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**CRNE Prep Guide**
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**DEFINITION**

- Diffusion : Moving water from high to low concentration, e.g. .
- Osmosis : Moving water from low to high concentration, e.g. intestine observing food.
- Dialysis : Separation of substances.
- Capillarity : Surface tension d/t contraction of water, e.g. $O_2$ to $CO_2$ exchange, soaking sterile gauge.

- Infiltration : Diffusion or accumulation in a tissue or cells in amounts in excess of the normal.
- Phlebitis : Inflammation of a vein.
- Thrombophlebitis : Blood clot causing inflammation.
- Tissue Ischemia : D/t edema $O_2$ ↓ and damage tissue.
- Gangrene : Release of iron from hemoglobin result in ferrous sulphide formation, makes dark tissue by Clostridium bac.
- Psoriasis : Dry and scaly skin = P<u>soriasis</u>. Steroid is used. Similar with Pemphigus v<u>ulgaris</u> which cause skin lesions.
- Scabies : By female mites and egg. Highly contagious.
- Hemophilia : Bleeding disorder. It cannot be stopping when wound <u>so elevate first</u> then apply thrombolytic factors.
- Enpnea : Normal respiration.
- Radiation : Energy radiated e.g. sunlight.
- Insulation : Energy protected or conserved.
- Convection : Energy circulated by air, e.g. fan, heater,
- Conduction : Energy circulated by touching, e.g. we use tepid to reduce body temp, in opposite like warm clothes.

- Cystitis : Inflammation of bladder cause urinary frequency, urgency, pain and hematuria.
- Nephrosis : Kidney condition cause proteinuria, hypoalbuminemia.

- Thyroid Gland : Controls calcium, proteins, metabolism, $O_2$, T3, T4, <u>cold tolerance</u>. Itself controlled by hypothalamus's TRH.
- Adrenal Gland : Top of renal, response to stress by making corticosteroids, cortisol, catecholamines, epinephrin).
- Pituitary Gland : Pea size master gland (thermostat), controls temp, growth, urine, testosterone, ovulation, estrogen.
- Pancreas Gland : Insulin, glucagon, somatostatin, juice and digestive enzymes to breakdown carbohydrates, protein & lipids.

- Autograft : Skin taken from healthy area of same pt.
- Hemo/Allograft : Skin taken from same species –human.
- Hetro/Xenograft : Skin taken from different species – pig.

- Negligence : <u>Failure to perform duty</u> normally other people do <u>also cause harm</u>.[Neg=No action, mal=wrong action]
- Malpractice : Failure to act in a prudent manner, client nurse relationship, <u>breach of duty, harm, failure to meet standard</u>.
- Assault : <u>Telling</u> to hurt or to make pt fearful. You are stupid.
- Battery : <u>Touching</u> or physical contact without consent.
- Slander : Saying bad to harm another professional body.
- Libel : Written word to harm another professional body.

- Echolalia : Repetition of other saying like echo others.
- Echopraxia : Repetition of other movement like copying movement.
- Neologism : New words are used as complete word as symbol.
- Overt System : Communication thru word.
- Covert : Communication thru body language.

- Tension : Caused by conflict, it is first reorganization process.
- Integration : Each member learn about each other.
- Resolution : Reconstruction of group norms and values.
- Paternalism : Opposite of self determination.
- Beneficence : Act in the best interest of patient.
- PC : After meal.
- Rectification : Voting.

**PROFESSIONAL RESPONSIBILITY, ACCOUNTABILITY.**

- Main objective is to provide safe, competencies, comp and ethical care.
- RPN = LPN. RN is responsible to delegate LPN to do their work. Make sure they know and have skills required to do the job.
- IV push is our within scope.
- Chart after each visit and intervention.
- When age is given it is key words so if age less than adult then asking about developmental skills.
- If RN don't know area send to her area and find another nurse.
- Never give ANY information via phone as it can indicate information.
- When nurse touch face of pt she can be accused of hurting pt.
- Always discuss the matter with nurse then go to manager. Only exception is when nurse is stealing narcotics-where you document and collect evidences and witness and then you report.
- Accept and thank for the small gift but must say you are sharing with your colleagues.
- When a client ask a question at home visit about other family member, nurse should answer coz she went for whole family.
- Whistle blowing – Need harm to client, pt, employee and have occurred before going to media.
- Whistle blowing → Internal : telling board members and External : going public on media.
- Only custodial parent can make informed consent.
- RN cannot read or initiate for consent for research or clinical trial. Doctor can do it.
- Nursing informatics is to use evidenced based practice and guidelines.
- If staff is DIMM adjust their schedule to the day shift.
- Risk management is to provide client safety, product safety and quality assurance.
- Doctor has a right to call police when client is driving with revoked license, so notify doctor.
- Poster is good way to increase awareness within the unit. Visual learner need handout to see things.
- Relevance is learning principle where client need to know the importance and need of learning first.
- Nonmaleficence is assessment of risk to the client to justify.
- Consent age varies in province.

- Nonmaleficence ("do no harm"):
- Beneficence (do good):
- Confidentiality (Secure information and know appropriate person to share get consent to share):
- Autonomy (control one's own destiny):
- Fidelity (faithfulness): Best for client, advocate for client
- Justice (fairness):

**THERAPEUTIC COMMUNICATION**

**TR Phase**

- Orientation : Introduction with open communication to collect data.
- Working : Nurse and client discuss and goals and intervention are established.
- Termination : End of TR relationship. Evaluation phase occurs and client may reject or anger. Separation anxiety.

- Strategy : Open ended question Reflection and paraphrasing Non judgmental acceptance of clients behavior
  Focus on emotional physical needs Having a TR goal for each interaction.
  Pt need to learn their own behavior Participation increases knowledge Identify strength and resources.
  Encourage to express positive and negative feelings Develop awareness what they like or dislike.
  Missing appointment is related to fear of finding new problem.
  Asking many question is related to fear of separation and death of illness.

- Nursing Principle : Accept regardless of their behavior and encourage to express their feelings.
  Limit or reject inappropriate behavior so help to set limits.
  With crying pt, sit quietly to give message that she cares.

- Explore : Explore the issues in depth.
- Clarifying : Giving example to understand better.
- Reflecting : Repeats the same sentences or saying what client is saying.

**KEY WORDS**

- Pay attention with word "priority", "next", "intervention", "age", "except", "immobilization", "not", "least", "most", "alleviate ↓".
- Pay attention to the month vs trimester, e.g. When nausea disappear by end of Third Month not Third Trimester.
- When question says pt is not able to cope then they need ask for help →select "do you like to discuss with social worker.
- When pt express concern select the question that address that concern. If pt is sad ask, "You are upset, tell me what's wrong."
- Like pt works at computer so here computer means sitting so nurse encourage her to walk.
- Also when there is time frame consider key word. What you tell during 1st trimester → select that is imp for 1st trimester not 3rd.
- Crisis = adjustment so let parents or clients express their feelings.
- Be careful on calculation like x 4/day is every 6 hours.
- TR = offer.
- Temp is included in vitals so pay attention.
- Paralysis is R/T neural impairment. So paralysis of bowel is d/t neural impairment.
- Rehab is related to "encourage".
- Select "Ensure", "Prevent", etc.
- When question says "essential" it is key word means 1 option must be done or all other options are not possible, e.g. for 7 years old child, essential is to check loose tooth before surgery (must), not to tell parents where to stay after surgery (optional).
- TR question is that starts with "Yes you look upset"
- TR relationship starts with assumption of "stranger" coz if nurse does not feel pt a stranger she cannot achieve goal.
- Restating is telling what pt is telling not suggesting. Suggestion is not Therapeutic Communication.
- When pt do not want sth like cold water, first thing is attempt to understand culture by asking her belief about cold water.
- Sometime direct answer e.g. Flu shot is safe for pregnant women.
- Sex related question refer to expert in sexual counseling. But do not tell your doctor will talk to you coz counseling is given by nurse. When rehab needed it is ok to refer from acute care. Outside of RN scope and for education refer OT, PT for Rx doctor.
- When pt is different like lesbian and give birth. Make sure to do value clarification like explain. What they want from you.
- Use language that is not assume heterosexuality. Calling by name is not enough.
- Rapport is created by being present, visible and available.
- When pt wants private room to pray, tell him you would try for quiet place coz private room may not be priority or available.
- Also if pt wants to pray provide private room if available.
- Self reflect is to tell coworker and offer help if coworker cannot perform his duty because he is busy.
- When a mental health pt is acting out physically, suggest her to use word to express word rather than hand it shows care & limit.
- Pt has the right however he would like to call so if economist wants him to call doctor, nurse should do so.
- First step to make a care plan is to establish the trusting and meaningful relationship with the clients.
- TR is obtaining information, developing trust and showing care with empathy not sympathy. Empathy="It is difficult for you."
- Self disclosure is like "my grandma died I was sad, are you feeling same?"
- Before providing support we need to listen the pt first.

***Select***

- Answer with "usually", "normally" as possible answer.
- Select answer like "okay to cry" and encourage her to speak.
- When pt are anxious and says they see bugs in the wall best answer is where nurse stay there until pt is calmer.
- For delusional pt do not say that lead to argue so make it simple. "The food is not poisoned". "You feel sbd wants to poison u?"
- Select the answer that tells your present with client, e.g. stay quietly, walked to the client, etc.
- Select the answer that both accept the pt and sets limits. "State/suggest that such behavior is unacceptable."
- Select "you seem angry with me." Select answer that set limits and explore further at same time but Y/N question do not explore.
- Select "monitor, understand and set limit".
- Select "I will stay with you for a while" or sit down next to the client as often as possible, but do not ask "Can I sit down with u?".
- Select first your safety→pts safety→fetus safety. Directly say, "We are watching you coz we are concern you can harm yourself".
- Select "you will not be alone" when pt is anxious.
- Select "Non commanding attitude/approach".
- Select "It must be difficult for you." To acknowledge the client's problem when pt don't want to talk.

- Select "Let's explore how you get help". This is therapeutic and offer help.
- Select option that requires developing an <u>self awareness and professional role</u> in the relationship – nurse must know this.
- Select "Have you done this procedure done before?" coz <u>before explaining assessment of past experience is important</u>.

***Never Select***

- Never select "assure", "re assure", and "Wh" & Closed-ended question except "Are you thinking to hurt yourself and other?"
- Says the conclusion of the study with guarantee with using word like "may", "possibility". E.g. Unhappy child is future druggist.
- Never say "your imagination/feelings is a part of your sickness when pt is anxious or any disorder". Select that explore further.
- Never select the answer that threat clients, "Unless you eat, we feed by tube".
- Never select answer that aim to punish pt. Like "If you continue I never stay with you".
- Never select "I will stay with your until your symptoms settles" → coz SS cannot settles soon it requires longer hospitalization.
- Never select which shows you are avoiding pt. "I will be with u <u>if you need me</u>?"
- Never select the statement that cut offs the conversation.
- Never select option that is said in client question, e.g. I feel bad in the morning? -> Tell me how you feel in the morning. XXX
- Normally do not select that use "must" e.g. Pregnant <u>must</u> adhere to a specific diet, pregnant diet is not specific.

**MEMORIZATION**

- Hand washing: friction is imp.
- Cold compress and hot compress for IV find out.
- Fleabite and infiltration differential.
- Tepid bath is sponge bath to reduce temp should be just below body temp 26-34.
- Foley catheter should be tapped in upper thigh, penis facing towards chest.
- DNR can be suspended or reinstated any time is correct, DNR must be <u>initiated</u> by Dr is incorrect. Anyone can initiated.
- Select "assess" as a first and main priority.
- Hypotonic glucose can be given at large vein.
- Ulcerative colitis – the affected bowel is curative.
- When you are asked question to ask pt make sure your asking question is matched with the question asked in scenario.
- When ask "family nursing" forget about confidentiality and educate or collect all family member not just a pt.
- Best answer may be concrete with complete information like when nurse refer community care assess center for consent.
- Allergy is also called Red Mark Syndrome.
- Select "<u>I like you</u>, but our relationship is <u>professional</u>" Do not select "It is against my professional ethics to date client".
- Nursing Research is to <u>improve health outcome</u>.
- Nursing Process = Step to provide nursing care.
- Nurse-client relationship is validated by client's feedback.
- Tort : One cause harm to another or their property. False imprisonment and battery is intentional tort.
- Nurses are still accountable and not protected from all legal charges during CPR of first aid during accident. Reporting is ok.
- Stress is controlled by ANS and Adrenal Glands.
- Before rapport and trust nurse must understand her personal feelings toward the client.
- When pt is <u>hostile</u> first <u>slightly</u> accept the client's behavior if does not work then withdraw for your safety, exploring does not work. If nurse TR then he would relax [simple].
- Key word Slightly.
- When pt finds mistake in dx it is probably d/t fear, if she denies then denial, else just simple fear.
- When pt ask question, make sure you choice answer the question. Don't select that does not answer.
- Also if Case do not tell do not assume. E.g. if case says a client, do not assume she has 2 babies.
- Also if when pt ask question do not select option which divert the question to other area.
- Don't select option that makes pt more anxiety or fear even though it offer empathy. It must be bad if your husband reject u. XX
- Remain guarded means it is about safety like suicide from emotional conflicts.
- <u>When pt is very Anxiety++ about procedure, explaining does not ↓ anxiety so encourage pt to express feeling first</u>.
- Positive attitude is similar with encouragement.
- If 0.9% is Isotonic then 0.45% is HYPOtonic coz 0.45 is half concentration than 0.9%.
- N+ and Cl+ and Plasma is extracellular and K+ is intracellular K+ is the one who does membrane potential. Intracellular 40%.
- Hypothalamus regulates the need of water.
- Molar is 1 gram solute in 1 L of solution.
- IMP Ph is within 7.35-7.45 in both compensation or un- compensation. Outside range is a dead person. So do not select 6.0.

- Vomit cause acid from gastric juice out so it cause Alkalosis Diarrhea cause acidosis. Acid is buffered by Bicarbonate.
- Post OP pt requires watch for K+ as it depletes d/t stress. Stress replace and keep Sodium.
- Colitis pt cannot absorb K+ cause Hypokalemia and muscle weakness and tachycardia.
- GI Suction watch for dehydration as GI takes water out.
- IV added Rx must be sterile technique. Any IV cannot run more than 24 hours coz of contamination.
- IV albumin (given to maintain oncotic pressure) must be very slow as it increases the BP also fluid is restricted.
- Malaria cause fluid and electrolytes imbalance coz it cause fever and NVD.
- ADH anti diuretic hormone cause ↓ urine ↑ fluid ↓ Sodium = Hyponatremia.
- Burn pt do not get K+ they get RL or plasma.
- Ascites is excess fluid d/t plasma in the space between tissues lining abdomen and abdominal organs (the peritoneal cavity).
- Lasix cause hypokalemia coz K+ passes with NaCl via urine. K+ effect muscle so in heat it lowers T wave.
- When K+ is too much Insulin is given coz K+ goes inside the cell with insulin (also glucose).
- K+ ↓ Hypokalemia SS is Apathy (Confusion), weakness and abdominal distension (d/t muscle weakness).
- K+ ↑ Hyperkalemia SS is Spasm, diarrhea, irregular pulse rate.
- Na ↑ SS is Edema, bounding pulse, confusion.
- Diabetic Ketoacidosis SS is Sunken Eyeballs, Kussmaul Breathing and Thirst.
- Calcium ↓ SS is Pale and muscle spasm.
- Pay attention to "mg" vs "ml" in math question during IV drop calculation.
- Pain, Fever, Pyrexia, and HR, Pulse are correlated.
- Rheumatic fever is associated with Beta Hemolytic Streptococci Group A bacteria.
- Shock indicated by dropping systolic BP from 130-100 (HR also ↑). [Note systolic min is 120 so 100 is not normal].
- Postural Hypotension is d/t dilation of vessels (capacitance).
- Thrmobophelebitis SS is numbness in one leg and funny tickling feelings in toes, edema (not pitting), redness, warmth, tenderness of legs. Most important keep client immobilized and call doctor. Leg exercise is done if possible to reduce risk. Although it cause pulmonary embolus deep breathing and coughing is nothing to do with Thrmobophelebitis.
- Endarterectomy to remove the plaque inside vessels so watch for pulse after surgery.
- Nicotine constricts the vessels and ↑ BP.
- Prolong urine adjustment increase or decrease BP in long term.
- Rx to reduce BP result cannot be seen in 30 min so regular BP while lying down for 5 minutes need to be taken.
- Ischemia is damage of muscle like heart d/t blockage or occlusion.
- Anginal pain is d/t myocardial ischemia (d/t lack of $O_2$ in muscle) not by coronary thrombosis (associated with MI not angina).
- Coronary Arteries carry blood from AORTA to Myocardium (not to Endocardium).
- Some activity cause Anginal pain therefore pt can take 1 tab of nitroglycerin before activity and take after 5 min if pain persists.
- Cholesterol are mainly in Whole milk which has high saturated fat. Good fish, Corn oil and margarine has unsaturated good fat.
- LOC is determined by response to painful stimuli.
- When pt ask question select the option that gives complete answer.
- Assurance whether +ve (it is ok) or –ve (no way) is not answer.
- Hypokalamia SS: Anorexia (Not Bradycardia, muscle spasm).
- Which of the following observation indicate readiness to participate: Select the one with pt's family ask to make sure she is doing well to take care of pt.
- Never select the option with work "family" and case do not tell if pt has family or not. Don't guess all pt has family.
- As opposite if pt has all family member mentioned in the case answer could be with the word "family".
- Key word emphasize.
- Key word Advocate → select that do something for pt.
- When young pt do not like to center ask her the ways to work together.
- When pt decides do or not to do it is about independence and maturity.
- Smoking RT fetal growth and retardation (not congenital abnormality which is RT genetic of family).
- Vigilant = extra precaution.
- Phase of shock – Initial Phase → Skin cool, pale and moist.
- Compensatory Phase → Hypotension 90/60, Thready pulse and ↑ HR.
- Irreversible Phase → Rapid, shallow breathing, crackles and wheezing lungs sound.
- When talking about the research do not select option that "guaranteed" result but select with work "link" if possible.
- Pt is anger encourage to express his feelings first.
- Key word initially → it means first so "assess" may be answer.
- Client current status includes all assessment like data, allergies, DNR etc.
- Dioxin Hold if pulse is <100 in adult but in child <80 (which ever their normal lowest pulse is).
- During labor partner helps back pressure.

- Iron rich food is spinach, liver and lima beans.
- Arm band is most accurate than asking name coz pt can be confused.
- Ax: First is to determine how much info needs based on clients issue THEN ONLY contact client and start TR and Trust. So just to determine the scope of information we do not need to worry about TR and Trust.
- Tracheotomy with inflated cuff, pt cannot speak but other ways of communication are there.
- CVA or Stroke call 911 before giving aspirin (Aspirin need to assess type of stroke).
- Cigarette is key word RT vascular disease like calf tenderness.
- Whenever question says "initial reaction" it is denial no matter what pt is saying.
- Lupus → autoimmune disorder.
- Left Hemisphere damage → Communication, Anxiety and mobility issues.
- Child abuse no need assessment report directly to authority.
- Butterfly catheter is not IV catheter. Butterfly is inserted at abdomen or upper thigh.
- Emergency pill need to be taken 72 hours after sex so it DELAYS to release the egg.
- Schizophrenia→ "I do not hear the voice that you hear" listen music. Do not crowd or close to pt if he is violent. Bi-weekly IM is given to maintain compliance. 10 years after 25% becomes better to be independent.
- Alogia → ↓ Thought or logic.
- Anhedonia → ↓ Happiness.
- Avolition → ↓ Action to plan.
- MARSA → Direct contact with skin or surface. Colonization when pt is not sick. Risk is pt with Chronic disease and antibiotic.
- 2 Year Child is possessive of toys and want to be independent, egotism, do not share toys.
- When feeding problem give them choices.
- G → # Pregnancy P → # of Living Child A → # Abortion.
- Early labor priority is to establish base line FHR.
- Contraction is called "strong" not firmed.
- Gush of fluid means assess perineum and FHR. Dry baby at birth first to reduce hypothermia.
- Post OP →To reduce Dumping Syndrome for gastric surgery pt give dry food with low carb & protein.
- Hypoglycemia SS → Sweaty and Anxious after eating so need frequent meal and low sugar food.
- Cardiac Catheterization pt check distal pulse.
- MI Cause cardiac disarrthymas.
- Key word "Observe" select which can be see or feel right now not in future.
- When pt agitated or anxious or shouting take them to quiet room to reduce stimulants.
- When "during 24 Hr" omit all option that can occur even after that periods like for burn pt infection, pain, electrolytes imbalance can occur anytime but pulmonary distress can occur within 24 hours and it is fetal.
- Tricky question – anyone like police can read pt's chart if pt allows.
- When pt has post op psychology problem if problem is not significant offer him to meet similar pt if significant refer to other.
- Do not message sub cue injection area.
- Basal temp decreases at the time of ovulation.
- Do not worry about dx when asked general question like what is the best birth control answer is hysterectomy (removal of uterus lining-no means) 100% proof, so do not select Pills, IUD, Vasectomy, Tubal Ligation coz these are not 100% guaranteed.
- Dementia → give pain medication regularly and observe their behavior.
- Head injury can increase ICP so put on semi flower position.
- Rural male highest risk for suicide.
- RN can ask manager to have another pt assignment if available.
- New born O2 about 87% is ok do nothing.
- Parkinson disease pt's mode is often swings.
- Pt complain about cramps during enema stop until cramps goes away if just simple discomfort lower it.
- Pernicious anemia – Intestine is not able to take Vit B12 so need injection of B12.
- If one kind of STI is noticed offer test for all other STI disease too.
- Loss of sensation is not normal after post surgery.
- Sigmoidoscopy → Enema self take by pt (Remember 2 large cup of enema)
- Crutches → Move good leg first then broken leg and crutches.
- Fluid and Electrolyte imbalance is DT diarrhea and vomit cause muscle weakness and tachycardia.
- IV 650 left from 1000 ml means 350 is taken as input.
- CPR → Clear Environment → Call for Help First → Check ABC → Give O2 → Check Pulse. (Removing shirt is not imp).
- Pregnant → Complete bed rest pt should be on side lie position with 1 pillow.
- Placenta Abruptio RT PIHTN.
- Pregnant → Increases glucose intolerance so required MORE insulin.

- Temper Tantrum, difficult to please is SS of independency around 18 months.
- Croup → Assess airway.
- Pneumonia Rx → Based on susceptibility (sensitivity) to organism.
- CF pt. Therapy is given on midway of feedings.
- Circumcision – Watch for hemorrhage coz it is highly vascular.
- Stunt requires periodical review.
- HEP A SS → N, RUQ Pain, headache, Tested by IMM-G. No hospitalization need just infection control measures, no LT damage.
- Suicide is often occur anniversary of love one.
- Tonometry is to check eye pressure.
- Glaucoma→ Treatment can prevent further damage. Need eye drop (remember our pt).
- If you don't know tell you don't know and offer help.
- Most IMP is "initial step" that must do to do others. E.g. foot pain while walking→ first put on bed then call doctor.
- Degenerative Osteoarthritis → Affects weight bearing joints and can be Asymmetrical.
- Hip surgery sleep on the unaffected side put pillow to support strain of the site.
- Rt HF → Edema, ascites, hepatomegaly, tachycardia, dyspnea and fatigue. Measure ankle to see edema objectively and raise feet.
- Spiritual Assessment question→ What is your source of strength during difficult situation.
- For mental disease like DD and Alzimer for safety first assess the level of cognitive and musculoskeletal system.
- Antenatal depression and Post partum depression are highly linked.
- Preceptor need to support and teach student. It is not possible to read all book to prepare.
- Poison→ Give Ipecac syrup and lots of fluid /water with it to increase the action.
- 4 Year old require play therapy.
- Low heparin → See creatine clearance test. But Heparin → See INR coagulation test.
- Endometriosm can be delayed by breastfeeding.
- Post OP Oral surgery pt, since local anapestic given at mouth, check gag reflex to see if food can be started.
- Ecstasy Street Drugs are hallucinogen drugs.
- Sanguinous (Blood) takes 10-12 hours to coagulate.
- Bile help to digest fat so bile problem pt do not digest fat.
- CHF → Edema, Increase Extracellular Fluid → Decrease Hgb and Hematocrit.
- Hormone Therapy is controversial so tell pt to talk to doctor.
- Active wound still draining need extra pad under dressing (Simple).
- Chest Tube→ <u>To d/c doctor order to clamp first and then Valsalva maneuver is done during removal</u>.
- When baby born first priority is to open airway of baby. New born baby HR is 120-160 same like FHR.
- Is my baby normal? Offer to see baby, coz crying is not necessarily tells baby is normal coz it ignore genetically disorders.
- Nurse cannot process paramedic's order.
- Advance dx Testing & Goal for Rehab → Tertiary Correction of diet → Secondary.
- Pay attention to Mr Vs Ms between case and options.
- Atelectasis → Diminishing breath sound.
- Coronary Occlusion lead to Ischemia of heart muscle.
- HIV lab is CD4 <200 is low and if one infection occur it is AIDS. Anti Retro Viral Therapy (ART) is to increase CD4 count and decrease Virus. D/T ART AIDS RT dementia is increasing.
- Child Obesity is RT to parents Obesity.
- 11 Year old needs 1900 cal.
- NG perform suction before dressing change with –Ve pressure is applied as the catheter is removed out.
- Viral disease spread when overcrowded not by cold.
- D/T high transportation cost in North side sugar food and soft drinks are cheaper than nutritional fresh food.
- Breast feeding is contraindicated to substance abuse and street drugs not with Inverted Nipple, Mastitis and Cancer.
- BF vs Bottle Feed" No difference in calories only is BF baby tend to be less fat and thin.
- By hydration status is obtained from <u>skin tugor, mucus membrane not by # of diaper</u>.
- Swaddle is best approach to reduce fussiness or to calm down baby.
- La Lache League International provides BG education.
- NG Tube drain is bright red first then later gradually darkens.
- If instill touch surgical site use NS or use sterile water. NG Tube irrigation need NS.
- Melanoma = Pigment can be treated with early detection.
- Tortiollis = neck.
- Access readiness to learn first to teach.

- Delirium is RT Older age.
- Gonorrha → find other sexual contact first and report later.
- DIMM pt can take alcohol but monitor the BGM.
- UTI need Berry Juice not citrus juice.
- Street Drug use can mimic schizophrenia SS.
- Consent can be nonverbal. Catheter to not need written but al least verbal or nonverbal consent is required.
- Iron IM at ventrogluetal site by Z track after changing needle.
- Asthma can use steroid before exercise to do exercise. They need to chart peak flow every day.
- Kegel → Pee and hold and pee exercise.
- Epistaxis → Nose bleeding so not imp as open fracture.
- 3-4 days new born gets Chlamydia trachomatis infection which makes purulent discharge.
- If BP is abnormal with new machine check again with manual before calling doctor.
- Warfarin is for to prevent stroke (CVA for all pts).
- Sinus Rhythm → Normal Heart Rhythm from sinus.
- Preeclampsia SS → HTN 140/90, Proteinurea after 20 wk. Put them in quite room to reduce stimulation. Seizure cause increase temp due to brain effect (not by muscle movement) and ends after 48 hours delivery.
- Rotavirus is causing GI problem in baby not E-coli.
- Transparent dressing provide moist to heal the wound (not to able to see).
- Lung cancer is #1 killer.
- COPD may not be bed ridden (Do not assume). So coordinate walking with pursed lips exercise is initial exercise.
- Anxiety Pt select "be with pt" over explaining all procedures.
- Septic Shock SS → Restlessness and increase HR. In shock catheter is used to measure void (not to prevention retention).
- If cars do not say airway obstruction select B (So give high O2).
- Rx Dopamine → Increase BP. Given for shock to make vasoconstriction coz in septic shock vasodilatation occurs.
- Insulin → Growth age, infection, stress requires increase insulin but exercise requires decrease insulin.
- "You feels someone wants to poison you" C/E question so select over "You are feeling of poison is part of your illness) XX.
- DIMM retinopathy is serious complication.
- Chicken Pox → fluid filled vascular rash.
- Early preschooler are influenced by parents food choice.
- NG Tube put them in RT side so d/t pyloric sphincter food goes to intestine fast.
- Always change needle after drawing Rx from vial.
- Hep B can be transmitted thru placenta and during birth.
- In Long Term care facility pt room are considered their own room so let them do whatever they want like sex.
- Resp Insufficiency SS→ Restlessness and Confusion.
- VIT A, D, K are fat soluble so stored in body but Vit C is water soluble so it is not stored in body.
- Febrile seizure take to ER (No need to call 911).
- Swollen eyes user warm moist heat to increase circulation and comfort.
- C-diff stool is taken from bed pan or diaper, rectal swab is not enough.
- Culture select option that is similar with culture.
- True labor → progressive dilation of cervix.
- Size of breast will not effect the BF, also amount of fat or tissue (size) do not determine the milk production.
- Rubella not for child disease protection it is to protect pregnant women.
- Hib B for meningitis (Bacteria).
- Normal BP of 1 year is 90/52.
- For child feber do not necessary need to be treated so just give Tylenol consult doctor if last 3 days.
- When addressing concern select option that acknowledge concern and give practical (possible) solution both.
- Lab neutropenic RT infection (Neutrophill) when less neutrophill (WBC).
- Prednisone (Steroid) SE is Euphoria, Mood Swing, Weight gain (Not Anorexia) but increase appetite.
- PKD is genetic disease (Polysystic Kidney Disease): BP is usually higher so need Rx to reduce.
- Kidney disease need reduce protein diet and Heart Disease need reduce sodium so both need reduce protein and salt.
- ECT pt sleeps so no pain felt after re-orient the pt.
- COPD → Also Emphysema reduced breath sound and prolonged expiration to fight airway resistance.
- COPD → Pt are adapted with low O2 so 88% is ok. Pulmonary Function Test is done to dx COPD.
- Anorexia reduces menes.
- Which of the following would best guide her decision-making? Professional standards of practice.

**DIABETES**

*Pancreatic Hormones to Homeostasis*

Insulin : When eating → Intestine converts complex sugar in simple sugar. Simple sugar enters in blood so BG level ↑.
When BG ↑, glucose leave the blood and goes inside beta cell in pancreases. Insulin act as vehicle.
In response, beta cell release insulin. Insulin enters in blood stream to go each cell in body also liver cell.
Liver cell converts glucose into glycogen as storage. So BG level ↓ as glucose is used by cell and liver to store.

Glucagon : When hungry → BG now ↓. Pancreas's alpha cell release glucagon into blood which binds on the liver cell.
Liver cell breaks down glucagon into glucose. Glucose is released.
Glucagon tablet is given when severe insulin-induced hypoglycemia occurs.

**HYPERGLYCEMIA**

Type: I IDDM Insulin Dependent Rapid Onset Destroyed or absence beta cell. Also Juvenile.
DIMM I - beta cell are destroyed so no insulin is produced.

II NIDDM Non Insulin Dependent Gradual D/t insulin resistance or decrease insulin associated with age/obesity.
DIMM II - beta cell produces insulin but target cell do not take up glucose.

Type: I & II Both When BG level rises and cell do not take all glucose so increase BG level.

Infection: Body releases stress hormones that help it fight the infection and cause an increase in BG by insulin resistance by impairing the body's ability to use glucose for energy.

D/t lack of insulin or insulin production, blockage of insulin, autoimmune issues to bind, excessive body fat to alter glucose.
Body does not have enough insulin to bind cell or not able to convert glucose in to glycogen cause high glucose level.
D/t osmotic pressure glucose is forced from kidney to urine and fluid also forced out so dehydration and thirst occurs.
D/t unused carbohydrates fat is oxidized and produces ketones.

Complication: Retinopathy, renal failure, CV disease, peripheral vascular and neuropathy.

Risk: Body fat, obesity, age and heredity.

*Clinical Finding S/S*

Subjective : Polydipsia (excessive thirst) Polyphagia (excessive appetite) Fatigue Blurred Vision Peripheral neuropathy.
Objective : Polyuria (excessive urination) Weight loss Neuropathy, Glycosuria (excess of sugar in the urine) Hyperglycemia
Nsg Watch : Hx of Impaired wound healing, UTI, Vision & Sensation changes, fungal infection, renal function, diet & exercise.
Nsg Teach : To use BGM, test urine for ketones, avoid infection, rotation of injection site, carrying carbohydrate sugar.
Use of diet chart, sterile technique to take injection, avoid tight shoes and smoke which constrict circulation.
See eye care specialist and podiatrist. Remove insulin pump in shower and during sexual activity. Teach S/S.

HyperG Test : Fasting glucose Glucose tolerance 2 Hr Postprandial Glycosylated HBA1c to test 2-3 month level.
Glycosylated Hemoglobin test to see glucose level for past 4 months.
Regular Monitor : Before meals and Bedtime daily and HBA1c at Vital. Also when preparing for the dinner means before meal.

TR Intervention : Weight Control Vigorous Exercise Diet Insulin

Vigorous Exercise : Walking, swimming, and stationary cycling. Jarring Exercise : Jogging and tennis, heavy sports.

Diet : 50-60% from complex carbohydrate, Protein 10-20 %, high water soluble fiber like oat, peas, beans protein rich fruits.
Avoid water insoluble fiber.
Ratio 5:1:2 of Carbohydrate : Protein : Fat Distribute food evenly during day with snacks.

Insulin: Cloudy, clear, clear, cloudy First air into cloudy vial, then clear, invert clear vial and draw insulin, then draw up cloudy.

No personal obligation, personal use and guidance only.

Because clear is fast acting, so this process eliminates possibility to go slow acting go into the vial. [O-E/E-O] Air/Draw.
Regular - Short acting 30-60 min. [Regular – Short: Extended – Long: All Other – Intermediate]
HPN, HumN, Nov N, Zinc / Isophane are intermediate acting 1-2 hr.
Extended (zinc) - 4-8 peak up to 10-30 hr.

Pill : For pt beta cell in islets of langerhans still working commonly in adults in late symptom.

**HYPOGLYCEMIA**

*Clinical Finding S/S*

Headache Nervousness Diaphoresis (excessive sweating) Rapid & therady Pulse Slurred Speech

Somogyi Effect : It is rebound hyperglycemia causing undetected hypoglycemia followed by hyperglycemia, during night. To treat is gradual reduction of insulin is very important.

Hypo Shock : Give simple sugar such as juice, soda, glucose tablets then ensure pt eat complex sugar like cheese &crackers. If pt is ↓LOC → Establish IV line, give 50% glucose solution. If unconscious then give IV/IM glucagon.

| **DIABETIC COMA (DIABETIC KETOACIDOSIS, DKA)** | **INSULIN COMA (HYPOGLYCEMIA COMA, SHOCK)** |
|---|---|
| Etiology: Pt with IDDM (I) Young age. when excessive BGL or lack of insulin, infection, diarrhea, vomiting, over indulge, stress, surgery & pregnancy. INDULGING.<br><br>When lack of insulin occurs, for energy fat and proteins are metabolized that cause acidosis and ketones are produces (ketone+acidosis=ketoacidosis). Ketone appear in urine and also cause fluid & electrolytes imbalances. | Etiology : Pt with diabetics when insulin or pills cause side effects to lower the glucose level.<br><br>When excessive insulin or lack of BGL pills to reduce sugar level, or when omits meal or over exercise. Hypoglycemic agents are pills and insulin. FASTING. |
| *Clinical Finding*<br>Subjective : Thirst, anorexia, drowsiness, headache.<br>Objective : BG ↑, BP ↓ = Hypotension, RR ↑ = rapid<br><br>Restlessness, NV, hot/dry/flushed skin, coma, Sweet/fruity order Kussmaul breathing (deep & labored breathing pattern associated with severe metabolic acidosis to blow off the $CO_2$). High BGL and Low $CO_2$ in blood (=acidosis)<br><br>Test : Ketones in urine sample.<br><br>TR Intervention: IV administration to balance electrolytes → Foley to monitor output → Give rapid acting insulin → Check cardiac function coz of electrolytes imbalances → Continuous monitor for hypoglycemia as pt can go low BGL. | *Clinical Finding*<br>Subjective : Sympathetic NS, weakness, diplopia (double vision), faintness, numbness, tingling in fingers, tongue, lips.<br>Objective : Diaphoresis, Trembling, Tachycardia, Tremors, Disorientation, Pallor (Pale, dry mucous membrane).<br><br>TR Intervention: Oral sugar, soda, juice if pt is alert and followed with complex sugar → Give glucagon → Assess IV Line for emergency → Admin 50% dextrose. |
| **NON KETOACIDOSIS COMA (HYPEROSMOLAR)** | **REACTIVE HYPOGLYCEMIA (ENDO)** |
| Etiology: Pt with NIDDM (II) and does not involve ketones. Fluid is main priority as cell are dehydrate. | Etiology: Overproduction of insulin like cancer or autoimmune disease or underproduction of glucose like ACTH deficiencies or drugs, alcohol, propranolol, salicylates.<br>TR Intervention: Low carbohydrate and high protein diet. Small and frequent diet rather than 3 big meals. Avoid simple sugar and fasting. Surgery. |

- If pt is already unconsciousness giving pills or sugar tablets are not possible so we need IV assess.
- Oral pills like metformin can be given only when some insulin production is possible.
- In ketoacidosis where fat & proteins are metabolized, it decreases HCO3 (bi-carbonate) means ↑ metabolic acidosis.
- Diet should be wide variety of commonly available food.
- When ketoacidosis occurs, Na+ comes out of the cell & K+ go inside cell making hypokalemia in blood serum.

