- 19.** 1. Flexing the knees exerts pressure on the veins in the popliteal space; this reduces venous return, which increases, not decreases, the risk of postoperative circulatory complications.
2. Isometric exercises strengthen muscles; they do not prevent postoperative circulatory complications. Isometric exercises change the muscle tension but do not change the muscle length or move joints.
- 3. Alternating dorsiflexion and plantar flexion (calf pumping) contracts and relaxes the calf muscles, including the gastrocnemius muscles. This muscle contraction promotes venous return, preventing venous stasis that contributes to the development of postoperative thrombophlebitis.**
4. Passive range-of-motion exercises are done by another person moving a patient's joints through their complete range of movement. This does not prevent postoperative circulatory complications because the power is supplied by a person other than the patient. To facilitate circulation a patient has to contract and relax muscles actively.
- 20.** 1. **Adventitious breath sounds are abnormal breath sounds that occur when pleural linings are inflamed or when air passes through narrowed airways or through airways filled with fluid. The absence of abnormal sounds is desirable.**
2. To expectorate secretions, coughing must be productive, not nonproductive. A nonproductive cough is dry, which means that no respiratory secretions are raised and spat out (expectorated) because of coughing.
3. Drinking fluid is an intervention that will liquefy respiratory secretions, thus facilitating their expectoration. However, just drinking fluid will not ensure that the secretions will be expectorated.
4. Although spitting out sputum reflects achievement of the goal in relation to expectorating lung secretions, it does not address the absence of respiratory complications, which is the ultimate goal of decreasing stasis of respiratory secretions.
- 21.** 1. Administering oxygen may or may not be necessary. The need for oxygen administration will depend on the results of other interventions that should be done first.
2. Suctioning the oropharynx is premature. Mucus or sputum may not be the cause of the problem.
3. Reducing environmental stimuli will serve no purpose at this time and is not the priority.
- 4. Early signs of hypoxia are restlessness, agitation, and irritability resulting from reduced oxygen to brain cells. A partial or completely obstructed airway prevents the passage of gases into and out of the lungs. The ABCs (Airway, Breathing, Circulation) of emergency care identify airway as the priority.**
- 22.** 1. A patient in a coma is unable to respond to an instruction to cough.
2. Massage increases circulation only in the localized area being massaged. In addition, massage should be performed around, not over, bony prominences.

3. A patient in a coma is unable to respond to an instruction to perform breathing exercises.
  4. **Changing the patient's position every 2 hours helps respirations by preventing fluid from collecting in the lung, which can cause infection; it helps circulation because activity increases circulation, and it relieves local pressure.**
- 23.
1. Producing a burp in this situation is ineffective. Whatever is causing the obstruction is not caught in the esophagus, which leads to the stomach, but in the respiratory system.
  2. Pressing on the heart (compression) is used in cardiopulmonary resuscitation (CPR).
  3. **When trapped air behind an obstruction is forced out in response to an abdominal thrust, the forced air may push out what is causing the obstruction.**
  4. Applying pressure against the stomach is ineffective in this situation. Whatever is causing the obstruction is not lodged in the esophagus, which leads to the stomach, but in the respiratory system.
- 24.
1. Pain is an expected response to the trauma of surgery and usually can be managed effectively.
  2. **Stridor is an obvious audible shrill, harsh sound caused by laryngeal obstruction. The larynx can become edematous because of the trauma of intubation associated with general anesthesia. Obstruction of the larynx is life-threatening because it prevents the exchange of gases between the lungs and the atmosphere.**
  3. Lethargy, which is drowsiness or sluggishness, is an expected response to anesthesia and opioid medications because these medications depress the central nervous system.
  4. Although diaphoresis is a cause for concern, it is not as immediately life-threatening as an adaptation in another option. Diaphoresis can be related to a warm environment, impaired thermoregulation, the general adaptation syndrome, or shock.
- 25.
1. All oxygen systems should have a flow meter to control and maintain the flow of oxygen.
  2. All oxygen is drying to the oral mucosa. Therefore, oral hygiene should be provided frequently to moisten the mucous membranes.
  3. The use of an oil-based lubricant is unsafe because it is a volatile, flammable material in the presence of oxygen. A water-based lubricant should be used.
  4. **A low-liter flow system administers a volume of oxygen designed to supplement the inspired room air to provide airflow equal to the person's minute ventilation (total volume of gas in liters exhaled from the lung per minute). A high-liter flow system administers a volume of oxygen designed to exceed the volume of air required for the person's minute ventilation. The low-liter flow system is less drying than the high-liter flow system, and humidification is unnecessary. A humidifier is a mechanical device that adds water vapor to air in a particle size that can carry moisture to the small airways.**
- 26.
1. **An upright sitting position in a bed or chair facilitates maximum thoracic excursion because it permits the diaphragm to contract without pressure being exerted against it by abdominal viscera.**
  2. The side-lying position is not ideal for the use of an incentive spirometer because it limits thoracic expansion. The side-lying position allows abdominal viscera to exert pressure against the diaphragm during inspiration, and the lung on the lower side of the body is compressed by the weight of the body.
  3. Although the orthopneic position allows for thoracic expansion, leaning forward with the arms on an over-bed table does not free the hands for holding the spirometer.
  4. The low-Fowler position does not maximize the effects of gravity. In the high-Fowler position gravity moves abdominal viscera away from the diaphragm and thus facilitates the contraction of the diaphragm, both of which promote thoracic expansion.
- 27.
1. Ensuring a fluid intake of at least 3,000 mL is unnecessary. A fluid intake of approximately 2,000 mL is adequate.
  2. Although this is extremely important, it is not the priority.

- 3. A tension pneumothorax may occur if the integrity of the chest drainage system becomes compromised (e.g., open to atmospheric pressure, clogged drainage tube, or mechanical dysfunction). Maintaining respiratory functioning is the priority.**
4. Although repositioning is done to promote drainage of secretions from lung segments and aeration of lung tissue, it is not the priority.
- 28. 1. Postoperative patients often experience hypoventilation, immobility, and ineffective coughing that may lead to stasis of respiratory secretions and the multiplication of microorganisms, causing hypostatic pneumonia. Dyspnea results from decreased lung compliance, chest pain results from coughing and the increased work of breathing, and purulent sputum results from the presence of pathogens in sputum.**
2. Hypovolemic shock is characterized by tachycardia, tachypnea, and hypotension.
3. Thrombophlebitis is characterized by localized pain, swelling, warmth, and erythema. If a thrombus breaks loose and travels through the venous circulation to the lung (pulmonary embolus), it will cause dyspnea and chest pain, not purulent sputum.
4. Pneumothorax is characterized by a sudden onset of sharp pain on inspiration, dyspnea, tachycardia, and hypotension.
- 29. 1. Although muscle deterioration (atrophy) can occur with immobility, it is unrelated to hypercoagulability. Muscle atrophy is the decrease in the size of a muscle resulting from disuse.**
- 2. Immobility promotes venous vasodilation, venous stasis, and hypercoagulability of the blood, which can precipitate the formation of a clot in a vein of the leg (venous thrombus) and inflammation of the vein (phlebitis).**
3. Hypotension, an abnormally low systolic blood pressure (less than 100 mm Hg), is not related to hypercoagulability precipitated by immobility.
4. Bradypnea, abnormally slow breathing (less than 10 breaths per minute), is unrelated to hypercoagulability caused by immobility.
- 30. 1. A productive cough indicates that the person is managing respiratory secretions adequately and keeping the airway patent.**
2. A sore throat indicates posterior oropharyngeal irritation or inflammation. This may or may not progress to respiratory distress.
- 3. Orthopnea, the ability to breathe easily only in an upright (standing or sitting) position, is a classic sign of respiratory distress. The upright position permits maximum thoracic expansion because the abdominal organs do not press against the diaphragm and inspiration is aided by the principle of gravity.**
4. Eupnea is respirations that are quiet, rhythmic, and effortless within the expected rate per minute for age.
- 31. 1. The use of a toe for pulse oximetry can result in inaccurate results because of concurrent problems, such as vasoconstriction, hypothermia, impaired peripheral circulation, and movement of the foot.**
- 2. An earlobe is an excellent site to monitor pulse oximetry. It is least affected by decreased blood flow, has greater accuracy at lower saturations, and rarely is edematous. This site is used for intermittent, not continuous, monitoring.**
3. Soap and water will not resolve edema. In addition, attaching a pulse oximeter clip sensor to an edematous finger is contraindicated because interstitial fluid interferes with obtaining an accurate oxygen saturation level.
4. The cause of the edema must be identified first because range-of-motion exercises may be contraindicated.
- 32. 1. Tightening the strap around the head is unsafe because it can compress the capillaries under the strap, which may interfere with tissue perfusion and result in pressure ulcers.**
2. Reapplying the mask every time the patient pulls it off may increase the patient's agitation and it is impractical.
3. Providing an explanation of why the oxygen is necessary will probably be ineffective because an agitated patient often does not understand cause and effect.
- 4. Agitated, confused patients generally tolerate a nasal cannula better than a**

face mask. A nasal cannula (nasal prongs) is less intrusive than a mask. Masks are oppressive and may cause a patient to feel claustrophobic.

33. 1. A hematocrit of 45% is within the expected range for hematocrit for men (42% to 52%) and women (36% to 48%).
2. A hemoglobin of 10 g/dL is less than the expected range for hemoglobin for men (14.0 to 17.4 g/dL) and women (12.0 to 16.0 g/dL).
3. An oxygen saturation of 90% is below the expected level of 95% or more. Adequate oxygen levels are necessary to meet the metabolic demands of activity that requires muscle contraction.
4. A red blood cell count of  $3.8 \times 10^6/\text{mm}^3$  is below the expected range of 4.71 to  $5.14 \times 10^6/\text{mm}^3$  for red blood cells for men. Hemoglobin, which carries oxygen, is a component of red blood cells.
5. A white blood cell (WBC) count of  $7.5 \times 10^6/\text{mm}^3$  is within the expected range of 4.5 to  $11 \times 10^6/\text{mm}^3$  for WBCs. WBCs are not related to a patient's oxygenation status; they are related to protecting the patient from infection.
34. 2. Holding the incentive spirometer level prevents factors, such as friction and gravity, from altering the correct function of the device.
5. A firm seal around the mouthpiece is necessary during inhalation, but the mouthpiece should be removed during exhalation.
1. Inspiration should be accomplished through a slow, deep breath. A rapid, forceful inhalation can collapse the airway and is contraindicated.
4. When the visual indicator reaches the preset goal during inhalation the inhalation should be maintained for 2 to 6 seconds to ensure ventilation of the alveoli.
3. Each exhalation should be an unforced, normal exhalation. A seal does not need to be maintained around the mouthpiece.
35. Answer: 408 mg  
To solve this problem, first convert 150 pounds to its equivalent in kilograms by using the formula for ratio and proportion.

$$\frac{\text{Desire } 150 \text{ lb}}{\text{Have } 2.2 \text{ lb}} = \frac{x \text{ kg}}{1 \text{ kg}}$$

$$2.2x = 150$$

$$x = 150 \div 2.2$$

$$x = 68.18 \text{ kg}$$

Round down to 68 because 0.18 is less than 0.5.

150 lb is equivalent to 68 kg.

Next calculate the number of milligrams to be administered by multiplying the patient's weight in kilograms by the ordered dose per kilogram:  $68 \text{ kg} \times 6 \text{ mg} = 408 \text{ mg}$ .

36. 1. In older adults, atrophy and thinning of both the epithelial and subcutaneous layers of tissue occur, collagenous attachments become less effective, sebaceous gland activity decreases, and interstitial fluid decreases. These changes lead to decreased skin elasticity and the potential to take longer for an incision to heal; however, these are not life-threatening complications associated with surgery and the aging process.
2. In older adults, bladder muscles weaken, bladder capacity decreases, the micturition reflex is delayed, emptying of the bladder becomes more difficult, and residual volume increases; however, these are not life-threatening complications associated with surgery and age-related changes.
3. In older adults there is an increased threshold for sensations of pain, touch, and temperature because of age-related changes in the nerves and nerve conduction; this is not a life-threatening complication associated with surgery and the aging process.
4. Age-related changes in older adults include calcification of costal cartilage (making the trachea and rib cage more rigid), an increase in the anteroposterior chest diameter, and weakening of thoracic muscles. These changes decrease respiratory excursion, which can result in multiple life-threatening postoperative complications such as atelectasis and hypostatic pneumonia.
5. In older adults there is a decrease in functioning capacity of the heart and vascular system. Atherosclerosis of the aorta, coronary arteries, and carotid arteries could decrease cardiac output, impair circulation to vital organs and distal extremities, and increase the

workload of the heart at times of stress. These age-related changes are associated with life-threatening dysrhythmias, thrombophlebitis, and pulmonary emboli.

- 37.** 1. These are the instructions for using an incentive spirometer. An incentive spirometer is designed to have a person deep breathe and expand the lungs to help prevent respiratory complications of immobility.
2. These are instructions for using a nebulizer. A nebulizer is a medication delivery system that delivers aerosol spray which is inhaled via a mouthpiece. Breathing deeply and slowly facilitates contact of the medication with the respiratory tract mucosa.
3. These are instructions for assessing tidal volume. Tidal volume is the volume of air inhaled and exhaled with each normal breath; a tidal volume is approximately 500 mL.
- 4. These are the instructions for using a peak expiratory flow meter (PEFM), which is the device in the photograph. A peak expiratory flow meter measures the peak expiratory flow rate (PEFR). A peak expiratory flow rate is the volume of air that can be forcefully exhaled after taking a deep breath.**
- 38.** 1. **Coughing and deep breathing should be encouraged because this helps to expand the lungs.**
2. Clamping the tube when providing for activities of daily living is contraindicated because clamping a chest tube may cause a tension pneumothorax.
3. The chest drainage system should be kept below the level of the insertion site to promote the flow of drainage from the pleural space and prevent the flow of drainage back into the pleural space.
- 4. An airtight dressing seals the pleural space from the environment. If left open to the environment, atmospheric pressure causes air to enter the pleural space, which results in a tension pneumothorax.**
5. Emptying chest tube drainage every shift is unnecessary. Chest drainage systems are closed, self-contained systems that have a chamber for drainage. At routine intervals (as per hospital policy) the date, time, and nurse's initials mark the level of drainage on the drainage collection chamber.

**6. Avoiding using pins to secure tubing averts the risk of puncturing the tubing, which will cause an air leak.**

- 39.** 1. Postural hypotension is unrelated to thrombophlebitis caused by immobility. Postural hypotension (orthostatic hypotension) is a decrease in blood pressure related to positional or postural changes from the lying down to sitting or standing positions.
- 2. Dyspnea is a clinical manifestation of a pulmonary embolus, a life-threatening condition. A thrombus that breaks loose from a vein wall and travels through the circulation (embolus) eventually will obstruct a pulmonary artery or one of its branches (pulmonary embolus).**
3. Blanchable erythema is unrelated to thrombophlebitis caused by immobility. Blanchable erythema (reactive hyperemia) is a reddened area caused by localized vasodilation in response to lack of blood flow to the underlying tissue. The reddened area will turn pale with fingertip pressure.
4. Dependent edema is unrelated to thrombophlebitis caused by immobility. Although fluid will collect in the interstitial compartment (edema) around a thrombophlebitis, it is localized, not dependent, edema. Dependent edema is the collection of fluid in the interstitial tissues below the level of the heart; it occurs bilaterally and usually is caused by cardiopulmonary problems.
- 5. Immobility promotes venous stasis, which in conjunction with hypercoagulability and injury to vessel walls predisposes patients to thrombophlebitis. These three factors are known as Virchow's triad. A thrombus can break loose from the vein wall and travel through the circulation (embolus), where eventually it obstructs a pulmonary artery or one of its branches and causes sudden, acute chest pain, dyspnea, coughing, and frothy sputum.**
- 40.** 1. This is not the equipment used for the purpose of gastric lavage.
- 2. The nurse is preparing to collect a sputum specimen via suctioning. The nurse is attaching a catheter to a sputum trap that attaches to the suction tubing.**

3. This is not the equipment used for gastric decompression.
  4. This is not the equipment used to administer a nebulizer treatment.
- 41. 1. Adjusting the flow meter to the ordered oxygen flow rate ensures that the patient is receiving the prescribed dose of oxygen.**
2. **Reassessing the patient's skin for signs of pressure every 2 hours ensures that tissue irritation or capillary compression does not occur from the nasal prongs or tubing. The tubing should be snug enough to keep the nasal prongs from becoming displaced but loose enough not to compress or irritate tissue.**
  3. Looping the tubing over the patient's ears and adjusting it firmly under the chin provide the correct placement of the tubing; however, the tubing should be secured gently, not firmly, under the chin.
  4. The use of an oil-based lubricant, a volatile, flammable material, should be avoided in the presence of oxygen. A water-based lubricant should be used.
  5. Placing the nasal prongs curving upward does not follow the natural curve of the nasal passage, which can cause tissue injury. The nasal prongs should always be curving downward to follow the natural curve of the nares.
- 42. 1. A dysrhythmia, a heart rate with an irregular rhythm, can occur with hypoxia but it is a late response.**
2. **Hypoxia is insufficient oxygen anywhere in the body. An early sign of hypoxia is restlessness, which is caused by impaired cerebral perfusion of oxygen.**
  3. **Irritability is an early sign of hypoxia caused by impaired cerebral perfusion of oxygen.**
  4. Cyanosis, a bluish discoloration of the skin and mucous membranes caused by reduced oxygen in the blood, is a late sign of hypoxia.
  5. Apnea, a complete absence of respirations, is the cause of, not a response to, hypoxia.
- 43. 1. Simvastatin 10 mg once a day is within the expected dose range of 5 to 40 mg daily and is not a cause for concern.** Simvastatin, a lipid-lowering agent, should be taken in the evening because the body produces the most cholesterol overnight.
2. A pulse rate of 100 beats per minute is within the expected range of 60 to 100 beats per minute and is not a cause for concern.
  3. **An oxygen saturation level of 85% is a cause for concern. An oxygen saturation level of 95% to 100% is considered expected. An oxygen saturation level less than 90% is considered low and is associated with hypoxemia.**
  4. A WBC count of 8,000/mm<sup>3</sup> is within the expected range of 5,000 to 10,000/mm<sup>3</sup> and is not a cause for concern.
- 44. 4. The first step is to attach the flow meter to the wall oxygen source. The flow meter controls the amount of oxygen delivered.**
3. **The second step is to attach the prefilled humidifier to the flow meter. Humidification reduces drying of the respiratory system mucous membranes and is essential when oxygen delivery is 4 L or higher.**
  5. **The third step is attaching the mask's tubing to the humidifier. This prepares the equipment for use.**
  6. **The fourth step is turning on the oxygen flow rate to 6 L. This primes the tubing and mask with oxygen so that there is no delay once the mask is applied to the patient's face.**
  1. **The fifth step is placing the mask on the patient's face. Applying it from the bridge of the patient's nose to under the chin limits oxygen from leaking around the edges of the mask.**
  2. **The sixth step is securing the elastic bands around the back of the patient's head. This helps to hold the mask in position.**
- 45. Answer: 2 tablets. First determine the number of milligrams prescribed for each dose. Divide the daily dose (40 mg) by the number of times the medication should be administered (2 times, once in the morning and once in the evening):**  $40 \div 2 = 20$  mg per dose. The package insert for zafirlukast states that each tablet is 10 mg. Solve the problem using the formula for ratio and proportion.
- $$\frac{\text{Desire } 20 \text{ mg}}{\text{Have } 10 \text{ mg}} = \frac{x \text{ tablet}}{1 \text{ tablet}}$$
- $$10x = 20 \text{ mg}$$
- $$x = 20 \div 10$$
- $$x = 2 \text{ tablets}$$

# Urinary Elimination

## KEYWORDS

The following words include English vocabulary, nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Acidic urine	Polyuria
Anuria	Prostate
Bacteriuria	Pyuria
Bladder cues	Reagent strips
Bladder irritability	Renal calculi
Bladder training	Renal perfusion
Catheter port	Residual urine
Commode chair	Retention
Credé maneuver	Specific gravity
Cystoscopy	Suprapubic distention
Detrusor muscles	Trigone
Dysuria	Turbidity
Enuresis	Urea
Excretion	Ureter
Foreskin	Urethra
Fracture bedpan	Urgency
Frequency	Urinary catheters:
Glomerular filtration rate	Condom (Texas)
Graduate	Indwelling (retention, Foley)
Hematuria	Straight
Hesitancy	Suprapubic
Incontinence, types:	Urinary diuresis
Functional	Urinary diversion
Overflow	Urinary drainage system
Reflex	Urinary meatus
Stress	Urinary obstruction
Total	Urinary output
Urge	Urinary tract infection
Incontinent	Urine clarity
Kegel exercises	Urine specimens:
Ketones	Clean catch
Micturition	From a catheter port
Nocturia	Urinalysis
Oliguria	24-hour urine collection
Perineal care	Void

F.A. LAVIS

COMPANY

## URINARY ELIMINATION: QUESTIONS

1. A nurse identifies that the patient has overflow incontinence. Which factor contributes to this clinical manifestation?
  1. Coughing
  2. Mobility deficits
  3. Prostate enlargement
  4. Urinary tract infection
2. A nurse must measure the intake and output (I&O) of a patient who has a urinary retention catheter. Which equipment is **most** appropriate to use to measure urine output from a urinary retention catheter accurately?
  1. Urinal
  2. Graduate
  3. Large syringe
  4. Urine collection bag
3. A patient's urine is cloudy, is amber, and has an unpleasant odor. Which problem may this information indicate that requires the nurse to make a focused assessment?
  1. Urinary retention
  2. Urinary tract infection
  3. Ketone bodies in the urine
  4. High urinary calcium level
4. A nurse is caring for a debilitated female patient with nocturia. Which nursing intervention is the **priority** when planning to meet this patient's needs?
  1. Encouraging the use of bladder training exercises
  2. Providing assistance with toileting every 4 hours
  3. Positioning a bedside commode near the bed
  4. Teaching the avoidance of fluids after 5 p.m.
5. A primary health-care provider orders a urine specimen for culture and sensitivity via a straight catheter for a patient. Which should the nurse do when collecting this urine specimen?
  1. Use a sterile specimen container.
  2. Collect urine from the catheter port.
  3. Inflate the balloon with sterile water.
  4. Have the patient void before collecting the specimen.
6. A nurse reviews the results of a patient's urinalysis. Which constituent found in urine indicates the presence of an abnormality?
  1. Electrolytes
  2. Protein
  3. Water
  4. Urea
7. A patient is reporting burning on urination. Which question should the nurse ask to **best** obtain information about the patient's dysuria?
  1. "Can you tell me about the problems you have been having with urination?"
  2. "How would you describe your experience with incontinence?"
  3. "What are your usual bowel habits?"
  4. "What color is your urine?"
8. A nurse is caring for a group of patients with a variety of urinary problems. Which patient's physical response should cause the **most** concern?
  1. Anuria
  2. Dysuria
  3. Diuresis
  4. Enuresis



9. A nurse is performing a physical assessment on a newly admitted patient. Which problem identified by the nurse is often associated with urinary incontinence?
  1. Chronic pain
  2. Reduced fluid intake
  3. Disturbed self-esteem
  4. Insufficient knowledge
10. A nurse is caring for two patients. One patient has reflex incontinence and the other has total incontinence. Which characteristic is common to both reflex incontinence and total incontinence?
  1. Urination following an increase in intra-abdominal pressure
  2. Loss of urine without awareness of bladder fullness
  3. Retention of urine with overflow incontinence
  4. Strong, sudden desire to void
11. Which clinical manifestation can a nurse expect when a postoperative patient experiences stress associated with surgery?
  1. Decreased urinary output
  2. Low specific gravity
  3. Reflex incontinence
  4. Urinary hesitancy
12. Which assessment is not related to monitoring both urine and stool?
  1. Constituents
  2. Urgency
  3. Shape
  4. Color
13. A nurse is assessing the urinary status of a patient. Which sign indicates that additional nursing assessments are necessary?
  1. Aromatic odor
  2. Pale yellow urine
  3. Output of 50 mL hourly
  4. Specific gravity of 1.035
14. A patient tells the nurse, "I have to urinate as soon as I get the urge to go." For which contributing factor to urinary urgency should the nurse implement a focused assessment?
  1. Anesthesia
  2. Dehydration
  3. Full bladder
  4. Urinary tract infection
15. Which is an effective nursing intervention to prevent urinary tract infections?
  1. Teach female patients to wipe from the back to the front after urinating.
  2. Advise patients to report burning on urination to health-care providers.
  3. Instruct patients to use bath powder to absorb perineal perspiration.
  4. Encourage patients to drink several quarts of fluid daily.
16. A patient has urinary incontinence. Which is the **best** nursing intervention for this patient?
  1. Providing skin care immediately after soiling
  2. Using a deodorant soap when providing skin care
  3. Drying the area well after providing perineal care
  4. Dusting the perineal area with a light film of cornstarch
17. A confused patient is incontinent of urine and stool and smears the stool on the bed linens and bed rails. Which should be the initial patient goal?
  1. The patient will be clean and dry continuously.
  2. The patient will become continent within a week.
  3. The patient will stop soiling the environment immediately.
  4. The patient will call for the bedpan whenever the urge to eliminate occurs.

18. A patient has a urinary retention catheter. Which is **most** important when the nurse cares for this patient?
1. Applying an antimicrobial agent to the urinary meatus 2 times a day
  2. Ensuring that the catheter remains connected to the collection bag
  3. Wearing sterile gloves when accessing the specimen port
  4. Increasing fluid intake to 3,000 mL a day
19. Which information about a patient is communicated when a nurse documents that the patient has polyuria?
1. Excreting excessive amounts of urine
  2. Experiencing pain on urination
  3. Retaining urine in the bladder
  4. Passing blood in the urine
20. A patient is experiencing bladder irritability. Which fluid should the nurse teach the patient to include in the diet?
1. Beer
  2. Coffee
  3. Orange juice
  4. Cranberry juice
21. Which clinical manifestation identified by the nurse commonly is associated with excessive production of antidiuretic hormone (ADH)?
1. Diuresis
  2. Oliguria
  3. Retention
  4. Incontinence
22. A nurse must obtain a urine specimen from a patient. Which nursing intervention is the **greatest** help to most people who need to void for a urine test?
1. Exerting manual pressure on the abdomen
  2. Encouraging a backward rocking motion
  3. Running water in the sink
  4. Providing for privacy
23. A patient is admitted to the emergency department because of hypertension and oliguria. For which additional clinical manifestation associated with this cluster of information should the nurse assess the patient?
1. Thirst
  2. Retention
  3. Weight gain
  4. Urinary hesitancy
24. A nurse must obtain a clean-catch urine specimen from one patient and a urine specimen via a straight catheterization from another. Which intervention is not performed for both when obtaining these specimens?
1. Cleanse around the urinary meatus with antiseptic swabs.
  2. Send the specimen to the laboratory immediately.
  3. Use a sterile cup for the collected urine.
  4. Wear sterile gloves.
25. A primary health-care provider discusses the need for a cystoscopy with a patient. Which is **most** important for the nurse to do when caring for this patient before the procedure?
1. Monitor the patient's I&O.
  2. Assess the patient's urine routinely.
  3. Encourage the patient to increase the intake of oral fluids.
  4. Have the patient sign an informed consent form before the procedure.

26. An older adult with an indwelling urinary catheter is receiving 75 mL of 0.9% sodium chloride hourly. The patient has had several hospital admissions in the last year for dehydration. The nurse is concerned about the patient's renal function. What is the **best** intervention by the nurse to assess this patient's renal functioning?
1. Inspect the patient's dependent areas for signs of edema.
  2. Calculate the patient's intake and output every shift.
  3. Monitor the patient's urine output hourly.
  4. Obtain the patient's weight daily.
27. A nurse is inserting an indwelling urinary catheter into a male patient. The nurse feels firm resistance while inserting the urinary catheter through the penis. What should the nurse do?
1. Lower the penis until it is parallel to the length of the body.
  2. Inflate the balloon of the catheter with 10 mL of normal saline.
  3. Interrupt the procedure and notify the primary health-care provider.
  4. Use a twisting motion and firmly advance the catheter 2 inches farther into the penis.
28. When a nurse assesses a patient, which clinical manifestations support the presence of urinary retention? **Select all that apply.**
1.  Nocturia
  2.  Hematuria
  3.  Bladder contractions
  4.  Suprapubic distention
  5.  Frequent small voidings
29. A nurse plans to clamp a patient's urinary drainage system to obtain a urine specimen for a urine culture and sensitivity. Indicate with an X, on the figure below, where the nurse should clamp the catheter drainage system.



30. A nurse is caring for a patient with a condom catheter. Which nursing actions are important? **Select all that apply.**
- P roviding perineal care every shift
  - A voiding kinks in the collection tubing
  - Ensu ring that the adhesive band is snug, not tight
  - Retr acting the foreskin before the catheter is applied
  - Lea ving one inch between the glans penis and drainage tubing
31. A primary health-care provider orders 250 mL 0.9% sodium chloride to be administered over 30 minutes to challenge a patient's kidneys to produce urine. The nurse obtains an electronic infusion device to administer the solution. At what rate should the nurse program the infusion device? **Record your answer using a whole number.**
- Answer: \_\_\_\_\_ mL/hour
32. A nurse is caring for a female patient on bedrest who has a urinary retention catheter. Which should the nurse do? **Select all that apply.**
- P osition the tubing through the side rail of the bed.
  - Ensu re the tubing is positioned over the leg.
  - La bel the tubing with the date of insertion.
  - Ir rigate the tubing to ensure its patency.
  - Sec ure the tubing to the patient's leg.
33. A primary health-care provider orders a bladder ultrasound scan be performed after a patient voids to determine the amount of residual urine. The nurse explains the test to the patient. Place the following steps in the order that they should be performed by the nurse.
- Clean the patient's abdomen to remove the gel and clean the scan head with isopropyl alcohol.
  - Put 5 mL of conducting gel on the patient's symphysis pubis and place the scan head on the gel.
  - Aim the scan head toward the patient's coccyx and press the scan head button.
  - Drape the patient exposing only the lower abdomen and suprapubic area.
  - Obtain the bladder volume and repeat the measurement several times.
  - Place the patient in the supine position.
- Answer: \_\_\_\_\_
34. Which should a nurse teach the patient to avoid to prevent urinary diuresis? **Select all that apply.**
- Na rcotics
  - C affeine
  - A ctivity
  - A lcohol
  - P rotein
35. A primary health-care provider prescribes furosemide 40 mg to be added to 50 mL of D<sub>5</sub>W to infuse at a rate of 3 mg/minute. Furosemide for IV infusion is 10 mg/mL. The nurse uses a secondary infusion set that has a drop factor of 10. How many drops per minute should the nurse administer?
- Answer: \_\_\_\_\_ drops/minute
36. Which nursing actions should be implemented by a nurse to facilitate bladder continence for a male patient who is cognitively impaired? **Select all that apply.**
- Of fer toileting reminders every 2 hours.
  - A pply a condom catheter in the morning.
  - P rovide clothing that is easy to manipulate.
  - Enc ourage avoidance of fluids between meals.
  - Ex plain the need to call for help with toileting every 4 hours.

37. When planning nursing care, which factors in the patient's history place the patient at risk for stress incontinence? **Select all that apply.**
1.  Lumbar spinal cord injury
  2.  Urinary obstruction
  3.  Six vaginal births
  4.  Menopause
  5.  Confusion
38. A patient returns from the surgical unit after a transurethral resection of the prostate gland. The nurse reviews the primary health-care provider's orders, obtains the patient's vital signs, and performs a focused patient assessment. Which is the **best** intervention by the nurse?
1. Discontinue the continuous compression devices to the lower extremities.
  2. Notify the surgeon of the status of the patient's urinary drainage.
  3. Obtain the patient's temperature using a rectal thermometer.
  4. Increase the flow rate of the continuous bladder irrigation.

### PATIENT'S CLINICAL RECORD

#### Primary Health-Care Provider's Orders

Regular diet

Vital signs every 4 hours

IV morphine via PCA pump: basal rate 1.5 mg/hour; PCA dose 1 mg; lockout interval 12 minutes; maximum dose over 4 hours, 26 mg

IVF: 0.9% sodium chloride 125 mL/hour

Docusate sodium 100 mg PO once daily

Out of bed to chair in p.m., ambulate twice a day

Continuous compression devices to lower extremities when in bed

Continuous bladder irrigation 0.9% sodium chloride to run at rate to keep output pink

#### Patient's Vital Signs

Temperature: 100.2°F, oral

Pulse: 88 beats per minute

Respirations: 20 breaths per minute

Blood pressure: 136/80 mm Hg

#### Focused Physical Assessment

IVF: 0.9% sodium chloride at 125 mL/hour, insertion site right forearm with no signs of infiltration or infection. Continuous compression devices in place. Pedal pulses palpable, toes pink and warm to touch. Patient reporting abdominal pain of 2 on scale of 0 to 10 with occasional severe abdominal cramps. CBI in progress at 150 mL per hour. Urinary drainage is light red with numerous clots.

39. A patient who had prostate surgery has a continuous bladder irrigation (CBI) in place. The nurse maintains the CBI at 200 mL/hour of GU irrigant as ordered. The urine drainage bag was emptied several times during the course of the shift for a total of 3,200 mL. How many milliliters should the nurse calculate was urine at the end of the 12-hour shift? **Record your answer using a whole number.**  
 Answer:      mL

40. A nurse must obtain a urine specimen for a culture and sensitivity test from a patient who has an indwelling urinary catheter. Place the following steps in the order in which they should be performed.
1. Wash your hands and don clean gloves.
  2. Remove the clamp from the drainage tubing.
  3. Drain the urine in the tubing into the drainage bag.
  4. Clamp the drainage tubing below the specimen port for 15 to 30 minutes.
  5. Swab the specimen port with an antiseptic and aspirate urine via a sterile syringe.
  6. Transfer the urine to a sterile specimen cup and discard the syringe into a sharps container.

Answer: \_\_\_\_\_



## URINARY ELIMINATION: ANSWERS AND RATIONALES

1. Coughing, which raises the intra-abdominal pressure, is related to stress incontinence, not overflow incontinence.
  2. Mobility deficits, such as spinal cord injuries, are related to reflex incontinence, not overflow incontinence.
  - 3. An enlarged prostate compresses the urethra and interferes with the outflow of urine, resulting in urinary retention. With urinary retention, the pressure within the bladder builds until the external urethral sphincter temporarily opens to allow a small volume (25 to 60 mL) of urine to escape (overflow incontinence).**
  4. Urinary tract infections are related to urge incontinence, not overflow incontinence.
1. Although urinals have volume markings on the side, usually they occur in 100-mL increments that do not promote accurate measurements.
  - 2. A graduate is a collection container with volume markings usually at 25-mL increments that promote accurate measurements of urine volume.**
  3. Using a large syringe is impractical. A large syringe is used to obtain a sterile specimen from a retention catheter (Foley catheter).
  4. A urine collection bag is flexible and balloons outward as urine collects. In addition, the volume markings are at 100-mL increments that do not promote accurate measurements.
1. These clinical manifestations do not reflect urinary retention. Urinary retention is evidenced by suprapubic distention and lack of voiding or small, frequent voidings (overflow incontinence).
  - 2. The urine appears concentrated (amber) and cloudy because of the presence of bacteria, white blood cells, and red blood cells. The unpleasant odor is caused by pus in the urine (pyuria).**
  3. These clinical manifestations do not reflect ketone bodies in the urine. A reagent strip dipped in urine will measure the presence of ketone bodies.
  4. These clinical manifestations do not reflect excessive calcium in the urine. Urine calcium levels are measured by assessing a 24-hour urine specimen.
1. Although encouraging the use of bladder training exercises should be done, it is not the priority.
  2. Toileting the patient every 4 hours may be too often or not often enough for the patient. Care should be individualized for the patient.
  - 3. The use of a commode requires less energy than using a bedpan and is safer than walking to the bathroom. Sitting on a commode uses gravity to empty the bladder fully and thus prevents urinary stasis.**
  4. Fluids may be decreased during the last 2 hours before bedtime, but they should not be avoided completely after 5 p.m. Some fluid intake is necessary for adequate renal perfusion.
- 1. A culture attempts to identify the microorganisms present in the urine, and a sensitivity study identifies the antibiotics that are effective against the isolated microorganisms. A sterile specimen container is used to prevent contamination of the specimen by microorganisms outside the body (exogenous).**
  2. The urine from a straight catheter (single-lumen tube) flows directly into the specimen container. Collecting a urine specimen from a catheter port is necessary when the patient has a urinary retention catheter.
  3. A straight catheter has a single lumen for draining urine from the bladder. A straight catheter does not remain in the bladder and therefore does not have a second lumen for water to be inserted into a balloon.
  4. Having the patient void before collecting the specimen may result in no urine left in the bladder for the straight catheter to collect. A minimum of 3 mL of urine is necessary for a specimen for urine culture and sensitivity.
1. Electrolytes are usual constituents of urine, and they fluctuate to help maintain fluid and electrolyte and acid-base balance.
  - 2. The presence of protein in the urine indicates that the glomeruli have become too permeable, which occurs with kidney disease. Most plasma proteins are too large to move out of**

the glomeruli, and the small proteins that enter the filtrate are reabsorbed by pinocytosis.

3. Urine usually is composed of 95% water.
  4. Urea is an expected constituent of urine. It is formed by liver cells when excess amino acids are broken down (deaminated) to be used for energy production.
- 7. 1. This open-ended question encourages the patient to talk about the problem from a personal perspective. Follow-up questions can be more specific.**
2. Dysuria is not necessarily related to incontinence.
  3. Dysuria is a problem associated with urine, not fecal, elimination.
  4. Although an abnormal color of urine may indicate a potential urinary tract infection, which is associated with dysuria, the question is too narrow because it focuses on only one issue.
- 8. 1. The inability to produce urine (anuria) is a life-threatening situation. If the cause is not corrected, the patient will need dialysis to correct fluid and electrolyte imbalances and rid the body of the waste products of metabolism.**
2. Although dysuria is a concern because it may indicate a urinary tract infection, it is not as serious as a response in another option.
  3. The secretion and excretion of large amounts of urine (diuresis) are a concern, but they are not as serious as a response in another option.
  4. Involuntary discharge of urine after an age when bladder control should be established (enuresis) is a concern, but it is not as serious as a response in another option.
- 9. 1. Urinary incontinence usually is not related to chronic pain. Chronic pain is the state in which an individual experiences pain that is persistent or intermittent and lasts for longer than 6 months.**
2. Reduced fluid intake is unrelated to urinary incontinence. A reduced fluid intake places an individual at risk of experiencing vascular, interstitial, or intracellular dehydration.
  - 3. Disturbed self-esteem is the state in which an individual experiences, or is at risk of experiencing, negative self-evaluation about self or capabilities. Incontinence may be viewed by a patient as regressing to child-like**
- behavior and has a negative impact on feelings about the self.**
4. Urinary incontinence may be unpreventable and uncontrollable. Sufficient knowledge may not prevent or promote continence. Inadequate knowledge is the state in which an individual experiences a deficiency in cognitive information or psychomotor skills, concerning a condition or treatment plan.
- 10. 1. Urination following an increase in intra-abdominal pressure is related to stress incontinence, which is an immediate involuntary loss of urine during an increase in intra-abdominal pressure.**
- 2. Involuntary voiding and a lack of awareness of bladder distention are related directly to both reflex incontinence and total incontinence. Reflex incontinence is the predictable, involuntary loss of urine with no sensation of urgency, the need to void, or bladder fullness. Total incontinence is the continuous unpredictable loss of urine without distention or awareness of bladder fullness.**
3. Retention of urine with overflow incontinence is related to urinary retention, which is the chronic inability to void followed by involuntary voiding (overflow incontinence).
  4. A strong, sudden desire to void is related to urge incontinence, which is an involuntary loss of urine associated with a strong, sudden desire to void.
- 11. 1. During surgery, because of the effects of the general adaptation syndrome, the posterior pituitary secretes antidiuretic hormone that promotes water reabsorption in the kidney tubules. Also, the anterior pituitary secretes adrenocorticotrophic hormone (ACTH) that stimulates the adrenal cortex to secrete aldosterone, which reabsorbs sodium and thus water.**
2. A low specific gravity reflects dilute urine. With the stress response, the urine will be concentrated and the specific gravity will be elevated.
  3. The stress response is unrelated to reflex incontinence. Reflex incontinence is a predictable, involuntary loss of urine with no sensation of urgency, the need to void, or bladder fullness.



4. The stress response is unrelated to urinary hesitancy. Hesitancy is the involuntary delay in initiating urination.
- 12.** 1. Both urine and stool have usual constituents. Urine has organic constituents (e.g., urea, uric acid, and creatinine) and inorganic constituents (e.g., ammonia, sodium, chloride, potassium, and calcium). Feces have waste residues of digestion (e.g., bile, intestinal secretions, and bacteria) and inorganic constituents (e.g., calcium and phosphorus).
2. A person can feel an overwhelming need to void as well as defecate.
- 3. Only stool can be assessed regarding shape. Stool usually is tubular in shape. Urine is a liquid that assumes the shape of the container in which it is collected.**
4. Both urine and stool can be assessed for color. Stool usually is brown and urine usually is yellow, straw-colored, or amber depending on its concentration.
- 13.** 1. An aromatic odor is the usual odor of urine.
2. Urine usually is pale yellow, straw-colored, or amber depending on its concentration.
3. Adequate renal perfusion and kidney function are reflected by an hourly urine output of 30 mL or more of urine.
- 4. Specific gravity is the measure of the concentration of dissolved solids in the urine. The expected range is 1.001 to 1.029. A specific gravity of 1.035 indicates concentrated urine.**
- 14.** 1. Anesthesia is a central nervous system depressant that tends to cause urinary retention, not urgency.
2. Dehydration causes a decrease in renal perfusion resulting in a diminished capacity to form urine (oliguria), not urgency.
3. The urinary bladder does not have to be full to precipitate the urge to void. The urge to void can be felt when 150 to 200 mL of urine collects and stimulates the trigone of the urinary bladder.
- 4. Feeling the need to void immediately (urgency) occurs most often when the urinary bladder is irritated. In the adult, the usual bladder capacity is 400 to 600 mL of urine, although the desire to urinate can be sensed when it contains as little as 150 to 200 mL. As the volume increases, the bladder wall stretches, sending sensory messages to the sacral spinal cord, and parasympathetic impulses stimulate the detrusor muscle to contract rhythmically. Bladder contractions precipitate nerve impulses that travel up the spinal cord to the pons and cerebral cortex, where the person experiences a conscious need to void.**
- 15.** 1. The opposite should be done to prevent microorganisms from the intestines (e.g., *Escherichia coli*) from being drawn from the anus toward the urinary meatus. Wiping from front to back follows the principle of clean to dirty.
2. This will not prevent a urinary tract infection. Burning on urination (dysuria) is a response to acetic urine flowing over inflamed mucous membranes and is a sign of a urinary tract infection.
3. Bath powder should be avoided because it has been implicated as a precipitating cause of gynecological cancer.
- 4. Drinking a minimum of 2,000 mL of fluid a day produces adequately dilute urine, washes out solutes, and flushes microorganisms from the distal urethra and urinary meatus.**
- 16.** 1. As soon as possible after an incontinence episode the patient should receive thorough perineal care with soap and water and the area dried well. This action removes urea from the skin, which can contribute to skin breakdown.
2. Plain soap, not deodorant soap, is all that is necessary when providing perineal care after urinary or bowel incontinence.
3. Although drying the area well after providing perineal care is done, it is not the best intervention of the options offered.
4. Dusting the perineal area with cornstarch should be avoided. Cornstarch can accumulate in folds of the skin and when damp can become like sandpaper, causing friction upon movement and then skin breakdown.
- 17.** 1. A patient's basic physical needs should be given first priority. As soon as a patient is incontinent of either urine or stool, the patient should receive perineal care. Remaining "continuously" clean and dry meets the criterion of a time frame when writing a goal.

2. The patient may not have the physical, mental, or emotional ability to achieve the goal of becoming continent.
  3. The patient may not have the physical, mental, or emotional ability to achieve the goal of continence and stop soiling the environment.
  4. The patient may not have the physical or cognitive ability to achieve the goal of calling for a bedpan.
- 18.**
1. Research demonstrates that cleansing the urinary meatus with soap and water daily is adequate to prevent an infection. An antimicrobial ointment provides no additional benefit. Also, it requires a prescription.
  2. **Maintaining the connection of the catheter to the collection bag prevents the introduction of microorganisms that can cause infection. A urinary retention catheter is a closed system that should remain closed.**
  3. Clean, not sterile, gloves should be worn. Surgical asepsis (use of a sterile syringe and alcohol swab) is necessary when accessing the specimen port on a urinary retention catheter.
  4. Although increasing fluid intake will increase urinary output, thereby flushing the bladder of microorganisms, it is not as important as another option.
- 19.**
1. **Polyuria is an excessive output of urine. This is associated with problems such as diabetes mellitus, diabetes insipidus, the acute (diuresis) phase after a burn injury, and reduced levels of antidiuretic hormone.**
  2. Pain on urination is the description of dysuria.
  3. Retaining urine in the bladder is the description of urinary retention.
  4. Passing blood in the urine is the description of hematuria.
- 20.**
1. Beer contains alcohol, which is irritating to the bladder.
  2. Coffee contains caffeine, which is irritating to the bladder.
  3. Orange juice, a citrus fruit, is irritating to the bladder. Citrus fruits are acidic.
  4. **Cranberries have no constituents that irritate the bladder. In addition, they produce a more acidic environment that is less conducive to the growth of microorganisms and prevents bacteria from adhering to the mucous membranes of the urinary tract, thus promoting bacterial excretion.**
- 21.**
1. Diuresis occurs when there is inadequate antidiuretic hormone.
  2. **Antidiuretic hormone increases the reabsorption of water by the kidney tubules, thus decreasing the amount of urine formed. Oliguria is diminished urinary output relative to intake (less than 400 mL in 24 hours).**
  3. With urinary retention, urine is formed, but it accumulates in the bladder and is not excreted.
  4. Antidiuretic hormone is unrelated to incontinence.
- 22.**
1. Manual bladder compression (Cred $\emptyset$  maneuver) is performed when a patient has bladder flaccidity.
  2. This rocking motion is used to promote a bowel movement, not voiding.
  3. Although running water in the sink may be helpful, it is not as effective as an intervention in another option.
  4. **Tending to bodily functions is a personal, private activity in the North American culture. Providing privacy supports patient dignity and generally promotes voiding.**
- 23.**
1. Thirst is associated with dehydration, not hypertension and oliguria.
  2. Urinary retention is unrelated to hypertension and oliguria. Urinary retention is the inability to empty the bladder. It is caused by urethral obstruction, lesions involving the nerve pathways to and from the bladder or involving reflex centers in the brain or spinal cord, and medications. Urine is retained in the bladder when high urethral pressure inhibits complete emptying of the bladder or until increased abdominal pressure causes urine to be lost involuntarily.
  3. **Oliguria is the inability to produce more than 400 to 500 mL of urine daily. Expected daily urinary output is 1,000 to 3,000 mL depending on the volume of fluid intake. If urine is not being produced in the presence of an average daily intake of 2,500 mL of fluid, then fluid will be retained and reflected in a gain in weight. One liter of fluid weighs 2.2 pounds. Excess fluid contributes to an increase in circulating blood volume, causing hypertension.**

4. Urinary hesitancy is an involuntary delay in initiating urination and is unrelated to hypertension and oliguria. It often is related to an enlarged prostate gland.
24.
    1. Both tests require the area around the urinary meatus to be swiped several times with an antiseptic solution. This limits the presence of microorganisms that can contaminate the urine specimen, thus preventing inaccurate test results.
    2. Both urine specimens should be sent to the laboratory immediately to prevent deterioration of the specimen that could result in inaccurate results. Casts in the urine will break down if urine is not tested for an extended period of time.
    3. A sterile cup maintains the sterility of the specimen, a requirement of both tests.
    4. **Sterile gloves must be worn when obtaining a urine specimen via a catheter. The nurse's hands touch the patient and catheter tubing, which must remain sterile. Clean, rather than sterile, gloves are worn when obtaining a clean-catch urine specimen. Urine flowing out of the patient is collected mid-stream into a sterile specimen cup.**
  25.
    1. Although monitoring the patient's intake and output (I&O) may be done, it is not the priority when a cystoscopy is scheduled.
    2. Although this should be done, it is not the priority before the procedure. The amount and color of urine are assessed after the procedure. Pink urine after a cystoscopy is common because of slight bleeding from irritation of the mucous membranes of the urinary tract.
    3. Although encouraging the intake of oral fluid before and after the procedure should be done, it is not the most important thing a nurse should do when a cystoscopy is scheduled. Keeping the patient well hydrated ensures that adequate intravascular fluid will pass through the kidneys, facilitating the production and passage of urine.
    4. **During a cystoscopy a fiberoptic instrument is inserted through the urethra and into the bladder. It is an invasive procedure that requires the patient's written permission. The primary health-care provider's discussion with the patient includes the purpose of the procedure, its risks and benefits, and alternatives.**
  26.
    1. Dependent edema is more of a reflection of cardiac output. Edema associated with renal disease usually is generalized rather than localized in dependent areas.
    2. A shift generally is 8 to 12 hours long. A period of 8 to 12 hours is too long a time to wait to collect information.
    3. **The kidneys should produce more than 30 mL/hour. The patient has an indwelling urinary catheter that facilitates the assessment of urine output hourly. Patients without an indwelling urinary catheter should void a minimum of 240 mL of urine in 8 hours.**
    4. Daily weights effectively monitor a patient's fluid balance because 1 L of retained fluid weighs 2.2 pounds. However, a 24-hour period is too long a time to wait to collect information.
  27.
    1. Lowering the penis until it is parallel to the length of the body will increase the trauma to the mucous membranes of the urinary tract because placing the penis parallel to the length of the body will create a 90-degree angle in the urethra where the shaft of the penis meets the abdominal wall. The penis should be held perpendicular to the patient's body during catheter insertion.
    2. Inflating the balloon of the catheter in this situation will traumatize the urethra and inflict pain. The balloon is inflated once urine flows and the catheter is advanced another 1 to 2 inches to ensure that it is completely inside the urinary bladder and not the urethra.
    3. **Resistance indicates that there may be a blockage in the urethra (e.g., enlarged prostate, tumor). The procedure should be discontinued when firm resistance is felt, to prevent trauma to the urinary system. The event should be documented in the patient's clinical record and the primary health-care provider notified.**
    4. Using force or a twisting motion while advancing the catheter is contraindicated because it can traumatize the structures and mucous membranes of the urinary tract.
  28.
    1. Excessive urination at night is called nocturia. A person with urinary retention will have small, frequent voidings or dribbling (overflow incontinence) rather

- than a complete discharge of urine from the bladder.
- Hematuria is the presence of red blood cells in the urine. It is associated with bladder inflammation, infection, or trauma, not urinary retention.
  - Urinary retention may produce an atonic bladder rather than bladder contractions.
  - The bladder lies in the pelvic cavity behind the symphysis pubis. When it fills with urine (600 mL), it extends above the symphysis pubis, and when greatly distended (2,000 to 3,000 mL), it can reach to the umbilicus.**
  - With urinary retention the bladder fills with urine, causing distention. Eventually the external urethral sphincter temporarily opens to allow a small volume of urine to pass out of the bladder (overflow incontinence, retention with overflow).**

29. The tubing from the collection bag that is attached to the catheter inserted into the bladder should be clamped 2 to 3 inches below the collection port. This location allows urine to collect above the port. The catheter inserted into the bladder should not be clamped to prevent trauma to the catheter lumen or the lumen leading to the inflated balloon.



- Providing perineal care every shift is unnecessary. Perineal hygiene should be performed at least once a day, after a bowel movement, and whenever the catheter is changed or replaced.
  - Avoiding kinks is essential so that urine flows unimpeded to the urine collection bag.**
  - The anchoring device (e.g., adhesive band, elastic strip, or inflatable ring) must be snug enough to prevent the condom from falling off but not so tight that it interferes with blood circulation to the penis.**
  - If the foreskin is left in the retracted position it can constrict the penis, resulting in edema and tissue injury.
  - Placing the condom over and beyond the glans penis and leaving one inch between the glans penis and drainage tubing prevents pressure against the glans penis that could cause excoriation and skin trauma.**
31. **Answer: 500 mL/hour. The electronic infusion device should be programmed for 500 mL/hour. An electronic infusion device uses milliliters (mL) per hour as the programmable infusion rate. The volume ordered (250 mL) is to be infused over 30 minutes. Therefore, the nurse must double the infusion volume to 500 mL to maintain a rate that will infuse the 250 mL in 30 minutes.**
- If retention catheter tubing is left on or through a side rail the catheter may inadvertently be pulled out when the side rail is moved. In addition, the collection bag must be kept below the level of the bladder to promote the flow of urine from the bladder by gravity and prevent a flow of urine back into the bladder from the catheter.
  - Ensuring the tubing is positioned over the leg prevents pressure of the leg on the drainage tube that can interrupt the flow of urine from the bladder.**
  - Labeling the tubing with the date of insertion should be documented on the patient's clinical record, not the tubing.
  - Irrigating the tubing is contraindicated because it may introduce microorganisms into the bladder that can cause an infection. Irrigation of a urinary retention catheter requires an order and is a dependent function of the nurse.

5. Securing the tubing to the patient's leg prevents tension on the urinary meatus.
33. 6. The supine position permits access to the patient's lower abdomen and suprapubic area.
4. Draping the patient and exposing just the lower abdomen and suprapubic area provide for patient privacy.
2. The use of conducting gel or an ultrasound gel pad improves transmission of the ultrasound image.
3. The scan head should be placed approximately 1.5 inches (4 cm) above the pubic bone midline below the umbilicus (symphysis pubis) while aiming the scan head toward the coccyx. This permits visualization of the urinary bladder. In women the bladder lies in front of and below the uterus. In men the bladder can be partly obstructed by the pubic bone and the scan head may require a slightly oblique angle to visualize the bladder.
5. Several measurements should be obtained to ensure accuracy of the results.
1. Removing the gel and washing the patient's abdomen promote hygiene and comfort. Cleaning the scan head removes the gel on the end of the probe.
34. 1. Narcotics are central nervous system depressants that can cause urinary retention, not diuresis.
2. Drinks with caffeine (e.g., coffee, tea, and some carbonated beverages) promote the secretion and excretion of increased amounts of urine. This may be related to the inhibition of phosphodiesterases and/or antagonism of adenosine receptors. Antagonism of adenosine receptors inhibits proximal tubular reabsorption resulting in an increased urine output.
3. Although activity increases renal perfusion, which may increase urinary output, the increased fluid lost during activity usually is through insensible losses (e.g., perspiration, moisture in exhaled breaths).
4. Alcohol limits the production of vasopressin, a hormone that tells the kidneys to reabsorb water. Urine output increases as fluid is not reabsorbed in the kidneys.
5. Avoiding protein does not prevent diuresis. The presence of protein in the urine indicates that the glomeruli have become too permeable, which occurs in kidney disease. Most plasma proteins are too large to move out of the glomeruli and the small proteins that enter the filtrate are reabsorbed by pinocytosis.
35. **Answer: 40 drops per minute. Four mL of furosemide must be added to the diluent, yielding a total volume of 54 mL to be infused. First determine how many milliliters contain 3 mg. Use ratio and proportion.**
- $$\frac{\text{Desire } 3 \text{ mg}}{\text{Have } 40 \text{ mg}} = \frac{x \text{ mL}}{54 \text{ mL}}$$
- $$40x = 162$$
- $$x = 162 \div 40$$
- $$x = 4.05 \text{ mL}$$
- Round 4.05 down to 4 because 0.05 is less than 0.5. Each 4 mL of solution contains 3 mg of furosemide.
- Now determine how many drops 4 mL contains when the drop rate of the secondary infusion set is 10.
- $$4 \text{ mL (mL to be administered in 1 minute)} \times 10 \text{ (drop factor of the infusion set)} = 40 \text{ drops per minute.}$$
36. 1. A cognitively impaired person may not be able to receive, interpret, or respond to cues for voiding. Reminding the person to void every 2 hours empties the bladder, which may limit episodes of incontinence.
2. Applying a condom catheter in the morning is unnecessary and intrusive. Also, it may create a safety issue because the patient's mobility may be impaired by the tubing and urine drainage bag.
3. Cognitively impaired individuals may have problems handling clothing, particularly when attempting to respond to the urge to void. Clothing that is easy to manipulate, such as articles with elastic waistbands and zippers, will facilitate undressing and dressing to void.
4. Restriction of fluid intake is an inappropriate way to manage urinary incontinence. The body needs fluids throughout the day to maintain renal perfusion, kidney function, and fluid balance.
5. Toileting every 4 hours is too long a period of time to wait between

opportunities to void and usually will result in an episode of incontinence. Also, a cognitively impaired individual may not understand cause and effect or be able to follow directions.

- 37.** 1. A person with a spinal cord injury will experience reflex incontinence, not stress incontinence.  
2. A person with a urinary tract obstruction will experience urinary retention, not stress incontinence.  
**3. Stress incontinence is an immediate involuntary loss of urine during an increase in intra-abdominal pressure. It is associated with weak pelvic muscles and structural supports resulting from multiple pregnancies, age-related degenerative changes, and overdistention between voiding.**  
4. **After menopause women experience a weakening of the muscles surrounding the urinary and reproductive systems.**  
5. Confused people may experience total, not stress, incontinence because they do not recognize bladder cues.
- 38.** 1. Discontinuing the continuous compression devices to the lower extremities is unsafe and may result in the patient experiencing deep vein thrombosis and pulmonary embolus. Maintaining this device is a dependent function of the nurse.  
2. Notifying the surgeon is unnecessary at this time. If the status of the patient's urinary drainage intensifies then the surgeon should be notified.  
3. Obtaining a rectal temperature from a patient who has had a prostatectomy is contraindicated. The rectal probe could traumatize the surgical area.  
**4. The surgeon's orders indicate that the continuous bladder irrigation should be maintained at a flow rate that keeps the urinary drainage pink; this also implies the absence of clots.**
- 39. Answer: 800 mL.** To calculate the amount of urine output of a patient receiving CBI, the total amount of the instilled irrigant must be subtracted from the total output. The patient received 200 mL of GU irrigant per hour for 12 hours. To determine the total amount of GU irrigant received, multiply  $200 \times 12$  (2,400). Subtract 2,400 mL from 3,200 mL (total amount of urinary drainage) to determine the amount of urine contained in the total output. 3,200 mL minus 2,400 mL equals 800 mL.
- 40.** 3. Draining the urine ensures that previously produced urine is not collected for a current specimen.  
4. Clamping the drainage tubing allows urine to collect above the specimen port.  
1. Washing the hands limits the amount of microorganisms on the hands. Clean gloves protect the nurse from the patient's body fluids. Both practices are part of standard precautions.  
5. The use of an antiseptic swab removes microorganisms on the specimen port and sterile equipment maintains the sterility of the closed urinary drainage system.  
6. The sterility of the specimen must be maintained to prevent contamination of the specimen, which can result in inaccurate results. Discarding used equipment in a sharps container prevents accidental injury to self or others.  
2. Removing the clamp from the drainage tubing reestablishes the flow of urine from the patient to the drainage bag. If it is left clamped, urine will not drain, causing bladder distention, and may precipitate a stasis-induced urinary tract infection.

# Fluids and Electrolytes

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

- Acid
- Active transport
- Aldosterone
- Anion
- Antidiuretic hormone
- Anuria
- Base
- Catheter
- Cation
- Colloid osmotic/oncotic pressure
- Dehydration
- Diaphoresis
- Diffusion
- Diluent
- Diuretic
- Edema:
  - Dependent
  - Peripheral
  - Pitting
  - Sacral
- Electrolytes:
  - Calcium
  - Magnesium
  - Phosphorus
  - Potassium
  - Sodium
- Fluid compartments:
  - Extracellular
  - Interstitial
  - Intracellular
  - Intravascular
  - Third-compartment spacing
- Fluid restriction
- Fluid volume:
  - Deficient
  - Excess
- Hydrostatic pressure
- Hypercalcemia/hypocalcemia
- Hyperkalemia/hypokalemia
- Hypermagnesemia/hypomagnesemia
- Hyperosmolar/hypo-osmolar
- Hypertension/hypotension
- Hypertonic/hypotonic
- Hypervolemic/hypovolemic
- Icteric
- Infiltration
- Infusion port
- Insensible fluid loss
- Ion
- Irrigant
- Isotonic
- Macro drip/micro drip
- Milliequivalent
- Osmolality
- Osmolarity
- Osmosis
- Primary infusion line
- Residual urine
- Secondary infusion line
- Sensible/insensible fluid loss
- Skin turgor
- Solute
- Specific gravity
- Tenting
- Thirst
- Vaporization

F.A. DAVIS

COMPANY

## FLUIDS AND ELECTROLYTES: QUESTIONS

1. A nurse is caring for a critically ill patient with a urinary retention catheter. Which hourly urine output should **first** alert the nurse that the primary health-care provider should be notified?
  1. 20 mL
  2. 30 mL
  3. 60 mL
  4. 120 mL
2. A nurse is caring for a patient who has dependent edema. Which pressure has caused the excess fluid in the interstitial compartment?
  1. Oncotic pressure
  2. Diffusion pressure
  3. Hydrostatic pressure
  4. Intraventricular pressure
3. A nurse evaluates a patient's fluid balance by monitoring the patient's intake and output. Which must the nurse understand about the ratio of the patient's fluid intake to output?
  1. Intake should be slightly more than the output.
  2. Intake should be higher than the fluid output.
  3. Intake should be lower than the urine output.
  4. Intake should be equal to the urine output.
4. Hydrochlorothiazide (HCTZ), a diuretic, is prescribed for a patient who is retaining fluid. The nurse should encourage the patient to ingest nutrients that contain which electrolyte?
  1. Magnesium
  2. Potassium
  3. Calcium
  4. Sodium
5. Which should a nurse do to encourage a confused patient to drink more fluid?
  1. Serve fluid at a tepid temperature.
  2. Explain the reason for the desired intake.
  3. Offer the patient something to drink every hour.
  4. Leave a pitcher of water at the patient's bedside.
6. A nurse suspects that an older adult may have a fluid and electrolyte imbalance. Which assessment **best** reflects fluid and electrolyte balance in an older adult?
  1. Intake and output results
  2. Serum laboratory values
  3. Condition of the skin
  4. Presence of tenting
7. A patient has continuous bladder irrigation. Which should the nurse do with the irrigant on the I&O sheet when calculating the fluid balance for this patient?
  1. Add it to the oral intake column.
  2. Deduct it from the total urine output.
  3. Subtract it from the intravenous flow sheet as output.
  4. Document the intake hourly in the urine output column.
8. A nurse is caring for two patients; one has oliguria and the other has polyuria. Which is the **priority** problem that is a concern for the nurse regarding both of these patients?
  1. Diarrhea
  2. Cachexia
  3. Fluid volume deficit
  4. Impaired skin integrity



9. A primary health-care provider orders a patient's IV fluids to be discontinued. Which is an essential nursing intervention when discontinuing the patient's intravenous infusion?
1. Withdraw the intravenous catheter along the same angle of its insertion.
  2. Use an alcohol swab to scrub the insertion site.
  3. Flush the line with normal saline.
  4. Don sterile gloves.
10. A patient is admitted to the hospital for a fever of unknown origin. The nursing assessment reveals profuse diaphoresis, dry, sticky mucous membranes, weakness, disorientation, and a decreasing level of consciousness. Which electrolyte imbalance does this data support?
1. Hyperkalemia
  2. Hypercalcemia
  3. Hyponatremia
  4. Hypermagnesemia
11. A patient exhibits an increasing blood pressure and 2-lb weight gain over 2 days. Which additional clinical manifestation can be clustered with these data?
1. Decrease in heart rate
  2. Increase in skin turgor
  3. Increase in pulse volume
  4. Decrease in pulse pressure
12. An assessment of which of the following is **most** important when a nurse is caring for an adult patient experiencing vomiting?
1. Oral mucous membranes
  2. Electrolyte values
  3. Bowel function
  4. Body weight
13. A primary health-care provider orders an intravenous infusion containing potassium for a patient. Which is the **most** important nursing intervention before administering this solution to the patient?
1. Assess the skin turgor.
  2. Obtain the blood pressure.
  3. Measure the depth of edema.
  4. Determine the presence of urinary output.
14. Which is the **best** choice for an appetizer when teaching a patient about a 2-g sodium diet?
1. Pigs in a blanket
  2. Stuffed mushrooms
  3. Cheese and crackers
  4. Fresh vegetable sticks
15. A nurse is documenting a patient's I&O. Which should be recorded at approximately half its volume?
1. Ice chips given by mouth
  2. A continuous bladder irrigation
  3. Solution used to maintain patency of a tube
  4. A tube feeding of half formula and half water
16. Several patients are taking supplemental calcium daily. The nurse teaches them to maintain their fluid intake at a minimum of 2,500 mL. The nurse explains that this intervention is designed to prevent which complication?
1. Mobilization of calcium from bone
  2. Irritation of the bladder mucosa
  3. Occurrence of muscle cramps
  4. Formation of kidney stones

17. A patient receiving an enteral feeding develops diarrhea. Which characteristic of the tube feeding formula does the nurse conclude precipitated the diarrhea?
1. Icteric
  2. Isotonic
  3. Hypotonic
  4. Hypertonic
18. A nurse identifies that an older adult patient may have a problem with excess fluid volume. Which characteristics of the patient's skin support this conclusion?
1. Dry and scaly
  2. Taut and shiny
  3. Red and irritated
  4. Thin and inelastic
19. When a patient is under extreme stress, there is an increased production of antidiuretic hormone (ADH) and aldosterone. The nurse plans to monitor the patient routinely because an increase in these hormones will cause a decrease in which of the following?
1. Blood pressure
  2. Urinary output
  3. Body temperature
  4. Sweat gland secretions
20. A nurse checks a meal tray for a patient on a clear liquid diet. Which item is acceptable on this diet?
1. Ginger ale
  2. Lemon sherbet
  3. Vanilla ice cream
  4. Cream of chicken soup
21. A nurse is caring for a patient who has a reduced fluid intake. The nurse assesses the patient for which response to this reduced fluid intake?
1. Urinary retention
  2. Frequent urination
  3. Incontinence of urine
  4. Decreased urine output
22. A nurse is monitoring a patient who is receiving intravenous fluid. Which clinical findings indicate that the patient has a fluid overload?
1. Chills, fever, and generalized discomfort
  2. Blood in the tubing close to the insertion site
  3. Dyspnea, headache, and increased blood pressure
  4. Pallor, swelling, and discomfort at the insertion site
23. With which complication of the administration of intravenous fluids should the nurse slow the rate of flow of the infusion rather than stop the infusion and remove the catheter?
1. Infiltration
  2. Extravasation
  3. Inflamed vein
  4. Fluid overload
24. When a nurse evaluates the effectiveness of patient teaching, which food selections by a patient indicate understanding regarding an abundant source of calcium? **Select all that apply.**
1. \_\_\_Br ead
  2. \_\_\_Y ogurt
  3. \_\_\_Sp inach
  4. \_\_\_Gr een beans
  5. \_\_\_P eanut butter

25. A nurse is caring for a postoperative patient over an 8-hour period. The patient vomits 300 mL of greenish-yellow fluid. The patient's intravenous fluids are infusing at 125 mL per hour. The patient received 2 intermittent infusions of antibiotics each in 50 mL of solution and they were infused at a different site than the IV fluid infusion. The patient was given 8 ounces of ice chips which were retained. The patient urinated twice—250 mL and 400 mL. Which is the patient's total fluid intake at the end of the 8-hour period? **Record your answer using a whole number.**

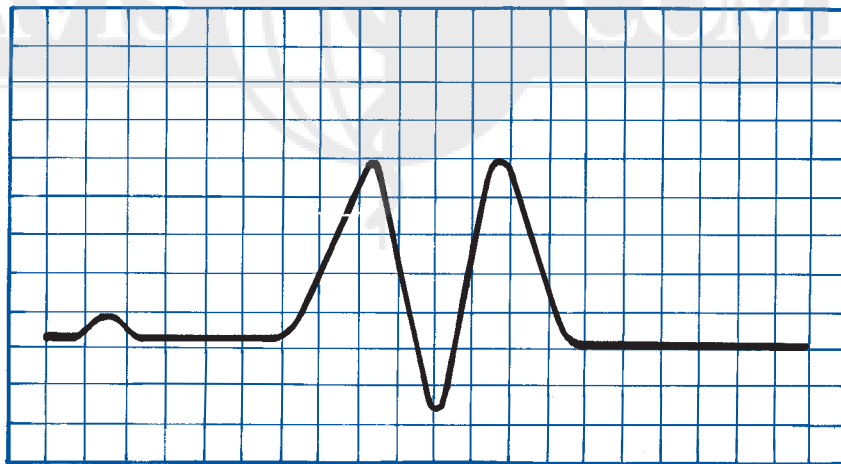
Answer: \_\_\_\_\_ mL

26. A patient's diet is progressed from clear liquid to full liquid. Which can the nurse include on the full-liquid diet that is not included on the clear-liquid diet? **Select all that apply.**

1.  Vanilla ice cream
2.  Cream of Wheat
3.  Cranberry juice
4.  Ginger ale
5.  Gelatin
6.  Milk

27. A nurse is caring for a patient in the emergency department. The patient's ECG tracing is indicated below. For which additional responses should the nurse assess the patient that can be clustered with the results of this ECG tracing? **Select all that apply.**

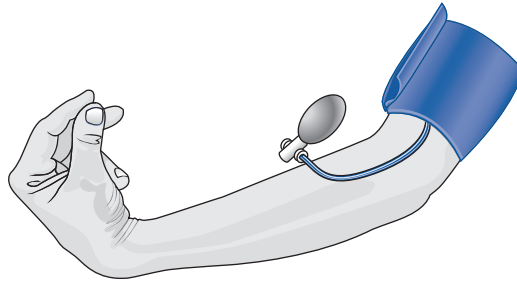
1.  Bradycardia
2.  Flaccid paralysis
3.  Increased bowel sounds
4.  Ventricular dysrhythmias
5.  Decreased deep tendon reflexes



28. A nurse is assessing several patients for fluid and electrolyte imbalances. Which responses are common to both excess fluid volume and deficient fluid volume? **Select all that apply.**

1.  Increased pulse amplitude
2.  Decreased blood pressure
3.  Difficulty breathing
4.  Mental confusion
5.  Muscle weakness

29. The illustration reflects a patient's upper extremity while the nurse is obtaining the patient's blood pressure. Which should the nurse do **next** after releasing the pressure in the sphygmomanometer cuff?
1. Notify the primary health-care provider of the patient's response.
  2. Assess the patient's radial pulse in the affected arm.
  3. Retake the patient's blood pressure.
  4. Tap over the patient's facial nerve.



30. A nurse is monitoring a patient who is receiving fluids intravenously. Which clinical manifestations at the insertion site indicate that the IV has infiltrated? **Select all that apply.**
1.  Redness
  2.  Swelling
  3.  Firmness
  4.  Coolness
  5.  Inflammation

31. An older adult is diagnosed with congestive heart failure and pulmonary edema, and the primary health-care provider prescribed furosemide 40 mg PO twice a day. The patient has slight dysphagia as a result of a brain attack a year ago. The nurse obtains an oral solution of furosemide that states that there is 8 mg/mL. How many milliliters should the nurse administer? **Record your answer using a whole number.**

Answer: \_\_\_\_\_ mL

32. A patient receiving a diuretic is encouraged to increase the intake of potassium. Which foods selected by the patient indicate that the teaching is understood? **Select all that apply.**
1.  Peas
  2.  Cabbage
  3.  Cantaloupe
  4.  Fresh salmon
  5.  Chicken liver

33. A nurse must discontinue a patient's intravenous infusion. The nurse shuts off the infusion, washes the hands, and dons clean gloves. Place the following steps in the order in which they should be performed.
1. Apply counter-traction to the skin while loosening the tape at the venipuncture site.
  2. Apply firm pressure to the site with sterile gauze for two to three minutes.
  3. Apply a sterile dressing with tape over the venipuncture site.
  4. Withdraw the needle/catheter along the line of insertion.
  5. Examine the end of the needle/catheter.

Answer: \_\_\_\_\_

34. A nurse is assessing a patient's fluid status. Which assessments indicate that the patient has a deficient fluid volume? **Select all that apply.**
1.  Negative balance of intake and output
  2.  Decreased body temperature
  3.  Increased blood pressure
  4.  Shortness of breath
  5.  Flat neck veins
  6.  Weight loss
35. A patient is to receive 250 mL of 0.9% sodium chloride over 30 minutes. The nurse obtains an electronic infusion device. At which hourly rate should the nurse set the infusion device? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ mL
36. A 2-g sodium diet is ordered for a patient with hypertension. Which foods should the nurse teach the patient to avoid? **Select all that apply.**
1.  American cheese
  2.  Canned tuna fish
  3.  Shredded wheat
  4.  Potatoes
  5.  Cashews
37. A nurse assesses a patient for electrolyte imbalances. Which clinical manifestations indicate that the patient may have a potassium deficiency? **Select all that apply.**
1.  Ventricular dysrhythmias
  2.  Increased blood pressure
  3.  Muscle weakness
  4.  Chest pain
  5.  Dry hair
38. A primary health-care provider orders 1,000 mL 0.9% sodium chloride to be infused over 6 hours. A gravity flow infusion set states that the drop factor is 15. At which rate should the nurse set the IV flow rate? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ drops/minute
39. Which characteristics associated with touching an intravenous insertion site support the conclusion that the insertion site may be inflamed? **Select all that apply.**
1.  Warmth
  2.  Softness
  3.  Firmness
  4.  Coolness
  5.  Discomfort

40. A patient in the hospital emergency department tells the nurse, “I feel lousy and I’ve had diarrhea for several days. I have nausea and I don’t feel like eating or drinking.” The nurse obtains the patient’s vital signs, performs a focused physical assessment, and reviews the results of laboratory studies. Which should the nurse conclude is the patient’s human response based on this information?
1. Hypokalemia
  2. Hypervolemia
  3. Metabolic acidosis
  4. Respiratory alkalosis

### PATIENT’S CLINICAL RECORD

#### Vital Signs

Temperature: 101.2°F, oral

Pulse: 92 beats per minute, regular, thready

Respirations: 26 breaths per minute, deep

Blood pressure: 100/60 mm Hg

#### Focused Physical Assessment

Weight loss of 4 pounds in 3 days

Tenting of the skin

#### Laboratory Values

Urine specific gravity: 1.036

Serum potassium: 5.3 mEq/L

Arterial blood gases:

pH: 7.30

Paco<sub>2</sub>: 24 mEq/L

HCO<sub>3</sub>: 18 mEq/L

## FLUIDS AND ELECTROLYTES: ANSWERS AND RATIONALES

1. The primary health-care provider should be notified long before the hourly urine output reaches 20 mL.
  2. **The circulating blood volume perfuses the kidneys, producing a glomerular filtrate of which varying amounts are either reabsorbed or excreted to maintain fluid balance. When a person's hourly urine output is only 30 mL, it indicates a deficient circulating fluid volume, inadequate renal perfusion, and/or kidney disease. The primary health-care provider should be notified.**
  3. An hourly urine output of 60 mL is close to the expected range of 1,400 mL to 1,500 mL/24 hours or 30 mL to 50 mL/hour.
  4. The primary health-care provider does not have to be notified about this. An hourly urine output of 120 mL indicates that there is adequate kidney perfusion.
1. Oncotic (colloid osmotic) pressure is the force exerted by colloids (e.g., proteins) that pull or keep fluid within the intravascular compartment. Oncotic pressure is the major force opposing hydrostatic pressure in the capillaries.
  2. Diffusion is a continual intermingling of molecules with movement of molecules from a solution of higher concentration to a solution of lower concentration.
  3. **Hydrostatic pressure is the pressure exerted by a fluid within a compartment, such as blood within the vessels. Hydrostatic pressure moves fluid from an area of greater pressure to an area of lesser pressure. Hydrostatic pressure within vessels of the body moves fluid from the intravascular compartment into the interstitial compartment. Interstitial fluid is extracellular fluid that surrounds cells.**
  4. Intraventricular pressure is the pressure that exists in the left and right ventricles of the heart. These pressures do not move fluid from the intravascular compartment to the interstitial compartment.
1. **The volume and composition of body fluids are kept in a delicate balance (total intake is slightly more than total output) by a harmonious interaction of the kidneys and the endocrine, respiratory, cardiovascular, integumentary, and gastrointestinal systems.**
  2. If the total intake is higher than the total output, the patient will develop an excess fluid volume.
  3. If the total intake is lower than the urine output, the patient will develop a deficient fluid volume.
  4. If intake and urine output are equal, the patient will develop a deficient fluid volume because of fluid loss through routes other than the kidneys. In addition to urine output, the body has insensible fluid loss through the skin, in feces, and as water vapor in expired air.
1. Although loop and thiazide diuretics enhance magnesium excretion, which may produce mild hypomagnesemia, it does not require magnesium supplementation.
  2. **Most diuretics affect the renal mechanisms for tubular secretion and reabsorption of electrolytes, particularly potassium. Because of potassium's narrow therapeutic window of 3.5 to 5.0 mEq/L and its role in the sodium-potassium pump and muscle contraction, depleted potassium must be supplemented by increasing the dietary intake of foods high in potassium and/or the administration of potassium drug therapy.**
  3. Serum calcium levels vary depending on the diuretic. Thiazide diuretics, such as HCTZ, decrease calcium excretion, which may produce hypercalcemia. Loop diuretics increase calcium excretion, which may produce hypocalcemia.
  4. Although sodium deficit (hyponatremia) may occur with diuretics, usually it is mild and does not require sodium supplementation.
1. Fluids should be administered at the temperature usually associated with the fluid, for example, cool temperatures for juice, soda, and milk and warm temperatures for tea, coffee, and soup. Hot liquids should be avoided for safety reasons.
  2. This explanation probably will be ineffective because a confused person has difficulty understanding cause and effect.

3. **Frequent smaller volumes of fluid (50 to 100 mL/hr) are better tolerated physiologically and psychologically than infrequent larger volumes of fluid.**
4. A confused patient, having difficulty understanding cause and effect, may ignore a pitcher of water.
6.
  1. Monitoring intake and output results assesses only fluid balance.
  2. **Laboratory studies provide objective measurements of indicators of fluid, electrolyte, and acid-base balance. Common diagnostic tests include serum blood studies of electrolytes (e.g., sodium, potassium, chloride, and calcium), osmolarity, hemoglobin, hematocrit, and arterial blood gases.**
  3. Assessment of the skin in the context of this question assesses only fluid balance. In addition, the changes in the integumentary system as a person ages complicate assessment of the skin for fluid balance disturbances in the older adult. Skin changes include loss of dermal and subcutaneous mass (thin and wrinkled), decreased secretion from sebaceous and sweat glands (dry skin), and less organized collagen and elastic fibers (wrinkles, decreased elasticity).
  4. Presence of tenting assesses only fluid balance. Tenting occurs when the skin of a dehydrated person remains in a peak or tent position after the superficial layers of the skin are pinched together. Caution is advised when assessing an older person because some degree of tenting may occur even when hydrated because of the decrease in skin elasticity and tissue fluid associated with aging. The skin over the sternum is the area that should be tested for tenting.
7.
  1. The irrigant of a continuous bladder irrigation is instilled into the urinary bladder, not the mouth.
  2. **When continuous bladder irrigation is in use, drainage from the urinary bladder will consist of both urine and the instilled irrigant. To determine the patient's urinary output, the amount of the irrigant instilled must be deducted from the total urinary output.**
  3. The IV flow sheet should not contain any information regarding I&O other than the amount and type of fluid that is instilled into the circulatory system.
4. Intake anywhere in the body should be recorded in the appropriate intake column, not in the urinary output column.
8.
  1. Frequent, loose, liquid stools, not oliguria or polyuria, are associated with diarrhea.
  2. Oliguria and polyuria are related to fluid balance and kidney functioning, not nutrition. Cachexia is a profound state of malnutrition.
  3. **The production of excessive amounts of urine by the kidneys (polyuria) without an increase in fluid intake can precipitate a fluid volume deficit. Oliguria, the production of excessively small amounts of urine by the kidney, is reflected as a negative balance in the intake and output. A negative balance of intake and output is a characteristic of fluid volume deficit.**
  4. Oliguria and polyuria are related to fluid balance and kidney functioning, not skin integrity. However, because oliguria may be related to fluid retention and subsequent edema and polyuria may ultimately cause dehydration and dry skin, the patient may eventually be at risk for impaired skin integrity.
9.
  1. **Removing an intravenous catheter by withdrawing it along the same path of its insertion minimizes injury to the vein and trauma to the surrounding tissue. This action limits seepage of blood and promotes healing of the puncture wound.**
  2. Scrubbing the area with an alcohol wipe is unnecessary. The area should be compressed with a sterile gauze pad. Pressure helps stop the bleeding and prevents the formation of a hematoma. A sterile gauze pad provides for surgical asepsis, which prevents infection.
  3. Flushing the line with normal saline is unnecessary.
  4. Clean, not sterile, gloves should be worn by the nurse to prevent exposure to the patient's body fluids.
10.
  1. Although muscle weakness and lethargy are associated with hyperkalemia, the patient's other responses are not.
  2. Although weakness and lethargy are associated with hypercalcemia, the patient's other responses are not.



3. **With profuse diaphoresis, the water loss exceeds the sodium loss, resulting in hypernatremia. Excess serum sodium precipitates changes in the musculoskeletal (weakness), neurological (disorientation and decreased level of consciousness), and integumentary (dry, sticky mucous membranes) systems.**
  4. Although muscle weakness, lethargy, and drowsiness are associated with hypermagnesemia, the patient's other responses are not.
11. 1. With an excess fluid volume the heart rate will increase, not decrease, in an attempt to maintain adequate cardiac output.
  2. In the early stages of an excess fluid volume, a change in skin turgor may not be evident. One liter of fluid is equal to approximately 2.2 pounds.
  3. **With an excess fluid volume the amount of circulating blood volume increases, resulting in full, bounding peripheral pulses.**
  4. The pulse pressure is the difference between the systolic and diastolic pressures of a blood pressure measurement, and the acceptable range is 30 to 50 mm Hg. With an excess fluid volume, the pulse pressure increases, not decreases.
12. 1. Although the mouth is assessed and oral care is provided, it is performed for comfort, not because there is a life-threatening problem.
  2. **Vomiting results in a loss of chloride (greatest amount), sodium (next greatest amount), and potassium (least amount), but of greatest importance because it can cause dysrhythmias and cardiac arrest).**
  3. Although assessing bowel function will be done, it is not the priority.
  4. Although obtaining a body weight will be done to assess fluid volume deficit (2.2 pounds equals approximately 1 L of fluid), it is not as critical as another assessment.
13. 1. Assessing skin turgor is unnecessary for the administration of potassium. This is part of the assessment of a patient's hydration status, particularly when the patient is at risk for dehydration.
  2. Although all the vital signs should be measured when a patient is receiving any fluids or electrolytes, monitoring the heart rate and rhythm is a more significant assessment than the blood pressure in relation to the administration of potassium. Both a serum potassium decrease (hypokalemia) and increase (hyperkalemia) cause cardiac dysrhythmias.
  3. Measuring the depth of edema is unnecessary for the administration of potassium. This is part of the assessment when a patient has a fluid volume excess in dependent tissues in which the hydrostatic capillary pressure is high.
  4. **Serum potassium has a narrow therapeutic window (3.5 to 5.0 mEq/L). When kidney function is impaired, potassium can accumulate in the body and exceed the therapeutic level of 5.0 mEq/L, which can cause cardiac dysrhythmias and arrest.**
14. 1. One-tenth of a pound of frankfurters contains approximately 168 mg of sodium and should be avoided on a 2-g sodium diet.
  2. Although mushrooms are low in sodium, when stuffed with seasoned bread crumbs ( $\frac{1}{2}$  cup contains approximately 370 mg of sodium) they should be avoided on a 2-g sodium diet.
  3. One ounce of cheese contains approximately 106 to 400 mg of sodium depending on the cheese. Two crackers contain approximately 44 to 165 mg depending on the product. These foods should be avoided on a 2-g sodium diet.
  4. **As a food group, fresh vegetables have low sodium content. The sodium content of vegetables includes 1 cup of broccoli, 17 mg; 1 cup of cauliflower, 20 mg; 1 carrot, 25 mg; 1 pepper, 2 mg; 1 radish, 1 mg; 1 cup of mushrooms, 3 mg; and 6 slices of cucumber, 1 mg.**
15. 1. **Ice chips are particles of frozen water that take up more volume when they are frozen than when they melt. When ice chips change from a solid to a liquid, the resulting fluid is approximately half the volume of the ice chips.**
  2. The total amount of the irrigant instilled into the urinary bladder is accounted for as intake. The total volume that was instilled is then deducted from the total

- urinary output to determine the patient's urinary output.
3. Whatever volume of solution is instilled into a catheter, the full volume used is recorded when the nurse documents the intervention.
  4. When a tube feeding solution consists of half formula and half water, the final combined volume of the formula and water is recorded on the appropriate intake column of the I&O record.
- 16.**
1. Calcium supplementation and weight bearing, not an increased fluid intake, prevent bone demineralization.
  2. Neither hypocalcemia nor hypercalcemia irritates the bladder mucosa.
  3. Excessive supplementation of calcium causes hypercalcemia. Muscle tremors and cramps are associated with hypocalcemia, not hypercalcemia.
  4. **A high fluid intake increases the volume of urine produced. The resulting frequent urination of dilute urine prevents the formation of renal calculi, which may occur because of the increased precipitation of calcium salts associated with calcium supplementation.**
- 17.**
1. Icteric is unrelated to enteral feedings and fluid shifts. Icteric is defined as pertaining to, or resembling, jaundice.
  2. Isotonic solutions have the same concentration of solutes as the blood. With isotonic solutions there is no net transfer of water across two compartments separated by a semipermeable membrane.
  3. Hypotonic solutions have a lesser concentration of solutes than does the blood. A hypotonic enteral feeding will result in fluid being absorbed from the gastrointestinal tract into the intravascular and intracellular compartments.
  4. **Hypertonic solutions have a greater concentration of solutes than does the blood. The high osmolarity of a hypertonic enteral feeding exerts an osmotic force that pulls fluid into the gastrointestinal tract, resulting in intestinal cramping and diarrhea.**
- 18.**
1. Dry skin and scaly skin are signs of aging and dehydration, not excessive fluid volume.
  2. **With excessive fluid volume, the increased hydrostatic pressure moves fluid from the intravascular compartment into the interstitial compartment. As fluid collects in the interstitial compartment (edema), the skin appears taut and shiny.**
3. Red skin and irritated skin are signs of the local inflammatory response, not of excessive fluid volume.
  4. Thin skin and inelastic skin are characteristics of skin in the older adult because of a loss of subcutaneous fat and a reduced thickness and vascularity of the dermis, not of excessive fluid volume.
- 19.**
1. The blood pressure will increase, not decrease, when the circulating fluid volume increases in response to these hormones.
  2. **Both hormones are involved with water reabsorption, which conserves fluid and results in a decreased urinary output. With decreased kidney perfusion, the juxtaglomerular cells of the kidneys release angiotensin II, which stimulates the release of aldosterone from the adrenal cortex. Aldosterone promotes the excretion of potassium and reabsorption of sodium, which results in the passive reabsorption of water. As the concentration of the blood (osmolality) increases, the anterior pituitary releases antidiuretic hormone (ADH). ADH causes the collecting ducts in the kidneys to become more permeable to water, thus promoting its reabsorption into the blood.**
  3. ADH and aldosterone do not regulate body temperature.
  4. ADH and aldosterone influence the kidneys to maintain fluid balance. They do not affect insensible fluid loss through the skin, lungs, or intestinal tract.
- 20.**
1. **Ginger ale is an easily ingested and digested liquid that is permitted on a clear liquid diet. It relieves thirst, prevents dehydration, and minimizes stimulation of the gastrointestinal tract.**
  2. Sherbet contains milk, which is not permitted on a clear liquid diet.
  3. When ice cream melts, it is not a clear liquid, and therefore is not permitted on a clear liquid diet. Milk contains protein and lactose, which stimulates the digestive process; this is undesirable when a patient is receiving a clear liquid diet.

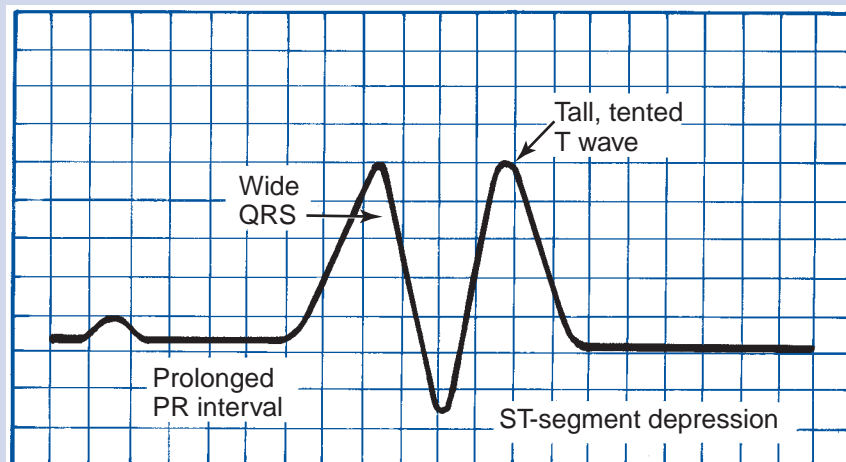
4. Cream of chicken soup contains milk and small particles of chicken, both of which are contraindicated on a clear liquid diet.
- 21.** 1. The accumulation of urine in the bladder with an inability to empty the bladder (urinary retention) is unrelated to a decreased fluid intake.
2. Frequent urination occurs with increased, not decreased, fluid intake.
3. Involuntary urination (incontinence) is not associated with a reduced fluid intake.
- 4. When the serum osmolarity increases because of insufficient fluid intake, antidiuretic hormone increases the permeability of the collecting tubules in the kidneys, which increases the reabsorption of water and decreases urine output.**
- 22.** 1. These physiological responses indicate the presence of an infection, not excess fluid volume.
2. Blood in the tubing is unrelated to fluid overload; it occurs when the IV bag is held lower than the IV insertion site and is an undesirable occurrence.
- 3. IV fluid flows directly into the circulatory system via a vein. Excess intravascular volume (hypervolemia) causes hypertension, pulmonary edema, and headache.**
4. These physiological responses indicate an IV infiltration, not excess fluid volume.
- 23.** 1. The infusion should be stopped and the catheter removed when a patient's IV infiltrates. When an IV catheter is displaced outside of a vein and IV fluid accidentally leaks into the interstitial compartment, it is called an infiltration. If the solution is just slowed, additional fluid will collect in the interstitial compartment and cause tissue damage.
2. The infusion should be stopped and the catheter removed when extravasation occurs. Extravasation occurs when an IV catheter is displaced outside of a vein and a vesicant solution accidentally leaks into the interstitial compartment. Vesicant solutions are extremely irritating solutions that cause tissues to blister, slough, and become necrotic.
3. The infusion should be stopped and the catheter removed when a patient's vein becomes inflamed because of the presence of the catheter. Inflammation of a vein (phlebitis) can progress to an infection or promote the development of a thrombus at the site.
- 4. When intravenous fluids are infused too rapidly or an excess amount of fluid is infused, the patient can experience an overload of fluid in the intravascular compartment. The nurse should slow the rate of infusion to keep the venous access viable and notify the primary health-care provider for directions.**
- 24.** 1. Grain products are not high in calcium. One slice of bread contains approximately 20 to 49 mg of calcium depending on the type of grain.
- 2. Yogurt is an excellent dietary source of calcium. Eight ounces of yogurt contain 415 mg of calcium.**
- 3. Spinach is an excellent dietary source of calcium. One cup of cooked fresh spinach contains 245 mg of calcium.**
4. Green beans are not high in calcium. One cup of green beans contains approximately 60 mg of calcium.
5. Peanut butter is not high in calcium. One tablespoon of peanut butter contains approximately 5 mg of calcium.
- 25. Answer: 1,220 mL. The patient's IV fluids infused at 125 mL/8 hours; therefore,  $125 \times 8 = 1,000$  mL of IV fluids. The patient received 2 intermittent infusions of 50 mL each; therefore,  $50 \times 2 = 100$  mL of antibiotic solution. The patient consumed 8 ounces of ice chips. When ice chips melt they are half the volume of the original amount of ice chips; therefore,  $8 \text{ ounces} \times 30 \text{ mL (amount of mL per ounce)} = 240$  (the total volume of ice chips before they melted). Then  $240 \div 2 = 120$  mL to determine the amount of fluid in ice chips that the patient consumed. Finally, to determine the total intake for 8 hours, add  $1,000 + 100 + 120 = 1,220$  mL.**
- 26.** 1. Vanilla ice cream is a liquid at room temperature and is permitted on a full-liquid diet, not a clear-liquid diet.
- 2. Cooked, refined cereals, such as Cream of Wheat, cream of rice, oatmeal, grits, and farina are permitted on a full-liquid diet, not a clear-liquid diet.**
3. Cranberry juice is a clear liquid.
4. Ginger ale is a clear liquid.
5. Gelatin is a clear liquid that is a solid when refrigerated and a liquid at room

temperature. It is permitted in either form on a clear liquid diet.

- 6. Milk contains a high solute load, including fat and proteins, which precipitates the digestive process. Milk is permitted on a full-liquid diet, not a clear-liquid diet.**

- 27. 1. The ECG tracing indicates hyperkalemia (tall, thin T wave; prolonged PR interval, ST-segment depression; widened QRS; and loss of P wave). Bradycardia is associated with hyperkalemia. Potassium, an electrolyte, is part of the sodium-potassium pump that is involved in muscle contraction. The heart is a muscle.**
- 2. The ECG tracing indicates hyperkalemia (tall, thin T wave; prolonged PR interval, ST-segment depression; widened QRS; and loss of P wave). Flaccid paralysis (muscles that lack tone and strength) is associated with hyperkalemia. Potassium, an electrolyte, is part of the sodium-potassium pump that is involved in muscle contraction.**
- 3. The ECG tracing indicates hyperkalemia (tall, thin T wave; prolonged PR interval, ST-segment depression; widened QRS; and loss of P wave). Increased bowel sounds are associated with hyperkalemia because of hyperactivity of gastrointestinal smooth muscle.**
- 4. Ventricular dysrhythmias are associated with hypokalemia, not hyperkalemia. The ECG tracing indicates hyperkalemia.**
- 5. Decreased deep tendon reflexes are associated with hypokalemia, not hyperkalemia. The ECG tracing indicates hyperkalemia.**

- 28. 1. The pulse amplitude is increased with fluid volume excess because of hypervolemia. The pulse amplitude is decreased with fluid volume deficit because of a decrease in the circulating blood volume (hypovolemia).**
- 2. A decrease in blood pressure is associated with fluid volume deficit, not excess, because of the decreased circulating blood volume.**
- 3. Dyspnea is associated with fluid volume excess, not deficit, because fluid overload causes pulmonary congestion.**
- 4. Brain cells require a delicate balance of fluids and electrolytes. Too much fluid and too little fluid affect the appropriate balance of electrolytes, particularly sodium and potassium. Fluid and electrolyte imbalances cause cerebral changes such as headache, confusion, combative behavior, unconsciousness, and coma.**
- 5. Muscle weakness is a musculoskeletal response to both increased fluid volume and decreased fluid volume because the fluid imbalances alter cellular and body metabolism.**
- 29. 1. Notifying the primary health-care provider is premature. The nurse should obtain additional information.**
- 2. Obtaining the radial pulse is not necessary. Trousseau sign is a result of neuromuscular irritability, not a circulatory impairment.**
- 3. It is not necessary to retake the patient's blood pressure. Information already has been obtained from performing this procedure.**
- 4. When a carpopedal spasm results from compression of a patient's arm by a sphygmomanometer cuff (Trousseau**



sign), it indicates that the patient may have hypocalcemia. Tapping over the patient's facial nerve will precipitate spasmodic spasms of the facial muscles (Chvostek sign) if the patient has hypocalcemia. This intervention provides more data to support the conclusion that the patient is hypocalcemic.

30. 1. When the insertion site of an IV is reddened, swollen, warm to the touch, and painful, the patient has phlebitis, not an infiltration of an IV.
2. When an IV line moves out of a vein and into subcutaneous tissue, the IV fluid will begin to collect in the interstitial compartment, causing swelling.
3. When IV fluid flows into the tissue surrounding a vein (infiltration), the area will feel soft and spongy, not hard.
4. The intravenous fluid that is infusing is at room temperature, which is cooler than body temperature. Therefore, IV fluid collecting at the site of an infiltration will cause the site to feel cool to the touch.
5. When the area at the insertion site of an IV appears inflamed, the patient has phlebitis, not an infiltration of an IV.

31. Answer: 5 mL. Solve the problem by using the formula for ratio and proportion.

$$\frac{\text{Desire } 40 \text{ mg}}{\text{Have } 8 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$

$$8x = 40$$

$$x = 40 \div 8$$

$$x = 5 \text{ mL}$$

32. 1. A half cup of pears contains only 100 mg or less of potassium.
2. A half cup of cabbage contains only 100 mg or less of potassium.
3. Cantaloupe is an excellent source of potassium. One cup of cantaloupe contains 427 mg of potassium.
4. Salmon is an excellent source of potassium. Three ounces of salmon contain 305 mg of potassium.
5. One cooked chicken liver contains only 28 mg of potassium.

33. 1. Counter-traction prevents pulling the skin and moving the needle/catheter, which can result in trauma and discomfort at the venipuncture site.

4. Withdrawing the needle/catheter along the line of insertion prevents injury to the vein.
2. Pressure prevents bleeding and the development of a hematoma at the venipuncture site. Sterile gauze maintains sterility of the procedure and prevents the transfer of microorganisms to the patient.
5. Examining the end of the needle/catheter ensures that it is intact and no portion remains in the patient.
3. A sterile dressing prevents exposure of the venipuncture site to the environment, limiting the risk of infection. The use of tape maintains pressure to prevent bleeding.

34. 1. A patient has a negative balance of I&O when the output exceeds the intake. This is a characteristic of a deficient fluid volume.
2. An elevated, not decreased, temperature is characteristic of a deficient fluid volume.
3. A low, not increased, blood pressure is characteristic of a deficient fluid volume.
4. Shortness of breath is a characteristic of excess, not deficient, fluid volume because of pulmonary congestion.
5. Flat neck veins are associated with a deficient fluid volume as a result of the decreased circulating blood volume.
6. Weight loss occurs with a deficient fluid volume; 1 liter of fluid weighs 2.2 pounds.

35. Answer: 14 drops/minute. Use the following formula to solve the problem.

$$\text{Drops per minute} = \frac{\text{total mL to be infused} \times \text{drop factor}}{\text{total time in minutes}}$$

$$\frac{1,000 \text{ (mL} \times 10 \text{ (drop factor))}}{60 \text{ (minutes in an hour)} \times 12 \text{ (hours to be infused)}}$$

$$\frac{10,000}{720} = 13.8$$

$$\frac{10,000}{720} = 13.8$$

Round 13.8 up to 14 because 0.8 of a drop cannot be administered and 0.8 is more than 0.5. The nurse should administer 14 drops/minute.

36. 1. One ounce of American cheese contains 406 mg of sodium and should be avoided on a 2-g sodium diet.
2. One and a half ounces of canned tuna fish contain approximately 400 mg of

**sodium and should be avoided on a 2-g sodium diet.**

3. Two-thirds of a cup of shredded wheat cereal contains 3 mg of sodium and is permitted on a 2-g sodium diet.
4. One baked potato contains approximately 16 mg of sodium and is permitted on a 2-g sodium diet.
5. One ounce of roasted cashews, with no added salt, contains about 4 mg of sodium and is permitted on a 2-g sodium diet.

**37. 1. Potassium is essential to the sodium-potassium pump that regulates muscle contraction. The heart is a major muscle. Hypokalemia can precipitate a weak, irregular pulse and ventricular dysrhythmias.**

2. Hypertension is associated with hypervolemia, not a potassium deficiency.
- 3. Potassium is an essential component in the sodium-potassium pump, cellular metabolism, and muscle contraction. Responses associated with hypokalemia include muscle weakness, fatigue, lethargy, leg cramps, and depressed deep-tendon reflexes.**
4. Chest pain is associated with a myocardial infarction (heart attack) and pulmonary embolus, not a potassium deficiency.
5. Dry hair is associated with malnutrition and hypothyroidism, not hypokalemia.

**38. Answer: 42 drops/minute. Solve the problem by using the following formula.**

**Drops per minute =**

$$\frac{\text{total mL to be infused} \times \text{drop factor}}{\text{total time in minutes}}$$

$$\frac{1,000 \times 15}{60 \times 6}$$

$$\frac{15,000}{360} = 41.6 \text{ drops/min}$$

**Round 41.6 up to 42 because 0.6 of a drop cannot be administered.**

**39. 1. Vasodilation related to inflammation increases blood flow to the affected area, which causes the site to feel warm and look red (erythema).**

2. The site of an inflammation will feel firm, not soft.

**3. Edema related to inflammation causes the affected area to feel firm.**

4. Vasodilation related to inflammation increases blood flow to the affected area, which causes it to feel warm, not cool.

**5. Inflammation of a vein (phlebitis) causes a movement of fluid from the intravascular compartment into the interstitial compartment. Pressure of fluid on nerve endings causes local discomfort.**

40. 1. The patient has hyperkalemia. The potassium is more than the acceptable range of 3.5 to 5.0 mEq/L.
2. The patient has hypovolemia, not hypervolemia, because of dehydration. The pulse is rapid and thready, and the urine specific gravity is increased. An abrupt weight loss indicates fluid loss (2.2 pounds is equal to 1 L of fluid), and the patient is exhibiting decreased intracellular and interstitial fluid, as evidenced by tenting of the skin. Also, the blood pressure is on the low extreme of the acceptable range of 90 to 119 mm Hg for systolic and 60 to 79 mm Hg for diastolic.
- 3. Intestinal secretions distal to the pyloric sphincter contain large amounts of bicarbonate, which is lost through diarrhea. The arterial blood gases indicate uncompensated metabolic acidosis: the pH is less than the acceptable range of 7.35 to 7.45; the HCO<sub>3</sub> is less than the acceptable range of 21 to 28 mEq/L; and the Paco<sub>2</sub> is within the acceptable range of 23 to 30 mEq/L.**
4. With respiratory alkalosis the pH will be more than 7.45, the Paco<sub>2</sub> will be less than 35 mm Hg, and the HCO<sub>3</sub> will be within the acceptable range of 21 to 28 mEq/L. Respiratory alkalosis usually is caused by hyperventilation precipitated by conditions such as anxiety, mechanical ventilation, early sepsis, and high fever.

# Gastrointestinal System

## KEYWORDS

The following words include English vocabulary, nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Abdomen	Fecal impaction
Abdominal distention	Feces
Anus	Flatus, flatulence
Borborygmi	Fracture bedpan
Bowel:	Gastrocolic reflex
Flora	Hemoccult test, guaiac
Habits	Hemorrhoids
Sounds	Hypermotility/hypomotility
Training	Irrigation
Cathartic	Laxative
Colon	Mucosal
Colorectal	Nasogastric tube
Constipation	Occult blood
Defecate	Ova and parasites
Diarrhea	Paralytic ileus
Distention	Perianal
Endoscopic	Perineal
Enema:	Peristalsis
Cleansing	Pinworms
Hypertonic	Prolapse
Hypotonic	Rectal tube
Isotonic	Rectum
Large volume	Sigmoidoscopy
Oil retention	Sitz bath
Return flow (formerly Harris drip/flush)	Spastic colon
Saline	Sphincter
Soapsuds	Steatorrhea
Tap water	Stoma
Evacuate, evacuation	Stool
Fecal diversion:	Suppository
Colostomy	Tarry stool (melena)
Ileostomy	

## GASTROINTESTINAL SYSTEM: QUESTIONS

1. Which statement by a patient with an ileostomy alerts the nurse to the need for further education?
  1. "I don't expect to have much of a problem with fecal odor."
  2. "I will have to take special precautions to protect my skin around the stoma."
  3. "I'm going to irrigate my stoma so I have a bowel movement every morning."
  4. "I should avoid gas-forming foods like beans to limit funny noises from the stoma."

2. A primary health-care provider orders a return-flow enema (Harris flush/drip) for an adult patient with flatulence. When preparing to administer this enema the nurse compares the steps of a return-flow enema with cleansing enemas. Which nursing intervention is unique to a return-flow enema?
  1. Lubricate the last 2 inches of the rectal tube.
  2. Insert the rectal tube about 4 inches into the anus.
  3. Raise the solution container about 12 inches above the anus.
  4. Lower the solution container after instilling about 150 mL of solution.
3. A nurse discourages a patient from straining excessively when attempting to have a bowel movement. Which undesirable physiological response is the primary reason why straining on defecation should be avoided?
  1. Dysrhythmia
  2. Incontinence
  3. Fecal impaction
  4. Rectal hemorrhoid
4. A school nurse is planning a health class about bodily functions. Which information should be included regarding the purpose of mucus in the gastrointestinal tract?
  1. Activates digestive enzymes
  2. Protects the gastric mucosa
  3. Enhances gastric acidity
  4. Emulsifies fats
5. A nurse is caring for a patient who is experiencing diarrhea. About which physiological response to diarrhea should the nurse be **most** concerned?
  1. Dehydration
  2. Malnutrition
  3. Excoriated skin
  4. Urinary incontinence
6. A nurse identifies that a patient's colostomy stoma is pale. Which should the nurse do?
  1. Notify the surgeon.
  2. Listen for bowel sounds.
  3. Wash the area with warm water.
  4. Gently massage around the stoma.
7. A nurse is caring for a group of patients. Which patient factor should the nurse identify as placing a patient at risk for bowel incontinence?
  1. Being ninety years old
  2. Taking a sedative for sleep
  3. Disoriented to time, place, and person
  4. Receiving multiple antibiotic medications
8. A patient is admitted with lower gastrointestinal tract bleeding. Which characteristic of the stool supports this diagnosis?
  1. Tarry stool
  2. Orange stool
  3. Green mucoid stool
  4. Bright red-tinged stool
9. A nurse determines that the teaching about a guaiac test of stool is understood when the patient states that it identifies the presence of which of the following?
  1. Ova and parasites
  2. Hidden blood
  3. Bacteria
  4. Bile



10. A nurse must collect a specimen for the presence of pinworms. Which action is essential to ensure accuracy of the specimen?
1. Press the sticky side of nonfrosted cellophane tape across the anus before the patient goes to bed at night.
  2. Pass a rectal swab beyond the internal anal sphincter and rotate gently to collect a specimen.
  3. Perform the procedure the first thing in the morning before the first bowel movement.
  4. Wash the rectal area gently with soap and water before collecting the specimen.
11. Which patient statement supports the nurse's conclusion that a patient understands the need to reestablish bowel flora after a week of diarrhea?
1. "I must wean myself off of the antibiotics one day after my temperature is normal."
  2. "I should eat a container of yogurt every day for a few days."
  3. "I have to add rice to my diet in one meal each day."
  4. "I ought to drink eight glasses of water a day."
12. A nurse is teaching a patient with a history of constipation about the excessive use of laxatives. Which effect of laxatives should the nurse include as the **primary** reason why their use should be avoided?
1. Weakens the natural response to defecation
  2. Results in distention of the intestines
  3. Causes abdominal discomfort
  4. Precipitates incontinence
13. A nurse identifies that a patient has tarry stools. Which problem should the nurse conclude that the patient is experiencing?
1. Upper gastrointestinal bleeding
  2. Pancreatic dysfunction
  3. Lactulose intolerance
  4. Inadequate bile salts
14. A nurse is teaching a patient with a cardiac condition to avoid the Valsalva maneuver. Which should the nurse teach the patient to do?
1. Eat rice several times a week.
  2. Take a cathartic on a regular basis.
  3. Attempt to have a bowel movement every day.
  4. Exhale while contracting the abdominal muscles.
15. A nurse is teaching a patient how to irrigate a colostomy. The patient asks why it is necessary to use the cone attachment to the irrigation catheter. What information should the nurse include in a response to this question?
1. Stops enema solution from flowing out of the bowel during the procedure
  2. Prevents prolapse of the bowel during evacuation of the solution
  3. Dilates the stoma so that the enema tube can be inserted
  4. Facilitates the elimination of drainage from the colon
16. Which outcome is **most** appropriate for a patient with perceived constipation?
1. Have a bowel movement without the use of a laxative.
  2. Verbalize the rationale for the use of laxatives.
  3. Drink eight glasses of water per day.
  4. Defecate every day.
17. Which action is important for the nurse to teach patients about the intake of bran to facilitate defecation?
1. Eat 3 tablespoons of bran each morning.
  2. Drink at least 8 glasses of fluids each day.
  3. Have a bowel movement right after ingesting the bran.
  4. Take a cathartic that will supplement the action of bran.

18. A primary health-care provider orders a tap-water enema for a patient. The patient asks about the purpose of the enema. Which specific information about the purpose of a tap-water enema should be included in the nurse's response?
1. "It reduces abdominal gas."
  2. "It drains the urinary bladder."
  3. "It empties the bowel of stool."
  4. "It limits nausea and vomiting."
19. Which word is specific regarding how a soapsuds enema works on the mucosa of the bowel?
1. Dilating
  2. Irritating
  3. Softening
  4. Lubricating
20. A nurse is caring for a patient with an intestinal stoma. Which intervention is **most** important?
1. Cleansing the stoma with cool water
  2. Spraying an air-freshening deodorant in the room
  3. Selecting a bag with an appropriate-size stomal opening
  4. Wearing sterile nonlatex gloves when caring for the stoma
21. Which should the nurse do when administering a small-volume hypertonic enema to an adult?
1. Insert the rectal tube 1 to 1.5 inches into the anal canal.
  2. Position the enema bottle 12 inches above the level of the patient's anus.
  3. Direct the rectal tube toward the vertebrae as it is inserted into the rectum.
  4. Maintain the compression of the enema container until after withdrawing the tube.
22. Which should the nurse do before collecting a stool sample for occult blood?
1. Plan to collect the first specimen of the day.
  2. Secure a sterile specimen container.
  3. Wash the patient's perianal area.
  4. Ask the patient to void.
23. A nurse performs a physical assessment of a newly admitted patient who is incontinent of stool. For which characteristic related to bowel incontinence should the nurse assess the patient?
1. Frequent, soft stools
  2. Involuntary passage of stool
  3. Impaired anal sphincter control
  4. Greenish-yellow color to the stool
24. A nurse is collecting a bowel elimination history from a newly admitted patient with a medical diagnosis of possible bowel obstruction. Which question takes **priority**?
1. "Do you use anything to help you move your bowels?"
  2. "When was the last time you moved your bowels?"
  3. "What color are your usual bowel movements?"
  4. "How often do you have a bowel movement?"
25. While providing a health history the patient tells the nurse, "I have gastroesophageal reflux disease." Which **most** serious consequence associated with this disorder should the nurse anticipate this patient may develop?
1. Diarrhea
  2. Heartburn
  3. Gastric fullness
  4. Esophageal erosion

26. A nurse is implementing an ordered bowel preparation for a patient who is scheduled for a colonoscopy. Which is the **most** serious consequence that is prevented by an effective bowel preparation?
1. Psychological stress
  2. Wasted expense
  3. Misdiagnosis
  4. Discomfort
27. A nurse is assessing a patient who has a distended abdomen resulting from flatulence. The patient has an order for a regular diet and an activity order for out of bed. Which can the nurse do to promote passage of the intestinal gas?
1. Instruct the patient to increase the amount of fluid intake.
  2. Suggest that the patient avoid cruciferous foods.
  3. Obtain a prescription for a laxative.
  4. Encourage the patient to ambulate.
28. A nurse should use a fracture bedpan for patients with which conditions? **Select all that apply.**
1.  P eripheral vascular disease
  2.  Sp inal cord injury
  3.  Fr actured hip
  4.  Deme ntia
  5.  Ob esity
29. A nurse is performing a physical assessment of a patient concerning the gastrointestinal system. Place the following interventions in the order in which they should be performed.
1. Palpate the abdomen.
  2. Inspect the anus and perianal area.
  3. Percuss the abdomen for the quality of sounds.
  4. Auscultate the entire abdomen for bowel sounds.
  5. Observe the contour and symmetry of the abdomen.
- Answer: \_\_\_\_\_
30. A patient is experiencing constipation. Which independent nursing actions facilitate defecation of a hard stool? **Select all that apply.**
1.  A pplying a lubricant to the anus
  2.  P roviding a sitz bath after defecation
  3.  Instill ing warm mineral oil into the rectum
  4.  P lacing a warm wet washcloth against the perianal area
  5.  Enc ouraging the patient to rock forward and back while defecating
31. A patient with flatulence is concerned about the production of unpleasant odors. Which should the nurse encourage the patient to avoid? **Select all that apply.**
1.  A sparagus
  2.  A lcohol
  3.  Raisins
  4.  Onio ns
  5.  Eggs
32. A primary health-care provider prescribes docusate sodium in liquid form for a patient who is constipated but has difficulty swallowing tablets. The prescription is for 200 mg daily to be divided into two doses, one in the a.m. and one at hour of sleep. The package insert states that there is 50 mg/5 mL. How much solution of docusate sodium should the nurse administer per dose? **Record your answer using a whole number.**
- Answer: \_\_\_\_\_ mL

33. A nurse is assisting a patient with a regular bedpan. Which nursing actions are essential? **Select all that apply.**
- Position the patient slightly off the back edge of the bedpan.
  - Fold the top linen out of the way when putting the patient on the bedpan.
  - Remain outside the curtains of the bed until the patient is done using the bedpan.
  - Elevate the head of the bed to the Fowler position after the patient is on the bedpan.
  - Raise the side rails on both sides of the bed after the patient is positioned on the bedpan.
34. A nurse is providing dietary teaching to a patient with diverticulitis who has an order for a low-fiber diet. Which food selected by the patient indicates that the dietary teaching was understood? **Select all that apply.**
- White rice
  - Split peas
  - Soft tofu
  - Oatmeal
  - Pasta
35. A patient is attending the health clinic for treatment of hemorrhoids. The nurse reviews the patient's history, interviews the patient, and performs a focused assessment. Which factors does the nurse conclude may have influenced the development of the hemorrhoids? **Select all that apply.**
- Stands for long periods of time at work
  - Drinks a glass of wine with dinner
  - Has had multiple pregnancies
  - Tends to have constipation
  - Is obese

#### PATIENT'S CLINICAL RECORD

##### Patient History

Married for 18 years

Has 5 children between the ages of 7 and 17: 3 single births and a set of twins

Works as a cashier 4 days a week

##### Patient Interview

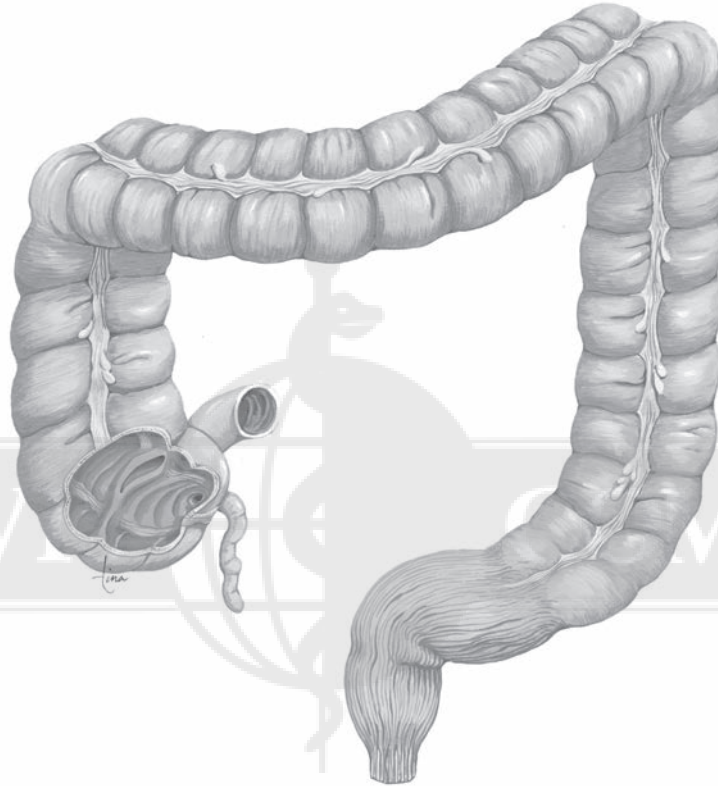
Patient states that she drinks a glass of wine with dinner. When the hemorrhoids became increasingly painful and a continuous problem she decided to do something about them. States she sometimes takes a stool softener when she is constipated.

##### Focused Assessment

Patient is 60 pounds more than ideal body weight for height. Three external hemorrhoids are bright red, swollen, and oozing blood. Patient states, "My rectal area is itchy and painful."

36. A nurse is caring for a group of patients with a variety of gastrointestinal problems. Which of the following can cause both diarrhea and constipation? **Select all that apply.**
- Inability to perceive bowel cues
  - Cancer of the large intestines
  - Side effects of medications
  - High-solute tube feedings
  - Increased metabolic rate

37. Which statements by a patient with diverticulosis alert the nurse that the patient needs additional health teaching? **Select all that apply.**
1.  “ I should avoid eating high-fiber cereal.”
  2.  “ I sit on the toilet for 10 minutes after breakfast every day.”
  3.  “ I am going to drink 8 glasses of water a day when I get home.”
  4.  “ I should hold my breath and bear down when having a bowel movement.”
  5.  “I like to massage my lower abdomen when I’m trying to have a bowel movement.”
38. A nurse is caring for a patient with a colostomy, and the patient’s stool has a pasty consistency. Place an X over the area of the intestine where the nurse can expect a colostomy to produce stool with a pasty consistency.



39. A patient had a colonoscopy with several polyps excised for biopsies. The nurse teaches the patient routine post-procedure expectations. Which physical responses should the nurse instruct the patient to report to the primary health-care provider? **Select all that apply.**
1.  Intermittent passage of gas from the anus
  2.  Continuous abdominal cramping
  3.  Extensive abdominal bloating
  4.  Minimal rectal bleeding
  5.  Mild fatigue
40. A nurse is to administer an oil-retention enema, a tap-water enema, and a return-flow enema to three different patients. Which nursing interventions should be performed with all three enemas? **Select all that apply.**
1.  Use between 500 and 1,000 mL of solution.
  2.  Place the patient in the left side-lying position.
  3.  Use water-soluble jelly to lubricate the tip of the rectal probe.
  4.  Pull the curtain around the patient’s bed and drape the patient.
  5.  Hold the enema solution a minimum of 12 inches above the anus.

## GASTROINTESTINAL SYSTEM: ANSWERS AND RATIONALES

1. The odor from drainage is minimal because fewer bacteria are present in the ileum compared with the large intestine. An ileostomy is an opening into the ileum (distal small intestine from the jejunum to the cecum).
  2. Cleansing the skin, skin barriers, and a well-fitted appliance are precautions to protect the skin around an ileostomy stoma. The drainage from an ileostomy contains enzymes that can damage the skin.
  - 3. This statement is inaccurate in relation to an ileostomy and indicates that the patient needs more teaching. An ileostomy produces liquid fecal drainage, not formed stool that requires irrigation.**
  4. An ileostomy stoma does not have a sphincter that can control the flow of flatus or drainage, resulting in noise.
1. All rectal tubes should be lubricated to facilitate entry of the tube into the anus and rectum and prevent mucosal trauma.
  2. The anal canal is 1 to 2 inches (2.5 to 5 cm) long. Inserting the rectal tube 3 to 4 inches (7 to 10 cm) ensures that the tip of the tube is beyond the internal and external anal sphincters. This action is appropriate for all types of enemas.
  3. The solution container should be raised no higher than 12 inches for all enemas; this allows the solution to instill slowly, which limits discomfort and intestinal spasms.
  - 4. Lowering the container of solution creates a siphon effect that pulls the instilled fluid back out through the rectal tube into the solution container. The return flow promotes the evacuation of gas from the intestines. This technique is used only with a return-flow enema. When performing a cleansing enema, the tubing is removed after all the solution is instilled.**
- 1. Straining on defecation requires the person to hold the breath while bearing down (Valsalva maneuver). This maneuver increases the intrathoracic and intracranial pressures, which can precipitate dysrhythmias, brain attack (stroke), and respiratory difficulties; all of these can be life-threatening.**
  2. The loss of the voluntary ability to control the passage of fecal or gaseous discharges through the anus (bowel incontinence) is caused by impaired functioning of the anal sphincters or their nerve supply, not straining on defecation.
  3. Fecal impaction is caused by the accumulation and prolonged retention of fecal material in the large intestine, not straining on defecation.
  4. Although straining on defecation can contribute to the formation of hemorrhoids, this is not the primary reason straining on defecation is discouraged. Hemorrhoids, although painful, are not life-threatening.
1. The presence of fluid or food activates digestive enzymes, not mucus.
  - 2. Mucus secreted by mucous membranes and glands is a viscous, slippery fluid containing mucin, white blood cells, water, inorganic salts, and exfoliated cells. Mucin, a mucopolysaccharide, is a lubricant that protects body surfaces from friction and erosion.**
  3. Mucus does not enhance gastric acidity. Gastric acidity enhances digestion.
  4. The low surface tension of bile salts contributes to the emulsification of fats in the intestine.
- 1. Usually digestive juices of 3.5 to 5.0 L are secreted and reabsorbed by the body daily. With diarrhea, the transit time through the intestine is decreased, interfering with the reabsorption of water, resulting in frequent, loose, watery stools and dehydration.**
  2. Although malnutrition may be related to diarrhea, particularly if it is prolonged, it is neither life-threatening nor the priority in comparison with another option.
  3. Although the skin may become excoriated in the presence of diarrhea because the enzymes in fecal material can erode the skin, it is neither life-threatening nor the priority in comparison with another option.
  4. Diarrhea is unrelated to urinary incontinence.
- 1. A pale stoma indicates that the circulation to the stoma is compromised, and viability of tissue is**

**questionable without immediate intervention. The primary health-care provider should be notified immediately.**

2. Although assessing bowel sounds might be done, it is not the priority. Active bowel sounds indicate peristalsis and the presence of flatus in the small intestines, which can occur even if there is an impending problem in the large intestine.
  3. Washing the area with warm water is inappropriate. This will not improve circulation to the stoma and will waste valuable time.
  4. Massaging around the stoma is inappropriate. This will not improve circulation and may injure surrounding tissue.
- 7.**
1. Constipation, not bowel incontinence, is more common in older adults than in other age groups. Constipation in older adults is caused by decreased bowel motility, inadequate hydration, lack of fiber, sedentary lifestyle, abuse of laxatives, and side effects of medications.
  2. Sedatives depress the central nervous system, which may precipitate constipation, not bowel incontinence.
- 3. When a person is disoriented to time, place, and person, the individual may not have the cognitive ability to perceive and interpret intestinal distention and rectal pressure cues to defecate, resulting in bowel incontinence.**
4. Antibiotic medications are known for causing diarrhea, not bowel incontinence.
- 8.**
1. Tarry stools indicate upper gastrointestinal bleeding.
  2. Orange stools indicate the presence of infection.
  3. Green mucoid stools indicate the presence of infection.
  4. **Bright red-tinged stools are the cardinal sign of lower gastrointestinal bleeding. When bleeding occurs close to the anus, enzymes have not digested the blood, so the blood has not turned black.**
- 9.**
1. Ova and parasites are identified through microscopic examination of feces, not the guaiac test.
  2. **Testing the feces for occult blood is called the guaiac test. This test uses a chemical reagent to detect the**

**presence of the enzyme peroxidase in the hemoglobin molecule. Occult blood is obscure (hidden) and may not be visible to the naked eye.**

3. Bacteria are identified in feces through a stool culture, not the guaiac test.
  4. Bile is an expected constituent of fecal material and is not detected with the guaiac test.
- 10.**
1. Specimen collection is done immediately after awakening from sleep, not before sleep.
  2. Passing a rectal swab beyond the internal anal sphincter and rotating it gently are unnecessary and can injure the anal and rectal mucosa.
- 3. Performing the procedure the first thing in the morning before the first bowel movement ensures that there will be eggs available for collection at the perianal area. The adult pinworm (*Enterobius vermicularis*) exits the anus at night to lay eggs. The cellophane tape (Scotch tape) test is performed first thing in the morning before a bowel movement or bathing so that these eggs are not disrupted or removed before obtaining a specimen for testing.**
4. Washing the rectal area before collecting the specimen will remove any eggs that are present in the perianal area, which will interfere with accurate test results.
- 11.**
1. Weaning off the antibiotic 1 day after the temperature is normal will not reestablish bowel flora. Discontinuing antibiotics before the full course of therapy is completed can result in a return of the original infection or precipitate the development of a superinfection.
  2. **Yogurt is merely milk that is curdled by the addition of bacteria, specifically *Lactobacillus bulgaricus* and *Streptococcus thermophilus*. Eating yogurt helps to restore the bacterial balance of the resident flora of the intestine.**
  3. Although rice helps to limit diarrhea, it will not reestablish bowel flora.
  4. Although water is essential for all body processes, and to replace fluid lost in the diarrhea, it does not reestablish bowel flora.
- 12.**
1. **Laxatives cause a rapid transit time of intestinal contents. When they are used excessively, the bowel's natural**

**responses to intestinal distention and rectal pressure weaken, resulting in chronic constipation.**

2. Laxatives increase peristalsis, which helps evacuate the bowel, preventing, not promoting, abdominal distention from flatus or intestinal contents.
  3. Although excessive laxative use can cause cramping, it is temporary and does not have long-term implications, as does the problem in another option.
  4. The loss of the voluntary ability to control the passage of fecal or gaseous discharges through the anus (bowel incontinence) is caused by impaired functioning of the anal sphincters or their nerve supply, not excessive laxative use.
- 13. 1. When blood from bleeding in the upper gastrointestinal tract is exposed to the digestive process, the fecal material becomes black (tarry). In addition, ingestion of exogenous iron, red meat, and dark green vegetables can make the stool look black.**
2. Pancreatic dysfunction results in impaired digestion of fats (by lipase), protein (by trypsin and chymotrypsin), and carbohydrates (by amylase). Pancreatic dysfunction results in pale, foul-smelling, bulky stools, not tarry stools.
  3. A reduction or lack of the secretion of lactase from the wall of the small intestine results in the inability of the body to break down lactose to glucose and galactose. Lactose intolerance causes diarrhea, gaseous distention, and intestinal cramping, not tarry stools.
  4. Inadequate bile salts result in less bile entering the intestinal tract. The brown color of stool is caused by the presence of stercobilin and urobilin, which are derived from a pigment in bile (bilirubin). The stool will appear clay colored with inadequate bile salts.
- 14. 1. Rice thickens stool, which promotes the development of constipation. Constipation may result in straining on defecation, which employs the Valsalva maneuver.**
2. Prescribing a cathartic is a dependent, not an independent, function of the nurse. Regular use of a cathartic is contraindicated because it leads to dependence.
  3. Attempting to have a bowel movement every day may result in straining, which employs the use of the Valsalva maneuver. Also, the patient may not need to have a daily bowel movement.
- 4. Exhaling requires the glottis to be open, which prevents the Valsalva maneuver. The Valsalva maneuver is bearing down while holding the breath by closing the glottis, which increases intrathoracic pressure. The Valsalva maneuver briefly interferes with blood flow to the heart. When the glottis opens during exhalation, the pressure is released and a surge of blood flows to the heart, which may precipitate a dysrhythmia in a person with a cardiac condition.**
- 15. 1. The cone advances into the stoma until it effectively fills the opening, which prevents a reflux of solution while the irrigating solution is being instilled. In addition, it helps prevent accidental perforation of the bowel with the rectal catheter.**
2. A cone will not prevent the prolapse of the bowel. If a prolapse should occur, the surgeon should be notified immediately.
  3. Using a cone to dilate the stoma so that the enema tube can be inserted is not the purpose of the cone. The catheter is threaded through the center of the cone.
  4. The cone is removed before the bowel evacuates its contents.
- 16. 1. Having a bowel movement without the use of a laxative is the most appropriate goal for a patient with perceived constipation. People with perceived constipation believe that they should have a daily bowel movement and use laxatives, suppositories, and/or enemas to achieve this objective.**
2. Although knowledge is essential, behavioral outcomes determine if a goal is achieved.
  3. Drinking eight glasses of water per day is an intervention, not a goal. Although desirable for everyone, it does not specifically relate to perceived constipation.
  4. The need to have a bowel movement every day is unnecessary, unrealistic, and a myth. Patterns of bowel elimination vary considerably depending on a multitude of factors.



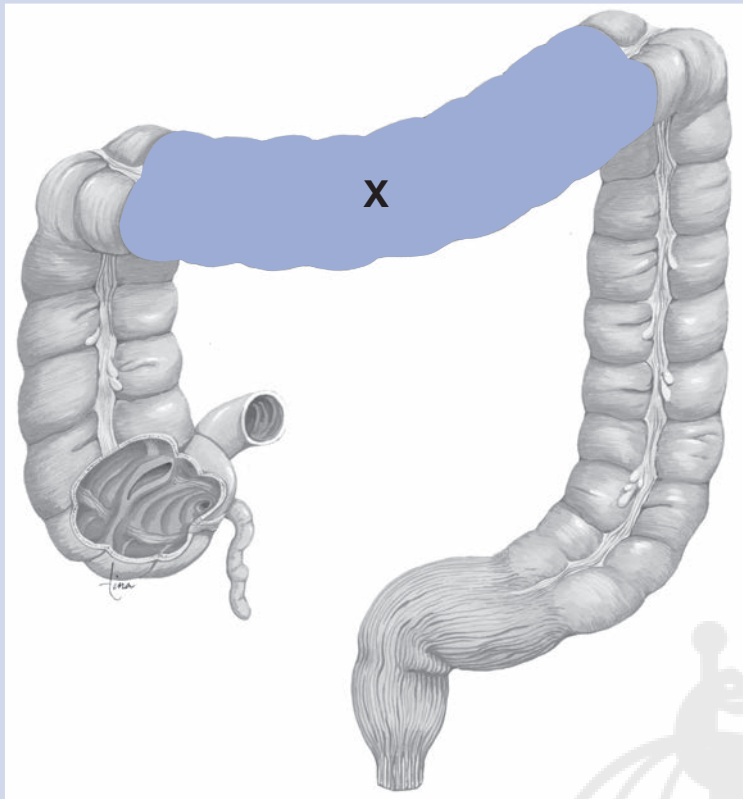
17.
  1. Eating 3 tablespoons of bran each morning is too stimulating for the intestines initially. Bran use should begin with 1 tablespoon and gradually increase as tolerated because it can cause flatus and distention.
  2. **Bran is an insoluble fiber that increases bulk in the intestines. Eight glasses of water daily keep the body well hydrated and the stool soft. Intestinal elimination is dependent on the relationships among fiber, water, and activity.**
  3. Having a bowel movement right after ingesting the bran is too soon to expect a physiological response to the bran.
  4. Taking a cathartic is counterproductive. Cathartic use will weaken the bowel's natural responses to intestinal distention and rectal pressure, resulting in chronic constipation.
18.
  1. A return-flow enema (Harris flush, Harris drip) helps eliminate intestinal gas.
  2. A urinary retention catheter (Foley), not a tap-water enema, drains the urinary bladder of urine.
  3. **A tap-water enema instills fluid into the large intestine; the pressure of this volume stimulates peristalsis, causing the colon to evacuate stool.**
  4. A tap-water enema will not affect nausea and vomiting; taking nothing by mouth or medication can be used to limit nausea and vomiting.
19.
  1. High-volume (not soapsuds) enemas, such as tap-water or saline enemas, work by distending (dilating) the lumen of the intestine.
  2. **Although a soapsuds enema works by increasing the volume in the colon, its unique attribute is that soap is irritating to the intestinal mucosa. Irritation of the mucosa precipitates peristalsis, which facilitates the evacuation of fecal material.**
  3. An oil-retention enema, a small-volume enema, introduces oil into the rectum and sigmoid colon; this softens the feces and lubricates the rectum and anal canal, facilitating defecation.
  4. An oil-retention, not soapsuds, enema lubricates the rectum and anal canal, facilitating the passage of feces.
20.
  1. Although a stoma can be cleaned with water as long as it is not at the extremes of hot or cold, it is not the priority.
  2. Although this might be done, it is not the priority.
  3. **The opening of the appliance must be large enough to encircle the stoma to within  $\frac{1}{2}$  to  $\frac{1}{8}$  inch to protect the surrounding tissue from the enzymes present in the intestinal discharge without impinging on the stoma. Pressure against the stoma can damage delicate mucosal tissue or impede circulation to the stoma, both of which can impair the viability of the stoma.**
  4. Clean, not sterile, gloves should be worn when caring for a stoma. Medical, not surgical, asepsis should be practiced. Latex or nonlatex gloves can be worn as long as the patient or nurse does not have a latex allergy.
21.
  1. Inserting a rectal tube 1 to 1.5 inches into the anal canal will not permit safe administration of the enema solution. The rectal tube must be inserted 3 to 4 inches to ensure that the catheter is beyond both the external and internal anal sphincters.
  2. A small-volume enema bottle is held directly outside the anus because the solution container is attached to the prelubricated nozzle. The container of a large-volume enema should not exceed a height of 12 inches above the anus.
  3. Directing the rectal tube toward the vertebrae as it is inserted into the rectum will injure the intestinal mucosa. The catheter should be directed toward the umbilicus, not the vertebrae.
  4. **Maintaining compression of the enema container until after withdrawing the tube prevents suctioning back of the fluid that has just been instilled. Releasing compression on the bottle causes a vacuum at the tip of the nozzle that can injure mucous membranes.**
22.
  1. Collecting the first specimen of the day is unnecessary.
  2. Using a sterile specimen container is unnecessary. Medical, not surgical, asepsis should be followed.
  3. Washing the perineal area is unnecessary. However, the nurse may assist the patient to perform perineal hygiene after the stool specimen is obtained.
  4. **Emptying the urinary bladder before attempting to have a bowel movement prevents accidental contamination of the specimen by urine.**

- 23.** 1. Frequent, soft stools are associated with diarrhea. Diarrhea is loose, liquid stools and/or increased frequency (three times a day or more) of stools.
- 2. An involuntary passage of stool is a major clinical finding associated with bowel incontinence, which is the state in which an individual experiences a change in usual bowel habits characterized by involuntary passage of stool.**
3. Impaired anal sphincter control is not a characteristic a nurse can evaluate when performing a physical assessment.
4. A greenish-yellow color to the stool is unrelated to bowel incontinence. A green or orange color to the stool indicates intestinal infection.
- 24.** 1. Although asking if anything is used to help move the bowels may be done, it is not the priority at this time.
- 2. A cardinal sign of a bowel obstruction is the lack of a bowel movement (obstipation).**
3. Although asking about the color of bowel movements will be done, this information relates more to malabsorption, biliary problems, and gastrointestinal bleeding.
4. Although asking how often one has a bowel movement will be done to obtain baseline information about intestinal elimination, it is not specific to the presenting problem.
- 25.** 1. Diarrhea is not associated with gastroesophageal reflux disease (GERD).
2. Pain occurring behind the sternum (heartburn) and sore throat are the predominant symptom of GERD. Although these responses are a concern, they can be treated.
3. Although feeling full, distended, or bloated can occur with GERD, it is not life-threatening and the patient can be taught interventions to limit its occurrence.
- 4. With GERD a backflow of the contents of the stomach into the esophagus occurs. Gastric juices are acedid (pH less than 3.5), which can cause erosion of the mucous membranes of the esophagus, necessitating surgery. Cellular changes in the lining of the esophageal mucosa (Barrett's esophagus) are a risk factor for developing esophageal cancer.**
- 26.** 1. Although psychological stress is a serious consequence, it is not life-threatening.
2. Although a cancelled or repeated colonoscopy may incur a wasted expense, this consequence is not life-threatening. A test may be cancelled or performed a second time if the patient has an ineffective bowel preparation.
- 3. Fecal material in the intestines can interfere with the visualization, collection, and analysis of data obtained through a colonoscopy, resulting in diagnostic errors.**
4. Although discomfort may occur, it is not the most serious outcome of an inappropriate preparation for a colonoscopy.
- 27.** 1. Increasing the amount of fluid intake will not facilitate the evacuation of intestinal gas.
2. Limiting the intake of cruciferous foods will prevent the development of intestinal gas, not promote its evacuation.
3. A laxative is an excessive intervention for a patient with flatulence.
- 4. Ambulation increases metabolic activity, which increases intestinal peristalsis. Increased intestinal peristalsis moves intestinal gas toward the anus, where it can be expelled.**
- 28.** 1. A regular bedpan is appropriate for a patient with peripheral vascular disease.
- 2. A fracture bedpan has a low back that promotes functional alignment of the patient's lower back while on the bedpan.**
- 3. A fracture bedpan has a low back that promotes functional alignment of the patient's lower back and hips while on the bedpan. A regular bedpan will raise the hips and place stress on the site of the fracture.**
4. A regular bedpan is appropriate for a patient with dementia.
5. A regular bedpan is appropriate for a patient who is obese.
- 29.** **5. Inspection should occur first because it is the least invasive assessment. The abdomen should be assessed before turning the patient, which slightly rearranges the internal organs.**
- 2. The anus and perianal area should be inspected after a less invasive assessment and before other**

- assessment techniques that can alter the results of inspection.
4. Auscultation should occur after less invasive assessment techniques and before other more invasive assessment techniques that can alter the results of auscultation.
  3. Percussion should occur after less invasive techniques but before a more invasive assessment technique that can alter the results of percussion.
  1. Palpation should occur after less invasive assessment techniques are completed.
30. 1. A lubricant reduces friction, which facilitates the passage of a hard, dry stool through the anus. Nurses are legally permitted to diagnose and treat human responses. Constipation is a human response, and applying a water-soluble lubricant to the anus is an independent function of the nurse.
2. A sitz bath requires a primary health-care provider's order and is a dependent, not independent, function of the nurse. A sitz bath will not promote the passage of a hard, dry stool, but it may promote hygiene and comfort after the bowel movement.
  3. An oil-retention enema softens the feces and lubricates the rectum and anus. However, it requires a primary health-care provider's order and is a dependent, not independent, function of the nurse.
  4. A warm wet washcloth placed against the perianal area may facilitate defecation by relaxing the surrounding muscles and the external sphincter.
  5. Rocking forward and back when attempting to defecate increases both tension against the abdomen and intra-abdominal pressure; these facilitate the passage of stool from the rectum and anus.
31. 1. Asparagus contains a sulfurous compound called mercaptan. Mercaptan, when broken down in the digestive system, releases by-products that cause the urine to smell. In addition, the patient should be taught about other odor-producing foods, such as fish, garlic, green peppers, mustard, radishes, and spicy foods.
2. Alcohol may cause gas, but it does not produce an odor.
  3. Raisins may cause gas, but they do not produce an odor.
  4. Onions contain mercaptan, which when broken down in the digestive system will produce odorous gas.
  5. Eggs contain mercaptan, which when broken down in the digestive system will produce odorous gas.
32. Answer: 10 mL. First determine the amount of mg per dose of medication prescribed.  $200$  (total mg of medication daily)  $\div$   $2$  (number of doses in the day) =  $100$  mg (amount of mg of medication per dose). Next, solve the problem by using the formula for ratio and proportion.
- $$\frac{\text{Desired } 100 \text{ mg}}{\text{Have } 50 \text{ mg}} = \frac{x \text{ mL}}{5 \text{ mL}}$$
- $$50x = 500$$
- $$x = 500 \div 50$$
- $$x = 10 \text{ mL}$$
33. 1. Positioning a patient slightly off the back edge of a regular bedpan is unsafe and uncomfortable. The patient should be positioned so that the buttocks rest on, not slightly off of, the smooth, rounded rim of a regular bedpan.
2. Folding the top linen out of the way when putting the patient on the bedpan is unnecessary. The top linen can be draped over the patient in such a way as to promote placement of the bedpan while maintaining the privacy and dignity of the patient.
  3. Remaining outside the curtains of the patient's bed while the patient is on the bedpan allows the nurse to be in close proximity to the patient. The nurse is available to assist the patient if needed and it provides a sense of security for the patient.
  4. Elevating the head of the bed so that the patient is in the high-Fowler position assumes the familiar, usual position for having a bowel movement. A vertical position utilizes gravity and hip flexion raises intra-abdominal pressure, both of which maximize evacuation of feces.
  5. Raising both side rails provides support on which the patient can rest the upper extremities and maintains patient safety.
34. 1. One cup of white rice contains just 0.6 g (grams) of fiber. Low-fiber foods limit the amount of material (residue) left in the intestines after the digestive process; this lessens the bulk of stool,

which is less irritating to the intestinal mucosa.