- Diabetes insipidus is not a glucose metabolism disorder therefore it does not affect BGL. It is from trauma when kidney do not re absorbed water makes urine more dilute which is low urinary specific gravity. So intension is to make kidney nephron reabsorb the water by anti-diuretic hormone ADH hormone released by posterior pituitary gland.
- Megaly=big so growth hormone make things big.
- Hypophysectomy is the surgical removal of the hypophysis (pituitary gland) inside brain so checking of ICP is priority.
- All ingested food is not sources of glucose so Liver Glycogen is a primary source to maintain nor BGL when BGL↓.
- Coma-Hyper → Fluid and Hypo→ Sugar. Ketoacidosis give K+ IV to replace K deficits coz K+ goes inside cell cause Hypokalemia.
- Starvation ↑ ketones coz ketones are produced when fats/protein are breakdown.
- Acidosis is always cause by ketones not by glucose coz glucose do not affect ph only ketones effects ph level.
- When pt is giving self insulin for many years, nurse do not need to supervise, so document no need "w/o supervision".
- Insulin pump can program to deliver bolus of infusion to bring down high premed glucose.
- When pt drink alcohol Hypoglycemia can occur within 14 hr. Alcohol do increase insulin.
- Diabetic retinopathy is leading cause of blindness.
- DIMM urine dipstick is used to check ketoacidosis. [Not protein].
- Kussmaul breathing to blow off the $CO_2$ is on HYPO Coma not HYPER coma.
- Coma with acetone odor breath is HYPERglicemia after treatment pt without history of DIMM.
- DIMM cause hypokalemia so need K+ when become acidosis.
- DIMM pt need bed time snacks to counteract late insulin activity that is hypo during night.

**Cushing's Syndrome**

Hormone disorder caused by high levels of cortisol in the blood. S/S moon face, buffalo hump, rapid growth hypertension. It is caused by Hyperplasia of Adrenal glands which produces excessive ACTH hormone. ↑ ACTH ↑ BGL. Adrenalectomy is done to correct which then cause hypotension. Steroids Hydrocortisone is given to adjust the stress d/t adrenalectomy.
In Sympathetic situation Adrenal gland release epinephrine to burst energy during stress.

**Addison's Disease**

Also chronic adrenal insufficiency, hypocortisolism, and hypoadrenalism where adrenal glands do not produce sufficient steroid hormones like glucocorticoids (cause inflammation and hypoglycemia) and mineralocorticoids (cause hypotension).

**Myxedema Disease Hypothyroidism**

- Thyroid gland does not make enough thyroid hormone so sensitive to cold, depression, fatigue, dry skin, weight gain, weakness.
- Hypothyroidism cause weight gain and cold so they need ↓ food and ↑ fiber and fluid.
- Hypothyroidism cause cholesterol ↑ and this cause hearth and circulation problem.

**Graves Disease Hyperthyroidism**

Too much hormone in blood (thyroid storm) makes anxiety, enlarge breast, difficulty concentrating, eyeball out, double vision, sweating, insomnia. To meet high metabolic rate, pt need high calories diet. To dx TSH assay and T3 test are done. After surgery tracheostomy is required. Speaking ability is to assess every hour. Tetany, involuntary contraction of muscles can lead to death if surgery went wrong.

Parathyroid Hormone (like Vit-D) helps absorb calcium from intestine and kidney so increase blood calcium level. Hyperparathyroid also take calcium from bone making porous weak bone. When too much calcium level it can make renal calculi so ↑ fluid intake is necessary. In opposite, Calcitonin prevent bone so it decrease blood calcium level.

**CF**

It cause abdominal distension d/t abnormal mucus plugs the intestine to bulge by stool. Only different is adult also sweat excessively but newborn do not sweat. They require pancreatic enzyme and mist to digest and loosen the mucus.

**CV DISEASE / CHF/CVA/MI**

Angina / MI : Can be relieved by rest, nitro and both.

- MI and Angina aim is to reduce anxiety and making pt happy like short family visit.
- Diet should be low protein coz protein has fat that has LDL.
- MI pt need to reduce metabolic rate of digestion to ↓ demand of $O_2$ by clear fluid diet.
- MI pt's heart tissues goes under tissue necrosis within 24 to 48 hr which ↑ body temp like infection but it is not infection.
- For MI heart pt, allow family visitors to ↓ anxiety.
- MI pt check ECG during initial hours of admission.
- Arterial disease cause hypoxia and when walk pt feels weak and dizzy before meal.
- Hemiplegia, caused CVA stroke is total paralysis of one side of muscle. When hemiplegia at RT side – during mouth care place SIMS position head towards dependent site. So placement in SIMS position is first priority then we can brush, feed, etc. Then priority is also protect joint discomfort.
- Even heart problem like low ejection fraction, CVA, CHF, etc. pain is always priority coz by controlling we can manage other.
- Pt has angioplasty and puncture at thigh – check for bleeding before VS coz blood is hidden under the bed so check. Visual inspection is also a first part of Assessment.
- Dietary changes reduced cholesterol levels, a progressive increase in activity, and effective coping strategies for stress reduction should all be included to assist in rehabilitation and reduce the risk of recurrence. Unsaturated fat is good so increase.
- CVA SS→ visual field deficits (homonymous, hemianopsin) d/t smoking, HTN, Cholesterol.
- CVA associated with dysphasia (swallowing difficulty).
- A-fib and V-fib can use AED shock.
- Speech is in left side of brain so when Rt side hemiplegia pt cannot speak or understand.

**LUNGS DISEASE/ASTHMA**

- Resistive Obstructive Pulmonary Disease (ROPD)
- COPD risk factors are smoking, respiratory infection and hereditary.
- COPD increase viscosity at cold so cold air give problem so COPD wants to stay inside.
- Nurse is anti-smoker, so tell nurse to work without prejudice but first learn yourself and tell name.
- $CO_2$ retainer has sat of 95% but LOC ↓ so no need of $O_2$ but all other COPD pt if $O_2$ < 89 give 2l $O_2$.
- Asthma is triggered by environment pollution so aim is to protect from pollution.
- When LOC ↓ check $O_2$.
- COPD pt need small meal throughout the day coz digestion requires energy to metabolize so lungs can work better.
- TB can be protected by Particulate N95 Respirator, gown and globes. Six feet is not enough.
- Mantoux test is +ve when >10mm. When many inmates have TB make sure they are hospitalized and treated then report. Priority is to get them treated not report.
- Two step Mantoux test means 1 given one day and see in 48-72 hours and if negative another second given within 1-4 weeks and again check within 48-72 hours.
- Pnumothorax cause Dyspnea, ↓ breath sound on affected area.
- Pnumothorax is air penetrating in plural space by blunt force.
- COPD → Obstruction cause wheezing and hypoxia, hypoxia cause tachycardia and tachycardia cause restlessness.
- Lung related issues requires rest to ↓ $O_2$ demand.
- Rapid RR with grunting and sterna retractions are SS of illness.
- TB – family members also require treatment with INH.

**URINARY / KIDNEY / REPRODUCTIVE**

**Renal / Hepatic Disease**

- Renal disease pt need low protein and low phosphate diet.
- A sterile closed drainage system should always be used for short term catheterization.
- Renal disease pt also need daily weight to see excessive fluid volume.
- When kidney fails RBC ↓.
- Pr has AVF in his arm so do not check BP at this arm coz risk of infection ↑ by clotting the blood.
- Cholelithiasis SS is jaundice when calculus lodges in bile duct.
- Pancreatitis → NV and anorexia coz pancreases makes enzymes so lack of digestive juice make indigestion.
- Renal Failure at the last stage cause excess volume, hypernatremia, hypokalemia so Restrict fluid, Na and K - main priority.
- AIDS cause immune system ↓ which leads → to pneumonia, sarcoma and herpes, or whatever inactive disease pt has before.
- Since immune system is ↓ exercise and nutrition is very important to prevent of transmission.

- Hemodialysis pt are at risk of Hep d/t regular blood product exchange.
- Renal failure with DIMM pt need low protein and limited water.

**CANCER**

- Sarcomas is cancer of connective tissues.
- Basal Carcinoma is skin cancer d/t sun radiation.
- All metastatic cancer is related to lymph issues coz circulates from lymphs.
- Chemotherapy should be given by free flowing IV line.

**NUTRITION**

- Vit – C   Ascorbic Acid like cement most imp, help to promote wound healing by coagulation.
- Vit – K+   Coagulation, also imp to heal wound. When pt is taking a diuretic, furosemide (Lasix) K+↓ (3.2 mmol/L) so to confirm hypokalemia you see muscle weakness and a weak, irregular pulse. Remember Diarrhea cause hyperkalemia not hypo.
- Vit – A   Also imp to heal wound.
- Vit – B12   RBC.
- Calcium : Related to lower Tetany like tetanus.
- Cholesterol : Imp for cellular membrane structure not blood clotting.
- Hypokalemia (3.2) cause muscle weakness and weak and irregular pulse.
- Dehydration makes concentrated urine d/t diarrhea.
- Heart Pt needs Cholesterol ↓, Progressive activity ↑, and Coping Strategy ↑.
- Diarrhea cause electrolyte imbalance → sodium and calcium → makes extremely weak muscle and tachycardia. [No tetany].
- Ice Milk and Bread is not in same food group.
- Low fat yogurt has highest calcium [Think bone picture on miningo].
- Falls are more riskier for people with flexed forward posture because of new balance. [Not by reaction time].
- Urge to urinate is number one reason for fall.
- TPN contain dextrose, amino acid and electrolytes. [No Fat].
- TPN pt monitor urine for sugar and maintain BGM < 8.3. [Less than 8.3 not 5.3]

**LAB VALUES AND TESTS**

*Know lab values, i.e. arterial blood gases, urea and electrolytes values*

Hematocrit : Common for burn pt.
BUN :
PTT : To check Hemophilia (clotting factors in blood).
Na+ : 135-145 -130 means it is low so we need to do fluid restriction coz. Fluid ↓ Na+ ↑. F Overload cause Hypo Na+.
RBC : When RBC ↓ pt need to stop to visit other sick people coz ↓ RBC means immunosuppressant.
Platelet : In Leukemia RBC ↓, Low platelet.
K+ with IV : To give IV K+ check urine output not weight.
Creatinine & K+ : Furosemide (Lasix) & Digoxin both given- Creatinine is priority if not given only then K+ is tested.
BUN & Creatinine : To check renal function d/t renal issues e.g. calculi.
Hgb ↑ & HCT ↑ : RT Dehydration. Hematocrit/Packed cell vol (PCV)/Erythrocyte vol fraction (EVF) is vol % of RBC in blood.

***Arterial Blood Gas (ABG)***

| Respiratory | PH | PCO2 | By Kidney +/- | HCO3 |
|---|---|---|---|---|
| Acidosis | ☐ | ☐ | To Compensate | ☐ |
| Alkalosis | ☐ | ☐ | To Compensate | ☐ |

| Metabolic | PH | HCO3 | By Lung +/- | PCO2 |
|---|---|---|---|---|
| Acidosis | ☐ | ☐ | To Compensate | ☐ |
| Alkalosis | ☐ | ☐ | To Compensate | ☐ |

No personal obligation, personal use and guidance only.

Respiratory Acidosis : Any disease related to respiratory and heart function e.g. Cardiac Arrest, Respiratory Distress. COPD, Asthma, Head Injury, Pulmonary Edema, Aspiration, Thorax, etc. Narcotic, PCA, Aesthesis, Hypoxia/hypoventilation/Altitude. Increase O2, HBO>30, Lips breathing so help exchange. CPAP.

Respiratory Alkalosis : Any disease related to hyperventilation, e.g. fear, anxiety, pain, fever, infection, labor brain tumor.

Metabolic Acidosis : Any metabolic and Diarrhea problem, e.g. DIM Sugar Ketoacidosis, Renal Failure. Ilesostomy, Starvation. Here loosing base or ingesting acid. Bi carbonate leaves with diarrhea. So clear fluid only no thick fluid like milk.

Metabolic Alkalosis : Any electrolytes and Vomiting problem, e.g. Acidity, diuretics Rx (zides & mide), Hypercalcemia.

| PH (7.35-7.45) | PCO2 (35-45) | HCO3 (22-26) | PO2 (80-100) | AC/AL | RESP/META | Compensated? See Range & Opposite |
|---|---|---|---|---|---|---|
| 7.15 ACD | 40 N | 08 ACD | 88 N | ACD | M | No |
| 7.35 NL ACD | 24 ALK | 08 ACD | 88 N | ACD | M | Full |
| 7.52 ALK | 40 N | 36 ALK | 80 N | ALK | M | No |
| 7.52 ALK | 24 ALK | 24 N | 88 N | ALK | R | No |
| 7.45 NH ALK | 55 ACD | 36 ALK | 85 N | ALK | M | Full |
| 7.45 NH ALK | 24 ALK | 15 ACD | 84 N | ALK | R | Full |
| 7.15 ACD | 60 ACD | 24 N | 78 N | ACD | R | No Hypoxia 78 (Mild) |
| 7.35 NL ACD | 60 ACD | 39 ALK | 80 N | ACD | R | Full |
| 7.25 ACD | 60 ACD | 25 N | 60 L | ACD | R | No Hypoxia 60 |
| 7.36 N ACD | 70 ACD | 32 ALK | 80 N | ACD | R | Full |
| 7.55 ALK | 25 ALK | 26 N | 65 L | ALK | R | No Hypoxia [PaO2 65=SaO2 88 (>90%)] |
| 7.18 ACD | 22 ALK | 10 ACD | 94 N | ACD | M | Partially [SaO2 98 normal >95%] |
| 7.28 ACD | 56 ACD | 25 ALK | 70 L | ACD | R | Partially [SaO2 89%] |
| 7.28 ACD | 43N ACD | 20 ACD | 88 N | ACD | M | No coz R is still Acid side. [SaO2 96%] |
| 7.02 ACD | 55 ACD | 14 ACD | 77 L | ACD | Mix | Sepsis Metabolic Cause and SOB Respiratory Cause [SaO2 89%] Hardly compensating. Need mechanical ventilation and bi-carb. |
| 7.37 ACD | 63 ACD | 35 ALK | 58 L | ACD | R | [SaO2 89% Hypoxia] Most imp is PH here normal so do not give more O2. So even SaO2 is lower it is his base line coz Ph is normal. |

Compensated — PH Normal Both CO2 & HCO3 Abnormal — One system corrects other
Partial — All Abnormal — One system attempt to correct
Uncompensated — PH and Either One is Abnormal — Coz opposite system did not tried.

Mix when PaCO2 and HCO3 goes in its predicted direction.

Step Classify the PH ➔ Find Cause

PaO2 30 = SpO2 60 PaO2 60 = SpO2 90 Ph < 7.15 cell death give lots of O2. C/S cannot read >35.

- Hypoxia SS is Tachypnea, Orthopnea, Tachycardia, Cyanosis, PaO2 <90.
- Hypoxia when brain need $O_2$ & glucose so it tells bone marrow to make high Hgb so COPD has more Hgb like people in Altitude.
- Pt with anemia may have SaO2 100 % but still lack of OC and looks blue coz Hgb is less coz SaO2 is how many Hgb carrying O2.
- Resp Acidosis → ↑ $CO_2$ in Blood or $PaCO_2$. $CO_2$ ↑ ACD ↓ ALK Blood Resp HCO3 Metabolic.
- Body system to fix Ph is Respiratory and Urinary. Respiratory → ↑ RR ↓$CO_2$ ↓ H+ ↑ Ph ↓ Acidity ↑ Alk. Urinary → ↑ or ↓ HCO3.
- Ammonia is Bi-carbonate HCO3.

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- Blood plasma and interstitial fluid is same things at same place with same ions.

## MEDICATION

- For all Rx SE select the one that warns pt to use machinery and driving.
- For all Rx SE select to stop the Rx when you see jaundice coz it is RT liver. So stop to damage liver. Other SE notify doctor.
- When medication error occurs first priority is to check the status (ABC) of the patient not to call physicians.
- When medication error occurs stay with pt do not leave them and use call bell.
- When you see unattended medication on the pt's table priority is to grab that Rx then we can call nurse who did it.
- Psychotropic Rx is not to cure it is to treat specific symptoms.
- When it says gradual minimize of withdrawal of XYZ Rx select by reducing XYZ Rx, this is how withdrawal can minimize.
- Most medication the abrupt withdrawal cause seizures.
- Nurse can do repacking and labeling if Rx is already dispense and pt goes on pass, but dispense should be done by pharmacy.
- SALAD, sound alike looks alike drugs, do not place in an alphabetical order.
- Two antibiotics are combined to reduce drug resistance.
- When giving multiple tablet aim is to minimize the number of tablet.
- Radioactive Iodine is mildly active after given so safety precaution is required.
- Senior student nurse can be witness for the narcotic waste.
- Anti HTN Rx SE is orthostatic Hypotension so pt need to sit a while in the edge of the bed before standing up.
- Mental Rx cause orthostatic hypotension.

### Heart

- Lasix : It is diuretic so ↑ sodium output on urine.
  It is directly related K+ coz it waste K+ so it cause lack of K+ in body to cause weakness and palpitation.
  When any pt with Lasix feel palpation need to call doctor immediately.
- Digoxin : For MI pt. SE is irregular and slow heartbeat, disarrhythmias.
- Metoropolol : Stop if HR <45 coz lol is given to relax heart for MI/Angina pt. Don't worry about RR like 6. Give if HR>100.
- Furosemide : Lasix is loop diuretic for CHF.
- CCB : Like Adalat, Calcium Channel Blocker is given for Angina so side effect is peripheral edema.
- Lipitor : Cause ↑ muscle pain and ↓ urine output. Mayo = muscle.
- Hydrochloride : Avoid contact with skin.

### Lungs

- Bronchodilator : Salbutamol (Ventolin), Pirbuterol (Maxair), Epinephrine (Primatene). Give first to dilate lungs than steroid.
- Ventolin : For asthma avoid ASA coz ASA is inflammatory so opposite of asthma. Ventolin – No ASA.
- Steroid : Beclomethasone, glucocorticoids, cortisol, hydrocortisone. Steroids have potent anti-inflammatory actions.
  Steroid cause trunk obesity (fat tummy) and thin extremities (thin hand and legs).
- Corticosteroids : Cause osteoporosis and muscle atrophy.
  Corticosteroids promote the growth of bugs coz it is classified as immunosuppressant.
  Corticosteroids when use longer depress own hormone production so sudden stop cause hormonal crisis.

### Antibiotics / Antiviral

- Antibiotics : When infection and tachycardia and if said select "give antibiotics as order".
- Antibiotic : When case said bacterial infection first priority is to give Antibiotic asap if it is ordered "as ordered".
  Then second priority is isolation. Because isolation don't save pt. Save first. Select "as ordered".
  Oral antibiotics are selected by sensitivity and susceptibility.
- Tetanus toxoide : Given for burn pt asap to prevent from Clostridium tetany.
- Ampicillin : Safest Rx for baby to infection (itis). Tetracycline cause staining teeth.
- Isonizide : For TB need to take 1 year and cause hepatic failure so assess eyes and skin color for jaundice.
- Tamiflu : For severe viral case prolong many days tamiflu can be given only within 2 days.

### Pain

- Advil : GI Upset is most common SE.

No personal obligation, personal use and guidance only.

- Tylenol : Not necessary unless temp is >39. <38 comfort measures is enough unless pt. is distress.
- Acetylcysteine : Also called mucomyst. It is antidote of Tylenol given when Tylenol overdose occur.
  Given with mucomyst in juice it stays in stomach even vomiting. Tylenol overdose can do hepatic failure.
- NSAID : Or Codin Rx's common side effect is gastrointestinal irritation.

**Narcotics**

- Demerol : Narcotics Analgesic, cause newborn respiratory depression, given with Phenergan to ↑ effect of Demerol.
  Both in combination increase the pain threshold but not reduce the pain.

**Blood Thinner**

- Heparin : Given to pregnant to thin the blood clot, heparin cannot pass the placenta coz molecule is bigger.
  Heparin antagonist is Protamines Sulfate [Not Vit - K].
- Warfarin : When Warfarin overdose INR ↑ and need Vitamin K.

**Mental**

- Magnesium S. : CNS depressant so reduce RR and disappear reflex like, knee-jerk reflex.
- Lithium : Used in Manic phase of bipolar DO and fluid and salt need to ↑ when pt on lithium also need to check blood.
  Still need to take normal sodium so do not reduce it cause lithium toxic.
  Lithium toxicity cause diarrhea (toxicity = diarrhea)
- Ritalin : Used for attention deficit disorder. Also combined with Dexedrine.
- Narcan/Nalline : To treat sedative drug overdose and treatment of withdrawal symptoms, it competes with receptors.
  But when Narcan is mobilized the heroin again takes effect.
- Lorazepam : Ativan is Benzodiazepines which is anti-anxiety Rx.
- Tranquillizers : Neuroleptics, given for hallucination or to bring violent behavior in control.
- Hypnotics : Give to promote sleep.
- Anectine : To paralyze muscle during ECT.
- Prolixin Deconate : Modecate, To treat schizophrenic pt who is not able to take oral medication. Given IM every 2 weeks.
- Neuroleptics : To treat psychosis side effect is Tardive Dyskinesia and muscle rigidity, tremors, difficulty swallowing).
  Unintentional tremors can be manageable SE.
- Antipsychotic Rx : Also used to treat Extrapyramidal symptoms (parkinsonism like) that are usually SE of neuroleptic.
  Common SE is Tardive Dyskinsia which is irreversible.
- Chlorpromazine : HCL avoid sun it cause photosensitization (chloro in light so reactive to light). Watch eye for jaundice.

**Other**

- Oxytocin : Given to fasten birth and need to stop or reduce when fetal tachycardia, watch for contraction (time & freq).
- Ritodrine Yutopar : Given for Preterm labour to reduce frequency and duration of contraction.
- RH0 D : To prevent antibody formation in the mother.
- Radiation : External radiation therapy is not harmful for pregnant women.

**Antianxiety Rx**

- Benzo (all ZEPAM) and Barbi (all Barbital). Anxiety Rx is also used as sleep medication, e.g. benzodiazepines.
  SE is dependency, depression and withdrawal syndrome when withdrawn immediately.
- Neuroleptics : All APINE (e.g. quetapine, olanzapine) All DOL (Haldol), All AZINE (chlorpromazine).
  Combined with Antianxiety Rx to increase the compliance of Rx and to reduce tardive Dyskinesia.
- Parkinsonian side effect is usually irreversible.
- Like all other drug these psychotic Rx also interacts with alcohol and other drugs.
- SE includes cardiac disease, cold sore throat, jaundice, orthostatic hypotension, constipation, urinary retention, photosensitive, Extrapyramidal side effects such as Dystonia (muscle spasm), Pseudoparkinsonism (tremor, gait, rigidity), Akathisia (motor agitation, restless legs jitters), Akinesia (fatigue, weakness), Tardive Dyskinesia (involuntary movement of jaw, tongue, lips, tics, diaphragmatic movements to impair breathing).

- Watch SS of hepatic toxicity like jaundice, watch hypotension and tachycardia, take BP and stop <90/60.
- Dry mouth is common SE so offer candy or gum. Suggest to avoid sunlight and use sun cream and glasses.
- Suggest high fiber diet to avoid constipation. Avoid crowded place, alcohol, OTC Rx, Antacid, caffeine.
- Expect weight gain so control weight with appropriate diet plan.
- Call doctor if Extrapyramidal SE and sore throat and fever.

**Antidepressants Rx**

- All MINE, TYLINE, ALINE, ETINE (Prozac, Zoloft, Paxil), SSRI, MAOI, Trycyclic.
- SE like Antianxiety but also blur vision and opposite of Antianxiety like sleep problem and anxiety itself as SE.
- For SSRI SE also include GI irritation.
- Nursing Care: Assess for suicide, and BGM. Suggest to change position slowly. Except delayed response 2-4 wks.
- MAOI Monamine only Rx that should not eat tyramine food, fermented, wine, caffeine, yogurt, soy sauce, cheese and liver.
- Monitor hypertensive crisis such as occipital headache, palpitations, and stiff neck.
- Antidepressants also cause headache.
- Antidepressants takes 2 to 4 weeks to work so tell this client if they complain Rx is not working.

**Antimanic and Mood DO Rx**

- All LITH, Valporic Acid, Gabapentin, AZEPINE. Lithium is drug of choice.
- Interaction with salt so ↓ salt. Beside SS include toxic effects, thirst, renal failure, slurred speech., confusion.
- Nursing Care: Tell takes time to work, watch thirst and hyponatremia low sodium, and lithium toxicity.
- Watch of toxic SS like diarrhea, vomiting, drowsiness, weakness, confusion and seizure, lithium level and hypothyroidism.

**COMMUNITY**

- Cultural competencies is when a nurse understands culture and make nursing care plan.
- Culture is shared belief, values and behaviors.
- Self awareness allows nurse to examine how bias and assumption interfere the TR.
- When we see a health issues in many people in a community the collaboration is key aspect e.g. many babies are not BF.
- Collaboration even comes before assessment in community.
- Harm Reduction is what is the best option not what is better e.g. when babies are not breast feed then harm reduction is to convince them to barest feed at least for 6 months not starting with breast and bottle feed at a same time.
- Harm reduction is when we use breath detector to turn the car on for a person with alcohol abuse coz he is not going to reduce.
- Best place for all concern for the community client is CHN at Community Health Center.
- Case Management Nursing is to ↓ rate of hospitalization.
- School health use socio-environmental approach.
- Community Assessment start with focus group and the priority is to negotiate between different interest within the groups.
- When there is a racial tension priority is to invite all stakeholder to discuss.
- Intervention can be done with the help of stakeholders.
- Marketing needs enough resources such as enough immunization clinic.
- When endemic make sure to put doxycycline (antibiotics) are enough.
- When 5 pt comes with abdomen pain → ask if they ate at same place.
- Parish nurse is NOT who worked with religious group she is who is called to minister.

**GROWTH AND DEVELOPMENT**

**Erikson's**

Erikson : Development is in response to social interaction and relationships.

| | |
|---|---|
| Stage 1 = Trust / Mistrust | Psychological crisis - a potential turning point can yield different outcomes. |
| Stage 2 = Autonomy / Shame/Doubt | Can I do myself or I need to rely on others. Toddler – independency vs dependency. Also dependent vs independents so baby says "no" all the time. |
| Stage 3 = Initiative / guilt | Am I good or bad. Child learns new things. |
| Stage 4 = Industry / Inferiority | Am I successful or worthless. Learn function effectively in school with peers. |

No personal obligation, personal use and guidance only.

| | |
|---|---|
| Stage 5 = Identity / Confusion | Adolescence, who/where I am going, identity (physical, vocal, cognitive) crisis struggle. |
| Stage 6 = Intimacy / Isolation | Early Adulthood, Shall I share my life with other. |
| Stage 7 = Generatively/Absorption | Middle Adulthood, Will I produce something of real value future generation. |
| Stage 8 = Integrity / Despair | Late Adulthood, Have I lived a full life or have I failed. |

**Freud**

Freud : Human behavior is governed by motives and unconscious. So best when psychosexual needs are meet.

| | | | |
|---|---|---|---|
| Oral | : | 0-1 | Needs meet orally. Separation anxiety occurs here. |
| Anal | : | 1-3 | Level ↑ independence. Concern and see environment. |
| Phallic | : | 3-5 | Sex drive. Role identification with same sex parents.<br>Oedipal love opposite sex parents and hate same sex parents (not siblings so boy fight with dad). |
| Latency | : | 6-12 | Relationship with same sex peers as to prepare for industry. |
| Genital | : | 12+ | Sexual maturity, heterosexual relationship develop. |

**Piaget**

Piaget : Development according to physical growth and ability to think.

| | | |
|---|---|---|
| Sensorimotor | : | Reflex, gradual thinking skills. |
| Preoperational | : | Imitate and play with symbols and language. Internalization – preschooler. |
| Concrete | : | Reasoning and logic. |
| Formal | : | Abstract and problem solving. |

**AGE RT**

- Adult age group – seatbelts, drinking and driving and speeding.
- Middle age women – Osteoporosis, breast cancer and cervical cancer.
- Older – Fall, exercise, nutrition, safety and dehydration.
- When 5 year old it is Initiative vs Guilt so explain it is not your fault.
- Teen agers do not like to hear what to or not to do so care start with "trust" then "collaboration".
- When age 4 screams just sit quietly by his bedside.
- When child is in ER with Rx poison make sure pt is stable else they're not receptive. So stabilize pt then teach pt precautions.
- For 4 year old when teaching hand washing demonstrate and have child practice with you.
- For 3 mo baby is crying wait until he stops crying to take vitals coz giving mom to hold may not stop her to cry.
- For 3 Yr old distraction don't work so use stuff bear and show her what is being done.
- Fluid for baby remember to read first word like One, Two, Four. E.g. when baby is 10 kg. FOUR 250ml/day coz 4x250=1000.
  1. Take weight 2. 100ml/kg for 1st 10 kg 3. 50ml/kg for 2nd 10 kg. 4. 20ml/kg for reminder kg.
- Immunization starts from 2 months of age and there is no need to interrupt the immunization if other family member get sick.
- Infant→ First Most rapid, Puberty (growth spurt)→ Second most rapid, Preschooler→Small, Post puberty→No growth.
- Cephalocaudal → Head to toe and Proximodistal → Center to periphery.
- Prenatally → Head faster than trunk then trunk faster than head.

| | HR | BP | RR | % of Water in body | |
|---|---|---|---|---|---|
| Neonate | 80-180 | 40-70/65-140 | 30-35 | 80% | |
| Infant | 10-120 | +2-3 every year | 30-35 | 80% | |
| Childhood | 70-110 | | 20-24 | 80% | |
| Adolescence | 60-100 | | 16-18 | 60% | |
| Older | 60-100 | | 16-18 | 40% | (<40% is severe dehydration) |

- Maternal Deprivation is lack of interaction with mom or primary care giver and they are susceptibility to variety of illness.
- When feeding for difficult children give them option.
- Parallel Play is played separately but being aware of other kids. Solitary play is not being aware other kids.
- Role play helps kids to express themselves.
- At age two children is very possessive of toys.
- 4 your old boast, exaggerate, impatient, noisy and selfish so they are difficult to relate with others.
- To allow parents to be the baby during surgery assess the parents anxiety and tolerance level.
- 5 year old fear of self harm.

- After 14 years setting limit don't work so help them to make decision.
- Second level of separation anxiety is when baby stay quiet and depressed.
- Tympanic is Most accurate. Rectal is not recommend. Oral not good for <3 years. Axillaries less accurate. >38 need to see doc.
- 2 year old is separation anxiety.
- Reward and punishment is very bad way of feeding. Need to feed as socialization.

**MENTAL HEALTH**

- Mental illness is evidenced when an a person has difficulty relating to others.
- Setting limit should be definite "action", appropriate, reinforceable and consistence.
- Mentally healthy person is who is able to meet his basic needs independently because issues comes when basics are not met.
- Suicide rate ↑ when antidepressant started to work d/t burst of energy.
- Select the answer that says "Are you thinking of harming yourself or others". This is only direct question in CRNE.
- When you see bruising ask Y/N question. R U abused?
- In mental health, select answer that establish strict rules, regulation and boundaries.
- Pt is anxiety of stab wound so TR is ask if he like to talk about his anxiety not refer to social worker. Refer is not TR if in scope.
- When adult gain weight of 5kg per week, they do not take medication so action is to "explore further about medication." Not to access the nutritional status coz it is enough already to increase 5kg per week.
- Mutilation, biting self is harming self body.
- When pt is disable tell him that it takes time to gain loss of ability.
- SSRI Rx cause weight gain and ortho hypotension.
- Attention Deficit Disorder is when pt is not able to concentrate in their work usually schoolwork.
- Low self esteem is identified when pt makes excuses for other, e.g. I love my husband he is too busy to be with me.
- Pain is also associated with culture.
- In drug abuse related treatment, priority to put pt in group activity to ↓ isolation and increase high calorie and protein diet.
- Evaluation of drug related treatment includes acceptance of personal responsibility without blaming others and verbalize feelings.
- In Anorexia and Bulimia nervosa, priority is to see weight and electrolyte balance and establish behavioural modification program.
- Personality and mode can change anytime in life. Personality development is dynamic but starts in 2 years of age with parent.
- Personality is mixed of biology, psychologic development and cultural settings NOT with socioeconomic status and race.
- Parent and child relationship and self recognition and group acceptance is very important for personality development.
- Communication ties with social surroundings to start socialization.
- Socialization and emotional development is learnt thru family by learning identity and roles.
- In groups, groups helps to identify acceptable behaviors within the members.
- Even mental issue parents, like other, experiences feelings of resentment towards their children.
- Voluntary pt is similar with involuntary pt for their rights, they can refuse medication. All pt may have some restrictions.
- Chronic lateness is an example of passive aggressive behavior. These people cannot meet others demand.
- Beginning the bond starts with looking at infant and strokes his head then crying.
- Group therapy only works when pt feels that they have a problem.
- Child Abuse child talks about sex topics all the time so report to authority.
- When mental health pt refuses the Rx ask why before forcing.
- Placebo – refuse it as it is not real medication.

| | | |
|---|---|---|
| Schizophrenia | : | Makes it difficult to tell the difference between real and unreal experiences. |
| Disorder Thought | : | When writing letter as soon as write "t" pt remembers to have a cup of "tea". |
| Dystonia | : | Has Pain. Side effect of PINE medication.<br>Neurological movement disorder of muscle contractions cause twisting and repetitive movements. |
| Tardive Dyskinesia | : | No Pain. Progress slowly (tardive). Repetitive, involuntary, purposeless movements, such as grimacing, tongue protrusion, lip smacking, puckering, rapid eye blinking d/t antipsychotic drugs. |
| Precautionary | : | The "poison" or somebody is trying to kill, cheated, spied, drugged, harassed me is key word. |
| Grandiose | : | I am queen and I don't need medication. Fells that pt has some great talent. |
| Somatic | : | I must have a cancer. No medical reason. |
| Nihilistic | : | Delusion that things (including the self) do not exist; a sense that everything is unreal. |
| Erotomanic | : | Feels that other person is in love with client. |
| Borderline DO | : | Personality disorder that pt praise and dump the nurse so quick to manipulate.<br>In borderline DO, setting up a definite rule and specific behavioural rule is very important. |
| Autism | : | Is spectrum disorder with variety of SS, commonly social interaction and communication and imagination. |

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Mainly boys. Lack of eye contact, repetitive activity, alter attachment, sensitive to light, sound, smell.
Retardation, seizure, tantrum, lack of insight self vs environment, stereotype body movement.
Nursing care: watch rejection of physical contact, no intimacy, repetitive spinning, energy inward.
Altered family process, impaired communication, anxiety, risk for self-mutilation.
Autism can be seen at age 2 and lack of wanting to eat is first SS and interested on self.
Goal: able to sit with group, increase first person speech, decrease self destruction and repetitive action.

Attention Deficit : Assess learning needs and realistic goal, test hearing, gait and visual acuity, structural learning, quiet time.
Anorexia : Do not want to eat d/t fear of weight gain. Provide diet with high nutrients rich food.
Bulimia Nervosa : Over eat fast and purge. Limit the dietary intake.

Id : Instincts and impulses and urges – all unconscious. Does not tolerate frustration. Need / demand gratification.
Source of creative energy like to have sex bird dances so it is instinctive/genetic.
"I want what I want" = Instant gratification.

Ego : I – to deal with reality – presented to others. It is ability to tolerate frustration and delayed gratification.
"I can wait for what I want". Wait = delayed gratification.
Ego strength need to be supported to deal with crisis situation.

Superego : It controls and regulates impulses to establish in the society. Controls id. It develops from environments & family.
Superego is always conscience because it leads to right vs wrong and guilt vs shame so it is conscience=ethics.
"I should not want that" = conscience, ethical decision.
In children superego needs to be internalized so that superego control id to prevent from traumatic experiences.

Self : Is total sum of Id, Ego and Superego.

Mature : Mature personality is when Ego acts as a balance between demand of Id and control of superego.

- Emotionally disturbed child is who does not respond to the environmental stimuli = lack of reality check.
- Self esteem are "no one listens to me" attitude.
- Child before 3 are trying to identify their own needs so telling for toilet training is poorly handle and become issue for them.

Conscious : Materials
Preconscious : Ideas and feelings.
Unconscious : Past attitudes, feelings and desires. Does not deal with frustration.

**Compensatory / Defensive mechanism**: To maintain, protect and enhance the integrity of self.

Stage of dying : Anger Denial Depression Acceptance (need more emotional care)
Denial : Ignoring unpleasant reality. When baby comes out deformity, "You must have brought other's baby".
Denial is first stage of crisis where pt ask second opinion. Is there other doctor or option?
Criticizing is not first step.
Bargaining : In stage of dying, pt promise over the one option.
Detachment : In stage of dying, pt accept the death. They becomes happy and no anxiety but lack of involvement.
Acceptance : Need more emotional support, do not want visitor so nurse stay with pt not speaking. Pt do not cry here.
Displacement : Pent - up emotion to other rather than primary source.
Disassociation : Disassociation from real self. How are you -> The man is not good. Don't remember faulty accident.
Compensation : If one cannot do d/t limitation choose other, e.g. short boy goes for dance instead of basketball.
Ideas of Reference :
Hostility : Self or other
Fantasy : Imaginary activity to escape from reality, daydream, wishes.
Intellectualization
Rationalization : Justifying behavior that is not socially acceptable.
Rigidity : Compulsiveness
Reaction Formation: Acting as if nothing wrong. Telling just opposite that what pt is actually feeling.
Regression : In crisis, pt becomes more dependent. Repeat of past behavior e.g. Feed by bottle or use diaper.
Repression : Unconsciously keeping unacceptable feelings out of awareness.??
When child misses mother for many days then he like other as he is repressing his feelings for the mother.