2. One cup of cooked split peas contains 16.3 g of fiber and should be avoided on a low-fiber diet.
  3. **One cup of soft tofu contains just 0.5 g of fiber.**
  4. One cup of oatmeal contains 4 g of fiber and should be avoided on a low-fiber diet.
  5. **Refined white flour products (e.g., pasta) contain just 1.6 g or less of fiber per one cup serving.**
- 35. 1. Prolonged standing or sitting increases pressure on the hemorrhoidal veins that can cause them to become dilated, enlarged, and inflamed.**
2. One drink a day with or without food will not precipitate hemorrhoids. However, liver disease associated with prolonged abuse of alcohol can cause hemorrhoids.
  3. **Pregnancy increases intra-abdominal pressure causing elevated systemic and portal venous pressure, which is transmitted to the anorectal veins. The added pressure of multiple births and having twins aggravates the problem. Eventually the distended veins separate from the smooth muscle surrounding them, and prolapse of the hemorrhoidal vessels occurs.**
  4. **Repeated straining on defecation increases intra-abdominal pressure, eventually causing the anorectal veins to distend and become inflamed, resulting in hemorrhoids. Repeated straining causes them to enlarge.**
  5. **Increased intra-abdominal pressure associated with obesity causes elevated systemic and portal venous pressure, which is transmitted to the anorectal veins. Eventually the veins distend and become inflamed, resulting in hemorrhoids.**
- 36. 1.** An inability to perceive bowel cues for defecation results in a lack of response that further weakens the defecation reflex, ultimately causing constipation, not diarrhea.
2. **Cancer of the large intestine can cause constipation, diarrhea, and/or alternating constipation and diarrhea. The mass in the intestinal lumen may partially obstruct the lumen. The leakage of stool around the tumor results in a condition that appears to**
- be diarrhea. The mass in the lumen can totally obstruct the passage of stool, resulting in a condition that appears to be constipation.**
3. **Medications, depending on their physiological action, side effects, and toxic effects, can cause either constipation or diarrhea.**
  4. A high-solute tube feeding has a greater osmotic pressure than surrounding interstitial tissue; it draws fluid into the gastrointestinal tract, which may result in diarrhea, not constipation.
  5. An increased metabolic rate will increase peristalsis and possibly result in diarrhea, not constipation.
- 37. 1. High-fiber foods are encouraged because they prevent constipation. Constipation increases intraluminal intestinal pressure, which promotes intestinal mucosal outpouching. Foods low in fiber are ordered when a patient has an acute inflammation of a diverticulum (diverticulitis) until the inflammation resolves.**
2. Sitting on the toilet for 10 minutes after breakfast every day is an accepted practice. Bowel elimination should follow a familiar routine, and attempting to defecate after breakfast takes advantage of the gastrocolic reflex.
  3. Drinking 8 glasses of water a day is desirable for effective bowel function. An adequate intake of fluid ensures that after water is reabsorbed through the large intestines for essential body processes there is enough water left in the intestine to create a soft, formed stool.
  4. **The Valsalva maneuver increases intraluminal intestinal pressure, which promotes intestinal mucosal outpouching and should be avoided.**
  5. Massaging the lower abdomen when trying to have a bowel movement is an accepted practice. Light stroking of the skin (effleurage) reduces abdominal muscle tension, which may facilitate defecation.
- 38. An X anywhere along the highlighted area is the correct answer. Stool in the ascending colon is the most liquid, but as it travels through the transverse colon, fluid is reabsorbed and stool becomes pasty in consistency. In the descending colon, stool becomes more dry, solid, and formed.**



- 39.** 1. This is an expected response after a colonoscopy. Carbon dioxide is inserted into the intestine (CO<sub>2</sub> insufflation) to distend the lumen, which permits visualization of internal intestinal structures. This gas will be passed through the anus for 24 to 48 hours after the procedure. Ambulation facilitates the passage of this gas.
- 2. Some abdominal cramping may occur from irritability of the intestine. However, it should not be severe or continuous. Severe abdominal cramping may indicate perforation of the intestinal wall.**
- 3. Some abdominal bloating is expected after a colonoscopy. However, it should not be extensive. Abdominal bloating and distention that is excessive or continues beyond 24 hours after the test may indicate perforation of the intestinal wall.**
4. Minimal rectal bleeding is expected after a colonoscopy when polyps are removed. When tissue is excised, the intestinal mucosa is traumatized and the site will leak blood and body fluids. The patient should be informed that an amount equal to several tablespoons of blood may exit the anus the day after the test.
5. Mild fatigue is expected after a colonoscopy. Fatigue results from the sedatives and conscious sedation used as well as the carbon dioxide that was inserted into the intestine during the procedure.
- 40.** 1. The amount of solution used depends on the type of enema ordered. A tap-water enema uses 500 to 1,000 mL of tap water to distend the intestine and promote defecation. An oil-retention enema has 200 to 250 mL of an oil-based solution to soften feces and promote defecation. A return-flow enema begins with approximately 300 to 500 mL of tap water in the enema container. A small volume of the solution (e.g., 150 to 200 mL) is instilled and the enema container is immediately lowered below the anus to withdraw fluid and gas into the collection container. The purpose of a return-flow enema is to reduce abdominal distention caused by intestinal gas.
- 2. The left side-lying position allows the fluid to flow via the principle of gravity as the fluid follows the normal curve of the anus, rectum, and sigmoid colon.**
- 3. Lubrication of the tip of the catheter or probe limits trauma to the mucous membranes of the intestine.**

4. Enemas require that the patient's perianal area be exposed. Pulling the curtain around the patient's bed and draping the patient provide for patient privacy and dignity.
5. Oil-retention enemas and hypertonic enemas are administered in small volumes

(e.g., 4.5 to 7.8 mL) via a soft-sided container. The container is squeezed and rolled slowly from the distal to the proximal end until empty. With tap-water and soapsuds enemas the solution is instilled holding the enema container 8 to 12 inches above the anus.



# Pain, Comfort, Rest, and Sleep

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

Addiction	Episodic
Back rub	Intermittent
Bedtime routines	Intractable
Biofeedback	Malignant
Breakthrough pain	Neuropathic
Circadian rhythm	Phantom
Cold therapy	Radiating
Continuous positive airway pressure (CPAP)	Remittent
Contralateral stimulation	Visceral
Distraction techniques	Patient-controlled analgesia (PCA)
Enuresis	Physical dependence
Epidural analgesia	Placebo
Fatigue	Progressive muscle relaxation
Gate control theory	Psychological dependence
Grimacing	Rest
Guarding behaviors	Self-hypnosis
Guided imagery	Self-splinting
Heat therapy	Sleep:
Intensive care unit psychosis	Non-rapid-eye-movement (NREM) sleep
Intrathecal analgesia	Rapid-eye-movement (REM) sleep
Massage	Sleep disorders:
Meditation	Bruxism
Nocturia	Hypersomnia
Nonopioid	Insomnia
Opioid	Narcolepsy
Pain, characteristics:	Night terrors
Aggravating factors	Parasomnia
Duration	Restless legs
Intensity	Sleep apnea
Onset	Sleep deprivation
Quality	Somnambulism
Relieving factors	Sleepiness
Pain scale	Sleep rituals
Pain threshold	Snoring
Pain tolerance	Sundowning
Pain, types:	Transcutaneous electrical nerve stimulation
Acute	
Chronic	

F.A. DAVIS

COMPANY

## PAIN, COMFORT, REST, AND SLEEP: QUESTIONS

1. A nurse is caring for a patient who is experiencing pain. For which common psychological response to pain should the nurse assess the patient?
  1. Experiencing fear related to loss of independence
  2. Withdrawing from social interactions with others
  3. Asking for pain medication to relieve the pain
  4. Verbalizing the presence of nausea
2. Which is the appropriate patient outcome for an adult who has disturbed sleep because of nocturia?
  1. Report fewer early morning awakenings because of a wet bed.
  2. Demonstrate a reduction in nighttime bathroom visits.
  3. Resume sleeping immediately after voiding.
  4. Use an incontinence device at night.
3. A patient who had a total abdominal hysterectomy two days ago reports abdominal pain at level 5 on a 0-to-10 pain scale. After assessing the pain further, which should the nurse do **first**?
  1. Reposition the patient.
  2. Offer a relaxing back rub.
  3. Use distraction techniques.
  4. Administer the prescribed analgesic.
4. A nurse is caring for a patient who is diagnosed with narcolepsy. Which is the **most** serious consequence of this disorder?
  1. Inability to provide self-care
  2. Impaired thought processes
  3. Potential for injury
  4. Excessive fatigue
5. A patient is experiencing discomfort associated with gastroesophageal reflux. In which position should the nurse teach the patient to sleep?
  1. Right lateral
  2. Semi-Fowler
  3. Prone
  4. Sims
6. A patient is experiencing anxiety. Which aspect of sleep should the nurse expect **primarily** will be affected as a result of the anxiety?
  1. Onset
  2. Depth
  3. Stage II
  4. Duration
7. A patient requests pain medication for severe pain. Which should the nurse do **first** when responding to this patient's request?
  1. Use distraction to minimize the patient's perception of pain.
  2. Place the patient in the most comfortable position possible.
  3. Administer pain medication to the patient quickly.
  4. Assess the various aspects of the patient's pain.
8. A nurse is planning a teaching program for a patient with a diagnosis of obstructive sleep apnea. Which should the nurse plan to discuss with this patient?
  1. Using the ordered device that supports airway patency
  2. Placing two pillows under the head when sleeping
  3. Requesting a sedative to promote sleep
  4. Sleeping in the supine position



9. Which is the **most** important nursing intervention that supports a patient's ability to sleep in the hospital setting?
  1. Providing an extra blanket
  2. Limiting unnecessary noise on the unit
  3. Shutting off lights in the patient's room
  4. Pulling curtains around the patient's bed at night
10. A patient has a history of severe chronic pain. Which is the **most** important intervention associated with providing nursing care to this patient?
  1. Asking what is an acceptable level of pain
  2. Providing interventions that do not precipitate pain
  3. Focusing on pain management intervention before pain is excessive
  4. Determining the level of function that can be performed without pain
11. Which concept should the nurse consider when assessing a patient's pain?
  1. The expression of pain is not always congruent with the pain experienced.
  2. Pain medication can significantly increase a patient's pain tolerance.
  3. The majority of cultures value the concept of suffering in silence.
  4. Most people experience approximately the same pain tolerance.
12. Which **most** common cause of sleep deprivation in the hospital should the nurse consider when planning care?
  1. Fragmented sleep
  2. Early awakening
  3. Restless legs
  4. Sleep apnea
13. A nurse is performing an admitting interview. Which patient statement about pain should cause the **most** concern for the nurse?
  1. "I try to pretend that it is not part of me, but it takes a lot of effort."
  2. "My pain medication works, but I'm afraid of becoming addicted."
  3. "At home I take something for the pain before it gets too bad."
  4. "They say my pain may get worse, and I can't stand it now."
14. A patient has been in the intensive care unit (ICU) for 3 days. For which common adaptation indicating ICU psychosis associated with sleep deprivation should the nurse assess the patient?
  1. Hypoxia
  2. Delirium
  3. Lethargy
  4. Dementia
15. Which concept associated with sleep should the nurse consider to plan nursing care for a hospitalized patient?
  1. People require eight hours of uninterrupted sleep to meet energy needs.
  2. Frequency of nighttime awakenings decreases with age.
  3. Fear can contribute to the need to stay awake.
  4. Bedrest decreases the need for sleep.
16. A nurse is assessing a patient in pain. Which word might the nurse use when documenting the pattern of a patient's pain?
  1. Tenderness
  2. Moderate
  3. Episodic
  4. Phantom
17. A nurse is obtaining a health history from a newly admitted patient. Which patient statement about alcohol intake is based on a common physiological response?
  1. "After I go drinking, I have to urinate during the night."
  2. "When I drink, I get hungry in the middle of the night."
  3. "Falling asleep is hard, but once asleep I sleep great."
  4. "If I drink too much, I oversleep in the morning."

18. A nurse is assessing a patient experiencing acute pain. Which characteristic is more common with acute pain than with chronic pain?
1. Self-focusing
  2. Sleep disturbances
  3. Guarding behaviors
  4. Variations in vital signs
19. At which time does a nurse medicate a patient for pain for it to be considered preemptive analgesia?
1. Before a patient goes to sleep
  2. At equally distant times around the clock
  3. As soon as a patient reports the occurrence of pain
  4. Before doing a dressing change that has been painful in the past
20. A patient is diagnosed with chronic fatigue syndrome. Which is **most** important for the nurse to explore in relation to the patient's status?
1. Ability to provide self-care
  2. Physical mobility
  3. Social isolation
  4. Gas exchange
21. Which is **most** important for nurses to understand when caring for patients in pain?
1. Patients who are in pain will request pain medication.
  2. Patients usually are able to describe the characteristics of their pain.
  3. Patients need to know that the nurse believes what they say about their pain.
  4. Patients will demonstrate vital signs that are congruent with the intensity of their pain.
22. A patient is experiencing lack of sleep because of pain. Which is the **most** appropriate goal for this patient?
1. The patient will be provided with a back massage every evening before bedtime.
  2. The patient will report feeling rested after awakening in the morning.
  3. The patient will request less pain medication during the night.
  4. The patient will experience four hours of uninterrupted sleep.
23. A nurse is helping a patient who is experiencing mild pain to get ready for bed. Which nursing action is **most** effective to help limit pain?
1. Assisting with relaxing imagery
  2. Obtaining a prescription for an opioid
  3. Encouraging the patient to take a warm shower
  4. Recommending that the patient be more active during the day
24. During which time frame do people tend to be the sleepiest?
1. 12 noon and 2 p.m.
  2. 6 a.m. and 8 a.m.
  3. 2 a.m. and 4 a.m.
  4. 6 p.m. and 8 p.m.
25. Which patient statement indicates that the patient is experiencing bruxism?
1. "I walk around in my sleep almost every night, but I don't remember it."
  2. "I annoy the whole family with the loud snoring noises I make at night."
  3. "I occasionally urinate in bed when I am sleeping, and it's embarrassing."
  4. "I am told by my wife that I make a lot of noise grinding my teeth when I sleep."
26. A nurse is caring for patients receiving a variety of interventions for pain management. Which pain relief method has the shortest duration of action?
1. Patient-controlled analgesia
  2. Intramuscular sedatives
  3. Intravenous narcotics
  4. Regional anesthesia

27. A nurse is teaching a community health education class about rest and sleep. Which concept related to sleep should the nurse include?
1. Total time in bed gradually decreases as one ages.
  2. Sleep needs remain consistent throughout the life span.
  3. Alcohol intake interferes with one's ability to fall asleep.
  4. Bedtime routines are associated with an expectation of sleep.
28. A nurse is teaching a patient various techniques to promote sleep. Which internal stimulus that **most** commonly interferes with sleep should the nurse include in the teaching?
1. Ringing in the ears
  2. Bladder fullness
  3. Hunger
  4. Thirst
29. A nurse is giving a back rub. Which stroke is **most** effective in inducing relaxation at the end of the procedure?
1. Percussion
  2. Effleurage
  3. Kneading
  4. Circular
30. A patient states, "The pain moves from my chest down my left arm." Which characteristic of pain is associated with this statement?
1. Pattern
  2. Duration
  3. Location
  4. Constancy
31. A nurse is providing health teaching for a patient with the diagnosis of obstructive sleep apnea. Which aspect of sleep should the nurse explain is **most** often affected?
1. Amount
  2. Quality
  3. Depth
  4. Onset
32. A patient is being admitted to the hospital and the nurse is performing a complete assessment. Which is the **most** therapeutic question the nurse can ask about the quality of the patient's sleep?
1. "How would you describe your sleep?"
  2. "Do you consider your sleep to be restless or restful?"
  3. "Is the number of hours you sleep at night good for you?"
  4. "Does your bed partner complain about your sleep behaviors?"
33. A nurse strains a back muscle when moving a patient up in bed. Which can the nurse do at home that utilizes the gate-control theory of pain relief to minimize the discomfort?
1. Use guided imagery.
  2. Perform progressive muscle relaxation.
  3. Apply a cold compress to the site for 20 minutes.
  4. Take a nonsteroidal anti-inflammatory medication every 6 hours.
34. A patient is having difficulty sleeping and may be experiencing shortened non-rapid-eye-movement (NREM) sleep. Which patient assessments support this conclusion?  
**Select all that apply.**
1.  Decreased pain tolerance
  2.  Inability to concentrate
  3.  Excessive sleepiness
  4.  Irritability
  5.  Confusion

35. A primary health-care provider prescribes oxycodone oral solution 15 mg every 6 hours. The drug is supplied in a 500-mL bottle that indicates 5 mg/5 mL. How much oral solution should the nurse administer? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ mL
36. A 12-year-old boy is experiencing nocturnal enuresis. Which strategies should the nurse explore with the boy and his parents? **Select all that apply.**
1.  Limiting fluid intake after dinner
  2.  Voiding immediately before going to bed
  3.  Eliminating caffeinated beverages from the diet
  4.  Thinking about waking up dry when going to bed at night
  5.  Having the boy change his own bed linens when he wets the bed
37. A nurse is using the FLACC behavioral scale to assess an 8-month-old child's level of pain. The nurse identified that the patient's legs were drawn up to the abdomen and the patient was whimpering. The patient was squirming and shifting back and forth and had a constant frown and the chin was quivering. The infant was reassured when cuddled by the nurse. On a scale of 0 to 10, which is the child's level of pain?
1. 3
  2. 5
  3. 7
  4. 9

FLACC Behavioral Scale

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

Each of the 5 categories—(F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability—is scored from 0-2, which results in a total score between 0 and 10.

38. Which concepts associated with rest and sleep must the nurse consider when planning nursing care? **Select all that apply.**
1.  Energy demands increase with age.
  2.  Metabolic rate increases during rest.
  3.  Sleep requirements increase during stress.
  4.  Catabolic hormones increase during sleep.
  5.  Lack of awareness of the environment increases with sleep.

39. A nurse is caring for a patient who is having difficulty sleeping. Which patient responses indicate to the nurse that the patient is not obtaining adequate rapid-eye-movement (REM) sleep? **Select all that apply.**
1.  Hyperresponsiveness
  2.  Immunosuppression
  3.  Irritability
  4.  Confusion
  5.  Vertigo
40. An older female adult explains to the nurse that she has insomnia. The nurse interviews the patient and her husband and reviews the patient's medication reconciliation form. Which factors does the nurse conclude are associated with the patient's insomnia? **Select all that apply.**
1.  Metformin
  2.  Older adult
  3.  Female gender
  4.  Alcohol intake
  5.  Diphenhydramine
  6.  Catnaps during the day

#### Interview with Patient

Patient reports having difficulty falling asleep, waking frequently during the night, and having difficulty falling back to sleep. Patient states, "I never feel rested in the morning."

#### Interview with Patient's Husband

My wife's problem with sleeping has been going on for several months. She is so tired during the day that she takes several 10 minute catnaps during the day. I encourage her to have a drink of whiskey to knock her out when she goes to bed.

#### Medication Reconciliation Form

Diphenhydramine 50 mg PO at hour of sleep  
Metformin 100 mg PO twice a day

41. Which are **most** important for a nurse to consider when a patient reports the presence of pain? **Select all that apply.**
1.  The extent of pain is directly related to the amount of tissue damage.
  2.  Fatigue increases the intensity of pain experienced by the patient.
  3.  Behavioral adaptations are congruent with statements about pain.
  4.  Giving opioids to a patient in pain will lead to an addiction.
  5.  The person feeling the pain is the authority on the pain.
42. Which statements by a patient indicate a precipitating factor associated with pain? **Select all that apply.**
1.  "I usually feel a little dizzy and think I'm going to vomit when I have pain."
  2.  "My pain usually comes and goes throughout the night."
  3.  "I usually have pain after I get dressed in the morning."
  4.  "My pain feels like a knife cutting right through me."
  5.  "My incision hurts when I cough."
43. A nurse administers a back rub to a patient after first providing for privacy and maintaining standard precautions. Place the following steps in the order in which they should be implemented.
1. Apply warmed lotion to your hands.
  2. Position the patient in the side-lying position.
  3. Assess the skin for color, turgor, and skin breakdown.
  4. Arrange the gown and top linens so that the patient's back is exposed.
  5. Use a variety of strokes to massage the muscles of the back and sacral area.
- Answer: \_\_\_\_\_

44. When assessing patients who have difficulty sleeping, the nurse assesses for which common physiological responses to insomnia? **Select all that apply.**
1.  Vertigo
  2.  Fatigue
  3.  Irritability
  4.  Headache
  5.  Frustration
45. A nurse is assessing a patient experiencing chronic pain. Which characteristics are more common with chronic pain than with acute pain? **Select all that apply.**
1.  Gradual onset
  2.  Long duration
  3.  Anticipated end
  4.  Psychologically depleting
  5.  Responds to conventional interventions



## PAIN, COMFORT, REST, AND SLEEP: ANSWERS AND RATIONALES

- 1. Psychological or affective responses to pain relate to feelings and emotional distress. Fear of being dependent on others and loss of self-control are psychological responses to pain.**
  - Withdrawing from social interactions with others is a behavioral response to pain.
  - Requesting pain medication is a behavioral response to pain.
  - Nausea is a physiological response to pain.
1. Reporting fewer early morning awakenings because of a wet bed relates to enuresis, which is recurrent involuntary urination that occurs during sleep.
  - 2. Demonstrating a reduction in nighttime bathroom visits is an appropriate outcome for nocturia, which is voluntary urination during the night.**
  - Resuming sleeping immediately after voiding relates to insomnia, which is difficulty initiating or maintaining sleep.
  - Using an incontinence device at night is an intervention, not an outcome.
1. Repositioning is effective for mild, not severe, pain.
  2. A back massage is ineffective for acute, severe pain; however, it may relax the patient and increase the effectiveness of analgesic medication.
  3. Guided imagery is more effective for mild pain, not acute, severe pain.
  - 4. Major abdominal surgery involves extensive manipulation of internal organs and a large abdominal incision that require adequate pharmacological intervention to provide relief from pain.**
1. Although the overwhelming daytime sleepiness associated with narcolepsy may interfere with the ability to perform some self-care activities, this is not the major problem related to narcolepsy.
  2. Narcolepsy does not involve disturbed thought processes, which is the state in which an individual experiences a disruption in mental activities, such as conscious thought, reality orientation, problem solving, and judgment.
  - 3. Narcolepsy is excessive sleepiness in the daytime that can cause a person to fall asleep uncontrollably at inappropriate times (sleep attack) and result in physical harm to self or others.**
4. Although a person with narcolepsy may verbalize a lack of energy, this is not the primary concern associated with narcolepsy.
  1. The right-lateral position is a horizontal position that increases the pressure of the abdominal organs against the stomach and increases gastric reflux.
    - 2. Gastric secretions increase during rapid-eye-movement (REM) sleep. The semi-Fowler position limits gastroesophageal reflux because gravity allows the abdominal organs to drop, which reduces pressure on the stomach and results in less stomach contents flowing upward into the esophagus.**
    3. The prone position is a horizontal position that increases the pressure of the abdominal organs against the stomach and increases gastric reflux. The abdomen rests on the mattress and the body exerts direct pressure on the stomach.
    4. The Sims position is a horizontal position halfway between lateral and prone. Direct pressure exerted on the stomach, particularly in the left Sims position, promotes gastric reflux.
- 1. Anxiety increases norepinephrine blood levels through stimulation of the sympathetic nervous system, which results in prolonged sleep onset.**
  2. Patients with anxiety still reach the depth of stage IV non-rapid-eye-movement (NREM) sleep.
  3. Stage IV, not stage II, of NREM sleep is affected.
  4. The duration of sleep is affected indirectly, not directly, because of the prolonged onset of sleep.
1. Distraction is not effective for severe pain.
  2. There is not enough information to indicate that this intervention may be effective. In addition, the position the patient considers most comfortable may be contraindicated based on the provider's orders or safety issues.
  3. Administering pain medication to the patient quickly is a hasty, impulsive response that may or may not be necessary.

- 4. All the factors that affect the pain experience should be assessed, including location, intensity, quality, duration, pattern, aggravating and alleviating factors, and physical, behavioral, and attitudinal responses. Assessment must precede intervention.**
- 8.** 1. Encouraging sleeping in the supine position increases the episodes of sleep apnea because the structures of the mouth and oropharynx (i.e., tonsils, adenoids, mucous membranes, uvula, soft palate, and tongue) drop by gravity and ultimately obstruct the airway.
2. Sedatives do not limit episodes of sleep apnea.
3. Positioning two pillows under the head flexes the neck, which narrows the upper airway and thus contributes to episodes of sleep apnea. Pillows under the upper shoulders and head or small blocks under the head of the bed may assist in keeping the upper airway open.
- 4. A continuous positive airway pressure (CPAP) device worn when sleeping keeps the upper airway patent by maintaining an open pathway that facilitates gas exchange.**
- 9.** 1. Although meeting the basic physiological need to feel warm is appropriate, a hospital's environment generally is warm, so a top sheet and spread are adequate.
- 2. Noise is a serious deterrent to sleep in a hospital. The nurse should limit environmental noise (e.g., distributing fluids, providing treatments, rolling drug and linen carts) and staff communication noise.**
3. Shutting off lights in the patient's room is unsafe. Dim the lights or put a night-light on to provide enough illumination for safe ambulation to the bathroom.
4. Although pulling curtains around the bed at night provides privacy, it does not limit the environmental factors that usually interfere with sleeping in a hospital.
- 10.** 1. Although the nurse will ask this question to determine the patient's level of pain tolerance, it is not the priority.
2. Although the nurse will attempt to provide interventions that do not precipitate pain, there may be significant interventions that must be performed that may precipitate pain.
- 3. Administration of analgesics around the clock (ATC administration) at regularly scheduled intervals or by long-acting controlled-release transdermal patches maintains therapeutic blood levels of analgesics, which limit pain at levels of comfort acceptable to patients.**
4. Although the nurse and patient will determine the level of function that can be performed without pain, there may be unavoidable activities that may precipitate pain.
- 11.** 1. **An obvious response to pain is not always apparent because psychosociocultural factors may dictate behavior. Fear of the treatment for pain, lack of validation, acceptance of pain as punishment for previous behavior, and the need to be strong, courageous, or uncomplaining are factors that influence behavioral responses to pain.**
2. The opposite may be true. As a person experiences relief from pain, the person may be unwilling to endure previously acceptable levels of pain.
3. This is not a true statement. Although a generalization, many members of Jewish, Italian, Greek, and Chinese ethnic groups, for example, are able to express pain.
4. Pain tolerance varies widely among people and is influenced by experiential, psychological, and sociocultural factors.
- 12.** 1. **Sleep deprivation occurs with frequent interruptions of sleep because the sleeper returns to stage I rather than to the stage that was interrupted. There is a greater loss of stage III and IV non-rapid-eye-movement (NREM) sleep, which is essential for restorative sleep.**
2. Although early awakenings often do occur in hospital settings, it is not the most common cause of sleep deprivation in the hospital.
3. Restless legs syndrome, an intrinsic sleep disorder, is not the most common cause of sleep deprivation in the hospital.
4. Only 1% to 4% of the population has sleep apnea.
- 13.** 1. This is not the statement of greatest concern. Nonpharmacological measures to relieve pain, such as imagery and self-hypnosis, use the mind-body (psyche-soma) connection to reduce pain.



- The nurse should encourage the use of these measures and validate the energy expended.
2. The concern of addiction is not the priority among these statements. The nurse can respond to this common concern through education and judicious medication administration.
  3. This is desirable because it keeps pain under control before it becomes excessive.
  4. **The level of pain tolerance is exceeded. The present pain must be relieved and the patient assured that future pain also will be controlled.**
14. 1. Hypoxia is associated with obstructive sleep apnea because episodes of upper airway obstruction occur 50 to 600 times a night.
2. **Melatonin regulates the circadian phases of sleep. Environmental triggers called synchronizers adjust the sleep-wake cycle to a 24-hour solar day. Intensive care units have bright lights and increased sensory input that cause disorientation to day and night and interrupt sleep. Interrupted sleep results in lability of mood, irritability, excitability, suspiciousness, confusion, and delirium.**
3. Lethargy and fatigue are early signs of sleep deprivation, not ICU psychosis.
  4. Sleep deprivation may cause impaired memory, confusion, illusions, and visual or auditory hallucinations, not dementia.
15. 1. Although uninterrupted sleep is advantageous for restorative sleep, the number of hours required depends on the individual.
2. In older adults, the length of stage IV sleep is markedly decreased; they awaken more frequently, and it takes them longer to go back to sleep.
  3. **Fear of loss of control, the unknown, and potential death results in the struggle to stay awake, which interferes with the ability to relax sufficiently to fall asleep.**
  4. Bedrest does not decrease the need for sleep. The body still needs stage IV restorative sleep. Often the physiological problems requiring the bedrest increase the need for sleep.
16. 1. Tenderness is a sensory word that describes pain and is related to the quality of pain.
2. The description of pain as being moderate is related to intensity of pain.
  3. **The word *episode* refers to an incident, occurrence, or time period; therefore, the word *episode* refers to a pattern of pain and is concerned with time of onset, duration, recurrence, and remissions.**
  4. Phantom pain is related to location of pain. Phantom pain is a painful sensation perceived in a body part that is missing.
17. 1. **Alcoholic beverages are fluids that have a mild diuretic effect. Frequent nighttime awakening to empty a full bladder is called nocturia.**
2. Drinking may cause nausea and vomiting rather than hunger.
  3. Alcohol hastens, not delays, the onset of sleep.
  4. Alcohol disrupts sleep and causes early morning awakening.
18. 1. Self-focusing is associated with chronic, not acute, pain because of chronic pain's unrelenting, prolonged nature it interferes with pursuing a normal life. As a result, there may be changes in family dynamics, sexual functioning, financial status, and self-esteem that result in introspection and depression.
2. Pain is an internal stimulus that can interrupt sleep. Because chronic pain is unrelenting and prolonged, over time, interrupted sleep results in sleep deprivation.
  3. Guarding behaviors occur in both acute and chronic pain. However, because of the unrelenting and prolonged nature of chronic pain, behavioral responses, such as guarding, stooped posture, and altered gait, may become permanent adaptations.
  4. **Acute pain stimulates the sympathetic nervous system, which responds by increasing pulse, respirations, and blood pressure. Chronic pain stimulates the parasympathetic nervous system, which results in lowered pulse and blood pressure.**
19. 1. Hour of sleep (h.s., *hora somni*) medications usually are sedatives that promote rest and sleep; they are not analgesics.
2. Medications administered around the clock (ATC) at regularly scheduled intervals usually maintain therapeutic drug levels regardless of other factors influencing the patient.

3. Medication administered when necessary at the patient's request will have a primary health-care prescription that states prn (*pro re nata*).
  4. **The word *preemptive* means preventive, anticipatory, and defensive. Therefore, preemptive analgesia is administered before an activity or intervention that may precipitate pain in an attempt to limit the anticipated pain.**
20. 1. **Chronic fatigue syndrome is a condition characterized by the onset of disabling fatigue. The fatigue is so overwhelming and consuming that it interferes with the activities of daily living.**
2. Chronic fatigue syndrome does not impair mobility. Impaired physical mobility is the state in which an individual experiences limitation of physical movement but is not immobile.
  3. The fatigue of chronic fatigue syndrome may be unrelated to social isolation, which is a state in which an individual experiences or perceives a desire for increased involvement with others but is unable to make that contact.
  4. Although fatigue is related to impaired gas exchange, the fatigue caused by hypoxia is unrelated to chronic fatigue syndrome, which is a very different condition.
21. 1. Psychosociocultural factors influence patients' lack of request for medication when experiencing pain. Patients may not request medication because they fear the possibility of addiction, consider the pain as punishment for previous behavior, or need to be strong, courageous, or uncomplaining.
2. Patients, particularly children and those who are cognitively impaired, often have problems describing the characteristics of pain because of difficulty interpreting painful stimuli or having never experienced the sensation before.
  3. **Pain is a personal experience, and the nurse must validate its presence and severity as perceived by the patient. This conveys acceptance and respect and promotes the development of trust.**
  4. Acute pain increases vital signs because of sympathetic nervous system stimulation, but chronic pain will not.
22. 1. This is a planned nursing intervention, not a goal.
2. **Sleep is a sensory experience that restores cerebral and physical functioning. Evaluations related to sleep are based on patient reports because effectiveness of sleep is a subjective assessment.**
  3. This is a goal that relates to relieving pain; it is not related to lack of sleep, which is the main issue in the question.
  4. Four hours of sleep is not enough for most adults. Most adults require 6 to 8 hours of sleep.
23. 1. **Imagery, the internal experience of memories, dreams, fantasies, or visions, uses positive images to distract, which reduces stress, limits mild pain, and promotes relaxation and sleep.**
2. The use of opioids should be a last resort. Nursing interventions or nonopioid medications usually are effective in limiting mild pain.
  3. Bathing preferences are highly individual, and the patient may not prefer a shower. In addition, a shower is stimulating and may be counterproductive.
  4. Although daytime activity does promote sleep at night, patients with pain may be reluctant to be active.
24. 1. At this time of day, most people are engaged in stimulating activities and generally are not sleepy.
2. By this time of the sleep cycle, most people have had sufficient sleep and are beginning to awaken.
  3. **Research demonstrates that most people experience sleep-vulnerable periods between 2 a.m. and 6 a.m. and between 2 p.m. and 5 p.m.**
  4. At this time of day, most people are engaged in stimulating activities, such as preparing and eating dinner.
25. 1. Somnambulism, sleepwalking, is a parasomnia that occurs during stages III and IV of non-rapid-eye-movement (NREM) sleep.
2. Snoring relates to obstructive sleep apnea, which is a periodic cessation of airflow during inspiration that results in arousal from sleep.
  3. Nocturnal enuresis, bedwetting, is a parasomnia that occurs when moving from stages III to IV of NREM sleep.
  4. **Bruxism, clenching and grinding of the teeth, is a parasomnia that occurs during stage II NREM sleep. Usually,**

**it does not interfere with sleep for the affected individual but rather the sleeper's partner.**

- 26.** 1. Patient-controlled analgesia delivers an intermittent dose of an opioid on demand within safe limitations. Pain relief can be maintained for hours to days.  
 2. Intramuscular injections of analgesics usually are effective for 3 to 6 hours.  
**3. Intravenous analgesics act within 1 to 2 minutes but drug inactivation (biotransformation) also is fast, so there is a short duration of action.**  
 4. With regional anesthesia (e.g., nerve block, Bier block, spinal, epidural), an anesthetic agent is instilled around nerves to block the transmission of nerve impulses, thus reducing pain for many hours.
- 27.** 1. The healthy older adult spends more time in bed, spends less time asleep, awakens more often, stays awake longer, and naps more often. Rapid-eye-movement (REM) sleep and stage IV non-rapid-eye-movement (NREM) sleep are reduced, resulting in less restorative sleep. Naps lead to desynchronization of the sleep-wake cycle.  
 2. The need for sleep varies and depends on factors such as age, activity level, and health.  
 3. Alcohol hastens the onset of sleep. Alcohol is associated with early awakening.  
**4. An expectation of an outcome of behavior usually becomes a self-fulfilling prophecy. Bedtime rituals include activities that promote comfort and relaxation (e.g., music, reading, and praying) and hygienic practices that meet basic physiological needs (e.g., bathing, brushing the teeth, and toileting).**
- 28.** 1. Although tinnitus can interfere with sleep, it is not the most common problem.  
**2. Bladder fullness causes pressure in the pelvic area that interrupts sleep. Awakening to void during the night is a common occurrence, particularly in older adult men.**  
 3. Although hunger can interfere with sleep, it is not the most common problem. A light evening snack or glass of milk prevents hunger.  
 4. Although thirst can interfere with sleep, it is not the most common problem. Thirst is prevented by drinking water as part of the bedtime routine.
- 29.** 1. Percussion involves gentle tapping of the skin. Percussion is stimulating and usually is performed during the middle of a back massage.  
**2. Effleurage involves long, smooth strokes sliding over the skin. When performed slowly with light pressure at the end of a back rub it has a relaxing, sedative effect.**  
 3. Kneading (pétrissage) involves squeezing the skin, subcutaneous tissue, and muscle with a lifting motion. Kneading is stimulating and usually is performed during the middle of a back rub.  
 4. Circular strokes usually are performed in the area around the buttocks, lower back, and scapulae. They are stimulating and are performed during the beginning of a back rub.
- 30.** 1. The pattern of pain refers to time of onset, duration, recurrence, and remissions.  
 2. Duration refers to how long the pain lasts, which is an aspect of the pattern of pain.  
**3. This is referred pain, which is pain felt in a part of the body that is at a distance from the tissues causing the pain. Referred pain is related to location of pain.**  
 4. Constancy refers to whether the pain is continuous or if there are periods of relief from pain, both of which relate to the pattern of pain.
- 31.** 1. The amount of time spent sleeping usually is not affected.  
**2. Sleep apnea is the periodic cessation of breathing during sleep. Episodes occur during rapid-eye-movement (REM) sleep (interfering with dreaming) and non-rapid-eye-movement (NREM) sleep (interfering with restorative sleep), both of which reduce the quality of sleep.**  
 3. Patients still reach the depth of stage IV NREM sleep.  
 4. Sleep apnea does not influence the onset of sleep.
- 32.** 1. **This open-ended question requires patients to explore the topic of sleep as it relates specifically to their own experiences.**  
 2. This direct question gathers information about only one aspect of sleep.

3. This direct question precipitates just a yes or no response.
4. This direct question precipitates just a yes or no response about only one aspect of sleep.
- 33.** 1. The gate-control theory of pain relief is not activated through guided imagery. Guided imagery uses positive thoughts and emotions to promote relaxation and limit discomfort.
2. The gate-control theory of pain relief is not activated through progressive muscle relaxation. The performance of progressive muscle relaxation requires the mind to focus on an issue other than the pain. It interferes with the perception and interpretation of pain because the mind can process only a certain amount of information at a time.
- 3. Thermal therapy (e.g., application of heat or cold) stimulates the large A-delta fibers that close the gate that allows the transmission of pain impulses to the central nervous system.**
4. Nonsteroidal anti-inflammatory medication, such as ibuprofen, inhibits prostaglandin synthesis. Nonsteroidal anti-inflammatory medications do not activate the gate-control theory of pain relief.
- 34.** 1. **An increased sensitivity to pain is associated with disturbed non-rapid-eye-movement (NREM) sleep. During NREM sleep the body is engaged in restoring physiological properties of the body.**
2. An inability to concentrate is associated with disturbed rapid-eye-movement (REM) sleep. REM sleep is involved with cognitive and emotional restoration processes.
- 3. During NREM sleep the parasympathetic nervous system dominates and the vital signs and metabolic rate are low; also, growth hormone is consistently secreted, which provides for anabolism. Shortened NREM sleep decreases these restorative processes, resulting in fatigue, lethargy, and excessive sleepiness.**
4. Irritability and excitability are associated with disturbed REM, not NREM, sleep.
5. REM, not NREM, sleep is essential for maintaining mental and emotional equilibrium and, when interrupted, results in confusion, irritability, excitability, suspiciousness, delusions, and hallucinations.
- 35. Answer: 15 mL. Solve the problem by using the formula for ratio and proportion.**
- $$\frac{\text{Desired } 15 \text{ mg}}{\text{Have } 5 \text{ mg}} = \frac{x \text{ mL}}{5 \text{ mL}}$$
- $$5x = 75$$
- $$x = 75 \div 5$$
- $$x = 15 \text{ mL}$$
- 36.** 1. **Limiting fluid intake after dinner reduces the amount of urine production while asleep.**
2. **Voiding empties the bladder and makes room for urine produced during the night.**
3. **Caffeine irritates the mucous membranes of the urinary system and stimulates the need to void.**
4. **Positive imagery supports self-esteem and may become a self-fulfilling prophesy.**
5. This intervention may be perceived by the boy as parental disapproval or punishment. Linens and clothing should be changed with a nonjudgmental, nonchalant demeanor to support the boy's self-esteem.
- 37.** 1. A score of 3 is too low for the behaviors exhibited by the infant.
2. A score of 5 is too low for the behaviors exhibited by the infant.
- 3. According to the FLACC behavioral scale to assess pain, the child's level of pain is 7. A constant frown with a quivering chin receives a score of 2. Legs drawn up to the abdomen receives a score of 2. Squirming and shifting back and forth receives a score of 1. Moaning and whimpering receives a score 1. Reassured by hugging receives a score of 1.**
4. A score of 9 is too high for the behaviors exhibited by the infant.
- 38.** 1. Energy requirements decrease with age as metabolic processes slow and older adults become more sedentary.
2. The metabolic rate decreases by 5% to 25% during rest.
- 3. Stress precipitates the sympathetic nervous system, increasing cortisone, norepinephrine, and epinephrine, which increase the metabolic rate.**

**Physical and psychic energy expended is restored through rest and sleep.**

4. Catabolic hormones (cortisol and epinephrine) increase with activity, not during sleep. Catabolism is the breaking down of muscle and lean body mass to produce glucose to meet energy needs (gluconeogenesis).
  5. **Individuals experience varied levels of consciousness when asleep. There is a progressive lack of awareness of the environment as one passes from stages 1 through 4.**
- 39.
1. Hyporesponsiveness, withdrawal, apathy, flat facial expression, and excessive sleepiness are physiological responses associated with a lack of non-rapid-eye-movement (NREM) sleep.
  2. A depressed immune system is a physiological response to a lack of NREM sleep.
  3. **Rapid-eye-movement (REM) sleep is essential for maintaining mental and emotional equilibrium and, when interrupted, results in irritability and excitability.**
  4. **REM sleep is essential for maintaining mental and emotional equilibrium and, when interrupted, results in confusion and suspiciousness.**
  5. Shortened NREM sleep can result in vertigo, which is a physiological response to sleep deprivation.
- 40.
1. Metformin is an antidiabetic medication that decreases hepatic glucose production, decreases intestinal absorption of glucose, and increases sensitivity of cells to insulin. Side effects are abdominal bloating, diarrhea, nausea, and vomiting, not insomnia.
  2. **Sleep patterns tend to change as one ages. Older people become sleepy earlier and wake up earlier (alteration in circadian rhythms), wake up more frequently (lower levels of growth hormone and melatonin), and experience less deep sleep (more rapid sleep cycles).**
  3. **Hormonal shifts in women occur throughout life: monthly related to ovulation, during pregnancy, and during and after menopause. Hormonal changes can precipitate nausea, anxiety, weight gain, generalized discomfort, restless legs syndrome, acid reflux, and frequent urination. All of these physiological responses can precipitate insomnia.**
4. **Alcohol is a sedative that can help one fall asleep but it prevents deeper stages of sleep and causes one to awaken frequently during the night and earlier in the morning.**
5. The medication diphenhydramine antagonizes the effects of histamine at H<sub>1</sub> receptor sites. It causes drowsiness and often is taken before retiring at night to treat insomnia.
  6. Catnaps, if they do not exceed 10 to 30 minutes, can be rejuvenating. Longer catnaps can interfere with sleep at night, thus aggravating insomnia.
- 41.
1. This statement may or may not be true.
  2. **Fatigue decreases a person's coping abilities which increases the intensity of pain.**
  3. This statement may or may not be true. There may be behavioral signs of pain, such as guarding, grimaces, and clenching the teeth, at the same time that there are no verbal statements indicating the presence of pain. In some cultures it is unacceptable to complain about pain or tolerance of pain signifies strength and courage.
  4. This is not a true statement. The judicious use of opioids does not necessarily result in addiction.
  5. **Pain is a personal experience. Margo McCaffery, a pain researcher, has indicated that pain is whatever the person in pain says it is and exists whenever the person in pain says it exists.**
- 42.
1. These are physiological responses, not precipitating factors, associated with the pain experience.
  2. This statement reflects the pattern (e.g., onset, duration, and intervals) of the pain experience.
  3. **Anything that induces or aggravates pain is considered a precipitating factor of pain. For example, precipitating factors may be physical (e.g., exertion associated with activities of daily living, Valsalva maneuver), environmental (e.g., extremes in temperature, noise), or emotional (anxiety, fear).**
  4. This statement reflects the quality of the pain. Descriptive adjectives, such as

- knife-like, burning, or cramping explain how the pain feels.
5. **Anything that induces or aggravates pain is considered a precipitating factor of pain. Coughing raises intra-abdominal pressure, which can aggravate the pain of a surgical incision. Patients are taught to support the operative site with the hands or a pillow when coughing to limit the extent of pain.**
43. 2. The first step is to position the patient in the side-lying position because this provides for a comfortable, supported position during the procedure.
4. The second step is to arrange the gown and linens so that the patient's back is exposed because this provides access to the patient's back.
3. The third step is to assess the skin to ensure that there are no indications of a problem that is a contraindication for having a back rub.
1. The fourth step is to warm the lotion in your hands because warm lotion is more comfortable and supports muscle relaxation.
5. A variety of strokes (e.g., effleurage, pétrissage, tamponage, small circular movements, and feathering) relieves muscle tension, promotes physical and emotional relaxation, and increases circulation to the area.
44. 1. **Shortened non-rapid-eye-movement (NREM) sleep can result in vertigo, which is a physiological response to sleep deprivation.**
2. **Interrupted NREM sleep can result in fatigue, which is a physiological response to sleep deprivation.**
3. Irritability is a psychological response to sleep deprivation. As the difficulty of initiating or maintaining sleep continues, the person becomes progressively more upset about the lack of the amount and quality of sleep, further precipitating insomnia.
4. **Shortened NREM sleep can result in headache, which is a physiological response to sleep deprivation.**
5. Frustration is a psychological response to sleep deprivation.
45. 1. **Chronic pain has a gradual progressive onset because it usually is related to a long-term problem (e.g., diabetic neuropathy). Acute pain has a rapid onset because it usually is related to abrupt trauma to the body (e.g., surgical incision, damage from an automobile collision).**
2. **Chronic pain is categorized as pain longer than 6 months' duration. Acute pain is categorized as pain shorter than 6 months' duration.**
3. An anticipated end is associated with acute pain. Chronic pain is associated with conditions that usually are lifelong with no anticipated end in sight.
4. **Chronic pain is psychologically depleting because it drains both physical and emotional resources; this is related to the unrelenting nature of the pain and that it usually continues for life.**
5. Chronic pain usually does not respond to conventional interventions such as back rub, imagery, distraction, and analgesics. Complementary and alternative modalities such as acupuncture, biofeedback, hypnosis, yoga, and therapeutic touch may provide some relief.

# Perioperative Nursing

## KEYWORDS

The following words include nursing/medical terminology, concepts, principles, and information relevant to content specifically addressed in the chapter or associated with topics presented in it. English dictionaries, nursing textbooks, and medical dictionaries, such as *Taber's Cyclopedic Medical Dictionary*, are resources that can be used to expand your knowledge and understanding of these words and related information.

- Abdominal binder
- Anesthesia, types:
  - Epidural
  - Conscious sedation
  - General
  - Local
  - Nerve block
  - Regional
  - Spinal
- Antiembolism stockings:
  - Elastic
  - Sequential compression devices
- Bowel preparation
- Collagen production
- Deep breathing and coughing
- Drains, types:
  - Penrose
  - Portable wound drainage systems:
    - Hemovac
    - Jackson-Pratt
- Dressings, types:
  - Alginates (exudate absorbers)
  - Dry sterile dressing
  - Hydrocolloids
  - Impregnated
  - Transparent
  - Wet-to-damp/moist
- Granulation
- Hypostatic pneumonia
- Informed consent
- Laparoscopic
- Latex allergy
- Leg exercises
- Medication reconciliation
- Nasogastric decompression
- Negative pressure
- NPO status
- Pain management
- Patient-controlled analgesia (PCA)
- Perioperative:
  - Preoperative
  - Intraoperative
  - Postoperative
- Postanesthesia care unit (PACU)
- Postoperative complications:
  - Aspiration
  - Deep vein thrombosis
  - Dehiscence
  - Evisceration
  - Malignant hyperthermia
  - Pneumonia
  - Postoperative ileus
  - Pulmonary embolus, emboli
  - Wound infection
- Preoperative checklist
- Residual limb
- Skin preparation
- Surgery, purposes of:
  - Ablative
  - Constructive
  - Diagnostic
  - Palliative
  - Reconstructive
  - Transplant
- Surgery types:
  - Ambulatory surgery
  - Elective surgery
  - Urgent surgery
  - Emergency surgery
  - Minor surgery
  - Major surgery
- Surgical asepsis
- Verification process:
  - Patient identification
- Wound drainage:
  - Purulent
  - Sanguineous
  - Serosanguineous
  - Serous

F.A. DAVIS

COMPANY

## PERIOPERATIVE NURSING: QUESTIONS

1. There are discharge criteria for patients in the postanesthesia care unit (PACU) regardless of the type of anesthesia used and additional criteria for specific types of anesthesia. Which is the criterion specific for the patient who has received spinal anesthesia?
  1. Oxygen saturation reaches the presurgical baseline.
  2. Motor and sensory function returns.
  3. Nausea and vomiting are minimal.
  4. Headache is reported as tolerable.
2. A patient is admitted to the postanesthesia care unit. Which nursing action is **most** important during the patient's stay in this unit?
  1. Monitoring urinary output
  2. Assessing level of consciousness
  3. Ensuring patency of drainage tubes
  4. Suctioning mucus from respiratory passages
3. A postoperative patient is transferred back to the surgical unit with an abdominal dressing and a Penrose drain. Which is the **most** important nursing action associated with caring for a patient with a Penrose drain?
  1. Removing the excess external portion until drainage stops
  2. Changing the soiled dressing carefully
  3. Maintaining the negative pressure
  4. Pinning the drain to the dressing
4. A patient has abdominal surgery. Which should the nurse do to **best** assess for a sign of postoperative ileus in this patient after surgery?
  1. Identify the time of the first bowel movement.
  2. Monitor the tolerance of a clear liquid diet.
  3. Palpate for abdominal distention.
  4. Auscultate for bowel sounds.
5. Four days after abdominal surgery, while being transferred from a bed to a chair, a patient says to a nurse, "My incision feels funny all of a sudden." Which should the nurse do **first**?
  1. Take the vital signs.
  2. Apply an abdominal binder immediately.
  3. Place the patient in the low-Fowler position.
  4. Encourage slow deep breathing by the patient.
6. Which factor places a patient at the **greatest** risk for postoperative nausea and vomiting after receiving general anesthesia?
  1. Obesity
  2. Inactivity
  3. Hypervolemia
  4. Unconsciousness
7. On the second postoperative day after an above-the-knee amputation, the patient's elastic dressing accidentally comes off. Which should the nurse do **first**?
  1. Wrap the residual limb with an elastic compression bandage.
  2. Apply a saline dressing to the residual limb.
  3. Notify the primary health-care provider.
  4. Place two pillows under the limb.



8. A nurse is caring for a postoperative patient. Which action is effective in preventing postoperative urinary tract infections?
  1. Eating foods with roughage
  2. Taking sitz baths twice a day
  3. Drinking an adequate amount of fluid
  4. Increasing the intake of citrus fruit juices
9. A patient received conscious sedation during a colonoscopy. Which should the nurse expect regarding the patient's experience with this procedure?
  1. Patient will be unresponsive and pain free.
  2. Patient will be at risk for malignant hyperthermia.
  3. Patient will be sleepy but able to follow verbal commands.
  4. Patient will be positioned in the supine position to prevent headache.
10. Which patient having emergency surgery should the nurse anticipate to be at the **greatest** risk for postoperative mortality?
  1. Individual who has alcoholism
  2. Person who has epilepsy
  3. Middle-aged adult
  4. Infant
11. A nurse is caring for a patient who had an abdominal hysterectomy. Which intervention **best** prevents postoperative thrombophlebitis?
  1. Utilization of compression stockings at night
  2. Deep breathing and coughing exercises daily
  3. Leg exercises 10 times per hour when awake
  4. Elevation of the legs on 2 pillows
12. A patient has abdominal surgery for removal of the gallbladder. Which should the nurse be **most** concerned about if exhibited by the patient?
  1. Constipation
  2. Urinary retention
  3. Shallow breathing
  4. Inability to provide self-care
13. A patient arrives in the postanesthesia care unit. Which is the **most** important information that the nurse needs to know?
  1. Anxiety level before surgery
  2. Type and extent of the surgery
  3. Type of intravenous fluids administered
  4. Special requests that were verbalized by the patient
14. A nurse compares the advantages and disadvantages of a central venous catheter inserted into a peripheral vein and a central venous catheter inserted into a subclavian vein. Which of the following reasons does the nurse conclude is the reason why a peripheral catheter is more desirable?
  1. Because it will not be in the superior vena cava
  2. Because it will not cause a tension pneumothorax
  3. Because it will not prevent the development of an infection
  4. Because it will not allow large volumes of fluid to be administered
15. How many days after surgery should the nurse anticipate that a postoperative patient will begin to exhibit signs and symptoms of a wound infection if it should occur?
  1. Fifth day
  2. Third day
  3. Ninth day
  4. Seventh day

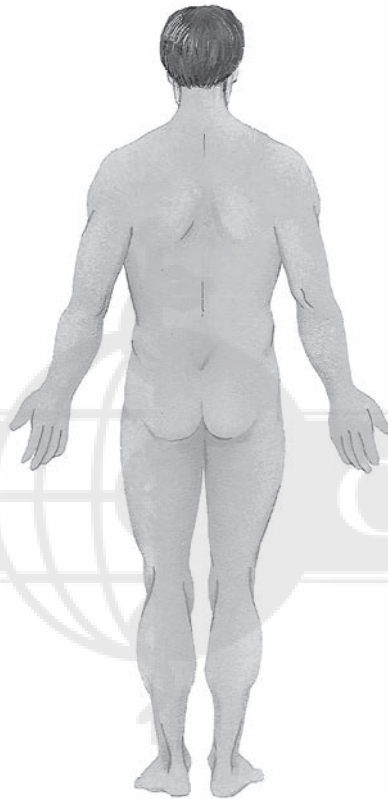
16. A nurse is assessing a patient who had spinal anesthesia. For which common response should the nurse assess the patient?
1. Headache
  2. Neuropathy
  3. Lower back discomfort
  4. Increased blood pressure
17. A hospitalized patient who has been receiving medications via a variety of routes for several days is scheduled for surgery at 10 a.m. Which should the nurse plan to do on the day of surgery?
1. Use an alternative route for the oral medications.
  2. Withhold all the previously prescribed medications.
  3. Withhold the oral medications and administer the other drugs.
  4. Obtain directions from the primary health-care provider regarding the medications.
18. Which is the **most** common dietary order the nurse can anticipate after a patient who had abdominal surgery exhibits a return of intestinal peristalsis?
1. Clear liquids
  2. Full liquids
  3. Low fiber
  4. Regular
19. Which patient responses **best** support the decision to discharge the patient from the postanesthesia care unit?
1. Sao<sub>2</sub> of 95%, vital signs stable for 30 minutes, active gag reflex
  2. Tolerable pain, ability to move extremities, dry intact dressing
  3. Urinary output of 30 mL/hr, awake, turning from side to side
  4. Afebrile, adventitious breath sounds, ability to cough
20. A postoperative patient experiences tachycardia, sudden chest pain, and low blood pressure. Which complication associated with the postoperative period should the nurse conclude that the patient **most** likely experienced?
1. Pulmonary embolus
  2. Hemorrhage
  3. Heart attack
  4. Pneumonia
21. A nurse is assessing a postoperative patient. Which patient response identified by the nurse indicates altered renal perfusion?
1. Oliguria
  2. Cachexia
  3. Yellow sclera
  4. Suprapubic distention
22. A nurse is evaluating the effectiveness of nursing interventions for meeting the nutrient needs of patients during the first 2 days after abdominal surgery. Which outcome is **most** important?
1. Nausea and vomiting have not occurred.
  2. Fluid and electrolytes are balanced.
  3. Wound healing is progressing.
  4. Oral intake is reestablished.
23. Which is the next **most** important assessment made by the nurse after ensuring a postoperative patient has a patent airway?
1. Condition of drains
  2. Level of consciousness
  3. Stability of the vital signs
  4. Location of the surgical dressing

24. In which position should the nurse in the operating room place the patient who is to undergo perineal surgery?
1. Sims
  2. Supine
  3. Lithotomy
  4. Trendelenburg
25. A nurse is caring for two patients. One of the patients has a Jackson-Pratt drain and the other patient has a Hemovac drain. Which does the nurse understand is the difference between these two drains?
1. The size of the collection container
  2. How the pressure within the collection container is reestablished
  3. The type of pressure that promotes drainage to the collection container
  4. Where the collection container should be placed in relation to the insertion site
26. A nurse is caring for several patients who received general anesthesia. Which concurrent health problem poses the **greatest** risk for the development of a postoperative complication?
1. Gastroesophageal reflux disease
  2. Reduced reflexes
  3. Hypothyroidism
  4. Emphysema
27. A nurse is caring for a patient who had abdominal surgery. Which type of incisional drainage should the nurse expect 4 hours after surgery?
1. Serous wound drainage
  2. Purulent wound drainage
  3. Sanguineous wound drainage
  4. Serosanguineous wound drainage
28. A patient spikes a fever during the first postoperative day after major abdominal surgery. The nurse suspects that the fever indicates an infection. Which site does the nurse conclude **most** likely is the source of the infection?
1. Intestines
  2. Bladder
  3. Wound
  4. Lungs
29. A nurse is to apply a transparent wound barrier over a patient's incision. Which nursing action is appropriate?
1. Stretch the transparent dressing snugly over the entire wound.
  2. Clean the skin with normal saline before applying the dressing.
  3. Cover the transparent wound barrier with a gauze dressing and secure with paper tape.
  4. Ensure the reinforcing tape extends several inches beyond the edges of the transparent wound barrier.
30. A nurse in the operating room is to position a patient for surgery. Which factor is **most** important for the nurse to consider?
1. Allow for skeletal deformities.
  2. Prevent pressure on bony prominences.
  3. Provide for adequate thoracic expansion.
  4. Avoid stretching of neuromuscular tissue.
31. When should the nurse initiate planned interventions regarding a patient's perioperative management?
1. When the consent form is signed
  2. When the decision for surgery is made
  3. When the patient is admitted for surgery
  4. When the patient is transferred to the operating room

32. One hour after the reduction of a compound fracture of the ulna and radius and application of a cast the nurse observes a centimeter circle of drainage on the patient's cast. Which should the nurse do **first**?
1. Inform the surgeon immediately.
  2. Reinforce the cast with a gauze dressing.
  3. Monitor the area frequently for expansion.
  4. Circle the spot with a pen and date, time, and initial the area.
33. A nurse is caring for a patient with a nasogastric tube attached to suction. What is the **most** important nursing action in relation to the nasogastric tube?
1. Using sterile technique when irrigating the tube
  2. Recording intake and output every 2 hours
  3. Providing oral hygiene every 4 hours
  4. Setting suction at the ordered level
34. A nurse is considering the commonalities and differences of equipment used for gastric decompression. Which is the major advantage to using a double-lumen tube?
1. Minimizes the risk of bowel obstruction
  2. Ensures drainage of the intestines
  3. Prevents gastric mucosal damage
  4. Promotes gastric rest
35. A nurse is performing preoperative teaching a week before surgery. The patient is taking 650 mg of aspirin twice a day for arthritis. Which should the nurse instruct the patient to do?
1. Continue to take the aspirin indefinitely.
  2. Stop taking the aspirin 5 days before surgery.
  3. Hold the dose of aspirin on the morning of surgery.
  4. Reduce the dose of aspirin to 81 mg a day until after surgery.
36. A patient has negative pressure wound therapy (vacuum-assisted closure [VAC]) after the amputation of a toe. The tubing is connected to intermittent negative pressure. What should the nurse do when the film over the wound collapses when negative pressure is exerted?
1. Notify the primary health-care provider.
  2. Decrease the extent of negative pressure.
  3. Apply a new transparent film over the wound.
  4. Continue to observe the functioning of the device.
37. A primary health-care provider orders antiembolism stockings for a patient. Place the following steps in the order in which they should be implemented when applying these stockings.
1. Assess the patient for contraindications to the use of antiembolism stockings.
  2. Apply the antiembolism stockings before getting the patient out of bed in the morning.
  3. Ensure that the applied stockings are 1 to 2 inches below the popliteal fold (bend) in the back of the knee.
  4. Explain that antiembolism stockings are ordered by the primary health-care provider and what is to be done and why.
  5. Measure the smallest circumference of the ankle, the largest circumference of the calf, and the length from the heel to 1 to 2 inches below the popliteal fold (bend) in the back of the knee.
  6. Turn the stocking inside out so that the foot portion is inside the stocking leg, stretch each side of the stocking and ease it over the toes, center the heel, and pull the stocking over the heel and up the leg.

Answer: \_\_\_\_\_

38. A nurse is caring for a patient recovering from abdominal surgery. Which nursing actions are effective in facilitating ventilation? **Select all that apply.**
1.  Encouraging fluid intake
  2.  Preventing abdominal distention
  3.  Positioning in the side-lying position
  4.  Implementing passive range-of-motion exercises
  5.  Ensuring that an incentive spirometer is used every hour when awake
39. A nurse is caring for a patient in the ambulatory surgery unit who just had a laparoscopic cholecystectomy. The patient reports the presence of pain that is commonly associated with the migration of CO<sub>2</sub> used to inflate the abdominal cavity to improve visualization during surgery. Shade in the location of this referred pain on the illustration.



F.A. DAVIS

COMPANY

40. A patient has a tonsillectomy. Which are appropriate for the nurse to encourage this patient to have during the first 24 hours after surgery? **Select all that apply.**
1.  Warm pudding
  2.  Milk shakes
  3.  Apple juice
  4.  Ice pops
  5.  Gelatin
41. A nurse in the postanesthesia care unit at 3 p.m. receives report from the nurse who is completing the day shift. The following information about a 65-year-old man who was admitted to the unit at 1:30 p.m. after repair of a double inguinal hernia is reported. Which information does not meet the standard criteria for discharge from the unit?
1. Stability of vital signs
  2. Level of consciousness
  3. Absence of bowel sounds
  4. Presence of a urinary catheter

**Vital Signs**

Temperature: 99°F, temporal  
 Pulse: 98 beats per minute  
 Respirations: 30 breaths per minute  
 Blood pressure: 170/90 mm Hg

**Physical Assessment**

Abdominal dressing dry and intact; IV 0.9% sodium chloride at 125 mL per hour, site in left hand dry and intact, free of complications. Removed oral airway at 2 p.m.; gag reflex present; coughing, deep breathing and moving all extremities on command. Urinary catheter draining more than 50 mL per hour; bowel sounds absent.

**Oxygen Status**

Oxygen saturation 97% with nasal cannula at 2 L; breathing freely on own

42. A nurse is caring for a postoperative patient. The patient asks the nurse why vitamin C was prescribed by the primary health-care provider. Which information should the nurse include in a response to this question? **Select all that apply.**

1.  Facilitates healing
2.  Improves digestive processes
3.  Supports collagen production
4.  Encourages growth of red blood cells
5.  Minimizes formation of deep vein thrombosis

43. A nurse assesses the patient on admission to the postanesthesia care unit and collects the following data: receiving oxygen via a simple face mask; oxygen saturation 92%; opens eyes and responds to commands to move all four extremities; deep breathes and coughs; and vital signs are temperature—97.8 F, pulse—82 beats per minute, respirations—18 breaths per minute, and blood pressure—140/88 mm Hg which is consistent with his previous blood pressures. Calculate the patient's Aldrete score.