Suppression : Unconsciously keeping unacceptable feelings and thoughts out of awareness.??
Projection : Blaming others for own mistake. The nurse don't like me.

Introjections : Inject other inside, mimicking father when father dies, e.g. taking other quality inside.
Withdrawal
Sublimation : Use socially approved behavior instead of socially unapproved behavior.
Confrontation : Demand other to seek alternative or to watch themselves.
Feedback : Response to the message.
Narcissism : Huge dependency which is impossible for others to meet.
Transference : Project significant people (often parents) onto others, and then expect them to behave in that way.
Counter-transference: FROM NURSE to client. When nurse thinks clients as a sister.
School Phobia : Has legal and emotional aspect and parents should continue in a clam environment.

Conversion : By which pt reduces anxiety by converting emotional conflicts into the physical symptom, leg pain, blind.

**Cognitive Disorder : Delirium, Dementia, and Alzheimer's Disease**

- Anxiety related to changes in tissues in the brain d/t memory loss, threat, changes in environment, and sensory loss.
- Main goal is to provide safe, quiet and supervised environment. Continue orient pt with time and place.
- Main intervention is to maintain a familiar daily routine. DT dead brain cell nurse need to simplify the environment w/o choices.
- When agitated or aggressive these pt needs a controlled environment with set limits.
- These CD pt do not care about personal appearance also nurses need to simplify their environment with little choice.
- For agitating pt provide pleasant stimulation such as nice music or TV to calm down or distract them. Your safety first.
- When pt is agitating you cannot explore their meaning of behaviors coz they do not participate in discussion.
- The current trend for these pt is to maintain them in the community.
- Confabulation is a memory disturbance that is characterized by inaccurately describe past "honest lying" to mask memory lost.
- Functional mental illness is result of social environment and this disorder pt cannot perform job (hear) but nothing wrong.
- On discharge psychiatric pt should be encourage to continue in an aftercare situation (group therapy may not work).
- Sensory deprivation is lack of sensory organ so more organ damage more deprived.

**Delirium** : Temporarily by infection, it is, toxic like AIDS, COPD, electrolytes issues, etc lead to confusion, disorientation.

- Quiet place reduce the stimuli also provide routine. Monitor IO.
- Provide high calories, protein and vitamin diet. Eliminate causative agent such as fever and toxins and provide safe environment.
- For delirium pt it is important to provide sensory equipment such as glass and hearing aid.

**Dementia** : Gradual onset d/t alzheimer and vascular disease, trauma, toxin, infection, circulatory problem to damage brain.
Aphasia: language problem Apraxia : Motor problem Agnosia: Familiar object reorganization problem.
- Toilet client frequently, provide safe environment.
- Vascular dementia pt use old & familiar defense mechanism in a exaggerated way, they cannot create new defense mechanism.

**Alzheimer's**: Memory loss dementia d/t areas of brain senile plaques destruction.

- Pt needs sameness and consistent environment therefore it is important to maintain familiar daily routine.

**Schizophrenia**

- Associated with damage in DNA Chromosome 1 it cause Apathy and flatness, emotionally cold and introverted.
- Trust is first priority intervention for schizoid pt so foster the trusting environment first.

**Depression Mood Disorder**

- Depression is disturbance in mood as a reaction to a real or perceived loss.
- For depressive pt ask, "How you feel?" No need explorative coz they cannot comprehend also do not ask What/Y/N question.
- So activity starts from → Self activity like paintings → 2-3 person activity like dance → Group therapy.
- Depress is usually caused by unrealistic need so long term goal is that pt realizes realistic need.
- Suicidal pt need to monitor when suspected but removing all objects is already done before pt comes so this is not the answer.

- Depress client always fear of losing others so they have hard time to show anger towards others.
- Like anxiety pt, depress client feel anxiety with complex decision so make their task with minimal decision.
- Suicidal pt attempt successful suicide when medication works and pt feels more happy during discharge coz of energy.
- Suicidal risk goes when there is certain day like anniversary of lost one. Directly ask "do you think of harming yourself?"
- Suicidal pt tells their suicide plan because they are fearful of their own impulses and to seek protection.
- Suicidal pt tells that he is better and not going to kill. Nurse must explore so ask like she wants to talk more about it.
- ECT therapy: pt are induced so they do not feel the treatment. After ECT pt requires reorientation of time-place d/t memory loss.
- ECT use Anectine to paralyze muscle so need artificial ventilation to breath coz diaphragm cannot move.
- Depressive pt attempt to introspection others so if one attempts to suicide other also try.
- Preschools are most benefitted by play therapy not group therapy.
- For quit pt first intervention is 1 to 1 so nurse go and help grooming then success take her to the group, but first 1-1. To start communication first use non-threatening subject then second discuss feelings, but first 1-1 then non-threatening.

**Anxiety / Somatoform / Dissociative**

Anxiety : When two goals or needs are in conflict and result in apprehension or tension. Treated with Benzodiazepines.
Sympathetic NS initiate flight of fight situation by secreting adrenal's epi and norepi.
HR ↑ Vessels Constrict Bronchioles dilate and RR ↑ to supply more $O_2$ to cell. Pupil dilates to increase vision.
Liver releases the glucose quickly to provide energy fast.
Anxiety starts with anticipation of perceived threat. So ↓ it.

Mild : Can do without assistance. Alert and aware of surroundings. It also enhance the power.
Moderate : Can do with assistance. Focus only on the area of concern. Lack of attention.
Severe : Only focus on specific concern.
Panic : In bed can do nothing. Thinking and behavior are disorganized.

Illusion : Misinterpretation of object like painting, wallpapers, etc.
Delusion : False believe that cannot change even by a evidence. FBI is trying to kill me – delusion of persecution.
Hallucination : From stimuli, false sensory,
Idea of Reference : Believe someone is talking about him.
Paranoid : Fear of others.

| | | | |
|---|---|---|---|
| Dopamine | : | Excess → Schizophrenia | Deficiency → Parkinson's. |
| Norepinephrine | : | Excess → Manic Behavior | Deficiency → Depression. |
| Serotonin | : | Excess → Hypersomnia | Deficiency → Depression and Insomnia. |

- Anxiety is normal response to real or imagined threat. Explain also to the family. Acting out is not SS of anxiety it is with disorder.
- Anxiety is sympathetic NS so pupils dilates to se far to run, Pulse ↑ to circulate $O_2$, peripheral vasoconstriction to ↑ BP.
- Unsatisfied needs → Anxiety ↑ → Physical Action ↑ → Tension ↓ → pt's level of comfort ↑.
- For anxiety pt → always stay close → then assess primary concerns. If going for treatment explain detail if not stay close.
- When pt is anxiety because child is in ICU then bring parents inside.
- When client is paces = walk lot give them simple but monotonous task to save their energy, giving single room don't work.
- When pt see NEW staffs they show sign of anxiety.
- Pt with anxiety d/t hostility or captivity becomes incontinent urine.
- When pt is in 4 bed room and sleep problem first attempt is to move them into single bed to see if it works before Rx.
- For phobic pt it is important to learn new and better coping skills to reduce anxiety.
- Phobia do not occur until pt comes direct contact with the feared object.
- Person with anxiety disorder have insight when he comes early and sits quietly coz he knows the procedures.

**Conversion Disorder**

- Conversion DO, anxiety is relieved by physical symptom. But this physical symptom don't get permanently worse.
- The physical symptoms are evidence of emotional conflict.
- For conversion DO pt feel pain in leg which is necessary for him to cope with the anxiety creating situation, can reoccurrence.
- Conversion DO starts when two different demands kicks in, e.g. need to be independent and dependent at a same time.

- People with Conversion DO seems calm and composed since their anxiety is conversed to physical illness so stop paying attention to their physical symptom.
- Malingering is a person who deliberately pretends an illness.
- Somatoform is physical SS without diagnosable medical condition.

**Hyperactive / Maniac / Bi-polar**

- Hyperactive behavior such as manic phase being bossy is Mood Disorder.
- Hyperactive pt do not eat food coz they believe they do not need food at this time since they are busy so give finger food.
- When client is disruptive → Understand them and also set limit but do not restrict them.
- Always use firm, warm and consistent approach.
- Hyperactive client- don't need to encourage to speak so intervention is to divert their excessive energy in different simple task.
- For manic phase encourage to dress appropriate.
- When pt uses bad word, recognize it is the part of problem but set limit.
- Antisocial personality, violent criminal behavior is because pt cannot postpone gratification (Superego cannot control Id).
- Antisocial personality is also associated with lifelong maladaptive behavior.

**OCD**

- For OCD pt the aim is not to prevent rituals it is to gradually reduce it by neutral environment to reduce conflicts so allow time.
- OCD pt are rigid, narrow and overly conscientious (=thorough, meticulous). Don't let them plan their work, but let them be slow.
- OCD cannot reduce in one day so in starting phase let them do what they want, e.g. give tissue to open door knob.
- OCD pt are trying to unconsciously control unacceptable impulses or feelings.
- When OCD pt are encourage to express concern they are more anxious.
- Main goal of OCD client to reduce the amount of rituals activity gradually as setting the limits.

**Eating Disorder**

Anorexia Nervosa : Fear of growing up and being older. Initial goal is to gain at least 1 pound per week.
Bulimia Nervosa : Episode of binge eating and purging.

- Both pt "trust" is initial and key step.
- Both pt AN or BN requires realistic limits it is not required to talk about food as they do positively or negatively.

**Substance Abuse**: Excessive drug used with unacceptable medical practice for passion for self gratification.

- Substance abuse is done to blur reality, pt needs props to blur reality and becomes dependency.
- Alcoholic are denial to reduce their feeling of guilt. Alcoholism→korsa Syndrome which requires thiamine (enzyme like glucose) IM.
- AA do not help to cope with problem they only do to get insight. Membership with AA is best treatment for alcoholic pt.
- AA or NA main aim is to deal with present behavior to change behavior they do not care underlying cause of that problem.
- AA is successful coz pt feels belongings. Like all group therapy the main aim is to show that the problems are not unique.
- In group therapy when a pt has concern nurse try to see if other feels the same way.
- Most drugs abusers also abuse alcohol. Alcoholic must have insight and they are primary rehabilitator, readiness is key.
- Methadone HCL is to convert illegal drug use to legal drug use.
- Narcotic withdrawal → SS is similar with anxiety like agitation and attempt to escape.
- Alcohol withdrawal → 12 Hr= shakes, perspiration, weakness, 24 Hh = acute wdl Seizures, 72 Hr = major wdl delirium tremens.
- Alcohol Withdrawal → Fever, HTN, LOC ↓, Hallucination.
- Alcoholism involves the entire family – research shows.
- Tranquilizers are used to ↑ receptiveness to psychotherapy.
- Daycare helps to maintain goals attained during hospitalization.

Withdrawn Pt : Main objective is to keep them in reality oriented to reality so that they do not fall back to their private world.

**SHOCK**

- In all shock BP ↓ and peripheral circulation ↓.
- Shock is loss of O2 in cell so respiration ↑ . Only vital organ gets blood and bowel sound is absent coz bowel is not vital organ.
- In Hypovolomic Shock First BP ↓ Pulse ↑ RR ↑ Bowel Sound ↓ Long-term Urine ↓ and skin becomes cold and clumsy.
- SS of shock is Pallor (yellow), Cold extremities (to supply blood to vital organ) and tachycardia (to fasten the $O_2$ demand).
- Lack of circulation is a local area also causing local pallor, numbness and coolness.
- Hemorrhagic shock SS→ Hypotension, cold, clumsy skin, weak therady pulse (tachycardia).
- Compensated Shock : HR ↑, RR ↑, Constriction of Peripheral Circulation and Pale-Cold-Clumsy Skin.
- De-compensated Shock : Low Blood Volume Hypovolemia, Lack of Perfusion, Low BP.
- Hypovolomic Shock: DT blood loss and plasma coming out from cell from burn and trauma.
- Cardiogenic Shock: DT MI by lack of O2 in mycardium, irregular heart.
- Neurogenic Shock: DT paralysis, blood vessel widens but blood do not loss.
- Sepsis, Infection, Allergies also cause shock.
- Ortho surgery- now pt is confused, temp ↑, BP ↓ and Urine is only 9ml/hr so looks septic shock – Priority is to give IV fluid.
- Pt with septic shock – level of lactate is elevated so need IV.
- When pulse is absent anywhere first priority is to call doctor. It is an emergency.
- When pt is hypotensive raise leg 30 degree.
- When pt is dizzy and pale give IV or increase rate if it is already in place.
- Atrial circulation when lack SS is lack of pedal pulse, coolness and reduced sensation (artery=pulse, venous no pulse)
- Bolus is required so even pt has IV already make big bore IV line to give bolus rapidly.
- Vesovegal reaction is d/t stress not by circulating overload.

**HEAD INJURY / ACCIDENT / EMERGENCY**

- If head injury pt is stable and conscious ask their address to assess memory loss.
- If pupil size are different it means ↑ ICP.
- Meningitis cause purple skin rash and peripheral circulatory collapse.

**DYING / PALLIATIVE CARE**

- Dying pt is felt cold, clammy skin, irregular and noisy breathing.
- When palliative pt with cancer main priority is to give comfort with morphine for pain management changing position or other Rx do not help dying patient. Also when palliative pt urine output is ↓ like 10 cc/hr, the death is imminent. Also when pt is dying and cannot speak then respect the families' wishes. Use cultural safety and do not reflect your death and dying values.
- When a palliative dehydrates- IV does not provide comfort so use ice chips or sips of water to provide comfort not IV.
- Palliative main priority is pain, $O_2$ and position to ↑ comfort.

**PROCESS / CARE PLAN**

| | | |
|---|---|---|
| Primary | : | All education for risk factor. When it says "risk factors" there is no disease yet so it is primary. Counseling for health population. |
| Secondary | : | Counseling for sick people with disease already. |
| Tertiary | : | Rehab is not primary coz there is already disease. |

| | | |
|---|---|---|
| Assessment | : | Hx, S/S. Assess is first priority when pt ask question to know. Initial action is Assessment. Always select physical assessment first if other options are intervention and assessment is not done. Assessment is most important first nursing process. |
| Diagnosis | : | It is interpretation of assessment data. Also Analysis from lab. |
| Planning | : | Starts with verb like Assist, help, teach, encourage, supply etc. It is goal and priority setting phase. |
| Evaluation | : | Starts with verb like Complies, verbalizes, maintain, establishes, experiences, carries supply, identifies, etc. |
| Psychosocial | : | This assessment is habits, family, social and sexual patterns. |
| Health Hx | : | To identify level of health and past illness. |
| Physical | : | Inspection→ Palpation → Precaution → Auscultation [IPPA] [Pa-Pr] |

- Care plan and counseling requires assessment first to plan SMART and gradual progress.
- Prevention is successes in outcome so decreased episode of bleeding is outcome of hemophilia disease pt's goal.
- Referral always comes after education is ended.

- When question already said finding like "the nurse observes that pt is no longer responding and his face is cyanosed" means she already assessment so now she need to do intervention not assessment so here since pt is not responding intervention is clear the room immediately and call for the resuscitation team. No need to assess his level of consciousness and respiration – Done.
- Critical Thinking is recognizing own learning needs and knowledge deficiencies.
- Family assessment question: <u>How is your condition affecting your family member and their role</u>?
- Coping ability assessment question: <u>How your family handle difficult situation before and what strength emerged</u>?

***Pre and Post Operation***

- Pre OP tell family member when and where the patient will be after surgery.
- Pre OP education includes movement, deep breathing and coughing. It is preoperative goal.
- Post OP education include deep breathing exercise and dressing change.
- Post OP pt do not need urinary retention as initial assessment until 6-8 hours.
  So only after 6-8 hr if not void (a) assess lower abdomen (b) if more than 8 hours already just insert catheter.
- Post OP <u>immobility</u> ↑ blood calcium level, ↓ bone density, <u>Hypo</u>tension and paralytic ileus.
- To transfer from bed to WC make sure pt are closer to WC and he sees it.
- <u>Post OP</u>, unless the surgery is related to bone, <u>first priority is to turn side by side every 2 hours</u>. To prevent venous stasis and improve muscle tone, circulation, and respiratory function, the client should be encouraged to move.
- Pain medication will be administered to permit movement.
- Post OP pt <u>Swallow</u> is first priority to assess because anaesthesia interferes with the gag reflex until the gag reflex returns, the patient cannot swallow without a risk of aspiration. NOT Inhale voluntarily, Breathe deeply and Speak.
- Post OP pt says "Life will never be the same." You say → <u>You're concerned when you think about how this will change your life?</u> Best answer coz it is attune to the feelings of sadness and dejection as well as the content of the patient's statement.
- Post OP like mastectomy <u>operated side is elevated higher with pillow to prevent strain and edema</u>.
- When Post OP pt's bowel started to work it increases the cramp and pain and bowel sounds are present in all 4 quadrants.
- Post OP assessment includes vitals, LOC, pain, wound dressing.
- Priority among many post OP pt, first pt is the one with most recent operation performed coz they can go bad so fast.
- Post OP pt 's first goal is to maintain airway.
- Post OP pt watch for swallow ability not breathing or speaking.
- Post Op pt urine output must be 125ml/hr but BP less is ok like 100/70.
- $O_2$ type depends on pt's pathological issues and need humidifier. $O_2$ is given to counter respiratory acidosis.
- Turn frequently to prevent pneumonia, urinary status, DVT.
- Any post OP pt requires diaphragmatic breathing (IS) exercise.
- Pneumonia is possible when lack of mobilization.

***Orthopedic***

- Hip # pt → assess for neurovascular status, provide pain Rx, Encourage deep breathing and coughing exercise change position and ambulate as much as possible and early.
- Hip # pt → prevent internal rotation and adduction.
- Hip # pt → during ambulation walk at unaffected side (good leg side). [Do not be on the effected fractured side]
- For cast check leg for edema for circulation.
- <u>Cane</u> should be <u>held on the affected side</u> [not on affected side].
- Compartment Syndrome is mainly d/t trauma e.g. fall and accident R/T fractured.
- Compartment Syndrome SS→ severe pain increases when planterflexion, tender and tense muscle in a calf and Paresthesia.
- Paresthesia is a sensation of tingling, burning, pricking, or numbness of a person's skin.
- Osteoporosis etiology is Smoking, Low calcium diet, sedentary lifestyle.
- Incomplete Spinal Cord Injury SS→ voluntary motor and sensory function below the injury.
- Complete spinal cord injury do not have sensory and motor function.
- C3-C4 is RT respiration so need mechanical ventilation and Cortisteroid given to reduce damage.
- Broken bone cause contraction of muscle so leg become short + lack of coordination cause external rotation.
- Broken bone shortens so we use traction to pull.
- For <u>pedal pulse always check for symmetry and amplitude</u>.
- Cast pt need in bed exercise. Cast can interrupt the circulation.
- Rheumatoid arthritis gives pain during morning when awaken and long rest by stiffness.
- After amputation pt need to be in functional alignment so that stump can move easily.

- To lift pt keep your feet apart to extend and lower the centre of gravity.
- C0-C4 effects the breathing so it effects lungs. Heart does itself. T5-T12 effect bladder and urinary so when pt breaks T5-12 need catheter to manage bladder otherwise it effect heart as dysreflexia autonomic problem (=cause hypertension when sympathetic NS is stimulated).
- Open fracture - infection prevention is main priority.
- Arthritis is not related to sedentary lifestyle. It is related to hereditary, ..
- Naproxen is bone pain metastatis.

***Burns***

2nd Degree : Partial burn, pain still there since receptor are not damaged.

- More body surface more fluid loss. So when full thickness burn BP ↑.
- Mechanical ventilator the fluid level in the nanometer fluctuates with pt's respiration.
- Alkali burn use weak acid and Acid burn use bicarbonate.
- Supportive nursing care is provided to care wound immediately when no doctor's order made yet. Doctor's order required.
- When bitten by raccoons first aid is to clean with soap to clean virus at first place.
- Incomplete spinal cord injury is when spinal cord is still intact but d/t inflammation it will break and turn complete. So it is very important to give hydrocortisone to ↓ inflammation within 4-6 hours.
- For burn pt first take vital, skin Turgor, age and wt then pt gets Ringer Lactate RL and watch for kidney failure.
- Burn pt priority is to watch pulmonary stress coz burn cause inflammation with block airway.

***Blood Transfusion***

- If blood is transfusing and pt fills chills and headache stop transfusion but if IV is given slow down to keep vein open.
- Hemolytic Transfusion Reaction is mainly due to failure to verify the pt name tag.
- Reaction SS is Chills, low back pain, dyspnea, itching.
- Blood transfusion – all unit should be initiated within 30 minutes of receiving from bank and should run NO faster than 50ml/hr for 1st 15 minute.
- RBC is given only with 0.9 NS.
- When whole blood cell given nurse should look for acute transfusion reaction which include Pruritus (itchiness rashes). Other common reactions include fever, chills, or urticaria, SOB, red urine and LOC ↓ may be the first indication of a more severe.

***NG / Chest Tube / PICC / Tracheostomy***

- NG Tube cause nausea and abdomen distension.
- Most important to check placement by aspiration and ph only then important to measure the length of the tube. Also check patency and amount of drainage. But placement is most important.
- Suctioning should be <10-15 sec only and done when enough respiration and $O_2$.
- Suctioning when neck hyperextended and turned one side and position pt in semi fowlers position and hyperoxygenated.
- Chest Tube → Check dressing and tube for drainage. Assess cuff pressure for minimal air leak.
- When PICC is inserted we do X-ray to see any pnumothorax or puncture so auscultation not required coz x-ray does both.
- Tracheostomy – deflating cuff means pulling suction so no need to give $O_2$. But when inserting give $O_2$ plus no more than 10 sec.
- If chest tube is disconnect tell pt to cough or exhale forcefully then cover immediately.
- For Chest tube → Palpate crepitus (air in plural area). Drainage is 100-300 ml first 3-4 hr then <1000ml in 24 hr.
- Formula is liquid (Not Chemical), e.g. rise of formula means rise of fluid level increased to be over flow.
- During NG tube insertion watch for cyanosis.
- Tracheostomy care use sterile globe as it is risk for infection.
- Tube feeding- nurse need to put him on right side before and after tube feeding coz of pyloric sphincter.

***IV Catheter / Foley / Ostomy***

- IV good for 24 hours intermittent (not using regularly).
- IV overload is circulatory overload→ Pulse ↑, RR ↑, Wt ↑, Jugular vein distension, frothy sputum.
- IV Rx bypass peripheral circulation and ↓ pain fast, e.g. morphine takes only 5 minutes to work.
- If pt is constantly pulling nesogastric tube d/t delirium, providing private room do not solve problem he will still pull so the answer is reorient the client frequently and schedule ahead of time.

- Intermediate catheter do not need iodine clean up coz it does not go all the way inside also it comes out immediately so ↓ UTI.
- Indwelling catheter goes further inside and stays there for longer it ↑ the chance of UTI.
- Do not perform digital discompacting to a cardiac pt coz of vesovegal syndrome.
- IV-Phlebitis SS→ Red line, pain, edema so first d/d IV then apply warm compress to enhance inflammatory response.
- Catheterization do not need special consent as it is routine practice of consented major procedures.
- NS is isotonic solution.
- More IV given urine becomes lighter color like straw color. [Straw color is lighter than amber color].
- Fluid Restricted pt → arrange more fluid during day than night.
- Ileal Conduit also connected with urine so urine drain continuously.
- Urinary incontinent pt take pt to bathroom before bed. [Routine bathroom for pee does not work].
- For Ostomy pt, low residue diet (no bowel irritating diet) is good.
- Low residue diet is Lean Roast Beef, butter white Rice, Egg, White Bread, Tea and Sugar.
  [Not vegetable and juice d/t celluloid and No cream as it contain lactulose which irritates colon]
- Ostomy R/T emotion cause intestinal peristalsis and are risk for enema. Coz Hemopoietic factor like V-B12 (extrinsic factor) are not able to observe. V-B12 observed in last part of ileum.
- Stoma Hernia is used to protect skin. Same like AM BM encourage pt to drain bag at same time routinely.
- IV need to flush with heparin, need change 24-72 hr, need to monitor for infection but do not need rotation of IV site.
- Valsalva maneuver (holding breath) to avoid air embolism during IV.
- Thrombosis is main cause of IV occlusion so need regular flush.
- Catheter mal position cause pain.
- Daily weight is taken to see fluid balance.

***Pain / Fever Management***

- Pain Rx takes only ½ hr to work so if does not work ask doctor to ↑ dose.
- PCA has a lock out period and takes about 15 minutes to work so let pt know.
- PCA Morphine when used 2-3 days may be addicted.
- PCA ↓ RR so main priority is to watch for RR rate and depth.
- If presser ulcer is not blanching when pressing just apply transplant film dressing, doughnut cushion is not good at coxys.
- Pt taking Morphine also takes NSAID to ↓ the side effect of Morphine.
- Non Rx management include message, warm/cold application, guided imagery and tens to alleviate (↓) pain.
- Injection site at IM Iliac Crest greater trochanter between $2^{nd}$ and $3^{rd}$ finger.
- What questions would you ask to determine his coping abilities? How is this illness impacting you and your family?
- Pyrexia – high fever id d/t dehydration and convulsion.
- Febrile convulsion occurs in minor illness so if seizure occur do nothing just keep environment safe, not even $O_2$, just observe.
- Sedative is common practice for small babies before other procedures like IV. So give sedative to put IV for baby.
- Injection apply warm soaks to vasodilate to reduce pain.
- If pt request pain Rx and it is not time yet, always ask doctor to increase dose. 30 min rule do not apply.

***Wound Management***

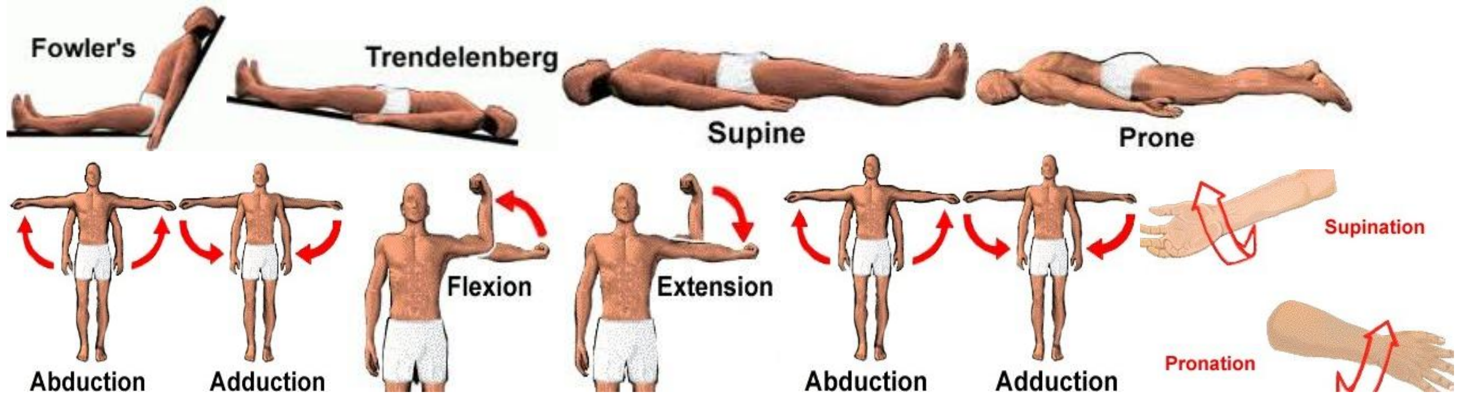
- Swab is taken after cleansing the wound.
- Surgical site infection is d/t natural skin flora entering to the wound.
- Incisional Infection SS is Purpulant drainage (pip), Temp ↑ 38, Pain.
- Wound healing requires short proliferative phase which requires amino acids as building block (so nutrition helps faster the proliferation process).
- Abdominal aneurysm can be heard at abdomen by auscultation to see bruit.
- Reactive Hyperemia → when red spot blanches to white and returns when finger is removed. [React with finger].
- Shearing forces is associated with immobility. When redness seen scan for blanching.
- Serous drainage is clear watery plasma.
- Sanguineous is fresh red blood.
- Purulent is thick yellow foul smelling d/t/ infection. PIP.
- Hydrocolloid is enzyme dressing to remove narcotic tissue.

***Isolation Precaution***

- Antibiotic Resistance like MRSA need contact precaution [Not Isolation or other precaution].

- SARS, like TB, Severe acute respiration syndrome is transmitted by droplet within 3 ft.
- Vericela – Chickenpox is airborne so it requires mask.
- Needle stick injury is per-cue injury.
- Chickenpox are not transmitted when lesions are curst.

### *Position*




- Sims Position: For unconscious pt. Normal side sleeping position with head to side is better to prevent choking by tongue.
- Fowlers Position: Good for asthma pt also good to ↑ $O_2$ and ventilation for conscious pt.
- Chest pain, dyspnea, anxiety put pt on fowlers position, give $O_2$ and ordered Pain Rx.
- Pulmonary Embolism d/t DVT put on Fowler position, give $O_2$, and call doctor.
- Thrmbophlebitis, DVT, pt need complete bed rest and feet is elevated.
- One Side Rail up is to provide mobility needs not for safety.
- Air embolism pt is left side in deep trendelenburg position. [Not right side coz heart is in left side].
- Cardio pulmonary disease need semi fowler $45^o$ position.
- Heart Pt put on High Fowler $90^0$ position to reduce lung congestion and to reduce venous return.
- Supine is worst for all CV pt. Coz abdomen presses the diaphragm to cause difficulty breathing.
- Supine is only good for spinal or cervical injury pt.
- Heart pt is also good for orthopenic position (like napping in table) coz diaphragm ↓ down breathing makes easy.
- Tracheostomy care put on straight position not semi-fowler position.
- Pt with snoring sound means tongue blocking so put them in side position no other position.
- Supine position is good for newborn as it decrease risk for SIDS.
- R/L Side position with their head flat is the best sleeping position for New Born. [Not backs]. Back after few weeks.
- Trendelenburg position also test to confirm varicose vein and vein valve after vein is fixed keep supine with feet elevated.

### *Emergency Care*

- When pt is unconscious → call Code and do CPR until status is finalized.
- For DNR pt, do not need vital call doctor no supervisor and do not perform CPR.
- Life saving procedures and unconscious pt no need of consent.
- If wrong RX is given notify supervisor if doctor is unavailable but nothing to do with pharmacist.
- ICP is indicated by widening pulse pressure (difference between Systolic and Diastolic) and Bradycardia.
- Rattling sound indicate obstructed airway, so clear airway, highest priority.
- When pt falls unconscious first is to assess by asking "Are you ok" to check LOC then ABC.

### *Admission / Discharge / Rehab Teaching*

- Orientation phase comes first when pt enters to the unit.
- When pt is discharge nurse can tell the pt to call the unit anytime when pt has a problems.
- When pt don't know after teaching → review teaching method and add or modify new teaching tools or approach.
- When teaching assess pt's past experiences.
- Maintain independence is when pt knows how to take care herself.
- To reduce stress and anxiety explain procedures and routine.
- Cannot follow direction → loss of abstract thinking disability.

- Cannot measure distance → impaired judgment.
- Past experience, understanding of illness and coping abilities is most influenced for current illness and emotion.
- Reinforcement is key to increase independency level.
- For $O_2$ taking pt teach fire safety (first priority).
- For DIMM child teach parent and child to give injection before d/c.

***Group Therapy***

- Group therapy creates a new learning environment. In Group therapy nurse focus on how pt's feelings affect their behavior.

**Mom and Baby**

**Fetal Development**

1. Gametes : 23 Chromosome at Ova and Sperm Both goes under meiosis to divide nucleus.
   Female XX Male XY If male sperm got X then girl if Y then boy.
   Abnormality : Chromosome Turner Syndrome : No Y. Klinefelter's Syndrome : >= 2 X
   Down Syndrome : CH 21. Mutation d/t x-ray, radiation & chemical cause hypotonia (↓ muscle tone).
   Down syndrome is also R/T cardiac problem so monitor heart sound.

   Blood : OO→ A A + O/A → A B + O/B → B AB → AB

2. Fertilization : 1-24 hr at fallopian tube at 1/3 down. Sperm must be within genital tract within 4-6 hr.
3. Cleavage : Zygotes make mass cell called morula that descends.
4. Implantation : 7-8 days after fertilization.
   Ovum is only viable for 24 to 36 hours. Ovulation happens about 14 days prior to menses.
   Ovulation can be determined by basal temperature.
   Before ovulation Estrogen ↑ and basal temp ↓ when ovulation occurs Progesterone ↑ temp ↑.
   Since infection and stress ↑ temp these alter basal temp similar to ovulation.
   Bicarbonate douches reduces acidity in vaginal canal to reduce ph related infertility.
   Implantation can be tested 1-2 days of ovulation coz Chorionic Gonadotropin is present in urine.
   D/t Chorionic Gonadotropin mother feels morning sickness.
   To calculate LMP use day of menes not the day of some spotting, it can occur after pregnancy.

Pregnancy Sign :
- Goodell's Sign : Cervix softening
- Ladin Sign : Cervix softening but with increase vascularity.
- Hegar's sign : Lower Uterine Softening.
- Chadwick Sign : Cervix and vaginal mucosa becomes purple.

Mom can visit hospital when contraction is about 7-10 not when 10-15 minutes apart, too early.
True labor always brings progressive cervical dilation and do not change when activity.

Placenta : Dual origin (maternal and fetal side). Change of food, gas and waste. Functions as fetal digestive tract, lungs, kidney, glands to produce all hormone. Allow barrier against harmful Rx and organism.

Umbilical Cord : Attached central of placenta to fetus. AVA. 1 V for nutrients and 2 A for waste.

Amnion Fluid : After 12 days from to protect baby as cushion, temp and pressure. Amnion membrane=bag.

Embryo : First 7-8 week embryo then called Fetus.

Fetus :
- 2 wk → Heart, Brain, Spinal Cord and Some Muscle.
- 4 – 5 wk → Bud of arm & leg, fingers. All as cartilage + Umbilical Cord visible.
- 7 wk → Bone at arm and legs.
- 8 wk → All other growth and development occurs. So in this 1st trimester no Rx.
- 12 wk → Heart audible with doptone. Baby moves and swallows.
  To accommodate fetus, uterus rises out of pelvis and becomes abdominal organ.
- 16-20 → Mom can feel fetal movement. Vernix and laguno covers the body.
- 20-24 → Eye closed, heart audible with fetoscope.
- 24-28 → Eye open, amniotic fluid ↑, and lungs makes surfactants ↑.
- 28-30 → Fat deposit ↑. Third trimester when baby grow rapid.

32-36 → Protein storage ↑.

Above timeline can be asked differently e.g. Mom get rubella in first trimester which organ effected.

Circulation : Foramen Ovale → R/L atria to bypass lungs. Ductus close in 1hr of birth.
Ductus Arteriosus → Pulmonary trunk and aorta to bypass lungs. Heart murmur common < 1 mo.
Ductus Venous → Umbilical vein and venacava to bypass to liver.
Tidal air also increases as the lower rib began expansion to let larger air intake.

**Pregnancy Issues**

PIH SS : Edema, HTN, Proteinuria after >20 wk. Disappear in 6 wk of birth, Epigastric Pain, Blurred Vision.
Gestational HTN : BP ↑ but no Edema and Proteinuria present.
Preeclampsia : Systolic BP ↑ by 30, and Diastolic BP ↑ by 15. Edema. Proteinuria.
Eclampsia : Seizure and coma, HTN, Edema and Proteinuria.
HELLP : Hemolysis Elevated Liver Enzymes Low Platelet Count --> Pain around UR Quadrant, Proteinuria.
Low PLT and RBC d/t broken RBC.
Nursing Care : Increase protein to 60g daily, Increase calories by 10%, Require sedation to promote rest.
Monitor IO, Insert catheter, Monitor Mg, Maintain seizure precaution.
Limit visitors and maintain quite environment. Assess anxiety and concern.
Normal salt diet is ok also to reduce feet edema (Edema= elevate feet and take adequate fluid).

Threaten Abortion : All or some productions of conceptions are expelled.
Threatened: Cervix is closed. Incomplete: Some expelled. Missed (no expelled but fetus dies).
Spontaneous abortion cause hemorrhage and infection abortions cause by germ defects.
Spotting stain may indicated threatened abortion.
When the abortion occurs check the fundus for firmness to see bleeding before calling doctor.

Nursing Care : Bed rest, Blood count, Blood type, RH, Anxiety, Pain, Length of Pregnancy.

Epotic Pregnancy : Implantation at fallopian tube, abdomen, ovaries or cervix. SS only by ultrasound.
Nursing Care : Internal bleeding to lead shock, radiating pain, blood replacement, Rx, surgery.

Placenta Previa : Implantation at lower uterine. SS Bright red bleeding, hemorrhage, painless, possible infection.
Nursing Care : Shock, Blood replacement, C-sec, FHR up/down, Anxiety, No vaginal examination allowed.

Placenta Abruptio : Premature separation of placenta. SS Pain, Dark red bleeding, contraction, , hyper fetal activity.
Nursing Care : Hemorrhage, Bed rest, Lt side lying, vasodilatation Rx to relax smooth muscle.

Gestational Diabetic: Pt with gestational diabetes requires ↓ insulin. Baby will be large >4kg (=macrosomia).
Hypoglycemia and preterm baby, HTN are common.
Baby of diabetic mom is kept in special high risk care. Huge baby d/t increase glucose utilization.
D/t moms high insulin baby gets hypo with tremors, apnea, cyanosis and lack of sucking ability.

Episiotomy : REEDA, Get note, Sitz bath, Kegel Exercises and Low-residue diet.

Pre-term Baby : Fat ↓ , Wrinkle skin, laguno at face, absent eyebrows, poor cartilage at ears (SC fat ↓=feels cold)
High risk for jaundice and respiratory distress d/t lack of surfactant Rapid RR (=Atelectasis).
Newborn metabolize fat to keep warm use fat which is not good.
Ratio of head is larger than chest, poor heat regulation, Cyanosis, shrill cry,
More than 200 cal/kg required. Risk for hypothermia, hypoxia, aspiration, airway, infection.
Underdeveloped kidney produces large amount of urine d/t reduced GFR ↓.

Discomfort : Mild Hyperthyroidism so Insulin ↓ deficiency So mom gets ↓ glucose and baby gets ↑ glucose.
Progesterone and Estrogen ↑ up to 6 months to prevent contraction before time.
After 6 mo Oxytocin ↑ cause Progesterone and Estrogen ↓ cause Contraction ↑ makes ready for birth.
After birth Oxytocin contracts uterine and when placenta out prolactin release to let milk down.

During 1st at the pelvic and during 2nd and 3rd at abdomen.
Constipation d/t hyperperistalsis, lack of fluid, hemorrhoids, progesterone ↑.
HCL ↓ cause nausea and pyrosis (heart burn).
At 1st and 3rd cause urinary frequency and cause lower specific gravity.
Blood volume ↑ by 50% (75 plasma 25 RBC) which cause HCT level ↓.
Increased blood volume also cause physiologic anemia.
Cardiac Output ↑ by 25-50% $O_2$ Need ↑ 15%. HR ↑ 10-15 BPM cause palpitation
At 1st and 3rd BP ↓ RR ↑ cause lightning at 38 wk and slow down.
Baby FHR is NOT twice of Mother (mom's variable baby=120-160). It is rapid so tell not to be worry.
Most common is SOB on exertion d/t high demand of $O_2$ and elevated diaphragm.
Cause hyperventilation to blow off the $CO_2$ produced from baby.
Supine Hypotension Syndrome Palpitation, headache, faintness, edema, varicose at leg & perineum.
D/t Estrogen ↑ Nasal Congestion and d/t fetus waste cause skin diaphoresis.
D/t Estrogen ↑ and Relaxin ↑ bones becomes soft and hypocalcaemia cause leg cramps and fatigue.
Ectopic pregnancy cause sharp knife like lower abdominal pain that radiates to the shoulder.
During first trimester frequency of urination increases d/t ascending uterus.

Nursing Care : For Nausea avoid tea, coffee, chocolate, spicy food, fried food
Eat smaller meal often. Avoid antacid. Avoid fluid with meal. Reduce fat and increase carbohydrates.
For gum softness to cause gingivitis → regular oral care needed.
D/t ↑ estrogen cause ↑ saliva (ptyalism=excessive saliva.)
No calorie reduction and weight bearing exercise during pregnancy.
Increase Protein, Vt, FA (FA 3 months prior conception), Iron, Iodine, CA, Zinc, Sodium.
Gain weight 15 kg for slim and 11 kg for obese.
Avoid ALL drugs, alcohol and smoking during first trimester.
Sex during pregnancy is contraindicated only when ROM occurs to prevent from infection.

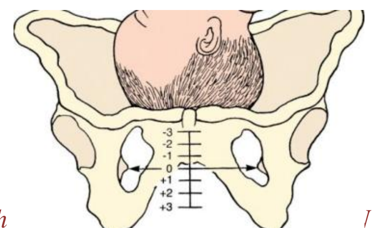
Weight Gain : Fetus →10 to 15 kg, ~50%. Fluid Retention→ 25% Increase blood volume → 15%.
Pattern of weight gain is more important than total weight. 11kg is recommended.

Huhner : To see number and condition of sperm (Huhner-male).
Rubin : To see patency of fallopian tubes (Rubin=female).
Papinicolaou : To see cervical cancer (also called pap test=female).
Biopsy : To see any area with tissue sample.
Cystoscopy : To see urinary bladder.
Culdoscopy : To see female pelvic area.
Hystero…gram : To see all uterus, tubes and pelvic organs of reproduction.

HcG Test : HcG and ultrasonography to see fetal heart. Ultrasonography also tells fetal position and placenta.
EDC : 9 mo+7 d. 9 Calendar Month or 270 days or 10 lunar mo / 280 days.
Fundal Height : Symphysis pubis to the top of fundus, 1 cm per wk, 20 wk at umbilical and 36 wk below xiphoid.
Immediately after birth fundus is at midway between Symphysis and the umbilicus.
Ultrasound : To measure head to find EDC. Pt must have full bladder so encourage fluid intake.
Lab : Blood group, RH Antibody, Hematocrit and Hgb.
Rh : When Rh-ve mom have Rh+ve fetus, antibodies cross the placenta and destroy fetal RBC causing acute hemolytic anemia.
Disease Test : Rubella, Hip, HIV, Syphilis, Genetic, Glucose, Mantoux. Tay for Jewish and Sickle cell for African.
Initial Ax : Base line vitals, EDC, Full vital and weight.
Monthly Ax : Edema, Supine Hypotension, FHR, Fundal Height, Glucose, Albumin, Ketones, Acetones.
Dx : Self Esteem, constipation, Reduced cardiac output, fear, anxiety, altered elimination, risk for trauma.

Presentation : Fetus body to mom pelvic → Cephalic Breech Transverse (need C-sec)
Position : Fetus presenting part to mom pelvis 4 quardants (R/L O/M/S A/P)

| | | | | | | |
|---|---|---|---|---|---|---|
| Occipital | : | Vertex | LOA | LOP | ROA | ROP |
| Montum | : | Face | LMA | LMP | RMA | RMP |
| Sacrum | : | Breech | LSA | LSP | RSA | RSP |



Station : From pelvic level 1→ Floating (Above) 2→ Engage (At) 3→ Station
Station Below Spines +1, +2, +3 Station Above Spines -1, -2, -3.

Fluid : Fluid S-ROM : During mid or late labour but can occur before.
Fluid A-Rom : Done at Lower Station (0, +1, +2) station.
Nitrazine Paper : Dark blue menses ready to birth d/t alkaline.
Color : Straw color, greenish indicate me conium, non offensive, musky order, 1 liter.

**RX During Birth**

Oxytocin : Stimulates contraction so given after contraction begins.
Mom SE → HTN, Tachycardia, Dysarrhythmias, Uterine Rupture, Seizure, Comma, Water Intoxication.
Baby SE → Bradycardia, Hyperbilirubinemia, Anoxia, Asphyxia, Dysarrhythmias

Nursing Care : Never leave mom, have $O_2$ ready, Use IV control device, Monitor Contraction,
Check BP and HR q 15min, Monitor FHR, Evaluation and Teaching.
Oxytocin given only when monitor is possible and normal condition.
Oxytocin increase strength of contraction which cause uterine tetany (=muscle cramps).

Prostaglandins : Used to soften the cervix if bloody show (unplug) is already happen it is not necessary.
AROM is done when cervix is soft, effaced and dilated but there is NO contraction.

Analgesic : Sedative → Lorazepam (Ativan) to relax.
Entonox → Laughing gas to control and aid of breathing.
Narcotics → Demerol IM.
Pudendal Block → To numb the perineal area when full dilation to relief pain for tear.

Regional : Epidural → Local anesthetic in epispace, pain relived below breast also to prepare for C-sec.
Spinal → For C-sec only to paralysis all motor and pain.
General → Only for C-sec.

Nursing Care : Observe Mom and Fetal Respiratory Status. Evaluate mom's response and teaching.
If hypotension occurs position mom on left side, increase IV and give $O_2$.

**During Contraction**

Nursing Care: Tachycardia (>160) d/t fluid ↓ and Rx so check mom temp and increase fluid.
Bradycardia (<110 for >10 min) d/t hypoxia or Rx, mom hypotension, cord compression.
Reposition mom on side, assess prolapsed cord, elevate moms lower extremity, give $O_2$.
Take temp and pulse (increase indicate infection or dehydration).
Hypertension (=preeclampsia) and hypo (d/t Rx).
FHR Abnormality d/t fetal distress so give $O_2$, change position, reduce Rx and increase IV.
Teach breathing technique based on stage of labor and contraction.
Encourage ambulation to help fetal descend.
Amniotic Fluid's color=should be colorless with white specks of Vernix caseosa,
odor (foul indicates infection-"itis").

S/S of Labor : Lightening d/t fetus falls on pelvis.
Braxton Hicks d/t contraction for true labor → Contraction # ↑, Strength ↑ and Duration ↓.
Secretion ↑ Ripening and softening ↑, ROM, Bloody show (d/t unplug expelled Blood)

Stage : 1st : Latent→ 0-3 cm Short Contraction Happy/Excited Follow direction and listen nurse. \
Priority at this phase is to establish trust and welcome to the unit by introduction.
Active → 4-7 cm Strong Contraction Bloody show
ONLY Rx, support and comfort need NO education coz pt don't want to listen & follow.
Transit → 7-10 cm Strong every 1-2 min lasting 45-60, bloody show,
Pt is irritable, agitated, tremor, perspiration, nausea, vomit, BM & don't follow direction.
Bright-red painless bleeding may indicate placenta previa.

On each contraction perineum bulging occurs which indicate immediate birth.
On each contraction pt has to push with glottis open to hasten birth.
Meconium stained fluid may indicate breech position or sign of fetal distress.
When pushing watch for FHR. Encourage deep breathing.
Pt is ok to walk or up, walk or standing up even improve contraction and help birth.
When ROM occurs prolapsed cord leading fetal stress may happen so monitor FHR.

In any phase changing position often helps to reduce back pressure. So tell to change position.
These there phase, risk of aspiration is higher so hold any food coz undigested food cause NV.
Place both legs at same time which reduces the trauma to the uterine ligaments.

2nd : 10 cm to Birth, leg cramps common, grunting, irritability, perineum bulges. Monitor FHR.
3rd : Birth to Placenta separation 5-30 minutes after birth, laceration.
Clear airway of mucus.
Use APGAR to see respiratory distress and physical status. >=7 at 5 min is good.
Maintain heat and dry skin. Admin eye Antibiotic and Vit K IM.
Give mom and encourage bonding.
Assist delivery of placenta and document.
RH-ve mom need immunoglobulin (Win Rho or HypoRho-D)

| APGAR | (0) | (1) | (2) |
|---|---|---|---|
| HR | Absent | <100 | >100 |
| Respiratory Effort | Absent | Weak Cry | Strong Cry |
| Muscle Tone | Limp/Flaccid=4 | Some in Extremities | Active |
| Reflex | Absent | Grimace | Cry |
| Color | Cyanotic | Body Pink Ext Cyanotic | All Pink |

7-10 Good 3-6 Moderately depressed 0-2 Severely depressed (Need CPR).

4th : Placenta separation to 4 hours.
Discharge Lochia Rubra, chills, nausea, excitement, fatigue, dozing, firm fundus.
Check fundus q15 min, bladder, perineum, vital,
Give Oxytocin to increase contraction decrease bleeding.
Check episiotomy (apply ice bag/cold compress to reduce edema, after 24 hr sitz bath).
Keep mom warm, give fluid and food as DAT and obtain cord blood sample.
At home encourage kegal exercise to strength pelvic muscle.
Encourage high protein and high calorie diet to restore loss.

Phase : Taking in → Mom don't care baby don't touch or caries.
So talk about mom not about baby and fulfill need of mom.
Transition → Take and carry baby, talks and touch finger.
Taking Hold → Kisses, embraces, eye contact, call baby name, hold tight.

**Intrapartal Period**

Nursing Care: Mom → Watch for hypovoluminia d/t muscle relax and hyperventilation d/t labour.
Watch for pain, urinary retention d/t anesthesia.
Baby → Watch for impair airway clearance d/t mucus, meconium aspiration.
Watch for decrease cardiac output and injury d/t birth pressure.
Watch for ineffective thrmoregulation d/t ↓ heat, lack of shivering and fat breakdown.
Should void within 24 hr and by 2 week 20/day.
D/t dehydration albumin and urates brick red stain is common.
Looses 5-10% wt in first week and from 2nd week gains.
Metabolism screening test done within 48 hr.

**MOM AND BABY**

- After birth, pt should void within 4-6 hours. If not first palpate (assessment), then encourage (intervention).
- Full bladder cause, infection, bladder atony and postpartum bleeding and displaced fundus.
- Frequent small void indicate overflow so palpate for distension. Sneezing is common after birth.
- Ambivalence and anxiety about mothering are common. Give support & enough time for her to inspect baby.
- Offer help and let dad go outside if he is not feeling well. Once birth if mom suspect unwrap the baby.
- No matter the outcome, bring the baby to parents asap, bonding is first priority.
- With hold extraordinary care means let new born die naturally but euthanasia is intervention to let die.
- When mom is discharge she has a right to take her baby home no matter the situation.
- Metrorrhagia is bleeding beside menses caused by endometriosis (extra tissue) to prevent pregnancy, painful.
- Hysterectomy is removal of uterus so means stops but all hormone continues.
- After birth, immediate contact to mother is basic priority.
- Adolescent Pregnancy is high risk d/t lack of physical, emotional maturity and meet of developmental task.
- Menopause is caused by inability of ovary to respond Gonadotropin hormone treated by Est & Pro hormone.
- Osteoporosis, decrease bone substance, requires weight bearing exercise like walking and calcium.
- After delivery encourage to mobilize coz d/t ↑ clotting factor mobilization increase peripheral vasomotor activity.
- Cow milk has more protein, more calcium and less carbohydrates.
- Don't wash the breast with soap. It can irritate breast.
- For home visit priority is the convenient for the family.
- Leg cramps may be d/t hypocalcaemia so tell pt to take milk.
- Immunity via placenta is passive natural d/t from mom and d/t birth.
- Precipitous birth maintain baby's airway first (by putting head lower than chest rubbing back to make cry to get $O_2$.
- APGAR score does not deal with Respirator Rate it deals with Respiratory Effort but most imp is HR if >120<160.
- New born assessment 1. Respiratory 2. Temp 3. Pulse. [RPT]
- Respiratory Rate is irregular, abdominal, 40-60 BPM and shallow.
- Changing baby equibilirum is the best way to see moro reflex not by loud noise (test hearing and startle reflex).
- Newborn intestine are sterile so bacteria is not there to synthesis prothrombin.
- Teaching don't depend on schedule coz it is as it comes when teaching give and show example.
- Regurgitates d/t underdeveloped cardiac sphincter.
- Smoking cause vasoconstriction to both mom and baby.
- Bed rest mom need lye on her side lying position with small pillow to perfume baby and to reduce cervical pressure.
- Teen pregnant are linked with PI HTN.
- Multiple gestation is linked with perinatal mortality also linked to uterine dystocia (stretch).
- Placenta Previa is painless vaginal bleeding but Abruptio Placenta is painful.
- Both need complete bed rest (not limited bed rest) to delay birth coz preterm possible. Priority is record bleeding.
- When heavy bleeding, pain and hard fundus it indicate Abruptio Placenta (complete) so prepare for C-sec.
- Hard fundus is coz blood is stopped by placenta also cause pain.
- Bleeding is when lack of fibrinogenemia (hypofibrinogenemia), PTT also but second.
- PIH is related to Abruptio Placenta.
- Premature labour needs as minimum medication as possible.
- PPH are d/t multi-fetus birth, uterus atony, retained placenta fragment, over distended bladder, hydrominos.
- Main indication of C-sec is cephalopelvic disproportion.
- C-sec mom gets Oxytocin to contract uterus since palpation is painful. Oxytocin clamp the blood vessels.
- Preeclampsia pt needs quite room without any stimuli.
- Seizure and high temp may occur d/t malfunction cerebral thermal center.
- Breach delivery cause compressed or prolapsed cord to injury baby so put mom on trendelenburg position (coz mom head below hip to reduce pressure).
- After 4-5 mo cardiac acceleration increases HR ↑. Plasma ↑, Hgb ↓ after 34 wk cardiac output also ↑.
- After delivery there is huge shift in blood which makes heart most compromised by creating extra burden.
- Cardiac compensation also associated and anemia coz in anemia O2↓ so heart need to work harder.
- Sleep Position → Semi-flower = ↑ $O_2$ Sideling (left lateral) - ↑ Circulation Elevated shoulder.
- Elevated shoulder relieve pressure on diaphragm to ease breathing.
- Rheumatic Arthritis pt gets antibiotics after delivery.
- CHF and Respiratory distress always go side by side (CV).
- DIMM moms carbohydrates and lipid metabolism alter metabolism so also ↑ insulin after $2^{nd}$ half of pregnancy.
- DIMM moms should not decrease calorie should increase to meet demand of fetus.
- Street moms need assessment of drug abuse and R/T risk of low birth wt.
- Hep B can be transmitted thru transplacentally or during vaginal delivery.

- Pin worm lay egg during night so cellophane tape is effective in morning before bath and waking up.
- Pin worm Rx should be used by all family members.

**Newborn Assessment**

Appropriate Gestational Age (AGA) : 10-90 % LGA >90 SGA < 10or 250 gram
Term : 38-42 Preterm <37 week Postterm >42 (d/t placental insufficiency)

Vitals : BP : 65-80 / 30-40 HR : 100-160 RR : 30-60 TMP : 36.3-37.3 (axilla)
Head : 32-37cm Chest : 30-33 Length : 46 - 56cm Weight : 2500-4000g

- Weight is not considered to define preterm, term or post term only week.
- Pathologic Jaundice appears during first 24 hours. Jaundice after 24 hr d/t immature liver to breakdown excessive Hgb but abnormal <24 Hr.
- Apical Pulse of the heart (Below L Axilla) Brachial pulse at arm by finger femoral at rowing.
- Anterior fontanel=Diamond; Posterior fontanel=Triangle; Fontanel should be flat. If bubble ICP. if Hydration if depress.
- Eye ointment is within 1 hr.
- Top of penea is level at outer canthus of the eye. Low is chromosomal abnormality. Tag=renal malfunction.
- Recoil to determine gestation.
- Nose flaring is to increase size.
- Face drooping is by nerve damage during birth. Paralysis.
- Epstein Pearl is white milky teeth removed by dr.
- Circum moral cyanosis around lips -make cry should be gone.
- Suck by touching check side turns that side. Reflex is less active if preterm.
- Breast bud beneath nipple and breast enlargement to determine gestation also due to hormone.
- Check abdominal bulging to see hernia or disturb intestine.
- Observes cord clamp secure and holding only umbilical cord and not skin
- See cord stump should have 2 A 1 V.
- Meconium must be before 24 hr.
- See pilonidal dimple/sinus and gluteal folds for symmetry. If gluteal folds is not symmetrical = may be fracture.
- Foot creases to determine gestation
- In female, labia majora and labia minora to determine gestation, normal discharge from vagina (white mucus + blood coz of maternal period). In male, scrotum fully rugated and testes to determine gestation and hydroseal is common.

**Reflexes**

- Rooting: touching mouth/cheek causes NB to turn towards stimulus and open mouth to suck
- Suck reflex: When an object is placed in the mouth or lips. they suck even they are sleeping
- Tonic neck reflex: baby straightens extremities on one side, and flexes those of the opposite side when laying supine
- Grasping: grasp object when palm stimulated.
- Babinski: Upward stroke from heel in "J". Babinski and plantar grasp reflex=when finger in hand/feet he covers like snake. Babinski is when stroke at heal cross tows fan outward.
- Moro reflex: When newborn is startled by a loud nose or lifted slightly above the crib and then suddenly lowered. In response, newborn straightens arms and hands outwards while knee flex. This reflex may persist up to 6 months.
- Ortolani and Barlow tests are only accurate for the first 1 to 4 week of age. After that Abduction tests is recommended and it is cost effective. Ultra sound is not cost effective but accurate. When palpating hips Ortolani sound can be heard.
- Motor function: There should be symmetric movement and strength in extremities. Head lag shouldn't be over 45 degrees. Neck adequate to maintain head erect briefly. Baby might twitch or be jerky.

**New Born Initial Care**

- Newborn (NB) dried and placed in radiant heat unit or mother's chest (skin-to-skin contact promotes attachment keep warm.
- NB put in trendelenburg position (:/)—gravity aids drainage of mucous from airways. Bulb syringe used to suction nose & mouth.
- Hollister clamp placed on umbilical cord before cord is cut. Umbilical cord stump examined for blood vessels AVA.
- Erythromycin ophthalmic ointment given prophylactically within one hour of birth. Usually done after baby makes eye contact with parents (to protect against gonorrhea eye infection)

- Vitamin K Phytonadione injection within one hour of birth. It is recommended to prevent hemorrhage (which may occur due to low prothrombin levels).
- Heart rate should be auscultate at the apex (between the 4th and 5th intercostals space). Note any variations in rate or the presence of murmurs. It is expected that the heart rate increase while the infant is crying and decrease while resting or quiet.
- Respirations are best heard in the right upper lobe. Some crackles may be expected due to inhalation of amniotic fluid. Note any signs of respiratory distress: nasal flaring, chest retractions, asymmetrical rise of the chest, cyanosis, and abnormal respiratory rate.
- Temp is very important. If too high, it may indicate dehydration, infection, or overheating; if too low may indicate sepsis. Infants exposed to GBS require more frequent monitoring.
- Use apical pulse to count. Assess in both sitting and reclining positions. Count apical rate for 1 min. Brachial or radial pulse rate should be same with apical rate.
- S1 - Location at Apex of the heart, tricuspid area and Mitral Area. S2 - at Base of the heart, aortic area and pulmonic area.
- Physiologic splitting location at pulmonic area.
- S3 - Location at Mitral area. (This is when blood rushes through the mitral valve and splashes into the left ventricle and heard in diastole just after S2.
- Listen for murmurs (swishing sound) most often closing Patent Ductus Arteriosus. Most common reason for a murmur is – Sounds are produced by blood passing through a defective valve, great vessel and other heart structures. Check for intensity, location, radiation, timing, quality.

**Skin Characteristics**

- Color should be congruent with genetic background. Color can be an indicator of jaundice, inadequate tissue perfusion, etc.
- Texture should be soft and flexible. Some peeling on hands and feet normal a sign of gestational age.
- Turgor assessed on abdomen, forearm, or thigh. Skin should return to original shape rapidly after pinching.
- Healthy newborn skin : Sin color varies with genetic background but all healthy skin have a pink tinge to their skin. The ruddy hue results from increased red blood cell concentrations in the blood vessels and limited subcutaneous fat deposits. Caucasian have pinkish red skin for few hours after birth and Hispanic and Asian have an olive or yellow skin tone. Pigmentation deepens over time.
- Post mature skin
- Laguno: It is a fine hair covering, decreases as gestational age increases. The amount is peak at 28-30 weeks and then disappears.
- Vernix caseosa: It is whitish greasy cheese-like substances, covers the fetus while in utero and lubricates the skin of the new born. Peeling is common especially on the hands and feet.
- Mongolian spots: these are macular areas of bluish black or gray blue pigmentation on the dorsal area and the buttocks. Looks like bruises and should be documented on the newborn chart. Common on Asian, Hispanic and African descent. 90% of dark skinned babies, 10% Caucasian and it fades over 1- 3 years.
- Acrocyanosis: For the first 2 - 6 hours after birth skins appears bluish discoloration of the hands and feet. It is caused by poor peripheral circulation mainly when exposed with cold. Need to check for oxygenation.
- Milia: Small white and raised spot is seen around the face especially across the nose. No treatment needed.
- Stork bite (nevus simplex): Also called Telangiectatic nevi. It appears as pale pink or red spots usually around eyelids, nose, and lower occipital bone. these areas have no clinical significance and usually fade by second birthday.
- Erythema toxicum (newborn rash, toxic rash): It is eruption of lesions in the area surrounding a hair follicle. It is also called new born rash or flea bite. It appears suddenly around trunk and diaper area but not in the palms and soles. Peak is at 24 to 48 hours of life and can last up to 5 days. No treatment necessary the cause is also unknown.
- Petechiae: It is small pinpoint red or purple hemorrhagic spots on the mucous membranes or skin. This symptom are related to the degree of bone marrow failure that cause aplastic anemia. Around groin, face, axilla.
- Strawberry hemangioma: Also called nevus Vasculosus. It is raised and lobulated capillary hemangioma. It consists of newly formed and enlarged capillaries in the dermal and sub dermal layers. It is raised and dark red in color. It is rough and commonly found in head region. it grows rapidly and after 1 to 3 months it begin to shrink to resolve. Parents are very concerned with birth mark and they may experience guilt. Nurse provide education about cause and should document.
- Port wine stain (nevus flammeus): It is a capillary angioma directly below the epidermis. It is a none elevated, sharply demarcated area of dense capillaries. Shape and size vary but commonly appears on the face. Does not resolve.
- Ecchymosis: Bruising from delivery.

**Head**: 2-3months for posterior fontanels, 18-24months for anterior fontanels. Bulging fontanels can indicate intracranial pressure where as a sunken one can indicate dehydration.

**Cephalohematoma**: collection of blood between cranial bone and periosteal membrane. Due to ruptured blood vessels. Feels loose and slightly edematous. This does not cross suture lines and usually does not present immediately (but within the first two days of life). Cephalohematoma will resolve within 2weeks to 3months postpartum.

**Caput succedaneum**: localized soft area of scalp—an accumulation of fluid in the presenting part of the skull due to increased pressure causing slowed venous return in the area. Due to long difficult labour or vacuum. Caput will cross suture lines. It is noticeable at birth and will resolve within 12hours to several days.

**Positional Plagiocephaly**: It is the asymmetrical head shape that results from infants lying in the same position over time. To prevent vary position during sleep, change toy, mobile crib positions, encourage supervised prone and side lying awake times, recognizing and treating torticollis and imbalance of sternocleidomastoid muscle early.

**Eyes / Ears / Mouth**: Around 4th days baby eyes can get conjunctivitis infected by Chlamydia trachomatis infection which cause purulent discharge. Chlamydia also associated with newborn pneumonia. Test blink reflex—should blink in response to light. Eyelids shouldn't droop. Will be puffy initially due to pressure of birth. Visual acuity is 20/100 at birth and 20/20 by one year. When head moves without eyes it may indicate motor problem. Low set ears are a sign of Down's syndrome. Ear recoil is a measure of gestational age (at less than 37 weeks the cartilage is not well formed—when folded on itself the ear will remain folded or recoil very slowly. Quick recoil is a sign of a term infant. Skin tags on the ears indicate need for renal assessment as kidneys form at a similar time to ears in utero. Note length of nipple beds, as this is a sign of gestational age. A nipple bed of 5-10mm diameter is indicative of a term infant. In infants at 41weeks, the labia majora should completely cover labia minora and clitoris. In infants of 36-40weeks, labia minora and majora are equally prominent. Prior to 36 weeks, the clitoris is very prominent, and labia majora widely separated with labia minora protruding. In a 40 week infant, scrotum is well rugated, testes are at the bottom of the scrotum. At 37weeks, testes are high within the scrotum, and fewer rogue noted. Infants born prior to 37 weeks will have un-descended testes. While infant is suckling, assess mobility of tongue and check for a short frenulum or "tongue tie".

**Food & Nutrients**: Assess by monitoring output of wet and soiled diapers in a 24 hour period. Stools from breastfed babies should be yellow and curdy. Signs that infant is hungry: active bowel movements, rooting and sucking, hands to mouth, active and alert. Crying is at the late stage of hunger. Initial feeding: The 1st feeding should be within 2 hours of birth; baby is most alert 20-30 minutes after birth. The 1st feeding is important for the nurse to assess for any problems with breastfeeding. Start with an iron-fortified cereal at 6 months of age, as iron is required for brain development. Start with just two teaspoons and gradually increase the amount each day. Introduce each new food on their own for about three days to monitor for signs of intolerance (e.g. redness around the mouth, eczema, hives, vomiting, tummy cramps, diarrhea, or if serious: swelling of the tongue and throat with breathing difficulty). Symptoms will usually appear within minutes to 2 hours after eating a suspect food. Timing of feeding is ideally determined by physiological and behavioral cues rather than a set schedule. Hunger cues are munching fist, fussy, smack sound.

- Calories: 110-130 Cal/kg/day Milk--> Brest Feeding : 8-12 Bottle : 6-8
- Breast or bottle feeding should be on self demand scheduled every 2-3 hr length is 20 min.
- Size of breast will not affect the milk production baby's suckling determines the milk production so attitude of mom is imp.
- Breastfed infants should be fed on cue, about 8-12 times in 24 hour. There is no schedule for feeding, depends on baby's psychosocial and behavioural cues, however, baby often eventually set a schedule.
- No breastfeeding during pregnancy it cause premature contraction. IMP, IMP, IMP. Mastitis, herpes, inverted nipple is ok.

**Breast Feeding**: Encourage mother to try different positions, warm bath to avoid common complications with breastfeeding. Optimal attachment with latching is very important. Anything that contributes to a shallow latch is going to cause nipple soreness and other complications. Hear suckling sound and swallow sound, look for weight gain, and jaw movement. Put one finger inside baby mouth to off the baby from nipple so it will reduce soreness. Baby BM will be curdy and seedy and curd like indicate hind milk. Cluster feeding are common for growth sprout at 3 wk, 6 wk, 3 mo and 6 mo. First milk is skim but hind is creamy. Feed 8-12 /24 hr. Contraindications are HIV, HEP, Substance Abuse?, Radio/Chemotherapy, (Active TB/ Vericela, Chaga's disease-ok to pump), CV Disease, Renal Disease and some Rx.

**Formula**: Use iron fortified/iron added. NEVER replace formula with: 1% or 2% or skim milk, soy or rice beverages, coffee whitener, condensed or evaporated milk.

**Solid**: Introduce rice cereal at 4-6 months Rice cereal is easy to digest-low allergenic potential, contains iron. Introduce fruits or vegetable at 6-8 months-some health care providers recommend vegetables before fruits Fruits and vegetables provide needed vitamins. Vegetables are not as sweet as fruits; introducing them first may enhance acceptability to the infant. Introduce meats at 8-10 months Meats are harder to digest, have protein load, should not be fed until close to 1 year. Introduce one new food at a time, waiting at least 3-4 days to introduce another. Delay feeding eggs, strawberries, wheat, corn, fish and nut products until close to 2-3 years of age. If a food allergy or intolerance develops, it will be easy to identify.

**Water**: Baby body doesn't instinctively demand water to replace losses so mother need to be aware of water demand. Water may be sued to quench thirst for 12 month but <12 month water is not recommended. Cow milk is also not recommended. After six months, and once your baby is drinking out of a cup, you can offer water to quench baby's thirst.

**Juice**: 0 – 6 months = Not recommended. 6 – 18 months= Juice is not necessary for baby. After 6 months, if you decide to give juice, choose 100% unsweetened, pasteurized fruit juice and offer it in an open cup as part of a meal or snack. Babies should have no more than 2 to 4 oz (120 ml / 1/2 cup) of juice a day. Juice should not be given in a bottle as this can lead to tooth decay (rotten teeth). Choose to offer baby fruits and vegetables instead. Vitamin : 400 iu daily for darker skin baby and 800 iu in winter (October-March). Solids: After 6 Month (Appendix B-7) before risk for aspiration, digestion and safety delayed lack of nutrients such as iron and VD.

**Nutrition**: BF mother should increase her calories by about 200 kcal over the pregnancy requirement. VD do not cross from milk so even mom taking baby need extra VD during breast feeding of 400 IU. Formula feed do not need.

**Elimination**

Normal urine output
Day 1: 1 void and 2 me conium stool by 24 hr.
Day 2: 2 void and 2 me conium stools. Stools may be thinning but still dark.
Day 3: 3 void and 3 transitional stools.
When mother's milk is in, 6- 8 wet diapers/day.
Uric acid crystals in diaper normal (brick colored stain).

Stooling Pattern
Meconium – dark, sticky made up of amniotic fluid, desquamated epithelial cells and billirubin.
Transitional stool – green with yellow curds.
Breast- fed baby stool – yellow curds.
Formula- fed baby stool – paler yellow, may be greenish due to iron in formula.
Should stool once daily, often many more, sometimes less.

- A single prominent crease is called a Simian Crease and is indicative of Down's Syndrome.
- Assess back of neck for fat pad (sign of Down's Syndrome)
- Note presence of pilonidal dimple (sign of neural tube defects)
- In an infant 36 weeks or less, creases will cover anterior two thirds of foot. In term infants, creases will be present throughout the foot.

**Mom Assessment**

Maternal History

| | | |
|---|---|---|
| Antepartum | : | The baby's environment while in utero |
| Obstetrical | : | The history of mother's previous pregnancies |
| Intrapartum | : | The time spent as a passenger of birth |
| Maternal | : | The mother's health in general |
| Family | : | The baby's biological family history |
| Social | : | The baby's new family |

Gravida : Pregnancy Number

Primigravida : Pregnant for the first time or who has been pregnant once.
From the time a woman gets pregnant the first time until she gets pregnant second time, she can be referred to as a primigravida (or gravida 1)
Multiple pregnancies (twins, triplets, etc.) are still just one pregnancy.

Multigravida : Who is currently pregnant or who has been pregnant two or more times (gravida 2, 3,etc.)

Parity : Number of times a woman has given birth whether stillborn or live-born

| | | | |
|---|---|---|---|
| Para 0 | : | Nulliparous | Never given birth |
| Para 1 | : | Primiparous | Given birth once |
| Para 2 | : | Biparous | Given birth twice |
| Multiparous | : | Given birth two or more times. | |

Term : Number of babies the woman has given birth to from 37 weeks onward.
Preterm : Number of babies the woman has given birth to from 20 weeks, or 24 weeks.
Abortions : Either miscarriages or induced abortions.
Living : Children the woman has, regardless of when they died or how old they were.

- Twin still consider 1 pregnancy. When mom is not interested with BF in first follow up assess baby over the phone. Also when 1 twin feed more and other fall sleep, tell to feed the sleepy baby first and other twin next. Also encourage fluids to mom.
- Estimated Date of Confinement/Delivery (EDC/D) = Nagele's rule: EDB+280=9 Mo+7 D. First day of LMP Dec 10 = Sept 17.
- When painless vaginal bleeding occur NO manual pelvic exam but Leopold maneuvers can be done.
- Ectopic rupture can occur within 3 months.
- Give priority on mom's health not fetus if given choice.
- Take "after" or "before" carefully as it tells the priority. Example Before – get support for mom abuse services. If it says "after" then after birth possibility is child abuse.
- Primpara 34wk pregnant, vomit even the clear fluid so give IV not keep her NPO coz she becomes hypoglycemic.
- Here if question says she is nor DAT do not assume she is still NPO to answer.
- Now DAT mom when vomit is controlled she can take chicken, vegetable and ginger tea.
- Teaching and learning when pt knows how to complete kick count is imp that is <3 kick in 1 hr is risk. Level of literacy is not imp.
- When home visit nurse finished talking about breast feeding next is birth control. Read question clearly what is just finished.
- Rubella – German Measles transmitted thru direct contact and indirect contact with feces, urine and fluid.
- When baby have fever of >40 degree without seizure mom can give Tylenol so no need to go hospital. But seizure, lethargy, difficulty waking up tell mom to go hospital.
- It is ok to immunize even a baby already have rubella.
- Teaching is retained when repetition and feedback. Also ask how mom likes to learn.
- Clunk sound during hip assessment of newborn is dysplasia.
- When there is a second hand smokers → discuss readiness to quite. Coz to see decision you need to see readiness.
- Post partum blues should resolve within 10 days.
- Risk of PPD is Hx of depression, unwanted pregnancy, single status.
- When mom is worried coz she wanted to be a good mother tell her to have realistic expectation.
- When other family member wants to touch newborn baby suggest them to wait until a bath.
- When pt has viral N1H1 disease with SOB and dizziness but other vitals are ok they just need supportive care coz it is viral.
- HCP and Nurse must be immunized it is a professional responsibility.
- Mom wants internet information so tell her that treatment must be examined if it appropriate for you.
- When a mom had a Hx of preterm birth and she has now contraction @ 34 wk ask her if she has Hx of preterm.
- Birth control Diaphragm should be left for 6 hours.
- HELLP syndrome is a group of symptoms that occur in pregnant women who have: H- hemolysis (the breakdown of red blood cells), EL - elevated liver enzymes, LP - low platelet count.
- When 5 cm dilated it is time to give pain Rx.
- To insert catheter during contraction do between contractions.
- SIDS RT sleeping prone or exposed to tobacco smoke are at greater risk than infants sleeping supine or unexposed to smoke.
- Uterine tenderness upon palpation is when bleeding d/t abruption placenta.
- 1st Degree Tear :
- 2nd Degree Tear:
- 3rd Degree Tear:
- 4th Degree Tear:

Fundal height or McDonald's rule, is a measure of the size of the uterus used to assess fetal growth and development. It is measured from the top of the mother's uterus to the top of the mother's pubic bone in centimeters. It should match the fetus" gestational age in weeks within 1 to 3 cm, e.g., a pregnant woman's uterus at 26 weeks should measure 23 to 29 cm. This is valid from 24 weeks.