1. 10
2. 9
3. 8
4. 7

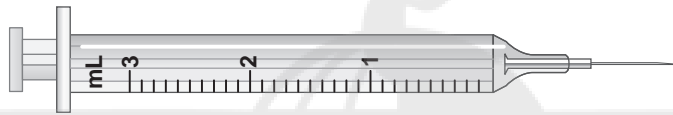
Aldrete Score	On Admission to PCAU	5 Min	15 Min	30 Min	45 Min	60 Min	At Discharge
Able to move 4 extremities voluntarily or on command = 2 Activity							
Able to move 2 extremities voluntarily or on command = 1							
Able to move 0 extremities voluntarily or on command = 0							
Able to deep breathe and cough freely = 2 Respiration							
Dyspnea or limited breathing = 1							
Apneic = 0							
BP ± 20% of Pre-anesthetic level = 2 Circulation							
BP ± 20%–50% of Pre-anesthetic level = 1							
BP ± 50% of Pre-anesthetic level = 0							
Fully awake = 2 Consciousness							
Arousable on calling = 1							
Not responding = 0							
Able to maintain O <sub>2</sub> saturation >92% on room air = 2 O <sub>2</sub> saturation							
Needs O <sub>2</sub> inhalation to maintain O <sub>2</sub> saturation >90% = 1							
O <sub>2</sub> saturation <90% even with O <sub>2</sub> supplement = 0							
TOTAL							

44. A patient has a right abdominal incision. Which should the nurse teach the patient to do when getting out of bed? **Select all that apply.**
- Ex it from the left side of the bed.
  - A sk the nurse to apply an abdominal binder.
  - Ho ld a pillow against the abdomen with both hands.
  - Use the left arm to push up to a sitting position on the side of the bed.
  - Sit on the side of the bed for a few minutes before moving to a standing position.
45. A nurse must initiate placement of a continuous passive motion machine after the patient had a total knee replacement. Place the following steps in the order in which they should be implemented.
1. Position the extremity on the platform so the knee is centered over the break in the platform.
  2. Set the degree of flexion, speed, and time on and off the machine as ordered.
  3. Ensure that the extremity is aligned with the patient's hips and torso.
  4. Assess the patient's skin and provide skin care after the procedure.
  5. Position sheepskin on the platform especially at the gluteal fold.
  6. Position the controller within easy reach of the patient.
- Answer: \_\_\_\_\_
46. A nurse is teaching a postoperative patient the nutrients that are the best for supporting collagen production that promotes wound healing. Which foods selected by the patient indicate that the teaching was effective? **Select all that apply.**
- Yellow bell peppers
  - Whole grain bread
  - Cantaloupe
  - Oranges
  - Kiwifruit
47. A nurse is caring for a patient with the following type of portable wound drainage device. Identify the appropriate nursing actions associated with caring for a patient with this type of drainage system. **Select all that apply.**



- Empty the container and then compress the collection container, close the port, and release hand compression.
- Wear sterile gloves when emptying the collection container.
- Keep the collection container below the insertion site.
- Shorten the length of the tubing by one inch daily.
- Empty the collection container when full.
- Attach tubing to clothing.

48. A nurse is caring for a postoperative patient who had abdominal surgery. The patient states, "The wound just felt like it gave way." The nurse identifies that the patient had a dehiscence with slight evisceration. Identify the actions that the nurse should implement. **Select all that apply.**
1.  **I**nstruct the patient to avoid coughing or bearing down.
  2.  **N**otify the primary health-care provider immediately.
  3.  **P**osition the patient in the supine position.
  4.  **C**over the incision with a sterile dressing.
  5.  **P**repare the patient for surgery.
49. Which interventions help prevent thrombophlebitis during the postoperative period? **Select all that apply.**
1.  **A**pplying lower extremity sequential compression devices when in bed
  2.  **W**earing antiembolism stockings when out of bed
  3.  **W**alking in the hall several times a day
  4.  **U**sing an incentive spirometer
  5.  **C**oughing and deep breathing
  6.  **K**eeping the legs uncrossed
50. The primary health-care provider prescribes morphine sulfate 12 mg subcutaneously STAT for a postoperative patient. The morphine sulfate vial states that there are 10 mg per mL. Indicate on the syringe the line to which it should be filled to administer the prescribed dose.



F.A. DAVIS

COMPANY



## PERIOPERATIVE NURSING: ANSWERS AND RATIONALES

1. The respiratory status of all postoperative patients should be stable and adequate regardless of the type of anesthesia used.
  2. **The ability to move and feel sensations in all four extremities is especially important after receiving spinal anesthesia (subarachnoid block) because it indicates that nerve damage has not occurred because of the lumbar puncture necessary for the introduction of the anesthetic agent into the subarachnoid space.**
  3. Nausea and vomiting are associated with general, not spinal, anesthesia.
  4. This is unrealistic. Although a headache may be associated with spinal anesthesia (subarachnoid block), it may manifest after discharge from the postanesthesia care unit and persist for several days until the cerebrospinal fluid pressure returns to an acceptable level.
2. 1. Although monitoring urinary output is done to ensure that the minimal hourly urine output is 30 mL, it is not the priority.
  2. Although assessing level of consciousness is part of the routine assessment of a patient recovering from anesthesia, particularly conscious sedation and general anesthesia, it is not the priority.
  3. Although tubes and equipment are always monitored and maintained, the patency of drainage tubes is not the priority.
  4. **Maintaining a patent airway is always the priority to prevent respiratory distress and hypoxia. This follows the ABCs (airway, breathing, circulation) of patient care.**
3. 1. Although this is done, it is not the priority action associated with a Penrose drain. A Penrose drain, a small pliable, flat tube, extends beyond the insertion site by approximately 2 inches. This prevents it from being lost inside the wound and allows its placement between gauze dressings to absorb drainage. As a Penrose drain is shortened, it is withdrawn approximately 1 inch and cut to maintain the same 2-inch length outside the body.
  2. **Changing a soiled dressing carefully is necessary to prevent inadvertent removal of the Penrose drain because it is placed between several layers of gauze to absorb drainage.**
4. 1. A bowel movement will occur long after the first signs of intestinal motility are evident.
  2. Administration of fluids before intestinal motility has returned is unsafe and contraindicated. A clear liquid diet is not administered until there are definitive signs of intestinal motility.
  3. Although palpating the abdomen for distention is done, it is not the best assessment for paralytic ileus. Abdominal distention can be caused by problems other than paralytic ileus, such as hemorrhage, peritonitis, and urinary retention.
  4. **Bowel sounds are high-pitched gurgling sounds that vary in frequency, intensity, and pitch; they are caused by the propulsion of intestinal contents through the lower alimentary tract. These sounds are the first indication that intestinal motility is returning.**
5. 1. Vital signs should be assessed eventually, but it is not the priority.
  2. An abdominal binder may be used in high-risk patients to prevent, not treat, dehiscence and evisceration.
  3. **The low-Fowler position, a back-lying position, permits inspection of the operative site and promotes retention of abdominal viscera by gravity if dehiscence has occurred. Also, slight flexion of the hips reduces tension on the abdominal musculature.**
  4. Deep breathing is contraindicated because it increases intra-abdominal pressure, which could cause evisceration.
6. 1. **Obese people have excess adipose tissue that exerts pressure on the abdominal cavity, which raises intra-abdominal pressure. Increased intra-abdominal pressure exerts pressure on the gastrointestinal tract, increasing the risk of nausea and vomiting.**

2. Although inactivity delays recovery of intestinal motility after surgery, a diligent activity and ambulation schedule should prevent postoperative ileus and its related nausea and vomiting.
  3. Intestinal hypomotility, not hypervolemia, is related to postoperative nausea and vomiting. Hypervolemia is an increase in intravascular blood volume.
  4. Unconsciousness is not directly related to postoperative nausea and vomiting.
- 7. 1. Gentle compression is desirable because it prevents bleeding and promotes molding and shrinkage of the residual limb.**
2. A saline dressing is unsafe because soaking promotes the breakdown of connective tissue fibers (maceration), which impedes wound healing by primary intention.
  3. Notifying the primary health-care provider should be done eventually, but caring for the patient is the immediate priority.
  4. Elevating the limb is unsafe because it promotes hip flexion contractures.
- 8. 1.** Dietary roughage prevents constipation, not urinary tract infections.
- 2.** A sitz bath can promote the development of a urinary tract infection if medical aseptic techniques are not followed.
- 3. Adequate (2,000 to 3,000 mL/day) fluid intake daily promotes a dilute urine and more frequent emptying of the bladder, both of which limit the development of a urinary tract infection. The stasis of concentrated urine promotes microbial growth.**
- 4.** The ingestion of citrus juice causes an alkaline urine, which provides a favorable environment for the multiplication of microorganisms and the development of a urinary tract infection.
- 9. 1.** Unresponsiveness and being pain free occur with general anesthesia, not conscious sedation.
- 2.** Life-threatening malignant hyperthermia is a rare, autosomal dominant-inherited syndrome that is precipitated by anesthetic inhalation agents and neuromuscular blocking medications used to induce general anesthesia, not conscious sedation.
- 3. Conscious sedation involves the use of intravenous opioids and sedatives to decrease the level of consciousness to a degree where the person can still maintain an airway, can respond to verbal commands, and cannot remember the procedure.**
- 4.** Patients who have received spinal anesthesia (subarachnoid block), not conscious sedation, are placed in the supine position to limit leakage of cerebrospinal fluid from the needle insertion site. Bedrest in the supine position, hydration, and pressure against the infusion site limit headache associated with spinal anesthesia.
- 10. 1. Chronic alcoholism disrupts the structure and function of the liver. A decrease in the synthesis of bile salts prevents the absorption of vitamin K, which is essential for the production of clotting factors II, VII, IX, and X. Therefore, these patients are at risk for hemorrhage. In addition, malnutrition results in decreased protein synthesis, anemia, and vitamin deficiencies, all of which interfere with fluid and electrolyte balance and wound healing. Finally, the patient will have to be medically managed to minimize the responses to alcohol withdrawal.**
- 2.** Although patients with epilepsy have their own unique problems that must be considered, they are not at the greatest risk for postoperative mortality as a group in another option.
- 3.** Middle-aged adults are not at the greatest risk for postoperative mortality as a group in another option.
- 4.** Although infants have a greater surgical risk than children and young to middle-aged adults because they have a lower total blood volume, a larger percentage of body fluid, and difficulty maintaining body temperature as a result of an immature shivering reflex, they are not at the greatest risk for postoperative mortality as a group in another option.
- 11. 1.** Although compression stockings at night are helpful, they will promote venous return for a limited amount of time (approximately 8 hours). The patient will be at risk for the remaining time in the day (approximately 16 hours).
- 2.** Deep breathing and coughing exercises help to prevent atelectasis and pneumonia, not thrombophlebitis; these exercises should be performed hourly when awake.
- 3. Leg exercises are an active intervention by the patient that contracts the**

**muscles of the legs. This rhythmically compresses the veins, which promotes venous return and prevents venous stasis.**

4. Elevating the legs on two pillows is undesirable because pressure on the popliteal space constricts the vessels, which impedes venous return, promotes venous stasis, and injures tissues. Vessel injury, venous stasis, hypercoagulability, and dehydration all contribute to thrombophlebitis.
12.
    1. Although constipation as a result of anesthesia is a concern, it is not life-threatening.
    2. Although urinary retention as a result of anesthesia is a concern, it is not life-threatening.
    3. **After abdominal surgery patients frequently have shallow respirations because when the diaphragm contracts with a deep breath it increases intra-abdominal pressure, which causes pain at the operative site. Shallow breathing may result in atelectasis and/or hypostatic pneumonia.**
    4. Although a person may experience an impaired ability to provide self-care during recovery from surgery, it is not life-threatening.
  13.
    1. The patient's level of anxiety may be communicated; however, in the immediate postoperative period the physiological needs of the patient are the priority.
    2. **The type and extent of the surgery are significant pieces of information because there are unique stressors and expected responses to various types of surgery that may direct the plan of care for the patient.**
    3. Although the type and amount of IV fluids ordered are important and should be communicated, this is only one aspect of the patient's care.
    4. Although reasonable requests are honored, the status of the patient or the environment may prohibit them.
  14.
    1. Both entry sites place the catheter in the superior vena cava.
    2. **A tension pneumothorax is not a concern with a peripherally inserted central venous catheter. Pneumothorax is a complication of a central venous catheter inserted into a subclavian vein because of the close proximity of its insertion site to the apex of the lung.**
  3. Both entry sites carry a risk of infection because the first line of defense, the skin, has been pierced.
  4. Both entry sites allow for the administration of large volumes of fluid because the distal ends of their catheters are both in the superior vena cava.
15.
    1. A wound infection is less likely to occur 5 days after surgery because the proliferative or reconstructive phase of wound healing begins approximately 3 days after tissue damage. By the fifth postoperative day, the wound has filled with highly vascular fibroblastic connective tissue that protects the body from microorganisms.
    2. **Microorganisms introduced into a surgical site take 72 hours to multiply and present local adaptations of pain, swelling, erythema, warmth, and purulent discharge and systemic adaptations of fever and tachycardia.**
    3. A wound infection is less likely to occur at the ninth day because by the second postoperative week there is progressive collagen accumulation and the formation of the basic structure of the scar, which protect the body from microorganisms.
    4. A wound infection is less likely to occur at the seventh day because by the seventh postoperative day the surface epithelium has an appropriate thickness and the subepithelial layers are bridged, which protect the body from microorganisms.
  16.
    1. **Leakage of cerebrospinal fluid from the needle insertion site reduces cerebrospinal fluid pressure, which causes a headache.**
    2. Neuropathy, resulting from inflammation or degeneration of the peripheral nerves, is not a response to spinal anesthesia.
    3. Although the needle insertion site may feel uncomfortable in some people, it is not a common problem after spinal anesthesia.
    4. Anesthetic agents cause a decrease, not increase, in blood pressure.
  17.
    1. Changing the route of a prescribed oral medication is beyond the scope of the legal practice of nursing.
    2. Withholding medications without a significant reason is unsafe. These medications may be essential to maintain the patient's physical or emotional status.

3. It is unsafe to withhold medications without an important reason. The withheld medications may be essential to maintain the patient's physical or emotional equilibrium.
  4. **This intervention meets the patient's needs and adheres to the laws that govern the practice of nursing. A change in the route of medication delivery requires a prescription because medication administration is a dependent function of the nurse.**
- 18. 1. The molecules in clear liquids are less complex and easier to ingest, tolerate, and digest than those in a full-liquid diet or food.**
2. A full-liquid diet is not the most common diet ordered postoperatively, although a full-liquid diet frequently precedes solid food.
  3. A low-fiber diet is ordered for specific problems, such as intestinal inflammation or infection. When able to be tolerated postoperatively, dietary fiber promotes intestinal motility and prevents constipation.
  4. A regular diet is not the most common diet ordered postoperatively, although most initial postoperative diets eventually progress to a regular diet.
- 19. 1. These clinical findings are essential for discharge from the postanesthesia care unit because they reflect the body's vital functions, such as airway, breathing, and circulation.**
2. A dry dressing may be unrealistic. Some drainage from a surgical incision is expected in the immediate postoperative period. The other listed clinical findings are desirable.
  3. A postoperative patient may not be able to turn from side to side, but the patient should be able to move all extremities. The other listed clinical findings are desirable for discharge.
  4. The lack of a fever is not a criterion for discharge from the postanesthesia care unit because a low-grade fever is an expected response to the stress of surgery. Adventitious breath sounds are abnormal breath sounds (e.g., wheeze, crackles, and rhonchi) and indicate a respiratory problem. The ability to cough is desirable.
- 20. 1. These are the classic clinical manifestations of a pulmonary embolus. Chest pain results from local tissue hypoxia, tachycardia from systemic hypoxia, and hypotension from decreased cardiac output. A pulmonary embolus is caused by an embolus lodging in a vessel in the pulmonary circulation, occluding blood supply to the capillary side of the alveolar-capillary membrane.**
2. Although tachycardia and hypotension occur with hemorrhage, chest pain does not.
  3. Although tachycardia and chest pain occur with a myocardial infarction (heart attack), the blood pressure probably will increase, not decrease. If cardiogenic shock occurs, the blood pressure decreases eventually.
  4. Pneumonia, inflammation of the lung with consolidation and exudation, is associated with tachycardia and chest discomfort. However, it does not have a sudden onset and the blood pressure will increase, not decrease.
- 21. 1. Oliguria is diminished urine secretion in relation to fluid intake, which is indicated by a negative balance in the intake and output record or an hourly urine output of less than 30 mL. Oliguria is caused by decreased renal perfusion or kidney disease.**
2. Cachexia is not an adaptation related to altered renal perfusion. Cachexia is malnutrition and emaciation associated with serious diseases such as cancer.
  3. Yellow sclera indicates jaundice. Jaundice is the accumulation of bile pigments in tissue, which is associated with liver or biliary problems, not altered renal perfusion.
  4. Suprapubic distention indicates urinary retention, which is an inability of the bladder to empty, not a problem with renal perfusion. If it occurs, usually it becomes evident 6 to 8 hours after surgery.
- 22. 1. This is an unrealistic expectation considering all the stressors that can contribute to these problems. Essential nutrient needs can be met despite the presence of nausea and vomiting.**
- 2. Fluid is the most basic nutrient of the body, and it contains compounds such**

as electrolytes. Electrolytes help maintain fluid balance, contribute to acid-base balance, and facilitate enzyme and neuromuscular reactions. The narrow safe limits of the volumes and composition of fluid compartments are essential for the life-sustaining processes of nutrition, metabolism, and excretion.

3. Wound healing takes time, and it is difficult to evaluate during the inflammatory phase, which lasts 1 to 4 days.
  4. Oral intake should not be reestablished until intestinal motility returns, which may take several days.
- 23.**
1. Although the condition of drains ultimately will be assessed, the physiological status of the patient is the priority.
  2. Although the patient's level of consciousness eventually will be assessed, it is not the priority at this time.
  - 3. Assessment in acute situations always follows the ABCs: airway, breathing, and circulation. Respirations and pulse reflect the cardiopulmonary status of the patient.**
  4. Both the location and status of the dressing should be assessed but not until more critical assessments are completed.
- 24.**
1. The Sims position is not used during the intraoperative period for perineal surgery.
  2. The supine position is the most common position for abdominal, not perineal, surgery.
  - 3. The lithotomy position, back-lying with the hips and knees flexed and the legs supported in stirrups, provides optimal visualization of and access to the area related to perineal surgery.**
  4. A patient's legs are adducted when in the Trendelenburg position, which does not permit visualization of or access to the perineal area.
- 25.**
- 1. A Hemovac is designed to accommodate 100, 400, or 800 mL of drainage depending on the system used, whereas a Jackson-Pratt system accommodates volumes less than 100 mL of drainage.**
  2. Both create a vacuum by closing the drainage port while compressing the device.
3. Both work by gentle negative pressure that draws fluid from the tissues to the collection chamber.
  4. Both collection chambers should be placed below the site of insertion to allow gravity to work in conjunction with the negative pressure within the self-contained systems.
- 26.**
1. Gastroesophageal reflux disease is not a problem with general anesthesia because of interventions such as NPO status before surgery, use of a cuffed endotracheal tube, and positioning.
  2. Although reduced reflexes are significant to know when monitoring a patient throughout the surgical experience, they do not place a patient at the greatest risk.
  3. Although a decreased metabolism is taken into consideration when monitoring reflexes during the induction, maintenance, and reversal phases of anesthesia, hypothyroidism does not place a patient at the greatest risk.
  - 4. Respiratory problems complicate the administration of inhalation anesthesia. Emphysema is characterized by destruction of alveoli, loss of elastic recoil, and narrowing of bronchioles, which result in alveolar hyperinflation and increased airflow resistance.**
- 27.**
1. Serous exudate is a clear, watery fluid consisting mainly of serum. It is the exudate expected before final wound healing.
  2. Purulent exudate is a thick drainage known as pus, which consists of leukocytes, liquefied dead tissue debris, and bacteria. This is unexpected and indicates the presence of a wound infection. Wound infections generally become apparent 2 to 11 days postoperatively.
  3. Sanguineous (hemorrhagic) exudate consists of large amounts of red blood cells and is associated with open wounds or hemorrhage.
  - 4. Serosanguineous exudate, a combination of serous and sanguineous drainage, consists of plasma and red blood cells and is pale red and watery. This is the initial drainage expected after surgery.**
- 28.**
1. The absence of intestinal motility (paralytic ileus), not infection, is the intestinal response that can occur during the first 24 to 36 hours after surgery.

- Abdominal distention and absent bowel sounds, not a fever, indicate this problem.
2. A urinary catheter usually is inserted before major abdominal surgery. A bladder infection will not be apparent during the first 24 hours after catheterization because microorganisms take at least 72 hours to multiply sufficiently to manifest symptoms.
  3. Microorganisms introduced into the incision at the time of surgery take at least 72 hours to multiply sufficiently to manifest symptoms.
  4. **When postoperative pneumonia (an inflammation of the lung with consolidation and exudation) occurs, patient symptoms are evident usually any time within 36 hours after surgery.**
29. 1. This action restricts mobility and may exert undue pressure on the surface of the wound. The dressing should be laid gently over the wound and the edges pressed against the skin to ensure adherence.
2. **This action removes exudate and ensures adhesion of the dressing. Transparent adhesive films are nonabsorbent semipermeable, which allows oxygen exchange, dressings that are impermeable to water and bacteria.**
3. These actions defeat one of the purposes of a transparent dressing, which is the ability to visualize the wound.
  4. A transparent dressing is self-contained, and reinforcing tape usually is not necessary.
30. 1. Although allowing for skeletal deformities is always taken into consideration when positioning a patient during the intraoperative period, it is not the priority.
2. It is impossible to prevent all pressure on bony prominences during the intraoperative period. Specific positions are necessary to allow exposure and access to the operative area. Positioning devices and padding are used to minimize trauma.
  3. **Facilitating respirations always is the priority because permanent brain damage can result from cerebral hypoxia in as little as 4 to 6 minutes.**
  4. Although stretching of neuromuscular tissue should be avoided during the intraoperative period, it is not the priority.
31. 1. Significant nursing care must be provided before this point in time. The operative consent form is signed during the preoperative phase of the perioperative experience.
2. **The surgical experience begins as soon as the decision for surgery is made. Perioperative nursing responsibilities begin immediately and continue throughout the preoperative, intraoperative, and postoperative phases.**
  3. A nurse is negligent if nursing care begins at this point in the surgical experience.
  4. The nurse is negligent if nursing care begins only at this point in the surgical experience. This is the intraoperative phase of the perioperative experience.
32. 1. Informing the surgeon is premature, because some drainage occurs with a compound fracture.
2. Reinforcing the cast with a gauze dressing is undesirable, because it impedes the ability to assess the site in the future.
  3. The determination of expansion is a subjective assessment without objective parameters and is undesirable as a form of measurement.
  4. **Circling the spot with a pen and indicating the date, time, and initials is appropriate. This determines objectively the time and extent of the bleeding and the person who performed the assessment. The extent of progression of the bleeding can be established objectively using the original circle as a standard.**
33. 1. Medical, not surgical, asepsis is necessary.
2. It is unnecessary to monitor the intake and output (I&O) this frequently. The I&O must be recorded at routine intervals as per hospital policy, usually every 8 and 24 hours.
  3. Oral hygiene should be provided more frequently than every 4 hours. Because there is no food or fluid to stimulate salivary gland secretion and the tube in the nose may interfere with breathing, precipitating mouth breathing, the mouth becomes dry.
  4. **The level of suctioning is part of the primary health-care provider's order for nasogastric decompression. Low suction pressure is between 80 and 100 mm Hg, and high suction pressure is between 100 and 120 mm Hg. Suctioning must be maintained continuously with a double-lumen**


tube (e.g., Salem sump) to prevent reflux of gastric secretions into the vent lumen, which will obstruct its functioning and result in mucosal damage. A single-lumen tube requires low intermittent suction to prevent the tube from adhering to the stomach mucosa.

- 34.** 1. A double-lumen tube will not minimize the risk of a bowel obstruction.  
 2. All nasogastric tubes attached to suction remove drainage from the stomach, not the intestine. Nasointestinal tubes attached to suction remove fluid from the intestine.  
**3. A double-lumen tube has two lumens: one allows stomach secretions to be removed by suction (first lumen) and the other allows air to be drawn into the stomach (second lumen). The second lumen (blue pigtail) is open to environmental (atmospheric) air, which is drawn into the stomach to equalize the outside pressure with the pressure inside the stomach. This prevents the catheter tip from attaching to the gastric mucosa when the drainage lumen is attached to suction, limiting mucosal damage.**  
 4. All nasogastric tubes attached to suction empty the stomach contents in an effort to promote gastric and intestinal rest. Gastric glands produce up to 4 to 5 liters of fluid a day that stimulate the intestine unless removed.
- 35.** 1. Continuing the aspirin is unsafe. Acetylsalicylic acid (aspirin) is a salicylate that inhibits thromboxane which binds platelet molecules together. Continuing the aspirin can interfere with platelet aggregation and may result in hemorrhage.  
 2. **Acetylsalicylic acid (aspirin) is a salicylate that inhibits thromboxane which binds platelet molecules together. It has a half-life of 15 to 30 hours. It should be discontinued at least 5 days before surgery. Some providers advocate discontinuing aspirin 7 days before surgery.**  
 3. It is unsafe to continue to take aspirin until the evening of surgery. On the day of surgery there will still be chemical properties of aspirin in the patient's body that inhibit platelet aggregation which may result in hemorrhage.

4. The dose of 81 mg of aspirin will still interfere with platelet aggregation which may result in hemorrhage on the day of surgery. Also, changing the dose of a medication is not within the legal practice of nursing.

- 36.** 1. It is not necessary to notify the primary health-care provider because this is an expected response when negative pressure is applied to the device.  
 2. It is not necessary to change the setting of the negative pressure. Changing the setting of the negative pressure requires an order; it is a dependent function of the nurse. The pressure can be continuous or intermittent and set between 5 and 123 mm Hg.  
 3. Changing the transparent film is not necessary because the device is intact. The film is expected to collapse when negative pressure is exerted.  
**4. The device is functioning appropriately. The transparent film will collapse or wrinkle as negative pressure is applied to the wound. This indicates that there are no leaks in the dressing and the negative pressure is functioning.**
- 37.** 4. **Patients have a right to know what is going to be done and why.**  
 1. **Antiembolism stockings should not be applied to a patient with such conditions as excessive peripheral edema or lower extremity arterial disease because doing so may make these conditions worse.**  
 5. **Antiembolism stockings must fit the size of the patient for compression to be effective. If the stockings are too loose they will not provide adequate compression to facilitate venous return, and if they are too tight they will have a tourniquet effect.**  
 2. **The supine position facilitates venous return via gravity, thereby limiting trapping of blood pooled in the lower extremities. When the legs are dependent, they can develop dependent edema. Antiembolism stockings should be applied before the patient gets out of bed in the morning before dependent edema has a chance to occur. Antiembolism stockings are elastic garments worn around the leg; they exert pressure against the legs,**

thus reducing the diameter of the veins. When the diameter of veins are reduced the volume and velocity of blood flow increases, preventing venous stasis. Venous stasis promotes the formation of a thrombus.

6. Turning the stocking inside out and stretching each side make it easier to get the elastic over the toes and heel. Centering the heel keeps the stocking straight, providing for even compression.
  3. Avoiding placement of antiembolism stockings over the popliteal fold prevents damage to nerves and blood vessels in the popliteal area.
38. 1. Increasing fluid intake will make respiratory secretions less viscous and easier to expectorate, thereby facilitating ventilation.
2. Abdominal distention raises the pressure within the abdominal cavity, which exerts pressure against the diaphragm, impeding its contraction and limiting thoracic excursion.
  3. When in a side-lying position, aeration of the dependent side of the lung is limited because of pooling of secretions and the weight of the body compressing the dependent part of the body.
  4. Passive range-of-motion exercises do not facilitate respirations; they help prevent contractures.
  5. An incentive spirometer will help increase depth of inspirations, preventing stasis of secretions in the respiratory tract, which in turn will facilitate ventilation.
39. The carbon dioxide that is used to insufflate the abdominal cavity during a laparoscopic cholecystectomy that is not released or absorbed by the body can be trapped in the subdiaphragmatic recesses. This can irritate the diaphragm, causing referred pain to the right shoulder and scapular area. In addition, the retained carbon dioxide can irritate the phrenic nerve, causing dyspnea. Positioning the patient in the left Sims position will help move the gas away from the diaphragm. The nurse should encourage the patient to walk and breathe deeply periodically once fully recovered from anesthesia.
- 
40. 1. Warm liquids and food are contraindicated during the first several days after a tonsillectomy because they cause vasodilation, which may increase bleeding from the vascular mucous membranes of the oropharynx.
2. Milk and milk products are avoided during recovery from oral surgery because some health-care professionals believe milk increases the consistency of phlegm.
  3. Apple juice is a clear liquid that when cool will promote vasoconstriction and limit bleeding from the operative site.
  4. An ice pop is a frozen clear liquid that promotes vasoconstriction and limits bleeding from the operative site. However, flavors that have a red color are contraindicated because they complicate assessing for bleeding.
  5. Cool gelatin desserts promote vasoconstriction limiting bleeding from the operative site. Flavors that have a red color are contraindicated because they complicate assessing for bleeding.
41. 1. The patient's vital signs are not stable. Respirations at a rate of 30 are too rapid. A pulse rate of 98 is within the expected range of 70 to 100; however,



it is in the high range of normal, and the blood pressure of 170/90 mm Hg is higher than the expected range of 150/90 mm Hg for an older adult. The patient should be monitored further.

2. The patient's level of consciousness meets the criteria for discharge from the postanesthesia care unit. The patient is easily aroused as indicated by "coughing and deep breathing on command and able to move all extremities on command."
  3. The absence of bowel sounds is an expected response to surgery and the use of anesthesia. The presence of bowel sounds is not a criterion for discharge from the postanesthesia care unit.
  4. Urinary retention catheters are frequently in place postoperatively. The ability to void is not a criterion for discharge from a postanesthesia care unit.
- 42. 1. Vitamin C (ascorbic acid) promotes collagen production, an essential component of the proliferative phase of wound healing. In addition, vitamin C enhances capillary formation, decreases capillary fragility, increases the tensile strength of the wound, and provides a defense against infection because of its role in the immune response.**
2. Vitamin C does not improve digestion.
  - 3. Vitamin C promotes collagen production, an essential component of the proliferative phase of wound healing. In addition, vitamin C enhances capillary formation, decreases capillary fragility, increases the tensile strength of the wound, and provides a defense against infection because of its role in the immune response.**
  4. Vitamin B<sub>12</sub> (cobalamin), folic acid, and iron promote red blood cell production, not vitamin C.
  5. Vitamin C promotes the strength of capillaries, not large veins. Ambulation, leg exercises, and hydration prevent deep vein thrombosis.
- 43. 1. Ten is not the patient's Aldrete score.**
- 2. Nine is the correct Aldrete score for this patient. The patient received 2 points for moving all four extremities on command, 2 points for breathing deeply and coughing freely, 2 points for a blood pressure consistent with pre-anesthetic levels, 1 point for being aroused on calling, and 2 points for oxygen saturation of 92%.**
  3. Eight is not the patient's Aldrete score.
  4. Seven is not the patient's Aldrete score.
- 44. 1. When exiting from the left side of the bed, the left lateral side of the abdomen will be compressed against the bed by body weight. The left, not right, side of the abdomen will absorb the majority of the muscular strain exerted by the transfer.**
2. Although an abdominal binder might be applied for patients at high risk for dehiscence, abdominal binders are not used routinely because they increase intra-abdominal pressure; this exerts a force against the diaphragm that impedes maximum respiratory excursion.
  3. Holding a pillow against the abdomen with both hands is unsafe. At least one upper extremity should be used to help raise the body to a sitting position and promote balance during the transfer out of bed.
  - 4. Using the left arm to assist in lifting the body to a sitting position on the side of the bed places less strain on abdominal muscles in the area of the incision.**
  - 5. Sitting on the side of the bed for a few minutes before moving to a standing position allows the blood pressure to adjust to the change in position, thus avoiding orthostatic hypotension.**
- 45. 5. Positioning sheepskin on the platform especially at the gluteal fold, provides a soft base on which to position the extremity. The site of the gluteal fold is the site that is most at risk for excess pressure.**
- 1. Positioning the extremity on the platform so that the knee is centered over the break in the platform ensures that flexion occurs at the site of the knee joint when the device is in motion.**
  - 3. Ensuring that the extremity is aligned with the hips and torso prevents stress and strain on the muscles, bones, joints, ligaments, and tendons of the body.**
  2. Setting the degree of flexion, speed, and time on and off the machine as ordered ensures that the plan of care is implemented as ordered.

6. Positioning the controller within easy reach of the patient allows the patient to turn off the device if unable to tolerate the procedure.
  4. Assessing the skin once the extremity is removed from the device ensures that a skin problem is immediately identified. Providing skin care keeps skin clean, dry, and moisturized, which helps to keep skin supple and intact.
46. 1. Selecting yellow bell peppers indicates learning. A half a cup of yellow bell peppers contains approximately 170 mg of vitamin C. Vitamin C promotes collagen production, which is essential in the proliferative and maturation phases of wound healing.
2. Selecting whole grain bread does not indicate learning. Whole grains contain trace amounts or no vitamin C necessary for collagen production. Whole grains are noted primarily for containing vitamin E and potassium.
  3. Selecting cantaloupe indicates learning. A cup of cantaloupe contains approximately 68 mg of vitamin C. Vitamin C promotes collagen production, which is essential in the proliferative and maturation phases of wound healing.
  4. Selecting an orange indicates learning. One medium orange contains approximately 69 mg of vitamin C. Vitamin C promotes collagen production, which is essential in the proliferative and maturation phases of wound healing.
  5. Selecting kiwi indicates learning. One kiwi contains approximately 72 mg of vitamin C. Vitamin C promotes collagen production, which is essential in the proliferative and maturation phases of wound healing.
47. 1. Compressing the collection container, closing the port, and releasing hand compression after emptying the container establish negative pressure within the collection container.
2. Clean, not sterile, gloves should be worn when emptying a Jackson-Pratt drain. Although the nurse should maintain sterile technique when emptying a Jackson-Pratt drain, it can be accomplished without wearing sterile gloves. Clean gloves are worn by the nurse to protect the nurse from the patient's blood or body fluids.
3. Keeping the collection container below the insertion site augments the negative pressure of the system.
4. A primary health-care provider may order a Penrose drain to be shortened daily, not the tubing of a Jackson-Pratt drain.
  5. The collection container should be emptied when half full, not when full. This action prevents weight of the bulb pulling on the tubing and helps maintain negative pressure. The amount of negative pressure decreases as drainage in the collection container increases.
6. Attaching tubing to clothing prevents tension on the tubing.
48. 1. Coughing or bearing down will increase tension on the suture line, potentially extending the dehiscence and evisceration, and should be avoided.
2. The patient needs emergency surgical care and the primary health-care provider should be notified immediately.
  3. The patient should be placed in the low-Fowler, not the supine, position with the knees slightly flexed to reduce stress on the suture line.
  4. Covering the wound with a sterile dressing protects the open wound from contamination.
  5. The patient should be prepared for surgery because the surgeon will most likely return the patient to the operating room for surgical repair of the incision.
49. 1. Sequential compression devices apply pressure progressively from the ankles to the thighs, promoting venous return. Volume and velocity of blood flow in the superficial and deep veins in the legs increase, preventing venous stasis. Venous stasis promotes the development of a thrombus.
2. Antiembolism stockings are elastic garments worn around the leg; they exert pressure against the legs reducing the diameter of the veins. When the diameter of veins is reduced the volume and velocity of blood flow increases, preventing venous stasis. Venous stasis promotes the formation of a thrombus.

3. Walking contracts the muscles of the lower extremities and increases cardiac output. Both increase the volume and velocity of blood flow through the veins of the lower extremities, preventing venous stasis and thrombus formation.
4. Using an incentive spirometer prevents atelectasis, not thrombophlebitis.
5. Coughing and deep breathing prevent atelectasis, not thrombophlebitis.
6. Keeping the legs uncrossed eliminates pressure against the calves or behind the knee (popliteal space) depending on where the legs are crossed. Pressure

to these areas impairs venous return, which promotes venous stasis and thrombus formation.

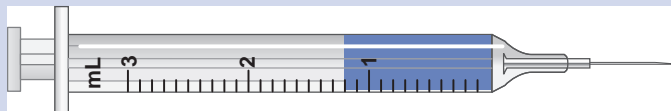
50. Solve the problem using the formula for ratio and proportion.

$$\frac{\text{Desire } 12 \text{ mg}}{\text{Have } 10 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$

$$10 x = 12$$

$$x = 12 \div 10$$

$$x = 1.2 \text{ mL}$$



F.A. DAVIS

COMPANY

# Alternate Item Formats

# 6

National Council Licensure Examinations (NCLEX) include multiple-choice questions and alternate item format questions. A typical multiple-choice question (one answer) presents a statement or situation and requires the test taker to identify the correct answer from among four presented options. Alternate item formats use the benefits of computer technology to assess knowledge via various methods. Alternate item formats include questions that require test takers to do the following: identify multiple answers (multiple-response items); identify a location on a presented image (hot spot items); perform a mathematical calculation (fill-in-the-blank calculation items); respond to a question in relation to an image such as a picture, table, photograph, or illustration (graphic items); identify priorities (drag and drop/ordered response items); and answer a question in relation to a patient situation that presents data such as information from a patient's clinical record (exhibit items). All item types may include multimedia such as illustrations, charts, tables, audio, or video technology to present information in the question. Alternate item formats are able to measure entry-level nursing competence in ways that are different from the typical multiple-choice format. It is believed that some nursing content is more readily and authentically evaluated using alternate item formats. This chapter includes 60 questions that use formats other than multiple-choice questions. For specific test-taking techniques for answering alternate item questions, see *Test-Taking Techniques for Beginning Nursing Students*. This is an F. A. Davis textbook written by Nugent and Vitale.

## ALTERNATE ITEM FORMATS: QUESTIONS

### Multiple-Response Items

A multiple-response item presents a statement or situation that asks a question that has more than one answer among presented options. The test taker is required to select all options that correctly answer the question.

1. A patient comes to the emergency department with a lacerated thumb. For which clinical manifestations associated with the local adaptation syndrome (LAS) should the nurse assess the patient? **Select all that apply.**
  1.  Pain
  2.  Heat
  3.  Erythema
  4.  Increased heart rate
  5.  Decreased blood pressure
  6.  Elevated blood glucose level
2. A nurse is assisting a postoperative patient to ambulate. Which postoperative complications will ambulation help prevent? **Select all that apply.**
  1.  Hypovolemia
  2.  Constipation
  3.  Atelectasis
  4.  Dehiscence
  5.  Infection

3. A patient is learning self-care in relation to a 2-g sodium diet. Which foods selected by the patient indicate to the nurse that further teaching is necessary? **Select all that apply.**
1.  Apple juice
  2.  Feta cheese
  3.  Corned beef
  4.  Canned soup
  5.  Broccoli spears
4. A nurse is monitoring a patient's IV infusion. Which data are necessary to determine that the IV is "on time"? **Select all that apply.**
1.  Drop rate per minute
  2.  Time the bag was hung
  3.  Solution indicated on the IV bag
  4.  Volume of solution in the IV bag
  5.  Milliliters per hour ordered by the primary health-care provider
5. A patient who was in an automobile collision is brought to the emergency department by ambulance. The patient is exhibiting signs and symptoms of multiple trauma. For which common responses to hemorrhage should the nurse assess the patient? **Select all that apply.**
1.  Bradypnea
  2.  Tachycardia
  3.  Flushed skin
  4.  Bounding pulse
  5.  Delayed capillary refill
6. A nurse is caring for several postoperative patients who require common therapeutic interventions that involve the principle of gravity. Identify interventions that are associated with the principle of gravity. **Select all that apply.**
1.  Foley catheter
  2.  Penrose drain
  3.  Tap-water enema
  4.  Gastric decompression
  5.  Portable wound drainage system
7. A nurse is supervising a nursing team consisting of two nurses and two nursing assistants. Which tasks can the nurse delegate to the nursing assistants? **Select all that apply.**
1.  Helping a patient who is constipated choose foods from a diet menu
  2.  Teaching a patient how to walk with a walker
  3.  Applying antifungal cream to unbroken skin
  4.  Weighing a patient using a bed scale
  5.  Emptying a urine collection bag
8. Which actions are based on principles of surgical asepsis? **Select all that apply.**
1.  Washing hands
  2.  Keeping a sterile field dry
  3.  Holding sterile objects above the waist
  4.  Wearing personal protective equipment when providing care
  5.  Considering the outer half inch of the sterile field as contaminated
9. A newly admitted patient's respiratory status is assessed by a nurse who identifies the presence of gurgles and a productive cough. For which additional clinical manifestations associated with this data cluster should the nurse assess the patient? **Select all that apply.**
1.  Dyspnea
  2.  Purulent sputum
  3.  Decreased blood pressure
  4.  Decreased pulse oximetry level
  5.  Bronchovesicular breath sounds

10. A nurse is caring for a patient who is receiving continuous enteral feedings through an enteral tube via the nose. Which nursing interventions support comfort? **Select all that apply.**
- Check tube patency frequently.
  - Administer oral hygiene every 2 hours.
  - Apply lubricant after cleaning the nares.
  - Ensure that the tube is secured to the nose.
  - Instill 30 mL of water into the tube every 4 to 6 hours.
11. A patient is receiving a diuretic that contributes to the loss of potassium, and the nurse provides dietary teaching. Which foods selected by the patient indicate an understanding of excellent sources of potassium? **Select all that apply.**
- Cooked spinach
  - Baked potato
  - Green beans
  - Bran flakes
  - Lean meat
12. A nurse is caring for a patient who has the following medication prescribed by the primary health-care provider: albuterol sulfate inhalation aerosol 90 mcg, 2 puffs via a metered dose inhaler with a spacer, every 12 hours. Which actions should the nurse teach the patient to implement when using this inhaler? **Select all that apply.**
- Seal the lips around the mouthpiece of the spacer.
  - Exhale fully through the nose before taking a dose.
  - Breathe in deeply and quickly after activating the canister.
  - Rinse the mouth with water and spit it out after the procedure.
  - Remove the cap, shake it well, and spray it into the air three times when using a metered dose inhaler for the first time.
13. A nurse is providing dietary teaching for a patient with the diagnosis of osteoporosis. Which foods selected by the patient indicate that the teaching was understood? **Select all that apply.**
- Cheese
  - Lettuce
  - Peppers
  - Oranges
  - Sardines
14. Which nursing actions are important when applying antiembolism stockings? **Select all that apply.**
- Eliminating the wrinkles in the stockings
  - Ensuring the toe window is properly positioned
  - Applying the stockings after the patient is out of bed
  - Flexing the knee as the stocking is pulled over the knee
  - Removing the stocking once a day for at least thirty minutes

### Hot-Spot Items

A hot-spot item asks a question in relation to an illustration. The test taker must identify a location on the illustration that answers the question.

1. A patient with a primary health-care provider's order for bedrest consistently lies in the right lateral position. Place an X over the bony prominence the nurse should assess because it has the **greatest** risk for the development of a pressure ulcer?



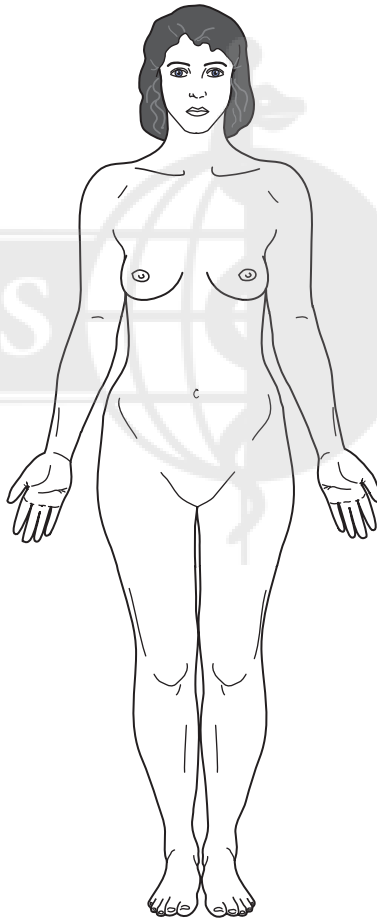
2. A nurse is caring for a patient who had the creation of a colostomy. Place an X over the large intestine that produces the most liquid stool, thereby placing the patient at risk for skin breakdown.



3. A nurse is to administer an intermittent tube feeding via a nasogastric tube. A nurse obtains gastric contents via the nasogastric tube and then assesses the patient's abdomen with a stethoscope when returning the gastric contents. Mark an X where the nurse should place the stethoscope when double-checking placement of the nasogastric tube.

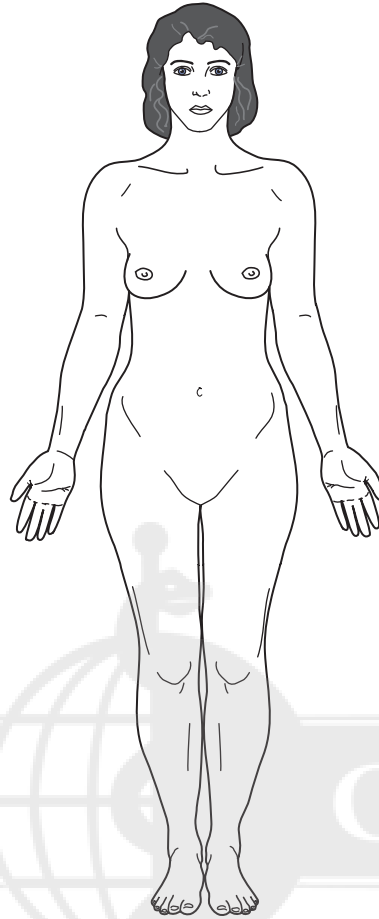


4. A primary health-care provider prescribes heparin 5,000 units subcutaneously twice a day. Place an X over the site that is most commonly used by the nurse to administer this medication.

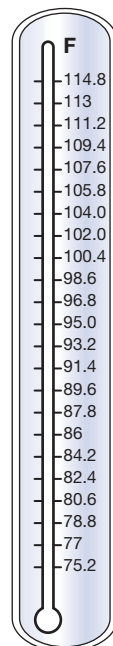




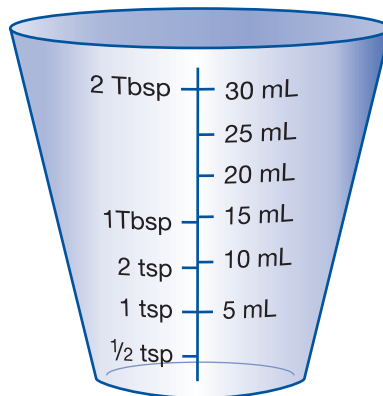
5. Two nurses are performing CPR on a postoperative patient. One nurse performs sternal compressions, and the other delivers breaths and monitors the patient. Place an X over the preferred site to obtain this patient's pulse.



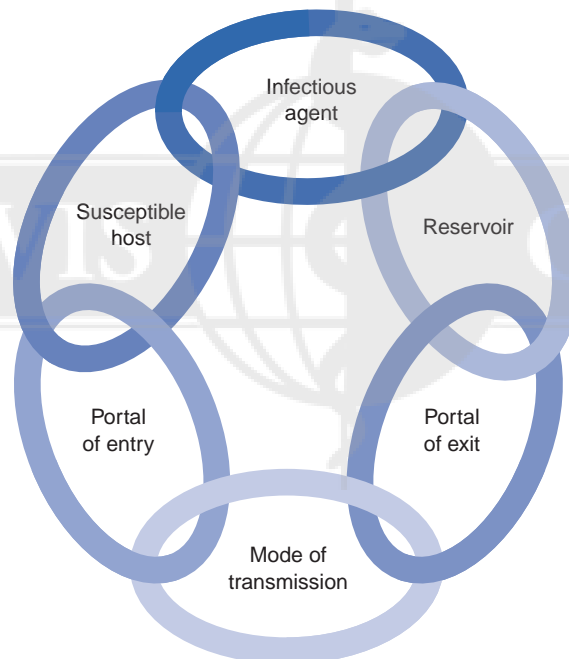
6. After assessing a patient and taking the temperature, the nurse determines that the patient is experiencing pyrexia. Put an X within the range of temperatures on the thermometer scale that reflects pyrexia.



7. A primary health-care provider prescribes diphenhydramine 25 mg PO four times a day to minimize allergy symptoms. Diphenhydramine is supplied as a syrup 12.5 mg/5 mL. Put an X at the point on a graduated medicine cup that indicates the dose of diphenhydramine the nurse must dispense.



8. A nurse is caring for a patient who is receiving airborne precautions because of tuberculosis. Place an X within the chain of infection when the nurse wears a particulate filter mask (N95 respirator).



### Fill-in-the-Blank Calculation Items

A fill-in-the-blank item asks a question that requires the test taker to perform a calculation. Fill-in-the-blank items are associated with pharmacological and parenteral therapies and other situations requiring a calculation.

1. A primary health-care provider prescribes an antidysrhythmic medication of 2 g in 1,000 mL D<sub>5</sub>W at 4 mg/min. At what rate should the nurse set the infusion pump?  
**Record your answer using a whole number.**

Answer: \_\_\_\_\_ mL/hr

2. A primary health-care provider prescribes an antibiotic of 400,000 units IVPB every 6 hours. The medication vial contains 1 million units with the following directions: add 4.6 mL of diluent to yield a concentrated solution of 200,000 units/mL. How much solution of the antibiotic should the nurse prepare to be added to IVPB solution? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ mL
3. A primary health-care provider prescribes digoxin 0.25 mg PO once daily. Tablets are available that contain 0.125 mg. How many tablets should the nurse administer? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ tablets
4. A primary health-care provider prescribes diphenhydramine elixir 25 mg PO twice a day for 3 days. The bottle of diphenhydramine states that there are 12.5 mg/mL. When preparing the first dose, how much solution should the nurse administer? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ mL
5. A primary health-care provider prescribes human recombinant erythropoietin 100 units/kg/dose subcutaneously three times a day for a patient who weighs 110 pounds. The medication states that there are 2,000 units/mL. How much solution should the nurse administer? **Record your answer using one decimal place.**  
Answer: \_\_\_\_\_ mL
6. A primary health-care provider prescribes ondansetron 6 mg to be administered via oral suspension to a 12-year-old child 30 minutes before chemotherapy and then every 8 hours for two more doses. The medication states that there are 4 mg/5 mL. How much oral solution should the nurse administer per dose? **Record your answer using one decimal place.**  
Answer: \_\_\_\_\_ mL
7. A patient initially received ramipril 1.25 mg daily. The dose was increased to 2.5 mg once a day for several days, and finally the primary health-care provider increases the dose to 5 mg every day. The patient says to the nurse, "I still have a lot of 1.25-mg tablets left. Can I use these up with the new dose the doctor prescribed?" How many 1.25 mg tablets should the nurse instruct the patient to take? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ tablets
8. A primary health-care provider prescribes warfarin sodium 10 mg PO once a day on the even days of the month and 15 mg on the odd days of the month. The 10-mg tablets supplied are scored. How many tablets should the nurse administer on the fifth day of the month? **Record your answer using one decimal place.**  
Answer: \_\_\_\_\_ tablets
9. A primary health-care provider orders an IV infusion of 1,000 mL of D<sub>5</sub>W with 20 mEq of potassium chloride to be administered at 125 mL/hr. The infusion set has a drop factor of 15. At how many drops per minute should the nurse set the IV infusion? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ drops/min
10. A patient has a prescription for regular insulin. The prescription states: administer regular insulin before meals and at bedtime based on the patient's glucose monitoring results.  
Blood glucose 71 to 150: no insulin  
151 to 200: 3 units  
201 to 250: 5 units  
251 to 300: 7 units  
301 to 350: 9 units  
351 to 400: 11 units and call the primary health-care provider

The patient's blood glucose at 11:30 a.m. is 230. How many units of regular insulin should the nurse administer? **Record your answer using a whole number.**

Answer: \_\_\_\_\_ units

11. A nurse is calculating a patient's intake and output for an 8-hour period of time. The patient has 1,000 mL of 0.9% sodium chloride infusing intravenously at 75 mL/hour. The patient received 2 intermittent doses of an intravenous antibiotic in 50 mL of solution each. The intravenous antibiotic solutions were administered over 20 minutes each via a secondary intravenous line that was hung higher than the primary infusion of sodium chloride. For breakfast the patient had 4 ounces of coffee and 6 ounces of orange juice. For lunch the patient ingested 240 mL of beef broth. Later the patient experienced nausea and vomited 300 mL of greenish fluid. The patient consumed 8 ounces of ice chips. What was the patient's total fluid intake? **Record your answer using a whole number.**

Answer: \_\_\_\_\_ mL

12. A patient who is taking a prescribed liquid oral medication at home calls the clinic for instructions. The dose prescribed is 30 mL but a measuring device is not supplied with the medication. How many tablespoons of the liquid medication should the nurse instruct the patient to take? **Record your answer using a whole number.**

Answer: \_\_\_\_\_ ta blespoons

13. A patient with the diagnosis of anorexia nervosa is admitted to the hospital. A nurse is calculating the total calories that the patient ingested for lunch. The patient ate 10 grams of carbohydrates, 4 grams of protein, and 3 grams of fat. How many calories did the patient consume with lunch? **Record your answer using a whole number.**

Answer: \_\_\_\_\_ c alories

14. A primary health-care provider prescribes a medication for a patient that should be administered based on body weight. The prescription states to administer 0.5 mg per kilogram of body weight once a day. The patient weighs 160 pounds. How many milligrams of medication should be administered per dose? **Record your answer using one decimal place.**

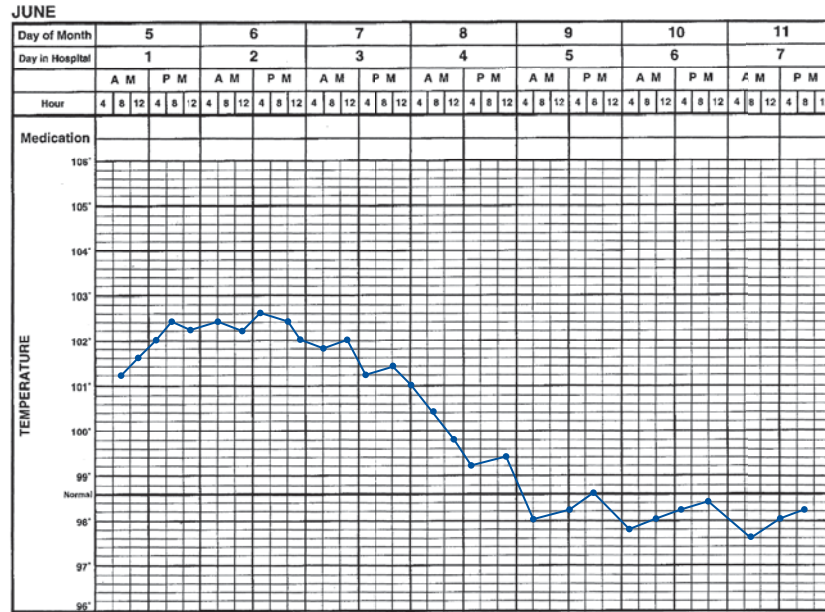
Answer: \_\_\_\_\_ mg

### Graphic Items (Items Using a Graphic, Chart, Table, or Illustration)

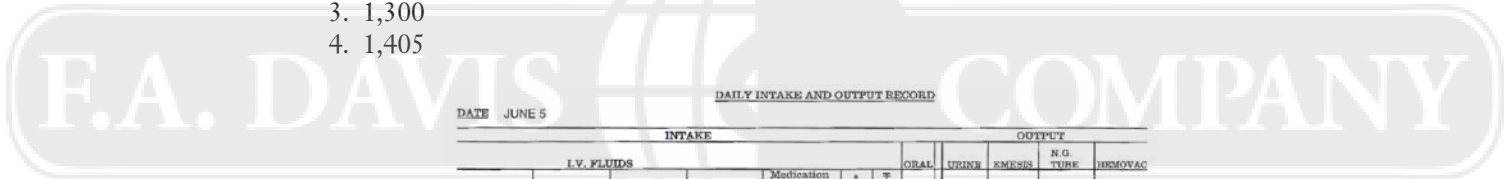
An item using a chart, table, or graphic image requires the test taker to refer to the illustration presented to arrive at the correct answer. It tests the ability to identify, calculate, analyze, or interpret data from a chart, table, or graphic image to arrive at the correct answer.

1. A nurse is reviewing a patient's temperatures over the course of hospitalization. What was the patient's temperature on June 7th at 4 p.m.?
1. 97.8 F
  2. 99.2 F
  3. 101.2 F
  4. 102.6 F

Room No. 104 Hosp. No. 427396



2. A nurse is caring for a patient who has an order for intake and output. Referring to the intake and output flow sheet, what was the patient's total output for the hours between 7 a.m. and 3 p.m.?
1. 355
  2. 720
  3. 1,300
  4. 1,405



DATE JUNE 5 DAILY INTAKE AND OUTPUT RECORD

Time	INTAKE				OUTPUT				
	I.V. FLUIDS		Medication and Dosage	* ABS	† LIB	ORAL	URINE	EMESIS	N.G. TUBE
Bottle	Amount	Solution							
8	1	1000	NS	20 mEq KCl		650			
8:30					380				
10:00					120				
11:30					240	150			
12:00							160		
1:40							90		60
2:15						250			
3:00					525	475			45
7-8 TOTAL		8-HR TOTAL							
3-11 TOTAL		8-HR TOTAL							
11-7 TOTAL		8-HR TOTAL							
24 HOUR TOTAL									

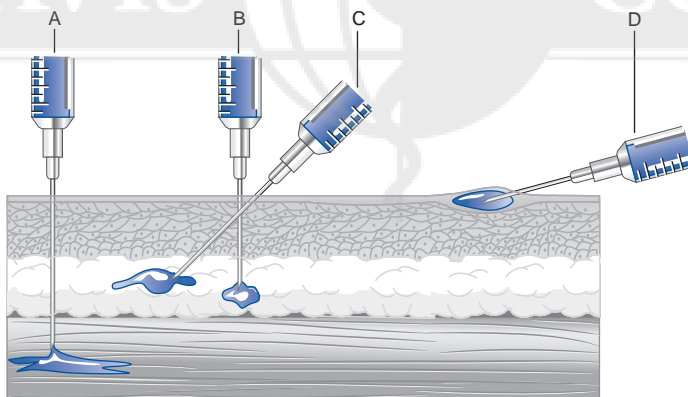
INTAKE GRAND TOTAL       OUTPUT GRAND TOTAL

\*ABS. = amount absorbed    † LIB = left in bag

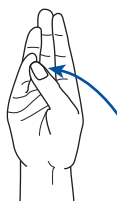
3. A nurse is making rounds at the beginning of a shift and enters the room of the patient depicted in the photograph. What should the nurse do? **Select all that apply.**
1.  Move the straps of the mask to above the patient's ears.
  2.  Put a second pillow under the patient's head.
  3.  Obtain the patient's oxygen saturation level.
  4.  Elevate the head of the patient's bed.
  5.  Place a hospital gown on the patient.



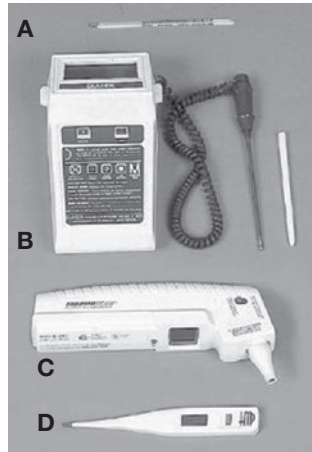
4. A patient is admitted to the emergency department for treatment after stepping on a rusty nail at a job site. The primary health-care provider prescribes tetanus immune globulin 250 units IM STAT. Which illustration indicates the angle at which this injection should be administered by the nurse?
1. A
  2. B
  3. C
  4. D



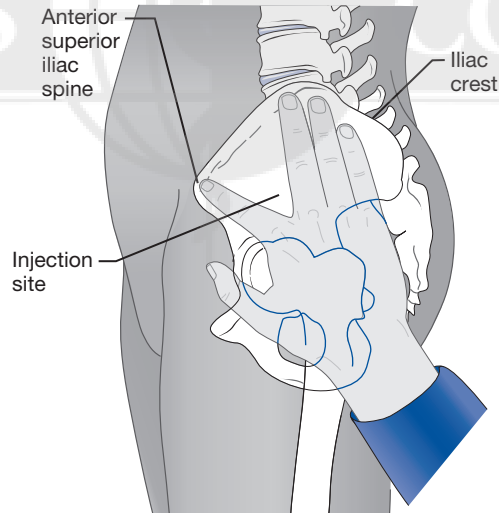
5. A patient is admitted to an extended-care facility after initially recovering from a brain attack resulting in right-sided hemiplegia. The nurse begins passive range-of-motion exercises on the patient's right upper and lower extremities. Which movement is indicated in the illustration?
1. Inversion
  2. Adduction
  3. Supination
  4. Opposition



6. Which illustration indicates the type of thermometer that the nurse should use to obtain a temperature of an alert and active 2-year-old child?
1. A
  2. B
  3. C
  4. D



7. Review the illustration, and identify which site the nurse is landmarking for the administration of an intramuscular injection.
1. Dorsogluteal
  2. Ventrogluteal
  3. Rectus femoris
  4. Vastus lateralis



8. What instructions should the nurse give a patient who is using the device in the illustration?
1. Breathe out slowly and completely, seal your mouth around the mouthpiece, press down on the canister, slowly inhale, and hold your breath for ten seconds.
  2. Hold the device, seal your mouth around the mouthpiece, and breathe in and out slowly and deeply.
  3. Seal your mouth around the mouthpiece and breathe in and out normally.
  4. Take a deep breath and forcefully exhale through the mouthpiece.



### Drag and Drop/Ordered Response Items

A drag and drop/ordered response item presents a situation followed by a list of statements. The test taker is asked to place the statements in order of priority.

1. At the beginning of a 7 a.m. to 7 p.m. shift, a nurse receives a report, which is completed by 7:20 a.m. Place in order of priority the tasks that should be performed by the nurse.
  1. Give a prn pain medication to a patient in pain.
  2. Change a patient's dressing that must be done two times a day.
  3. Obtain the vital signs of a patient reporting shortness of breath.
  4. Administer the ordered 8 a.m. medications to the patients on the unit.

Answer: \_\_\_\_\_

2. When assessing a patient's abdomen, nurses should follow a logical sequence. Place these assessments in the order in which they should be performed.
  1. Percuss the suprapubic area to determine bladder distention.
  2. Auscultate the four quadrants of the abdomen for bowel sounds.
  3. Observe the abdomen for contour and visible signs of peristalsis.
  4. Palpate the abdomen to determine the presence of tenderness and fluid.

Answer: \_\_\_\_\_

3. A nurse must always be prepared for, and ready to respond to, a fire that may occur on a hospital unit. Place the following activities in the order in which they should be implemented.
  1. Know the location and use of alarms and extinguishers.
  2. Rescue patients in danger when a fire is identified.
  3. Pull the fire alarm to notify others about the fire.
  4. Close doors and windows on the unit.
  5. Be alert for the signs of a fire.

Answer: \_\_\_\_\_

4. A nurse plans to reposition an unconscious patient from the supine position to the right side-lying position. Initially, the nurse explains the care to the patient, closes the door for privacy, and performs hand hygiene before touching the patient. Place the following nursing actions in the order they should be performed.
  1. Move the right shoulder and arm forward and downward.
  2. Place the patient's arms across the chest and the left foot over the right foot.
  3. Place pillows behind the patient's back and under the head, left arm, and left leg.
  4. Roll the patient toward the right side using one hand behind the patient's shoulder and the other behind the patient's hip.

Answer: \_\_\_\_\_



5. A primary health-care provider orders a soapsuds enema for an adult patient. The nurse explains the procedure to the patient and arranges for the bathroom to be available. The nurse then performs hand washing, collects the equipment, and begins to prepare the enema equipment. Arrange the following interventions in the order in which they should be performed.
1. Add soap to the container, and gently rock the enema bag to disperse the soap.
  2. Lubricate the catheter tip with water-soluble jelly.
  3. Fill the container with 1,000 mL of 110 F water.
  4. Flush the tubing with water.
  5. Clamp the tubing.
- Answer: \_\_\_\_\_
6. A patient who had a total abdominal hysterectomy 2 days ago is ambulating and reports shortness of breath and stabbing chest pain on inspiration. A nursing assessment reveals a pulse of 110 beats per minute and respirations of 35 breaths per minute. Place the nursing interventions in priority order.
1. Administer oxygen.
  2. Assess breath sounds.
  3. Notify the primary health-care provider.
  4. Return the patient to bed by wheelchair.
  5. Place the patient in the high-Fowler position.
- Answer: \_\_\_\_\_
7. A nurse receives the following information about patients at the change-of-shift report. The nurse plans to assess the following patients in priority order depending on the importance of their needs. List the patients in order based on which patient should be assessed first, progressing to the patient who should be assessed last.
1. A patient who reported feeling nauseated
  2. A patient who just was informed of having cancer
  3. A patient who is receiving a titrated medication via an infusion pump
  4. A patient whose vital signs include an irregular pulse and labored respirations
  5. A patient who received an analgesic by mouth for pain immediately before report
- Answer: \_\_\_\_\_
8. An older adult experienced a number of events during the last year while living in an assisted living residence. Place the following events in order progressing from the first-level need to the last-level need according to Maslow's Hierarchy of Needs theory.
1. Learning how to use a computer
  2. Falling while walking in a hallway
  3. Having an episode of shortness of breath
  4. Being the honoree at a family birthday party
  5. Winning an art contest at the assisted living residence
- Answer: \_\_\_\_\_

### Exhibit Items

An exhibit item asks a question that requires the test taker to analyze and interpret data, which are organized into sections such as information commonly found in a patient's clinical record, physical assessment results, and results of patient/family member interviews. The test taker must review all of this information to arrive at a conclusion to answer the question.

1. An older adult with multiple health problems is admitted to the hospital after a fainting episode. An electrocardiogram reveals a dysrhythmia, and the patient is scheduled for a cardiac catheterization. Twelve hours after admission a nurse reads the collected information about the patient and performs a physical assessment. Which response does the nurse conclude that the patient is exhibiting?
  1. Systemic infection
  2. Anaphylactic shock
  3. Fluid volume excess
  4. Orthostatic hypotension

### PATIENT'S CLINICAL RECORD

#### Health History

Health problems: atherosclerosis, heart failure

Daily medications: digoxin, furosemide

#### Vital Signs on Admission

Temperature: 100.2°F, oral

Pulse: 94 beats/min, irregular

Respirations: 24 breaths/min

Blood pressure: 150/92 mm Hg

#### Physical Assessment

Subjective

Headache

Extreme fatigue

Short of breath

Objective

1+ pitting edema of ankles

Crackles in base of lungs

Vital signs

Pulse—100 beats/min

Respirations—26 breaths/min

Blood pressure—170/96 mm Hg

2. A 75-year-old man who had been having transient ischemic attacks (TIAs) is admitted to the hospital after experiencing a brain attack (cerebrovascular accident [CVA]). The patient is semicomatose and has right hemiplegia. The nurse reviews the patient's clinical record. Which complication is this patient at the **greatest** risk of developing?
  1. Diarrhea
  2. Hemorrhage
  3. Pressure ulcers
  4. Excessive serum glucose

## PATIENT'S CLINICAL RECORD

### Physical Assessment

Right hemiplegia  
Muscle flaccidity  
Urinary and fecal incontinence  
Responsive only to painful stimuli

### Health History

Atherosclerosis, iron deficiency anemia

### Laboratory Tests

RBC: 3.5 million/mcL  
WBC: 9,000 mcL  
Hb: 10.0 g/dL  
Ferritin: 14 ng/mL  
Fasting blood glucose: 85 mg/dL

3. A nurse is monitoring a patient who had major abdominal surgery. At 11 a.m. the patient reports difficulty breathing. The nurse reviews the patient's previous vital signs, performs a focused physical assessment, and obtains current vital signs. Which complication should the nurse conclude that the patient may be experiencing?
1. Pulmonary embolus
  2. Respiratory infection
  3. Subcutaneous emphysema
  4. Postoperative hemorrhage

## PATIENT'S CLINICAL RECORD

### Vital Signs

10:30 a.m.: P—72 beats/min, R—16 breaths/min, BP—120/72 mm Hg  
10:45 a.m.: P—70 beats/min, R—20 breaths/min, BP—118/74 mm Hg

### Physical Assessment

Diaphoresis  
Blood-tinged sputum  
Right-sided chest pain  
Dyspnea, decreased breath sounds on right side  
Abdomen flat and nontender, abdominal dressing dry and intact

### Current Vital Signs—11 a.m.

Temperature 100.2°F, temporal  
Pulse: 92 beats/min, regular  
Respirations: 28 breaths/min, shallow, labored  
Blood pressure: 160/92 mm Hg

4. A nurse is caring for a patient who had abdominal surgery at 8 a.m., 12 hours ago. An abdominal dressing, two Jackson-Pratts, an IV of 1,000 mL of 0.95% NaCl with 20 mEq of KCl at 125 mL/hr, a PCA pump with an analgesic, and a urinary catheter are present. The nurse reviews the clinical record and performs a physical assessment. Which response does the nurse conclude that the patient is experiencing?
1. Pain
  2. Hemorrhage
  3. Urinary retention
  4. Excess fluid volume

**PATIENT'S CLINICAL RECORD****Vital Signs**

4 p.m.: P—76 beats/min, R—18 breaths/min, BP—116/72 mm Hg

6 p.m.: P—80 beats/min, R—20 breaths/min, BP—120/76 mm Hg

**I&O: 8 a.m. to 8 p.m.**

Intake: IVF—1,500 mL

Output: urine—1,050 mL; wound drainage systems—210 mL

**Physical Assessment at 8 p.m.**

Dressing dry and intact

Pain of 8 on a scale of 0 to 10

IVF intact and infusing at 125 mL/hr

Retention catheter draining clear amber urine, no suprapubic distention

Vital signs: Pulse: 86 beats/min, Respirations: 24 breaths/min, Blood pressure: 136/80 mm Hg

5. An older adult who is dehydrated is to receive rehydration therapy. The nurse collects a health history, obtains the vital signs, and performs a physical assessment. Which complication is this patient at the **greatest** risk for developing?
1. Infection
  2. Aspiration
  3. Malnutrition
  4. Constipation

**PATIENT'S CLINICAL RECORD****Health History**

Brain attack 6 months ago

Flu and pneumonia vaccines in past 4 months

**Vital Signs**

Temperature: 99.6°F, oral

Pulse: 88 beats/min, regular rhythm

Respirations: 22 breaths/min, shallow

Blood pressure: 109/68 mm Hg

**Physical Assessment**

Lethargic

Dysphagia

Dysarthria

Diminished gag reflex

Skin dry, exhibiting “tenting”

Borborygmi auscultated in all four quadrants

6. An older adult is admitted to the hospital after several days of nausea, vomiting, and diarrhea. The nurse performs an assessment and reviews the patient's clinical record. Which does the nurse conclude that the patient is experiencing based on the data collected?
1. Hypokalemia
  2. Hypocalcemia
  3. Hypernatremia
  4. Hypermagnesemia

**PATIENT'S CLINICAL RECORD****Physical Assessment**

Patient reports muscle weakness and leg cramps  
Decreased bowel sounds  
Weak irregular pulses  
Weight loss of 8 pounds over the past few days

**Laboratory Tests**

Serum potassium: 3.1 mEq/L  
Serum sodium: 138 mEq/L  
Serum magnesium: 2.2 mEq/L  
Serum calcium: 9 mg/dL

**Medications**

Furosemide 40 mg, PO once daily  
Simvastatin 20 mg, PO at hour of sleep

7. A patient returns to the surgical unit from the postanesthesia care unit after surgical resection of the colon and removal of numerous regional lymph nodes. Two hours later, after a change-of-shift report, the oncoming nurse reviews the patient's vital signs flow sheet, performs a physical assessment, and interviews the patient. Which patient complication does the nurse identify after considering all the information?
1. Pain
  2. Atelectasis
  3. Hemorrhage
  4. Constipation

**PATIENT'S CLINICAL RECORD****Vital Signs**

3 p.m.: P—86 beats/min, R—20 breaths/min, BP—116/70 mm Hg  
4 p.m.: P—102 beats/min, R—26 breaths/min, BP—100/60 mm Hg

**Physical Assessment—5 p.m.**

Vital signs: P—126 beats/min, R—28 breaths/min, BP—86/60 mm Hg  
Urinary retention catheter draining clear amber urine, 50 mL in collection bag  
Intravenous solution infusing at 125 mL/hr  
Absence of bowel sounds, no bowel movement  
Two portable wound drainage devices in abdomen; one has 250 mL of sanguineous drainage, and the other has 300 mL of sanguineous drainage  
Abdominal dressing is dry and intact  
Vesicular, bronchovesicular, and bronchial breath sounds heard on auscultation of the lungs  
Appears restless (e.g., moving around in bed, clenching and unclenching fists)

**Patient Interview**

Reports pain as 4 on a 0 to 10 numerical pain scale  
Reports feeling anxious

8. A patient who sustained trauma to the right lower extremity in an automobile collision is placed in traction and scheduled for surgery in the morning. The nurse on the orthopedic unit obtains the patient's vital signs, interviews the patient, and reviews the patient's laboratory results. Which data should cause the nurse the **most** concern?
1. Sadness over death of his wife
  2. Avoidance of prostate surgery
  3. Pulse and respiratory rates
  4. Smoking history

### PATIENT'S CLINICAL RECORD

#### Vital Signs

Temperature: 97.8°F, temporal

Pulse: 96 beats/min, regular rhythm

Respirations: 24 breaths/min

Blood pressure: 150/88 mm Hg

#### Patient Interview

The patient is a 70-year-old retired man whose wife of 42 years died 4 months ago. He stated, "I miss her terribly and I'm so sad." He has 3 married sons and 8 grandchildren. He looks forward to playing with his grandchildren every day. He stated, "I am relatively healthy but I smoke 2 packs of cigarettes a day, am 40 pounds overweight, and drink a glass of wine every night." He has urinary hesitancy and a slow stream from an enlarged prostate but refused surgery. When asked about his current situation he stated, "I am not happy about having surgery for my leg but I really don't have a choice."

#### Laboratory Results

Hb: 16 g/dL

Hct: 45%

WBC: 8,000 mcL

F.A.

AVIS

COMPANY

## ALTERNATE ITEM FORMATS: ANSWERS AND RATIONALES

### Multiple-Response Items

1. 1. Pain is caused by irritation of nerve tissue by chemical substances and the pressure of fluid congestion in the area of local trauma.
  2. Heat is caused by an increased blood flow in response to release of histamine at the site of local trauma.
  3. Erythema is caused by an increased blood flow in response to release of histamine and an increased capillary permeability in response to kinins at the site of local trauma or infection.
  4. An increased heart rate is unrelated to the local adaptation syndrome (LAS). An increased heart rate is associated with activation of the sympathetic nervous system related to the general adaptation syndrome (GAS).
  5. A decreased blood pressure is unrelated to the LAS. An increased, not decreased, blood pressure is associated with activation of the sympathetic nervous system related to the GAS.
  6. An elevated blood glucose level is unrelated to the LAS. An elevated blood glucose level occurs in response to secretion of glucocorticoids in the GAS.
2. 1. Ambulation will not prevent blood loss that results in hypovolemia. Providing adequate hydration and assessing for hemorrhage help prevent hypovolemia.
  2. Ambulation promotes intestinal peristalsis that may result in a bowel movement.
  3. Ambulation promotes deep breathing that helps alveoli to expand, preventing the collapse of alveoli (atelectasis).
  4. Ambulation will not help prevent dehiscence. Supporting the incisional site during coughing, deep breathing, and activity helps prevent dehiscence.
  5. Ambulation will not help prevent infection. The use of sterile technique and hand washing help prevent infection.
3. 1. Apple juice contains approximately 7 mg of sodium per cup and is permitted on a 2-g sodium diet.
  2. A quarter cup of crumbled feta cheese contains approximately 418 mg of sodium and should be avoided on a 2-g sodium diet.
  3. Corned beef contains approximately 800 mg of sodium per 3 ounces and should not be included on a 2-g sodium diet.
  4. Most canned soups contain between 800 and 1,000 mg of sodium per cup and are contraindicated on a 2-g sodium diet. Even soups stipulated as low sodium or heart healthy may contain significant amounts of sodium.
  5. One broccoli spear contains approximately 20 mg of sodium and is permitted on a 2-g sodium diet.
4. 1. It is not necessary to know the drip rate per minute when determining whether an IV is “on time.”
  2. The time that the IV bag was hung is essential for the nurse to know when determining whether an IV is “on time.” The nurse must identify how many minutes/hours the IV has been running and then multiply this number by the milliliters of solution ordered by the primary health-care provider per minute/hour. This volume is then deducted from the original volume in the IV bag. The actual volume in the bag should be compared with the volume that should be in the bag. If the volumes match, the IV is “on time”; if there is more fluid than should be in the bag, then the IV is “behind schedule”; and if there is less fluid than should be in the bag, then the IV is “ahead of schedule.”
  3. The solution indicated on the IV bag is necessary to know to ensure that it is identical to the solution ordered by the primary health-care provider, not to determine whether an IV is “on time.”
  4. The volume of solution in the IV bag is essential for the nurse to know to determine whether an IV is “on time.” The nurse must identify how many minutes/hours the IV has been running and then multiply this number by the milliliters of solution ordered by the primary health-care provider per minute/hour. This volume is then deducted from the original volume in the IV bag. The actual volume that is in the bag should be compared with

- the volume that should be in the bag. If the volumes match, the IV is “on time”; if there is more fluid than should be in the bag, then the IV is “behind schedule”; and if there is less fluid than should be in the bag, then the IV is “ahead of schedule.”
5. The number of milliliters per hour ordered by the primary health-care provider is essential for the nurse to know to determine whether an IV is “on time.” The nurse must identify how many minutes/hours the IV has been running and then multiply this number by the milliliters of solution ordered by the primary health-care provider per minute/hour. This volume is then deducted from the original volume in the IV bag. The actual volume that is in the bag should be compared with the volume that should be in the bag. If the volumes match, the IV is “on time”; if there is more fluid than should be in the bag, then the IV is “behind schedule”; and if there is less fluid than should be in the bag, then the IV is “ahead of schedule.”
5. 1. Tachypnea, not bradypnea, occurs in response to sympathetic nervous system stimulation as the body attempts to deliver more oxygen to body tissues.
  2. **Tachycardia occurs in response to sympathetic nervous system stimulation as the body attempts to deliver more oxygen to body tissues.**
  3. The skin becomes pale and cold, not flushed, in response to hemorrhage as peripheral vasoconstriction occurs in an attempt to shunt blood to vital organs of the body.
  4. A bounding pulse is reflective of fluid overload (hypervolemia), not hypovolemia associated with hemorrhage. A weak, thready pulse is related to hypovolemia.
  5. **Delayed capillary refill occurs in response to peripheral vasoconstriction in an attempt to shunt blood to vital organs.**
6. 1. Gravity is the force that pulls mass toward the center of the earth. Urine flows by gravity out of the bladder through a tube (indwelling catheter, Foley catheter) into a collection bag placed below the level of the bladder.
  2. A Penrose drain is a flexible collapsible tube with a potential diameter of approximately 1 inch that drains fluid from inside a surgical site to a dressing via gravity.
  3. **Enema fluid flows from a container through a rectal tube into the large intestine via gravity. The force of the flow is regulated by raising or lowering the height of the enema bag in relation to the anus. Raising the bag increases the force; lowering the bag decreases the force.**
  4. A nasogastric tube removes fluid from the stomach via negative pressure, not gravity.
  5. A portable wound drainage system is a closed system that uses negative pressure, not gravity, to drain secretions from an incisional site.
7. 1. Helping a patient who is constipated choose foods from a diet menu is outside the scope of practice of a nursing assistant. It requires knowledge about foods, fiber, and teaching principles.
  2. Patient teaching is an independent role of the nurse, not a nursing assistant. Teaching a patient how to walk with a walker requires an understanding of anatomy and principles of physics and teaching.
  3. Applying an antifungal cream includes assessment of the area and correct application requiring the knowledge and skill of a nurse. Antifungal cream is a topical medication that requires a primary health-care provider’s prescription, and applying it is a dependent function of the nurse.
  4. **Weighing a patient using a bed scale is within the scope of practice of nursing assistants. Nursing assistants can collect vital statistics such as a patient’s weight, temperature, pulse, respiration, and intake and output. However, it is the responsibility of the nurse to interpret the results.**
  5. **Emptying a urine collection bag is within the scope of practice of nursing assistants. Nursing assistants have been taught to implement medical aseptic principles and standard precautions. Once the nursing assistant documents the output on the I&O flow sheet, it is the responsibility of the nurse to interpret the results.**



8. 1. Hand washing is based on principles of medical, not surgical, asepsis.
  2. **Keeping a sterile field dry requires actions based on the principles of surgical asepsis. Moisture contaminates a sterile field by facilitating the movement of microorganisms from the unsterile surface below the field to the sterile field by capillary action.**
  3. **Holding sterile objects above the waist is based on a principle of surgical asepsis. Sterile items, including sterile gloved hands, should be held above the waist; when held below the waist, they are considered contaminated because they may be out of the visual field of the nurse.**
  4. Wearing personal protective equipment protects the caregiver and is a principle of medical, not surgical, asepsis.
  5. A 1-inch, not  $\frac{1}{2}$ -inch, border of a sterile field is considered contaminated. This is based on a principle of surgical, not medical, asepsis.
9. 1. **The presence of gurgles and a cough indicate respiratory impairment. Difficult or uncomfortable breathing (dyspnea) is a clinical manifestation associated with impaired respiratory function.**
  2. **The presence of gurgles and a cough indicate respiratory tract impairment. These clinical manifestations along with purulent sputum may indicate the presence of a respiratory tract infection. A respiratory tract infection can be confirmed with a chest radiograph and sputum culture.**
  3. The presence of gurgles and a cough indicate impaired respiratory function. The blood pressure does not decrease with impaired respiratory function. However, it may increase with respiratory distress because of the influence of the sympathetic nervous system. A decreased blood pressure is associated with a decreased circulating blood volume, which is often caused by dehydration or hemorrhage.
  4. **A pulse oximeter is a device that measures a patient's arterial blood oxygen saturation (Sao<sub>2</sub>) via a sensor attached to the patient (e.g., finger, earlobe). A value that is less than 95% indicates respiratory impairment.**
5. Bronchovesicular breath sounds are expected sounds associated with an uncompromised respiratory function.
10. 1. Checking tube patency does not contribute to comfort. Checking tube patency ensures that the patient is receiving the ordered volume of formula.
  2. **Administering oral hygiene every 2 hours helps prevent drying of the oral mucosa, may relieve thirst, and supports oral comfort.**
  3. **Applying lubricant after cleaning the nares helps prevent drying of the respiratory mucosa of the nares, which supports comfort.**
  4. **Ensuring that the tube is secured to the nose helps reduce friction and trauma to the nares by the tube, which supports comfort.**
  5. Flushing the tubing helps maintain tube patency; it does not contribute to comfort. In addition, flushing the tubing is based on the primary health-care provider's order or a hospital policy.
11. 1. **Spinach is an excellent source of potassium. One cup of cooked spinach contains approximately 838 mg of potassium.**
  2. **A baked potato is an excellent source of potassium. A baked potato, depending on its size, contains approximately 844 to 955 mg of potassium.**
  3. A half cup of green beans provides less than 100 mg of potassium.
  4. Bran flakes do not contain potassium.
  5. Depending on the type of meat, 3 ounces of meat contain only 57 to 323 mg of potassium, and this is not the best choice of the options offered.
12. 1. **Sealing the lips around the mouthpiece prevents medication from escaping from around the mouth and mouthpiece and allows delivery of an accurate dose.**
  2. The patient should exhale through the mouth. Back pressure occurs when exhaling through the nose because the nostrils are smaller than the mouth. When using an inhaler, it is important to empty the lungs of as much air as possible to make a larger surface area available to come into contact with the subsequent inhaled medication.

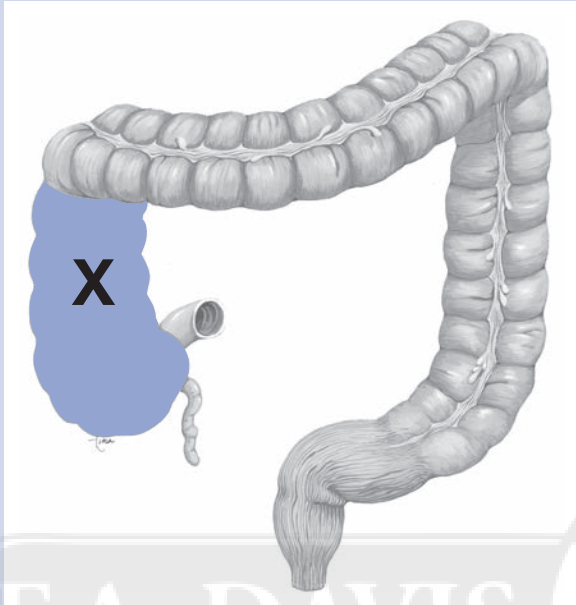
3. Breathing in deeply is a correct action because it delivers medication deep into the lungs. However, inhalation should be slow, not quick. Inhaling slowly allows for even contact of the medication with the lining of the respiratory tract.
  4. **Medication in a metered-dose inhaler may cause irritation of the oral mucosa or a fungal infection of the oral cavity. A swish and spit procedure with water reduces the exposure of the oral mucosa to the medication and reduces the risk of irritation to or a fungal infection of the oral cavity.**
  5. **Removing the cap, shaking it well, and spraying it into the air, repeating this three times before using it for the first time, primes the inhaler and ensures that the user is getting the correct dose. Also, this should be done when the inhaler has not been used for 14 or more days or when it has been dropped.**
13. 1. **Cheese, a dairy product, is an excellent dietary source of calcium. One ounce of cheese contains 150 to 406 mg of calcium depending on the type of cheese. Calcium is essential to maintain bone structure in addition to several neuromuscular, cardiac, and coagulation functions.**
    2. Lettuce is not high in calcium. One cup of shredded leaf lettuce contains approximately 38 mg of calcium.
    3. Peppers are not high in calcium. One pepper contains approximately 4 mg of calcium.
    4. Oranges are not high in calcium. One orange contains approximately 52 mg of calcium.
    5. **Sardines are high in calcium because they contain soft, edible bones. Three ounces of sardines (about seven fish) contain approximately 320 mg of calcium.**
  14. 1. **Wrinkles create ridges causing unnecessary pressure that can lead to tissue injury.**
    2. **The toe window should be positioned over the toes or sole of the feet depending on the manufacturer. This ensures that the stocking is aligned correctly and the distal portion of the foot can be accessed to perform the blanch test to assess peripheral circulation.**
3. The stockings should be applied before, not after, the patient gets out of bed. Standing permits the development of dependent edema because of the force of gravity. Putting antiembolism stockings on while still in bed helps prevent dependent edema. If stockings are applied after getting out of bed, they will compress edematous tissues and cause tissue injury.
  4. Flexion of the knee impedes, while extension of the knee promotes, application of an antiembolism stocking. Most antiembolism stockings are knee high rather than thigh high.
  5. Removing the stocking once a day for at least 30 minutes is inadequate. Antiembolism stockings should be removed every 8 hours for 30 minutes. This permits inspection and physical hygiene.

### Hot-Spot Items

1. **This site is at risk because it is dependent when lying in a right lateral position; the majority of body mass overlies the greater trochanter. The area over the greater trochanter has limited subcutaneous tissue, and when exposed to pressure more than 32 mm Hg, the capillaries are compressed, and blood does not bring oxygen and nutrients to the tissues.**



2. An X anywhere along the highlighted area is the correct answer. This site is the ascending colon, which contains the most liquid stool because it is at the beginning of the large intestine. As stool moves through the large intestine, fluid is reabsorbed, and stool becomes more dry and formed.

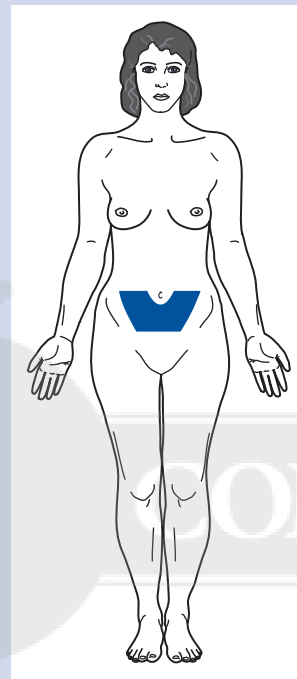


3. Auscultating over the left upper quadrant slightly to the left of the midsternal line will detect whooshing, gurgling, or bubbling sounds in the stomach as gastric content or air is instilled through the nasogastric tube.

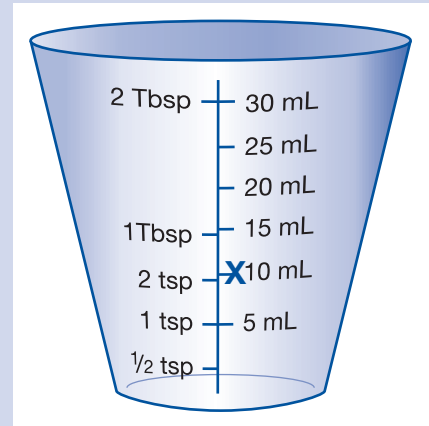
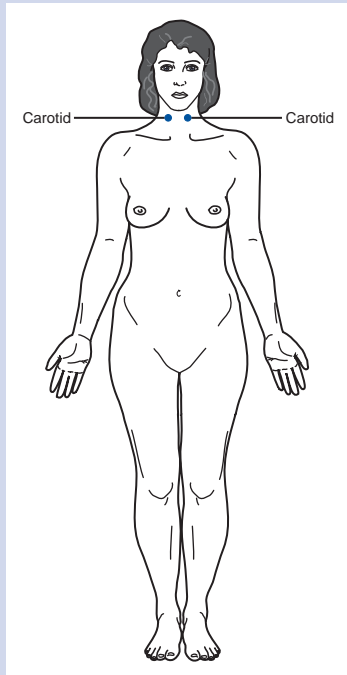


4. An X anywhere within the shaded area of the illustration is a correct answer. The abdomen, level with or below the level of the umbilicus, is the preferred site for a subcutaneous injection of 5,000 units of heparin. The nurse must avoid the area 2 inches around the umbilicus. The abdomen generally

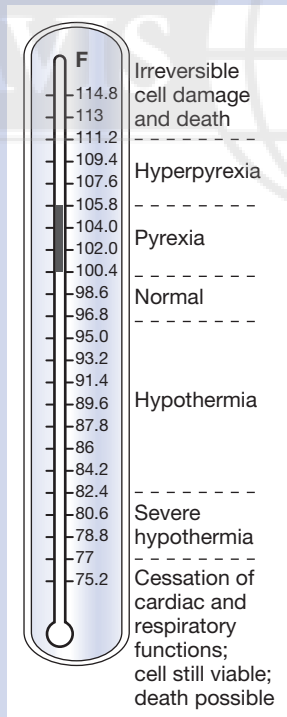
provides a layer of fat located below the dermis and above the muscle for heparin to be administered deep into the subcutaneous tissue. Also, it allows for faster absorption than subcutaneous sites on thighs and buttocks. A large area of subcutaneous tissue, which generally is found over the abdomen, is preferred because heparin may cause a hematoma and pain if accidentally administered intramuscularly.



5. An X over either the right or left carotid artery is a correct answer. The nurse performing sternal contractions is next to the patient's chest and abdomen. The nurse delivering breaths and monitoring the patient is next to the patient's head. The preferred site to assess the pulse is the carotid artery on the side in which the nurse delivering breaths is positioned because the nurse is next to the patient's head.



6. A temperature in the range of 100.4°F to 105.8°F is called pyrexia or fever. An X placed anywhere within this range is a correct answer.



7. Solve for x using ratio and proportion.

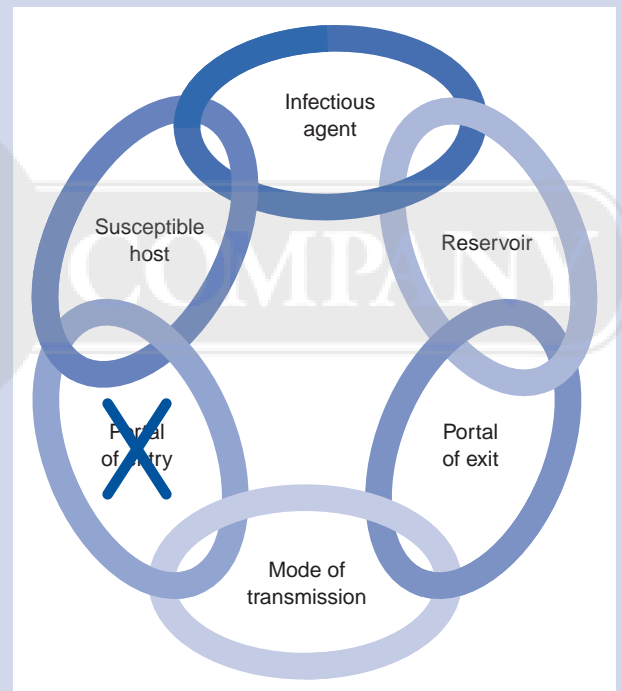
$$\frac{\text{Desired } 25 \text{ mg}}{\text{Have } 12.5 \text{ mg}} = \frac{x \text{ mL}}{5 \text{ mL}}$$

$$12.5 x = 125$$

$$x = 10 \text{ mg}$$

The 10-mL line is the second line up from the bottom on the right side of the medicine cup.

8. When a nurse wears a particulate filter mask (N95 respirator), the nurse is protected from exposure to the patient's respiratory pathogen, *Mycobacterium tuberculosis*.



### Fill-in-the-Blank Calculation Items

1. Answer: 120 mL. The nurse has to calculate how many milliliters to administer per minute to deliver 4 mg/min. Solve for x using ratio and proportion after converting 2 g to its equivalent of 2,000 milligrams.

$$\frac{\text{Desired } 4 \text{ mg}}{\text{Have } 2,000 \text{ mg}} = \frac{x \text{ mL}}{1,000 \text{ mL}}$$

$$2,000 x = 4,000$$

$$x = 4,000 \div 2,000$$

$$x = 2 \text{ mL (2 mL contains 4 mg)}$$

The hourly volume to be infused is calculated by multiplying the milliliters per minute (2) by the number of minutes (60). Therefore, the infusion pump should be set at 120 mL per hour.

2. Answer: 2 mL. Solve for x by using ratio and proportion.

$$\frac{\text{Desired } 400,000 \text{ mg}}{\text{Have } 200,000 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$

$$200,000 x = 400,000$$

$$x = 400,000 \div 200,000$$

$$x = 2 \text{ mL of the antibiotic solution}$$

3. Answer: 2 tablets. Solve for x by using ratio and proportion.

$$\frac{\text{Desired } 0.25 \text{ mg}}{\text{Have } 0.125 \text{ mg}} = \frac{x \text{ tab}}{1 \text{ tab}}$$

$$0.125 x = 0.25$$

$$x = 0.25 \div 0.125$$

$$x = 2 \text{ tablets}$$

4. Answer: 10 mL. Solve for x by using ratio and proportion.

$$\frac{\text{Desired } 25 \text{ mg}}{\text{Have } 12.5 \text{ mg}} = \frac{x \text{ mL}}{1 \text{ mL}}$$

$$12.5 x = 25$$

$$x = 25 \div 12.5$$

$$x = 10 \text{ mL}$$

5. Answer: 2.5 mL. Use ratio and proportion to convert 110 pounds to kilograms.

$$\frac{\text{Desired } 110 \text{ pounds}}{\text{Have } 2.2 \text{ pounds}} = \frac{x \text{ kg}}{1 \text{ kg}}$$

$$2.2 x = 110$$

$$x = 110 \div 2.2$$

$$x = 50 \text{ (50 kg is equal to 110 pounds)}$$

Now calculate the number of units of medication required using ratio and proportion.

$$\frac{\text{Desired } 50 \text{ kg}}{\text{Have } 1 \text{ kg}} = \frac{x \text{ units}}{100 \text{ units}}$$

$$1 x = 50 \times 100$$

$$x = 5,000 \text{ units}$$

Now calculate the amount of solution needed to administer the prescribed dose of 5,000 units by using ratio and proportion.

$$\frac{\text{Desired } 5,000 \text{ units}}{\text{Have } 2,000 \text{ units}} = \frac{x \text{ mL}}{1 \text{ mL}}$$

$$2,000 x = 5,000$$

$$x = 5,000 \div 2,000$$

$$x = 2.5 \text{ mL}$$

6. Answer: 7.5 mL. Solve the problem by using ratio and proportion.

$$\frac{\text{Desired } 6 \text{ mg}}{\text{Have } 4 \text{ mg}} = \frac{x \text{ mL}}{5 \text{ mL}}$$

$$4 x = 30 \text{ mL}$$

$$x = 30 \div 4$$

$$x = 7.5 \text{ mL}$$

7. Answer: 4 tablets. Solve the problem by using ratio and proportion.

$$\frac{\text{Desired } 5 \text{ mg}}{\text{Have } 1.25 \text{ mg}} = \frac{x \text{ tab}}{1 \text{ tab}}$$

$$1.25 x = 5$$

$$x = 5 \div 1.25$$

$$x = 4 \text{ tablets}$$

8. Answer: 1.5 tablets. Solve the problem by using ratio and proportion. Five is an odd-numbered day.

$$\frac{\text{Desired } 15 \text{ mg}}{\text{Have } 10 \text{ mg}} = \frac{x \text{ tab}}{1 \text{ tab}}$$

$$10 x = 15$$

$$x = 15 \div 10$$

$$x = 1.5 \text{ tablets}$$

9. Answer: 31 drops/min. Solve the problem by using the following formula.

$$\frac{\text{Total volume to be infused} \times \text{drop factor}}{\text{Total time in minutes}}$$

$$\frac{125 \text{ (volume to be infused)} \times 15 \text{ (drop factor)}}{1 \text{ hour} \times 60 \text{ minutes}}$$

$$\frac{1,875}{60} = 31.25 \text{ drops/min}$$

Because 0.25 is less than half a drop, round the answer down to 31 drops/min.

10. Answer: 5 units of regular insulin. According to the prescription, the nurse should give 5 units of regular insulin when the blood glucose level is between 201 and 250 mg/dL.

11. Answer: 1,310 mL. Compute the amount of IV solution received.

The patient's intravenous fluid was prescribed at 75 mL/hour. Over an 8-hour period the patient should have received 600 mL of sodium chloride. Every 20 minutes 25 mL of the solution of the primary infusion should have infused. However, the primary infusion was interrupted for 40 minutes while the intermittent antibiotic infusions were

administered. Therefore, for 40 minutes the patient received 100 mL of antibiotic solution rather than 50 mL of the primary solution of sodium chloride.

Add the amount of intravenous solution the patient received.

7 hours at 75/hour of the primary sodium chloride infusion = 525 mL.

100 mL of antibiotic solution (two doses of 50 mL each) over 40 minutes = 100 mL.

25 mL of the primary sodium chloride infusion over 20 minutes = 25 mL.

$525 + 100 + 25 = 650$  mL of intravenous solution (total amount of intravenous solution).

Now compute the patient's amount of oral intake. One ounce is equal to 30 mL.

4 ounces of coffee = 120 mL.

6 ounces of orange juice = 180 mL.

Beef broth = 240 mL.

8 ounces of ice chips = 120 mL. Ice chips are calculated as half their volume when melted.

Add the amount of oral fluid the patient received.

$120 + 180 + 240 + 120 = 660$  mL.

To determine the total fluid intake for the patient over 8 hours, add the total intravenous intake (650 mL) and the total oral fluid intake (660 mL):  $650 \text{ mL} + 660 \text{ mL} = 1,310 \text{ mL}$ .

12. Answer: 2 tablespoons. There are 15 mL of solution in 1 tablespoon; this is a memorized equivalent. Therefore, 2 tablespoons contain 30 mL of solution. Also, you can solve this problem by using ratio and proportion.

$$\frac{\text{Desired } 30 \text{ mL}}{\text{Have } 15 \text{ mL}} = \frac{x \text{ tablespoons}}{1 \text{ tablespoon}}$$

$$15x = 30$$

$$x = 30 \div 15$$

$$x = 2 \text{ tablespoons}$$

13. Answer: 83 calories. There are 4 calories per gram of carbohydrate; therefore,  $10 \times 4 = 40$  calories of carbohydrate. There are 4 calories per gram of protein; therefore,  $4 \times 4 = 16$  calories of protein. There are 9 calories per gram of fat; therefore,  $3 \times 9 = 27$  calories. Total the number of calories:  $40 + 16 + 27 = 83$  calories.

14. Answer: 36.4 mg. First determine how many kilograms are equal to 160 pounds by using a formula for ratio and proportion.

$$\frac{\text{Desired } 160 \text{ pounds}}{\text{Have } 2.2 \text{ pounds}} = \frac{x \text{ kilograms}}{1 \text{ kilogram}}$$

$$2.2x = 160$$

$$x = 160 \div 2.2$$

$$x = 72.72 \text{ kilograms is equal to } 160 \text{ pounds.}$$

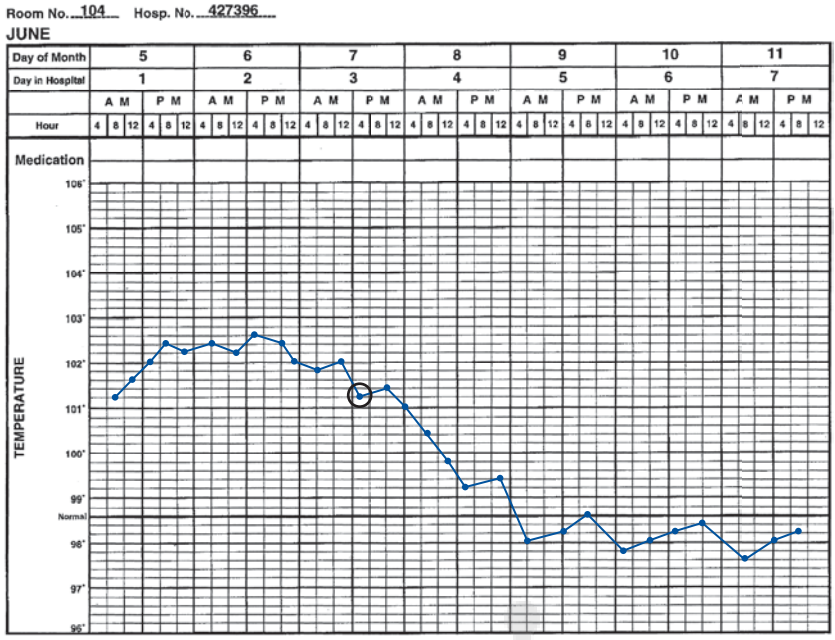
Next multiply 72.72 kilograms by the ordered dose of 0.5 mg to determine the total dose to be administered.

$$72.72 \times 0.5 = 36.36 \text{ mg. Round the dose up to } 36.4 \text{ because the } 6 \text{ following the } 3 \text{ is more than } 5.$$

Therefore, the dose is 36.4 mg.

### Graphic Items (Items Using a Graphic, Chart, Table, or Illustration)

1. A temperature of 97.8°F occurred on the sixth day of hospitalization (June 10) at 4 a.m.
2. A temperature of 99.2°F occurred on the fourth day of hospitalization (June 8) at 4 p.m.
3. Find the box in the top left that indicates "Day of Month." Read toward the right across the row until you see the box with the 7 (indicating the seventh day of the month, also called the third day in hospital, as indicated in the box below it). Look two rows down below the box with the 7 until you see the box with p.m. Now look below the p.m. box for the box with the 4. Guide your eye down the column until you find a dot on a line. From the dot on the line, guide your eye left across the row until you reach the numbers running along the left end of the graph. The nearest dark line below the row with the dot that indicates a full degree of temperature is 101. The dot in the 4 p.m. column is one light-colored line above the 101 line indicating two-tenths of a degree of temperature. Therefore, the dot in the 4 p.m. column indicates a temperature of 101.2°F.
4. A temperature of 102.6°F occurred on the second day of hospitalization (June 6) at 4 p.m.



2. 1. This is an incorrect calculation.
2. This is an incorrect calculation.
3. This is an incorrect calculation.
4. The total output between the hours of 7 a.m. and 3 p.m. is 1,405 mL. The nurse must first calculate the urine, emesis, and Hemovac totals and insert

the amounts in the “7 to 3 Total” row under the appropriate column. Then the nurse must add the totals of the three columns (1,050 + 250 + 105 = 1,405) to arrive at the overall total output for the hours between 7 a.m. and 3 p.m.

DAILY INTAKE AND OUTPUT RECORD

DATE JUNE 5

INTAKE						OUTPUT				
I.V. FLUIDS						ORAL	URINE	EMESIS	N.G. TUBE	HEMOVAC
Time	Bottle	Amount	Solution	Medication and Dosage	* ABS.	† LIB				
8	1	1000	NS	20 mEq KCl			850			
8:30							360			
10:00							120			
11:30							240	150		
12:00									160	
1:40									90	60
2:15							250			
3:00					525	475				45
<b>7-3 TOTAL</b>		<b>8 HR TOTAL</b>			525	475	720	1050	250	105
<b>8-11 TOTAL</b>		<b>8-HR TOTAL</b>								
<b>11-7 TOTAL</b>		<b>8-HR TOTAL</b>								
<b>24 HOUR TOTAL</b>										

INTAKE GRAND TOTAL       OUTPUT GRAND TOTAL   
 \* ABS. = amount absorbed    † LIB = left in bag

3. **1. Moving the straps of the mask to above the ears should be done to ensure that the mask is correctly positioned over the patient's nose and mouth.**
  2. Two pillows under the head will flex the neck causing stress and strain on the anatomical structures of the neck which should be avoided. One pillow is sufficient to ensure functional alignment of the head and neck in relation to the torso.
  3. **Monitoring a patient's oxygen saturation level is an objective assessment of a patient's respiratory status. This is an important assessment to make at the beginning of a shift and routinely throughout the shift of a patient with an oxygenation problem.**
  4. **A patient who has a medical condition impairing respiratory function requiring oxygen therapy should be positioned in the mid-Fowler or high-Fowler position. These Fowler positions cause abdominal structures to move down and away from the diaphragm via gravity facilitating respiratory exertion.**
  5. **A gown should be applied to provide for patient comfort and privacy.**
4. **1. This illustration indicates a medication being administered into a muscle. The standard practice for an intramuscular injection is to use a 1.5-inch needle that is administered at 90 degrees into muscle tissue.**
  2. This illustration indicates a medication being administered with a  $\frac{3}{8}$ -inch needle inserted at 90 degrees into subcutaneous tissue. A  $\frac{1}{2}$ -inch needle inserted at 90 degrees into subcutaneous tissue is also an acceptable technique. Both are considered standard practice.
  3. This illustration indicates a medication being administered with a  $\frac{3}{8}$ -inch needle inserted at 45 degrees into the subcutaneous tissue and is considered standard practice.
  4. This illustration indicates an intradermal injection whereby solution is injected just beneath the skin surface.
5. **1. Inversion is when the foot is turned inward medially.**
  2. **Adduction is when a body part (e.g., leg, arm) is moved toward the midline.**
3. **Supination is when the forearm and hand are turned facing upward.**
  4. **Opposition is when the thumb is moved so that it touches the tip of each finger.**
6. **1. A plastic thermometer that requires insertion into the mouth or rectum is inappropriate for a 2-year-old child. A 2-year-old child does not have the cognitive ability to follow instructions or the behavioral ability to remain still during the 3 minutes required to obtain an accurate temperature.**
  2. **An electronic thermometer that requires the insertion of a probe into the mouth for the temperature to register is inappropriate for a 2-year-old child. A 2-year-old child does not have the cognitive ability to follow instructions or the behavioral ability to remain still during the 15 to 30 seconds required to obtain an accurate temperature.**
  3. **An electronic infrared tympanic membrane thermometer is most appropriate from among the options presented for a 2-year-old child because it takes only 2 to 5 seconds to register a temperature. Its ease of use and rapid measurement make it an effective choice for taking the temperature of an alert and active 2-year-old child.**
  4. **A plastic digital thermometer requires the insertion of a probe into the mouth or rectum for 10 or more seconds for an accurate result and is inappropriate for a 2-year-old child. A 2-year-old child does not have the cognitive ability to follow instructions or the behavioral ability to remain still during the 10 or more seconds required to obtain an accurate temperature.**
7. **1. This is not an illustration landmarking the dorsogluteal site. To landmark the dorsogluteal site, the nurse palpates the posterior superior iliac spine and then draws a line to the greater trochanter. The dorsogluteal site is superior to halfway along this line.**
  2. **This is an illustration landmarking the ventrogluteal site. Place the heel of the hand on the greater trochanter with the fingers toward the patient's head. Use the right hand for the patient's left hip and the left hand for patient's right**



hip. Place the index finger on the patient's anterior superior iliac spine, and stretch the middle finger dorsally (toward the buttocks), palpating the iliac crest and then pressing below it. The triangle formed by the third finger, the index finger, and the edge of the crest of the ilium is the ventrogluteal site.

3. This is not an illustration of the rectus femoris site. The rectus femoris is on the anterior aspect of the thigh.
  4. This is not an illustration landmarking the vastus lateralis site. To landmark the vastus lateralis, the nurse identifies the middle third of the vastus lateralis muscle that is on the anterior lateral aspect of the thigh. It is within a rectangular area between a handbreadth above the knee and a handbreadth below the greater trochanter of the femur.
- 8. 1. These are the instructions for using a metered-dose inhaler, which is the device in the photograph. A prefilled pressurized canister delivers a measured dose of medication, which is inhaled by the patient. The patient must coordinate pushing the canister and inhaling the medication. This photograph exhibits a metered-dose inhaler with an extender (spacer). Rather than delivering a dose via a mouthpiece directly into the patient's mouth, a dose is pumped into the extender's chamber, where it is then inhaled by the patient. An extender can increase the volume of medication that moves deep into the lungs.**
2. These are the instructions for using a nebulizer. A nebulizer is a medication delivery system that produces an aerosol spray that is inhaled via a mouthpiece. Breathing deeply and slowly facilitates contact of the medication with the respiratory tract mucosa.
  3. These are instructions for assessing tidal volume. Tidal volume is the volume of air inhaled and exhaled with each normal breath, which is approximately 500 mL.
  4. These are the instructions for using a peak expiratory flow meter (PEFM), which measures the peak expiratory flow rate (PEFR). A PEFR is the volume of air that can be forcefully exhaled after a deep inspiration.

## Drag and Drop/Ordered Response Items

1. 3. The basics of assessment should follow the ABCs (airway, breathing, and circulation). Shortness of breath reflects a potential respiratory or cardiac problem, and a further assessment is the priority.
1. Relieving pain is a basic physiological and safety/security need. Relief from pain is not as high a priority as maintaining a patient's respiratory status but is more important than routine tasks.
4. Administering medications is a dependent function of the nurse. It is accepted practice that medications ordered for 8 a.m. can be dispensed up to 1 hour before or 1 hour after the ordered time.
2. A task ordered twice a day gives the nurse a range in the time frame in which it must be performed. Among the tasks presented, this task can be performed last because the others have greater priority.
2. 3. Inspection uses purposeful observation in a systematic manner. It does not require touching the patient; therefore, it will not precipitate a response that will influence future assessments.
2. Auscultation involves listening to sounds produced within the body. It requires the gentle placement of a warmed stethoscope progressively over all four quadrants of the abdomen; it will minimally influence future assessments.
4. Palpation is the use of touch to assess temperature, turgor, texture, dampness, vibration, shape, and presence of fluid. Areas of tenderness are palpated last in the palpation process. Light palpation may cause responses that influence future assessments, but it is less invasive than another assessment listed.
1. Percussion is striking a part of the body with short, sharp blows of the fingers. The sound obtained helps to determine the size, position, and density of the underlying body parts. It should be performed last in the assessment process because it is the most disruptive.

3. 1. Knowing where fire alarms/ extinguishers are located saves time in the event of a fire.
5. By identifying a fire early, it may be extinguished quickly before it becomes a danger to patients.
2. Once the presence of a fire is identified, patients in danger must be rescued to prevent patient injury.
3. The fire alarm should be activated once patients in the immediate vicinity of the fire are removed from danger.
4. After patients in danger are moved to safety and the fire alarm is activated, the nurse should close all doors and windows on the unit to contain the fire.
4. 2. Crossing the arms facilitates turning and protects the patient's arms. Crossing the left leg over the right leg uses the patient's weight to facilitate movement.
4. Turning the patient with the hands spread apart and at strategic points of the patient's anatomy permits the body to turn along its vertical axis, minimizing strain on the patient's vertebral column.
  1. Moving the right shoulder and arm forward and downward minimizes pressure on the ball-and-socket joint and rotator cuff of the shoulder.
  3. Pillows under the head and extremities keep them in functional alignment. A pillow behind the back maintains the patient on the side and keeps the vertebral column in functional alignment.
5. 5. Clamping the tubing allows the water to collect in the container once it is added.
  3. Soapsuds enema for an adult should be 500 to 1,000 mL of water at 105°F to 110°F. The volume is sufficient to distend the intestinal lumen, and the temperature is slightly more than body temperature to provide for comfort.
  4. This action expels air from the tubing and prevents air from entering the intestine.
    1. Soap is added after the container is filled to prevent the formation of bubbles and after the tubing is flushed to ensure that the soap is diluted in the total volume of solution (3 to 5 mL of soap per 1,000 mL of water). Gently rocking the enema bag prevents bubble formation while dispersing the soap evenly throughout the fluid.
    2. The catheter is lubricated to limit trauma as the catheter is inserted into the patient's anus and rectum.
6. 4. The patient most likely experienced a pulmonary embolus. Using a wheelchair limits muscle activity. Activity can contribute to more emboli and increase the demand on the heart and lungs.
  5. The high-Fowler position facilitates thoracic expansion and respirations, which are necessary to promote pulmonary functioning.
    1. Administering oxygen is essential to provide more oxygen for gas exchange, which will increase oxygen to body cells.
    2. After initial interventions the nurse can take the time to auscultate breath sounds to collect information that may be helpful to the primary health-care provider when making a medical diagnosis.
    3. The primary health-care provider should be notified after immediate interventions are performed to assess and facilitate respirations.
  7. 4. This patient should be assessed first. These vital signs are outside the expected range; therefore, this patient should be assessed first because these adaptations may indicate a life-threatening situation.
    2. This patient should be assessed second. The diagnosis of cancer may have precipitated a crisis for this patient. Psychosocial needs of patients are as important as physiological needs.
      1. This patient should be assessed third. Although nausea should be assessed, it is not life-threatening. Other patients are a greater priority.
      3. This patient should be assessed fourth. Infusion pumps deliver fluid volumes safely. Other patient situations are a greater priority.
      5. This patient should be assessed last. An analgesic by mouth takes approximately 30 minutes to be effective. This patient's response to the medication can be evaluated after other patients' needs are met.

8. 3. Having an episode of shortness of breath is related to physiologic needs, the first step of Maslow's Hierarchy of Needs theory.
2. Experiencing a fall is related to safety and security needs, the second step of Maslow's Hierarchy of Needs theory.
4. Being the honoree at a family birthday party is related to loving and belonging needs, the third step of Maslow's Hierarchy of Needs theory.
5. Winning an art contest at the assisted living residence is related to self-esteem needs, the fourth step of Maslow's Hierarchy of Needs theory.
1. Learning how to use a computer is related to self-actualization needs, the fifth step of Maslow's Hierarchy of Needs theory.

### Exhibit Items

1. Answer: 3. Fluid volume excess

#### PATIENT'S CLINICAL RECORD

##### Health History

Health problems:  
Atherosclerosis  
Heart failure

##### Daily medications:

Digoxin  
Furosemide

##### Vital Signs on Admission

Temperature: 100.2°F, oral  
Pulse: 94 beats/min, irregular  
Respirations: 24 breaths/min  
Blood pressure: 150/92 mm Hg

##### Physical Assessment

###### Subjective:

Headache  
Extreme fatigue  
Short of breath

###### Objective:

1+ pitting edema of ankles  
Crackles in base of lungs

###### Vital signs:

Pulse—100 beats/min  
Respirations—26 breaths/min  
Blood pressure—170/96 mm Hg

1. Although the patient is manifesting increases in temperature, pulse, respirations, and blood pressure, which are associated with a systemic infection, the patient is not experiencing the other classic responses to a systemic infection which include chills, diaphoresis, malaise, and change in mental status.
2. Anaphylactic shock, caused by exposure to an allergen, is manifested by anxiety, tachypnea, throat tightness, stridor, diaphoresis, flushing, and urticaria. Except for tachypnea, none of the other responses are exhibited by the patient.
3. Fluid volume excess in this situation is caused by the inefficient pumping action of the heart. A decreased cardiac output results in decreased renal perfusion that stimulates a renin/angiotensin response; this precipitates vasoconstriction and the increased release of aldosterone, which causes sodium and fluid retention, resulting in a fluid volume excess. The patient has a history of heart failure and has been receiving digoxin, which slows and strengthens the heart rate and acts as a mild diuretic, and furosemide, which is a loop diuretic. Objective data: the vital signs have increased, particularly the blood pressure, which indicates an increase of fluid in the intravascular compartment, and the pulse and respirations, which indicate an attempt to increase the amount of oxygen being delivered to body cells. Pitting edema results because of the movement of excess fluid from the intravascular to the interstitial compartment. Crackles in the lungs indicate pulmonary edema associated with fluid moving from the capillaries in the lung into the alveoli. Subjective data: these symptoms all support a fluid volume excess as the body responds to the excess accumulated fluid.
4. Orthostatic hypotension, caused by inefficient vasomotor responses in the circulatory system, is manifested by lightheadedness, vertigo, weakness, and diaphoresis when transferring from lying to sitting or from sitting to standing. The patient is not experiencing these physiological responses.

2. Answer: 3. Pressure ulcers

3. Answer: 1. Pulmonary embolus

### PATIENT'S CLINICAL RECORD

#### Physical Assessment

Right hemiplegia  
Muscle flaccidity  
Urinary and fecal incontinence  
Responsive only to painful stimuli

#### Health History

Atherosclerosis  
Iron deficiency anemia

#### Laboratory Tests

RBC: 3.5 million/mcL  
WBC: 9,000 mcL  
Hb: 10.0 g/dL  
Ferritin: 14 ng/mL  
Fasting blood glucose: 85 mg/dL

- The patient is unable to control the passage of stool (fecal incontinence) and does not have diarrhea. Diarrhea is the passage of three or more liquid or unformed stools a day.
- No data indicate the presence of hemorrhage. The CVA may be related to the development of a thrombus or embolus associated with the history of atherosclerosis and TIAs.
- The patient is anemic. Older men should have an RBC count of 3.7 to 6.0 million/mcL; Hb level of 11.0 to 17.0 g/dL; and serum ferritin value of 18 to 270 ng/mL. The patient is underweight and has less subcutaneous fat because of aging. Urine and feces are irritating to the skin because of their acidity and enzyme content, respectively. The presence of inadequate nutrition, the inability to move the right side of the body, the potential presence of urine and feces on the skin, and the characteristics of skin in the aged all create a risk for pressure ulcers.**
- The patient's serum glucose is within the acceptable range for an older adult (70 to 120 mg/dL).

### PATIENT'S CLINICAL RECORD

#### Vital Signs Flow Sheet

10:30 a.m.: P—72 beats/min, R—16 breaths/min, BP—120/72 mm Hg  
10:45 a.m.: P—70 beats/min, R—20 breaths/min, BP—118/74 mm Hg

#### Physical Assessment

Diaphoresis  
Blood-tinged sputum  
Right-sided chest pain  
Dyspnea, decreased breath sounds on the right side  
Abdomen flat and nontender, abdominal dressing dry and intact

#### Vital Signs—11 a.m.

Temperature: 100.2°F, temporal  
Pulse: 92 beats/min, regular  
Respirations: 28 breaths/min, shallow, and labored  
Blood pressure: 160/92 mm Hg

- When an embolus obstructs an artery in the lung, it interrupts gas exchange at the cellular level. This precipitates unilateral chest pain, blood-tinged sputum (hemoptasis), and respirations that become rapid, shallow, and labored (dyspnea). Decreased breath sounds occur over the affected alveoli as a result of the lack of gas exchange. Diaphoresis and an increase in vital signs occur as a result of the release of epinephrine.**
- Although the patient is in respiratory distress, the patient responses do not support the presence of a respiratory infection. With a respiratory infection the sputum would be yellow or green rather than blood tinged unless the infection was severe and prolonged, which is unlikely because of preoperative testing. Also, the temperature would be elevated. A temperature of 100.2 F is common after the stress of surgery.
- The patient is not exhibiting manifestations of subcutaneous

emphysema. Tenderness and crackling occur when suspect tissue is palpated. Subcutaneous emphysema is the presence of air in the subcutaneous tissue; this may occur with an open pneumothorax or around the side of a thoracotomy tube.

- The patient is not experiencing hemorrhage. The dressing is dry and intact, and the abdomen is flat and nontender. Also, the blood pressure increased rather than decreased. If the patient were hemorrhaging, the blood pressure would decrease as a result of hypovolemia.

#### 4. Answer: 1. Pain

### PATIENT'S CLINICAL RECORD

#### Vital Signs

4 p.m.: P—76 beats/min, R—18 breaths/min, BP—116/72 mm Hg  
6 p.m.: P—80 beats/min, R—20 breaths/min, BP—120/76 mm Hg

#### I&O: 8 a.m. to 8 p.m.

Intake: IVF—1,500 mL  
Output: urine—1,050 mL; wound drainage systems—210 mL

#### Physical Assessment at 8 p.m.

Dressing dry and intact  
Pain of 8 on a scale of 0 to 10  
IVF intact and infusing at 125 mL/hr  
Retention catheter draining clear amber urine, no suprapubic distention  
Vital Signs:  
Pulse: 86 beats/min  
Respirations: 24 breaths/min  
Blood pressure: 136/80 mm Hg

- The patient is in pain, as evidenced by a rating of 8 on a pain scale of 0 to 10. The increase in the pulse, respirations, and blood pressure reflects the response to the stress-related catecholamines.
- The patient is not hemorrhaging. If the patient were hemorrhaging, the blood pressure should have decreased, not increased, the portable wound drainage systems would contain more than 210 mL, and the dressing may have evidence of blood.
- The patient is not experiencing urinary retention. The urinary retention catheter

is draining clear amber urine, the suprapubic area is not distended, and the I&O are approximately equal, taking into consideration the fluid lost during surgery.

- If the patient were experiencing excess fluid volume, the blood pressure would be much higher, and the fluid intake would exceed the output on the I&O record.

#### 5. Answer: 2. Aspiration

### PATIENT'S CLINICAL RECORD

#### Health History

Brain attack 6 months ago  
Flu and pneumonia vaccines in past 4 months

#### Vital Signs

Temperature: 99.6°F, oral  
Pulse: 88 beats/min, regular rhythm  
Respirations: 22 breaths/min, shallow  
Blood pressure: 109/68 mm Hg

#### Physical Assessment

Lethargic  
Dysphagia  
Dysarthria  
Diminished gag reflex  
Skin dry, exhibiting "tenting"  
Borborygmi auscultated in all four quadrants

- Although older adults have a diminished immune system, the patient is not at high risk for an infection because of medical aseptic practices in the hospital and the fact that the patient has received appropriate immunizations.
- The patient is exhibiting imperfect articulation of speech (dysarthria), difficulty swallowing (dysphagia), a diminished gag reflex, and lethargy, which all are associated with brain attack (stroke, cerebrovascular accident). These clinical manifestations place the patient at high risk for aspiration. Airway is the priority as per the ABCs (airway, breathing, and circulation) of patient assessment.
- With a mechanical soft diet and supervision during meals, the patient should ingest adequate nutrients to prevent malnutrition.

- Although constipation may occur in the patient because of lethargy and decreased peristalsis associated with aging, the complication of constipation is not as likely as a complication in another option. The patient has borborygmi in all four quadrants of the abdomen, indicating the presence of intestinal peristalsis. Also, if constipation occurs, it can be diminished with stool softeners.

**6. Answer: 1. Hypokalemia**

**PATIENT'S CLINICAL RECORD**

**Physical Assessment**

Patient reports muscle weakness and leg cramps  
 Decreased bowel sounds  
 Weak irregular pulses  
 Weight loss of 8 pounds over the past few days

**Laboratory Tests**

Serum potassium: 3.1 mEq/L  
 Serum sodium: 138 mEq/L  
 Serum magnesium: 2.2 mEq/L  
 Serum calcium: 9 mg/dL

**Medications**

Furosemide 40 mg, PO once daily  
 Simvastatin 20 mg, PO at hour of sleep

- Muscle weakness, leg cramps, decreased bowel sounds, and a weak, irregular pulse are all clinical manifestations of hypokalemia. The serum potassium level of 3.1 mEq/L is below the expected range of 3.5 to 5.0 mEq/L. Furosemide is a diuretic that prevents the reabsorption of water and electrolytes from the tubules of the kidney into the bloodstream. When fluid is lost in response to furosemide, potassium is also eliminated, increasing the risk for hypokalemia. In addition, potassium is lost via vomiting and diarrhea. Weight loss occurs with dehydration.**
- The patient is not experiencing hypocalcemia. The serum calcium level of 9 mg/dL is within the expected range of 8.5 to 10.5 mg/dL. The patient is not exhibiting the following clinical manifestations of hypocalcemia: depressed deep tendon reflexes, bone pain, polyuria, lethargy, and a positive Chvostek or Trousseau sign.

- The patient is not experiencing hypernatremia. The serum sodium level of 138 mEq/dL is within the expected range of 135 to 145 mEq/L. Although the patient has nausea, vomiting, and muscle weakness, which are associated with hypernatremia, the patient is not exhibiting the following clinical manifestations of hypernatremia: thirst; dry, sticky mucous membranes; red, dry, swollen tongue; confusion; and agitation.
- The patient is not experiencing hypermagnesemia. The serum magnesium level of 2.2 mEq/L is within the normal range of 1.5 to 2.5 mEq/L. The patient is not exhibiting the following clinical manifestations of hypermagnesemia: peripheral vasodilation, flushing, paralysis, hypotension, bradycardia, lethargy, and respiratory depression.

**7. Answer: 3. Hemorrhage**

**PATIENT'S CLINICAL RECORD**

**Vital Signs**

3 p.m.: P—86 beats/min, R—20 breaths/min, BP—116/70 mm Hg  
 4 p.m.: P—102 beats/min, R—26 breaths/min, BP—100/60 mm Hg

**Physical Assessment—5 p.m.**

Vital signs: P—126 beats/min, R—28 breaths/min, BP—86/60 mm Hg  
 Urinary retention catheter draining clear amber urine, 50 mL in collection bag  
 Intravenous solution infusing at 125 mL/hr  
 Absence of bowel sounds, no bowel movement  
 Two portable wound drainage devices in abdomen; one has 250 mL of sanguineous drainage, and the other has 300 mL of sanguineous drainage  
 Abdominal dressing is dry and intact  
 Vesicular, bronchovesicular, and bronchial breath sounds heard on auscultation of the lungs  
 Appears restless (e.g., moving around in bed, clenching and unclenching fists)

**Patient Interview**

Reports pain as 4 on a 0 to 10 numerical pain scale  
 Reports feeling anxious

1. A 4 on a pain scale of 0 to 10 usually indicates that the patient can tolerate the pain and perform essential activities.
  2. Atelectasis is an incomplete expansion of the lung. Although restlessness and anxiety may accompany atelectasis, other clinical findings should include dyspnea, diminished breath sounds over the affected area, crackles, and cyanosis. Vesicular, bronchovesicular, and bronchial breath sounds heard on auscultation of the lungs are expected breath sounds and indicate effective pulmonary functioning.
  3. **Hemorrhage is an excessive loss of blood. It is evidenced by sympathetic nervous system–precipitated responses such as tachycardia (heart rate more than 100 beats/min), tachypnea (respiratory rate more than 20 breaths/min), presence of behavioral signs of restlessness, and reports of feeling anxious. The decrease in the systolic and diastolic blood pressures reflects the decrease in the circulating blood volume. The inadequate urinary output in relation to the fluid intake reflects a decrease in kidney perfusion and the kidney’s attempt to conserve fluid because of the decreased circulating blood volume. The collection of 550 mL of blood in the portable wound drainage systems is excessive. The patient is experiencing internal hemorrhage.**
  4. Constipation is infrequent bowel movements (fewer than 2 per week) or hard, dry feces. After abdominal surgery, particularly surgery involving the intestine, peristalsis will be interrupted temporarily because of the effects of anesthesia and the manipulation of the intestines. The absence of bowel sounds and a bowel movement is not significant at this time.
- 8. Answer: 4. Smoking history**
1. The patient’s sadness over the death of his wife is within the realm of expected grieving because the death occurred only 4 months ago. The fact that he looks forward to playing with his grandchildren every day indicates that he is looking toward the future.
  2. Although the patient’s avoidance of prostate surgery may be a concern in the future, it is not the priority at this time.

## PATIENT’S CLINICAL RECORD

### Vital Signs

Temperature: 97.8°F, temporal  
Pulse: 96 beats/min, regular rhythm  
Respirations: 24 breaths/min  
Blood pressure: 150/88 mm Hg

### Patient Interview

The patient is a 70-year-old retired man whose wife of 42 years died 4 months ago. He stated, “I miss her terribly and it makes me so sad.” He has 3 married sons and 8 grandchildren. He looks forward to playing with his grandchildren every day. He stated, “I am relatively healthy but I smoke 2 packs of cigarettes a day, am 40 pounds overweight, and drink a glass of wine every night.” He has urinary hesitancy and a slow stream from an enlarged prostate but refused surgery. When asked about his current situation he stated, “I am not happy about having surgery for my leg but I really don’t have a choice.”

### Laboratory Results

Hb: 16 g/dL  
Hct: 45%  
WBC: 8,000 mcL

3. A pulse of 96 beats per minute and respirations of 24 breaths per minute most likely are in response to anxiety associated with the scheduled surgery. Although the patient is unhappy with the need for surgery and the nurse should explore the patient’s feelings, they are not as much a concern as another option.
4. **Based on Maslow’s hierarchy of needs the patient’s smoking history poses a serious physiological concern about his respiratory status. The reduced respiratory compensatory reserve associated with aging, the 2 pack a day smoking history, and the fact that general anesthesia will be administered during surgery to repair his right leg place him at risk for impaired oxygenation.**

# Comprehensive Final Book Exam

# 7

This 100-item examination provides an opportunity to take a test that integrates content from among the topics included in Chapters 2 through 5. It includes alternate item formats that reflect the questions presented in Chapter 6. The answer(s) and rationales are provided to enhance your knowledge concerning the information being tested in each question. A Critical-Thinking Strategy (the RACE model), which is described in Chapter 1, is applied to every question to illustrate a methodical approach to analyze questions, eliminate options, and arrive at the correct answer.

## COMPREHENSIVE FINAL BOOK EXAM

1. Which early responses indicate to the nurse that the patient is experiencing hypoxia?

**Select all that apply.**

- Increased heart rate
  - Difficulty breathing
  - Restlessness
  - Bradypnea
  - Irritability
2. A patient has a history of chronic pain because of arthritis but dislikes taking large doses of analgesics. Which concept unique to unrelieved chronic pain should the nurse consider when caring for this patient?
- Generally, pain is better tolerated as the duration of exposure increases.
  - Pain minimally interferes with activities of daily living.
  - Usually, pain is related to the current pathology.
  - Pain rarely affects the immune response.
3. A nurse is assessing several patients who had surgery the previous day. Which sudden patient response should the nurse identify as a potential life-threatening event?
- Slightly elevated temperature
  - Separation of wound edges
  - Edema of the legs
  - Chest pain
4. A patient states, "I like to have a bowel movement every morning." Which additional information collected by the nurse supports a concern with perceived constipation?
- Hard, dry stools defecated daily
  - Laxatives used excessively
  - Abdominal distention
  - Straining at stool
5. A nurse must administer a sedative to a patient before surgery. Which should the nurse do **first**?
- Verify that the preoperative checklist is completed.
  - Check that the surgical consent is signed.
  - Ensure an intravenous line is in place.
  - Assess vital signs.



6. A primary health-care provider prescribes 500 mg of an antibiotic to be administered IVPB every 6 hours for a patient with a systemic infection. The vial dispensed by the hospital pharmacist contains 1 g of the prescribed antibiotic in powder form. The instructions on the vial state: "Instill 9.6 mL to yield 10 mL." How many milliliters of the antibiotic should the nurse add to the IVPB bag? **Record your answer using a whole number.**  
Answer: \_\_\_\_\_ mL
7. Which mechanism is designed to facilitate tracking a patient's progress as a cost-containment strategy in managed care?
1. Primary nursing
  2. Critical pathways
  3. Functional method
  4. Quality management
8. A nurse is assisting a patient who has cognitive deficits with a bed bath. Which is important for the nurse to do?
1. Explain in detail everything that will be done during the bath before beginning.
  2. Arrange the basin within the center of the patient's visual field.
  3. Encourage attention to each task of bathing.
  4. Check the patient every few minutes.
9. When interviewing the wife of a patient, which statements about her husband support the presence of obstructive sleep apnea? **Select all that apply.**
1. \_\_\_ "He snores and gasps all night long and wakes me up."
  2. \_\_\_ "He falls asleep sometimes when he drives, so now I do all the driving."
  3. \_\_\_ "He kicks and thrashes so much that the bed linen is upside down by morning."
  4. \_\_\_ "He has nightmares that are so scary that he wakes me up because he is afraid."
  5. \_\_\_ "He has these episodes and never wakes up but I do and then I can't get back to sleep."
10. A primary health-care provider orders a clear liquid diet for a patient who had abdominal surgery 3 days ago. Which does the nurse conclude is the reason why a clear liquid diet was ordered for this patient?
1. Relieves abdominal distention
  2. Stimulates digestive enzymes
  3. Prevents postoperative ileus
  4. Digests easily
11. For which common problem associated with prolonged diarrhea should the nurse assess a patient with this problem?
1. Skin breakdown
  2. Self-care deficit
  3. Sexual dysfunction
  4. Disturbed body image
12. A nurse causes harm to a hospitalized patient because of improper use of medical equipment. Which is this tort specifically called?
1. Battery
  2. Assault
  3. Negligence
  4. Malpractice

13. A patient with type 2 diabetes is experiencing blurred vision, generalized weakness, and fatigue. A nurse receives a report from the nurse on the previous shift and obtains additional information from the patient's clinical record. Which should the nurse conclude that the patient is experiencing?
1. Fluid retention
  2. Kidney impairment
  3. Hyperglycemic event
  4. Hypertensive episode

### PATIENT'S CLINICAL RECORD

#### Laboratory Results

BUN: 18 mg/dL  
 Creatinine: 1.2 mg/dL  
 Hemoglobin A<sub>1c</sub>: 8%  
 Serum glucose: 350 mg/dL

#### I&O Record (past 24 hours)

Intake: 2,400 mL  
 Output: 4,200 mL

#### Nursing Progress Note

10 a.m.—patient reports “being thirsty and urinating a lot” and has lost 20 pounds over the past 2 months; has poor skin turgor and dry mucous membranes.