TPR is monitored to screen for signs of infection associated with preterm Premature rupture of membranes (PROM).
BP is monitored for signs of hypertension. Normal BP during first trimester of pregnancy is less than or equal to 135/85 (falls in second trimester). Greater than 140/90 or increase of 30 mm Systolic and 15 mm Diastolic (preeclampsia).
Hypertension = vasospasm, irritability, convulsions, cerebro vascular accident, increased renal damage.
Hypertension to the neonatal: decreased placental perfusion, can lead to low birth weight, and can result to preterm birth.
ROM is premonitory signs of labor. When ROM occurs without engagement, there is danger that the umbilical cord washing out with the fluid (prolapsed cord). The open pathway increases risk for infection.
Uration When: before or during labor. Assess fluid at regular intervals for me conium staining.
Color: Normal findings – amniotic fluid clear, with earthy or human odor.
Abnormal findings - check color for signs of fetal stress (greenish amniotic fluid) and abruption placenta (bloody fluid)
Odor: Normal findings – no foul-smelling odor. Abnormal findings - check for signs of amnionitis (strong or foul odor)
Amount: large amount of bloody show may lead to false-positive results. It may be due to previous vaginal examination. Reassure woman that amniotic fluid is continually produced.
Dilation: progressive cervical dilatation from size of fingertip to 10 cm
Effacement: progressive thinning of the cervix
Station: The concept of "station" denotes the degree of engagement of the fetal head as it navigates the maternal pelvis. Station is the relationship of the presenting part to an imaginary line drawn between the Ischial spines of the pelvis. The Ischial spines are two bony prominences that demarcate the middle of the pelvis.
Leopold's maneuvers : are a systematic way to evaluate the maternal abdomen. It is used not only to indicate the probable location of the FHR, but also to help determine the presence of multiple fetuses, fetal lie and fetal presentation.

**Contractions**

Duration : is measured from the beginning of contraction to the completion of that same contraction.
Quality or Intensity : refers to the strength of the contraction during acme (peak of). At wall mild, moderate and strong.
Frequency : refers to the time between the beginning of one contraction and beginning of the next contraction.

**FHR**: FHR never goes below 100 and above 160. Early Deceleration is 100-120 BPM.

**Decelerations**: are periodic decreases in FHR from the normal baseline. They are categorized as early, late, and variable according to the time of their occurrence in the contraction cycle and their waveform. <u>When the fetal head is compressed, cerebral blood flow is decreased, which leads to central vagal stimulation and results in early deceleration</u>.

**Accelerations**: are transient increases in the FHR normally caused by fetal movement. When the fetus moves, the heart rate increases, just as the heart rates of adults increase during exercise. Often, accelerations accompany uterine contractions, usually due to fetal movement in response to the pressure of the contractions. <u>Accelerations of this type are thought to be a sign of fetal well-being and adequate oxygen reserve. The accelerations with fetal movement form the basis for non-stress tests</u>.

Variability: one of the three factors affecting the FHR. It is a measure of the interplay (the push-pull effect) between the sympathetic and parasympathetic nervous systems over a 10-minute period. It reflects baseline fluctuations that are irregular in frequency and amplitude.

- Absent : amplitude undetectable
- Minimal : amplitude detectable but 5 bpm or less
- Moderate : amplitude 6 to 25 bpm
- Marked : amplitude greater than 25 bpm
- Note : reduced variability is the best single predictor for determining fetal compromise.
  Fetal acidosis and subsequent hypoxia are highest in fetuses that have absent or minimal variability.

**Breasts**: Initiate BF within ½ hour after birth. By third-fifth day breast feel full and tender – milk comes in d/t increased prolactin levels. Care of breasts – avoid soaps, apply colostrums and air dry, Lansinoh cream, ***teach proper latch. Imp of Breastfeeding includes decrease incidence and severity of illness i.e. URI, UTI, gastro infection, protective effect for SIDS, from Crohn's, UC, IDDM, lymphoma, allergies, asthma, eczema and obesity. Improved cognition and reduced risk of cardiovascular disease. Reduced risk of breast cancer, ovarian cancer, osteoporosis and anemia. Increased spacing between pregnancies and promotes postpartum recovery and Involution.

**Lactation**: During pregnancy, estrogen stimulate breast duct development and increased progesterone promote the development of lobules and alveoli to prepare lactation. Once placenta is expelled at birth progesterone levels falls to trigger the milk

production. Prolactin double each time the baby suckles the breast then this prolactin stimulates the milk secreting cells in the alveoli to produce milk. If breast stimulation is not done the prolactin level drops so mother can be encouraged to stimulate her breast more frequently. The starting milk is called foremilk. The foremilk is watery milk high in protein and low in fat. Oxytocin helps ejecting milk. The process called Milk ejection reflex. Milk flows in this process is called Hind milk which is fatty. Colostrums is initial milk that begins to be secreted during mid-pregnancy and it is available to the baby at birth. It is thick fat contained milk. It contains concentrated protein, vitamins and minerals. It also contains IgA to protect infants from disease and illness. It also works as a laxative to help baby pass me conium stools. Colostrums present from 4th month of pregnancy to about 5 days postpartum, low in volume, high in nutrients. Transitional milk day 6-13 postpartum. milk "coming in" and Mature milk day 10 postpartum and beyond foremilk and hind milk.

**Engorgement**: Onset immediately postpartum. Nurse frequently and regularly. Take a warm shower or apply moist heat to the breast before nursing. Apply a cool compress to the breast after nursing. The infant's chin should be embedded into the mother's breast. Flanged - angle of the lips on the breast greater than 140°. As the baby begins to suckle, there should be no dimpling of the infant's cheeks and no smacking noises. Size of bra : 1 size bigger is better during milk production.

**Afterpains**: Caused by intermittent uterine contractions. It also occurs if the uterus has been distended. This afterpains cause severe discomfort for 2 to 3 days after birth. Breastfeeding also increases the frequency and severity of the afterpains. A warm water bottle placed against the low abdomen may reduce the pain and mile analgesic agent may also help. After pains – d/t Oxytocin release – common during breastfeeding and multip mothers - can last up to five days.

**Uterus**: Is the womb, and where the baby lived and now must involutes/go back to its pre pregnancy place. Ensure bladder is emptied prior to palpating uterus/fundus. Ensure head of bed is lowered for ensure accuracy. Uterus is at the level of the umbilicus on the day of delivery – U/U. <u>One finger or 1 cm/day and should be at pre pregnancy position by day 10 not possible to palpate after 7 days</u>. Uterus should be at midline and firm. <u>Never palpate c-Section Mom</u>.

**Bowels**: <u>First BM occur in two-three days postpartum –encourage fluids, fiber, and ambulation and stool softeners</u>. Sluggish after birth d/t effects of progesterone, dehydration, decreased mobility, decreased muscle tone, medications, and fear of having a bowel movement (hemorrhoid). Always assess perineum even if mom's perineum is intact, as she may have hemorrhoids. Hemorrhoids may be present before or after delivery, d/t pressure in perineal area – use hemorrhoid ointment. Post-op caesarean section mothers may experience gas pains – encourage ambulation, fluids, fiber, stool softeners. Immediately administer prescribed stool softeners if mom taking Codeine, or has a third or fourth degree tear.

**Bladder**: Teach mother to void often coz full bladder is main cause of a post partum hemorrhage. Bladder should be non-palpable. Uterus will become boggy and elevated off center if bladder is full, interfere with normal involution thus cause hemorrhage. Teach mom how to use the Peri-bottle – for comfort and hygiene.

**Lochia**: Rubra→Serosa→Alba. Is vaginal discharge after delivery, is bloody, has earthy and fleshy odor, should not be foul smelling. Amount: scant, light, moderate, heavy (<u>soaking one pad within one hour is considered to be heavy flow</u>) Remember it is <u>normal for moms to experience a large gush of blood when they stand up</u> from getting out of bed or while they are breastfeeding. Examine clots for tissue – examine all clots that are larger than a loonies – retained placenta. Lochia should never exceed moderate amount. Ask the patient how long the perineal pad has been in place prior to assessing amount of lochia. Ask the patient if she has passed clots while ambulating or voiding. <u>Menses for BF mom 24 wk and no BF mom 6 wk</u>.

**C Section**: Check incision using REEDA. We only initially palpate the fundus; we DO NOT palpate it routinely after initial checks (unless worried about lochia or clots). Lochia is much lighter than a mother who delivered vaginally. Encourage mobilization- teach mothers how to get out of bed- using the log roll method (have mom lye on her side and then push up with her arms – you help guide her legs).

**Emotions**: <u>Baby Blues from day 2-14, effects 70% of women, d/t hormones changes, fatigue</u>. <u>S/S: crying for no reason, let down feeling, sadness, anxiety, restlessness, insomnia</u>. If longer than 2 wk tell dr. PPD 2 weeks to 1 year. Assess Hx. <u>PPD 0-4 wk requires medical intervention also cause post partum psychosis. S/S: extreme sadness, poor bonding, feeling inadequate, compulsive thoughts, inability to care for self or baby, thoughts of hurting self or baby, suicidal thoughts.</u>

Add Phases

**Cord**: Clean the area where the cord attaches to the skin especially well. Keep the diaper folded and keep the cord clean and dry. Clean the area at the base of the cord 2 to 3 times a day with a Q-tip or cotton ball dipped in rubbing alcohol or warm water. Use

a damp washcloth or cotton ball for baths until the cord falls off. It will drop off usually between 1 to 2 weeks. Check for a foul smell or oozing discharge, and report this to your baby's pediatrician.

**Circumcision**: Do not need to pull back the foreskin to clean it for the first year of life. After 1 to 2 years of age, you can try to pull back the foreskin partially for cleaning. When your child is 5 or 6 years old, teach him to pull back.
Circumcision: Clean your baby's penis by washing with water 3 times a day or with diaper changes after first day. Petroleum jelly can be put on the Plastibell ring after cleaning. The ring should fall off 4 to10 days after the circumcision. Don't pull the Plastibell ring off because this can cause bleeding. Circumcised men have a lower prevalence of HIV infection, infection for male and female and penis cancer, UTI for female than uncircumcised men.

**Birth Control**: Menstruation for non-nursing mom returns between 6-10 weeks post partum. For breastfeeding moms, menstruation is prolonged, but ovulation may still occur while breast feeding without a period. Therefore, mom can still get pregnant even if she is not menstruating. Must use progestin only oral pills with breastfeeding as estrogen/progestin will alter breast milk composition and supply. Pills reduces FSH to stop ovulation.
All oral mono, bi and tri are 100% effective, but independence so not taken during sex.

Mono Phasic : Estrogen for 21 days and 7 day free.
Bi Phasic : High Estrogen for 11 days and low estrogen for 10 days = 21 days.
Tri Phasic : Estrogen and Progesterone both mixed.
Mini Pill : Only progesterone and good for nursing mom.
Nursing Care: Thrmobophelebitis ↑ (PTT ↑ ), HTN, Hyperglycemia, Bleeding, Breast Tenderness.

Pills are not for Diabetic, HTN, Thrmobophelebitis, CVA and Breast malignancy pt so they use foam and condom.
Also UID cause infection so these pt do not use Intrauterine Device.
UID is foreign body so body inflames in response to bleed so excessive bleeding is possible by inflammation it block the sperm.

Infertility is when couple are unable to have a baby for a year.

**PPH**: Heavy bleeding may be caused by uterine relaxation and retained placental fragments. During 1-3 days clots in a postpartum mom's flow is most common? It is concern if clot is still visible after 3rd day. Clot indicates bleeding at the placental site. So access location and firmness of fundus, assess voiding pattern. Tissues are bigger and clots are thinner and smaller. And also clot dissolve in water but tissue do not.

**Episiotomy**: Assess for REEDA = Redness, Edema, Ecchymosis, Discharge, Approximation (How well edges of an incision holding together). Assess for hematoma – results from injury to a blood vessel from birth trauma, results from a collection of blood, most commonly are vaginal or vulvae hematomas. Looks circular red. Comfort measures – ice packs, prescribed analgesic, peri bottle Healing – initial takes two-three weeks, complete healing can take 4-6 months. Sitz bath provides comfort, decreases pain and promotes circulation which helps healing of the wound. During birth side lying position for pushing which helps slow birth and minimize tears. Warm or hot compresses on the perineum and firm counter-pressure. Encouraging a gradual expulsion of the infant by encouraging the mother to "push, take a breath" so easing infant out. If hemorrhoids tell to squeeze butt before sitting and then relax.
1st tears involve only the lining or mucosa of the vagina.
2nd tears involve the vaginal lining and the deeper (sub mucosal) tissues but do not involve the anal sphincter/rectum.
3rd tears extend from the vaginal lining through the anal sphincter but do not involve the rectal lining.
4th tears include the vaginal lining, sub mucosal tissues, anal sphincter, and rectal lining.
Ischial Spines are the narrowest diameter of pelvis which determines birth difficulty.
Episiotomy is done to prevent laceration during birth which is difficult to sew.

**DVT**: Vein Homan's Sign from 1- 2 day post delivery. Assess for redness, warmth cold, pain, heaviness, difference in calf diameter. Edema of feet and ankles is common – can last up to one week post partum. Consider Virchow's triangle (for causes of thrombosis) d/t Immobile, Dehydration and Injury coz of improper positioning. DVT also d/t changes in blood coagulabity (increase clotting factors fibrinogen & platelet during post partum period), changes in vessel wall (pressure from stress of hypertension) and changes in blood flow (venous stasis of blood flow – therefore mom needs to ambulate). Risk factors are increased blood pressure, smoking, obesity, increased maternal age, bed rest, varicosities, clotting disorders, prolonged periods of standing, previous case. May need to be prescribed anticoagulant therapy. A pulmonary embolism occurs when an artery in your lung becomes blocked by a blood clot (thrombus) that travels to your lungs from another part of your body, usually your leg. Also

Post-phlebitis syndrome where legs are swelling and painful. Regular leg exercise and ambulation are key. Beside avoid crossing legs and knees.

**SIDS**: Put your baby on his or her back to sleep. It's important for your baby to be on his or her stomach during the day while awake to strengthen arm and leg muscles. Place your baby on a firm mattress or bedding to sleep. Do not place your baby on a waterbed, sheepskin, pillow, or other soft surface to sleep. Do not use soft pillows and thick blankets. Use a fan in your baby's room. Once your baby is 2 to 4 weeks old, consider giving your baby a pacifier when you put him or her to sleep. After your baby falls asleep, don't re-insert the pacifier into his or her mouth. Don't force your baby to take a pacifier if he or she doesn't want it. Make sure your caregiver is aware of these recommendations.

Pyelonephritis cause prematurity which is number 1 neonatal death in Canada.

**Test**: Metabolic Screen Test : These disorders might be related to the body's ability to use food normally, the body's ability to produce hormones or cystic fibrosis and to check if the body is able to break down some substances in food like fat, proteins and sugar. Endocrine disorders to check hormones, Cystic fibrosis to check trouble with digestion.
Ultrasound: Finds gestational age and placenta location during 20wk. Encourage fluid and void before test.
Amniocentesis: To detect sex, fetal age, billirubin level, lung maturity. Have client void and encourage rest.

| | | | | |
|---|---|---|---|---|
| NST | : | Reactive | : >=2 Accelerations of 15 BPM lasting 15 seconds | --> No intervention required. |
| | | Non reactive | : No acceleration or deceleration < 15 sec | --> Monitor further. |
| | | Unsatisfactory | : Un-interpretable | --> Repeat 24 hr. |
| Ph | : | More acidic indicates birth soon. | | |

**Hormones**: Prostaglandins are local hormones that act directly at the site where they are secreted and causes the womb to contract and push out its contents, including the placenta and the fetus/unborn baby, whether living or not.
Oxytocin/Syntocinon can be used before and during labor for contractions, during 3rd stage of labor and during the 4th stage or early postpartum period for postpartum hemorrhage by contracting uterus.

| | | |
|---|---|---|
| Estrogens | : | Develop female reproductive organs. Start Contraction.<br>Also ↑ Na and H2O absorption by kidney. Also protein and calcium anabolism.<br>High estrogens inhibits FSH so FSH ↓. Low Estrogens cause osteoporosis. |
| Luteinizing | : | LH Start Ovulation. |
| Progesterone | : | Stop Contraction during pregnancy. Implant fertilize egg ovum to uterus,<br>Stop Oxytocin release to stop milking. |
| Placenta Out | : | Estrogens and progesterone ↓ , stimulates anterior pituitary gland to ↑ prolactin to produce milk. |
| Suckling | : | Stimulates a) Anterior Pituitary Gland to ↑ prolactin to produce milk.<br>b) Posterior Pituitary Gland to ↑ Oxytocin to produce milk (let down reflex). |
| Testosterone | : | Develop secondary sexual characteristic like breast. |
| Gonadotropin | : | Cause NV. |
| Melanocyte | : | Makes nigra black nipple and melasma lines. Melanocyte is produced by Pituitary Gland. |
| Menstruation | : | Both Estrogens and Progesterone ↓ in 25 day cycle so menses in 28 days (20-45)<br>Decreased Estrogens stimulates APG to produce Follicle Stimulatory Hormone (FSH). |

| | | | | | |
|---|---|---|---|---|---|
| 1st Stage | : | 4-6 days | Bleeding, | Both Estrogens and Progesterone ↓ | FSH and LH ↑ |
| 2nd Stage | : | 8-10 days | Ovulation (12-16 from 1st stage). | | |
| 3rd Stage | : | 9-13 days | If Fertilize | Both Estrogens and Progesterone ↑ | - Occurs Implantation. |
| | | | If Not Fertilize | Both Estrogens and Progesterone ↓ | - Returns to 1st Stage. |

Hormones During Pregnancy
- Estrogens levels ↑ during pregnancy and proliferation of ductal system starts and enhances & inhibits Prolactin.
- Progesterone levels ↑ during pregnancy and development of breast tissue begins and inhibits Prolactin.

- Before placenta is developed Corpus Luteum makes estrogen and progesterone.
- After placenta is fully developed (3mo), placenta makes estrogen and progesterone.
- Leukorrhea is d/t increased Estrogen. Here large mucus is produced by epithelial cell.

Hormones After Delivery

- Progesterone and Estrogen levels ↓ just prior to delivery
- Prolactin levels ↑ with delivery of placenta and delivery of placenta promotes secretion, levels ↑ with nipple stimulation
- Prolactin levels ↓ to normal in 7 days if BF not initiated.
- Oxytocin secreted in response to suckling and causes milk ejection reflex (letdown) also causes uterus to contract.
- Oxytocin creates ↑ in skin temperature and can cause mother's to be thirsty during feeds.

**GBS Mother**: Newborns become infected in one of two ways: by vertical transmission from the mother during birth or from horizontal transmission from colonized nursing personnel or colonized infants. GBS causes severe, invasive disease in infants. Risk factors for GBS neonatal sepsis include preterm labor, maternal intrapartum fever, prolonged rupture of the membranes, previous birth of an infected infant, and GBS bacteria in the current pregnancy.

**Immunization**

Chickenpox : Encephalitis is by worst chicken pox.
Rubeola : Measles which is blotchy rash.

**Cultural Competency**

It is the skills and knowledge necessary to appreciate, respect, and effectively work with individuals from different cultures and vulnerable population groups. It requires self-awareness, awareness and understanding of cultural differences, and the ability to adapt clinical skills, and practices as needed by integrating them into the family's belief system.
Performs Comprehensive and Family Assessments : Health Hx, monitoring, developmental assessment, psycho-social assessment, assessment of family functioning, assessment for substance abuse or domestic violence issues, and assessment of basic needs such as food, housing, income, resources and supports (health determinants), and access to health care (primary health care principles).
Assesses need for patient referral based on information gathered.
Documents assessment and participates in community assessment, understands incidence and prevalence data and knows how to access basic community epidemiological data.

1. Appreciation: The nurse then thinks about their global understandings of culture and works with the client to put observed behaviors into perspective. The common assessment question that leads to this first step is, "Tell me more about..." Then listening carefully to the client's response, the provider decides whether or not any intervention is really necessary.
2. Accommodation : Accommodation requires out-of-the-box thinking about how care can be adapted to meet client needs.
3. Negotiation : Effective cultural negotiation requires careful assessment as do appreciation and accommodation and often is a chance for the demonstration of creativity. The goal with negotiation is to arrive at a win-win solution that meets the needs of the patient and family, the provider, and institution or agency.
4. Explanation : Explanation comes into play when efforts at appreciation, accommodation, and negotiation fail. This step would only be appropriate when assessment reveals that what the client, family, or community wants and needs is immoral, illegal, abusive, or unsafe in some way that puts it beyond the realm of negotiation.

**Public Health Act**

Revoke, suspense medical license of chief medical officer and nurses.
Nurses should be aware that the minister of health can audit their records, inspect their area.
If there is a public health emergency, outbreak nurses are also obligated to report that person.
Treatment can also be initiated without consent

**Documentation Type** SOAP : Subjective, objective, Assessment and Plan.
SIER : Subjective, Intervention, Evaluation and Revision.
PIE : Problem, Intervention and Evaluation.
CBE : Charting By Exception
ASSMT : BUBBLE VERNA

**MASS**

1. Pt is 17 kg    Order is 10-15mg/kg  q4-6 hr.    Min 10x17=170 x 4 = 680    Max 15x17= 255 x 6 = 1530.    = 680-1530.
2. Order 26.67 mg/kg q6h and Pt is 30 kg    26.67 x 30 x ¼    6 hr = ¼    4hr is 1/6 3 hr=1/8

1 Question 1

Mrs. Soo Lee, 80 years old, widowed, lives with her daughter, son-in-law, and two grandchildren. Her daughter and son-in-law work full-time outside of the home. The two grandchildren attend university full-time. Mrs. Soo Lee has been recently diagnosed with early stage Alzheimer's disease. She speaks English but has been using Mandarin more and more in all her communications in the last 3 months. A non-Mandarin speaking nurse has been assigned to assess how Mrs. Soo Lee and her family are coping with this situation.
How should the nurse initially collect data about Mrs. Soo Lee's situation?
1) Ask Mrs. Soo Lee and her daughter to describe changes Mrs. Soo Lee may have recently experienced.
**2) Ask Mrs. Soo Lee's daughter to translate the nurse's questions and Mrs. Lee's answers.**
3) Interview Mrs. Soo Lee's family members to explore their perceptions of the situation over the past few months.
4) Have Mrs. Soo Lee's daughter describe the changes she has seen in her mother.

Question 2

What suggestion should the nurse make to the family in order to promote Mrs. Soo Lee's safety in the home?
1) Ensure all exit doors are securely locked.
2) Arrange to have Mrs. Soo Lee supervised at all times.
**3) Identify and eliminate potential hazards in the home.**
4) Do not allow Mrs. Soo Lee to use any electrical appliances.

Question 3

Mrs. Soo Lee's daughter reveals to the nurse that her mother has become increasingly frustrated and angry in the last 2 weeks. Which of the following explanations by the nurse would best assist the family in understanding Mrs. Soo Lee's change in behaviour?
1) Making demands on Mrs. Soo Lee will lead to further agitation.
2) Frustration may be eased by performing complex tasks for Mrs. Soo Lee.
3) Mrs. Soo Lee's outbursts are characteristic of the illness and are predictable.
**4) Mrs. Soo Lee's behaviour could be due to her awareness that she cannot remember.**

4 Question 4

Mrs. Soo Lee becomes anxious and distracted during mealtime with the family and seldom finishes her meals. What suggestion should the nurse give to the family?
**1) Family members should speak one at a time during mealtime.**
2) Mrs. Soo Lee's daughter should guide the mealtime conversations.
3) Mrs. Soo Lee should have her meals in a separate room.
4) The grandchildren should be encouraged to speak Mandarin during meals.

Question 5

Mrs. Soo Lee's daughter expresses to the nurse that the family and Mrs. Soo Lee prefer to use traditional Chinese medicine. What is the nurse's most appropriate response?
1) "It is understandable that you would want to consider other treatment alternatives."
2) "I understand your reluctance to accept Western medicine though it offers the best hope for a quality life."
**3) "I would like to know more about your beliefs regarding health and illness."**
4) "A combination of Western and Chinese medicine might be appropriate to meet everyone's needs."

Question 6

Mrs. Soo Lee tells the nurse about feeling lonely during the day. Which one of the following actions by the nurse would best address these concerns?
1) Encourage family members to spend more time with Mrs. Soo Lee during the day.
**2) Explore with Mrs. Soo Lee and her family the possibility of participating in community programs for persons with Alzheimer's disease.**
3) Provide Mrs. Soo Lee and family members with information on in-patient care for persons with Alzheimer's disease.
4) Reassure Mrs. Soo Lee and her family that this is a common concern for elderly persons.

Question 7

A group of people have been meeting to support individuals who are seropositive for Human Immunodeficiency Virus (HIV) or who have Acquired Immunodeficiency Syndrome (AIDS). People involved in this group include people living with HIV/AIDS, their family and friends, and interested individuals

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from the community. A nurse from the HIV/AIDS clinic is working with this group within the community.
The group is currently addressing the need for an AIDS hospice within the community. Group members are in conflict over the need for such a facility. Which of the following actions by the nurse would be most useful in assisting this group to address this issue?
1) Providing data on the number of individuals in the community who have AIDS.
**2) Encouraging an assessment of the needs of the community for this type of facility.**
3) Evaluating the effectiveness of care provided to persons within the existing facilities.
4) Contacting local health services officials to determine their willingness to provide funding.

Question 8

Group members continue to be in conflict over the appropriate course of action regarding the AIDS hospice. Which of the following actions by the nurse would best assist members to resolve their conflict?
**1) Encourage members to vote on the appropriate course of action.**
2) Encourage individuals with similar opinions to support one another.
3) Encourage members to state their own views in greater detail.
4) Encourage members to examine the values underlying the various positions.

Question 9

What type of information would be most useful to this group in their planning for the hospice and the programs to be offered?
1) The number of individuals diagnosed with HIV in the community
2) Local demographic information about individuals with HIV/AIDS
**3) Grants available for health services and programs offered in other communities**
4) Common modes of transmission and effective treatments

Question 10

Which of the following activities by the nurse would encourage the group to assume ownership for the development of their proposal for a hospice?
1) Contact local media to publicize the group's efforts.
**2) Arrange for group members to interview influential community persons.**
3) Assist the group to connect with hospices in other communities.
4) Contact local politicians to assist the group with their proposal.

Question 11

The group members have been discussing the factors that influence the health outcomes of individuals who have AIDS. Which of the following is a social determinant of health for these individuals?
1) Mode of transmission of HIV
2) Presence of Pneumocystis carinii pneumonia
**3) Financial stability and support**
4) Gender and ethnic background

Question 12

Marie Jameson, a group member, asks the nurse about prevention of transmission of HIV among family members. Her son, Jim, has recently been diagnosed as seropositive for HIV. Which of the following is the most effective strategy for teaching this information?
**1) Provide her with pamphlets describing standard (universal) precautions in the home setting.**
2) Begin by answering Marie's questions about prevention of transmission of HIV.
3) Provide current research information about modes of transmission of HIV.
4) Refer Marie to library resources that describe various infection control measures.

Question 13

Mr. Chalmers, 53 years old, is admitted to the hospital. During the nursing assessment, he tells the nurse that he has had blood in his urine for several weeks, is urinating frequently, and is experiencing pain when he urinates. He also states that he does not feel his bladder is empty after he voids. Blood work and a cystoscopy confirm the diagnosis of cancer of the prostate.
Based on the information obtained from the client, which of the following lab results should be expected to return abnormally elevated?
1) HCG
2) PSA
3) AFP
4) CEA

Question 14

Mr. Chalmers, 53 years old, is admitted to the hospital. During the nursing assessment, he tells the nurse that he has had blood in his urine for several weeks, is urinating frequently, and is experiencing pain when he urinates. He also states that he does not feel his bladder is empty after he voids. Blood work and a cystoscopy confirm the diagnosis of cancer of the prostate.
Mr. Chalmers undergoes a radical prostatectomy and returns to his room with a three-way urinary catheter with bladder irrigation. Six hours postoperatively, Mr. Chalmers reports a feeling of fullness in his abdomen and states that he has the urge to void. Which of the following actions should the nurse do?
**1) Assess the catheter drainage system for patency.**
2) Increase his fluid intake for the next 2 hours.
3) Inform him that this is expected and encourage him to relax.
4) Remove and reinsert the catheter.

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Question 15

Mr. Chalmers is receiving morphine via a Patient Controlled Analgesia (PCA) pump, on a demand dosage schedule. Mrs. Chalmers tells the nurse that she is concerned that her husband will overdose himself. Which of the following is the best response by the nurse?

1) "If you prefer, the nurse could administer his medication."
2) "It would be helpful if you record the frequency of his morphine use."
3) "There is not enough morphine in the pump to cause serious harm."
**4) "The pump is programmed to prevent morphine overdosage."**

Question 16

The nurse assesses Mr. Chalmers response to his morphine. He states that he is feeling comfortable. The nurse notes the following: BP 98/62 mmHg, P 82, R 14, drowsy, but rouses easily. Based on this assessment, what should the nurse do?

1) Turn the PCA pump off.
2) Decrease the dose of the morphine.
**3) Notify the physician of the client's vital signs.**
4) Continue routine assessment of the client.

Question 17

Mr. Chalmers asks the nurse if he will be able to have sexual intercourse with his wife when he recovers from his surgery. How should the nurse respond to Mr. Chalmers' question?

1) "You will need to discuss this further with your doctor."
**2) "What have you been told regarding the effects of your surgery?"**
3) "There are many other ways of experiencing sexual intimacy."
**4) "Were you experiencing problems prior to surgery?"**

Question 18

Mr. James, a 19-year-old student, abruptly dropped out of college and returned home. His parents take him to the family doctor, stating that his behaviour is increasingly bizarre. They say that he appears to be listening to and responding to voices that no one else can hear. He is anxious, restless, and unable to sleep. He has not eaten regularly and has lost 10 kg from his normal weight of 75 kg. He has not washed or changed his clothes in the last 5 days. Mr. James tells the physician that he is very frightened and wants to go to hospital because the "voices hate women. I'm afraid of what they may make me do". Mr. James is admitted to the psychiatric ward of the local hospital as a voluntary client.

At dinner time on his first hospital day, the nurse suggests to Mr. James that he wash his face and change his shirt before he joins the other clients in the dining room. Mr. James says he wants to stay in his room. What is the nurse's most appropriate response?

**1) Ask him if he would like dinner brought to him in his room.**
2) Remind him that socializing with others is part of his therapy.
3) Respect his wishes and leave him alone in his room.
4) Suggest to him that not eating is unhealthy.

Question 19

Mr. James tells the nurse, "the voices are with me now.". Which answer by the nurse best reflects both a therapeutic and respectful response to his statement?

**1) "I don't hear the voices. Tell me about the voices you hear."**
2) "The voices aren't really there. Only you are hearing them."
3) "I don't hear any other voices in this room."
4) "Your voice is the only one that I can hear."

Question 20

For the first 2 days of his hospitalization, Mr. James continues to remain agitated, anxious, and fearful. Which of the following activities should the nurse suggest for the client at this time?

**1) Walking with his primary nurse.**
2) Constructing a jigsaw puzzle.
3) Playing cards with the nurse.
4) Attending group therapy.

Question 21

By his fourth hospital day, Mr. James is pacing almost constantly, continues to hear voices, and has become increasingly irritable. When female staff approach, he clenches his fists, tenses up, and moves away. Mr. James' admission status is changed from voluntary to involuntary. Sedation, oral or injectable, has been ordered. Mr. James refuses to let the nurse near him to give the medication. What is the nurse's most appropriate first action?

1) Ask another nurse to administer the medication to the client.
**2) Offer the client the choice of receiving the medication by mouth or by injection.**
3) Inform the client he will be put in the seclusion room if he fails to cooperate.
4) Respect his right to refuse the medication and report the situation to his doctor.

Question 22

Mr. James continues to receive medications to control his anxiety and agitation. He is allowed to walk about the nursing unit, but he is not allowed to go outside. While in the client lounge he gets into a confrontation with a female client. He starts to scream and throw furniture. He punches a hole in the wall, and attempts to punch the other client, but misses. What is the best nursing approach for initial management of this incident?

**1) Call for assistance.**
2) Attempt to calm the client.
3) Physically restrain the client.
4) Ask the female clients to leave the lounge.

Question 23

Mr. James' condition improves sufficiently to allow him to have his admission status returned to a voluntary one. Plans are made for his discharge to a semi-independent facility (half-way house) near his family home. What is the most appropriate initial intervention to help Mr. James make a positive transition from the hospital to the community facility?

1) Make arrangements for Mr. James and his assigned counsellor from the half-way house to meet at the hospital before the client is discharged.
2) Arrange for Mr. James and his family to have a tour of the half-way house when he is discharged from the hospital.
**3) Give Mr. James and his family as much information as possible about half-way houses and their purposes.**
4) Have another client who has used this facility come to talk with Mr. James about the half-way house.

Question 24

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.
Mrs. Ford's doctor has recently treated her for a urinary tract infection using antibiotic therapy. She asks the nurse how to avoid urinary tract infections in the future. Which initial action would be most appropriate for the nurse to take?
1) Provide her with a pamphlet on urinary tract infections.
**2) Explore what she knows about urinary tract infections.**
3) Explain to her that she should increase her fluid intake.
4) Review with her the causes of urinary tract infection.

Question 25

Mrs. Ford asks about the antibiotic drug prescribed to treat her urinary tract infection. She is concerned that the medication may have affected her unborn child. Which of the following interventions by the nurse is most appropriate?
1) Reassure her that physicians prescribe drugs carefully to pregnant clients.
**2) Discuss with her written information about the drug.**
3) Explain to her that antibiotics do not cross the placental barrier.
4) Refer her to the pharmacist for further teaching.
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Question 26

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.
Mrs. Ford eats very little meat and is concerned that this will affect her breast milk. Which response by the nurse would be the most appropriate?
1) "With additional calories, women who eat small amounts of meat will produce adequate breast milk."
2) "The quality of breast milk is not affected by the amount of meat in the diet."
3) "Breastfeeding does not require any modifications in a woman's usual diet."
**4) "You can replace meat with other sources of protein and maintain a well-balanced diet for breastfeeding."**
Question 27

Mr. Ford has two sons from his first marriage, aged 16 and 19 years, who live with their mother. Mrs. Ford confides to the nurse that she and her husband disagree about the involvement of his two sons in their family. Her husband wants to invite his sons to spend the summer with them. Which of the following responses by the nurse would be most appropriate?
1) "How would you like to deal with this situation?"
2) "Are you concerned about not getting along with your husband's two sons?"
**3) "You seem concerned by this situation with your family."**
4) "It seems that your husband would like you to involve his sons at this time."
Question 28

A 60-year-old male client with a diagnosis of depression tells the nurse that the paroxetine (Paxil) he has been on for the past 1 week is not helping. He states that he still feels depressed and lacks energy.
Which of the following responses by the nurse would be most therapeutic?
1) Advising the client that it takes 1 to 4 weeks to feel the therapeutic benefit of this medication.
2) Informing the client that it takes 4 to 6 weeks to feel his mood and other symptoms improving.
3) Telling the client that the physician will be notified so that a change in medication can be made.
4) Teaching the client about the need to exercise daily in order to feel the full benefit of the medication.

Question 29

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.
Mrs. Ford tearfully explains to the nurse that she is very fearful of labour and is not sleeping well. Which action by the nurse would be most appropriate?
1) Explore with her the possible use of epidural analgesia for labour.
2) Provide her with information on positions that promote sleep.
3) Discuss with her the concerns she has about labour.
4) Encourage her to discuss bedtime sedation with her physician.
Question 30

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin

dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.
Which of the following actions by the nurse would best acknowledge the developmental needs of this group?
1) Involve the parents in the education sessions.
2) Plan a class session on the physiology of puberty.

3) Ensure that participants make independent decisions.
4) Plan learning activities that involve peer support.

Question 31

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.
In planning for teaching the group about diabetes management, which of the following actions should the nurse implement initially?
1) Distribute an outline and sequence of all topics to be addressed.
2) Ask each participant to list their needs for information regarding diabetes.
3) Identify the priority components of diabetes management, beginning with insulin administration.
4) Determine the group's understanding of diabetes and develop an outline together.

Question 32

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.
Which of the following strategies would be most effective in teaching nutritional management of diabetes?
1) Discussion with handouts
2) Game on food selection
3) Videotape with follow-up quiz
4) Presentation by a dietitian

Question 33

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.
Which one of the following food selections by the group members would indicate to the nurse that they understand how to treat initial symptoms of hypoglycemia?
1) A glass of milk
2) An apple
3) A can of diet cola
4) A slice of bread

Question 34

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.
Which of the following activities would best meet the exercise criteria for adolescents with diabetes?
1) Hiking twice weekly
2) Roller blading daily
3) Cycling on weekends
4) Swimming once a week

Question 35

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.
After 4 days of diabetic teaching at the camp, Sean, 13 years old, is keen to take more responsibility for his care. Which of the following actions by the nurse would best help Sean to achieve his goal?
1) Reviewing with Sean his blood glucose levels for the last 4 days.
2) Reviewing Sean's dietary needs with him.
3) Supervising Sean while he prepares and administers his own insulin.
4) Discussing Sean's plan of care with his parents.

Question 36

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.
Mr. Edwards tells his admitting nurse that he is worried he will "wake up with a colostomy". What is the nurse's most appropriate response to this concern?
1) "That is unlikely given the location of your tumour."
2) "What has your surgeon told you about the planned surgery?"
3) "May I call your doctor so that your concern can be clarified?"
4) "That is a common concern; what would you like to know about colostomies?"