14. Nurses on a unit are personally and professionally mature and motivated. Which classic leadership style should the nurse manager employ when working with this group?
1. Directive
  2. Autocratic
  3. Democratic
  4. Laissez-faire
15. A nurse transfers a patient from a bed to a wheelchair. Which is an important nursing intervention after placing the patient in the wheelchair?
1. Ensure the patient's popliteal areas are not touching the seat edge.
  2. Attach the patient's transfer belt to clips on the wheelchair.
  3. Support the patient's back with a pillow.
  4. Put the patient's feet flat on the floor.
16. A nurse identifies a patient's perception of health. Which can the nurse do as a result of obtaining this information?
1. Identify the patient's needs based on Maslow's Hierarchy of Human Needs.
  2. Provide meaningful assistance to help the patient regain a state of health.
  3. Help the patient prevent the occurrence of human responses to disease.
  4. Choose a place for the patient along the health-illness continuum.
17. An older adult asks the nurse, “I want to make sure I get enough vitamin A to keep my eyes healthy. Which fruits can I eat because I am not fond of vegetables?” Which fruits should the nurse explain are excellent sources of vitamin A? **Select all that apply.**
1.   C antaloupe
  2.   A pricots
  3.   P eaches
  4.   Ra isins
  5.   P runes

18. When caring for patients under stress, which is an important concept that nurses must consider when making assessments about nonverbal behavior?
1. It is controlled by the conscious mind.
  2. It carries less weight than what the patient says.
  3. It does not have the same meaning for everyone.
  4. It is a poor reflection of what the patient is feeling.
19. Which action should the nurse use to landmark the left dorsogluteal site for an intramuscular injection that is to be administered to a patient?
1. Locate the lower edge of the acromion and the midpoint of the lateral aspect of the arm.
  2. Identify the line from the posterior superior iliac spine to the greater trochanter.
  3. Place the heel of the hand on the greater trochanter.
  4. Palpate the anterior lateral aspect of the thigh.
20. Which level need in Maslow's Hierarchy of Needs is supported when the nurse places the patient's get-well cards where the patient can see them?
1. Love and belonging
  2. Safety and security
  3. Self-actualization
  4. Physiological
21. A patient has a diagnosis of osteoporosis. Which nutrients should the nurse encourage this patient to eat? **Select all that apply.**
1.  Rice
  2.  Milk
  3.  Yogurt
  4.  Sardines
  5.  Almonds
  6.  Tomatoes
22. A nurse must obtain a urine specimen from a patient with a urinary retention catheter (Foley) and drains urine in the tubing down into the collection bag. Which should the nurse do **next**?
1. Cleanse the exit tube at the bottom of the drainage bag with an alcohol swab.
  2. Use a clamp to constrict the tubing immediately distal to the collection port.
  3. Position the patient in a semi-Fowler position.
  4. Don a pair of clean gloves.
23. Which nursing action is appropriate in relation to the concept, "Bacteria and enzymes in stool are irritating to the skin"?
1. Wearing a pair of sterile gloves when collecting a patient's stool for culture and sensitivity
  2. Applying a moisture barrier to the perianal area of incontinent patients
  3. Encouraging a patient to drink a cup of cranberry juice daily
  4. Toileting a confused patient before each meal
24. A nurse decides to give a partial bath to a patient instead of a complete bath. How was the nurse working when this decision was made?
1. Dependently
  2. Independently
  3. Collaboratively
  4. Interdependently
25. A primary health-care provider orders a 2-g sodium diet for a patient. Which fluids should the nurse teach are high in sodium? **Select all that apply.**
1.  Cocoa
  2.  Seltzer
  3.  Lemonade
  4.  Low-fat milk
  5.  Tomato juice

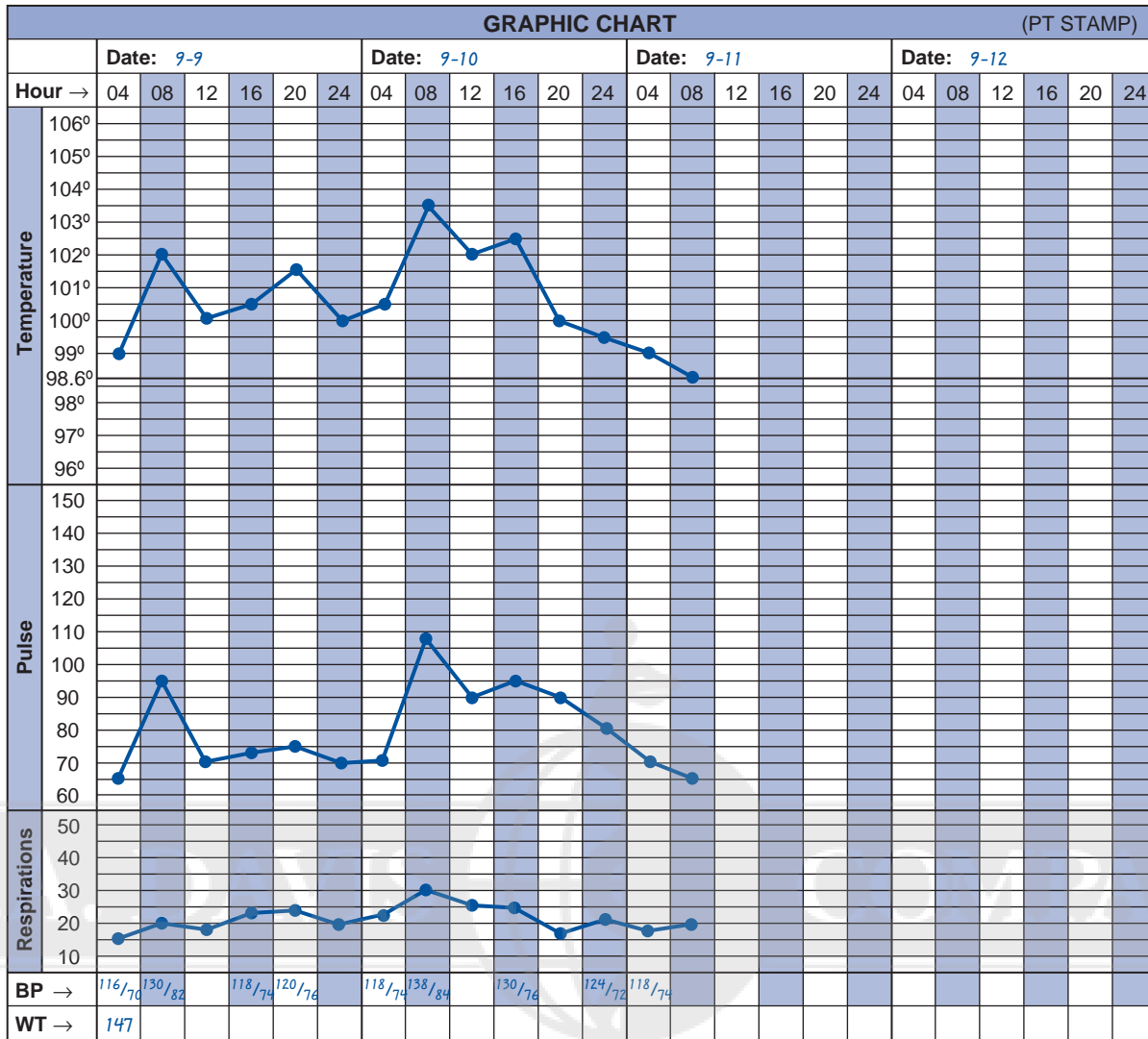
26. For which **most** serious complication of intubation associated with the administration of general anesthesia should the nurse assess a postoperative patient?
1. Stomatitis
  2. Atelectasis
  3. Sore throat
  4. Laryngeal spasm
27. A patient in pain tells the nurse, "It feels like something is on fire." Which characteristic of pain is associated with this statement?
1. Intensity
  2. Location
  3. Quality
  4. Pattern
28. A nurse places a patient who had abdominal surgery in the semi-Fowler position. What is the rationale for this nursing intervention?
1. Supports ventilation
  2. Promotes the passing of flatus
  3. Encourages urinary elimination
  4. Facilitates drainage in the portable wound drainage system
29. A nurse is teaching a group of nursing assistants about the administration of enemas. Which enema solution that works by irritating the intestinal mucosa should be included in the teaching?
1. Oil
  2. Soap
  3. Tap water
  4. Normal saline
30. A nurse is administering oral medications to several patients. Which factor associated with the administration of medication will increase the absorption of oral medications?
1. Given with water
  2. Taken on an empty stomach
  3. Administered in the morning
  4. Provided when the patient is resting
31. A nurse in the postanesthesia care unit is assessing several patients in pain. Patients in which age group should the nurse anticipate will be **most** sensitive to pain?
1. Infants
  2. Adolescents
  3. Older adults
  4. Pregnant women
32. A nurse is caring for a patient who is practicing Orthodox Judaism. Which should the nurse consider about dietary regulations when assisting the patient to plan meals? **Select all that apply.**
1. \_\_\_C\_\_\_offee and tea are restricted during Passover.
  2. \_\_\_M\_\_\_eat from cloven-footed and cud-chewing animals is permitted.
  3. \_\_\_D\_\_\_airy products and eggs are forbidden after sundown on Fridays.
  4. \_\_\_D\_\_\_airy foods should not be ingested at the same meal as meat and meat products.
  5. \_\_\_S\_\_\_hellfish is permitted but must be prepared according to biblical religious rituals.
33. A newly admitted patient arrives on the unit. Which is **most** important for the nurse to do to help minimize the development of anxiety.
1. Validate anxious feelings.
  2. Teach relaxation techniques.
  3. Minimize environmental stimuli.
  4. Explain procedures to the patient.

34. A home health-care nurse is helping a patient negotiate the health-care system within the community. Which word **best** reflects this role of the nurse?
1. Leader
  2. Resource
  3. Surrogate
  4. Counselor
35. Which patient statement indicates to the nurse that an older adult understands the teaching about how to care for dry skin effectively?
1. "I will increase the amount of water that I drink."
  2. "I can use baby powder on my skin rather than lotion."
  3. "I should have a bath every day using a moisturizing soap."
  4. "I ought to wear clothing made of wool rather than cotton."
36. A patient has a prescription for a vaginal suppository. Which actions should the nurse perform when administering this medication? **Select all that apply.**
1.  Lubricate the suppository and the index finger of a gloved hand before insertion of the suppository.
  2.  Instruct the patient to remain flat in bed for twenty minutes after insertion of the suppository.
  3.  Irrigate the vagina with normal saline before inserting the suppository.
  4.  Place the patient in the dorsal recumbent position for the procedure.
  5.  Advance the suppository along the posterior vaginal wall.
  6.  Insert the suppository while wearing clean gloves.
37. A nurse is taking a patient's temperature using the instrument in the illustration. Place the following steps in the order in which they should be implemented.



1. While holding the button down and keeping the probe flat against the forehead, slide the instrument across the forehead, stopping when the hairline on the side of the face is reached.
  2. Position the probe flat on the middle of the forehead halfway between the hairline and the eyebrow and hold the button down.
  3. While continuing to hold the button, touch the probe to the soft area behind the earlobe and below the mastoid.
  4. Clean the probe following the manufacturer's directions.
  5. Release the button.
- Answer: \_\_\_\_\_
38. A patient sustains soft tissue injuries from a motor vehicle collision. Which intervention is helpful in limiting the stress of both edema and bleeding into tissue?
1. Applying a cold compress
  2. Exerting direct pressure
  3. Performing effleurage
  4. Providing massage

39. Which response by a patient in the postanesthesia care unit is the **priority** concern for the nurse?
1. Pain
  2. Nausea
  3. Reduced level of consciousness
  4. Excessive loss of fluid through indwelling drains
40. Which should the nurse do when the vent of a patient's double-lumen nasogastric tube for decompression becomes obstructed?
1. Instill 10 mL of air into the vent lumen.
  2. Place the patient in the high-Fowler position.
  3. Position the vent below the level of the stomach.
  4. Withdraw 30 mL of gastric contents from the drainage lumen.
41. In which situations is a nurse required to complete an incident report? **Select all that apply.**
1.  Patient refused to go to physical therapy as ordered by a primary health-care provider.
  2.  Patient climbed over raised side rails and fell but was not injured.
  3.  Visitor ambulated a patient who should have been on bedrest.
  4.  Nurse left work early without reporting to the supervisor.
  5.  Patient did not receive a prescribed medication.
  6.  Nurse falls in the hall and breaks an arm.
42. A patient who has a transdermal analgesic patch for cancer experiences breakthrough pain with activity. Which is **most** important for the nurse to do?
1. Encourage the avoidance of moving around.
  2. Seek a dose increase in the long-acting opioid.
  3. Administer the prescribed shorter-acting opioid.
  4. Obtain a prescription for an antianxiety medication.
43. A nurse must perform a procedure and is unsure of the exact steps of the procedure. Which should the nurse do **first**?
1. Refer to a fundamentals of nursing skills textbook.
  2. Call the staff education department for assistance.
  3. Check the nursing policy and procedure manual.
  4. Refuse to do the nursing procedure.
44. A nurse is caring for a patient with a pressure ulcer. Which type of stressor is a pressure ulcer?
1. Microbiological
  2. Developmental
  3. Physiological
  4. Physical
45. At which day and time did the patient have a respiratory rate of 15 breaths per minute?
1. 9-9 at 04
  2. 9-9 at 08
  3. 9-10 at 08
  4. 9-10 at 16



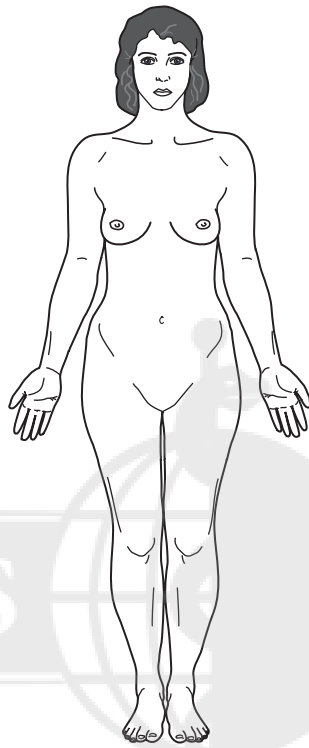
46. A patient appears agitated and states, “I’m not sure that I want to go through with this surgery.” Which response by the nurse uses the technique of paraphrasing?
  1. “Are you saying that you want to postpone the surgery?”
  2. “You are undecided about having this surgery?”
  3. “You seem upset about this surgery.”
  4. “Tell me more about your concerns.”
  
47. A nurse is planning to apply a transdermal patch to a patient. Which actions should the nurse implement? **Select all that apply.**
  1.  Use different sites each time to limit skin irritation and excoriation.
  2.  Rub the area to promote comfort and vasodilation before applying the patch.
  3.  Shave the area to facilitate adherence of the patch and medication absorption.
  4.  Wear clean gloves to protect one’s self from absorbing the medication through the hands.
  5.  Remove the old patch an hour after applying the new patch to ensure a therapeutic blood level of the drug.
  
48. Which should the nurse do when providing a backrub for a patient?
  1. Use continuous light gliding strokes with fingertips when finishing.
  2. Concentrate deep circular motions across the scapulae and sacrum.
  3. Knead firmly and quickly over the shoulders and the entire back.
  4. Massage gently over the bony prominences of the vertebrae.

49. A patient is told by the primary health-care provider that the patient has metastatic lung cancer and is seriously ill. After the provider leaves the room, the patient has a severe episode of coughing and shortness of breath and says, "This is just a cold. I'll be fine once I get over it." How should the nurse respond?
1. "What did you just find out about having a serious illness?"
  2. "Didn't you receive some bad news today?"
  3. "This is not a cold; it's lung cancer."
  4. "Tell me more about your illness."
50. A patient develops diarrhea after receiving several intermittent tube feedings. Which should the nurse consider is the cause of the diarrhea?
1. A high osmolarity of the feeding
  2. An inadequate volume of the feeding
  3. Failure to test for a residual before the feeding
  4. Lying in the high-Fowler position during the feeding
51. While in a restaurant, a pregnant woman exhibits a total airway obstruction because of a bolus of food. How should the nurse modify the thrusts of the abdominal thrust (Heimlich) maneuver for this person?
1. Perform them when the woman is in the supine, rather than standing, position.
  2. Use the pinkie finger side of the fist, rather than the thumb side, against the woman's body.
  3. Compress against the middle of the woman's sternum rather than between the umbilicus and xiphoid process.
  4. Initiate the procedure after the woman becomes unconscious, and discontinue it after six tries if unsuccessful.
52. A nurse is planning care to support a patient's ability to sleep. Which factor from among the options presented **most** commonly interferes with the sleep of hospitalized patients?
1. Napping during the day
  2. Disrupted bedtime rituals
  3. Medication administration
  4. Difficulty finding a comfortable position
53. A nurse is providing dietary teaching for a patient who is a pure vegan. Which food combinations that are substitutes for a complete protein should the nurse include in the dietary teaching? **Select all that apply.**
1.  Pasta and peas
  2.  Yogurt and fruit
  3.  Bread and cheese
  4.  Legumes and rice
  5.  Peanut butter and jelly
54. A nurse is administering medication to an older adult. A decrease in which of the following increases the risk of drug toxicity in this patient?
1. Serum calcium level
  2. Red blood cell count
  3. Glomerular filtration
  4. Frequency of urination
55. A nurse instills medicated drops into the ear of an adult. Which should the nurse do to ensure that the medication flows toward the eardrum?
1. Pull the pinna of the ear backward and downward.
  2. Insert the drops into the center of the auditory canal.
  3. Press the tragus of the ear several times after insertion.
  4. Roll the patient from the side-lying to the supine position.



56. A nurse identifies that an adult patient is exhibiting antisocial behavior. According to Erikson, the negative resolution of which stage of development is **most** commonly associated with antisocial behavior?
1. Preschool age
  2. Adolescence
  3. School age
  4. Infancy
57. Which nursing techniques will result in an accurate measurement when obtaining a patient's blood pressure? **Select all that apply.**
1.  **P** ositioning the arm at the level of the heart
  2.  **W** rapping the lower edge of the cuff over the antecubital space
  3.  Pumping the cuff about 30 mm Hg above the point where the brachial pulse is lost on palpation
  4.  Releasing the valve on the cuff so that the pressure decreases at the rate of 2 to 3 mm Hg per second
  5.  Deflating the cuff completely and waiting 2 minutes before reinflating the blood pressure cuff to take the pressure again
58. Which should the nurse use to **best** provide oral care to an unconscious patient?
1. Gauze-wrapped tongue blades with a saline solution
  2. Half-strength mouthwash and saline
  3. Packaged glycerin swabs
  4. Nonfoaming toothpaste
59. A patient is admitted to the hospital with a medical diagnosis of diverticulitis. Which is the **best** question the nurse should ask when obtaining an admission history from this patient?
1. "What did you eat yesterday?"
  2. "How long have you had diverticulitis?"
  3. "What led up to your coming to the hospital today?"
  4. "Have you ever had any previous episodes of diverticulitis?"
60. A primary health-care provider orders peak and trough levels for a patient receiving an intravenous antibiotic. What time should the nurse obtain a blood sample to determine a trough level when the antibiotic was administered at 12 noon?
1. 11 a.m.
  2. 11:30 a.m.
  3. 12:30 p.m.
  4. 1 p.m.
61. A nurse is planning care for a patient in the spiritual realm. Which age group generally is more involved with expanding and refining spiritual beliefs?
1. Adolescents
  2. Older adults
  3. Young adults
  4. Middle-aged adults
62. Which actions are specifically related to the principle, *the greater the base of support, the more stable the body*? **Select all that apply.**
1.  **A** ssisting a patient to walk
  2.  Using a walker when ambulating
  3.  **L** o cking the wheels of a wheelchair
  4.  **H** o lding objects close to the body when walking
  5.  **K** eeping the back straight when lifting an object

63. Which is the **most** effective nursing intervention to promote sleep that is appropriate for a patient in any situation?
1. Providing a backrub
  2. Playing relaxing music
  3. Offering a glass of warm milk
  4. Following a routine at bedtime
64. A nurse is performing an assessment of a patient. Place an X on the figure of the body where the nurse should place the stethoscope to assess for the presence of borborygmi.



65. Which is the **most** important nursing intervention to help prevent falls from physical hazards in a hospital?
1. Positioning the telephone within easy reach
  2. Storing belongings in a safe place
  3. Ensuring adequate lighting
  4. Using an over-bed table
66. A patient prefers and excessively maintains the supine position. For which potential problem associated with this position should the nurse assess the patient?
1. Pressure on the heels
  2. Pressure on the trochanters
  3. Internal rotation of the hips
  4. Flexion contracture of the knees
67. A patient is using the call bell numerous times an hour and requesting assistance with activities that the patient is capable of achieving independently. Which should the nurse do to help this patient?
1. Set limits verbally.
  2. Alternate care with another nurse.
  3. Point out the behavior to the patient.
  4. Attempt to see the situation from the patient's perspective.

68. A nurse going off duty is making rounds with the nurse coming on duty and provides a report on each patient in the district. Which information reported by the nurse is **most** complete?
1. The patient was given an antiemetic and reports resolution of the nausea.
  2. The patient's family members just visited and the patient appears happy.
  3. The patient seems less anxious than earlier in the day.
  4. The patient's blood pressure is now stable.
69. A nurse is bathing a patient. Which nursing actions support a principle associated with medical asepsis? **Select all that apply.**
1.  W ashing from the inner canthus to the outer canthus of the eye
  2.  Rep lacing the top covers with a clean flannel bath blanket
  3.  C hanging the bath water after washing the perineal area
  4.  Ha ving the patient void before beginning the bed bath
  5.  W earing clean gloves when washing the perineum
70. Health teaching regarding a kitchen fire should include what to do if grease in a frying pan catches on fire. A nurse teaches that in this situation people should first call 911. Which should people be taught to do **next**?
1. Pour water in the pan.
  2. Put the lid on the pan.
  3. Close the door to the kitchen.
  4. Use a class A fire extinguisher.
71. A patient who self-administers an aerosol medication by a metered-dose inhaler complains of "the nasty taste of the medication." Which should the nurse encourage the patient to do?
1. Suck on a hard candy after the procedure.
  2. Shake the cartridge longer before using it.
  3. Perform oral hygiene before inhalation of medication.
  4. Attach an aerosol chamber to the metered-dose cartridge.
72. Which is the **most** important purpose of the orientation phase of a therapeutic relationship?
1. Collect data.
  2. Build rapport.
  3. Identify problems.
  4. Establish priorities.
73. A patient has a temperature of 102 F and complains of feeling cold. Which additional responses should the nurse expect during this onset phase (cold or chill phase) of a fever? **Select all that apply.**
1.  Letha rgy
  2.  P ale skin
  3.  Shiver ing
  4.  Dia phoresis
  5.  Dehy dration
74. Which patient should the nurse identify will benefit the **most** from soaking the feet for several minutes as part of a bath?
1. Has a personal preference for taking showers
  2. Has lower extremity arterial disease
  3. Is ambulating with paper slippers
  4. Is on bedrest
75. A nurse is assessing the skin of an older adult. Which assessment is the **greatest** concern?
1. Flat, brown spots on the skin
  2. Thin, translucent skin
  3. Tenting of the skin
  4. Dry, flaky skin

76. A nurse is caring for a patient using an incentive spirometer. Which behaviors observed by the nurse indicate that further teaching is necessary? **Select all that apply.**
- Inha les slowly and deeply using the spirometer
  - T ilt the incentive spirometer while breathing in
  - Ra ises the inspiratory goal on the spirometer once a day
  - T akes several regular breaths and then uses the spirometer again
  - Ex hales while keeping the mouth sealed firmly around the mouthpiece
77. A nurse on a postpartum unit is teaching a class for new mothers about umbilical cord care. The nurse identifies that one mother does not become involved with the discussion and is withdrawn. Which is the **best** action by the nurse to help this new mother learn about umbilical cord care?
- Give the mother written material about cord care.
  - Invite the mother to the next class about cord care.
  - Bring an audiovisual cassette into the mother's room about cord care.
  - Provide informal individual instruction for the mother about cord care.
78. A nurse is teaching a patient with dysphagia how to eat safely. Which should the nurse encourage the patient to do? **Select all that apply.**
- T ilt the head backward when swallowing.
  - Dr ink fluids when eating bites of solid food.
  - Red uce environmental stimuli to a minimum.
  - Make sure that the mouth is empty after eating.
  - K eep food in the front of the mouth when chewing.
79. A patient consistently eats only 25% of every meal. Which should the nurse do to encourage the dietary intake of this patient?
- Help the patient to select preferred foods.
  - Teach the patient to avoid fluids and foods that cause flatus.
  - Encourage the patient to engage in light exercise before meals.
  - Persuade the patient to drink between-meal supplements twice daily.
80. A charge nurse is delegating assignments to a Registered Nurse and Nursing Assistant on the nursing team. Which actions should be implemented only by a Registered Nurse? **Select all that apply.**
- Eva luating a patient's response to activity
  - T aking the pulse of a patient with a dysrhythmia
  - T eaching a patient how to change a colostomy bag
  - A pplying a condom catheter on a patient who is incontinent
  - C hanging the linen on an occupied bed for a comatose patient
81. A nurse wants to influence a patient's beliefs so that new healthy behaviors are incorporated into the patient's lifestyle. Within which learning domain does the nurse need to direct teaching?
- Affective
  - Cognitive
  - Psychomotor
  - Physiological
82. A nurse is teaching a family member how to perform range-of-motion exercises of the hand. Which motion occurs when the angle is reduced between the palm of the hand and forearm?
- Hyperextension
  - Opposition
  - Abduction
  - Flexion

83. A patient with terminal cancer says to the nurse, "I've been fairly religious, but sometimes I wonder if the things I did were acceptable to God." How should the nurse respond?
1. "Not knowing what the future brings can be a frightening thought."
  2. "God will appreciate that you went to religious services."
  3. "If you were good, you have nothing to fear."
  4. "In life, all we have to do is try to be good."
84. A nurse is administering a lozenge to a patient's buccal area of the mouth. Which should the nurse do? **Select all that apply.**
1.  Ensure the patient stays awake while the lozenge dissolves.
  2.  Instruct the patient to take occasional sips of water.
  3.  Place the medication under the patient's tongue.
  4.  Alternate the cheeks from one dose to another.
  5.  Administer the lozenge just before meals.
85. Which question by the nurse assesses a patient's pain tolerance?
1. "At what point on a scale of 0 to 10 do you feel that you must have pain medication?"
  2. "What activities help distract you so that you don't feel the need for medication?"
  3. "How intense on a scale of 0 to 10 is the pain that you feel right now?"
  4. "Do you take pain medication frequently?"
86. An obese patient asks the nurse, "What should I do to help myself lose weight?" How should the nurse respond considering the **best** behavior modification strategy for controlling food intake?
1. "Ask family members not to bring tempting food into the house."
  2. "Post piggy pictures on the refrigerator."
  3. "Avoid snacks between meals."
  4. "Maintain a daily food diary."
87. Which general concept related to growth and development should be considered by the nurse when caring for patients?
1. Individuals experience growth and development at their own pace.
  2. Each task must be achieved before moving on to the next task.
  3. Family members provide safe and supportive environments.
  4. Once a task is achieved, regression is minimal.
88. A primary health-care provider orders the insertion of an indwelling urinary catheter (retention, Foley) as part of the patient's preoperative orders. Place the following steps of the procedure in the order in which they should be performed by the nurse.
1. Don sterile gloves.
  2. Open the catheterization package.
  3. Place a fenestrated drape over the patient's perineal area.
  4. Maintain spread of labia while swiping directly over the urinary meatus.
  5. Maintain spread of labia while swiping each labium with a separate cotton ball.
- Answer: \_\_\_\_\_
89. A patient's vital signs are: apical heart rate—100 beats/min, radial heart rate—84 beats/min, respirations—20 breaths/min, blood pressure—140/84 mm Hg. What is the patient's pulse deficit? **Record your answer using a whole number.**
- Answer: \_\_\_\_\_
90. A patient is admitted to the emergency department after sustaining a crushing injury at work. Which characteristic of blood pressure should alert the nurse to impending shock?
1. Rising diastolic
  2. Decreasing systolic
  3. Widening pulse pressure
  4. Robust Korotkoff's sounds

91. A primary health-care provider orders antiembolism stockings for a patient. Which is an important action the nurse should teach the patient?
1. Put them on after the legs have been dependent for 5 minutes.
  2. Monitor the heels and toes for redness every 8 hours.
  3. Apply body lotion before putting them on.
  4. Remove and reapply them once a day.
92. Which is the important consequence of the use of Diagnosis Related Groups (DRGs) on the health-care system?
1. Increased quality of medical care
  2. Increased reliability of research data
  3. Decreased acuity of hospitalized patients
  4. Decreased length of an average hospital stay
93. A primary health-care provider prescribes 1 g of an antibiotic to be administered via the intramuscular route twice a day. Which nursing action reflects the planning step of the nursing process?
1. Sending a copy of the order to the hospital pharmacy
  2. Identifying body landmarks before giving the injection
  3. Determining the times when the medication should be given
  4. Verifying the patient's allergies in the chart and on the patient's allergy band
94. A nurse working in a nursing home routinely administers digoxin 0.125 mg by mouth to a patient every morning. Which patient responses should alert the nurse to withhold the medication? **Select all that apply.**
1.    Diplopia
  2.    Vomiting
  3.    Tachypnea
  4.    Bradycardia
  5.    Dysrhythmias
95. A nurse is giving a patient a bed bath. Which should the nurse do to increase circulation?
1. Wash the extremities with firm strokes toward the heart.
  2. Soak the feet in warm water for at least 20 minutes.
  3. Expose just the areas that are being washed.
  4. Ensure that the water is 120 F to 125 F.
96. A nurse is predicting the success of a teaching program regarding the learning of a skill. Which factor is **most** relevant?
1. Cognitive ability of the learner
  2. Amount of reinforcement
  3. Extent of family support
  4. Interest of the learner
97. Which is **most** important for the nurse to do when assisting a female patient with care of the hair?
1. Use rubbing alcohol to remove tangles.
  2. Ensure that the patient's hair is left dry, not wet.
  3. Ask the patient what should be done with her hair.
  4. Comb hair from the proximal to distal end of the hair shaft.
98. A patient who is secretly smoking in bed falls asleep and the cigarette ignites the patient's gown. Which should the nurse do **first** after discovering the fire?
1. Smother the flames with a blanket.
  2. Roll the patient from side to side.
  3. Activate the fire alarm.
  4. Close the door.

99. A nurse discovers that a patient is taking natural herbal remedies. Which action is **most** important for the nurse to do?
1. Learn about the supplements.
  2. Think of the supplements as drugs.
  3. Communicate the supplement use to the primary health-care provider.
  4. Include the details about supplement use in the patient's health history.
100. A patient sustained a traumatic brain injury resulting in neurological deficits after falling off a ladder at work. Which setting is **most** appropriate for assisting this patient to learn how to live with neurological limitations?
1. Hospice program
  2. Acute-care setting
  3. Extended-care facility
  4. Assisted-living residence



# COMPREHENSIVE FINAL BOOK EXAM: ANSWERS AND RATIONALES

1. **1. More than 100 beats per minute (tachycardia) is an early response to hypoxia. Hypoxia is insufficient oxygen anywhere in the body. To compensate for this lack of oxygen, the heart increases its rate to improve cardiac output, thereby increasing oxygen to all body cells.**
2. Difficulty breathing (dyspnea) is a late, not early, sign of hypoxia.
3. **Restlessness is an early sign of hypoxia. Restlessness occurs with hypoxia because of a decrease in oxygen to the brain.**
4. An increase in respirations more than 20 breaths per minute (tachypnea), not a decrease in respirations less than 12 breaths per minute (bradypnea), occurs as the body attempts to deliver more oxygen to body cells.
5. **Irritability is an early sign of hypoxia. Irritability occurs with hypoxia because of a decrease in oxygen to the brain.**

## CRITICAL-THINKING STRATEGY

Recognize keywords.	Which <b>early responses</b> indicate to the nurse that the patient is experiencing <b>hypoxia</b> ?
Ask what the question is asking.	Which are early signs of hypoxia?
Critically analyze each option in relation to the question and the other options.	Examine each option from the perspective of whether or not the response is associated with reduced oxygenation in the body. This requires an understanding of physiological responses to reduced oxygenation and why each occurs.
Eliminate incorrect options.	Options 2 and 4 are late signs of hypoxia and can be eliminated.

2. **1. Persistent chronic pain becomes an unchanging part of life. As the duration of exposure increases, the individual may learn cognitive and behavioral strategies to cope with the pain.**

2. Chronic pain can markedly impair activities of daily living.
3. Chronic pain may, or may not, have an identifiable cause.
4. Acute pain and chronic pain both decrease the efficiency of the immune system.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient has a history of <b>chronic pain</b> because of arthritis but dislikes taking large doses of analgesics. Which <b>concept unique to unrelieved chronic pain</b> should the nurse consider when caring for this patient?
Ask what the question is asking.	Which concept is related only to unrelieved chronic pain?
Critically analyze each option in relation to the question and the other options.	Compare and contrast the commonalities and differences between chronic and acute pain and then identify the one statement that is associated only with unrelieved chronic pain.
Eliminate incorrect options.	Options 2, 3, and 4 are inaccurate statements as indicated in their rationales and can be eliminated.

3. **1. A slight elevation of body temperature is expected after surgery because of the body's response to the stress of surgery.**
2. Dehiscence, separation of the wound edges, is more likely to occur between the fifth and eighth postoperative days, and it is not life-threatening.
3. Dependent edema indicates problems, such as a fluid and electrolyte imbalance, impaired kidney function, or decreased cardiac output. All are serious but generally manageable.
4. **An acute onset of chest pain within 24 hours of surgery may indicate myocardial infarction in response to the stress of surgery. Also, it can be caused by a pulmonary embolus, although this is more likely to occur between the 7th and 10th postoperative days. Both of these complications are life-threatening.**



## CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is assessing several patients who had <b>surgery the previous day</b> . Which <b>sudden patient response</b> should the nurse identify as a potential <b>life-threatening</b> event?
Ask what the question is asking.	Which clinical finding indicates a possible life-threatening event?
Critically analyze each option in relation to the question and the other options.	Critically review several expected or potential problems related to the stress of surgery. Then identify the one complication that is life-threatening.
Eliminate incorrect options.	Option 1 is an expected outcome; options 2 and 3 are complications that are not as life-threatening as chest pain. Chest pain may indicate a myocardial infarction, which is a life-threatening condition. Options 1, 2, and 3 can be eliminated.

4. 1. The passage of hard, dry stools supports the presence of constipation, not a concern with perceived constipation.
2. **The expectation of a daily bowel movement at the same time every day with the resulting overuse of laxatives, enemas, and/or suppositories supports a concern with perceived constipation.**
3. Abdominal distention supports the presence of constipation, not a concern with perceived constipation.
4. Straining at stool supports the presence of constipation, not a concern with perceived constipation.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient states, “ <b>I like to have a bowel movement every morning.</b> ” Which <b>additional information</b> collected by the nurse <b>supports</b> a concern with <b>perceived constipation</b> ?
Ask what the question is asking.	Which is a clinical finding associated with perceived constipation?

Critically analyze each option in relation to the question and the other options.	Analyze the differences between constipation and perceived constipation.
Eliminate incorrect options.	Perceived constipation has no relationship with the characteristics of stool but rather the fact that an enema or laxative is used to ensure a daily bowel movement. The clinical findings in options 1, 3, and 4 are associated with characteristics related to actual, not perceived, constipation. Options 1, 3, and 4 can be eliminated.

5. 1. Although checking the preoperative checklist is done, it is not the priority. It usually is done last before the intraoperative period.
2. **The consent for surgery must be signed before preoperative medications are administered because they depress the central nervous system, impairing problem-solving and decision making.**
3. Ensuring placement of an IV line is unnecessary. This can be done at any time during the preoperative phase or at the beginning of the intraoperative phase of surgery.
4. Although assessing vital signs is done, it is not the priority.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse must <b>administer a sedative</b> to a patient before surgery. <b>Which should the nurse do first?</b>
Ask what the question is asking.	Which intervention is necessary before giving a preoperative sedative?
Critically analyze each option in relation to the question and the other options.	Review the components of a preoperative checklist and the legal implications of a preoperative consent form in relation to the administration of a sedative.

Eliminate incorrect options.	Options 1, 3, and 4 are unrelated to when a presurgical sedative is administered; all these interventions can be done immediately before surgery and before or after the sedative is administered. Options 1, 3, and 4 can be eliminated.
------------------------------	---

6. **Answer: 5 mL. Use ratio and proportion to first convert 500 mg to its equivalent in grams as well as to solve the problem.**

$$\frac{\text{Desire } 500 \text{ mg}}{\text{Have } 1,000 \text{ mg}} = \frac{x \text{ gram}}{1 \text{ gram}}$$

$$1,000x = 500$$

$$x = 500 \div 1,000$$

$$x = 0.5 \text{ gram (is equal to 500 mg)}$$

Now proceed to solve the problem using ratio and proportion.

$$\frac{\text{Desire } 0.5 \text{ gram}}{\text{Have } 1 \text{ gram}} = \frac{x \text{ mL}}{10 \text{ mL}}$$

$$1x = 0.5 \div 10$$

$$x = 5 \text{ mL}$$

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A primary health-care provider prescribes <b>500 mg</b> of an antibiotic to be administered IVPB every 6 hours for a patient with a systemic infection. The <b>vial dispensed</b> by the hospital pharmacist contains <b>1 g</b> of the prescribed antibiotic in powder form. The instructions on the vial state: <b>"Instill 9.6 mL to yield 10 mL."</b> <b>How many milliliters</b> of the antibiotic should the nurse <b>add to the IVPB bag?</b>
Ask what the question is asking.	Compute the dose of the prescribed medication.
Critically analyze each option in relation to the question and the other options.	Use a mathematical formula to convert milligrams to grams. Then use a mathematical formula to compute the correct dose of medication prescribed. The information you need to insert into the formula is the Desired (prescribed: 500 mg [0.5 g]) dose and what you Have (how the medication is supplied: 1 g/10 mL).

Eliminate incorrect options.	There is no need to eliminate options because this is a fill-in-the-blank question.
------------------------------	---

7. 1. Primary nursing is not a cost-containment strategy in managed care but rather a nursing-care delivery system that ensures a comprehensive and consistent approach to identifying and meeting patients' needs. Primary nursing occurs when one nurse is assigned the 24-hour responsibility for the planning and delivery of nursing care to a specific patient for the duration of the patient's hospitalization.
2. **Critical pathways are a case management system that identifies specific protocols and timetables for care and treatment by various disciplines designed to achieve expected patient outcomes within a specific time frame. The purpose is to discharge patients sooner, thereby reducing the cost of health care.**
3. Functional method refers to a model of nursing-care delivery that assigns a specific task for a group of patients to one person. Although it is efficient, it is impersonal and contributes to fragmentation of care because it is task oriented rather than patient centered.
4. Quality management (also known as continuous quality improvement, total quality management, or persistent quality improvement) refers to a program designed to improve, not just ensure, the quality of care delivered to patients. Also, it includes an educational component to support growth and provide for corrective action.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	<b>Which mechanism</b> is designed to facilitate <b>tracking a patient's progress</b> as a <b>cost-containment strategy</b> in managed care?
Ask what the question is asking.	Which cost-containment measure manages and documents a patient's progress through the health-care system?

continued

continued

Critically analyze each option in relation to the question and the other options.	Recall the definition and components of each of the presented mechanisms. Determine which is a strategy that facilitates tracking a patient's progress as a cost-containment measure.
Eliminate incorrect options.	Options 1 and 3 are two different types of nursing-care delivery and are not strategies that track a patient's progress through the health-care system. Option 4 addresses ongoing activities designed to improve the quality of health care. Options 1, 3, and 4 can be eliminated.

8. 1. Explaining about the bath in detail may precipitate anxiety. The patient does not have the cognitive ability or attention span to comprehend a detailed explanation before a procedure.
2. The patient has a problem with cognition, not vision.
3. **When progressing through each aspect of the bath give simple, direct statements to limit the amount of incoming stimuli at one time. This will promote comprehension and self-care.**
4. Patients with dementia do not have the cognitive ability to perform a procedure independently. The patient should be supervised.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is <b>assisting</b> a patient who has <b>cognitive deficits with a bed bath</b> . Which is <b>important</b> for the nurse <b>to do</b> ?
Ask what the question is asking.	Which must the nurse do to safely ensure that a patient with cognitive deficits receives an adequate bath?
Critically analyze each option in relation to the question and the other options.	Integrate what a patient with cognitive deficits can and cannot do, that daily-living activities must be accomplished adequately and safely, and that nursing care must address a patient's physical, emotional, and mental needs.

Eliminate incorrect options.

Options 1 and 4 are unrealistic for a patient with a cognitive deficit. Although option 2 should be done, it will not ensure an adequate bath. Options 1, 2, and 4 can be eliminated.

9. 1. **Episodes of sleep apnea begin with loud snoring followed by silence, during which the person struggles to breathe against a blocked airway. Decreasing oxygen levels cause the person to awaken abruptly with a loud snort.**
2. Falling asleep abruptly describes narcolepsy, which is a sudden overwhelming sleepiness (hypersomnia) in the daytime.
3. Kicking and thrashing describe restless legs syndrome, a feeling of creeping or itching sensation occurring in the lower extremities causing an irresistible urge to move and kick the legs.
4. Dreams that cause fear describe nightmares. Nightmares are vivid frightening dreams that occur during REM sleep and awaken the sleeper.
5. **Patients with obstructive sleep apnea usually are not aware of awakening during an episode.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	When interviewing the wife of a patient, <b>which statements</b> about her husband <b>support</b> the presence of <b>obstructive sleep apnea</b> ?
Ask what the question is asking.	Which statements describe clinical findings related to obstructive sleep apnea?
Critically analyze each option in relation to the question and the other options.	Distinguish among behaviors associated with obstructive sleep apnea versus other sleep disorders.
Eliminate incorrect options.	Options 2, 3, and 4 are descriptions of narcolepsy, restless legs syndrome, and nightmares, respectively. Options 2, 3, and 4 can be eliminated.

10. 1. A clear liquid diet will not relieve abdominal distention. A clear liquid diet is contraindicated in the presence of abdominal distention because gas has accumulated in the intestines as a result of a lack of intestinal motility.
2. A clear liquid diet will minimally stimulate digestive enzymes. A full-liquid diet or food will more likely stimulate gastric enzymes.
3. A clear liquid diet will not prevent postoperative ileus. A clear liquid diet is administered after a postoperative ileus resolves, not to prevent its occurrence.
4. **The molecules in clear liquids are less complex and easier to ingest, tolerate, and digest than those in a full-liquid diet or food.**
2. Diarrhea is unrelated to the ability to provide self-care. The inability to care for self is the state in which the individual experiences an impaired motor or cognitive function, causing a decreased ability to perform self-care activities.
3. Diarrhea is not related directly to sexual dysfunction, which is the state in which an individual experiences or is at risk of experiencing a change in sexual function that is viewed as unrewarding or inadequate.
4. Diarrhea is not related directly to body image disturbance, which is the state in which an individual experiences, or is at risk of experiencing, a disruption in the way one perceives one's body image.

### CRITICAL-THINKING STRATEGY

<b>Recognize</b> keywords.	A primary health-care provider orders a clear liquid diet for a patient who had <b>abdominal surgery</b> three days ago. Which does the nurse conclude is the <b>reason why a clear liquid diet was ordered</b> for this patient?
<b>Ask</b> what the question is asking.	Which is the benefit of a clear liquid diet after abdominal surgery?
<b>Critically</b> analyze each option in relation to the question and the other options.	Analyze the physiological responses to abdominal surgery, particularly complications such as abdominal distention and postoperative ileus and the benefits of a clear liquid diet after abdominal surgery.
<b>Eliminate</b> incorrect options.	A clear liquid diet is contraindicated with abdominal distention and postoperative ileus; therefore, options 1 and 3 can be eliminated. A clear liquid diet will minimally stimulate gastric secretions, and therefore option 2 can be eliminated.

11. 1. **Diarrhea is related directly to a risk for damage to epidermal and dermal tissue. The gastric and intestinal enzymes present in feces are acids capable of eroding the skin.**

### CRITICAL-THINKING STRATEGY

<b>Recognize</b> keywords.	For which <b>common problem associated with prolonged diarrhea</b> should the nurse assess a patient with this problem?
<b>Ask</b> what the question is asking.	Which common problem is caused by prolonged diarrhea?
<b>Critically</b> analyze each option in relation to the question and the other options.	Explore the consequences of diarrhea and identify the most common human response to diarrhea. Consider Maslow's Hierarchy of Needs when analyzing these options.
<b>Eliminate</b> incorrect options.	Preventing skin breakdown in option 1 is addressing a physiological need, which is a first-level need when compared with later level needs such as sexuality and body image. Options 3 and 4 can be eliminated. Just because a patient has diarrhea does not mean that the person cannot provide self-care. There are no data that indicate the patient is dependent. Option 2 can be eliminated.

12. 1. This situation is not an example of battery. Battery is the purposeful, angry, or negligent touching of a patient without consent.

2. This situation is not an example of assault. Assault is an attempt, or threat, to touch another person unjustly.
3. Although negligence occurs when a nurse's actions do not meet appropriate standards of care and result in injury to another, this term is not as specific as another term.
4. **Malpractice is misconduct, an act of commission or omission, performed in professional practice that results in harm to another. With malpractice the nurse and patient have a professional nurse-patient relationship.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse causes harm to a hospitalized patient because of <b>improper use of medical equipment. Which is this tort specifically called?</b>
Ask what the question is asking.	Which is the name of the tort when a nurse caring for a patient causes harm to the patient?
Critically analyze each option in relation to the question and the other options.	Review the definitions and examples of situations that relate to a variety of intentional and unintentional torts. Use this information to assign a name of a tort to the situation presented.
Eliminate incorrect options.	Options 1 and 2 include intentional behaviors that are a threat to touch another unjustifiably (assault) or actual touching another unjustifiably (battery). Option 3 is a tort that does not address behaviors within a professional relationship. Options 1, 2, and 3 can be eliminated.

13. 1. The patient is not experiencing fluid retention. The urine output is almost twice the volume of the intake. With fluid retention the skin is taut and shiny, the mucous membranes are moist, and the patient will gain weight.
2. Kidney impairment can be ruled out because the 4,200 mL of urinary output indicates that the kidneys are functioning. Also, with kidney impairment, generally there is weight gain, not loss. The BUN and creatinine levels are within the normal

range and indicate that the kidneys are not impaired.

3. **The serum glucose value of 350 mg/dL is excessive and indicates a hyperglycemic event; the acceptable range is less than 110 mg/dL. A hemoglobin A<sub>1c</sub> level of 8% indicates inadequate glucose control over the past 90 to 120 days. The acceptable value for hemoglobin A<sub>1c</sub> for a person with diabetes mellitus is less than 7% (American Diabetes Association) or less than 6.5% (American Association of Clinical Endocrinologists). The acceptable range for hemoglobin A<sub>1c</sub> in a person without diabetes mellitus is 4.0% to 5.5%.**
4. There are no data to support the conclusion that this event is a hypertensive episode. With the degree of polyuria, poor skin turgor, and dry mucous membranes, hypotension resulting from dehydration, not hypertension, is expected.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient with <b>type 2 diabetes</b> is experiencing <b>blurred vision, generalized weakness, and fatigue</b> . A nurse receives a report from the nurse on the previous shift and obtains additional information from the patient's clinical record. <b>Which should the nurse conclude that the patient is experiencing?</b>
Ask what the question is asking.	Which is the patient's problem based on the information presented?
Critically analyze each option in relation to the question and the other options.	Analyze the information presented in the laboratory results, I&O record, and nursing progress record in relation to the clinical manifestations associated with the four different clinical conditions.
Eliminate incorrect options.	The data presented do not support the problems in options 1, 2, and 4. Eliminate options 1, 2, and 4.

14. 1. Directive is not one of the four classic leadership styles.

2. The autocratic leadership style is probably the least effective style to use with a professionally mature and motivated staff. Autocratic leaders give orders and directions and make decisions for the group. There is little freedom and a large degree of control by the leader, which frustrates motivated and professionally mature staff members.
3. The democratic leadership style is the second best style to use when staff is motivated and professionally mature. The democratic style offers fewer opportunities for autonomy for staff members who are mature and motivated than a leadership style in another option.
4. **The laissez-faire leadership style is appropriate for a group of individuals who have an internal locus of control and desire autonomy and independence. Individuals who are professionally mature and motivated more often have an internal locus of control.**

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	<b>Nurses</b> on a unit are personally and <b>professionally mature and motivated</b> . Which <b>classic leadership style should the nurse manager employ</b> when working with this group?
Ask what the question is asking.	Which classic leadership style works best when nurses are mature and motivated?
Critically analyze each option in relation to the question and the other options.	Review the descriptions of leadership styles and explore the situations in which each works best. Then you need to select the style that works best in the situation presented.
Eliminate incorrect options.	Option 1 is not a leadership style. Option 2 is too dictatorial for individuals with an internal locus of control. Although option 3 is more independent than an autocratic style, it is more restricted than a laissez-faire style. Eliminate options 1, 2, and 3.

15. 1. **Pressure on the popliteal areas can cause damage to nerves and interferes with circulation and must be avoided.**
2. The transfer belt should be removed after the transfer is totally completed.
3. A pillow will move the patient too close to the front of the seat and is unsafe.
4. The patient's feet should be positioned flat on the footrests of the wheelchair, not the floor, to protect the feet if the wheelchair is moved.

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse transfers a patient from a bed to a wheelchair. Which is <b>an important nursing intervention after placing the patient in the wheelchair</b> ?
Ask what the question is asking.	Which action is essential when a patient is in a wheelchair?
Critically analyze each option in relation to the question and the other options.	List the steps of the procedure—transferring a patient from a bed to a wheelchair. Then the behavior in each option must be compared with the steps in the transfer procedure. Finally, you must identify the option that reflects a safe, correct action by the nurse.
Eliminate incorrect options.	Options 3 and 4 are both unsafe interventions and may jeopardize the patient. Option 2 is unnecessary and may be uncomfortable for the patient. Eliminate options 2, 3, and 4.

16. 1. A patient's perceptions are only one part of the data that must be collected before the nurse can establish the priority of the patient's needs. Maslow's Hierarchy of Human Needs helps the nurse to determine the patient's needs in order of priority based on the collected data.
2. **Health perception reflects a person's knowledge, behavior, and attitudes regarding illness, disease prevention, health promotion, and what constitutes a healthy lifestyle. An assessment of these factors captures the uniqueness of each individual and provides essential data that must be considered**

before needs are identified and a plan formulated.

3. A healthy lifestyle can promote health and prevent some illness or even minimize complications; however, understanding a person's perceptions of health may not prevent human responses to disease.
4. Only a patient, not a nurse, can choose a patient's place along the health-illness continuum. How people perceive themselves is subjective and is influenced by their own attitudes, values, and beliefs.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse identifies a <b>patient's perception of health. Which can the nurse do as a result of obtaining this information?</b>
Ask what the question is asking.	Which can a nurse do after learning about the patient's beliefs about health?
Critically analyze each option in relation to the question and the other options.	Appreciate that health beliefs are specific to the individual. This concept must be analyzed in relation to the theories of Maslow's Hierarchy of Human Needs and the health-illness continuum.
Eliminate incorrect options.	Options 1, 3, and 4 are incorrect statements as indicated in their rationales and can be eliminated.

17. 1. **Cantaloupe is an excellent source of vitamin A. A half cup of melon balls contains approximately 2,993 International Units of vitamin A.**
2. **Apricots are an excellent source of vitamin A. A 3½-ounce serving of apricots contains approximately 7,240 International Units of vitamin A.**
3. **Peaches are an excellent source of vitamin A. A 3½-ounce serving of peaches contains approximately 2,160 International Units of vitamin A.**
4. Raisins are not high in vitamin A. A 3%ounce serving of raisins contains approximately 10 International Units of vitamin A.
5. **Prunes are an excellent source of vitamin A. A 3½-ounce serving of prunes contains approximately 1,990 International Units of vitamin A.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	An older adult asks the nurse, "I want to make sure I get enough vitamin A to keep my eyes healthy. Which fruits can I eat because I am not fond of vegetables?" <b>Which fruits</b> should the nurse explain <b>are excellent sources of vitamin A?</b>
Ask what the question is asking.	Which fruits have the highest vitamin A content?
Critically analyze each option in relation to the question and the other options.	Recall how much vitamin A is contained in each nutrient and then compare and contrast the nutrients among the options. The options with high vitamin A content are the correct answers.
Eliminate incorrect options.	Option 4 can be eliminated because raisins contain only small amounts of vitamin A versus larger amounts of vitamin A in the fruits in options 1, 2, 3, and 5.

18. 1. Nonverbal behavior is controlled more by the unconscious than by the conscious mind.
2. Nonverbal behavior carries more, not less, weight than verbal interactions because nonverbal behavior is influenced by the unconscious mind.
3. **Transculturally, nonverbal communication varies widely. For example, gestures, facial expressions, eye contact, and touch may reflect opposite messages among cultures and among individuals within a culture.**
4. The opposite is true. Nonverbal behaviors often directly reflect feelings.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	When caring for patients under stress, which is an <b>important concept</b> that nurses must consider <b>when making assessments about nonverbal behavior?</b>
Ask what the question is asking.	Which is important about nonverbal behavior that influences nursing assessments?

Critically analyze each option in relation to the question and the other options.	Review the variety of statements about nonverbal behavior, and determine their accuracy. Then select the option that is a true statement.
Eliminate incorrect options.	Options 1, 2, and 4 can be eliminated because the statements in the options are incorrect as indicated in the rationales.

19. 1. The lower edge of the acromion and the midpoint of the lateral aspect of the arm are anatomical landmarks that help to identify the deltoid muscle.
2. **The line from the posterior superior iliac spine to the greater trochanter is an anatomical landmark that helps to identify the dorsogluteal site. This site contains the well-developed gluteus muscles, particularly the gluteus maximus, in the buttocks.**
3. Placing the heel of the hand on the greater trochanter is the initial placement of the hand when identifying landmarks for the ventrogluteal site.
4. Palpating the anterior lateral aspect of the thigh is associated with identifying the vastus lateralis site. It is between one handbreadth above the knee and one handbreadth below the greater trochanter on the anterior lateral aspect of the thigh.

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which action should the nurse use to <b>landmark</b> the <b>left dorsogluteal site</b> for an <b>intramuscular injection</b> that is to be administered to a patient?
Ask what the question is asking.	What is the landmark for a dorsogluteal intramuscular injection?
Critically analyze each option in relation to the question and the other options.	List the steps in the procedure—landmarking the dorsogluteal injection site. Then identify the specific action included in one of the options that relates to the dorsogluteal site.
Eliminate incorrect options.	Options 1, 3, and 4 are options that present steps that are related to sites other than the dorsogluteal site and can be eliminated.

20. 1. **Taping a patient's get-well cards to the wall where the patient can see them supports the patient's need to feel loved and appreciated and meets love and belonging needs according to Maslow's Hierarchy of Needs.**
2. Placing get-well cards where the patient can see them does not support a patient's safety and security needs. Safety and security needs are related to being and feeling protected in the physiological and interpersonal realms.
3. Placing get-well cards where the patient can see them does not support a patient's self-actualization needs. Self-actualization involves the need to achieve the highest potential within abilities.
4. Placing get-well cards where the patient can see them does not support a patient's physiological needs. Physiological needs are related to having adequate air, food, water, rest, shelter, and the ability to eliminate and regulate body temperature.

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which level need in <b>Maslow's Hierarchy of Needs</b> is <b>supported</b> when the nurse places the patient's <b>get-well cards where the patient can see them</b> ?
Ask what the question is asking.	Exhibiting cards is related to which level of Maslow's Hierarchy of Needs?
Critically analyze each option in relation to the question and the other options.	Recall behaviors related to each level of Maslow's Hierarchy of Needs. Then compare the situation presented with this recalled information.
Eliminate incorrect options.	Options 1, 3, and 4 can be eliminated because they are associated with needs on levels other than love and belonging.

21. 1. Rice, regardless of the type, is not high in calcium. One cup of rice contains approximately 5 to 33 mg of calcium.
2. **Milk and products made with milk such as various forms of cheese are an excellent source of calcium. Eight ounces of 1% low-fat milk contain approximately 290 mg of calcium. Eight ounces of 2% reduced-fat milk contain approximately 285 mg of calcium.**



3. **Yogurt is an excellent source of calcium. Eight ounces of plain non-fat yogurt contains approximately 452 mg of calcium. Eight ounces of low-fat yogurt contains approximately 415 mg of calcium.**
4. **Sardines, which contain soft edible bones, are an excellent source of dietary calcium. Three ounces of sardines contain approximately 371 mg of calcium.**
5. **Almonds are an excellent source of calcium. One ounce of almonds (about 24) contains approximately 75 mg of calcium.**
6. Tomatoes are not high in calcium. One tomato (2 inches in diameter) contains approximately 9 mg of calcium.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient has a diagnosis of <b>osteoporosis</b> . Which nutrients should the nurse encourage this patient to <b>eat</b> ?
Ask what the question is asking.	Which foods facilitate bone maintenance?
Critically analyze each option in relation to the question and the other options.	Recall that osteoporosis is the reduction of bone mass and that an increase in calcium will support bone maintenance. Recall how much calcium is contained in each nutrient, and then compare and contrast the nutrients among the options. The options with the highest calcium content are the correct answers.
Eliminate incorrect options.	Options 1 and 6 can be eliminated because the nutrients in these options contain small amounts of calcium compared with the amounts of calcium in the nutrients in options 2, 3, 4, and 5.

22. 1. Cleansing the exit tube at the bottom of the drainage bag with an alcohol swab is unnecessary. When obtaining a specimen from a retention catheter, the aspiration port of the catheter (not the exit tube) is wiped with a disinfectant before inserting the syringe. Urine specimens from a

retention catheter should come from the port, not the bag, because this urine is the most recently excreted.

2. Clamping the tubing immediately distal to the collection port should not be done until a step mentioned in another option is performed first. The drainage tubing should be clamped 1 to 2 inches below the aspiration port for 15 to 20 minutes to allow urine to accumulate.
3. Positioning the patient in a semi-Fowler position is done later in the procedure if necessary. This position moves urine toward the trigone (the triangular area at the base of the bladder where the ureters and urethra enter the bladder) where it is accessible to the catheter.
4. **Wearing personal protective equipment, such as clean gloves, is a medical asepsis practice. Gloves protect the nurse from the patient's body fluids because the catheter is close to the perineal area and there is a potential for exposure to urine during the procedure.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse must obtain a <b>urine specimen</b> from a patient with a <b>urinary retention catheter</b> (Foley) and <b>drains urine in the tubing down into the urine collection bag</b> . Which should the nurse do next?
Ask what the question is asking.	When collecting a urine specimen from a urinary retention catheter, what should the nurse do after draining urine in the tubing into the collection bag?
Critically analyze each option in relation to the question and the other options.	List the step-by-step procedure for collecting a specimen from a urinary retention catheter. Then analyze the four options and select the option that reflects the next step of the procedure after urine in the tubing is drained into the collection bag.
Eliminate incorrect options.	Option 1 is not a step in this procedure. Options 2 and 3 are steps that are performed later in the procedure. Options 1, 2, and 3 can be eliminated.

23. 1. Clean gloves are adequate.  
 2. **A skin barrier protects the skin from the digestive enzymes in feces.**  
 3. Cranberry juice makes urine more alkaline; it does not influence bacteria and enzymes in stool.  
 4. Patients should attempt to have a bowel movement after a meal to take advantage of the gastrocolic reflex.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which nursing <b>action</b> is <b>appropriate in relation to</b> the concept, " <b>Bacteria and enzymes in stool are irritating to the skin?</b> "
Ask what the question is asking.	Which nursing intervention is necessitated by the fact that bacteria and enzymes are irritating to the skin?
Critically analyze each option in relation to the question and the other options.	This statement requires the integration of several concepts: bacteria are irritating to the skin; enzymes are irritating to the skin; and moisture barriers can protect the skin from irritating substances. To eliminate the other options, identify that they are either an inaccurate statement or are unrelated to the concept cited in the question.
Eliminate incorrect options.	The focus is on the connection between factors that irritate the skin and what can be done to prevent it. Option 1 is an inaccurate statement because sterile gloves are not necessary to obtain a stool specimen for culture and sensitivity and it does not relate to the concept cited in the question. Option 3 may help minimize the risk of a urinary tract infection but is unrelated to preventing irritation of the skin. Although option 4 is a true statement it is unrelated to preventing irritation of the skin. Options 1, 3, and 4 can be eliminated.

24. 1. The nurse does not need a primary health-care provider's order to provide nursing care that is within the realm of nursing practice.  
 2. **Providing hygiene, an activity of daily living, is within the scope of nursing practice.**  
 3. The nurse does not need to collaborate with other health-care professionals to provide nursing care.  
 4. The nurse does not need a primary health-care provider's order to implement nursing care that is within the realm of nursing practice.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse decides to give a <b>partial bath instead of a complete bath. How was the nurse working</b> when this decision was made?
Ask what the question is asking.	How is the nurse functioning in relation to the legal definition of nursing when giving a partial bed bath?
Critically analyze each option in relation to the question and the other options.	Each state has a nurse practice act that defines and describes the scope of nursing practice. You need to know that legally the nurse can work dependently, independently, collaboratively, and interdependently when implementing nursing care. Now analyze the situation and identify in what role the nurse is working.
Eliminate incorrect options.	Providing for a patient's hygiene needs is not a dependent, collaborative, or interdependent function of the nurse and therefore options 1, 3, and 4 can be eliminated.

25. 1. **Cocoa powder, containing non-fat dry milk, contains approximately 173 mg of sodium when mixed with 6 ounces of water and should be avoided when on a 2-g sodium diet.**  
 2. Seltzer contains no sodium and is permitted on a 2-g sodium diet.  
 3. Twelve fluid ounces of lemonade contains approximately 12 mg of sodium and is permitted on a 2-g sodium diet.

4. One cup of low-fat milk contains approximately 103 mg of sodium and should not be included in large amounts on a 2-g sodium diet.
5. One cup of tomato juice contains approximately 877 mg of sodium and should be avoided on a 2-g sodium diet.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A primary health-care provider orders a <b>2-g sodium diet</b> for a patient. Which <b>fluids</b> should the nurse teach are <b>high in sodium</b> ?
Ask what the question is asking.	Which fluids have the highest sodium content?
Critically analyze each option in relation to the question and the other options.	Identify the sodium content of a variety of fluids. Compare and contrast the fluids in the options presented, and identify the options with the highest sodium content.
Eliminate incorrect options.	Options 2 and 3 can be eliminated because these fluids contain no or small amounts of sodium versus the large amounts of sodium in fluids presented in options 1, 4, and 5.

26. 1. Although inflammation of the mouth (stomatitis) can occur from irritation caused by the tube used for delivering general anesthesia, it is uncommon and not life-threatening.
2. Although atelectasis is serious, it is not as serious as a response in another option. Anesthesia delivered by intubation can interfere with the action of surfactant, resulting in the collapse of alveoli (atelectasis).
3. Although the tube used for intubation commonly does irritate the posterior oropharynx, resulting in a sore throat, it is not as serious as a response in another option.
4. **Laryngeal spasm is a potentially life-threatening complication because it prevents the exchange of gases between the lungs and the atmosphere. Laryngeal spasm can result from irritation caused by the presence of the intubation tube in the space between the vocal cords (glottis) during surgery.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	For which <b>most serious complication of intubation</b> associated with the administration of general anesthesia should the nurse assess a postoperative patient?
Ask what the question is asking.	What is the most serious potential consequence of intubation?
Critically analyze each option in relation to the question and the other options.	First define each problem and recall the cause of each. Then explore each problem in relation to the stress of intubation. Finally, compare and contrast the problems and determine which is most serious among the options. The concept of airway, breathing, and circulation can be applied when the question requires you to prioritize information.
Eliminate incorrect options.	All of the options can occur, but their consequences vary in severity. Options 1 and 3 can be eliminated first because they are similar and not life-threatening. Although atelectasis in option 2 will compromise respiratory function, it is not an obstruction of the airway and therefore can be eliminated.

27. 1. Intensity refers to the strength or amount of pain experienced, which often is rated from mild to excruciating. Pain scales (e.g., numerical scale, Wong-Baker FACES Rating Scale) can facilitate pain assessment.
2. The word “something” is too general to be related to the location of pain, which is the actual site where the pain is felt.
3. **Quality refers to the description of the pain sensation. A total pain assessment is facilitated by the use of the mnemonic COLDERR (character, onset, location, duration, exacerbation, relief, and radiation).**
4. The pattern of pain refers to time of onset, duration, recurrence, and remissions.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient in pain tells the nurse, "It feels like something is on fire." Which characteristic of pain is associated with this statement?
Ask what the question is asking.	Which characteristic of pain is related to the statement, "It feels like something is on fire?"
Critically analyze each option in relation to the question and the other options.	First review the characteristics of pain. Use of the mnemonic COLDERR for pain assessment may be helpful for review of these characteristics. Then identify the characteristic that is reflected in the patient's statement.
Eliminate incorrect options.	Option 1 relates to the severity of the pain. Option 2 is related to location but the patient's statement is too general to identify the actual site of the pain. According to COLDERR, option 4 relates to onset, duration, exacerbation, and relief factors. Options 1, 2, and 4 can be eliminated because none of them refers to the character of the pain, which is reflective of the patient's statement.

28. 1. In the semi-Fowler position the abdominal organs drop by gravity, which permits maximum thoracic excursion. In addition, slight flexion of the hips reduces abdominal muscle tension, which limits pressure on the suture line and facilitates diaphragmatic (abdominal) breathing.
- Resting in bed in any position promotes flatus retention. Ambulation promotes intestinal motility, which promotes the passage of flatus.
  - Inactivity results in decreased detrusor muscle tone, incomplete bladder emptying, and urinary stasis. The high-Fowler position and ambulation use gravity to promote urinary elimination.
  - The semi-Fowler position does not facilitate drainage via a portable wound drainage system. Although negative pressure creates the vacuum that draws fluid into a portable wound drainage system, the collection container should be lower than the insertion site because its

negative pressure does not have to work against gravity.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse places a patient who had abdominal surgery in the semi-Fowler position. What is the rationale for this nursing intervention?
Ask what the question is asking.	Why is it beneficial to place a patient who had abdominal surgery in the semi-Fowler position?
Critically analyze each option in relation to the question and the other options.	First establish the relationship between abdominal surgery and the semi-Fowler position. Then explore nursing interventions that achieve the outcome identified in each option. Then connect the information among abdominal surgery, the semi-Fowler position, and each option.
Eliminate incorrect options.	For each option compare your list of nursing interventions that should accomplish the objective stated in the option. If the semi-Fowler position was not among your list, that option can be eliminated.

29. 1. Oil lubricates, not irritates, the intestinal mucosa.
- Soap irritates the intestinal mucosa and thus stimulates the circular and longitudinal muscles of the intestinal wall, which respond with wave-like movements (peristalsis) that propel intestinal contents toward the anus.
  - Tap water is a hypotonic solution that exerts a lower osmotic pressure than the surrounding interstitial fluid, causing water to move from the colon into interstitial spaces. In addition, the volume of the fluid distends the lumen of the intestine. These processes stimulate peristalsis and defecation.
  - Normal saline, a solution having the same osmotic pressure of surrounding interstitial fluid (isotonic), works by drawing fluid from interstitial spaces into the colon. This fluid, in addition to the original volume of saline instilled, exerts pressure against the intestinal mucosa, which stimulates peristalsis and defecation.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is teaching a group of nursing assistants about the administration of enemas. <b>Which enema solution that works by irritating the intestinal mucosa</b> should be included in the teaching?
Ask what the question is asking.	Which enema solution promotes fecal elimination by irritating the intestinal mucosa?
Critically analyze each option in relation to the question and the other options.	Recall the physiological action of each type of enema presented in the question. Then make the connection between the type of enema and its action, whether or not it works by irritating the intestinal mucosa.
Eliminate incorrect options.	An oil-retention enema, a tap-water enema, and an enema that uses normal saline each work by another action than irritating the intestinal mucosa. Eliminate options 1, 3, and 4.