Question 37

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.
Mr. Edwards returns to the unit with an intravenous infusing into a central line in the right subclavian vein. What is the most essential action for the nurse to take regarding the central line?
1) Check that all tubing connections on the central line are secure.
2) Monitor the solution flow rate every 15 minutes for the first hour.
3) Reinforce the dressing over the subclavian insertion site.
4) Ensure that the head of the bed is not elevated at more than 20 degrees.

Question 38

No personal obligation, personal use and guidance only.

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery. On the morning of his first postoperative day, Mr. Edwards has been receiving oxygen by nasal cannula at a rate of 4L/min. He is alert and his temperature is 38° C at 0800 hours. His arterial blood gas report shows the following results:

| Values | Client results | Normal values |
| --- | --- | --- |
| pH | 7.33 | (7.35 - 7.45) |
| PaO2 | 78 mmHg | (80mmHg or greater) |
| PaCO2 | 48 mmHg | (35 - 45 mmHg) |

What action should the nurse take after noting these results?
1) Increase the flow rate of oxygen through his nasal cannula to 10 L/min.
2) Put a cool air humidifier at his bedside and remove extra bed clothes.
.
3) Assist him to deep breathe and use his incentive spirometer stat and q.1h.
4) Notify the physician immediately of the client's status.

Question 39

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery. On the morning of his second postoperative day, the nurse observes that Mr. Edwards' abdomen is hard, distended and tender. The wound drainage device is filled with fresh blood. His pulse is 120/min and respirations are 30/min and shallow. His blood pressure is 90/60 mmHg. He is restless and anxious. His urine output for the last 2 hours totals 15 mL. What immediate action should the nurse take?
1) Inform the surgeon.
2) Check his bladder for distention.
3) Check peripheral pulses.
4) Apply pressure to his abdomen.

Question 40

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery. Mr. Edwards requires 2 units of packed red cells. Which of the following is the most appropriate nursing action in the administration of blood?
1) Allow each unit of blood to warm to room temperature before administration.
2) Infuse each unit of blood slowly for the first 15 minutes of the transfusion.
3) Ensure that each unit of blood infuses over a period of 4 - 6 hours.
4) Flush intravenous tubing with D5W between each unit of blood.

Question 41

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery. Mr. Edwards is unable to meet his nutritional needs postoperatively with a regular diet. The surgeon orders intermittent feedings via a nasogastric (NG) tube. What is the most appropriate nursing action when administering the tube feeding to Mr. Edwards?
1) Change the tube feeding solution bag every 72 hours.
2) Flush the NG tube with 60 mL of saline before each feeding.
3) Warm the feeding solution before giving it to Mr. Edwards.
4) Keep the head of Mr. Edwards' bed elevated during the feeding.

Question 42

A client with diabetes states, "Exercise, diet, glucose testing, and insulin work together to control my diabetes". The nurse asks "Do you exercise at the same time each day and check your sugars before you start?"
Which one of the following is the best rationale for the nurse's response?
1) To ensure the nurse can relate to the client's situation.
2) To validate the data ensuring accuracy.
3) To individualize care for the client.
4) To organize the data into meaningful clusters.

Question 43

Based on research findings, what should the nurse identify as the leading cause of gastric ulcer disease when teaching clients?
1) Hypersecretion of hydrochloric acid
2) Bacterium, H. pylori
3) Excessive intake of caffeine and spicy foods
4) Stressful lifestyle

Question 44

Mr. Robins, 75 years old, has been learning to care for his new ileostomy for the past week.
Which of the following statements indicates that Mr. Robins requires more information from the nurse about ileostomy self-care?
1) "I'll make a cuff at the pouch opening before emptying it."
2) "I'm planning to empty the pouch whenever it becomes full."
3) "I'll expect to see a little bleeding from my stoma when I clean it during appliance changing."
4) "I'm going to measure my stoma size each time I change the appliance for about 8 weeks."

Question 45

A nurse on the psychiatric unit admits a client in the acute manic phase of bipolar disorder. In addition, another client must be watched for high suicide risk. The nurse has many medications to administer, including two injections for the person admitted. He asks a colleague to help him perform his

duties, but the colleague says that she cannot help at the moment.
What should the nurse do?
1) Delay distribution of some medications until the situation stabilizes.
2) Ask the health care aide to watch the client at risk for suicide.
3) Place the newly admitted client in a private room.
4) Review the care priorities and once again ask for the colleague's help.

Question 46

Mr. Starsky, 45 years old, has returned to the nursing unit following abdominal surgery. He is restless; BP 160/86, P 82, RR 22. He rates his pain at 9 on a scale of 0-10. He has morphine sulfate (Morphine) 10-15 mg s.c. q.4h prn prescribed. He received morphine sulfate 10 mg s.c. 3 hours ago.
Which nursing intervention is most appropriate for Mr. Starsky's pain management at this time?
1) Administer 10 mg morphine sulfate s.c. now and reposition him.
2) Call the physician and ask for a stat order of morphine sulfate.
3) Reposition him, re-assess his pain, and then give 15 mg morphine sulfate.
4) Give 15 mg morphine sulfate s.c. at this time and re-assess in 15 min.

Question 47

Mr. O'Connor is 83 years old, recently widowed, and unable to live on his own. He was admitted 3 months ago to a long-term care facility for the elderly. He says he feels depressed and is reluctant to leave his room.
Which of the following would be the most effective intervention in promoting social interaction for Mr. O'Connor?
1) Notify his family and suggest that they telephone him daily.
2) Allow him some time alone and encourage him to go to the dining room for his meals.
3) Schedule him for participation in the facility's recreational activities.
4) Confer with his physician and recommend an antidepressant medication.

Question 48

What information about safe sexual practice should be included in a presentation to a group of adolescents?
1) The male condom should be applied before vaginal, anal or oral contact with the penis.
2) Contraceptive devices protect against sexually transmitted infections.
3) The female condom does not protect against sexually transmitted infections.
4) Diaphragms, coated with spermicidal gel, may be inserted 4-6 hours before sexual intercourse.

Question 49

Which of the following safety features should the school nurse recommend to be in place in a children's playground?
1) A concrete platform under the activity centre
2) An open slide that has an incline of not more than 60 degrees
3) Equipment that is no more than one meter from the ground
4) Foam, sand or wood chips under the swings

Question 50

Danielle Carter, 14 years old, has anorexia nervosa. She tells the nurse that when she is discharged she will go on a strict vegetarian diet.
Which one of the following shows that the nurse is communicating effectively with the health care team in relation to Danielle's intentions?
1) Records Danielle's remarks on the chart.
2) Consults the psychology service.
3) Requests a meeting of the health care team.
4) Conveys the information to the outpatient clinic team.

Question 51

Mr. Jones, age 71, has undergone a repair for a fractured hip. He confides in the nurse that he wished no one had found him after his fall. He states that since his wife of 45 years died, life "has not been worth living".
How should the nurse respond?
1) Explore his past feelings of self-worth.
2) Ask him how he was managing at home.
3) Ask him if he is having suicidal thoughts.
4) Explore his perceived adequacy of supports.

Question 52

Ms. Bryson, 65 years old, is a post-operative client who suddenly develops hemataemesis. She is pale, diaphoretic and says she feels faint. The nurse asks the student nurse to take Ms. Bryson's vital signs while she calls the physician. On returning to the client's room, the student nurse reports that the vital signs have not changed since earlier in the shift.
What should the nurse do?
1) Place the client in Trendelenburg position.
2) Instruct the student nurse to recheck the vital signs in 10 minutes.
3) Recheck the vital signs.
4) Administer a bolus of 200 mL of normal saline I.V.

Question 53

Jessica Thorton, 15 years old, has just been diagnosed with chlamydia. Jessica asks, "Who has to know about this?"
What would be the nurse's best response?
1) "Don't worry, I will keep your confidence."
2) "Because of your age, I am required to tell your parents."
3) "I am required to report this communicable disease to the public health authority."
diseases.

4) "I am not allowed to make any promises about keeping your diagnosis confidential."

Question 54

Mrs. Lane, 66 years old, is to receive an enema in preparation for a diagnostic test. The next morning, the nurse has made arrangements with Mrs. Lane to administer the enema after visiting hours around 2030 hours. Mrs. Lane's son, whom she has not seen for 2 years, arrives at 2020 hours.
What should the nurse do about administering the enema?
1) Ask Mrs. Lane's son to leave because visiting hours are over.
2) Ask her son to come back after the enema has been administered.
3) Delay the administration of the enema.
4) Try to postpone the diagnostic test.

Question 55

Which of the following contributing factors results in the highest death rates of adults in Canada?
1) Smoking
2) Automobile accidents
3) Alcohol consumption
4) Obesity

Question 56

The nurse arrives at work and discovers that there is a staff shortage for the shift. She notes that nursing students are assigned to the unit today. The nurse is assigned to 4 postoperative and 3 preoperative orthopedic clients. There are several intravenous medications to give and 2 clients have Type 1 diabetes (insulin dependent diabetes mellitus). In addition, several dressings require changing and staples need to be removed.
In evaluating this situation, which of the following actions should the nurse take?
1) Leave the dressing changes for the next shift of staff.
2) Offer to assign the preoperative teaching to a student nurse.
3) Report the situation to the unit manager.
4) Reprioritize nursing care to manage the workload effectively.

Question 57

The nurse is attending to Mr. Sagan, a postoperative client. The client is requesting an analgesic and repositioning. The health care aide enters the room to let the nurse know that another client's infusion pump's alarm is ringing.
What is the most appropriate nursing action?
1) Tell the health care aide to shut off the alarm, while the nurse repositions Mr. Sagan and obtains an analgesic.
2) Reposition and obtain an analgesic for Mr. Sagan with the help of the health care aide, and then attend to the alarm.
3) Tell the health care aide to obtain assistance to reposition Mr. Sagan, while the nurse attends to the alarm and obtains an analgesic.
4) Attend to the alarm first, and return to obtain an analgesic and to reposition Mr. Sagan later.

Question 58

Mr. Jonas, 83 years old, tells the nurse that he is refusing radiation therapy treatment because he wants to die in peace. After discussing this decision with Mr. Jonas, which one of the following replies by the nurse shows that she is fulfilling her responsibility?
1) "I will notify the physician immediately so he can stop the treatment."
2) "That is perhaps the best choice, because it's important to live in peace."
3) "I will let the other members of the healthcare team know of your decision."
4) "You can refuse your treatment today and we'll talk about it again tomorrow."

Question 59

A new nurse is in charge of a long-term care unit for elderly clients. The nurse notices on the night shift that the clients are not being turned every 2 hours as scheduled on the night shift because the 2 aides sleep. When the nurse talks to them about it, they reply, "Just look after your pills, we have more experience than you."
What should the nurse do?
1) Inform the aides that the situation will be reported to the immediate supervisor.
2) Chart that clients are not being turned every 2 hours.
3) Report the situation and her discussion with the aides to the day team.
4) Explain to the aides the consequences of their actions.

Question 60

Which lunch menu includes all food groups from Canada's Food Guide?
1) Green salad, roll and butter, fruit salad, 2% milk
2) Chicken sandwich, medium apple, tomato juice
3) Mushroom omelette, spinach salad, cranberry juice
4) Peanut butter sandwich, orange, skim milk

Question 61

Jeffrey, 6 months old, is 12 hours postoperative following correction of bilateral clubfeet and subsequent casting. He has been receiving an elixir of acetaminophen (Tylenol) and codeine po, q.4h. as ordered. His mother states that the prescribed analgesic is not effective in managing her infant's pain.
What action would be most appropriate for a nurse to take at this time?
1) Tell the mother that Jeffrey's discomfort stems from physical restraint of the casts and not from pain.
2) Tell the mother that it is to be expected that children will experience some pain following surgery.
3) Suggest to the mother that she try and distract Jeffrey by sitting in the rocking chair and singing to him.
4) Verify the mother's findings and contact the surgeon to request a change in the analgesic order.

Question 62

Which method would be appropriate when screening a class of Grade 1 children at high risk for exposure to tuberculosis?
1) Skin test
2) Sputum test
3) Respiratory assessment
4) Radiographic examination

Question 63

Mrs.Yew, 68 years old, calls the nurse to report that her intravenous bag is nearly empty.
In order to safely change to a new bag of intravenous fluid, what action should the nurse take?
1) Allow existing solution to clear the drip chamber.
2) Open roller clamp prior to spiking new bag.
3) Keep existing bag upright before closing the clamp.
4) Remove spike from existing bag prior to removing protective cover from new bag.

Question 64

Which one of the following must guide the nurse when providing nursing care?
1) Medical orders
2) The priorities determined by the nurse
3) Client needs
4) The nurse's skills based on the health situation

Question 65

Joey, 12 years, has terminal cancer. He has been melancholic all day.
1) "Would you like to take a break from all this and go to the teen room?"
2) "Joey, you're not in this alone. All of us are dying."
3) "This must be hard for you."
4) "I guess sometimes God works in mysterious ways."

Question 66

A 38-year-old male client with a diagnosis of paranoid schizophrenia is being treated with the neuroleptic medication olanzapine (Zyprexa). He comes to the nursing desk with a stiff neck deviating to one side, an enlarged tongue sticking out of his mouth and he is drooling. His arms and legs are stiff and he appears to be short of breath.
Which of the following prescribed prn medications should the nurse administer?
1) Benzotropine mesylate (Cogentin) I.M.
2) Trihexphenidyl (Artane) p.o.
3) Lorazepam (Ativan) I.M.
4) Olanzapine (Zyprexa) SL

Question 67

Mrs. Lee, 57 years old, is scheduled for a left femoral arteriogram. She states, "The physican told me I have to have an x-ray of my leg. Will I be able to go home right after?"
How should the nurse respond?
1) "Your physician should have explained the test. It's more involved than just an x-ray."
2) "This procedure is more than just an x-ray. What else did the physician tell you about this test?"
3) "With this type of x-ray, clients are allowed to go home right away."
4) "Clients who have this test need to be kept overnight to watch for complications."

Question 68

Peter, a 28- year-old skier, has just returned from the O.R. following an open reduction of a fractured femur. He is experiencing post-op pain. Acetaminaphen (Tylenol) 1 g, p.o., q 4h, p.r.n. has been ordered.
What action should the nurse take?
1) Give the medication and inform the client of the physician's order.
2) Give the medication and leave a request on the chart for a change in orders.
3) Call the physician and request a change in analgesia.
4) Give the medication and assess effect of the analgesic.

Question 69

The nurse is responsible for planning weekly interdisciplinary team meetings. She has observed that Dr. Cooper rarely attends, even though he is present on the unit.
How should the nurse respond?
1) Meet with him separately to discuss issues related to clients' care.
2) Remind him of his responsibility to collaborate with team members.
3) Discuss with him the reasons for not attending scheduled meetings.
4) Offer to reschedule meetings at a more convenient time.

Question 70

Mr. Porter, 67 years old, has prostate cancer with bone metastases. He says that he is in excruciating pain, which has not been alleviated.
What should the nurse know about use of pharmaceutical agents to manage Mr. Porter's pain?
1) Alleviation is usually optimal when the person can use a patient controlled analgesic pump.
2) Administering analgesics every 4 hours is sufficient to alleviate Mr. Porter's pain.
3) The analgesic doses must be spaced out as much as possible to prevent tolerance in Mr. Porter.
4) Codeine is particularly effective in alleviating cancer pain.

Question 71

Ms. Mitchell, 19 years old, arrives at the hospital having been beaten and sexually assaulted. She shares with the nurse that the perpetrator of the assault was her boyfriend. The police arrive at the hospital and ask the nurse for information regarding the identity of the perpetrator.
What should the nurse do?
1) Disclose the identity of the perpetrator to the police.
2) Tell the police to return after the assessment has been completed.
3) Ask the client if she would like to speak to the police.
4) Direct the police to the client's room.

Question 72

Which of the following statements should the nurse include when teaching parents of a 5-month-old infant about child safety?
1) Ensure that electrical outlets are covered or plugged.
2) Remove drapery cords that may dangle close to the crib.
3) Have prescriptions dispensed in containers with childproof caps.
4) Install safety latches on cabinets that contain cleaning products.

Question 73

Amy Carter, 4 years old, is scheduled for a cardiac catheterization.
What should the nurse do to prepare Amy for the procedure?
1) Describe the procedure to Amy and her parents.
2) Give Amy a tour of the procedure room and let her handle the equipment to be used.
3) Use a doll to help explain the procedure to Amy.
4) Show Amy a model of the heart and explain how the catheter is inserted.

Question 74

Mrs. Poole, 66 years old, goes into cardiac arrest. The physician asks the nurse who is a recent graduate to defibrillate Mrs. Poole.
Why is the nurse justified in refusing to defibrillate Mrs. Poole?
1) The nurse wishes to comply with the wishes of Mrs. Poole's spouse who does not want her resuscitated.
2) Cardiac defibrillation goes against the nurse's personal values.
3) The nurse must not perform any act outside the nurse's level of competence.
4) A colleague who is very familiar with defibrillation must guide the nurse in the technique.

Question 75

For several years, student nurses have come to the campus health nurse with disturbing levels of stress. They typically complain about an overwhelming workload. The nurse has raised the issue with faculty but has seen no changes.
What should the nurse do?
1) Work with the students to assist them with time management skills.
2) Bring the problem to the attention of the student body and faculty again.
3) Set up an after-hours class to teach them relaxation techniques.
4) Work with students to lobby nursing faculty for changes in student workload.

**Question 76**

The nurse wants to evaluate her performance as a caregiver. What should she do as a first step?

1) Conduct a self-assessment.
2) Validate her perceptions with her immediate supervisor.
3) Ask the opinion of the health care team members.
4) Question the clients for whom she is responsible.

**Question 77**

When teaching a parent from a specific ethnic background about family nutrition, what is the most appropriate nursing action?
1) Discuss the possible need to alter traditional cooking practices.
2) Reassure the parent that foods in Canada are of a high standard.
3) Ask the parent about the family's nutritional preferences.
4) Tell the parent to document the family's dietary habits for one week.

Question 78

A 65-year-old male client arrives at the local clinic. On examination, his colour is pink, but he states that he has been having increasing dyspnea on exertion which has now progressed to difficulty breathing while at rest. He does not have a cough or sputum production. He has an increased anterior-posterior chest diameter, decreased breath sounds, and decreased oxygen saturation.
Which one of the following questions would be appropriate for the nurse to ask based on these findings?
1) "Do you have a family history of emphysema?"
2) "Have you ever had any teaching on normal respiratory changes with aging?"
3) "Did you recently receive the flu vaccine?"
4) "Have you recently been in contact with a person with Tuberculosis?"

**Question 79**

No personal obligation, personal use and guidance only.

The nurse at an elementary school has observed a trend of pedestrian-vehicle accidents and wishes to promote a school safety patrol program.
How will the nurse best gain support for this program?
1) Write a letter to all the students of the school inviting them to participate in the program.
2) Collect data on the traffic patterns in the community and submit the findings to the local health department.
3) Make an appointment with the school principal and parent council to discuss a safety patrol program.
4) Submit a proposal to the school board requesting that a safety patrol program be mandated.

**Question 80**

A client is receiving palliative care at home. During a biweekly visit, the nurse finds that the client has begun to experience occasional nausea and retching.
Which of the following nursing actions is most appropriate?
1) Contact the physician to order an oral antiemetic.
2) Sit with the client and assist in identifying triggers.
3) Recommend that the client rest an hour after each meal in side-lying position.
4) Encourage adequate hydration by adding more fruit juices.

**Question 81**

Mr. Scott is a 37-year-old homeless person. The community health nurse finds him huddled in a doorway shaking. The nurse notes a large infected ulcer over his left lower leg and suggests he go to the nearest treatment facility.
What should the nurse do when Mr. Scott refuses?
1) Speak with Mr. Scott's homeless friends and ask them to encourage him to seek treatment.
2) Contact the community police and request that they escort Mr. Scott to a treatment facility.
3) Offer to buy Mr. Scott some coffee and a sandwich if he will agree to go for treatment.
4) Assess Mr. Scott's mental status to make sure that he is able to understand the need for treatment.

**Question 82**

Ms. Benoit is recovering from orthopaedic surgery 3 days ago. She requests acetaminophen (Tylenol) plain instead of her ordered dosage of acetaminophen with codeine 30 mg (Tylenol 3).
What should the nurse base her action on?
1) It is appropriate to give a lower dosage of analgesic than ordered.
2) Ms. Benoit should have her pain medication re-evaluated by her doctor.
3) At this level of pain, non-pharmacological interventions will be sufficient.
4) Ms. Benoit's request to have her analgesic reduced indicates concern about addiction.

**Question 83**

Mr. Davis, 73 years old, is a palliative client who has requested that he be allowed to die at home. Mrs. Davis tells the home care nurse that she is tired, and does not know how much longer she can cope with the responsibility of providing total care for her husband.
What course of action should the nurse take?
1) Offer to stay with Mr. Davis for a few hours while Mrs. Davis rests.
2) Discuss with her the necessity of Mr. Davis being admitted to the hospital.
3) Suggest that Mrs. Davis involve her family with her husband's care.
4) Discuss with Mrs. Davis possible options for respite care.

**Question 84**

The registered nurse (RN) in charge of a long-term care agency from midnight to 0800 is confronted with a clinical situation concerning a resident. She is the only RN on duty and is unsure about how to handle the situation. She is unable to find a written agency policy, protocol or procedure.
Which of the following would best guide her decision-making?
1) The client's wishes
2) Consultation with other night staff
3) Professional standards of practice
4) The client's health record

**Question 85**

What is the best advice a nurse can give to a day-care supervisor who wishes to decrease the incidence of bacterial conjunctivitis (pink eye)?
1) Improve waste disposal techniques in the classrooms.
2) Sterilize all visibly soiled toys at the end of each day.
3) Increase the frequency of handwashing by staff and children.
4) Ensure proper ventilation throughout the building.

## View multiple-choice questions and answers

Click on the question link to view the question details.
Click on ▼ to view all.
Click on the question link again to hide the question details.
Click on ▲ to hide all.

Green denotes the correct answer you provided. Blue denotes the correct answer. Red denotes the incorrect answer you provided.

Question 1

1

Mrs. Soo Lee, 80 years old, widowed, lives with her daughter, son-in-law, and two grandchildren. Her daughter and son-in-law work full-time outside of the home. The two grandchildren attend university full-time. Mrs. Soo Lee has been recently diagnosed with early stage Alzheimer's disease. She speaks English but has been using Mandarin more and more in all her communications in the last 3 months. A non-Mandarin speaking nurse has been assigned to assess how Mrs. Soo Lee and her family are coping with this situation.

**How should the nurse initially collect data about Mrs. Soo Lee's situation?**

1) **Ask Mrs. Soo Lee and her daughter to describe changes Mrs. Soo Lee may have recently experienced.**

   *Rationale:* Basic therapeutic communication requires the establishment of a respectful relationship with the client in order to obtain assessment data.

2) Ask Mrs. Soo Lee's daughter to translate the nurse's questions and Mrs. Lee's answers.

   *Rationale:* Approaching the daughter first assumes the mother is incapable of communicating and establishing a relationship.

3) Interview Mrs. Soo Lee's family members to explore their perceptions of the situation over the past few months.

   *Rationale:* Involving all the members of the family would be excessively confusing for the client with Alzheimer's.

4) Have Mrs. Soo Lee's daughter describe the changes she has seen in her mother.

   *Rationale:* Having the daughter describe the changes observed in Mrs. Lee may be valid but would not be the first step.

References:

Ignatavicius, D. D. & Workman, M. L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.) St. Louis, Missouri: Elsevier Saunders, p. 965-967.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing: Clinical management for positive outcomes* (7th ed.) St. Louis, Missouri: Elsevier Saunders, p. 2167.

Question 2

2

Mrs. Soo Lee, 80 years old, widowed, lives with her daughter, son-in-law, and two grandchildren. Her daughter and son-in-law work full-time outside of the home. The two grandchildren attend university full-time. Mrs. Soo Lee has been recently diagnosed with early stage Alzheimer's disease. She speaks English but has been using Mandarin more and more in all her communications in the last 3 months. A non-Mandarin speaking nurse has been assigned to assess how Mrs. Soo Lee and her family are coping with this situation.

**What suggestion should the nurse make to the family in order to promote Mrs. Soo Lee's safety in the home?**

1) Ensure all exit doors are securely locked.

   *Rationale:* Wandering does not occur until the later stages of Alzheimer's. Locking her in is likely to interfere with independence and self esteem.

2) Arrange to have Mrs. Soo Lee supervised at all times.

   *Rationale:* Early stage Alzheimer's may be forgetful but can function with some degree of independence.

3) **Identify and eliminate potential hazards in the home.**

   *Rationale:* Falls are common causes of injury in the elderly.

4) Do not allow Mrs. Soo Lee to use any electrical appliances.

   *Rationale:* Early stage Alzheimer's does not require this level of restriction of activities. Normal activities of daily living should be encouraged as long as possible.

References:

Ignatavicius, D. D. & Workman, M. L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.) St. Louis, Missouri: Elsevier Saunders, p. 970-972.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing: Clinical management for positive outcomes* (7th ed.) St. Louis, Missouri: Elsevier Saunders, p. 2169.

Question 3

3

Mrs. Soo Lee, 80 years old, widowed, lives with her daughter, son-in-law, and two grandchildren. Her daughter and son-in-law work full-time outside of the home. The two grandchildren attend university full-time. Mrs. Soo Lee has been recently diagnosed with early stage Alzheimer's disease. She speaks English but has been using Mandarin more and more in all her communications in the last 3 months. A non-Mandarin speaking nurse has been assigned to assess how Mrs. Soo Lee and her family are coping with this situation.

**Mrs. Soo Lee's daughter reveals to the nurse that her mother has become increasingly frustrated and angry in the last 2 weeks. Which of the**

**following explanations by the nurse would best assist the family in understanding Mrs. Soo Lee's change in behaviour?**

1) Making demands on Mrs. Soo Lee will lead to further agitation.

*Rationale:* This response is too general to be helpful.

2) Frustration may be eased by performing complex tasks for Mrs. Soo Lee.

*Rationale:* Performing tasks for her may decrease her self esteem and increase her frustration.

3) Mrs. Soo Lee's outbursts are characteristic of the illness and are predictable.

*Rationale:* Making excessive demands on Alzheimer's clients may lead to aggressive behavior.

4) **Mrs. Soo Lee's behaviour could be due to her awareness that she cannot remember.**

*Rationale:* Helping the family to understand the changes in Mrs. Lee may assist them to avoid unreasonable demands. Acceptance of this change in behavior is important in dealing with clients with Alzheimer's.

References:

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 466.

Smeltzer, S. C. & Bare, B. G. (2004). *Brunner and Suddarth's textbook of medical-surgical nursing* (10th ed.) Philadelphia, PA, Lippincott-Raven.

Question 4

4

Mrs. Soo Lee, 80 years old, widowed, lives with her daughter, son-in-law, and two grandchildren. Her daughter and son-in-law work full-time outside of the home. The two grandchildren attend university full-time. Mrs. Soo Lee has been recently diagnosed with early stage Alzheimer's disease. She speaks English but has been using Mandarin more and more in all her communications in the last 3 months. A non-Mandarin speaking nurse has been assigned to assess how Mrs. Soo Lee and her family are coping with this situation.

**Mrs. Soo Lee becomes anxious and distracted during mealtime with the family and seldom finishes her meals. What suggestion should the nurse give to the family?**

1) **Family members should speak one at a time during mealtime.**

*Rationale:* Each member of the family cooperates in a unified approach which reduces noise, confusion and sensory overload for Mrs. Lee.

2) Mrs. Soo Lee's daughter should guide the mealtime conversations.

*Rationale:* This puts unnecessary stress and responsibility on the daughter. The whole family needs to share the responsibility.

3) Mrs. Soo Lee should have her meals in a separate room.

*Rationale:* This discourages family interaction and is likely to make Mrs. Lee feel isolated.

4) The grandchildren should be encouraged to speak Mandarin during meals.

*Rationale:* This would not help Mrs. Lee to become less distracted at meal time. The family needs to interact, but in a calm, organized way.

References:

Ignatavicius, D. D. & Workman, M. L. (2006). Medical-surgical nursing: Critical thinking for collaborative care (5th ed.) St. Louis, Missouri: Elsevier Saunders, p. 968-969.

Smeltzer, S. C. & Bare, B. G. (2004). *Brunner and Suddarth's textbook of medical-surgical nursing* (10th ed.) Philadelphia, PA, Lippincott-Raven.

Question 5

5

Mrs. Soo Lee, 80 years old, widowed, lives with her daughter, son-in-law, and two grandchildren. Her daughter and son-in-law work full-time outside of the home. The two grandchildren attend university full-time. Mrs. Soo Lee has been recently diagnosed with early stage Alzheimer's disease. She speaks English but has been using Mandarin more and more in all her communications in the last 3 months. A non-Mandarin speaking nurse has been assigned to assess how Mrs. Soo Lee and her family are coping with this situation.

**Mrs. Soo Lee's daughter expresses to the nurse that the family and Mrs. Soo Lee prefer to use traditional Chinese medicine. What is the nurse's most appropriate response?**

1) "It is understandable that you would want to consider other treatment alternatives."

*Rationale:* This acknowledges the family's wishes but does not encourage further exploration of meaning.

2) "I understand your reluctance to accept Western medicine though it offers the best hope for a quality life."

*Rationale:* This response makes an assumption about the family's reluctance and reflects the nurse's perspective on both "quality of life" and Western medicine.

3) **"I would like to know more about your beliefs regarding health and illness."**

*Rationale:* This response shows cultural sensitivity and opens the opportunity for the daughter to provide and clarify cultural beliefs.

4) "A combination of Western and Chinese medicine might be appropriate to meet everyone's needs."

*Rationale:* This response offers the nurse's perspective without hearing the family's beliefs and rationale.

References:
Shives, L. R. (2005). *Basic concepts of psychiatric-mental health nursing* (6th ed.) Philadelphia, PA: Lippincott, Williams and Wilkins, p. 367-368.

Kozier, B., Erb, G., Berman, A. J., Burke, K., Bouchal, D. S. R., & Hirst, S. P. (2004). *Fundamentals of nursing: The nature of nursing practice in Canada.*Toronto: Prentice Hall, p. 177.

Question 6

6

Mrs. Soo Lee, 80 years old, widowed, lives with her daughter, son-in-law, and two grandchildren. Her daughter and son-in-law work full-time outside of the home. The two grandchildren attend university full-time. Mrs. Soo Lee has been recently diagnosed with early stage Alzheimer's disease. She speaks English but has been using Mandarin more and more in all her communications in the last 3 months. A non-Mandarin speaking nurse has been assigned to assess how Mrs. Soo Lee and her family are coping with this situation.

**Mrs. Soo Lee tells the nurse about feeling lonely during the day. Which one of the following actions by the nurse would best address these concerns?**

1) Encourage family members to spend more time with Mrs. Soo Lee during the day.

   *Rationale:* Family members may have difficulty addressing psychosocial needs of the client with Alzheimer's disease. They may not have additional time to spend with the individual.

2) **Explore with Mrs. Soo Lee and her family the possibility of participating in community programs for persons with Alzheimer's disease.**

   *Rationale:* Access to community resources may support family members in better addressing needs of the client with Alzheimer's disease in the home setting.

3) Provide Mrs. Soo Lee and family members with information on in-patient care for persons with Alzheimer's disease.

   *Rationale:* This distractor assumes that admission to an in-patient facility is the most effective way of addressing the client's needs. It may not be the wish of the family or client. Consideration of in-patient care is premature at this point.

4) Reassure Mrs. Soo Lee and her family that this is a common concern for elderly persons.

   *Rationale:* This distractor does not address the concerns expressed by the client.

References:
Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 468.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing: Clinical management for positive outcomes* (7th ed.) St. Louis, Missouri: Elsevier Saunders, p. 2169-2172.

Question 7

7

A group of people have been meeting to support individuals who are seropositive for Human Immunodeficiency Virus (HIV) or who have Acquired Immunodeficiency Syndrome (AIDS). People involved in this group include people living with HIV/AIDS, their family and friends, and interested individuals from the community. A nurse from the HIV/AIDS clinic is working with this group within the community.

**The group is currently addressing the need for an AIDS hospice within the community. Group members are in conflict over the need for such a facility. Which of the following actions by the nurse would be most useful in assisting this group to address this issue?**

1) Providing data on the number of individuals in the community who have AIDS.

   *Rationale:* Although this information would be useful for the current situation, it would not likely address future needs and is only one piece of information needed to support the decision-making.

2) **Encouraging an assessment of the needs of the community for this type of facility.**

   *Rationale:* A community assessment process is a much broader assessment tool to explore the issue more fully within the context of the community and its health service needs.

3) Evaluating the effectiveness of care provided to persons within the existing facilities.

   *Rationale:* Although the effectiveness of care with the current health facilities is useful information, it doesn't address future needs of this segment of the community.

4) Contacting local health services officials to determine their willingness to provide funding.

   *Rationale:* Community groups often need to lobby officials to identify needs for additional services. A proper needs assessment would provide rationale for the funding request.

References:
Hitchcock, J. E., Schubert, P. E. & Thomas, S. A. (2003). *Community health nursing: Caring in action* (2nd ed.) New York: Thomson Delmare Learning, p. 312.

Stamler, L. L. & Yiu, L. (2005). *Community health nursing: A Canadian perspective.* Toronto: Pearson Prentice Hall, p. 156.

Question 8

8

A group of people have been meeting to support individuals who are seropositive for Human Immunodeficiency Virus (HIV) or who have Acquired Immunodeficiency Syndrome (AIDS). People involved in this group include people living with HIV/AIDS, their family and friends, and interested individuals from the community. A nurse from the HIV/AIDS clinic is working with this group within the community.

**Group members continue to be in conflict over the appropriate course of action regarding the AIDS hospice. Which of the following actions by the nurse would best assist members to resolve their conflict?**

1) **Encourage members to vote on the appropriate course of action.**

   *Rationale:* Members are often unable to listen actively to opposing views when they are in dispute. A mechanism for examining opposing opinions is most useful.

2) Encourage individuals with similar opinions to support one another.

   *Rationale:* This strategy is more likely to polarize members and support them in current opinions rather than in resolving the conflict.

3) Encourage members to state their own views in greater detail.

   *Rationale:* This strategy may add to understanding of the position but more frequently results in more strongly stated positions without resolution of conflict. This action must be followed by group examination of the stated positions.

4) **Encourage members to examine the values underlying the various positions.**

   *Rationale:* This strategy encourages the whole group to examine values and beliefs underlying each stated position and to identify common values to be acted on, thus encouraging agreement.

References:
Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 673.

Allender, J. A. & Spradley, B. W. (2001). *Community health nursing: Concepts and practice* (5th ed.) Philadelphia, PA: Lippincott, p. 190.

Question 9

9

A group of people have been meeting to support individuals who are seropositive for Human Immunodeficiency Virus (HIV) or who have Acquired Immunodeficiency Syndrome (AIDS). People involved in this group include people living with HIV/AIDS, their family and friends, and interested individuals from the community. A nurse from the HIV/AIDS clinic is working with this group within the community.

**What type of information would be most useful to this group in their planning for the hospice and the programs to be offered?**

1) **The number of individuals diagnosed with HIV in the community**

   *Rationale:* This information is useful to determine possible future need for service but omits the characteristics of those needing service.

2) **Local demographic information about individuals with HIV/AIDS**

   *Rationale:* This data is most likely to provide both numbers of individuals affected and their characteristics as a basis for program planning.

3) Grants available for health services and programs offered in other communities

   *Rationale:* Research on programs in other communities could be very useful, but is not directly related to the needs of members of this community.

4) Common modes of transmission and effective treatments

   *Rationale:* This research information likely has little relevance to programs and services offered to those who are experiencing AIDS.

References:
Clemen-Stone, S., McGuire, S. L. & Eigsti, D. G. (2002). *Comprehensive community health nursing: Family, aggregate, & community practice* (6th ed.) St. Louis, Missouri: Mosby, p.454-467.

Allender, J. A. & Spradley, B. W. (2001). *Community health nursing: Concepts and practice* (5th ed.) Philadelphia, PA: Lippincott, p. 364.

Question 10

10

A group of people have been meeting to support individuals who are seropositive for Human Immunodeficiency Virus (HIV) or who have Acquired Immunodeficiency Syndrome (AIDS). People involved in this group include infected individuals, their families and friends, and interested individuals from the community. A nurse from the HIV/AIDS clinic is working with this group within the community.

**Which of the following activities by the nurse would encourage the group to assume ownership for the development of their proposal for a hospice?**

1) **Contact local media to publicize the group's efforts.**

*Rationale:* The nurse's action takes away from the group's decision-making concerning their plans.

2) Arrange for group members to interview influential community persons.

*Rationale:* The nurse has decided on a particular course of action which may be beneficial, but should come from the group.

3) **Assist the group to connect with hospices in other communities.**

*Rationale:* By arranging for the group to connect with other hospices, the group can then decide what type of hospice would best suit their needs, and begin the planning of their proposal.

4) Contact local politicians to assist the group with their proposal.

*Rationale:* The nurse has decided on a course of action for the group which may remove decision-making from the group. It would be more beneficial for the group to contact other persons.

References:
Clemen-Stone, S., McGuire, S. L. & Eigsti, D. G. (2002). *Comprehensive community health nursing: Family, aggregate, & community practice* (6th ed.) St. Louis, Missouri: Mosby, p. 490-491.

Allender, J. A. & Spradley, B. W. (2001). *Community health nursing: Concepts and practice* (5th ed.) Philadelphia, PA: Lippincott, p. 143.

Question 11

11

A group of people have been meeting to support individuals who are seropositive for Human Immunodeficiency Virus (HIV) or who have Acquired Immunodeficiency Syndrome (AIDS). People involved in this group include infected individuals, their families and friends, and interested individuals from the community. A nurse from the HIV/AIDS clinic is working with this group within the community.

**The group members have been discussing the factors that influence the health outcomes of individuals who have AIDS. Which of the following is a social determinant of health for these individuals?**

1) Mode of transmission of HIV

*Rationale:* Not a social determinant of health.

2) Presence of Pneumocystis carinii pneumonia

*Rationale:* Not a social determinant of health.

3) **Financial stability and support**

*Rationale:* This is a social determinant of health which has impact on the progress and outcome of the illness.

4) Gender and ethnic background

*Rationale:* Not a related social determinant of health for HIV.

References:
Stamler, L. L. & Yiu, L. (2005). *Community health nursing: A Canadian perspective.* Toronto: Pearson Prentice Hall, p. 76-78.

Potter, P. A. & Perry, A. G. (2006). *Canadian fundamentals of nursing* (3rd ed.) Toronto: Elsevier Mosby, p. 7-11.

Question 12

12

A group of people have been meeting to support individuals who are seropositive for Human Immunodeficiency Virus (HIV) or who have Acquired Immunodeficiency Syndrome (AIDS). People involved in this group include infected individuals, their families and friends, and interested individuals from the community. A nurse from the HIV/AIDS clinic is working with this group within the community.

**Marie Jameson, a group member, asks the nurse about prevention of transmission of HIV among family members. Her son, Jim, has recently been diagnosed as seropositive for HIV. Which of the following is the most effective strategy for teaching this information?**

1) Provide her with pamphlets describing standard (universal) precautions in the home setting.

*Rationale:* Use of pamphlets is an excellent means of reinforcing learning but should not take the place of the nurse's teaching role.

2) **Begin by answering Marie's questions about prevention of transmission of HIV.**

*Rationale:* The learning situation is most effective when the nurse responds directly to learner questions and allows the learner to guide the learning situation through her questions.

3) Provide current research information about modes of transmission of HIV.

*Rationale:* Assuming the learner's needs for information may result in information being presented to the learner unnecessarily and redundantly.

4) Refer Marie to library resources that describe various infection control measures.

*Rationale:* The nurse should respond to learner questions before referring clients to more extensive and independent sources of information which may be less useful to the learner.

References:
Potter, P. A. & Perry, A. G. (2006). *Canadian fundamentals of nursing* (3rd ed.) Toronto: Elsevier Mosby, p. 220, 328.

Kozier, B., Erb, G., Berman, A .J., Burke, K., Bouchal, D. S. R., & Hirst, S. P. (2004). *Fundamentals of nursing: The nature of nursing practice in Canada.* Toronto: Prentice Hall, p. 681-685.

Question 13

13

Mr. Chalmers, 53 years old, is admitted to the hospital. During the nursing assessment, he tells the nurse that he has had blood in his urine for several weeks, is urinating frequently, and is experiencing pain when he urinates. He also states that he does not feel his bladder is empty after he voids. Blood work and a cystoscopy confirm the diagnosis of cancer of the prostate.

**Based on the information obtained from the client, which of the following lab results should be expected to return abnormally elevated?**

1) HCG

*Rationale:* Human Chorionic Gonadotropin - elevated in ovarian and testicular cancers.

2) **PSA**

*Rationale:* Prostate Specific Antigen - elevated with prostatic cancer and benign prostatic hyperplasia.

3) AFP

*Rationale:* Alpha (sign)-fetoprotein - elevated with liver cancer.

4) CEA

*Rationale:* Carcinoembryonic Antigen - elevated in breast, colorectal and lung cancers.

References:
Ignatavicius, D. D. & Workman, M. L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.) St. Louis, Missouri: Elsevier Saunders, p. 1865-1866.

Smeltzer, S. C. & Bare, B. G. (2004). *Brunner & Suddarth's textbook of medical-surgical nursing* (10th ed.) Philadelphia, PA: Lippincott, Williams, & Wilkins, p. 1497.

Question 14

14

Mr. Chalmers, 53 years old, is admitted to the hospital. During the nursing assessment, he tells the nurse that he has had blood in his urine for several weeks, is urinating frequently, and is experiencing pain when he urinates. He also states that he does not feel his bladder is empty after he voids. Blood work and a cystoscopy confirm the diagnosis of cancer of the prostate.

**Mr. Chalmers undergoes a radical prostatectomy and returns to his room with a three-way urinary catheter with bladder irrigation. Six hours postoperatively, Mr. Chalmers reports a feeling of fullness in his abdomen and states that he has the urge to void. Which of the following actions should the nurse do?**

1) **Assess the catheter drainage system for patency.**

*Rationale:* Clots may form in the bladder and block the flow of urine postoperatively.

2) Increase his fluid intake for the next 2 hours.

*Rationale:* The problem is not inadequate fluid intake, but a blocked catheter.

3) Inform him that this is expected and encourage him to relax.

*Rationale:* The feeling of abdominal fullness is not normal with a patent Foley catheter.

4) Remove and reinsert the catheter.

*Rationale:* The catheter should be irrigated and the physician consulted before discontinuing and reinserting it.

References:
Ignatavicius, D. D. & Workman, M. L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.) St. Louis, Missouri: Elsevier Saunders, p. 1862-1864.

Smeltzer, S. C. & Bare, B. G. (2004). *Brunner & Suddarth's textbook of medical- surgical nursing* (10th ed.) Philadelphia, PA: Lippincott, Williams, & Wilkins, p. 1506-1507.

Question 15

15

Mr. Chalmers, 53 years old, is admitted to the hospital. During the nursing assessment, he tells the nurse that he has had blood in his urine for several weeks, is urinating frequently, and is experiencing pain when he urinates. He also states that he does not feel his bladder is empty after he voids. Blood work and a cystoscopy confirm the diagnosis of cancer of the prostate.

**Mr. Chalmers is receiving morphine via a Patient Controlled Analgesia (PCA) pump, on a demand dosage schedule. Mrs. Chalmers tells the nurse that she is concerned that her husband will overdose himself. Which of the following is the best response by the nurse?**

1) "If you prefer, the nurse could administer his medication."

   *Rationale:* This would not be the first option available and does not include the client.

2) "It would be helpful if you record the frequency of his morphine use."

   *Rationale:* PCA records the frequency and this does not address her concerns.

3) "There is not enough morphine in the pump to cause serious harm."

   *Rationale:* The PCA syringe does hold enough medication to cause serious adverse effects.

4) **"The pump is programmed to prevent morphine overdosage."**

   *Rationale:* This response provides accurate information to the client's wife.

References:
Ignatavicius, D. D. & Workman, M .L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.) St. Louis, Missouri: Elsevier Saunders, p. 351-352.

Potter, P. A. & Perry, A. G. (2006). *Canadian fundamentals of nursing* (3rd ed.) Toronto: Elsevier Mosby, p. 1264-1265.

Question 16

16

Mr. Chalmers, 53 years old, is admitted to the hospital. During the nursing assessment, he tells the nurse that he has had blood in his urine for several weeks, is urinating frequently, and is experiencing pain when he urinates. He also states that he does not feel his bladder is empty after he voids. Blood work and a cystoscopy confirm the diagnosis of cancer of the prostate.

**The nurse assesses Mr. Chalmers response to his morphine. He states that he is feeling comfortable. The nurse notes the following: BP 98/62 mmHg, P 82, R 14, drowsy, but rouses easily. Based on this assessment, what should the nurse do?**

1) Turn the PCA pump off.

   *Rationale:* The client's vital signs and physical status do not warrant discontinuing his PCA infusion.

2) Decrease the dose of the morphine.

   *Rationale:* The client's vital signs and physical status do not warrant decreasing the amount of the medication.

3) Notify the physician of the client's vital signs.

   *Rationale:* The client's vital signs and physical status do not warrant physician intervention at this time.

4) **Continue routine assessment of the client.**

   *Rationale:* These are normal side effects of morphine and the client should continue to be monitored for any adverse effects (e.g., further respiratory depression).

References:
Ignatavicius, D. D. & Workman, M. L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.) St. Louis, Missouri: Elsevier Saunders, p. 352-353.

Smeltzer, S. C. & Bare, B. G. (2004). *Brunner & Suddarth's textbook of medical-surgical nursing* (10th ed.) Philadelphia, PA: Lippincott, Williams, & Wilkins, p. 235-236.

Question 17

17

Mr. Chalmers, 53 years old, is admitted to the hospital. During the nursing assessment, he tells the nurse that he has had blood in his urine for several weeks, is urinating frequently, and is experiencing pain when he urinates. He also states that he does not feel his bladder is empty after he voids. Blood work and a cystoscopy confirm the diagnosis of cancer of the prostate.

**Mr. Chalmers asks the nurse if he will be able to have sexual intercourse with his wife when he recovers from his surgery. How should the nurse respond to Mr. Chalmers' question?**

1) "You will need to discuss this further with your doctor."

   *Rationale:* This response would not promote an open discussion with the client regarding his concerns.

2) **"What have you been told regarding the effects of your surgery?"**

   *Rationale:* Assesses the client's knowledge base prior to health teaching.

3) "There are many other ways of experiencing sexual intimacy."

   *Rationale:* This response makes the assumption that the client is impotent.

4) "Were you experiencing problems prior to surgery?"

*Rationale:* This does not answer the client's question or address his concerns.

References:
Ignatavicius, D. D. & Workman, M. L. (2006). *Medical-surgical nursing: Critical thinking for collaborative care* (5th ed.) St. Louis, Missouri: Elsevier Saunders, p.1860.

Smeltzer, S. C. & Bare, B. G. (2004). *Brunner & Suddarth's textbook of medical-surgical nursing* (10th ed.) Philadelphia, PA: Lippincott, Williams, & Wilkins, p.1500.

Question 18

18

Mr. James, a 19-year-old student, abruptly dropped out of college and returned home. His parents take him to the family doctor, stating that his behaviour is increasingly bizarre. They say that he appears to be listening to and responding to voices that no one else can hear. He is anxious, restless, and unable to sleep. He has not eaten regularly and has lost 10 kg from his normal weight of 75 kg. He has not washed or changed his clothes in the last 5 days. Mr. James tells the physician that he is very frightened and wants to go to hospital because the "voices hate women. I'm afraid of what they may make me do". Mr. James is admitted to the psychiatric ward of the local hospital as a voluntary client.

**At dinner time on his first hospital day, the nurse suggests to Mr. James that he wash his face and change his shirt before he joins the other clients in the dining room. Mr. James says he wants to stay in his room. What is the nurse's most appropriate response?**

1) **Ask him if he would like dinner brought to him in his room.**

*Rationale:* This shows appropriate concern and a respect for his decision, which may promote a trusting relationship. A voluntary client cannot be forced to participate in treatment.

2) Remind him that socializing with others is part of his therapy.

*Rationale:* This is true, but at this early stage he is likely too anxious to be in the company of many other people in what is still a strange environment.

3) Respect his wishes and leave him alone in his room.

*Rationale:* While this respects his wishes, this response fails to show an appropriate level of therapeutic concern.

4) Suggest to him that not eating is unhealthy.

*Rationale:* His failure to eat one more meal is not dangerous at this time. Any suggestion of pressure to comply may increase his anxiety and exacerbate his problems.

References:
Shives, L. R. (2005). *Basic concepts of psychiatric-mental health nursing* (6th ed.). Philadelphia, PA: Lippincott, Williams and Wilkins, p. 250.

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 406.

Question 19

19

Mr. James, a 19-year-old student, abruptly dropped out of college and returned home. His parents take him to the family doctor, stating that his behaviour is increasingly bizarre. They say that he appears to be listening to and responding to voices that no one else can hear. He is anxious, restless, and unable to sleep. He has not eaten regularly and has lost 10 kg from his normal weight of 75 kg. He has not washed or changed his clothes in the last 5 days. Mr. James tells the physician that he is very frightened and wants to go to hospital because the "voices hate women. I'm afraid of what they may make me do". Mr. James is admitted to the psychiatric ward of the local hospital as a voluntary client.

**Mr. James tells the nurse, "the voices are with me now.". Which answer by the nurse best reflects both a therapeutic and respectful response to his statement?**

1) **"I don't hear the voices. Tell me about the voices you hear."**

*Rationale:* This response works toward establishing a trusting relationship because it acknowledges his reality and anxiety. It correctly attempts to establish the nature of his hallucinatory experience before taking other steps in helping him control it.

2) "The voices aren't really there. Only you are hearing them."

*Rationale:* The hallucinations are very real for the client. It is an inappropriate first step to deny their existence. This approach tends to decrease the client's trust and increase his anxiety. It does not respect his experience.

3) "I don't hear any other voices in this room."

*Rationale:* Pointing out only that the nurse does not hear the voices will not encourage further discussion of the client's hallucinations.

4) "Your voice is the only one that I can hear."

*Rationale:* This is not the best response because it fails to clarify the nature of the hallucinations which is an important initial step in their management.

References:
Shives, L. R. (2005). *Basic concepts of psychiatric-mental health nursing* (6th ed.) Philadelphia, PA: Lippincott, Williams and Wilkins, p. 249-252.

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 408-412.

Question 20

20

Mr. James, a 19-year-old student, abruptly dropped out of college and returned home. His parents take him to the family doctor, stating that his behaviour is increasingly bizarre. They say that he appears to be listening to and responding to voices that no one else can hear. He is anxious, restless, and unable to sleep. He has not eaten regularly and has lost 10 kg from his normal weight of 75 kg. He has not washed or changed his clothes in the last 5 days. Mr. James tells the physician that he is very frightened and wants to go to hospital because the "voices hate women. I'm afraid of what they may make me do". Mr. James is admitted to the psychiatric ward of the local hospital as a voluntary client.

**For the first 2 days of his hospitalization, Mr. James continues to remain agitated, anxious, and fearful. Which of the following activities should the nurse suggest for the client at this time?**

1) **Walking with his primary nurse.**

   *Rationale:* He is too agitated to focus on complex activity. Walking under supervision may be physically and mentally relaxing.

2) Constructing a jigsaw puzzle.

   *Rationale:* This activity requires more focus and concentration than he is capable of at present. It is likely to increase his frustration and agitation.

3) Playing cards with the nurse.

   *Rationale:* This activity requires too much focus and the presence of other people may be anxiety provoking.

4) **Attending group therapy.**

   *Rationale:* The presence of other people may be too anxiety provoking for him. His agitation would likely disrupt group functioning.

References:

Shives, L. R. (2005). *Basic concepts of psychiatric-mental health nursing* (6th ed.) Philadelphia, PA: Lippincott, Williams and Wilkins, p. 250.

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 405-407.

Question 21

21

Mr. James, a 19-year-old student, abruptly dropped out of college and returned home. His parents take him to the family doctor, stating that his behaviour is increasingly bizarre. They say that he appears to be listening to and responding to voices that no one else can hear. He is anxious, restless, and unable to sleep. He has not eaten regularly and has lost 10 kg from his normal weight of 75 kg. He has not washed or changed his clothes in the last 5 days. Mr. James tells the physician that he is very frightened and wants to go to hospital because the "voices hate women. I'm afraid of what they may make me do". Mr. James is admitted to the psychiatric ward of the local hospital as a voluntary client.

**By his fourth hospital day, Mr. James is pacing almost constantly, continues to hear voices, and has become increasingly irritable. When female staff approach, he clenches his fists, tenses up, and moves away. Mr. James' admission status is changed from voluntary to involuntary. Sedation, oral or injectable, has been ordered. Mr. James refuses to let the nurse near him to give the medication. What is the nurse's most appropriate first action?**

1) Ask another nurse to administer the medication to the client.

   *Rationale:* Staff members present should be able to deal with the problem.

2) **Offer the client the choice of receiving the medication by mouth or by injection.**

   *Rationale:* The client may respond positively to this choice if it is presented in a calm and caring manner. An aggressive approach by the staff may increase the client's anxiety and escalate the problem. Administration of the drug is essential to control the client's behaviour.

3) Inform the client he will be put in the seclusion room if he fails to cooperate.

   *Rationale:* This may be necessary if other approaches fail. This approach should not be the first option.

4) Respect his right to refuse the medication and report the situation to his doctor.

   *Rationale:* The client is experiencing increasing agitation and needs to receive the ordered medication.

References:

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 640-641.

Boyd M. A. (2002). *Psychiatric Nursing: Contemporary Practice.* Philadelphia: Lippincott.

Question 22

22

Mr. James, a 19-year-old student, abruptly dropped out of college and returned home. His parents take him to the family doctor, stating that his behaviour is increasingly bizarre. They say that he appears to be listening to and responding to voices that no one else can hear. He is anxious, restless, and unable to sleep. He has not eaten regularly and has lost 10 kg from his normal weight of 75 kg. He has not washed or changed his clothes in the last 5 days. Mr. James tells the physician that he is very frightened and wants to go to hospital because the "voices hate women. I'm afraid of

what they may make me do". Mr. James is admitted to the psychiatric ward of the local hospital as a voluntary client.

**Mr. James continues to receive medications to control his anxiety and agitation. He is allowed to walk about the nursing unit, but he is not allowed to go outside. While in the client lounge he gets into a confrontation with a female client. He starts to scream and throw furniture. He punches a hole in the wall, and attempts to punch the other client, but misses. What is the best nursing approach for initial management of this incident?**

1) **Call for assistance.**

   *Rationale:* This crisis situation requires physical restraint of the client for his own protection and the protection of others. A minimum of 4 people must participate in the procedure in order to safely restrain the client.

2) Attempt to calm the client.

   *Rationale:* The client is violent and the nurse needs assistance from other staff in order to restrain Mr. James so he does not hurt himself, the female client, or the staff.

3) Physically restrain the client.

   *Rationale:* The nurse needs the assistance of at least 4 other people in order to physically restrain the client.

4) Ask the female clients to leave the lounge.

   *Rationale:* Other clients should be protected, but this response neglects the protection of the client.

References:

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 645.

Boyd M. A. (2002). *Psychiatric Nursing: Contemporary Practice.* Philadelphia: Lippincott.

## Question 23

23

Mr. James, a 19-year-old student, abruptly dropped out of college and returned home. His parents take him to the family doctor, stating that his behaviour is increasingly bizarre. They say that he appears to be listening to and responding to voices that no one else can hear. He is anxious, restless, and unable to sleep. He has not eaten regularly and has lost 10 kg from his normal weight of 75 kg. He has not washed or changed his clothes in the last 5 days. Mr. James tells the physician that he is very frightened and wants to go to hospital because the "voices hate women. I'm afraid of what they may make me do". Mr. James is admitted to the psychiatric ward of the local hospital as a voluntary client.

**Mr. James' condition improves sufficiently to allow him to have his admission status returned to a voluntary one. Plans are made for his discharge to a semi-independent facility (half-way house) near his family home. What is the most appropriate initial intervention to help Mr. James make a positive transition from the hospital to the community facility?**

1) **Make arrangements for Mr. James and his assigned counsellor from the half-way house to meet at the hospital before the client is discharged.**

   *Rationale:* This allows the client to begin to establish a trusting relationship with new people, while still receiving support and clarification from familiar staff. This should enhance his success at the new facility.

2) Arrange for Mr. James and his family to have a tour of the half-way house when he is discharged from the hospital.

   *Rationale:* Ideally, the client should be supported by nursing staff he already knows when he is first introduced to new people and a new environment. His family may not be able to address his issues and concerns.

3) Give Mr. James and his family as much information as possible about half-way houses and their purposes.

   *Rationale:* This is likely to be too much information, and too generic to be useful. He is unlikely to remember essential information if he is overwhelmed with excessive detail. This response omits needed interpretation and clarification by the nurse.

4) **Have another client who has used this facility come to talk with Mr. James about the half-way house.**

   *Rationale:* Recovered clients may not be very good sources of initial information, and may increase the client's anxiety. Their own experiences may or may not be positive.

References:

Stuart, G. W., & Laraia, M. T. (2005). *Principles & practice of psychiatric nursing* (8th ed) St. Louis, Missouri: Mosby.

Boyd M. A. (2002). *Psychiatric nursing: Contemporary practice.* Philadelphia: Lippincott.

## Question 24

24

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.

**Mrs. Ford's doctor has recently treated her for a urinary tract infection using antibiotic therapy. She asks the nurse how to avoid urinary tract infections in the future. Which initial action would be most appropriate for the nurse to take?**

1) Provide her with a pamphlet on urinary tract infections.

*Rationale:* This strategy is a good method of reinforcing teaching once the nurse has identified the learning needs of the client. This strategy by-passes appropriate assessment of learning needs.

2) **Explore what she knows about urinary tract infections.**

*Rationale:* The nurse correctly assesses Mrs. Ford's current level of knowledge prior to teaching information. The content taught should be specific to Mrs. Ford's learning needs.

3) Explain to her that she should increase her fluid intake.

*Rationale:* This would be appropriate information to give to Mrs. Ford, however her knowledge regarding urinary tract infections needs to be assessed first.

4) Review with her the causes of urinary tract infection.

*Rationale:* This approach assumes that Mrs. Ford's current practices and knowledge are inadequate, and that she needs to be taught all information. It suggests lack of assessment of current knowledge.

References:
Kozier, B., Erb, G., Berman, A. J., Burke, K., Bouchal, D. S. R, & Hirst, S. P. (2004). *Fundamentals of nursing: The nature of nursing practice in Canada.* Toronto: Prentice Hall, p. 674-676.

Potter, P. A. & Perry, A. G. (2006). *Canadian fundamentals of nursing* (3rd ed.) Toronto: Elsevier Mosby, p. 323.

Question 25

25

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.

**Mrs. Ford asks about the antibiotic drug prescribed to treat her urinary tract infection. She is concerned that the medication may have affected her unborn child. Which of the following interventions by the nurse is most appropriate?**

1) Reassure her that physicians prescribe drugs carefully to pregnant clients.

*Rationale:* Although this statement is usually true, it doesn't address Mrs. Ford's concern about the drug she was prescribed.

2) **Discuss with her written information about the drug.**

*Rationale:* This action by the nurse is evidence-based and addresses Mrs. Ford's concern about the safety of the drug for pregnant women.

3) Explain to her that antibiotics do not cross the placental barrier.

*Rationale:* This response provides incorrect information and falsely reassures the client.

4) Refer her to the pharmacist for further teaching.

*Rationale:* This response might be appropriate but negates the nurse's responsibility to provide evidence-based information.

References:
Potter, P. A & Perry, A. G. (2006). *Canadian fundamentals of nursing* (3rd ed.). Toronto: Elsevier Mosby, p. 327-329.

Pillitterri A. (2007). *Maternal & child health nursing: Care of the child and the childbearing family* (5th ed.) Philadelphia: Lippincott, Williams & Wilkins.

Question 26

26

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.

**Mrs. Ford eats very little meat and is concerned that this will affect her breast milk. Which response by the nurse would be the most appropriate?**

1) "With additional calories, women who eat small amounts of meat will produce adequate breast milk."

*Rationale:* Eating additional calories will not ensure quality breast milk in the absence of ingesting adequate amounts of protein

2) "The quality of breast milk is not affected by the amount of meat in the diet."

*Rationale:* The quality of breast milk would be negatively affected by inadequate levels of protein in the client's diet.

3) "Breastfeeding does not require any modifications in a woman's usual diet."

*Rationale:* Breastfeeding requires a well balanced diet and additional calories to support the process of lactation.

4) **"You can replace meat with other sources of protein and maintain a well-balanced diet for breastfeeding."**

*Rationale:* If the client does not eat meat, other sources of protein can be consumed to ensure quality breast milk.

References:
Lowdermilk, D. L. & Perry, S. E. (2004). *Maternity and women's health care* e (8th ed.) St. Louis, Missouri: Mosby, p. 371, 382-383.

Pillitterri, A. (2003). *Maternal and child health nursing: Care of the childbearing and the childrearing family* (4th ed.) Philadelphia, PA: Lippincott, Williams and Wilkins, p. 685.

Question 27

27

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.

**Mr. Ford has two sons from his first marriage, aged 16 and 19 years, who live with their mother. Mrs. Ford confides to the nurse that she and her husband disagree about the involvement of his two sons in their family. Her husband wants to invite his sons to spend the summer with them. Which of the following responses by the nurse would be most appropriate?**

1) "How would you like to deal with this situation?"

*Rationale:* This statement forces the client to discuss specific approaches when she may not be ready to do so. More exploration of the issue is indicated by the client's statement.

2) **"Are you concerned about not getting along with your husband's two sons?"**

*Rationale:* This response adds content to the statement made by the client and indicates assumptions made by the nurse.

3) **"You seem concerned by this situation with your family."**

*Rationale:* This statement correctly indicates acceptance of the content and feelings expressed and encourages further discussion of the issue.

4) "It seems that your husband would like you to involve his sons at this time."

*Rationale:* This response is judgmental and conveys the nurse's position on the client's problem.

References:

Kozier, B., Erb, G., Berman, A. J., Burke, K., Bouchal, D. S. R., & Hirst, S. P. (2004). *Fundamentals of nursing: The nature of nursing practice in Canada.* Toronto: Prentice Hall, p. 492-493.

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing* (8th ed.) St. Louis, Missouri: Elsevier Mosby, p. 30-35.

Question 28

28

A 60-year-old male client with a diagnosis of depression tells the nurse that the paroxetine (Paxil) he has been on for the past 1 week is not helping. He states that he still feels depressed and lacks energy.

**Which of the following responses by the nurse would be most therapeutic?**

1) **Advising the client that it takes 1 to 4 weeks to feel the therapeutic benefit of this medication.**

*Rationale:* The client should know that there is a lag time before a therapeutic response occurs.

2) **Informing the client that it takes 4 to 6 weeks to feel his mood and other symptoms improving.**

*Rationale:* The therapeutic response begins in the first week, but the client should feel a noticeable improvement within the first month.

3) Telling the client that the physician will be notified so that a change in medication can be made.

*Rationale:* If there is little improvement in mood and other symptoms after 4 to 8 weeks on a therapeutic dose, then the drug will likely be discontinued or changed.

4) Teaching the client about the need to exercise daily in order to feel the full benefit of the medication.

*Rationale:* Vigorous exercise gives a temporary "high" and is one treatment modality for depression. However, it would have no effect on the pharmacological action of the antidepressant. A client in the initial phase of treatment for depression would not be a candidate for vigorous exercise and would also be dependent on the client's physical health.

References:

Eisenhauer, L.A., Nichols, L.W., & Bergon, F.W. (1998). *Clinical pharmacology & nursing management* (5th ed.). New York: Lippincott, p. 402

Canadian Pharmacists Association. (2003). *Compendium of pharmaceuticals and specialties.* Ottawa: Author, p. 1259.

Question 29

29

Mrs. Ford, 32 years old, is at 34 weeks gestation with her first pregnancy, which is proceeding normally. She and her husband are attending prenatal classes.

**Mrs. Ford tearfully explains to the nurse that she is very fearful of labour and is not sleeping well. Which action by the nurse would be most appropriate?**

1) Explore with her the possible use of epidural analgesia for labour.

*Rationale:* This approach assumes a solution to Mrs. Ford's concerns. It takes the decision-making power away from Mrs. Ford and her partner.

2) Provide her with information on positions that promote sleep.

*Rationale:* This approach assumes a solution to Mrs. Ford's concerns without exploring the nature of these concerns.

3) **Discuss with her the concerns she has about labour.**

*Rationale:* The nurse needs to explore Mrs. Ford's concerns prior to initiating action.

4) Encourage her to discuss bedtime sedation with her physician.

*Rationale:* Sedation will not address her basic concern over labour care. Sedation should be used cautiously with pregnant women.

References:

Lowdermilk, D. L. & Perry, S. E. (2004). *Maternity and women's health care* (8th ed.). St. Louis, Missouri: Mosby, p. 371, 438-439.

Pillitteri, A. (2003). *Maternal and child health nursing: Care of the childbearing and the childrearing family* (4th ed.) Philadelphia, PA: Lippincott, Williams and Wilkins, p. 509.

Question 30

30

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.

**Which of the following actions by the nurse would best acknowledge the developmental needs of this group?**

1) Involve the parents in the education sessions.

*Rationale:* Although it is important that parents are informed regarding the care of their diabetic child, the adolescent is in need of developing an identity and autonomy.

2) Plan a class session on the physiology of puberty.

*Rationale:* Puberty is an issue for adolescents but this is not an appropriate focus or context.

3) Ensure that participants make independent decisions.

*Rationale:* Independent decision making is an important developmental transition in this age group though they must first have the knowledge to make appropriate decisions.

4) **Plan learning activities that involve peer support.**

*Rationale:* One hallmark of adolescence is the value and importance of friendships and relationships with peers as a means of developing self identity.

References:

Hockenberry, M. J. & Wong, D L. (2003). *Wong's nursing care of infants and children* (7th ed.) St. Louis, Missouri: Mosby, p. 1750-1752.

Jarvis, C. (2004). *Physical examination and health assessment* (4th ed.) St. Louis, Missouri: Elsevier, p. 25.

Question 31

31

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.

**In planning for teaching the group about diabetes management, which of the following actions should the nurse implement initially?**

1) Distribute an outline and sequence of all topics to be addressed.

*Rationale:* This may be somewhat overwhelming for the adolescent population as there is a large amount of material to cover. Some structure is necessary though this response does not allow for any client collaboration.

2) Ask each participant to list their needs for information regarding diabetes.

*Rationale:* Though this may be helpful in establishing some rapport and participation, it is unlikely that newly diagnosed clients would know what information they might need.

3) Identify the priority components of diabetes management, beginning with insulin administration.

*Rationale:* This response indicates assumptions by the nurse and does not reflect collaboration with the learners.

4) **Determine the group's understanding of diabetes and develop an outline together.**

*Rationale:* Client education should begin with the clients' understanding and assessment of their individual needs and the learning plan developed collaboratively.

References:

Hockenberry, M. J. & Wong, D. L. (2003). *Wong's nursing care of infants and children* (7th ed.) St. Louis, Missouri: Mosby, p. 1752-1755.

Kozier, B., Erb, G., Berman, A. J., Burke, K., Bouchal, D. S. R., & Hirst, S. P. (2004). *Fundamentals of nursing: The nature of nursing practice in Canada.* Toronto: Prentice Hall, p. 675.

Question 32

32

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.

**Which of the following strategies would be most effective in teaching nutritional management of diabetes?**

1) Discussion with handouts

*Rationale:* This may provide necessary information but without discussion regarding rationale, there is less chance of understanding.

2) **Game on food selection**

*Rationale:* Adolescents relate well to peers and group learning, when the group has a common learning need. Written information is helpful for reinforcement.

3) Videotape with follow-up quiz

*Rationale:* This method would not necessarily provide the understanding needed and would meet only one learning style. Quizzing may be threatening to some, thus decreasing trust with the nurse.

4) Presentation by a dietitian

*Rationale:* The use of speakers does not necessarily encourage learner involvement.

References:

Hockenberry, M. J. & Wong, D. L. (2003). *Wong's nursing care of infants and children* (7th ed.). St. Louis, Missouri: Mosby, p. 1745.

Pillitterri, A. (2003). *Maternal and child health nursing: Care of the childbearing and the childrearing family* (4th ed.) Philadelphia, PA: Lippincott, Williams & Wilkins, p. 1006-1015.

Question 33

33

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.

**Which one of the following food selections by the group members would indicate to the nurse that they understand how to treat initial symptoms of hypoglycemia?**

1) **A glass of milk**

*Rationale:* Provides 15 grams of carbohydrate, with a rapid release of lactose (simple sugar) followed by a more prolonged action from the protein and fat.

2) **An apple**

*Rationale:* Fruit is too rapidly absorbed and this amount would not provide adequate simple sugar.

3) A can of diet cola

*Rationale:* Diet soft drinks should be avoided as they do not contain sugar.

4) A slice of bread

*Rationale:* Bread is a more complex carbohydrate and will not be absorbed quickly. It might be taken after the ingestion of a simple sugar to maintain the blood glucose.

References:

Hockenberry, M. J. & Wong, D. L. (2003). *Wong's nursing care of infants and children* (7th ed.) St. Louis, Missouri: Mosby, p. 1740.

Pillitterri, A. (2003). *Maternal and child health nursing: Care of the childbearing and the childrearing family* (4th ed.) Philadelphia, PA: Lippincott, Williams & Wilkins, p. 1479.

Question 34

34

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.

**Which of the following activities would best meet the exercise criteria for adolescents with diabetes?**

1) Hiking twice weekly

*Rationale:* This activity is not frequent enough for a regular program.

2) **Roller blading daily**

*Rationale:* One hour of daily exercise provides a regular, planned, moderate activity and would facilitate the lowering of glucose levels. A minimum of 45 minutes of sustained activity, three times a week is necessary for an effective program.

3) **Cycling on weekends**

*Rationale:* Cycling would provide good physical exercise but would need to occur more regularly to be effective.

4) Swimming once a week

*Rationale:* This activity is not frequent enough for a regular program.

References:
Hockenberry, M. J. & Wong, D. L. (2003). *Wong's nursing care of infants and children* (7th ed.) St. Louis, Missouri: Mosby, p.1749-1750.

Ignatavicius, D. D., Workman, M. L., & Mishler, M. A. (1995). *Medical-surgical nursing: A nursing process approach* (2nd ed) Philadelphia, PA: W. B. Saunders, p.1892-93.

Question 35

35

The camp nurse plans an educational session for a group of adolescents with newly diagnosed diabetes Type 1 (insulin dependent diabetes mellitus). This small group is made up of teens ranging in age from 13 to 15 years.

**After 4 days of diabetic teaching at the camp, Sean, 13 years old, is keen to take more responsibility for his care. Which of the following actions by the nurse would best help Sean to achieve his goal?**

1) Reviewing with Sean his blood glucose levels for the last 4 days.

*Rationale:* This response reflects the nurse's role but is not meeting Sean's need for increased responsibility.

2) **Reviewing Sean's dietary needs with him.**

*Rationale:* This response also does not necessarily meet Sean's needs for increased responsibility for self care.

3) **Supervising Sean while he prepares and administers his own insulin.**

*Rationale:* This response does address Sean's need and demonstrates the nurse's role in assisting Sean with implementing his learning plan. Clients often become less anxious and able to attend to other aspects once insulin injection technique is mastered.

4) Discussing Sean's plan of care with his parents.

*Rationale:* This response is inappropriate at this point as it takes responsibility from Sean and does not address his needs.

References:
Hockenberry, M. J. & Wong, D. L. (2003). *Wong's nursing care of infants and children* (7th ed.) St. Louis, Missouri: Mosby, p. 1752-1755.

Pillitterri, A. (2003). *Maternal and child health nursing: Care of the childbearing and the childrearing family* (4th ed.) Philadelphia, PA: Lippincott, Williams & Wilkins, p. 1476.

Question 36

36

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.

**Mr. Edwards tells his admitting nurse that he is worried he will "wake up with a colostomy". What is the nurse's most appropriate response to this concern?**

1) "That is unlikely given the location of your tumour."

*Rationale:* While likely true, this is not the best first response as it fails to firmly establish the actual level of the client's baseline knowledge.

2) **"What has your surgeon told you about the planned surgery?"**

*Rationale:* This open-ended question elicits further discussion by encouraging the client to recall the physician's teaching, and provides opportunity for the nurse to clarify and expand the client's understanding.

3) "May I call your doctor so that your concern can be clarified?"

*Rationale:* This response does not address the client's concerns and knowledge level, and makes the nurse appear indecisive and unprofessional.

4) "That is a common concern; what would you like to know about colostomies?"

*Rationale:* This response is incorrect because it appears to confirm his doubts, suspicions, and misunderstandings. It is also likely to increase his anxiety.

References:
Lewis, S. M., Heitkemper, M. M. & Dirksen, S. R. (2006). *Medical-surgical nursing in Canada.* Toronto: Elsevier, p. 8.

Ross-Kerr, J. C. & Wood, M. J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 184.

Question 37

37

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.

**Mr. Edwards returns to the unit with an intravenous infusing into a central line in the right subclavian vein. What is the most essential action for the nurse to take regarding the central line?**

1) **Check that all tubing connections on the central line are secure.**

   *Rationale:* This is essential on return to the nursing unit since tubing connections may have been loosened in transport. A loose connection can result in an air embolus.

2) Monitor the solution flow rate every 15 minutes for the first hour.

   *Rationale:* All central lines must be placed in I.V. rate controllers which make q15 min checking unnecessary and wasteful of time.

3) Reinforce the dressing over the subclavian insertion site.

   *Rationale:* Central line dressings are changed according to strict protocols and are never changed unnecessarily. A dressing change is not called for unless the dressing has been compromised during client transport.

4) Ensure that the head of the bed is not elevated at more than 20 degrees.

   *Rationale:* The head of the bed can be elevated at any angle and this will not interfere with the flow of the I.V.

References:

Perry, A. G. & Potter, P. A. (2006). *Clinical nursing skills and techniques.* Toronto: Elsevier, p. 1049-1050.

Kozier, B., Erb, G., Berman, A. G. & Snyder, S. (2004). *Techniques in Clinical Nursing.* Toronto: Prentice Hall, p. 608.

Question 38

38

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.

**On the morning of his first postoperative day, Mr. Edwards has been receiving oxygen by nasal cannula at a rate of 4L/min. He is alert and his temperature is 38° C at 0800 hours. His arterial blood gas report shows the following results:**

| Values | Client results | Normal values |
|---|---|---|
| pH | 7.33 | (7.35 - 7.45) |
| PaO2 | 78 mmHg | (80mmHg or greater) |
| PaCO2 | 48 mmHg | (35 - 45 mmHg) |

**What action should the nurse take after noting these results?**

1) Increase the flow rate of oxygen through his nasal cannula to 10 L/min.