30. 1. Water will not increase the absorption of medications administered orally. Water will facilitate the swallowing and moving of medication down the esophagus to the stomach.
2. **Food can delay the dissolution and absorption of many drugs; therefore, most oral medications should be administered on an empty stomach. Oral medications should be administered with food only when indicated by the manufacturer's directions.**
3. The time of day does not influence the rate of absorption of medications administered orally.
4. Physical rest does not influence the rate of absorption of medications administered orally.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is administering oral medications to several patients. <b>Which factor</b> associated with the administration of medication will <b>increase the absorption of oral medications</b> ?
---------------------	---

Ask what the question is asking.	Which factor promotes the absorption of oral medications?
Critically analyze each option in relation to the question and the other options.	Identify the absorption rate of medication in relation to each option presented. Then compare and contrast the absorption rates among the options to identify the one that promotes the absorption of oral medication.
Eliminate incorrect options.	Options 2 and 4 are related to the time of day and patient activity, respectively. Neither is concerned with an activity that takes place in the stomach or intestines where the process of absorption begins/occurs. Water in option 1 neither promotes nor hinders medication absorption. Food in the presence of medication inhibits/prolongs the process of absorption because both are competing for absorption. Recall that some medication should be taken with food to prevent gastric irritation, not to promote absorption. Options 1, 2, and 4 can be eliminated.

31. 1. **Infants react to pain in an intense way including physical resistance and lack of cooperation. Separation of an infant from the usual comforting contact with parents contributes to separation anxiety, which in turn lowers pain tolerance, which intensifies the pain experience. Infants express pain by irritability, rolling of the head, flexing the extremities, overreacting to common stimuli, an inability to be comforted by holding and rocking, and physical responses indicating stimulation of the sympathetic nervous system.**
2. Adolescents are less sensitive to pain than an age group in another option. Adolescents generally want to behave in an adult manner and therefore demonstrate a controlled behavioral response to pain.
3. Older adults have a decreased capacity to sense pain and pressure. Older adults often fail to notice situations that will cause acute pain in younger people.

4. Pregnant women generally are not more sensitive to pain than when not pregnant.

### CRITICAL-THINKING STRATEGY

<b>Recognize keywords.</b>	A nurse in the postanesthesia care unit is assessing several patients in pain. Patients in <b>which age group</b> should the nurse anticipate <b>will be most sensitive to pain</b> ?
<b>Ask what the question is asking.</b>	Which age patients are most sensitive to pain?
<b>Critically analyze each option in relation to the question and the other options.</b>	Recall the age groups most at risk for health-related issues, specifically pain. Compare and contrast the identified age groups to identify the one that is most sensitive to pain.
<b>Eliminate incorrect options.</b>	The age groups most at risk for health-related issues are children and older adults. Eliminate options 2 and 4. Review the physiological differences between infants and older adults. Infants have immature neurological systems and have limited experiential backgrounds to have learned to cope with pain. Older adults have declining physiological responses to stressors and the experiential background to have learned to cope with pain. Eliminate options 2, 3, and 4.

- 32.** 1. Leavened bread and cake, not coffee and tea, are forbidden during Passover.  
**2. Meat from cloven-footed and cud-chewing animals is permitted as long as the animal is slaughtered and prepared following strict laws of Kashrut (Kosher diet).**  
 3. There are no restrictions on dairy products and eggs after sundown on Fridays.  
**4. Dairy products and meat/poultry are never served at the same meal or on the same set of dishes. Dairy products are not permitted within 1 to 6 hours after eating meat/poultry. Meat/poultry cannot be eaten for 30 minutes after consuming dairy products. Historically, this was practiced so that one food did not contaminate the other.**

5. All crustaceans, shellfish, and fish-like mammals, such as crab, shrimp, and lobster, scallops, oysters, and clams are forbidden.

### CRITICAL-THINKING STRATEGY

<b>Recognize keywords.</b>	A nurse is caring for a patient who is practicing <b>Orthodox Judaism</b> . Which should the nurse consider about <b>dietary regulations</b> when assisting the patient to plan meals?
<b>Ask what the question is asking.</b>	What are dietary regulations of Orthodox Judaism?
<b>Critically analyze each option in relation to the question and the other options.</b>	Recall beverages, dairy products, meat products, and shellfish that are influenced by dietary regulations of Orthodox Judaism. Compare the dietary regulations of Orthodox Judaism with the statements in the options.
<b>Eliminate incorrect options.</b>	Options 1, 3, and 5 have statements related to a specific factor (Passover, sundown on Friday, and rituals). After comparing your knowledge with the options and identifying that options 1, 3, and 5 have a factor as a focus and is different than options 2 and 4, which focuses just on food, you may use the test-taking skill of identifying which options are different. This technique may help you eliminate options 1, 3, and 5.

- 33.** 1. Although validating a patient's feelings will help the patient feel accepted, understood, and credible, there is no information indicating that the patient is experiencing anxiety.  
 2. Relaxation techniques are effective ways to reduce the autonomic nervous system response to a threat. However, it is not as effective as an intervention in another option.  
 3. Minimizing environmental stimuli may support rest and sleep, which is an essential aspect of stress management in any setting. However, it is not as helpful as another option.

4. **Anxiety is a response to an unknown threat to the self or self-esteem. Therefore, explaining what, how, why, when, and where of procedures to the patient will prevent and reduce anxiety by minimizing the unknown.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A newly admitted patient arrives on the unit. Which is <b>most important</b> for the nurse to do to <b>help minimize the development of anxiety</b> ?
Ask what the question is asking.	Which action will limit anxiety in a newly hospitalized patient?
Critically analyze each option in relation to the question and the other options.	The interventions in all the options may help reduce anxiety. The words <i>newly admitted</i> set a focus that must be addressed when analyzing the options. You are being asked to identify a priority action in relation to a parameter.
Eliminate incorrect options.	Options 2 and 3 are general interventions that address anxiety in any situation. Option 1 may minimize anxiety after it occurs, not before. Options 1, 2, and 3 can be eliminated.

34. 1. Although the leadership role is an important role and can be demonstrated in many different settings, a word in another option has a stronger relationship with the role of the nurse when helping a patient negotiate the health-care system.
2. **The health-care delivery system in the United States is complex and can be confusing at a time when patients have the least energy to explore and negotiate intervention options. When functioning as a resource person, the nurse identifies resources, provides information, and makes referrals.**
3. The surrogate role is not a professional role of the nurse. A surrogate role is assigned to a nurse when a patient believes that the nurse reminds them of another person and projects that role and the feelings he/she has for the other person onto the nurse.

4. The role of counselor is only one area of nursing practice and a word in another option has a stronger relationship with the role of the nurse when helping a patient negotiate the health-care system. Counseling is related only to helping a patient recognize and cope with emotional stressors, improve relationships, and promote personal growth.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A home health-care nurse is <b>helping a patient negotiate the health-care system</b> within the <b>community</b> . Which <b>word best reflects this role</b> of the nurse?
Ask what the question is asking.	What is a significant role of the nurse who is working in the community?
Critically analyze each option in relation to the question and the other options.	Define the word in each option. Explore behaviors of a nurse who is functioning in the role in each option. Your list of behaviors should parallel behaviors in the correct option as they relate to <i>helping a patient negotiate the health-care system</i> .
Eliminate incorrect options.	The patient assumes the role of leader in the nurse-patient relationship. Being a surrogate is not a professional nursing role. Being a counselor relates to providing emotional and psychological support. A resource person provides information and facilitates movement through the multidisciplinary health-care system. Options 1, 3, and 4 can be eliminated.

35. 1. **The percentage of body water dramatically decreases with age, and older adults have altered thirst mechanisms that place them at risk for inadequate fluid intake and dehydration. In addition, the skin of older adults is drier because of a decreased ability to sweat and a decreased production of sebum.**
2. Lotion is preferable to baby powder because lotion lubricates the skin. Also, baby powder should be avoided because, when aerosolized, it is a respiratory irritant.

3. Having a bath daily, even when using a moisturizing soap, is drying to the skin of older adults. Two to three times a week is adequate for an older adult who is continent.
4. Wool fabrics are coarse and irritate the skin and therefore should be avoided.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which patient statement indicates to the nurse that an older adult understands the teaching about <b>how to care for dry skin effectively</b> ?
Ask what the question is asking.	Which is the best intervention to treat dry skin?
Critically analyze each option in relation to the question and the other options.	Only one option is correct because you are not asked to identify a priority action. Explore interventions that can prevent or care for dry skin, particularly in the older adult. Compare your list to the options presented.
Eliminate incorrect options.	Having a daily bath is too drying for the skin of older adults. Eliminate option 3. Option 2 can be eliminated because lotion is preferable to baby powder. Eliminate option 4 because it is an incorrect statement.

36. 1. **Lubricating the suppository and index finger of a gloved hand before insertion facilitates insertion and limits trauma to vaginal mucous membranes.**
2. **Remaining flat in bed for 20 minutes will maintain the medication in place, which facilitates absorption.**
3. Perineal care, not a vaginal irrigation, should be performed before inserting a vaginal suppository.
4. **The patient should be placed in the supine position with the knees flexed (dorsal recumbent) to facilitate insertion of a vaginal suppository.**
5. **Advancing the suppository along the posterior vaginal wall facilitates the placement of the vaginal suppository just outside the cervical os so that when it melts it will eventually disperse through the entire vaginal canal.**

6. **The vagina is not a sterile cavity. Only medical asepsis is required for the insertion of a vaginal suppository.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient has a prescription for a <b>vaginal suppository</b> . Which <b>actions</b> should the nurse perform <b>when administering</b> this medication?
Ask what the question is asking.	Which are steps in the procedure for administering a vaginal suppository?
Critically analyze each option in relation to the question and the other options.	List the steps in the procedure for administering a vaginal suppository. Compare the statements in the options with your list.
Eliminate incorrect options.	Delete from consideration those options that do not correlate to your list of steps for administering a vaginal suppository. Eliminate option 3.

37. 4. **Cleaning the probe minimizes cross contamination from one patient to another.**
2. **Placing the temporal artery scanner in the middle of the forehead positions the instrument so that it is over the temporal artery as it is moved across the forehead and down toward the hairline on the side of the face.**
1. **The temporal artery is a major artery close to the heart via the carotid artery, which directly leads from the aorta. The temporal artery is close to the skin and provides easy access to measure true body temperature accurately. Holding the probe flat against the forehead keeps the instrument in contact with the skin and provides for a more accurate reading.**
3. **Touching the probe to the soft area just behind the earlobe helps to ensure an accurate reading if a person is sweating. Sweating causes cooling of the skin, and a reading given by a temporal scanner may be low. Research demonstrates that gently positioning the probe on the neck directly behind**



the earlobe below the mastoid provides accurate results.

5. Releasing the button instructs the instrument to display the temperature reading on the LCD display screen on the instrument.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is taking a patient's <b>temperature</b> using the <b>instrument in the illustration</b> . Place the following <b>steps in the order</b> in which they should be <b>implemented</b> .
Ask what the question is asking.	List the steps of using a temporal thermometer.
Critically analyze each option in relation to the question and the other options.	Identify the sequential steps when using a temporal thermometer. Refer to your list as you examine the options presented. Order the steps presented according to the order you identified.
Eliminate incorrect options.	There are no incorrect options.

38. 1. Cold lowers the temperature of skin and underlying tissue, which causes vasoconstriction, reducing blood flow to the area. This controls bleeding and slows the passage of fluid from the intravascular to the interstitial compartment, which limits edema.
2. Direct pressure may limit bleeding by compressing injured blood vessels, but it will not affect edema.
3. Long, smooth strokes sliding over the skin (effleurage) will not limit edema or bleeding into tissues. However, effleurage reduces pain by using the Gate-Control Theory of Pain. Peripheral stimuli transmitted via large-diameter nerves close the gate to painful stimuli that use small-diameter nerves, thereby blocking the perception of pain.
4. Cutaneous stimulation (massage) will not limit edema or bleeding into tissues. However, massage uses the Gate-Control Theory of Pain to limit pain.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient sustains soft tissue injuries from a motor vehicle collision. <b>Which intervention</b> is helpful in <b>limiting</b> the stress of <b>both edema and bleeding</b> into tissue?
Ask what the question is asking.	What can be done to limit edema and bleeding?
Critically analyze each option in relation to the question and the other options.	Explore the purpose and outcomes of cold compresses, direct pressure, effleurage, and massage. Then consider this information in relation to just edema, just bleeding into tissue, and both edema and bleeding into tissue.
Eliminate incorrect options.	Pressure only limits bleeding. Eliminate option 2. Effleurage and massage do not influence bleeding or edema. However, they are similar in that both may limit pain. When options are similar (one is not better than the other), usually they both can be eliminated. Eliminate options 3 and 4.

39. 1. Although the physical trauma of surgery causes pain and it must be relieved, it is not the priority.
2. Although general anesthesia can cause nausea, it is not the priority problem in the postanesthesia care unit.
3. **With an altered level of consciousness the pharyngeal, laryngeal, and gag reflexes may be impaired. The inability to cough or swallow can result in aspiration of oral secretions. When considering the ABCs of nursing intervention, the airway has priority.**
4. Excessive fluid loss precipitates a deficient fluid volume, but the nurse generally has time to meet this need safely.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	<b>Which response</b> by a patient in the <b>postanesthesia care unit</b> is the <b>priority concern</b> for the nurse?
---------------------	---

Ask what the question is asking.	Which patient response places a postoperative patient at the highest risk?
Critically analyze each option in relation to the question and the other options.	Explore the consequences of the patient responses in each option. Analyze the severity of each response in relation to the other responses. Identify the response that may be life-threatening. Analyze these options in relation to the ABCs (airway, breathing, and circulation) of patient assessment and needs.
Eliminate incorrect options.	Pain and nausea are not life-threatening issues in a postanesthesia care unit. Although fluid volume deficit has the potential to be a life-threatening problem if it is related to hemorrhage, it is a lower priority than another option because surgical patients are supported with IV fluids during and after surgery. Options 1, 2, and 4 can be eliminated.

- 40. 1. The only way to reestablish patency of the air vent lumen of a double-lumen nasogastric tube is to instill air into the lumen. The injected air will push the secretions blocking the lumen back into the stomach, where the fluid can be removed by the drainage lumen. Keeping the end of the air vent lumen higher than the stomach prevents reflux of gastric contents into the air vent lumen.**
2. Repositioning the patient will not reestablish patency of the air vent lumen. The patient is placed in this position as the tube is being inserted to facilitate its passage into the stomach.
  3. Placing the vent below the level of the stomach will draw fluid from the stomach into the air vent lumen by the principle of gravity.
  4. Withdrawing 30 mL of gastric contents from the drainage lumen will not reestablish patency of the air vent lumen. Withdrawing 30 mL of gastric contents via the drainage lumen is done to ensure that the catheter is in the correct anatomical location.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which should the nurse <b>do</b> when the <b>vent of</b> a patient's <b>double-lumen nasogastric tube</b> for decompression <b>becomes obstructed</b> ?
Ask what the question is asking.	How do you correct an obstruction in a double-lumen gastric tube?
Critically analyze each option in relation to the question and the other options.	Distinguish between what the nurse should do regarding routine care of a double-lumen nasogastric tube versus what specifically should be done when the tube is clogged.
Eliminate incorrect options.	Options 2, 3, and 4 are nursing interventions that will not clear the air vent of gastric fluid, which will permit effective functioning of the system.

- 41. 1. An incident report is unnecessary when a patient refuses treatment. Patients have the right to refuse care; however, the patient's refusal of care and the reasons for the refusal should be documented in the patient's clinical record.**
- 2. Any incident such as a fall that either results in harm to a patient, employee, or visitor or does not result in an injury must be documented in an incident report.**
  3. An incident report does not have to be completed when a visitor ambulates a patient who should have been on bedrest. The incident should be documented in the patient's clinical record.
  4. A nurse leaving work early without reporting to the supervisor does not require an incident report. The nurse manager should discuss this behavior with the nurse and may document it in the nurse's personnel file.
  - 5. Not receiving a prescribed medication may have the potential to cause harm. Therefore, an incident or adverse occurrence report should be completed to document the incident to add to the data so that similar situations can be prevented in the future.**
  - 6. Any incident such as a fall that either results in harm to a patient, employee,**

or visitor or does not result in an injury must be documented in an incident report.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	In <b>which situations</b> is a nurse <b>required</b> to complete <b>an incident report</b> ?
Ask what the question is asking.	Identify situations that require an incident report.
Critically analyze each option in relation to the question and the other options.	Recall and make a list of the variety of situations that require an incident report. Compare the situations presented in the options to your identified list of situations. Identify the parallel situations.
Eliminate incorrect options.	Patients have a right to refuse care. Visitors violating a primary health-care provider's order should be documented in progress notes rather than an incident report. A nurse leaving work early without reporting to the supervisor is an ethical situation that does not require an incident report. Options 1, 3, and 4 can be eliminated.

42. 1. Encouraging the avoidance of moving will not promote absorption via the transdermal patch; it could result in the destructive effects of immobility and may interfere with the quality of life.
2. Seeking a dose increase in the long-acting opioid is not the priority. Although this may eventually be necessary, the patient's pain must be relieved immediately.
3. **Intermittent episodes of pain that occur despite continued use of an analgesic (breakthrough pain) can be managed by administering an immediate-release analgesic to reduce pain (rescue dosing). This reduces pain during an unanticipated pain episode without unnecessarily raising the dosage of the long-acting analgesic.**
4. Antianxiety medication will be ineffective in this situation. The patient has intractable (resistant to treatment) pain that requires an opioid at this time.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient who has a transdermal <b>analgesic patch</b> for cancer experiences <b>breakthrough pain</b> with activity. Which is <b>most important</b> for the nurse to do?
Ask what the question is asking.	Which action will relieve intractable breakthrough pain?
Critically analyze each option in relation to the question and the other options.	Explore the outcome of the interventions in each option. Compare and contrast the benefits among the proposed interventions. Identify the priority nursing intervention that will relieve the patient's pain immediately.
Eliminate incorrect options.	Options 2 and 4 involve requesting additional medication. One is not better than the other, and it will take time to obtain a prescription. Options 2 and 4 can be eliminated. Transdermal patches are administered for the intractable pain associated with cancer; therefore, limiting movement will be ineffective to prevent severe pain. Eliminate option 1.

43. 1. Fundamental nursing textbooks are not the best source for a step-by-step review of a nursing skill. Generally, fundamental nursing textbooks do not address every nursing skill in a step-by-step approach, nor do they include intermediate or advanced skills.
2. Calling the staff education department for assistance should not be the first thing to do when unsure of the steps in a nursing procedure. Another action should be implemented first.
3. **Checking the nursing policy and procedure manual is the first resource the nurse should use when unsure of the steps in a nursing procedure. A review of the procedure in the procedure manual may refresh the memory or support the confidence of the nurse so that it is safe to proceed.**
4. Refusing to do the procedure is premature. Another action should be implemented first.

**CRITICAL-THINKING STRATEGY**

<b>Recognize keywords.</b>	A nurse must perform a procedure and is <b>unsure of the exact steps of the procedure. Which should the nurse do first?</b>
<b>Ask what the question is asking.</b>	Which should be done when unsure of the steps of a procedure?
<b>Critically analyze each option in relation to the question and the other options.</b>	All of the interventions in the options may eventually be done. Analyze each option in relation to the others to identify what should be done first. You are being asked to set a priority. If you cannot identify what should be done first, eliminate the option that would be done last. Repeat this process with the remaining three options. Make a final selection when you are down to two options.
<b>Eliminate incorrect options.</b>	Staff education personnel may not be immediately available. A fundamentals of nursing textbook does not provide comprehensive coverage of nursing procedures. Refusing to perform a procedure is a behavior of last resort. Options 1, 2, and 4 can be eliminated.

44. 1. A pressure ulcer is not a microbiological stressor. If an ulcer becomes infected, the organism causing the infection is a microbiological stressor.
2. A pressure ulcer is not a developmental stressor. Developmental stressors are physiological changes or transitional life events that occur during the expected stages of growth and development.
3. **A pressure ulcer is a physiological stressor because the change in structure or function causes further**

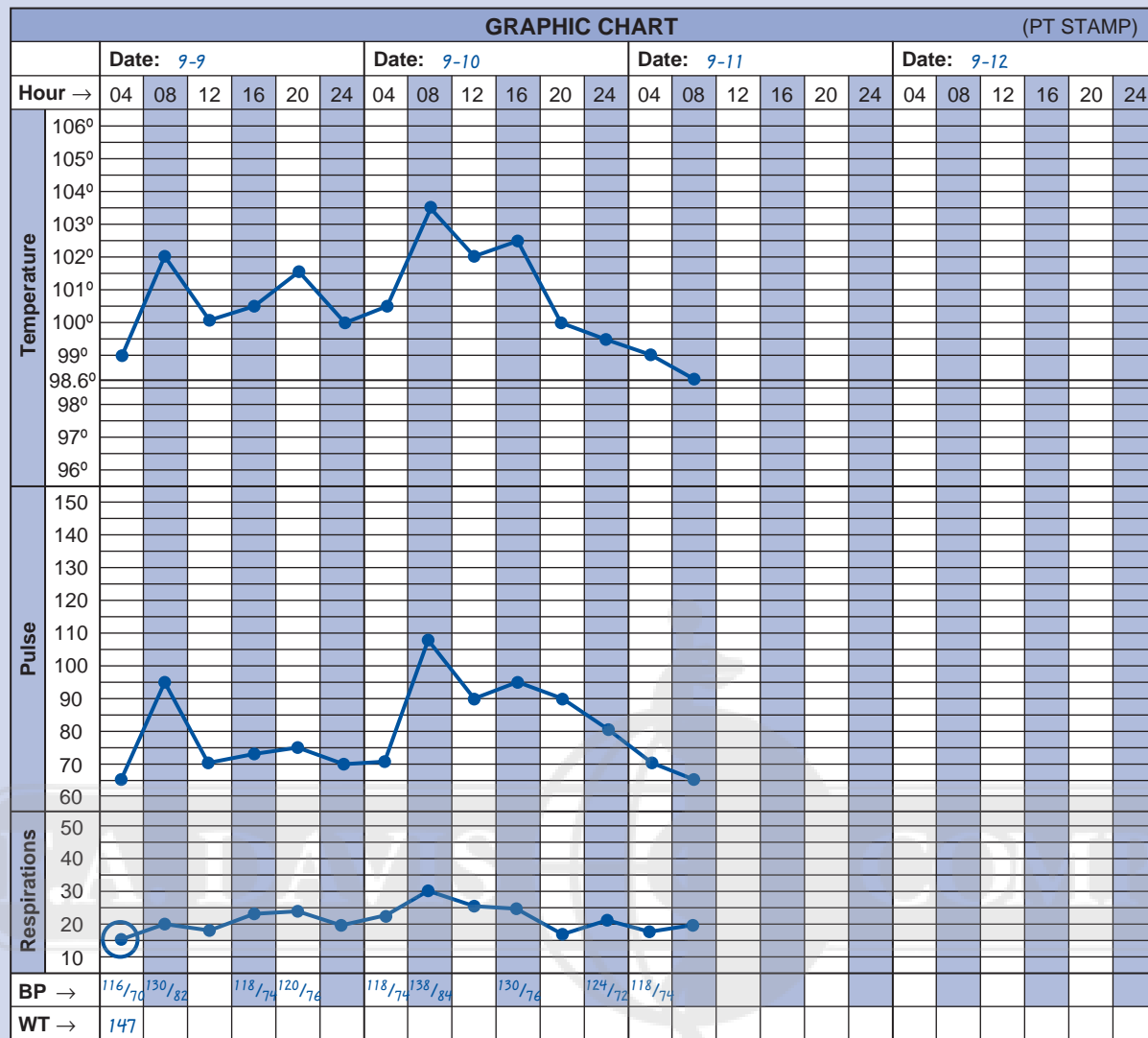
**stressors (secondary stressors) in the body.**

4. Pressure is a physical stressor that stimulates responses that cause an ulcer.

**CRITICAL-THINKING STRATEGY**

<b>Recognize keywords.</b>	A nurse is caring for a patient with a pressure ulcer. Which <b>type of stressor</b> is a <b>pressure ulcer</b> ?
<b>Ask what the question is asking.</b>	To which classification of stressor does a pressure ulcer belong?
<b>Critically analyze each option in relation to the question and the other options.</b>	Define the category of stressor in each option. Explore examples of stressors in each category. Compare your examples to a pressure ulcer. Identify a parallel between a pressure and an example from among those you identified in each option.
<b>Eliminate incorrect options.</b>	Microbiological stresses involve pathogens, and developmental stresses involve age-related issues. Options 1 and 2 can be eliminated. Physical stresses involve a stimulus from outside the body, whereas physiological stresses involve a stimulus from inside the body. Pressure ulcers occur within the body. Option 4 can be eliminated.

45. 1. **On 9-9 at 04 the respiratory rate was 15 breaths per minute.**
2. On 9-9 at 08 the respiratory rate was 20 breaths per minute.
3. On 9-10 at 08 the patient's respiratory rate was 30 breaths per minute.
4. On 9-10 at 16 the patient's respiratory rate was 25 breaths per minute.



### CRITICAL-THINKING STRATEGY

Recognize keywords.	At <b>which day and time</b> did the patient have a <b>respiratory rate of 15 breaths per minute</b> ?
Ask what the question is asking.	Interpret a graphic record to identify the date and time at which a patient had a respiratory rate of 15 breaths per minute.
Critically analyze each option in relation to the question and the other options.	Identify the location of the date and time for each option at the top of the graphic chart, and carefully proceed down the column to identify the rate of respirations indicated by the position of the dot. Repeat this action for each date and time indicated in each option. Identify the option that has a dot on the line that indicates 15 respirations.

Eliminate incorrect options.

Eliminate the 3 options where the dot is located on a line that is more than 15 respirations.

46. 1. This response is clarifying, not paraphrasing. In addition, to respond more accurately when using clarification the nurse should have said, “Are you saying that you do not want to have this surgery?” Not wanting surgery and postponing surgery are two different concepts.
2. **This response is an example of paraphrasing, which restates the content of the patient’s message in similar words.**
3. This response is an example of reflective technique, which focuses on feelings.
4. This response is an example of an open-ended statement, which invites the patient to elaborate on the stated concern.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient appears agitated and states, “I’m not sure that I want to go through with this surgery.” Which response by the nurse uses the technique of <b>paraphrasing</b> ?
Ask what the question is asking.	Which statement uses the technique of paraphrasing?
Critically analyze each option in relation to the question and the other options.	Define <i>paraphrasing</i> . Identify the communication technique being used in each nursing statement. Make a correlation between paraphrasing and the statement that restates what the patient said.
Eliminate incorrect options.	Option 1 uses clarification. Option 3 uses reflection. Option 4 is an open-ended statement. Eliminate options 1, 3, and 4.

- 47. 1. Sites for a transdermal patch should be rotated because doing so limits skin irritation and excoriation. Also, it allows time for the site to recover if irritated.**
- Both irritation of the skin and vasodilation can result from rubbing the skin, which can alter absorption of the medication.
  - A hairless site will ensure that there is effective contact with the skin.**
  - When preparing and applying the patch, the nurse may be exposed to the medication on the patch. Clean gloves provide a barrier and protect the nurse from absorbing some of the medication.**
  - The old patch should be removed at the same time that the new patch is applied.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is planning to apply a <b>transdermal patch</b> to a patient. Which actions should the nurse implement?
Ask what the question is asking.	Which steps are associated with applying a transdermal patch?

Critically analyze each option in relation to the question and the other options.	List the steps of the procedure for applying a transdermal patch. Identify which options are among your list of interventions.
Eliminate incorrect options.	Option 2 may harm the patient and is contraindicated. Permitting two patches to remain on the skin concurrently may result in absorption of excessive medication, which may harm the patient. Eliminate options 2 and 5.

- 48. 1. Effleurage involves long, smooth strokes sliding over the skin that have a relaxing, sedative effect. When performed slowly with light pressure at the end of a backrub, it is called “feathering off.”**
- Firm, not deep, circular motions are used with backrub.
  - Kneading (pressure) is not performed over the vertebrae because it is stimulating and traumatic for the vertebral column and spinal cord.
  - Rubbing the back over the vertebrae is contraindicated because it is traumatic to the vertebral column and spinal cord. A backrub should be performed on either side of the vertebrae.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	Which <b>should</b> the nurse <b>do</b> when providing a <b>backrub</b> for a patient?
Ask what the question is asking.	Which action is part of a backrub?
Critically analyze each option in relation to the question and the other options.	List the steps associated with a backrub. Identify what will happen if each action in the options is implemented. Identify the option that reflects a safe, correct action by the nurse.
Eliminate incorrect options.	Actions in options 2, 3, and 4 are contraindicated when providing a backrub. Eliminate these options.

49. 1. This response is a challenging statement and is inappropriate. It may take away the patient's coping mechanism and cut off communication; the patient is using denial to cope with the diagnosis. Also, it does not address what the patient thinks or feels about the diagnosis.
2. This response may take away the patient's coping mechanism, is demeaning, and may cut off communication. The use of the word "bad" may increase the patient's anxiety. The patient is using denial to cope with the diagnosis.
3. This response is too direct and demeaning and may cut off communication. The patient is using denial to cope with the diagnosis.
4. **This provides an opportunity to discuss the illness; eventually a developing awareness will occur and the patient will move on to other coping mechanisms.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A <b>patient is told</b> by the primary health-care provider that the patient <b>has metastatic lung cancer</b> and is seriously ill. After the provider leaves the room, the patient has a severe episode of coughing and shortness of breath and says, <b>"This is just a cold, I'll be fine once I get over it."</b> <b>How should the nurse respond?</b>
Ask what the question is asking.	Which response will encourage a patient in denial to talk?
Critically analyze each option in relation to the question and the other options.	Review therapeutic communication skills and barriers to communication. Examine the options and identify the action that is therapeutic and the ones that are not therapeutic.
Eliminate incorrect options.	Options 1, 2, and 3 are challenging and should be avoided. Responses should not take away a patient's coping mechanism. Eliminate options 1, 2, and 3.

50. 1. **A tube feeding formula usually is hypertonic, which exerts an osmotic force that pulls fluid into the stomach**

**and intestine, resulting in intestinal cramping and diarrhea.**

2. An inadequate volume of the feeding may result in fluid volume deficit and malnutrition, not diarrhea.
3. Failure to test for a residual before the feeding may result in vomiting, not diarrhea. If there is still fluid remaining from the previous feeding, failure to test for a residual before administering a tube feeding can result in adding more fluid than the patient's stomach can tolerate.
4. Placing a patient in the high-Fowler position during the administration of a tube feeding is done to prevent aspiration of the formula and will not cause diarrhea.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient develops diarrhea after receiving several <b>intermittent tube feedings</b> . Which should the nurse consider is the <b>cause of the diarrhea?</b>
Ask what the question is asking.	Why can intermittent tube feedings cause diarrhea?
Critically analyze each option in relation to the question and the other options.	Review the physiological response of the body to a hypertonic solution and an inadequate volume of formula. Explore why testing for a residual is performed before and a high-Fowler position is used during an intermittent tube feeding. Compare and contrast the information you gathered in your review with the reasons for diarrhea presented in each option.
Eliminate incorrect options.	Options 1 and 2 address the formula (osmolarity and volume). Options 3 and 4 address nursing interventions during the procedure. Option 2 is related to fluid and nutritional deficiencies, not diarrhea. Failure to test for a residual in option 3 may result in vomiting, not diarrhea. A high-Fowler position in option 4 prevents aspiration, not diarrhea. Eliminate options 2, 3, and 4.

51. 1. Placing the patient in the supine position is unnecessary. This is done when the person is unconscious.
2. When attempting to clear an airway of an obstruction, the thumb side of the hand should always be against the person's body.
3. **This is the appropriate modification of the abdominal thrust (Heimlich) maneuver for a pregnant woman. This provides thoracic compression while preventing pressure against the uterus that can result in trauma to the woman or the fetus.**
4. Waiting until the person becomes unconscious wastes valuable time and is unsafe. Delaying or discontinuing the maneuver before the obstruction is cleared will result in death.
52. 1. The lights, noise, and activity in the hospital environment can interfere with napping during the day. However, naps when they do occur usually are short and rarely reach stage IV restorative sleep.
2. Hospitalized patients can follow their usual bedtime rituals.
3. Most medications are administered by 10 p.m. to 11 p.m. and should not interfere with sleep.
4. **Studies support the fact that finding a comfortable position is one of the most common factors that interferes with sleep as reported by hospitalized patients. Patients frequently find hospital beds unfamiliar and uncomfortable. In addition, therapeutic regimens restrict movement or require patients to assume sleeping positions other than their preference.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	While in a restaurant, a <b>pregnant woman</b> exhibits a <b>total airway obstruction</b> because of a bolus of food. How should the nurse <b>modify</b> the thrusts of the <b>abdominal thrust</b> (Heimlich) maneuver for this person?
Ask what the question is asking.	How should the abdominal thrust maneuver be adapted for a pregnant woman?
Critically analyze each option in relation to the question and the other options.	List the steps of the abdominal thrust maneuver. Recall the physiological changes in a woman's body when pregnant. Compare these physiological changes with the steps of the procedure, and determine what step may harm the woman or fetus. Identify the modification of the procedure that will help dislodge the obstruction while protecting the woman and fetus.
Eliminate incorrect options.	Options 1 and 4 delay the initiation of the procedure. Eliminate options 1 and 4. Option 2 will be physically difficult to perform and will still compress the woman's abdominal area, which may harm the woman or fetus. Eliminate option 2.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is planning care to support a patient's ability to sleep. Which <b>factor</b> from <b>among the options</b> presented <b>most commonly interferes with the sleep of hospitalized patients</b> ?
Ask what the question is asking.	Which most hinders hospitalized patients' abilities to sleep?
Critically analyze each option in relation to the question and the other options.	Analyze each option in relation to a patient in the hospital environment. Then identify the option that most interferes with sleep.
Eliminate incorrect options.	The hospital environment impedes the ability to take naps. Eliminate option 1. Bedtime rituals can be maintained in a hospital. Eliminate option 2. Most medications are not administered between 11 p.m. and 6 a.m. Eliminate option 3.

53. 1. **Pasta is made from grains, and peas are legumes, which together provide amino acids that make a complete protein. Complete proteins supply all eight essential amino acids. Essential amino acids are those that cannot be**



**manufactured by the human body and must be obtained from food sources.**

2. Yogurt and fruit together do not provide a complete protein. In addition, pure vegetarians (vegans) eat only plants. Lactovegetarians eat vegetables and milk products; lacto-ovovegetarians eat vegetables, milk products, and eggs (some may occasionally eat fish or poultry).
3. Bread and cheese together provide a complete protein. However, pure vegetarians (vegans) eat only plants (which includes grains), not dairy products.
4. **Grains and legumes lack different amino acids. When these foods are combined, they substitute for a complete protein. Complete proteins supply all eight essential amino acids. Essential amino acids are those that cannot be manufactured by the human body and must be obtained from food sources.**
5. Peanut butter combined with a grain, not jelly, is a substitute for a complete protein.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is providing dietary teaching for a patient who is a <b>vegan. Which food combinations that are substitutes for a complete protein</b> should the nurse include in the dietary teaching?
Ask what the question is asking.	Which combination of food provides essential amino acids for a vegan?
Critically analyze each option in relation to the question and the other options.	Recall what a vegan does or does not eat. Identify the type of protein presented in each food combination. Analyze the food combinations presented, and conclude if they provide essential amino acids and are included in a vegan diet.
Eliminate incorrect options.	Eliminate options, 2, 3, and 5 because pure vegans eat only plants and the food combinations in the options do not provide essential amino acids.

54. 1. Calcium is essential for functioning, but it is unrelated to the risk for drug toxicity in

the older adult. Calcium is essential for cell membrane structure, wound healing, synaptic transmission in nervous tissue, membrane excitability, muscle contraction, tooth and bone structure, blood clotting, and glycolysis.

2. Red blood cells are responsible for delivering oxygen to cells and are unrelated to the risk for drug toxicity in the older adult.
3. **The glomerular filtration rate is reduced by as much as 46% at 90 years of age. In addition, decreased cardiac output can reduce the amount of blood flow to the kidneys by as much as 50%. When the glomerular filtration rate declines, the time necessary for half of a drug to be excreted increases by as much as 40%, which places the older adult at risk for drug toxicity.**
4. Frequency of voiding is unrelated to the risk for drug toxicity in the older adult.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is administering medication to an <b>older adult. A decrease in which of the following increases the risk of drug toxicity</b> in this patient?
Ask what the question is asking.	Which factor increases the risk for drug toxicity in older adults?
Critically analyze each option in relation to the question and the other options.	Analyze the relationship between the physiological changes associated with aging and drug toxicity while considering the factor in each option.
Eliminate incorrect options.	Consider that drug metabolism (biotransformation) occurs in the liver by microsomes that stimulate the enzymatic breakdown of drugs and that most medications are excreted via the kidneys. The efficiency of these organs decreases as people age. Eliminate options 1 and 2 because they are unrelated to the functioning of the liver or kidneys. Inadequate urinary output, not urinary frequency, is related to drug toxicity. Eliminate option 4.

55. 1. Pulling the pinna of the ear backward and downward is done to straighten the ear canal of an infant or a young child, not an adult.
2. Inserting the drops into the center of the auditory canal can injure the eardrum. Drops should be directed along the wall of the ear canal.
3. **Pressing gently on the tragus facilitates the flow of medication toward the eardrum.**
4. Rolling the patient from the side-lying position to the supine position can result in medication flowing out of the ear. The side-lying position with the involved ear on the uppermost side should be maintained for 2 to 3 minutes after the medication is instilled.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse instills medicated <b>drops into the ear</b> of an <b>adult</b> . Which should the nurse do to <b>ensure</b> that the <b>medication flows toward the eardrum</b> ?
Ask what the question is asking.	Which action disperses medication in the ear canal of an adult?
Critically analyze each option in relation to the question and the other options.	List the steps of administering medicated drops into a patient's ear. Recall the difference in the procedure for an adult versus an infant/young child. Compare the list and the difference identified to the options presented.
Eliminate incorrect options.	Option 1 is a technique used with infants and young children. Option 2 can harm the eardrum and is unsafe. Option 4 will result in fluid draining away from the eardrum. Eliminate options 1, 2, and 4.

56. 1. Preschoolers (age 3 to 5 years—Initiative versus Guilt) learn to separate from parents and develop a sense of initiative. Negative resolution will result in guilt, rigidity, and a hesitancy to explore new skills or challenge abilities.
2. **Adolescents (age 12 to 20 years—Identity versus Role Confusion) strive to develop a personal identity and**

**autonomy. This is a turbulent time as the adolescent internalizes the dramatic physical changes and the psychological stressors of new social conflicts. It is common for adolescents to experience mood swings, make decisions without having all the facts, challenge authority, and assert the self. However, these behaviors are left behind when the developmental tasks of adolescence are positively resolved. Negative resolution results in assertive, rebellious, and antisocial behavior.**

3. School-aged children (age 6 to 12 years—Industry versus Inferiority) learn to compete, compromise, and cooperate; develop relationships with peers; and win recognition through productivity. Negative resolution results in feelings of inadequacy, low self-esteem, and a reluctance to explore the environment.
4. Infants (birth to 18 months—Trust versus Mistrust) learn to depend on others to meet their needs, thereby developing trust and a beginning sense of self. Negative resolution of this task results in mistrust, dependency, lack of self-confidence, and shallow relationships in later stages of development.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse identifies that an adult patient is exhibiting antisocial behavior. According to <b>Erikson</b> , the <b>negative resolution</b> of which <b>stage of development</b> is most commonly <b>associated with antisocial behavior</b> ?
Ask what the question is asking.	To which stage of Erikson's theory of development is antisocial behavior most related?
Critically analyze each option in relation to the question and the other options.	Consider the developmental task and related behaviors associated with each age group presented. Recall the behaviors of a person with an antisocial personality disorder. Identify the stage that reflects behavior associated with behaviors of people with an antisocial personality disorder.

*continued*

continued

Eliminate incorrect options.	Infants are developing trust, preschoolers are developing initiative, and school-aged children are learning to compromise and cooperate. Usually infants, preschoolers, and school-aged children are not irresponsible and do not abuse substances, engage in illegal activities, or challenge authority. Eliminate options 1, 3, and 4.
------------------------------	--

- 57. 1. Positioning the arm at the level of the heart will result in an accurate blood pressure reading. If the arm is positioned higher than the level of the heart, the blood pressure will be inaccurately low. If the arm is positioned lower than the level of the heart, the blood pressure will be inaccurately high.**
- Wrapping the lower edge of the cuff over the antecubital space will cover the brachial artery and interfere with the accurate assessment of blood pressure. The lower edge of the cuff should be approximately 1 inch (2.5 cm) above the antecubital space.
  - The sphygmomanometer should be pumped up 20 to 30 mm Hg above the palpatory blood pressure reading. This ensures an accurate systolic reading without exerting undue pressure on the tissues of the arm.**
  - Releasing the valve slowly ensures that all five Korotkoff's sounds are heard accurately. Deflating the cuff too rapidly can result in a falsely low systolic reading, and deflating the cuff too slowly can result in a falsely high diastolic reading.**
  - When repeating a blood pressure the cuff should be completely deflated and the caregiver should wait 2 minutes before reinflating the blood pressure cuff. This action prevents congestion of the veins and an inaccurately high blood pressure reading.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which nursing <b>techniques</b> will result in an <b>accurate</b> measurement when obtaining a patient's <b>blood pressure</b> ?
---------------------	--

Ask what the question is asking.	Which are steps in obtaining a blood pressure measurement?
Critically analyze each option in relation to the question and the other options.	List the steps of the procedure for performing a blood pressure measurement. Compare and contrast the list with the options presented.
Eliminate incorrect options.	Inappropriate placement of the cuff and the sphygmomanometer will result in an inaccurate measurement. Eliminate option 2.

- 58. 1. Unconscious patients often bite down when something is placed in the mouth. Therefore, a padded tongue blade should be placed between the upper and lower teeth to help keep the mouth open during oral care. Other padded tongue blades, wetted with a small amount of saline, should be used to clean the oral cavity. This technique does not require flushing the oral cavity with fluid, which may compromise the airway.**
- Although half-strength mouthwash and saline may be used, it is not the best intervention because mouthwash contains ingredients that can be irritating to the mucous membranes.
  - Glycerin is not a cleansing agent and is not effective in cleaning the oral cavity.
  - Toothpaste should be avoided because it requires flushing the mouth with adequate amounts of water to prevent leaving an irritating residue on the mucous membranes. An unconscious patient usually has a diminished gag reflex and is at risk for aspiration.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which should the nurse use to <b>best provide oral care</b> to an <b>unconscious patient</b> ?
Ask what the question is asking.	What should be used to clean the oral cavity of an unconscious patient?

Critically analyze each option in relation to the question and the other options.	Consider the unique needs of a patient who is unconscious, particularly in relation to the ABCs (airway, breathing, and circulation). Analyze each option in relation to how it will impact on the patient's physical status.
Eliminate incorrect options.	Airway patency is always the priority. Options 2 and 4 require flushing the oral cavity with fluid, which may compromise the airway. Glycerin coats, rather than cleans, the oral mucosa. Eliminate options 2, 3, and 4.

59. 1. This question is too focused.  
 2. Although determining how long the patient has had diverticulitis is information that eventually may be obtained, it is not the immediate priority.  
 3. **This question invites the patient to expand on and develop a topic of importance that relates to the current problem.**  
 4. Although identifying previous episodes of diverticulitis is information that eventually may be obtained, it is not the immediate priority.

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient is admitted to the hospital with a medical diagnosis of <b>diverticulitis</b> . Which is the <b>best question</b> the nurse should ask when obtaining an <b>admission history</b> from this patient?
Ask what the question is asking.	Which question will obtain the patient's perspective of the situation?
Critically analyze each option in relation to the question and the other options.	Review the purpose of obtaining an admission history from a patient. Analyze each question to determine what information will be collected by the patient's response. Identify the most significant information the nurse should collect.

Eliminate incorrect options.	Options 1, 2, and 4 are direct questions that obtain limited information. Eliminate these options.
------------------------------	--

60. 1. 11 a.m. is too soon. The drug will not be at its lowest concentration in the blood.  
 2. **Thirty minutes before or closer to the next scheduled dose is the most appropriate time for a trough blood level to be obtained. The serum level of the drug will be at its lowest.**  
 3. Peak, not trough, levels are obtained 30 minutes after completion of drug administration.  
 4. The blood level of the drug increases after the drug is administered. A value taken at this time will not reflect the lowest serum level, which is the purpose of identifying a trough level.

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	A primary health-care provider orders peak-and-trough levels for a patient receiving an intravenous antibiotic. <b>What time</b> should the nurse obtain a blood sample to determine a <b>trough level</b> when the <b>antibiotic was administered at 12 noon?</b>
Ask what the question is asking.	When should a blood specimen for a trough level of a drug be obtained?
Critically analyze each option in relation to the question and the other options.	Recall the parameters for obtaining a specimen for a trough level of a drug. Identify the interrelationship of when the drug was administered and the times offered in each of the options.
Eliminate incorrect options.	A specimen of blood for a trough level should be obtained when the drug is at its lowest level (about 30 minutes before the next dose). Options 3 and 4 are too soon after the drug was administered. Eliminate options 3 and 4. Option 1 is too early compared with option 2. Eliminate option 1.

- 61.** 1. During adolescence, the individual is beginning to question life-guiding values such as spirituality. However, it is not uncommon for the adolescent to turn away from religious practices as part of dealing with role confusion and exploration of self-identity. Faith becomes centered around the peer group and away from the parents. This stage is called Synthetic-Conventional Faith by James Fowler.
2. People expand and refine spiritual beliefs at an earlier stage of development than older adulthood.
3. Young adults are just beginning to think about spirituality more introspectively at this age. Young adults generally enter a reflective period of time as discovery of values in relation to social goals are explored within their own frame of reference rather from the peer group frame of reference as during adolescence. This stage is called Individuative-Reflective Faith by James Fowler.
- 4. Middle-aged adults tend to engage in refining and expanding spiritual beliefs through questioning. Middle-aged adults are reported to have greater faith, have more reliance on personal spiritual strength, and be less inflexible in spiritual beliefs. Middle-aged adults integrate other viewpoints about faith, which introduces tension while working toward resolution of spiritual beliefs. This stage is called Conjunctive Faith by James Fowler.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is planning care for a patient in the spiritual realm. <b>Which age group generally is more involved with expanding and refining spiritual beliefs?</b>
Ask what the question is asking.	At what age are people more involved with expanding and refining spiritual beliefs?
Critically analyze each option in relation to the question and the other options.	Review the various age groups presented in relation to their concerns about spirituality. Use developmental and spiritual theories to place the beliefs and activities of the people in these age groups into perspective.

Eliminate incorrect options.

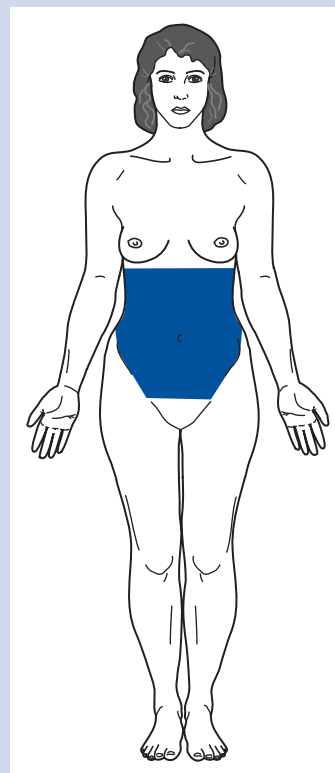
Generally adolescents are more concerned about peer relationships than spirituality. Eliminate option 1. Young adults are just beginning to explore spirituality, whereas older adults are refining previously explored beliefs. Eliminate options 2 and 3.

- 62. 1. Assisting a patient to walk widens the patient's base of support because the base extends to include the nurse's feet on the floor in addition to the patient's feet on the floor.**
- 2. Walkers surround a person on three sides and provide four points of contact with the floor. This wide base provides the best support available for assisted ambulation.**
3. Locking the wheels of a wheelchair follows the principle, *an object with wheels that are locked will remain stationary.*
4. Holding objects close to the body when walking follows the principle, *the closer an object is held to the center of gravity, the greater the stability and the easier the object is to move.*
5. Keeping the back straight when lifting an object follows the principle, *balance is maintained and muscle strain is limited as long as the line of gravity passes through the base of support.*

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which <b>actions</b> are specifically <b>related to</b> the principle, <b><i>the greater the base of support, the more stable the body?</i></b>
Ask what the question is asking.	Which actions provide a wide base of support?
Critically analyze each option in relation to the question and the other options.	Identify the projected outcome for the behavior in each option. Then consider the principle that underlines the behavior and its outcome.
Eliminate incorrect options.	Option 3 relates to safety, not a wide base of support. Options 4 and 5 relate to principles associated with body mechanics, rather than a wide base of support. Eliminate options 3, 4, and 5.

63. 1. A backrub is the therapeutic manipulation of muscles and tissues that relaxes tense muscles, relieves muscle spasms, and induces rest or sleep. However, it may be contraindicated, and some people do not like a backrub or consider it an invasion of their personal space.
2. Music can be relaxing or stimulating depending on the music and the individual.
3. Although milk contains the amino acid L-tryptophan that promotes sleep, many people do not like milk or avoid fluids before bedtime to limit voiding during the night (nocturia).
4. **Following routines provides consistency and comfort in an unfamiliar environment. Bedtime rituals meet basic physiological needs and usually include physically and emotionally relaxing behaviors.**



### CRITICAL-THINKING STRATEGY

Recognize keywords.	What is the <b>most effective</b> nursing <b>intervention to promote sleep</b> that is appropriate for a patient in <b>any situation</b> ?
Ask what the question is asking.	Which is the best method to promote sleep?
Critically analyze each option in relation to the question and the other options.	Identify the commonalities and differences of nursing interventions that relate to promoting sleep. A commonality is an intervention that may work regardless of the patient situation. A difference is an intervention that may work for a patient in a specific situation.
Eliminate incorrect options.	Options 1, 2, and 3 may work for certain patients in specific situations. The nursing interventions in these options cannot be implemented for all patients. Eliminate options 1, 2, and 3.

64. **An X in any part of the shaded area across the abdomen is a correct answer. A nurse should auscultate all four quadrants of the abdomen to determine the presence of borborygmi. Borborygmi are audible high-pitched, loud, gurgling sounds caused by the propulsion of gas through the intestine.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is performing an assessment of a patient. Place an X on the figure of the body where the nurse should <b>place the stethoscope</b> to assess for the <b>presence of borborygmi</b> .
Ask what the question is asking.	Where on the body are borborygmi heard?
Critically analyze each option in relation to the question and the other options.	Define borborygmi. Consider where these sounds are produced within the body. Place an X where a stethoscope should be placed to auscultate these sounds.
Eliminate incorrect options.	Other areas of the body will be eliminated when an X is placed over the shaded area indicated in the answer.

65. 1. Although positioning the telephone within easy reach should be done, because it avoids reaching for a phone that can result in a loss of balance and a fall, it is not the most important intervention to prevent injury in a hospital.

2. Although storing belongings in a safe place should be done, this is not a physical hazard.
3. **Adequate lighting provides for the safety of patients, staff, and visitors within a hospital. Inadequate lighting causes shadows, a dark environment, and the potential for misinterpreting stimuli (illusions) and is a major cause of accidents in the hospital setting.**
4. An over-bed table has wheels and therefore cannot provide a firm base of support. Over-bed tables are physical hazards that may contribute to falls if used inappropriately.
4. The knees are extended, not flexed, when in the supine position.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient prefers and excessively maintains the <b>supine position</b> . For which <b>potential problem</b> associated with this position should the nurse assess the patient?
Ask what the question is asking.	Which problem is associated with the supine position?
Critically analyze each option in relation to the question and the other options.	Visualize a patient in the supine position. Examine each option in relation to the visualization. Identify the option that may place the patient at risk for a negative outcome.
Eliminate incorrect options.	Pressure on the trochanters does not occur in the supine position. External, not internal, rotation of the hips occurs with the supine position if trochanter rolls are not used to maintain functional alignment. Hyperextension of the knees, not flexion contractures of the knees, can occur in the supine position. Options 2, 3, and 4 can be eliminated.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which is the <b>most important</b> nursing <b>intervention</b> to help <b>prevent falls from physical hazards</b> in a hospital?
Ask what the question is asking.	How can the nurse best prevent falls in a hospital?
Critically analyze each option in relation to the question and the other options.	Analyze the outcome of each intervention in relation to safety. Compare and contrast options to eventually identify the best intervention.
Eliminate incorrect options.	Option 2 is unrelated to safety and option 4 is unsafe. Eliminate options 2 and 4. Options 1 and 3 both relate to safety. Option 1 relates to just one limited aspect of a safe environment. Option 2 relates to a more pervasive issue—inadequate lighting. Therefore, eliminate option 1.

66. 1. **The supine position is a back-lying position that results in pressure on the heels (calcanei), which have minimal tissue between the bone and skin, making them vulnerable to the development of pressure ulcers.**
2. There is no pressure on either greater trochanter when in the supine position. Pressure on a greater trochanter occurs when the patient is in a lateral (side-lying) position.
3. External, not internal, rotation of the hips tends to occur when a patient is in the supine position.

67. 1. Setting limits will make the patient more anxious and demanding. Demanding behavior generally is an attempt to gain control over events in an effort to protect the self.
2. Alternating care with another nurse can be confusing to the patient and increase anxiety. Maintaining continuity in the nurse assignment will support the development of a trusting relationship and enable the nurse to explore the patient's feelings, as well as plan and implement interventions that encourage choices, all of which support feeling in control.
3. Pointing out demanding behavior is too confrontational at this time. Demanding behavior generally is a defense mechanism that reduces anxiety generated by powerlessness. To confront the behavior and take away the patient's coping mechanism will cause the patient to become more anxious.

4. Attempting to see the situation from the patient's perspective is an example of empathy, which is understanding a patient's emotional point of view. An empathic response communicates that the nurse is listening and cares.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient is using the call bell <b>numerous times</b> an hour and <b>requesting assistance</b> with activities that the patient is <b>capable of achieving independently</b> . <b>Which should the nurse do</b> to help this patient?
Ask what the question is asking.	Which should the nurse do when a patient calls the nurse excessively?
Critically analyze each option in relation to the question and the other options.	Review concepts related to psychological responses to stress. Identify that the patient's behavior reflects anxiety. Explore nursing actions that support emotional needs and reduce anxiety. Then examine each option in light of whether the action will increase or decrease anxiety.
Eliminate incorrect options.	Options 1, 2, and 3 will increase, not decrease, anxiety and can be eliminated.

68. 1. **This information includes a nursing intervention and an evaluation of the outcome, which is the most specific and complete of all the options.**
- No data are given to support the assumption that the patient is happy.
  - The words "less anxious" are relative and do not clearly evaluate the patient's status.
  - Every patient has his or her own baseline. Indicating that a blood pressure is stable is incomplete and unclear.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse going off duty is making rounds with the nurse coming on duty and provides a report on each patient in the district. <b>Which information</b> reported by the nurse <b>is most complete?</b>
---------------------	--

Ask what the question is asking.	Which information is most thorough?
Critically analyze each option in relation to the question and the other options.	Examine each option to determine if the information included is objective and comprehensive.
Eliminate incorrect options.	Options 2 and 3 use the terms "happy" and "less anxious," which are subjective and not measurable. Option 4 fails to provide the before and after blood pressures, making the information meaningless. Options 2, 3, and 4 can be eliminated.

69. 1. **The eye should always be washed from the inner to the outer canthus to prevent secretions from entering the lacrimal ducts, which may result in an infection.**
- A bath blanket promotes privacy and prevents heat loss during a bath and is unrelated to asepsis. If not soiled, a patient's bath blanket can be reused.
  - Changing bath water after cleaning the perineum prevents transferring microorganisms from the perianal, urinary meatus, and vaginal area in women to subsequent areas of the body that are being washed. This action promotes medical asepsis.**
  - Having a patient void before beginning the bed bath is related to a patient's comfort and elimination needs, rather than asepsis.
  - Clean gloves are required during this procedure to protect the nurse because the nurse may be exposed to body fluids.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is bathing a patient. <b>Which nursing actions support a principle associated with medical asepsis?</b>
Ask what the question is asking.	Which actions are based on principles of medical asepsis?

continued



continued

<b>Critically analyze</b> each option in relation to the question and the other options.	Visualize the steps of the procedure for bathing a patient. Recall principles associated with maintaining medical asepsis. Integrate the principles of medical asepsis with the visualized steps of the procedure. Analyze the options in relation to this information.
<b>Eliminate incorrect</b> options.	Although options 2 and 4 are part of the procedure of bathing, they are unrelated to principles of medical asepsis. Eliminate options 2 and 4.

- 70.** 1. Water is ineffective against a grease fire. It will scatter the flames and the fire will spread.
2. **The lid of the frying pan deprives the fire of oxygen. Without oxygen to support combustion the fire will go out.**
3. Although closing the door to the kitchen will help to contain the fire to the kitchen, there is a more appropriate intervention to contain the fire to the frying pan.
4. Using a class A fire extinguisher is inappropriate. A class A fire extinguisher is designed for fires consisting of paper, wood, upholstery, rags, and ordinary rubbish.

### CRITICAL-THINKING STRATEGY

<b>Recognize keywords.</b>	Health teaching regarding a kitchen fire should include what to do if <b>grease</b> in a frying pan catches on <b>fire</b> . A nurse teaches that in this situation people should <b>first call 911</b> . <b>Which</b> should people be taught <b>to do next</b> ?
<b>Ask what the question is asking.</b>	Which should be done after calling 911 in the event of a grease fire?
<b>Critically analyze</b> each option in relation to the question and the other options.	Identify the steps to follow when confronted with a fire and integrate the concept “oxygen supports combustion.” Refer to the mnemonic RACE ( <b>R</b> escue patients in immediate danger, <b>A</b> ctivate the alarm, <b>C</b> onfine the fire, <b>E</b> xtinguish the fire).

**Eliminate incorrect** options.

No one needs to be rescued, and 911 was called. The next steps include confining and then extinguishing the fire. Placing a cover on the pan accomplishes both because it eliminates oxygen, which supports combustion. Eliminate options 1 and 4 because the actions are inappropriate and unsafe. Although the action in option 3 may confine the fire, it does not extinguish the fire. Eliminate options 1, 3, and 4.

- 71.** 1. Sucking on a hard candy after the procedure addresses the problem after, rather than before, it occurs.
2. Shaking the cartridge longer before using it will ensure that the medication is dispersed throughout solution in the cartridge. It will not change the taste of the medication.
3. Oral hygiene should be performed after, not before, the procedure.
4. **The aerosolized medication enters the aerosol chamber, where the larger droplets fall to the bottom of the chamber. The smaller droplets are inhaled deep into the lungs rather than falling on the patient’s tongue.**

### CRITICAL-THINKING STRATEGY

<b>Recognize keywords.</b>	A patient who self-administers an aerosol medication by a <b>metered-dose inhaler</b> complains of “the <b>nasty taste</b> of the medication.” <b>Which should the nurse encourage the patient to do?</b>
<b>Ask what the question is asking.</b>	Which action will reduce the “nasty taste” of medication taken via a metered-dose inhaler?
<b>Critically analyze</b> each option in relation to the question and the other options.	Review the rationale for each step of the procedure when using a metered-dose inhaler. Identify the equipment that may be used when administering medication via a metered-dose inhaler. Compare and contrast this information in relation to resolution of the patient’s problem.

Eliminate incorrect options.	The action in option 1 will not prevent the problem. The action in option 2 will not change the taste of the medication. The action in option 3 is done after, not before, the procedure. Options 1, 2, and 3 can be eliminated.
------------------------------	--

72. 1. Collecting data is not the most important purpose of the orientation phase of a therapeutic relationship.
2. **The orientation phase (also called the introductory or pre-helping phase) of a therapeutic relationship sets the tone for the rest of the relationship. A rapport develops when the patient recognizes that the nurse is willing and able to help and can be trusted.**
3. Problems are identified, explored, and dealt with during the working, not orientation, phase of a therapeutic relationship.
4. Priority needs are identified and interventions planned and implemented during the working, not orientation, phase of a therapeutic relationship.

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which is the <b>most important purpose</b> of the <b>orientation phase</b> of a therapeutic relationship?
Ask what the question is asking.	Which is the main function of the orientation phase of a therapeutic relationship?
Critically analyze each option in relation to the question and the other options.	Recall the phases of a therapeutic relationship. Determine what is significant about the orientation phase versus the other phases of the therapeutic relationship. Examine the options and identify which one accurately reflects the purposes of the orientation phase that you have identified.
Eliminate incorrect options.	Options 3 and 4 relate to the working phase of a therapeutic relationship and can be eliminated. Although data are collected during the orientation phase of the therapeutic relationship, this is not the most important purpose and therefore option 1 can be eliminated.

73. 1. Lethargy, weakness, and aching muscles occur during the course phase (plateau phase), not onset phase (cold or chill phase), of a fever.
2. **Pale skin occurs as the peripheral blood vessels constrict in an attempt to increase the core body temperature.**
3. **Feeling cold, chills, and shivering are adaptations associated with the onset phase (cold or chill phase) of a fever. During this phase the body responds to pyrogens by conserving heat to raise body temperature.**
4. Profuse diaphoresis (sweating) occurs during the defervescence phase (fever abatement, flush phase) of a fever. During this phase the fever abates and body temperature returns to the expected range.
5. Dehydration can occur during both the course phase (plateau phase) and defervescence phase (fever abatement, flush phase) of a fever.

#### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient has a temperature of 102°F and complains of <b>feeling cold</b> . Which <b>additional responses</b> should the nurse expect during this <b>onset phase (cold or chill phase) of a fever</b> ?
Ask what the question is asking.	Which are signs associated with the onset phase (cold or chill phase) of a fever?
Critically analyze each option in relation to the question and the other options.	List the physiological responses associated with each phase of a fever. Compare the list with the options provided.
Eliminate incorrect options.	The response in option 1 is associated with the course phase (plateau phase) of a fever and can be eliminated. The responses in options 4 and 5 are associated with the defervescence phase (fever abatement, flush phase) of a fever and can be eliminated.

74. 1. The feet can be washed thoroughly when taking a shower.
2. **The warm water used to soak the feet promotes vasodilation, which improves circulation to the most distal portions**

of the feet. Soaking the feet loosens dirt and limits scrubbing, which prevent trauma to the skin. Soaking the feet should be done for just several minutes because prolonged soaking removes natural skin oils, which dries the skin and makes it prone to cracking.

3. Extra care with the feet is unnecessary because paper slippers provide a barrier between the feet and the floor.
4. When on bedrest, the feet do not get soiled with dirt. Bedrest does not necessitate soaking the feet during a bed bath.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which patient should the nurse identify will <b>benefit the most</b> from <b>soaking the feet</b> for several minutes as part of a bath?
Ask what the question is asking.	Which patient will benefit the most from soaking the feet?
Critically analyze each option in relation to the question and the other options.	Identify that warm bath water will increase vasodilation and improve circulation. Then compare and contrast each patient situation and establish which patient will benefit most from increased peripheral circulation.
Eliminate incorrect options.	The patients in options 1, 3, and 4 do not require an intervention that will increase peripheral circulation. These options can be eliminated.

75. 1. Flat, brown spots on the skin are an expected integumentary change in older adults. Brown spots (*lentigo senilis*) on the skin are caused by a clustering of melanocytes, which are pigment-producing cells.
2. A loss of subcutaneous fat and a reduced thickness and vascularity of the dermis that occur with aging result in thin, translucent skin in the older adult.
3. **Tenting occurs when the skin of a dehydrated person remains in a peak or tent position after the skin is pinched together. This is a sign of a fluid volume deficit. Care must be taken**

when assessing an older person because some degree of tenting may occur, even when hydrated, because of the decrease in skin elasticity and decrease in tissue fluid associated with aging; however, in the hydrated patient tenting will slowly resolve.

4. A decrease in tissue fluid and sebaceous gland activity associated with aging commonly results in dry, flaky skin.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is assessing the <b>skin</b> of an <b>older adult</b> . Which <b>assessment</b> is the <b>greatest concern</b> ?
Ask what the question is asking.	Which skin condition in an older adult is most serious?
Critically analyze each option in relation to the question and the other options.	Explore the causes and consequences of the clinical finding presented in each option. Review the expected skin changes associated with aging. Compare and contrast the options in relation to this information to identify the most serious clinical finding.
Eliminate incorrect options.	The signs in options in 1, 2, and 4 are expected changes associated with aging and are not as serious as tenting of the skin, which indicates dehydration. Options 1, 2, and 4 can be eliminated.

76. 1. Inhaling slowly and deeply using the spirometer is the correct way to inhale when using an incentive spirometer; it helps to keep the airways open.
2. **The patient is using the incentive spirometer incorrectly and needs further teaching. An incentive spirometer must be held in an upright position. A tilted flow-oriented device requires less effort to reach the desired inspiratory volume. A tilted volume-oriented device will not function correctly.**
3. Inspiratory goals progressively should be increased daily or more frequently depending on the patient's ability to maximize the inspiratory volume continually, which promotes alveoli ventilation.

4. Taking several breaths using the spirometer and then breathing without using the spirometer and then using the spirometer again are desirable practices because they prevent hyperventilation and respiratory alkalosis.
5. **The patient should be taught to remove the mouthpiece from the mouth before exhalation. An incentive spirometer is designed to encourage inhalation, not exhalation.**

**the patient's concerns and address the patient's individual needs in privacy.**

**CRITICAL-THINKING STRATEGY**

<b>Recognize keywords.</b>	A nurse is caring for a patient using an <b>incentive spirometer</b> . Which <b>behaviors</b> observed by the nurse <b>indicate</b> that <b>further teaching is necessary</b> ?
<b>Ask what the question is asking.</b>	Which actions demonstrate incorrect use of an incentive spirometer?
<b>Critically analyze each option in relation to the question and the other options.</b>	List the steps of the procedure—use of an incentive spirometer. The behavior in each option must be compared with the steps in the procedure. This question has negative polarity and expects you to identify the action that demonstrates the incorrect use of an incentive spirometer.
<b>Eliminate incorrect options.</b>	Options 1, 3, and 4 are correct actions when using an incentive spirometer and can be eliminated.

77. 1. Giving the mother written material about cord care assumes that the patient can read at the reading level of the presented material. Also, it does not provide an opportunity for the nurse to communicate with the patient.
2. If the patient was not participating in the present formal class, it is unlikely that the patient will participate in the next class.
3. Although an audiovisual cassette is an excellent strategy to provide instruction, it does not provide the nurse an opportunity to individualize one-on-one instruction.
4. **The nurse identified that the patient was quiet and withdrawn in the group class. Individual instruction provides the nurse the opportunity to explore**

**CRITICAL-THINKING STRATEGY**

<b>Recognize keywords.</b>	A nurse on a postpartum unit is teaching a class for new mothers about umbilical cord care. The nurse identifies that <b>one mother does not become involved</b> with the discussion and <b>is withdrawn</b> . Which is the <b>best action</b> by the nurse <b>to help this new mother learn</b> about umbilical cord care?
<b>Ask what the question is asking.</b>	Which teaching intervention is most helpful for a patient who is withdrawn?
<b>Critically analyze each option in relation to the question and the other options.</b>	This question requires the integration of several concepts: teaching-learning principles, strengths and weaknesses of various teaching strategies, and how best to teach a patient who is withdrawn. Examine the action presented in each option and determine if it will be effective for this patient considering what you explored about teaching-learning.
<b>Eliminate incorrect options.</b>	Options 1 and 3 support withdrawn behavior. Option 2 was not effective in the past and the teaching plan should be revised. Eliminate options 1, 2, and 3.

78. 1. Tilting the head backward increases the risk of aspiration because it straightens the trachea and anatomically makes it easier for food and fluid to enter the trachea rather than the esophagus.
2. Food and fluid should be consumed separately in the presence of dysphagia. Fluid is more difficult to control with dysphagia, and it may flush the solid food toward the trachea, where it can cause choking or a partial or total airway obstruction.
3. **A patient with dysphagia should concentrate on the acts of chewing and swallowing. Environmental stimuli can be distracting and can result in inadequate chewing or premature swallowing, which in turn can result in choking and aspiration.**

4. **Ensuring that the mouth is empty after eating reduces the risk of aspiration.**
5. Chewing food in the front of the mouth will increase the risk for aspiration. Food should be placed in the posterior, not anterior, part of the mouth toward the side. The molars in the back of the mouth are designed for chewing. Placing food to the side keeps it close to the molars for chewing and out of direct line with the trachea. Placing food in the posterior of the mouth limits the need for the tongue to manipulate the bolus of food toward the back of the mouth in preparation for swallowing (deglutition).

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is teaching a patient with <b>dysphagia how to eat safely</b> . Which should the nurse <b>encourage the patient to do</b> ?
Ask what the question is asking.	Which should a patient with dysphagia do when eating?
Critically analyze each option in relation to the question and the other options.	Identify the major problem associated with dysphagia—risk for aspiration. Identify a patient's response to each of the actions presented in the options. Determine if the action in each option is safe or unsafe. Identify the option that will have a safe outcome.
Eliminate incorrect options.	Eliminate the options that increase the risk of aspiration. Options 1, 2, and 5 can be eliminated.

79. 1. **A person's cultural, religious, educational, economic, and experiential background influences eating behaviors and food preferences. When familiar, preferred foods are available and personally selected, patients may feel that the care is individualized and that they are in more control, resulting in eating a greater percentage of the meal.**
2. Teaching the patient to avoid fluids and foods that cause flatus assumes that the inadequate intake is related to discomfort associated with flatus. This must be validated before engaging in this teaching.

3. Research indicates that exercise decreases appetite and increases the need for calories. Exercise releases beta-endorphin, which results in a state of relaxation and satisfaction with less food.
4. Drinking between-meal supplements may further decrease the consumption of food at mealtimes. Supplements are given in addition to, not to replace, the nutrients that are consumed with meals.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient consistently eats only 25% of every meal. Which should the nurse do to <b>encourage the dietary intake</b> of this patient?
Ask what the question is asking.	Which action will help increase food intake?
Critically analyze each option in relation to the question and the other options.	Determine the nursing actions that support nutritional intake. Compare and contrast the benefits among the proposed interventions in relation to this information. Eliminate those actions that are contraindicated and determine which is most effective of the remaining options.
Eliminate incorrect options.	Option 2 reads into the question and makes the assumption that the patient may have discomfort from flatus. Options 3 and 4 are inaccurate and contraindicated. Eliminate options 2, 3, and 4.

80. 1. **Evaluating a patient's response to activity requires the knowledge and judgment of a Registered Nurse. This evaluation requires multiple assessments (e.g., breathing, heart rate, and fatigue) and may require immediate nursing intervention if an activity intolerance is identified.**
2. **A task of this complexity requires the knowledge and judgment of a Registered Nurse. This assessment requires more than just obtaining a pulse rate. It requires an additional assessment of rhythm and volume.**
3. **Patient teaching is a complex task. It requires knowledge of principles, such**

as identifying readiness to learn, progressing from simple to complex information, using motivational theory, and evaluating outcomes. Also, it requires knowledge of principles related to colostomy care, such as the bag opening must be at least  $\frac{1}{8}$  inch larger than the stoma, a pale stoma may indicate ischemia, and what to include in an assessment of the characteristics of intestinal output.

4. Applying a condom catheter is not a complex task. It requires simple problem-solving skills, involves a predictable outcome, and employs a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented, it is within the scope of practice of a Nursing Assistant. It does not require the more advanced competencies of a Registered Nurse.
5. Making an occupied bed is not a complex task. It requires simple problem-solving skills, involves a predictable outcome, and employs a simple level of interaction with the patient. Although this task has the potential to cause harm if the critical elements of the skill are not implemented, it is within the scope of practice of a Nursing Assistant. It does not require the more advanced competencies of a Registered Nurse.

Eliminate incorrect options.

Health teaching and assessing patients experiencing complex problems or who are in high-risk situations are responsibilities of a Registered Nurse. Assignments that include the activities of daily living can be assigned to a Nursing Assistant. Eliminate options 4 and 5.

**81. 1. This is an example of learning in the affective domain. In the affective domain, learning is concerned with feelings, emotions, values, beliefs, and attitudes.**

2. Assuming new healthy behaviors is not an example of learning in the cognitive domain. In the cognitive domain, learning is concerned with intellectual understanding and includes thinking on many levels, with progressively increasing complexity.
3. Assuming new healthy behaviors is not an example of learning in the psychomotor domain. Learning in the psychomotor domain includes using motor and physical abilities to master a skill. It requires the learner to practice to improve coordination and dexterity manipulating the equipment associated with the skill.
4. There is no learning domain known as physiological.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A charge nurse is delegating assignments to a Registered Nurse and a Nursing Assistant on the nursing team. Which <b>actions</b> should be <b>implemented only by a Registered Nurse?</b>
Ask what the question is asking.	Which actions are within the legal scope of practice for a Registered Nurse.
Critically analyze each option in relation to the question and the other options.	In general terms contrast the responsibilities of a Registered Nurse and a Nursing Assistant. Assess each option and designate which member of the team can perform the assignment.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse wants to <b>influence</b> a patient's <b>beliefs</b> so that <b>new healthy behaviors</b> are incorporated into the patient's lifestyle. Within <b>which learning domain</b> does the nurse need to <b>direct teaching?</b>
Ask what the question is asking.	Which learning domain is associated with influencing beliefs?
Critically analyze each option in relation to the question and the other options.	Explore what you know about the three domains of learning— affective, cognitive, and psychomotor. Identify examples of learning that occur in each domain. Determine the domain in which beliefs, attitudes, feelings, emotions, and values are addressed.

*continued*

continued

Eliminate incorrect options.	Option 2 reflects the cognitive domain. Option 3 reflects the psychomotor domain. Option 4 is not related to any learning domain. Eliminate options 2, 3, and 4.
------------------------------	--

- 82.** 1. Hyperextension of the condyloid joint of the wrist is accomplished by bending the fingers and hand backward as far as possible.
2. Opposition of the thumb, which is a saddle joint, occurs when the thumb touches the top of each finger on the same hand.
3. Abduction of the fingers (metacarpophalangeal joints—condyloid) occurs when the fingers of each hand spread apart.
- 4. Flexion of the wrist, a condyloid joint, occurs when the fingers of the hand move toward the inner aspect of the forearm.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is teaching a family member how to perform range-of-motion exercises of the hand. <b>Which motion occurs when the angle is reduced between the palm of the hand and forearm?</b>
Ask what the question is asking.	Which range of motion is being described when the angle is reduced between the palm of the hand and forearm?
Critically analyze each option in relation to the question and the other options.	Review all the motions that are included when performing range-of-motion of the joints of the hand. Specifically recall the name of the motion associated with reducing the angle between the palm of the hand and forearm.
Eliminate incorrect options.	Options 1, 2, and 3 can be eliminated because they do not describe the action indicated in the question.

- 83. 1. This response recognizes the patient's feelings.**
2. This response denies the patient's feelings and gives false reassurance.
3. This response denies the patient's feelings and gives false reassurance.
4. This response denies the patient's feelings.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient with terminal cancer says to the nurse, "I've been fairly religious, but sometimes <b>I wonder if the things I did were acceptable to God.</b> " <b>How should the nurse respond?</b>
Ask what the question is asking.	Identify the therapeutic response by the nurse in this situation.
Critically analyze each option in relation to the question and the other options.	Review therapeutic communication techniques and barriers to communication. Examine the options and identify the response that promotes communication and the responses that are barriers to communication.
Eliminate incorrect options.	Options 2 and 3 are examples of false reassurance. Option 4 denies the patient's feelings. Options 2, 3, and 4 can be eliminated.

- 84. 1. If the patient falls asleep the patient may aspirate the lozenge, which can cause an airway obstruction.**
2. Fluid will interfere with the action and absorption of the lozenge. This action is unsafe because it can cause the patient to aspirate or swallow the lozenge.
3. Medication that dissolves under the tongue is administered via the sublingual, not buccal, route.
- 4. Alternating cheeks when placing a lozenge will limit irritation to the mucous membranes in the buccal area.**
5. A lozenge should be administered after, or between, meals. Food will interfere with the action and absorption of the medication.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is administering a <b>lozenge</b> to a patient's <b>buccal area</b> of the mouth. <b>Which should the nurse do?</b>
Ask what the question is asking.	Which interventions are implemented when administering a lozenge?

<b>Critically analyze</b> each option in relation to the question and the other options.	List the steps of the procedure—administering a lozenge to a patient’s buccal cavity. Examine the behavior in each option and compare it with the list.
<b>Eliminate incorrect options.</b>	Eliminate the options that have actions that are not on your identified list, which are associated with another route of administration, or are contraindicated. Options 2 and 5 are incorrect actions. Option 3 addresses the sublingual route. Eliminate options 2, 3, and 5.

- 85. 1. Pain tolerance is the maximum amount and duration of pain that a person is willing to tolerate. It is influenced by psychosociocultural factors and usually increases with age.**
- This question focuses on an alleviating factor, distraction, rather than on the concept of pain tolerance.
  - This question is determining the patient’s perception of the intensity of pain, not pain tolerance.
  - This question focuses on an alleviating factor, medication, rather than on the concept of pain tolerance.

**CRITICAL-THINKING STRATEGY**

<b>Recognize keywords.</b>	<b>Which question</b> by the nurse <b>assesses</b> a patient’s <b>pain tolerance</b> ?
<b>Ask what the question is asking.</b>	Which statement assesses pain tolerance?
<b>Critically analyze</b> each option in relation to the question and the other options.	Several concepts must be explored: characteristics of pain, the difference between pain threshold and pain tolerance, and how the nurse can best assess each characteristic of pain. Use of the mnemonic COLDERR (character, onset, location, duration, exacerbation, relief, and radiation) and an intensity pain scale (e.g., numerical scale, Wong-Baker FACES Rating Scale) may help to answer this question.

<b>Eliminate incorrect options.</b>	Options 2 and 4 focus on alleviating factors. Option 3 focuses on intensity. Options 2, 3, and 4 can be eliminated.
-------------------------------------	---

- 86. 1.** Asking family members not to bring tempting food into the house imposes on family members. A person must learn to cope with temptation regardless of where being exposed to desirable foods.
- 2.** Posting piggy pictures on the refrigerator is degrading and should be avoided. Pictures that reflect a positive outcome are more desirable.
- 3.** The rigidity and limitation of avoiding between-meal snacks may cause periods of hypoglycemia, overeating, and noncompliance. Between-meal snacks should be calculated into the weight-reduction program to meet both physical and emotional needs.
- 4. Behavior modification strategies are most successful when the person has an internal locus of control and is actively involved in self-care. Research demonstrates that self-monitoring of food intake is the single most helpful strategy in weight reduction.**

**CRITICAL-THINKING STRATEGY**

<b>Recognize keywords.</b>	An obese patient asks the nurse, “What should I do to help myself lose weight?” How should the nurse respond considering the <b>best behavior modification strategy for controlling food intake</b> ?
<b>Ask what the question is asking.</b>	Which is the best behavior modification strategy to control food intake?
<b>Critically analyze</b> each option in relation to the question and the other options.	Examine each option considering certain concepts: promote independence; avoid self-deprecation; physiological responses to dieting; and strategies to achieve dietary success.
<b>Eliminate incorrect options.</b>	Option 1 communicates to patients that they are unable to develop an internal locus of control. Option 2 is degrading. Option 3 will not meet the patient’s psychological or physical needs. Options 1, 2, and 3 can be eliminated.



**87. 1. Although there is a predictable sequence to growth and development, there are individual differences in the rate and pace in which developmental milestones are achieved. Therefore, achievement of milestones is measured in ranges of time to allow for individual differences.**

2. Task achievement refers to Erikson's Theory of Personality Development, which is only one aspect of growth and development. Erikson believed that each stage of personality development is characterized by the need to achieve a specific developmental task and that achievement of each task is affected by the social environment and influence of significant others. The success or failure to achieve a task at one stage will influence task achievement in subsequent stages, but it does not have to be achieved before moving on to the next task.
3. Unfortunately, not all families provide safe and supportive environments. In addition, the family is only one of many factors that influence the stages of growth and development.
4. Thinking that once a task is achieved regression is minimal is untrue. Regression is possible at any stage when one attempts to cope with a threat to the self.

Eliminate incorrect options.

Eliminate those options that are untrue or that are specific to a particular theorist rather than a general concept. Task achievement in option 2 is specific to Erikson. Not all families provide safe and supportive environments as indicated in option 3. Option 4 is untrue. Options 2, 3, and 4 can be eliminated.

**88. 2. The outside of the catheterization package is contaminated and should be opened with hands that have been washed with soap and water.**

1. The inside of the catheterization package is sterile. Sterile gloves are on the top of the supplies included because all subsequent equipment in the package must remain sterile.
3. The nurse's sterile gloved hands then place the fenestrated drape over the patient's perineal area to continue with the establishment of a sterile field.
5. Cleansing the labia moves from areas that are less likely to be contaminated than the urinary meatus as well as reduces the spread of microorganisms toward the urinary meatus.
4. Cleansing the urinary meatus last reduces the possibility of introducing microorganisms into the urinary meatus and bladder.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which <b>general concept related to growth and development</b> should be <b>considered</b> by the nurse <b>when caring for patients</b> ?
Ask what the question is asking.	Which general principle related to growth and development should be considered when caring for patients?
Critically analyze each option in relation to the question and the other options.	Review the basic concepts associated with various growth and development theorists (e.g., Erikson, Freud, Gesell, Havighurst, and Piaget). Examine each option in light of the basic concepts you have identified. The word "general" must be addressed when analyzing the options.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A primary health-care provider orders the insertion of an <b>indwelling urinary catheter</b> (retention, Foley) as part of the patient's preoperative orders. Place the following <b>steps of the procedure in the order</b> in which they should be <b>performed</b> by the nurse.
Ask what the question is asking.	What is the progression of steps for inserting an indwelling urinary catheter?

Critically analyze each option in relation to the question and the other options.	List the sequential steps of inserting an indwelling urinary catheter. Refer to your list as you examine the options presented. Order the steps presented according to the order you identified.
Eliminate incorrect options.	There are no incorrect options.

**89. Answer: 16.**

**The pulse deficit is the difference between the apical and radial pulse rates. Therefore, 100 (apical rate) minus 84 (radial rate) equals 16. The patient's pulse deficit is 16.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient's vital signs are: apical heart rate—100 beats/min, radial heart rate—84 beats/min, respirations—20 breaths/min, blood pressure—140/84 mm Hg. <b>What is the patient's pulse deficit?</b> Record your answer using a whole number.
Ask what the question is asking.	Calculate a pulse deficit from the information provided.
Critically analyze each option in relation to the question and the other options.	Define a pulse deficit. Analyze the situation to extract the information needed to calculate the pulse deficit. Perform the calculation.
Eliminate incorrect options.	There are no incorrect options.

- 90.** 1. The diastolic blood pressure decreases, not increases, during shock.  
**2. The initial stage of shock begins when baroreceptors in the aortic arch and the carotid sinus detect a drop in the mean arterial pressure resulting in a decrease in the systolic blood pressure. The systolic pressure is the pressure in the arteries during ventricular contraction.**  
 3. During shock there will be a narrowing, not widening, of pulse pressure. Pulse pressure is the difference between the systolic and diastolic pressures.

4. Weak or absent, not robust, Korotkoff's sounds are associated with shock. Korotkoff's sounds are the five distinct sounds that are heard when auscultating a blood pressure (I—faint, clear tapping; II—swishing sound; III—intense, clear tapping; IV—muffled, blowing sounds; V—absence of sounds).

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient is admitted to the emergency department after sustaining a crushing injury at work. Which <b>characteristic of blood pressure</b> should alert the nurse to <b>impending shock</b> ?
Ask what the question is asking.	Which abnormality in blood pressure is an early sign of shock?
Critically analyze each option in relation to the question and the other options.	Identify the physiological responses to impending shock (reduced oxygenation) and why each occurs. Compare and contrast the options and determine which option is a response to impending shock relative to the information you identified.
Eliminate incorrect options.	Options 1 and 4 are opposite of what will happen with impending shock. Korotkoff's sounds are expected and are not a sign of impending shock. Options 1, 3, and 4 can be eliminated.

- 91.** 1. Putting the stockings on after the legs are dependent is unsafe because pressure injures fluid-filled tissue. They should be applied before the legs are dependent because there will be less fluid in the tissues.  
**2. Elastic stockings provide external pressure on the patient's legs to prevent pooling of blood in the veins while not interfering with arterial circulation. However, if redness is observed the stockings may be too tight. Redness of the skin (erythema) is an early sign of tissue damage to skin resulting from a decrease in oxygen to cells.**  
 3. When applying elastic stockings, lotion increases friction that can injure tissue.

- Removing and reapplying the stockings only once a day can lead to tissue damage because of impaired circulation. Elastic stockings should be removed for 30 minutes three times a day; some orders require elastic stockings to be worn only when the patient is out of bed.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A primary health-care provider orders <b>antiembolism stockings</b> for a patient. Which is an <b>important action</b> the nurse should teach the patient?
Ask what the question is asking.	Which action is essential in relation to antiembolism hose?
Critically analyze each option in relation to the question and the other options.	Recall the steps and the rationale for each step in the procedure for applying and wearing antiembolism stockings. Identify the benefits and consequences of the action presented in each option. Compare and contrast the options relative to this information.
Eliminate incorrect options.	Eliminate options 1, 3, and 4 because these actions can injure tissue.

- The DRGs were not designed to increase the quality of medical care.
- DRGs are unrelated to increasing or decreasing reliability of research data. Reliability is the degree of consistency with which a research study measures a hypothesis and depends on how well the measurement tool and the research methods are designed.
- DRGs have increased, not decreased, the acuity of the hospitalized population. Patients who in the past were treated in the hospital are now treated in the home, in ambulatory care settings, or in less acute care settings, such as rehabilitation or extended-care centers.
- The DRGs, pretreatment diagnoses reimbursement categories, were designed to decrease the average length of a hospital stay, which in turn reduces costs.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which is the <b>important consequence</b> of the use of <b>Diagnosis Related Groups (DRGs) on the health-care system?</b>
Ask what the question is asking.	Which is the effect of DRGs on the health-care system?
Critically analyze each option in relation to the question and the other options.	List the purposes of the DRGs. Compare the list to the options presented in the question.
Eliminate incorrect options.	Identify those options that are either an inaccurate statement or are unrelated to the purpose of DRGs. The outcomes identified in options 1 and 2 are unrelated to the purpose of DRGs as indicated in the rationales. DRGs increase, not decrease, the acuity of hospitalized populations. Eliminate options 1, 2, and 3.

- Obtaining the medication is part of the procedure associated with giving medication, and therefore, this is an example of the implementation step of the nursing process.
- Identifying body landmarks before giving an injection is part of the procedure for administering an injection and, therefore, is an example of the implementation step of the nursing process.
- Determining when medications should be administered requires planning and therefore is part of the planning step of the nursing process.**
- Collecting data from a patient involves assessment, and therefore, verifying a patient's allergies is an example of the assessment step of the nursing process.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A primary health-care provider prescribes 1 g of an antibiotic to be administered via the intramuscular route twice a day. <b>Which nursing action reflects the planning step of the nursing process?</b>
---------------------	---

Ask what the question is asking.	Identify the action that is part of the planning step of the nursing process.
Critically analyze each option in relation to the question and the other options.	Recall the steps in the nursing process—assessment, analysis, planning, implementation, and evaluation. Review nursing actions associated with each step. Examine each option and identify which step of the nursing process is reflected by the action presented.
Eliminate incorrect options.	Options 1 and 2 are examples of actions in the implementation phase of the nursing process. Collecting data in option 4 is related to the assessment phase. Options 1, 2, and 4 can be eliminated.

- 94. 1. Digoxin can cause sensory changes, such as diplopia (double vision), halos, colored vision, blind spots, and flashing lights. If any of these symptoms of toxicity occurs, the medication should be withheld and a serum digoxin level assessed to determine if the drug is exceeding its therapeutic range of 0.5 to 2 ng/mL.**
- 2. Nausea and vomiting are common clinical indicators of digoxin toxicity resulting from irritation of the gastrointestinal system caused by an excessive dose.**
3. A respiratory rate more than 20 breaths per minute (tachypnea) is not a sign of digoxin toxicity.
- 4. Digoxin prolongs conduction through the SA and AV nodes, which slows the heart rate (negative chronotropic effect). When the heart rate is less than 60 beats per minute (bradycardia), the medication should be held to prevent a further decrease in the heart rate. Some primary health-care providers will stipulate the low and high levels of pulse rates at which the drug should be held.**
- 5. Dysrhythmias are a common sign of digoxin toxicity because of the negative effect of digoxin on cardiac tissue when a dose is excessive.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse working in a nursing home routinely administers <b>digoxin</b> 0.125 mg by mouth to a patient every morning. Which <b>patient responses</b> should alert the nurse to <b>withhold the medication</b> ?
Ask what the question is asking.	Which patient responses indicate digoxin toxicity?
Critically analyze each option in relation to the question and the other options.	Review the physiological action of digoxin. Analyze each option to determine if the response is unrelated to digoxin or is a toxic effect (plasma concentration of the drug that causes serious/ life-threatening responses) of digoxin, requiring its discontinuation.
Eliminate incorrect options.	As indicated in the rationales, option 3 is unrelated to digoxin toxicity and can be eliminated.

- 95. 1. The pressure of firm strokes on the skin moving from distal to proximal areas increases venous return. When venous return increases, cardiac output increases.**
2. Prolonged soaking removes the protective oils on the skin; the result is dry, cracked skin that is prone to further injury.
3. Exposing just the areas that are being washed prevents chilling, not increases circulation.
4. A temperature of 120 F to 125 F is too hot for bath water because it may cause tissue injury. Bath water should be 110 F to 115 F.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is giving a patient a <b>bed bath</b> . Which should the nurse <b>do to increase circulation</b> ?
Ask what the question is asking.	Which action will increase circulation during a bed bath?

*continued*

continued

Critically analyze each option in relation to the question and the other options.	Identify the consequences of the action in each option. Then compare and contrast the options relative to whether the action will or will not increase circulation.
Eliminate incorrect options.	Options 2 and 4 may cause tissue injury. Option 3 does not increase circulation. Options 2, 3, and 4 can be eliminated.

96. 1. Although a teaching program must be designed within the patient's developmental and cognitive abilities, they are not the most relevant factors when predicting success of the options presented.
2. Although reinforcement is important, it is not the most relevant factor when predicting success of the options presented.
3. Although family support is important, it is not the most relevant factor when predicting success of the options presented. Not all patients have a family support system.
4. **The motivation of the learner to acquire new attitudes, information, or skills is the most important component for successful learning; motivation exists when the learner recognizes the future benefits of learning.**

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse is <b>predicting</b> the <b>success of</b> a teaching program regarding the <b>learning</b> of a skill. Which <b>factor is most relevant?</b>
Ask what the question is asking.	Which factor is essential to the success of a teaching program?
Critically analyze each option in relation to the question and the other options.	Examine each option relative to its importance in facilitating learning. Compare and contrast the options.
Eliminate incorrect options.	Progressively eliminate the least important action until you arrive at a single option. Options 1, 2, and 3 can be eliminated because the factors in these options are not as important as motivation of the learner.

97. 1. A small amount of a lubricant, not alcohol, applied to the hair will facilitate the combing out of tangles.
2. After shampooing a patient's hair, it may be dried or just toweled dry until it is free of excess moisture.
3. **The appearance of one's hair is an extension of self-image. Therefore, the patient's personal preferences should be considered before grooming the hair.**
4. Combing or brushing should progress from the ends of the hair, then from the middle to the ends, and finally from the scalp to the ends (distal to proximal). This technique limits discomfort and prevents broken ends and damaged hair shafts.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	Which is <b>most important</b> for the nurse to do when assisting a <b>female</b> patient with <b>care of the hair?</b>
Ask what the question is asking.	Which is most essential when grooming a female patient's hair?
Critically analyze each option in relation to the question and the other options.	Identify the steps and rationales associated with caring for a patient's hair. Compare and contrast the options relative to these steps and rationales.
Eliminate incorrect options.	Eliminate the options that contain inaccuracies or that are not as important as another option. Options 1 and 4 present incorrect information. Option 2 is not as important as option 3. Options 1, 2, and 4 can be eliminated.

98. 1. **Smothering the flames with a blanket deprives the fire of oxygen. Without oxygen to support combustion, the fire will go out. Rescuing the patient is the first step of fire safety.**
2. Rolling the patient from side to side fans the flames, which will increase the intensity of the fire.
3. Activating the alarm is premature at this time, but it will be done eventually.
4. Closing the door will impede the evacuation of the patient from the room if it becomes necessary.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient who is secretly smoking in bed falls asleep and the <b>cigarette ignites</b> the patient's <b>gown</b> . Which should the nurse <b>do first</b> after discovering the fire?
Ask what the question is asking.	What is the first action when a patient's gown is on fire?
Critically analyze each option in relation to the question and the other options.	Identify the steps to follow when confronted with a fire and integrate the concept "oxygen supports combustion." Refer to the mnemonic RACE ( <b>R</b> escue patients in immediate danger, <b>A</b> ctivate the alarm, <b>C</b> onfine the fire, <b>E</b> xtinguish the fire). Identify the fact that to rescue the patient the nurse has to extinguish the fire. Identify ways in which the nurse can cut off oxygen that supports a fire. Examine options in light of the information you have explored.
Eliminate incorrect options.	Option 1 will impede departure from the room if it becomes necessary. Option 2 is premature. Option 3 is unsafe. Options 1, 2, and 3 can be eliminated.

99. 1. It is essential for the nurse to be an informed provider of care, but it is not the priority of care for this patient.  
 2. Although thinking of supplements as drugs should be done, it is not the priority of care for this patient.  
 3. **The primary health-care provider should be notified immediately because the herb may interact with prescribed medications or therapies.**  
 4. Although including the details about supplement use in the patient's health history should be done, it is not the priority. Medications or therapies may interact with the herb before the primary health-care provider reads the information in the health history.

## CRITICAL-THINKING STRATEGY

Recognize keywords.	A nurse <b>discovers</b> that a <b>patient is taking natural herbal remedies</b> . Which <b>action is most important</b> for the nurse to do?
Ask what the question is asking.	Which action is most important when the nurse identifies that the patient is taking natural herbal remedies?
Critically analyze each option in relation to the question and the other options.	Consider the significance of the word <i>discover</i> as it relates to the actions in the options—need for an immediate intervention. Identify the action that will protect the patient immediately. Although you first have to recognize that natural supplements are drugs, this will not protect the patient's safety. Analyze the other options and determine which action is most critical to ensure the patient's safety.
Eliminate incorrect options.	The actions in options 1 and 2 will not immediately provide for patient safety. Although documentation is important, it is not the priority. Eliminate options 1, 2, and 4.

100. 1. Hospice care is inappropriate for this patient because the patient is not dying. Hospice programs provide supportive care to dying patients and their family members to promote dying with dignity.  
 2. An acute-care setting generally is not the best setting to provide extensive rehabilitation services. The acute-care setting provides services that medically and emotionally support the patient during the critical and acute phases right after the traumatic event and until the patient is stable and out of danger.  
 3. **An extended-care facility is an inpatient setting where people live while receiving subacute medical, nursing, and rehabilitative care. Extended-care facilities that can meet the needs of this individual include intermediate-care facilities, nursing homes that provide subacute care/skilled nursing care, or rehabilitation centers.**  
 4. Once stabilized and out of danger, the individual in this scenario needs intensive rehabilitation services that generally cannot be provided in an assisted-living

residence. An assisted-living residence provides limited assistance with activities of daily living, meal preparation, laundry services, transportation, and opportunities for socialization. Residents are relatively independent.

### CRITICAL-THINKING STRATEGY

Recognize keywords.	A patient sustained a traumatic brain injury resulting in neurological deficits after falling off a ladder at work. Which <b>setting</b> is <b>most appropriate</b> for assisting this patient <b>to learn how to live with neurological limitations</b> ?
Ask what the question is asking.	Which setting is best for learning how to live with neurological deficits?

**Critically analyze** each option in relation to the question and the other options.

Identify the types of services provided by each of the health-care settings presented in the options. Examine the situation in the question and determine which of the settings best provides services that meet the needs of a patient with neurological deficits.

**Eliminate** incorrect options.

Hospice services, hospitals, and assisted-living residences are not designed to meet the intense rehabilitation needs of a patient learning to live with neurological limitations. Options 1, 2, and 4 can be eliminated.



# Glossary of English Words Commonly Encountered on Nursing Examinations

- Abnormality** — defect, irregularity, anomaly, oddity
- Absence** — nonappearance, lack, nonattendance
- Abundant** — plentiful, rich, profuse
- Accelerate** — go faster, speed up, increase, hasten
- Accumulate** — build up, collect, gather
- Accurate** — precise, correct, exact
- Achievement** — accomplishment, success, reaching, attainment
- Acknowledge** — admit, recognize, accept, reply
- Activate** — start, turn on, stimulate
- Adequate** — sufficient, ample, plenty, enough
- Angle** — slant, approach, direction, point of view
- Application** — use, treatment, request, claim
- Approximately** — about, around, in the region of, more or less, roughly speaking
- Arrange** — position, place, organize, display
- Associated** — linked, related
- Attention** — notice, concentration, awareness, thought
- Authority** — power, right, influence, clout, expert
- Avoid** — keep away from, evade, let alone
- Balanced** — stable, neutral, steady, fair, impartial
- Barrier** — barricade, blockage, obstruction, obstacle
- Best** — most excellent, most important, greatest
- Capable** — able, competent, accomplished
- Capacity** — ability, capability, aptitude, role, power, size
- Central** — middle, mid, innermost, vital
- Challenge** — confront, dare, dispute, test, defy, face up to
- Characteristic** — trait, feature, attribute, quality, typical
- Circular** — round, spherical, globular
- Collect** — gather, assemble, amass, accumulate, bring together
- Commitment** — promise, vow, dedication, obligation, pledge, assurance
- Commonly** — usually, normally, frequently, generally, universally
- Compare** — contrast, evaluate, match up to, weigh or judge against
- Compartment** — section, part, cubicle, booth, stall
- Complex** — difficult, multifaceted, compound, multipart, intricate
- Complexity** — difficulty, intricacy, complication
- Component** — part, element, factor, section, constituent
- Comprehensive** — complete, inclusive, broad, thorough
- Conceal** — hide, cover up, obscure, mask, suppress, secrete
- Conceptualize** — to form an idea
- Concern** — worry, anxiety, fear, alarm, distress, unease, trepidation
- Concisely** — briefly, in a few words, succinctly
- Conclude** — make a judgment, determine
- Confidence** — self-assurance, certainty, poise, self-reliance
- Congruent** — matching, fitting, going together well
- Consequence** — result, effect, outcome, end result
- Constituents** — elements, component, parts that make up a whole
- Contain** — hold, enclose, surround, include, control, limit
- Continual** — repeated, constant, persistent, recurrent, frequent
- Continuous** — constant, incessant, nonstop, unremitting, permanent
- Contribute** — be a factor, add, give
- Convene** — assemble, call together, summon, organize, arrange
- Convenience** — expediency, handiness, ease
- Coordinate** — organize, direct, manage, bring together
- Create** — make, invent, establish, generate, produce, fashion, build, construct
- Creative** — imaginative, original, inspired, inventive, resourceful, innovative
- Critical** — serious, grave, significant, dangerous, life-threatening
- Cue** — signal, reminder, prompt, sign, indication
- Curiosity** — inquisitiveness, interest, nosiness, snooping
- Damage** — injure, harm, hurt, break, wound
- Deduct** — subtract, take away, remove, withhold
- Deficient** — lacking, wanting, underprovided, scarce, faulty
- Defining** — important, crucial, major, essential, significant, central



- Defuse** — resolve, calm, soothe, neutralize, rescue, mollify
- Delay** — hold up, wait, hinder, postpone, slow down, hesitate, linger
- Demand** — insist, claim, require, command, stipulate, ask
- Describe** — explain, tell, express, illustrate, depict, portray
- Design** — plan, invent, intend, aim, propose, devise
- Desirable** — wanted, pleasing, enviable, popular, sought after, attractive, advantageous
- Detail** — feature, aspect, element, factor, facet
- Deteriorate** — worsen, decline, weaken
- Determine** — decide, conclude, resolve, agree on
- Dexterity** — skillfulness, handiness, agility, deftness
- Dignity** — self-respect, self-esteem, decorum, formality, poise
- Dimension** — aspect, measurement
- Diminish** — reduce, lessen, weaken, detract, moderate
- Discharge** — release, dismiss, set free
- Discontinue** — stop, cease, halt, suspend, terminate, withdraw
- Disorder** — complaint, problem, confusion, chaos
- Display** — show, exhibit, demonstrate, present, put on view
- Dispose** — get rid of, arrange, order, set out
- Dissatisfaction** — displeasure, discontent, unhappiness, disappointment
- Distinguish** — separate, classify, recognize differences
- Distract** — divert, sidetrack, entertain
- Distress** — suffering, trouble, anguish, misery, agony, concern, sorrow
- Distribute** — deliver, spread out, hand out, issue, dispense
- Disturbed** — troubled, unstable, concerned, worried, distressed, anxious, uneasy
- Diversional** — serving to distract
- Don** — put on, dress oneself in
- Dramatic** — spectacular
- Drape** — cover, wrap, dress, swathe
- Dysfunction** — abnormal, impaired
- Edge** — perimeter, boundary, periphery, brink, border, rim
- Effective** — successful, useful, helpful, valuable
- Efficient** — not wasteful, effective, competent, resourceful, capable
- Elasticity** — stretch, spring, suppleness, flexibility
- Eliminate** — get rid of, eradicate, abolish, remove, purge
- Embarrass** — make uncomfortable, make self-conscious, humiliate, mortify
- Emerge** — appear, come, materialize, become known
- Emphasize** — call attention to, accentuate, stress, highlight
- Ensure** — make certain, guarantee
- Environment** — setting, surroundings, location, atmosphere, milieu, situation
- Episode** — event, incident, occurrence, experience
- Essential** — necessary, fundamental, vital, important, crucial, critical, indispensable
- Etiology** — assigned cause, origin
- Exaggerate** — overstate, inflate
- Excel** — stand out, shine, surpass, outclass
- Excessive** — extreme, too much, unwarranted
- Exertion** — intense or prolonged physical effort
- Exhibit** — show signs of, reveal, display
- Expand** — get bigger, enlarge, spread out, increase, swell, inflate
- Expect** — wait for, anticipate, imagine
- Expectation** — hope, anticipation, belief, prospect, probability
- Experience** — knowledge, skill, occurrence, know-how
- Expose** — lay open, leave unprotected, allow to be seen, reveal, disclose, exhibit
- External** — outside, exterior, outer
- Facilitate** — make easy, make possible, help, assist
- Factor** — part, feature, reason, cause, think, issue
- Focus** — center, focal point, hub
- Fragment** — piece, portion, section, part, splinter, chip
- Function** — purpose, role, job, task
- Furnish** — supply, provide, give, deliver, equip
- Further** — additional, more, extra, added, supplementary
- Generalize** — take a broad view, simplify, to make inferences from particulars
- Generate** — make, produce, create
- Gentle** — mild, calm, tender
- Girth** — circumference, bulk, weight
- Highest** — uppermost, maximum, peak, main
- Hinder** — hold back, delay, hamper, obstruct, impede
- Humane** — caring, kind, gentle, compassionate, benevolent, civilized
- Ignore** — pay no attention to, disregard, overlook, discount
- Imbalance** — unevenness, inequality, disparity
- Immediate** — insistent, urgent, direct
- Impair** — damage, harm, weaken
- Implantation** — insertion
- Implement** — employ, execute, carry out
- Impotent** — powerless, weak, incapable, ineffective, unable
- Inadvertent** — unintentional, chance, unplanned, accidental

- Include** — comprise, take in, contain
- Indicate** — point out, sign of, designate, specify, show
- Ineffective** — unproductive, unsuccessful, useless, vain, futile
- Inevitable** — predictable, expected, unavoidable, foreseeable
- Influence** — power, pressure, sway, manipulate, affect, effect
- Initiate** — start, begin, open, commence, instigate
- Insert** — put in, add, supplement, introduce
- Inspect** — look over, check, examine
- Inspire** — motivate, energize, encourage, enthuse
- Institutionalize** — place in a facility for treatment
- Integrate** — put together, mix, add, combine, assimilate
- Integrity** — honesty
- Interfere** — get in the way, hinder, obstruct, impede, hamper
- Interpret** — explain the meaning of, make understandable
- Intervention** — action, activity
- Intolerance** — bigotry, prejudice, narrow-mindedness
- Involuntary** — instinctive, reflex, unintentional, automatic, uncontrolled
- Irreversible** — permanent, irrevocable, irreparable, unalterable
- Irritability** — sensitivity to stimuli, fretful, quick excitability
- Justify** — explain in accordance with reason
- Likely** — probably, possible, expected
- Liquefy** — change into or make more fluid
- Logical** — using reason
- Longevity** — long life
- Lowest** — inferior in rank
- Maintain** — continue, uphold, preserve, sustain, retain
- Majority** — the greater part of
- Mention** — talk about, refer to, state, cite, declare, point out
- Minimal** — least, smallest, nominal, negligible, token
- Minimize** — reduce, diminish, lessen, curtail, decrease to smallest possible
- Mobilize** — activate, organize, assemble, gather together, rally
- Modify** — change, adapt, adjust, revise, alter
- Moist** — slightly wet, damp
- Multiple** — many, numerous, several, various
- Natural** — normal, ordinary, unaffected
- Negative** — no, harmful, downbeat, pessimistic
- Negotiate** — bargain, talk, discuss, consult, cooperate, settle
- Notice** — become aware of, see, observe, discern, detect
- Notify** — inform, tell, alert, advise, warn, report
- Nurture** — care for, raise, rear, foster
- Obsess** — preoccupy, consume
- Occupy** — live in, inhabit, reside in, engage in
- Occurrence** — event, incident, happening
- Odorous** — scented, stinking, aromatic
- Offensive** — unpleasant, distasteful, nasty, disgusting
- Opportunity** — chance, prospect, break
- Organize** — put in order, arrange, sort, categorize, classify
- Origin** — source, starting point, cause, beginning, derivation, etiology
- Pace** — speed
- Parameter** — limit, factor, limitation, issue
- Participant** — member, contributor, partaker, applicant
- Perspective** — viewpoint, view, perception
- Position** — place, location, point, spot, situation
- Practice** — do, carry out, perform, apply, follow
- Precipitate** — cause to happen, bring on, hasten, abrupt, sudden
- Predetermine** — fix or set beforehand
- Predictable** — expected, knowable
- Preference** — favorite, liking, first choice
- Prepare** — get ready, plan, make, train, arrange, organize
- Prescribe** — set down, stipulate, order, recommend, impose
- Previous** — earlier, prior, before, preceding
- Primarily** — first, above all, mainly, mostly, largely, principally, predominantly
- Primary** — first, main, basic, chief, most important, key, prime, major, crucial
- Priority** — main concern, giving first attention to, order of importance
- Production** — making, creation, construction, assembly
- Profuse** — a lot of, plentiful, copious, abundant, generous, prolific, bountiful
- Prolong** — extend, delay, put off, lengthen, draw out
- Promote** — encourage, support, endorse, sponsor
- Proportion** — ratio, amount, quantity, part of, percentage, section of
- Provide** — give, offer, supply, make available
- Rationalize** — explain, reason
- Realistic** — practical, sensible, reasonable
- Receive** — get, accept, take delivery of, obtain
- Recognize** — acknowledge, appreciate, identify, aware of
- Recovery** — healing, mending, improvement, recuperation, renewal
- Reduce** — decrease, lessen, ease, moderate, diminish
- Reestablish** — reinstate, restore, return, bring back
- Regard** — consider, look upon, relate to, respect

**Regular** — usual, normal, ordinary, standard, expected, conventional

**Relative** — comparative, family member

**Relevance** — importance of

**Reluctant** — unwilling, hesitant, disinclined, indisposed, adverse

**Reminiscence** — recall and review remembered experiences

**Remove** — take away, get rid of, eliminate, eradicate

**Reposition** — move, relocate, change position

**Require** — need, want, necessitate

**Resist** — oppose, defend against, keep from, refuse to go along with, defy

**Resolution** — decree, solution, decision, ruling, promise

**Resolve** — make up your mind, solve, determine, decide

**Response** — reply, answer, reaction, retort

**Restore** — reinstate, reestablish, bring back, return to, refurbish

**Restrict** — limit, confine, curb, control, contain, hold back, hamper

**Retract** — take back, draw in, withdraw, apologize

**Reveal** — make known, disclose, divulge, expose, tell, make public

**Review** — appraisal, reconsider, evaluation, assessment, examination, analysis

**Ritual** — custom, ceremony, formal procedure

**Robust** — sturdy, vigorous

**Rotate** — turn, go around, spin, swivel

**Routine** — usual, habit, custom, practice

**Satisfaction** — approval, fulfillment, pleasure, happiness

**Satisfy** — please, convince, fulfill, make happy, gratify

**Secure** — safe, protected, fixed firmly, sheltered, confident, obtain

**Sequential** — chronological, in order of occurrence

**Significant** — important, major, considerable, noteworthy, momentous

**Slight** — small, slim, minor, unimportant, insignificant, insult, snub

**Source** — basis, foundation, starting place, cause

**Specific** — exact, particular, detail, explicit, definite

**Stable** — steady, even, constant

**Statistics** — figures, data, information

**Subtract** — take away, deduct

**Success** — achievement, victory, accomplishment

**Surround** — enclose, encircle, contain

**Suspect** — think, believe, suppose, guess, deduce, infer, distrust, doubtful

**Sustain** — maintain, carry on, prolong, continue, nourish, suffer

**Synonymous** — same as, identical, equal, tantamount

**Systemic** — affecting the entire organism

**Thorough** — careful, detailed, methodical, systematic, meticulous, comprehensive, exhaustive

**Tilt** — tip, slant, slope, lean, angle, incline

**Translucent** — see-through, transparent, clear

**Unique** — one and only, sole, exclusive, distinctive

**Universal** — general, widespread, common, worldwide

**Unoccupied** — vacant, not busy, empty

**Unrelated** — unconnected, unlinked, distinct, dissimilar, irrelevant

**Unresolved** — unsettled, uncertain, unsolved, unclear, in doubt

**Utilize** — make use of, employ

**Various** — numerous, variety, range of, mixture of, assortment of

**Verbalize** — express, voice, speak, articulate

**Verify** — confirm, make sure, prove, attest to, validate, substantiate, corroborate, authenticate

**Vigorous** — forceful, strong, brisk, energetic

**Volume** — quantity, amount, size

**Withdraw** — remove, pull out, take out, extract

# Bibliography

- Ackley, BJ, and Ladwig, GB: *Nursing Diagnosis Handbook: An Evidence-Based Guide to Planning Care*, ed.10. St. Louis: Mosby Elsevier, 2014.
- Aexaitus, I, and Broome, B: Implementation of a nurse-driven protocol to prevent catheter-associated urinary tract infections. *Journal of Nursing Care Quality* 29 (3):245-252, 2014.
- Ahern, J, and Kumar, C: Caring for a patient with mental illness in the acute care setting. *Nursing Made Incredibly Easy!* 11 (3):18-23, 2013.
- Alexander-Magalee, MA: Patient safety: Addressing pharmacology challenges in order adults. *Nursing* 203 4 (10):58-60, 2012.
- Aschenbrenner, DS: Drug watch: Preventing injuries from OTC eyedrops and nasal sprays. *American Journal of Nursing* 113 (2):23, 2013.
- Aschenbrenner, DS: Overuse of certain OTC laxatives may be dangerous. *American Journal of Nursing* 114 (5):25, 2014.
- Association for Professionals in Infection Control and Epidemiology, Greene, L. (Ed.). (2014, April 1). APIC Guide to Prevent Catheter-Associated Urinary Tract Infections. Retrieved September 15, 2014, from <http://bit.ly/1syFer5>.
- Association for the Advancement of Wound Care (AAWC). Education for the Generalist. <http://aawconline.org/education-for-the-generalist/>. Accessed 9/1/2014.
- Association for the Advancement of Wound Care (AAWC). The ABC's of Skin and Wound Care. <http://aawconline.org/wp-content/uploads/2011/04/ABCsPublic.pdf>. Accessed 9/1/2014.
- Babine, RL, Farrington, S, and Wierman, HR: Inspiring change: HELP© prevent falls by preventing delirium. *Nursing* 113 4 (5):17-20, 2013.
- Black, BP: *Professional Nursing: Concepts & Challenges*, ed. 7. St. Louis: Elsevier, 2014.
- Brous, E: Lessons learned from litigation: Maintaining professional boundaries. *American Journal of Nursing* 114 (7):60-63, 2014.
- Bryant, R, and Nix, D: *Acute and Chronic Wounds: Current Management Concepts*, ed. 4. St. Louis: Elsevier/Mosby, 2012.
- Buck, HG: Transitions: Help patients and families choose end-of-life care "wisely." *Nursing* 113 4 (7):16-17, 2013.
- Bulechek, G, Butcher, H, Dochterman, J, and Wagner, C (eds): *Nursing Interventions Classification (NIC)*, ed 6. St. Louis: Elsevier, 2012.
- Burton, MA, and Ludwig, LJ: *Fundamentals of Nursing Care: Concepts, Connections & Skills*. Philadelphia: F.A. Davis, 2011.
- Carter, D: In the News: The right balance between hand sanitizers and handwashing. *American Journal of Nursing* 113 (7)13, 2013.
- Castillo, SLM, and Werner-McCullough, M: *Calculating Drug Dosages: A Patient-Safe Approach to Nursing and Math*. Philadelphia: F.A. Davis, 2015.
- Centers for Medicare & Medicaid Services (CMS.gov). National Health Expenditure Projections 2012-2022. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/proj2012.pdf>. Accessed 10/28/2014.

- Center for Nursing Classification and Clinical Effectiveness. (CNC). [www.nursing.uiowa.edu/center-for-nursing-classification-and-clinical-effectiveness](http://www.nursing.uiowa.edu/center-for-nursing-classification-and-clinical-effectiveness). Accessed 8/29/2014.
- Chaffee, J: *Thinking Critically*, ed. 11. Stamford: Cengage Learning, 2015.
- Cherry, B, and Jacob, SR: *Contemporary Nursing: Issues, Trends, & Management*, ed.6. St. Louis: Elsevier, 2014.
- Child Health USA 2013. Infant Mortality: An illustrated collection of current and historical data, published annually. <http://mchb.hrsa.gov/chusa13/perinatal-health-status-indicators/p/infant-mortality.html>. Accessed 11/1/2014.
- Cohen, MR: Medication errors. *Nursing* 2014 48(9):72, 2014.
- Cohen, NL: Patient safety: Using the ABCs of situational awareness for patient safety. *Nursing* 2013 47(4):64-65, 2013.
- Costedio, E, Powers, J, and Stuart, TL: Student voices: Change-of-shift report: From hallways to the bedside. *Nursing* 2013 47(8):18-19, 2013.
- Crusse, EP, and Kent, VP: Making SENSE of sensory changes in older adults. *Nursing Made Incredibly Easy!* 11(5):20-30, 2013.
- Davis, D, Shuss, S, and Lockhart, L: Assessing suicide risk. *Nursing Made Incredibly Easy!* 12(1):22-29, 2014.
- Doenges, ME: *Nursing Care Plans*, ed. 9. Philadelphia: F.A. Davis, 2014.
- Fahlberg, B: Promoting patient dignity in nursing care. *Nursing* 2014 48(7):14, 2014.
- Fleming, C: US health spending growth projected to average 5.8 percent annually through 2022. *Health Affairs Blog*. <http://healthaffairs.org/blog/2013/09/18/us-health-spending-growth-projected-to-average-5-8-percent-annually-through-2022/>. Accessed 10/28/2014.
- Fowler, C: Caring for the caregiver. *Nursing* 2014 48(5):60-64, 2014.
- Fronczek, M: Physical restraints: To use or not to use? *Nursing Made Incredibly Easy!* 12(2):54-55, 2014.
- Fuchs, V: The gross domestic product and health care spending. *The New England Journal of Medicine*. 369:107-109 July 11, 2013. <http://www.nejm.org/doi/full/10.1056/NEJMp1305298>. Accessed 10/28/2014.
- Gibson, M, and Keeling, A: Shaping family and community health: A historical perspective. *Family & Community Health* 37(3):168-169, 2014.
- Goldsack, J, Cunningham, J, and Mascioli, S: Patient falls: Searching for the elusive "silver bullet." *Nursing* 2014 48(7):61-2, 2014.
- Hale, A, and Hovey, J: *Fluid and Electrolyte Notes*. F.A. Davis, 2013.
- Hargrove-Huttel, RA, and Colgrove, KC: *Pharmacology Success*, ed. 2. Philadelphia: F.A. Davis, 2014.
- Hargrove-Huttel, RA, and Colgrove, KC: *Prioritization, Delegation, & Management of Care for the NCIE & RNfi Exam*. Philadelphia: F.A. Davis, 2014.
- Harper, D: Infusion therapy: Much more than a simple task. *Nursing* 2014 48(7):66-67, 2014.
- Heron, M. Deaths: Leading causes for 2010. *National Vital Statistics Report*. Vol. 62, No. 6, December 20, 2013. [http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62\\_06.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_06.pdf). Accessed 11/1/2014.
- Hislop, JO: fighting frailty in older patients. *Nursing* 2014 48(2):64-66, 2014.
- Hopp, L: *Introduction to Evidence-Based Practice*. Philadelphia: F.A. Davis, 2012.
- Huston, CJ: *Professional Issues in Nursing: Challenges and Opportunities*, ed. 3. Baltimore: Lippincott Williams & Wilkins, 2014.
- Kelly, P, and Marthaler, M: *Nursing Delegation, Setting Priorities, and Making Patient Care Assignments*, ed. 2. Clifton Park, NY: Delmar Cengage Learning, 2011.
- Kelton, D, and Davis, C: Ask an expert: The art of effective communication. *Nursing Made Incredibly Easy!* 11(1):55-56, 2013.

- Kenneley, I: Clostridium difficile infection is on the rise. *American Journal of Nursing* 114 (3):62-67, 2014.
- KHN Morning Briefing. Health care costs to reach nearly one-fifth of GDP by 2021. *KHN Morning Briefing*. <http://kaiserhealthnews.org/morning-breakout/health-care-costs-4/>. Accessed 10/28/2014.
- Kirchner, RB: Introducing nursing informatics. *Nursing* 114 (9):22-23, 2014.
- Kubler-Ross, E: *On Death and Dying*. New York: Macmillan, 1969.
- Lange, JW: *The Nurse's Role in Promoting Optimal Health of Older Adults*. Philadelphia: F.A. Davis, 2011.
- Laskowski-Jones, L: The art of harmonious delegation. *Nursing* 114 (5):6, 2014.
- Leeuwen, AM, and Bladh, ML: *Davis's Comprehensive Handbook of Laboratory Tests With Nursing Implications*, ed. 6. Philadelphia: F.A. Davis, 2015.
- Lutz, CA: *Nutrition and Diet Therapy*, ed. 6. Philadelphia: F.A. Davis, 2014.
- MacDorman, MF, Hoyert, DL, and Mathews, TT: Recent declines in infant mortality in the United States, 2005-2011. *NCHS Data Brief*, No 120. April 2013. <http://www.cdc.gov/nchs/data/databriefs/db120.pdf>. Accessed 11/1/2014.
- March of Dimes, March of Dimes 2013 Premature Birth Report Card. <http://www.marchofdimes.org/materials/premature-birth-report-card-united-states.pdf>. Accessed 10/27/2014.
- Maslow, AH: *Hierarchy of Needs: A Theory of Human Motivation*. Eastford, CT: Martino Fine Books Publishers, 2013.
- McCarron, K: Blood essentials. *Nursing Made Incredibly Easy!* 11 (2):16-24, 2013.
- McCarron, K: Med check: Routine labs for common meds. *Nursing Made Incredibly Easy!* 11 (2):50-53, 2013.
- Moorhead, S, Johnson, M, Maas, M, and Swanson, E: *Nursing Outcomes Classification* (NOC), ed. 5. St. Louis: Elsevier, 2012.
- Murdock, A, and Griffin, B: How is patient education linked to patient satisfaction? *Nursing* 113 (6):43-45, 2013.
- Murphy, L., Xu, J, and Kochanek, K. Deaths: Final data for 2010. *National Vital Statistics Report*. Vol. 61, No 4, [http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61\\_04.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf). Accessed 10/30/2014. (most recent reported data as of 10/30/2014).
- Nugent, PM, and Vitale, BA: *Fundamentals of Nursing: Content Review PIR Practice Questions*. Philadelphia: F.A. Davis, 2014.
- Nugent, PM, and Vitale, BA: *Test Success: Test-Taking Techniques for Beginning Nursing Students*. Philadelphia: F.A. Davis, 2016.
- O'Keeffe, M, and Saver, C (contributors): *Communication, Collaboration & You: Tools, Tips, and Techniques for Nursing Practice*. Silver Spring, MD: American Nurses Association, 2014.
- Ortega, L, and Parash, B: Clinical queries: Improving change-of-shift report. *Nursing* 113 (2):68, 2013.
- Perry, SE: Hard of hearing. *American Journal of Nursing* 114 (8):13, 2014.
- Pfeifer, GM: In the news: The top nursing news story of 2012: Health care reform goes hand in hand with expanded nursing roles. *American Journal of Nursing* 113 (1):15, 2013.
- Phillips, J, Stinson, K, and Strickler, J: Avoiding eruptions: De-escalating agitated patients. *Nursing* 114 (4):60-63, 2014.
- Phillips, LD, and Gorski, L: *Manual of I.V. Therapeutics*, ed. 6. Philadelphia: F.A. Davis, 2014.
- Primeau, MS, and Frith, KH: Clinical queries: Teaching patients with an intellectual disability. *Nursing* 113 (6):68-69, 2013.
- Purnell, LD: *Guide to Culturally Competent Health Care*, ed. 3. Philadelphia: F.A. Davis, 2014.

- Purnell, LD: *Transcultural Health Care*, ed. 4. Philadelphia: F.A. Davis, 2012.
- Queensland Government. Health care providers' handbook on Hindu patients. *Queens land Health*. [http://www.health.qld.gov.au/multicultural/health\\_workers/hbook-hindu.asp](http://www.health.qld.gov.au/multicultural/health_workers/hbook-hindu.asp). Accessed 11/1/2014.
- Quinlan-Colwell, A: Controlling pain: Making an ethical plan for treating patients in pain. *Nursing 20B* 4 (10):64-68, 2013.
- Raines, V: *Davis's Basic Math Review for Nurses*. Philadelphia: F.A. Davis, 2009.
- Rank, W: Performing a focused neurologic assessment. *Nursing 2B* 4 (12):37-40, 2013.
- Roe, E: Using evidence-based practice to prevent hospital-acquired pressure ulcers and promote wound healing. *American Journal of Nursing 14* (8):61-65, 2014.
- Rogers, TL, and Darden, CD: How clinical nurse leaders can improve rural healthcare. *Nursing 24* 4 (9):52-55, 2014.
- Saathoff, A, and Turnham, N: Stick it to me: The complexities of glucose testing. *Nursing Made Incredibly Easy 2* (5):50-53, 2014.
- Said, AA, and Kautz, DD: Patient safety: Reducing restraint use for older adults in acute care. *Nursing 20B* 4 (12):59-61, 2013.
- Salladay, SA: Ethical problems. *Nursing 24* 4 (8):12-13, 2014.
- Seckel, MA: Patient safety: Maintaining urinary catheters: What does the evidence say? *Nursing 2B* 4 (2):63-65, 2013.
- Segobiano, A, Waters, J, and Davis, C: All about acetaminophen—I.V.!. *Nursing Made Incredibly Easy! 2* (2):50-52, 2014.
- Sukumaran, S: Hinduism and medicine: A guide for medical professionals. *Angelfire*, Copyright 1999. <http://www.angelfire.com/az/ambersukumaran/medicine.html>. Accessed 11/1/2014.
- Tompson, GS: *Nurses' Learning Anatomy & Physiology: A Visual, Auditory, Interactive Approach*, ed. 2. Philadelphia: F.A. Davis, 2015.
- Townsend, MC: *Psychiatric Nursing*, ed. 9. Philadelphia: F.A. Davis, 2014.
- Treas, LS, and Wilkinson, JM: *Basic Nursing: Concepts, Skills & Reasoning*. Philadelphia: F.A. Davis, 2014.
- United States Food and Drug Administration, How to Understand and Use the Nutrition Facts Label, <http://www.fda.gov/Food/IngredientsPackagingLabeling/LabelingNutrition/ucm274593.htm>, accessed 4/3/15.
- United States Food and Drug Administration, Proposed Changes to the Nutrition Facts Label, <http://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm385663.htm>, accessed 4/3/15.
- Ulbricht, C: *Davis's Pocket Guide to Herbs and Supplements*. Philadelphia: F.A. Davis, 2010.
- Vallerand, AH, and Sanoski, CA: *Davis's Drug Guide for Nurses* 14th ed. Philadelphia: F.A. Davis, 2014.
- Venes, D (ed): *Taber's Cyclopedic Medical Dictionary*, ed. 22. Philadelphia: F.A. Davis, 2013.
- Vitale, BA: *NCIE X RN: Core Review and Exam Prep*, ed. 2. Philadelphia: F.A. Davis, 2013.
- Weiss, SA, and Tappen, RM: *Essentials of Nursing Leadership & Management*, ed. 6. Philadelphia: F.A. Davis, 2014.
- Williams, W, Davis, C, and Brothers, K: I.V. essentials: Fluid management basics. *Nursing Made Incredibly Easy! 2* (4):48-51, 2013.
- Woods, AD: Implementing evidence into practice. *Nursing 2B* 4 (1-Supplement: Lippincott's 2013 Nursing Career & Education Directory):4-6, 2013.
- Zerwekh, JA, and Garneau, AZ: *Nursing Today: Transition and Trends*, ed. 8. St. Louis: Elsevier/Saunders, 2015.

# Index

Note: Page numbers followed by *f* indicate figures.

## A

Affective domain of learning, 12  
Alfaro-LeFevre, R., 1  
Alternate item formats, 437-472  
    answers and rationales for, 456-472  
    definition of, 437  
    questions in, 437-455  
    types of, 437  
    *See also specific types*  
Ambiguity, 12  
Analysis, definition of, 24  
Analysis questions  
    cognitive requirements for, 24  
    definition of, 13, 24  
    using RACE model for, 25-27  
Application, definition of, 21  
Application questions  
    cognitive requirements for, 21  
    definition of, 13, 21  
    using RACE model for, 21-24

## B

Barriers  
    to creativity, 11-12  
    to inquisitiveness, 10-11  
    to positive mental attitude, 6  
    to reflection, 9

## C

Charts, items using, 445-449, 463-466  
Clinical postconference, 7-8  
Cognitive competencies, 2-3, 3f, 4f  
Cognitive domain of learning, 12, 13  
Cognitive requirements  
    for analysis questions, 24  
    for application questions, 21  
    for comprehension questions, 17  
    for knowledge questions, 14  
Comfort, 400-415  
    answers and rationales for, 408-415  
    keywords for, 400  
    questions about, 401-407  
Communication, 128-141  
    answers and rationales for, 135-141  
    keywords for, 128  
    questions about, 128-134

Community-based nursing, 98-112  
    answers and rationales for, 104-112  
    keywords for, 98  
    questions about, 98-103  
Competencies, cognitive and personal, 2-3, 3f, 4f  
Comprehension, definition of, 17  
Comprehension questions  
    cognitive requirements for, 17  
    definition of, 13, 17  
    using RACE model for, 17-20  
Confidence, 6  
Courage, 9  
Creativity, 11-12  
Critical thinking  
    applied to test taking, 12-13  
    definition of, 1-4  
    Helix of, 2-4, 3f, 4f, 5f  
    RACE model of, 13-28  
    in reasoning processes, 2  
    strategies for maximizing, 6-12  
Curiosity, 10

## D

Decision making, 2  
Diagnostic reasoning, 2  
Discipline, 6  
Distractors, 13  
Drag and drop items  
    answers and rationales for, 466-468  
    definition of, 449  
    examples of, 449-450  
Drugs. *See* Medication administration;  
    Pharmacology

## E

Educational domains, 12  
Egocentric thinking, 11  
Electrolytes, 368-383  
    answers and rationales for, 376-383  
    keywords for, 368  
    questions about, 369-375  
Ethical issues, 45-59  
    answers and rationales for, 52-59  
    keywords for, 45  
    questions about, 46-51



## Examinations

- comprehensive final book, 473-536
  - answers and rationales, 489-536
  - questions, 473-488
- critical thinking applied to, 12-13
- reviewing performance on, 8
- See also* Test questions

## Exhibit items

- answers and rationales for, 468-472
- definition of, 450
- examples of, 450-455

**F**

## Fill-in-the-blank calculation items

- answers and rationales for, 461-463
- definition of, 443
- examples of, 443-445

## Fluids, 368-383

- answers and rationales for, 376-383
- keywords for, 368
- questions about, 369-375

## Formal reasoning processes, 2

**G**

## Gastrointestinal system, 384-399

- answers and rationales for, 391-399
- keywords for, 384
- questions about, 384-390

## Graphic items

- answers and rationales for, 463-466
- definition of, 445
- examples of, 445-449

**H**

## Health-care delivery, 77-97

- answers and rationales for, 86-97
- keywords for, 77
- questions about, 78-85

## Helix of Critical Thinking, 2-4, 3f, 4f, 5f

## Hot-spot items

- answers and rationales for, 459-461
- definition of, 439
- examples of, 439-443

## How questions, 9

## Humility, 9

## Hygiene, 283-298

- answers and rationales for, 291-298
- keywords for, 283
- questions about, 283-290

**I***If ... then* statements, 10

## Illustrations, items using, 445-449, 463-466

## Independence of thought, 12

## Infection control, 208-222

- answers and rationales for, 215-222
- keywords for, 208
- questions about, 208-214

## Inquisitiveness, 9-11

*It depends* statements, 10

- Items, definition of, 12-13. *See also* Alternate item formats; Multiple-choice questions

**J**

## Journal writing, 7

**K**

## Keywords, 8

- for communication, 128
- for community-based nursing, 98
- for fluids and electrolytes, 368
- for gastrointestinal system, 384
- for health-care delivery, 77
- for hygiene, 283
- for infection control, 208
- for leadership and management, 60
- for legal and ethical issues, 45
- for medication administration, 238
- for mobility, 299-300
- for nursing care across the life span, 113
- for nursing process, 173
- for nutrition, 316
- for oxygenation, 334-335
- for pain, comfort, rest, and sleep, 400
- for perioperative nursing, 416
- for pharmacology, 260-261
- for physical assessment, 189-190
- for psychological support, 142
- for safety, 223
- for teaching and learning, 157
- for theory-based nursing care, 29
- for urinary elimination, 352

## Knowledge, definition of, 14

## Knowledge questions

- cognitive requirements for, 14
- definition of, 13, 14
- using RACE model for, 14-17

**L**

## Leadership, 60-76

- answers and rationales for, 67-76
- keywords for, 60
- questions about, 60-66

## Learning, 157-172

- answers and rationales for, 164-172
- domains of, 12
- keywords for, 157
- questions about, 157-163

## Legal issues, 45-59

- answers and rationales for, 52-59
- keywords for, 45
- questions about, 46-51

## Life span, nursing care across the, 113-127

- answers and rationales for, 119-127
- keywords for, 113
- questions about, 114-118

**M**

- Management, 60-76
  - answers and rationales for, 67-76
  - keywords for, 60
  - questions about, 60-66
- Medication administration, 238-259
  - answers and rationales for, 249-259
  - keywords for, 238
  - questions about, 239-248
  - See also* Pharmacology
- Mental attitude, positive, 6
- Mental pictures, 7
- Mobility, 299-315
  - answers and rationales for, 308-315
  - keywords for, 299-300
  - questions about, 300-307
- Motivation, 11
- Multiple-choice questions
  - vs.* alternate item formats, 437
  - parts of, 12-13
- Multiple-response items
  - answers and rationales for, 456-459
  - definition of, 437
  - examples of, 437-439

**N**

- Nursing process, 173-188
  - answers and rationales for, 180-188
  - definition of, 2, 3
  - Helix of Critical Thinking in, 3-4, 5f
  - keywords for, 173
  - questions about, 174-179
- Nutrition, 316-333
  - answers and rationales for, 325-333
  - keywords for, 316
  - questions about, 317-324

**O**

- Open-mindedness, 11
- Options, in multiple-choice questions, 13
- Ordered response items
  - answers and rationales for, 466-468
  - definition of, 449
  - examples of, 449-450
- Oxygenation, 334-351
  - answers and rationales for, 343-351
  - keywords for, 334-335
  - questions about, 335-342

**P**

- Pain, 400-415
  - answers and rationales for, 408-415
  - keywords for, 400
  - questions about, 401-407
- Perioperative nursing, 416-436
  - answers and rationales for, 426-436
  - keywords for, 416
  - questions about, 417-425

- Perseverance, 10-11
- Personal competencies, 2-3, 3f, 4f
- Pharmacology, 260-282
  - answers and rationales for, 270-282
  - keywords for, 260-261
  - questions about, 261-269
  - See also* Medication administration
- Physical assessment, 189-207
  - answers and rationales for, 199-207
  - keywords for, 189-190
  - questions about, 190-198
- Positive mental attitude, 6
- Postconference, clinical, 7-8
- Problem-solving process
  - definition of, 2, 4
  - Helix of Critical Thinking in, 4, 5f
- Psychological support, 142-156
  - answers and rationales for, 149-156
  - keywords for, 142
  - questions about, 143-148
- Psychomotor domain of learning, 12

**Q**

- Questions, asking, 9-11. *See also* Test questions

**R**

- RACE model, 13-28
  - for analysis questions, 24-27
  - for application questions, 21-24
  - for comprehension questions, 17-20
  - for knowledge questions, 14-17
- Reasoning processes, 2
- Reflection, 6-9
- Rest, 400-415
  - answers and rationales for, 408-415
  - keywords for, 400
  - questions about, 401-407
- Retrospective reflection, 7-8
- Reviewing performance on exams, 8
- Risk taking, 12

**S**

- Safety, 223-237
  - answers and rationales for, 230-237
  - keywords for, 223
  - questions about, 223-229
- Scientific method, 2
- Sleep, 400-415
  - answers and rationales for, 408-415
  - keywords for, 400
  - questions about, 401-407
- Stems, in multiple-choice questions, 12-13

**T**

- Tables, items using, 445-449, 463-466
- Teaching, 157-172
  - answers and rationales for, 164-172
  - keywords for, 157
  - questions about, 157-163

Test questions, types of  
analysis, 13, 24, 25-27  
application, 13, 21-24  
comprehension, 13, 17-20  
knowledge, 13, 14-17  
multiple-choice, 12-13, 437  
*See also* Alternate item formats

Test taking  
critical thinking applied to, 12-13  
RACE model in, 13-28  
*See also* Examinations

Theory-based nursing care, 29-44  
answers and rationales for, 36-44  
keywords for, 29  
questions about, 29-35

Thinking  
egocentric, 11  
independence in, 12  
*See also* Critical thinking

**U**

Urinary elimination, 352-367  
answers and rationales for, 360-367  
keywords for, 352  
questions about, 353-359

**W**

*What* questions, 9  
*Why* questions, 9-10