   *Rationale:* Increasing Oxygen flow rates will be unlikely to address the issue of insufficient lung ventilation.

2) Put a cool air humidifier at his bedside and remove extra bed clothes.

   *Rationale:* There is no evidence that Mrs. Edwards has thick secretions which cannot be mobilized.

3) **Assist him to deep breathe and use his incentive spirometer stat and q.1h.**

   *Rationale:* The temperature and the blood gas results indicate very mild hypoxemia and respiratory acidosis likely due to retained pulmonary secretions. This is secondary to pain, anaesthetic agents, narcotics, age and immobility and is a common finding on the first post op day. It indicates the need for more frequent nursing measures.

4) Notify the physician immediately of the client's status.

   *Rationale:* The ABG results are not critical and do not warrant contacting the physician immediately.

References:

Lewis, S. M., Heitkemper, M. M. & Dirksen, S. R. (2006). *Medical-surgical nursing in Canada.* Toronto: Elsevier, p. 408, 410.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 305.

39 Question 39

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.

**On the morning of his second postoperative day, the nurse observes that Mr. Edwards' abdomen is hard, distended and tender. The wound drainage device is filled with fresh blood. His pulse is 120/min and respirations are 30/min and shallow. His blood pressure is 90/60 mmHg. He is restless and anxious. His urine output for the last 2 hours totals 15 mL. What immediate action should the nurse take?**

1) **Inform the surgeon.**

   *Rationale:* The results of the assessment necessitate immediate notification of the surgeon.

2) Check his bladder for distention.

   *Rationale:* This is not essential information at this time.

3) Check peripheral pulses.

   *Rationale:* This is not a priority action at this time.

4) Apply pressure to his abdomen.

   *Rationale:* This intervention is incorrect since application of external pressure will not affect intra-abdominal bleeding. In addition it is likely to increase client pain, anxiety, and intra-abdominal irritation and bleeding.

References:

Lewis, S. M., Heitkemper, M .M. & Dirksen, S. R. (2006). *Medical-surgical nursing in Canada.* Toronto: Elsevier, p. 407-421.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 305-310.

Question 40

40

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.

**Mr. Edwards requires 2 units of packed red cells. Which of the following is the most appropriate nursing action in the administration of blood?**

1) Allow each unit of blood to warm to room temperature before administration.

   *Rationale:* Allowing the blood to warm before infusing contributes to breakdown of components and enhances the likelihood of adverse client reactions. Blood should be started within 30 minutes of removal from storage.

2) **Infuse each unit of blood slowly for the first 15 minutes of the transfusion.**

   *Rationale:* Most serious transfusion reactions (anaphylaxis, incompatibility) occur within the first 15 mins or the first 50 mL of the transfusion. A slow infusion rate acknowledges this, and prevents the client from receiving excessive amounts of the blood product.

3) Ensure that each unit of blood infuses over a period of 4 - 6 hours.

   *Rationale:* Each unit of packed cells should infuse in under 4 hours. A longer time encourages growth of microorganisms and breakdown of components.

4) Flush intravenous tubing with D5W between each unit of blood.

   *Rationale:* The intravenous tubing needs to be flushed with NS as this is the only solution that is compatible with packed cells.

References:

Perry, A. G. & Potter, P. A. (2006). *Clinical nursing skills and techniques.* Toronto: Elsevier, p. 976.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 2283.

Question 41

41

Mr. Edwards, 60 years old, is scheduled to have a bowel resection for a diagnosis of adenocarcinoma of the transverse colon. He is admitted to the hospital the morning of his surgery.

**Mr. Edwards is unable to meet his nutritional needs postoperatively with a regular diet. The surgeon orders intermittent feedings via a nasogastric (NG) tube. What is the most appropriate nursing action when administering the tube feeding to Mr. Edwards?**

1) Change the tube feeding solution bag every 72 hours.

   *Rationale:* After use the bag and tubing is washed to reduce bacterial growth. A new bag should be used every 24 hours.

2) Flush the NG tube with 60 mL of saline before each feeding.

   *Rationale:* After every feeding, the NG tube is flushed with 30 mL of tap water to prevent plugging and discourage bacterial growth.

3) Warm the feeding solution before giving it to Mr. Edwards.

   *Rationale:* Tube feeding solutions are given at room temperature.

4) **Keep the head of Mr. Edwards' bed elevated during the feeding.**

*Rationale:* This is an essential safety measure to decrease the likelihood of regurgitation and aspiration of gastric contents.

References:
Perry, A. G. & Potter, P. A. (2006). *Clinical nursing skills and techniques.* Toronto: Elsevier, p. 1032.

Lewis, S. M., Heitkemper, M. M. & Dirksen, S. R. (2006). *Medical-surgical nursing in Canada.* Toronto: Elsevier, p. 992-994.

Question 42

42

A client with diabetes states, ''Exercise, diet, glucose testing, and insulin work together to control my diabetes''. The nurse asks ''Do you exercise at the same time each day and check your sugars before you start?''

**Which one of the following is the best rationale for the nurse's response?**

1) To ensure the nurse can relate to the client's situation.

*Rationale:* The data (not the nurse) has to relate to the client's situation.

2) **To validate the data ensuring accuracy.**

*Rationale:* Validation involves asking the client to confirm the information obtained.

3) To individualize care for the client.

*Rationale:* Not the best rationale: Although care needs to be individualized, this occurs when interventions are based on a nursing diagnosis (indirectly accurate data).

4) To organize the data into meaningful clusters.

*Rationale:* Not the rationale for this question. Validation of data should occur before clustering of information.

References:
Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 68.

Ross-Kerr, J. C. & Wood, M .J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 273.

Question 43

43

**Based on research findings, what should the nurse identify as the leading cause of gastric ulcer disease when teaching clients?**

1) Hypersecretion of hydrochloric acid

*Rationale:* Recent research demonstrates that only 10% of gastric ulcers show evidence of hypersecretion of HCl.

2) **Bacterium, H. pylori**

*Rationale:* This bacterium is present in 50-70% of clients with gastric ulcer disease. It produces an enzyme which interferes with the resistance of the gastric mucosa to gastric juices.

3) Excessive intake of caffeine and spicy foods

*Rationale:* Research has not supported diet as a cause of gastric ulcer disease though it may be an aggravating factor.

4) Stressful lifestyle

*Rationale:* Stress is a risk factor in peptic ulcer disease but is not proven to be a causative factor.

References:
Lewis, S. M., Heitkemper, M. M. & Dirksen, S. R. (2006). *Medical-surgical nursing in Canada.* Toronto: Elsevier, p. 1037.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 663.

Question 44

44

Mr. Robins, 75 years old, has been learning to care for his new ileostomy for the past week.

**Which of the following statements indicates that Mr. Robins requires more information from the nurse about ileostomy self-care?**

1) "I'll make a cuff at the pouch opening before emptying it."

*Rationale:* Appropriate as cuffing the pouch keeps end clean reducing odour.

2) **"I'm planning to empty the pouch whenever it becomes full."**

*Rationale:* Shows that he requires teaching interventions regarding pouch emptying. The client should be taught to empty the pouch when it is no more than half full as the added weight may disrupt the pouch seal and cause leakage.

3) **"I'll expect to see a little bleeding from my stoma when I clean it during appliance changing."**

*Rationale:* Some bleeding is normal and client should be taught about this to reduce anxiety.

4) "I'm going to measure my stoma size each time I change the appliance for about 8 weeks."

*Rationale:* Shrinkage occurs particularly in the first 4-8 weeks. Measuring each time ensures a good appliance fit.

References:
Perry, A. G. & Potter, P. A. (2006). *Clinical nursing skills and techniques.* Toronto: Elsevier, p. 1154.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 826.

## Question 45

45

A nurse on the psychiatric unit admits a client in the acute manic phase of bipolar disorder. In addition, another client must be watched for high suicide risk. The nurse has many medications to administer, including two injections for the person admitted. He asks a colleague to help him perform his duties, but the colleague says that she cannot help at the moment.

**What should the nurse do?**

1) Delay distribution of some medications until the situation stabilizes.

*Rationale:* Medications need to be administered as ordered and should not be delayed for someone in an acute manic phase.

2) **Ask the health care aide to watch the client at risk for suicide.**

*Rationale:* A threat to client safety is a priority.

3) Place the newly admitted client in a private room.

*Rationale:* This does not resolve the problem of the medications and the client on suicide watch.

4) Review the care priorities and once again ask for the colleague's help.

*Rationale:* This takes time and it is not certain that the colleague will be able to help.

References:
Ross-Kerr, J.C. & Wood, M.J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 152-155.

Kozier, B., Erb, G., Berman, A.G. & Snyder, S. (2004). *Techniques in clinical nursing.* Toronto: Prentice Hall, p. 9-10.

## Question 46

46

Mr. Starsky, 45 years old, has returned to the nursing unit following abdominal surgery. He is restless; BP 160/86, P 82, RR 22. He rates his pain at 9 on a scale of 0-10. He has morphine sulfate (Morphine) 10-15 mg s.c. q.4h prn prescribed. He received morphine sulfate 10 mg s.c. 3 hours ago.

**Which nursing intervention is most appropriate for Mr. Starsky's pain management at this time?**

1) Administer 10 mg morphine sulfate s.c. now and reposition him.

*Rationale:* This dose did not manage his pain for 4 hours. His pain is now severe and it would be inadequate for him now. The order is q. 4h and still an hour before the nurse can legally give it.

2) **Call the physician and ask for a stat order of morphine sulfate.**

*Rationale:* The goal in pain management is to have the pain relieved before it becomes too severe. A post-op client requires regular around-the-clock pain management. The physician would need to order a stat dose of morphine to get his pain under control.

3) **Reposition him, re-assess his pain, and then give 15 mg morphine sulfate.**

*Rationale:* His pain is too severe at this time and inappropriate to have him wait.

4) Give 15 mg morphine sulfate s.c. at this time and re-assess in 15 min.

*Rationale:* His order is q.4h. and legally the nurse cannot give him the 15 mg now without a new physician's order.

References:
Lewis, S. M., Heitkemper, M. M. & Dirksen, S. R. (2006). *Medical-surgical nursing in Canada.* Toronto: Elsevier, p. 415-416.

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 309.

## Question 47

47

Mr. O'Connor is 83 years old, recently widowed, and unable to live on his own. He was admitted 3 months ago to a long-term care facility for the elderly. He says he feels depressed and is reluctant to leave his room.

**Which of the following would be the most effective intervention in promoting social interaction for Mr. O'Connor?**

1) Notify his family and suggest that they telephone him daily.

*Rationale:* Family contact is important for the institutionalized elderly client, but this does not address his need for social interaction at the facility.

2) **Allow him some time alone and encourage him to go to the dining room for his meals.**

*Rationale:* This will allow him some time to grieve, and have control over his activities, but also will encourage his participation in social activities in the facility, which may help expedite the grieving process.

3) **Schedule him for participation in the facility's recreational activities.**

*Rationale:* It is important that the client be allowed to go through the grieving process. Organized recreational activities may overwhelm the client at this time. In addition, the client is not provided any choice.

4) Confer with his physician and recommend an antidepressant medication.

*Rationale:* Medications should not be the first intervention used to improve his mood.

References:

Matzo, M. L. & Sherman, D. W. (2004). *Gerontologic palliative care nursing.* Toronto: Mosby, p. 149.

Agich, G. J. (2003). *Dependence and autonomy in old age: An ethical framework for long-term care.* New York: Cambridge University Press, p. 173.

## Question 48

48

**What information about safe sexual practice should be included in a presentation to a group of adolescents?**

1) **The male condom should be applied before vaginal, anal or oral contact with the penis.**

*Rationale:* Contact with another person's body fluids around the head or an open lesion on the skin, anus, or genitalia can transmit a STI.

2) Contraceptive devices protect against sexually transmitted infections.

*Rationale:* Not all contraceptives protect against STI.

3) The female condom does not protect against sexually transmitted infections.

*Rationale:* The female condom acts as an effective barrier to protect against STI.

4) **Diaphragms, coated with spermicidal gel, may be inserted 4-6 hours before sexual intercourse.**

*Rationale:* Is a true statement about diaphragms however they do not protect against STI. Requires a body awareness and comfort with body not common in adolescents.

References:

McKinney, E. S., James, S., Murray, S. & Ashwill, J. (2005). *Maternal-child nursing.* Toronto: Elsevier, p. 193-196.

Ladewig, P. A.W., London, M. L. & Davidson, M.R. (2006). *Contemporary maternal-newborn nursing care.* Toronto: Prentice Hall, p. 86-89.

## Question 49

49

**Which of the following safety features should the school nurse recommend to be in place in a children's playground?**

1) A concrete platform under the activity centre

*Rationale:* Activity centres should have resilient surfaces to reduce the impact from a fall. Concrete is a hard material.

2) **An open slide that has an incline of not more than 60 degrees**

*Rationale:* Open slides should have inclines of no more than 30 degrees.

3) Equipment that is no more than one meter from the ground

*Rationale:* This is not reasonable for children's playground equipment.

4) **Foam, sand or wood chips under the swings**

*Rationale:* Sand and wood chips provide a soft surface that reduces the impact from a fall from the swings, and reduces the possibility of an injury.

References:

Stanhope, M. & Lancaster, J. (2004). *Community and public health nursing.* Toronto: Mosby, p. 635.

Hockenberry, M. J., Wong, D. L., Wilson, D., Winkelstein, M. L. & Kline, N. E. (2003). *Wong's nursing care of infants and children.* Toronto: Mosby, p. 618.

## 50 Question 50

Danielle Carter, 14 years old, has anorexia nervosa. She tells the nurse that when she is discharged she will go on a strict vegetarian diet.

**Which one of the following shows that the nurse is communicating effectively with the health care team in relation to Danielle's intentions?**

1) Records Danielle's remarks on the chart.

*Rationale:* Although it should be recorded this does not ensure that action will be taken.

2) Consults the psychology service.

*Rationale:* This requires a multidisciplinary approach and the health care team needs to be informed.

3) **Requests a meeting of the health care team.**

*Rationale:* The health care team needs to be informed.

4) Conveys the information to the outpatient clinic team.

*Rationale:* Delays action and thus does not ensure a proper diet upon discharge.

References:

McKinney, E. S., James, S., Murray, S. & Ashwill, J. (2005). *Maternal-child nursing.* Toronto: Elsevier, p. 1540-1541.

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing.* Toronto: Elsevier, p. 529.

Question 51

51

Mr. Jones, age 71, has undergone a repair for a fractured hip. He confides in the nurse that he wished no one had found him after his fall. He states that since his wife of 45 years died, life "has not been worth living".

**How should the nurse respond?**

1) Explore his past feelings of self-worth.

*Rationale:* The client is feeling helpless and hopeless now. His past is not the most important concern.

2) Ask him how he was managing at home.

*Rationale:* Although this may assess his adaptation, it does not assess his feelings

3) **Ask him if he is having suicidal thoughts.**

*Rationale:* The nurse should recognize the client is acutely depressed, and take measures to assess the risk of suicide.

4) Explore his perceived adequacy of supports.

*Rationale:* This will not deal with his immediate need.

References:

Kneisl, C. R., Wilson, H. S. & Trigoboff, E. (2006). *Contemporary psychiatric-mental health nursing.* Toronto: Prentice Hall, p. 534.

Matzo, M. L. & Sherman, D.W. (2004). *Gerontologic palliative care nursing.* Toronto: Mosby, p. 150-155.

Question 52

52

Ms. Bryson, 65 years old, is a post-operative client who suddenly develops hemataemesis. She is pale, diaphoretic and says she feels faint. The nurse asks the student nurse to take Ms. Bryson's vital signs while she calls the physician. On returning to the client's room, the student nurse reports that the vital signs have not changed since earlier in the shift.

**What should the nurse do?**

1) Place the client in Trendelenburg position.

*Rationale:* The vomiting may cause airway difficulties if the client's head is down.

2) Instruct the student nurse to recheck the vital signs in 10 minutes.

*Rationale:* The student nurse’s vital signs did not match the clinical picture of this client when she took them the first time.

3) **Recheck the vital signs.**

*Rationale:* The RN needs to be accountable for the previous decision of delegating VS to the student nurse. The RN should verify. The immediate physical exam for a client with an upper GI bleed must include an emphasis on blood pressure and pulse.

4) Administer a bolus of 200 mL of normal saline I.V.

*Rationale:* IV administration has not been ordered. Do not have enough information about the client's condition to do this.

References:

Lewis, S. M., Heitkemper, M. M. & Dirksen, S. R. (2006). *Medical-surgical nursing in Canada.* Toronto: Elsevier, p. 1030.

Ross-Kerr, J. C. & Wood, M. J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 156.

Question 53

53

Jessica Thorton, 15 years old, has just been diagnosed with chlamydia. Jessica asks, "Who has to know about this?"

**What would be the nurse's best response?**

1) "Don't worry, I will keep your confidence."

*Rationale:* This is a false statement. By law the nurse must report sexually transmitted diseases.

2) "Because of your age, I am required to tell your parents."

*Rationale:* This is a false statement. The nurse is not required to tell Jessica's parents about her diagnosis.

3) **"I am required to report this communicable disease to the public health authority."**

*Rationale:* Jurisdictions in Canada have mandatory reporting legislation for named communicable diseases.

4) "I am not allowed to make any promises about keeping your diagnosis confidential."

*Rationale:* This statement implies that the nurse may have the option to keep the diagnosis confidential.

References:

Canadian Nurses Association (2002). *Code of ethics for registered nurses.* Ottawa: CNA, p.14.

Fry, S. T. & Johnstone, M .J. (2002). *Ethics in nursing practice.* Malden, MA: Blackwell, p. 25.

Question 54

54

Mrs. Lane, 66 years old, is to receive an enema in preparation for a diagnostic test. The next morning, the nurse has made arrangements with Mrs. Lane to administer the enema after visiting hours around 2030 hours. Mrs. Lane's son, whom she has not seen for 2 years, arrives at 2020 hours.

**What should the nurse do about administering the enema?**

1) Ask Mrs. Lane's son to leave because visiting hours are over.

*Rationale:* There is no reason for the son not to visit. Leaving may increase Mrs. Lane’s anxiety. The enema can be done following the visit.

2) Ask her son to come back after the enema has been administered.

*Rationale:* There is no specific time to administer the enema. Also following the enema, Mrs. Lane will need to use the washroom.

3) **Delay the administration of the enema.**

*Rationale:* There is no specific time for the enema.

4) Try to postpone the diagnostic test.

*Rationale:* There is no reason to do this at this time.

References:

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p. 276.

Perry, A. G. & Potter, P. A. (2006). *Clinical nursing skills and techniques.* Toronto: Elsevier, p. 1129.

Question 55

55

**Which of the following contributing factors results in the highest death rates of adults in Canada?**

1) **Smoking**

*Rationale:* Tobacco is a risk factor for 25 diseases and accounts for approximately 15% of deaths from all causes, according to the WHO.

2) **Automobile accidents**

*Rationale:* Incorrect

3) Alcohol consumption

*Rationale:* Incorrect

4) Obesity

*Rationale:* Incorrect

References:

Ross-Kerr, J. C. & Wood, M. J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 58.

Lundy, K. S. & Janes, S. (2003). *Essentials of community-based nursing.* Toronto: Jones & Bartlett, p. 221-222.

Question 56

56

The nurse arrives at work and discovers that there is a staff shortage for the shift. She notes that nursing students are assigned to the unit today. The nurse is assigned to 4 postoperative and 3 preoperative orthopedic clients. There are several intravenous medications to give and 2 clients have Type 1 diabetes (insulin dependent diabetes mellitus). In addition, several dressings require changing and staples need to be removed.

**In evaluating this situation, which of the following actions should the nurse take?**

1) Leave the dressing changes for the next shift of staff.

   *Rationale:* Nurses have responsibilities and accountabilities for their client assignments.

2) **Offer to assign the preoperative teaching to a student nurse.**

   *Rationale:* Students are supernumerary and are not counted on for service.

3) **Report the situation to the unit manager.**

   *Rationale:* Nurse managers intervene to minimize the present danger when client safety is threatened due to inadequate resources.

4) Reprioritize nursing care to manage the workload effectively.

   *Rationale:* Reprioritizing nursing care is not the first action the nurse should take. The unit manager needs to be informed of a potentially unsafe situation regarding understaffing.

References:

Canadian Nurses Association (2002). *Code of ethics for registered nurses.* Ottawa: CNA, p. 9-10, 16-17.

Ross-Kerr, J. C. & Wood, M. J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 152-153.

Question 57

57

The nurse is attending to Mr. Sagan, a postoperative client. The client is requesting an analgesic and repositioning. The health care aide enters the room to let the nurse know that another client's infusion pump's alarm is ringing.

**What is the most appropriate nursing action?**

1) Tell the health care aide to shut off the alarm, while the nurse repositions Mr. Sagan and obtains an analgesic.

   *Rationale:* Manipulating infusion pumps is not part of the health care aide's responsibilities. This action does not solve the reason for the alarm.

2) **Reposition and obtain an analgesic for Mr. Sagan with the help of the health care aide, and then attend to the alarm.**

   *Rationale:* The nurse has other tasks that require her expertise at this time.

3) **Tell the health care aide to obtain assistance to reposition Mr. Sagan, while the nurse attends to the alarm and obtains an analgesic.**

   *Rationale:* This is appropriate delegation that frees the nurse to attend to the other tasks at hand.

4) Attend to the alarm first, and return to obtain an analgesic and to reposition Mr. Sagan later.

   *Rationale:* This delays client comfort and does not make effective use of available resources.

References:

Black, J. M. & Hawks, J. H. (2005). *Medical-surgical nursing.* Toronto: Elsevier, p.152.

Ross-Kerr, J. C. & Wood, M. J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 156.

Question 58

58

Mr. Jonas, 83 years old, tells the nurse that he is refusing radiation therapy treatment because he wants to die in peace.

**After discussing this decision with Mr. Jonas, which one of the following replies by the nurse shows that she is fulfilling her responsibility?**

1) "I will notify the physician immediately so he can stop the treatment."

   *Rationale:* This is not a decision that the physician makes independently.

2) "That is perhaps the best choice, because it's important to live in peace."

   *Rationale:* This is not a decision for the nurse to make independently. She needs to discuss this with the health care team.

3) **"I will let the other members of the healthcare team know of your decision."**

   *Rationale:* This is an ethical decision and should involve the health care team. The nurse can be an advocate for the client at the meeting.

4) "You can refuse your treatment today and we'll talk about it again tomorrow."

*Rationale:* This is not an option that is either ethical or medically sound.

References:
Matzo, M. L. & Sherman, D. W. (2004). *Gerontologic palliative nursing care.* Toronto: Mosby, p. 85.

Fry, S. T. & Johnstone, M. J. (2002). *Ethics in nursing practice.* Malden, MA: Blackwell, p. 98-103.

Question 59

59

A new nurse is in charge of a long-term care unit for elderly clients. The nurse notices on the night shift that the clients are not being turned every 2 hours as scheduled on the night shift because the 2 aides sleep. When the nurse talks to them about it, they reply, "Just look after your pills, we have more experience than you."

**What should the nurse do?**

1) **Inform the aides that the situation will be reported to the immediate supervisor.**

*Rationale:* As the nurse was not able to resolve the problem with the aides – she must report it to the supervisor.

2) Chart that clients are not being turned every 2 hours.

*Rationale:* This does not resolve the problem and the nurse has an ethical responsibility to report unsafe care.

3) Report the situation and her discussion with the aides to the day team.

*Rationale:* The report needs to go to the supervisor who can resolve the situation. The day shift may not be able to do anything.

4) Explain to the aides the consequences of their actions.

*Rationale:* This can be done – but based on the aides response will not resolve the issue.

References:
Canadian Nurses Association (2002). *Code of ethics for registered nurses*. Ottawa: CNA, p. 9-10, 16-17.

Ross-Kerr, J. C. & Wood, M .J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 107-108.

Question 60

60

**Which lunch menu includes all food groups from Canada's Food Guide?**

1) Green salad, roll and butter, fruit salad, 2% milk

*Rationale:* Does not include meat and alternatives.

2) **Chicken sandwich, medium apple, tomato juice**

*Rationale:* Does not include milk products.

3) Mushroom omelette, spinach salad, cranberry juice

*Rationale:* Does not include grain or milk products.

4) **Peanut butter sandwich, orange, skim milk**

*Rationale:* Contains all 4 food groups: meat and alternatives, grain products, vegetables and fruits, and milk products.

References:
Ross-Kerr, J. C. & Wood, M.J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 1285.

Kozier, B., Erb, G., Berman, A. J. & Snyder, S. (2004). *Fundamentals of nursing.* Toronto: Prentice Hall, p. 984.

Question 61

61

Jeffrey, 6 months old, is 12 hours postoperative following correction of bilateral clubfeet and subsequent casting. He has been receiving an elixir of acetaminophen (Tylenol) and codeine po, q.4h. as ordered. His mother states that the prescribed analgesic is not effective in managing her infant's pain.

**What action would be most appropriate for a nurse to take at this time?**

1) Tell the mother that Jeffrey's discomfort stems from physical restraint of the casts and not from pain.

*Rationale:* Parents know their children best. This response shows a lack of respect for the mother's judgement.

2) Tell the mother that it is to be expected that children will experience some pain following surgery.

*Rationale:* This response does not address the mother's concern. There is no reason that a child should have to experience post-operative

pain. Total pain relief should be the goal.

3) Suggest to the mother that she try and distract Jeffrey by sitting in the rocking chair and singing to him.

*Rationale:* Distraction is one non-pharmacologic strategy for managing pain. This may be useful for a period of time, but may not be effective in controlling severe post-operative pain.

4) **Verify the mother's findings and contact the surgeon to request a change in the analgesic order.**

*Rationale:* Parents know their children best and are sensitive to changes in their behavior. This child's analgesic order may not be adequate to effectively manage his post-operative pain.

References:
McKinney, E. S., James, S., Murray, S. & Ashwill, J. (2005). *Maternal-child nursing.* Toronto: Elsevier, p. 994.

Pillitteri, A. (2007). *Maternal & child health nursing. Austin, Philadelphia: Lippincott Williams & Wilkins, p. 1162.*

Question 62

62

**Which method would be appropriate when screening a class of Grade 1 children at high risk for exposure to tuberculosis?**

1) **Skin test**

*Rationale:* This is the recommended testing.

2) Sputum test

*Rationale:* Young children can not cough deeply enough to produce a sputum sample.

3) Respiratory assessment

*Rationale:* Inaccurate and inconclusive.

4) Radiographic examination

*Rationale:* This is not a routine screening test. It would be done as a follow-up to a positive skin test.

References:
McKinney, E. S., James, S., Murray, S. & Ashwill, J. (2005). *Maternal-child nursing.* Toronto: Elsevier, p. 1246.

Pillitteri, A. (2007) *Maternal & child health nursing.* Austin, Philadelphia: Lippincott Williams & Wilkins, p. 1268.

Question 63

63

Mrs.Yew, 68 years old, calls the nurse to report that her intravenous bag is nearly empty.

**In order to safely change to a new bag of intravenous fluid, what action should the nurse take?**

1) Allow existing solution to clear the drip chamber.

*Rationale:* Fluid should be left in chamber to provide fluid to vein when bag is changed and prevent air from entering tubing.

2) Open roller clamp prior to spiking new bag.

*Rationale:* The clamp should be closed to prevent air from entering the system.

3) **Keep existing bag upright before closing the clamp.**

*Rationale:* This prevents air from getting into the tubing.

4) **Remove spike from existing bag prior to removing protective cover from new bag.**

*Rationale:* Does not permit quick, smooth change over and increase the chances of contaminating spike.

References:
Perry, A. G. & Potter, P. A. (2006). *Clinical nursing skills & techniques.* Toronto: Elsevier, p. 943.

Kozier, B., Erb, G., Berman, A. J. & Snyder, S. (2004). *Fundamentals of nursing.* Toronto: Prentice Hall, p. 1394-1396.

Question 64

64

**Which one of the following must guide the nurse when providing nursing care?**

1) Medical orders

*Rationale:* The nurse needs to ensure that medical orders are completed but they do not guide the nurse in planning her care.

2) **The priorities determined by the nurse**

*Rationale:* Priorities are determined with the client and not only by the nurse.

3) **Client needs**

*Rationale:* Nursing care should be client centered.

4) The nurse's skills based on the health situation

*Rationale:* The client is the focus of care – not the nurse's needs.

References:

Wilkinson, J. M. (2001). *Nursing process and critical thinking.* Toronto: Prentice Hall, p. 12, 250.

Ross-Kerr, J. C. & Wood, M. J. (2006). *Canadian fundamentals of nursing.* Toronto: Elsevier, p. 149-154.

Question 65

65

Joey, 12 years, has terminal cancer. He has been melancholic all day.

**Which response by the nurse would be the most supportive?**

1) **"Would you like to take a break from all this and go to the teen room?"**

*Rationale:* May cut off discussion.

2) "Joey, you're not in this alone. All of us are dying."

*Rationale:* True, but not helpful. "All of us" are not dying right now.

3) **"This must be hard for you."**

*Rationale:* Acknowledges Joey's condition.

4) "I guess sometimes God works in mysterious ways."

*Rationale:* May explain death for the nurse, but can be little comfort to a person who does not envision it to be true.

References:

McKinney, E. S., James, S., Murray, S. & Ashwill, J. (2005). *Maternal-child nursing.* Toronto: Elsevier, p. 1343.

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing.* Toronto: Elsevier, p. 819- 820.

Question 66

66

A 38-year-old male client with a diagnosis of paranoid schizophrenia is being treated with the neuroleptic medication olanzapine (Zyprexa). He comes to the nursing desk with a stiff neck deviating to one side, an enlarged tongue sticking out of his mouth and he is drooling. His arms and legs are stiff and he appears to be short of breath.

**Which of the following prescribed prn medications should the nurse administer?**

1) **Benzotropine mesylate (Cogentin) I.M.**

*Rationale:* Dystonia is characterized by involuntary muscle spasm, especially of the head and neck. It can progress to laryngopharyngeal constriction with respiratory impairment. It requires immediate action by the nurse which is administering the anticholinergic medication by injection.

2) **Trihexphenidyl (Artane) p.o.**

*Rationale:* The client would not be able to swallow the tablet. A tablet would not act quickly enough to relieve the client's serious symptoms. Benzotropine mesylate (Cogentin) is the only anti-cholinergic medication available which can be given by injection.

3) Lorazepam (Ativan) I.M.

*Rationale:* The symptoms are characteristic of a dystonic reaction rather than anxiety.

4) Olanzapine (Zyprexa) SL

*Rationale:* Giving an antipsychotic would exacerbate the condition as extrapyramidal effects and dystonic reactions are side effects.

References:

Austin, W., & Boyd M. A. (1998). *Psychiatric nursing for Canadian practice.* Philadelphia: Lippincott Williams & Wilkins, p. 313-314.

Deglin J. H., & Vallerand, A. H. (2005). *Davis's Drug Guide for Nurses.* (9th ed.) Philadelphia: F. A. Davis, p. 192-193.

Question 67

67

Mrs. Lee, 57 years old, is scheduled for a left femoral arteriogram. She states, "The physican told me I have to have an x-ray of my leg. Will I be able to go home right after?"

**How should the nurse respond?**

1) "Your physician should have explained the test. It's more involved than just an x-ray."

*Rationale:* This is blaming. The nurse is not providing the client with further information, and not exploring what she has been told.

2) **"This procedure is more than just an x-ray. What else did the physician tell you about this test?"**

*Rationale:* The nurse is assessing the client's knowledge and providing information.

3) "With this type of x-ray, clients are allowed to go home right away."

*Rationale:* Incorrect, the x-ray would require staying for observation.

4) "Clients who have this test need to be kept overnight to watch for complications."

*Rationale:* Inaccurate information. Using the word complications may frighten the client. Also, the nurse is not accurately responding to the client's question.

References:
Smeltzer, S. C. & Bare, B. G (2004). *Brunner & Suddarth's textbook of medical-surgical nursing* (10th ed). Philadelphia, PA, Lippincott-Raven.

Fischbach, F. (2004). *A manual of laboratory and diagnostic tests.* PA: Lippincott, Williams & Wilkins.

## Question 68

68

Peter, a 28- year-old skier, has just returned from the O.R. following an open reduction of a fractured femur. He is experiencing post-op pain. Acetaminaphen (Tylenol) 1 g, p.o., q 4h, p.r.n. has been ordered.

**What action should the nurse take?**

1) Give the medication and inform the client of the physician's order.

*Rationale:* Incorrect: The client has just returned from the OR and would need an analgesic that would have a more immediate action. This action would not be addressing the client's needs as Tylenol would take more time to be effective.

2) Give the medication and leave a request on the chart for a change in orders.

*Rationale:* Incorrect: The doctor may not see this message for several hours and the client would not receive any pain relief during this time. The client needs an analgesic that would be effective sooner.

3) **Call the physician and request a change in analgesia.**

*Rationale:* Correct: This action would be most appropriate in addressing the client's needs. Parenteral medications are the most effective in relieving post-op pain, while this oral analgesic takes more time to be effective.

4) **Give the medication and assess effect of the analgesic.**

*Rationale:* Incorrect: This action would not be addressing the client's needs. Tylenol is effective with mild pain and would not be effective for immediate post-op pain of a fractured femur.

References:
Potter, P. A., & Perry, A. G. (2006). *Canadian fundamentals of nursing.* St. Louis: Mosby.

Deglin, J. H. & Vallerand, A. H. (2005). *Davis's drug guide for nurses* (9th ed.) Philadelphia, F. A. Davis, p. 86-87.

## Question 69

69

The nurse is responsible for planning weekly interdisciplinary team meetings. She has observed that Dr. Cooper rarely attends, even though he is present on the unit.

**How should the nurse respond?**

1) Meet with him separately to discuss issues related to clients' care.

*Rationale:* Incorrect: Avoiding the problem would not solve the issue of absence, and may reinforce missing interdisciplinary team meetings is acceptable.

2) Remind him of his responsibility to collaborate with team members.

*Rationale:* Incorrect: Confrontation would not explore the issue. This assumes the Dr. Cooper is intentionally missing the meetings.

3) **Discuss with him the reasons for not attending scheduled meetings.**

*Rationale:* Correct: First step in exploring the problem. This allows the opportunity to understand the cause.

4) Offer to reschedule meetings at a more convenient time.

*Rationale:* Incorrect: Assumes that the time is inconvenient. This may not be the problem. Assumes that the physician is key to the meetings.

References:
Austin,W. & Boyd, M. A. (1998). *Psychiatric nursing for Canadian practice.* Philadelphia: Lippincott Williams & Wilkins, p. 256–267.

Beebe, S. A., Beebe, S. K., Redmond, M. V. & Geerinck T. M. (2004). *Interpersonal communication: Relating to others* (3rd ed.). Toronto: Pearson Education Canada, p. 6-8; 10-11.

Question 70

70

Mr. Porter, 67 years old, has prostate cancer with bone metastases. He says that he is in excruciating pain, which has not been alleviated.

**What should the nurse know about use of pharmaceutical agents to manage Mr. Porter's pain?**

1) **Alleviation is usually optimal when the person can use a patient controlled analgesic pump.**

   *Rationale:* Correct: When the client has control over pain this can help minimize the pain. This type of medication achieves pain control more quickly than nurse administered intermittent doses.

2) Administering analgesics every 4 hours is sufficient to alleviate Mr. Porter's pain.

   *Rationale:* Incorrect: Mr. Porter's pain is not being relieved and needs something that will relieve his excruciating pain.

3) The analgesic doses must be spaced out as much as possible to prevent tolerance in Mr. Porter.

   *Rationale:* Incorrect: This is not an effective way of relieving pain. Analgesic need to be given on routine basis and as the client requires to relieve pain.

4) Codeine is particularly effective in alleviating cancer pain.

   *Rationale:* Incorrect: Codeine is not as effective in alleviating cancer pain. Morphine slow release or hydromorphone (dilaudid) is effective in alleviating cancer pain.

References:

Ross-Kerr, J. C., & Wood, M. J. (2006) *Canadian fundamentals of nursing* (3rd ed.). Toronto: Elsevier, p. 1245.

Deglin, J. H. & Vallerand, A. H. (2005). *Davis's drug guide for nurses* (9th ed.) Philadelphia, F. A. Davis, p. 606-607.

Question 71

71

Ms. Mitchell, 19 years old, arrives at the hospital having been beaten and sexually assaulted. She shares with the nurse that the perpetrator of the assault was her boyfriend. The police arrive at the hospital and ask the nurse for information regarding the identity of the perpetrator.

**What should the nurse do?**

1) Disclose the identity of the perpetrator to the police.

   *Rationale:* Incorrect: Nurses disclose confidential information only as authorized by the client unless there is a legal obligation to disclose. There is no legal obligation to disclose here.

2) Tell the police to return after the assessment has been completed.

   *Rationale:* Incorrect: This information is confidential and will still be confidential upon completion of the client's assessment.

3) **Ask the client if she would like to speak to the police.**

   *Rationale:* Correct: Nurses disclose confidential information only as authorized by the client unless there is a legal obligation to disclose.

4) Direct the police to the client's room.

   *Rationale:* Incorrect: Nurses must safeguard the trust of clients. Information learned in the context of a professional relationship should be shared only with the client's permission or as legally required. Physicians have a similar duty to maintain confidentiality in this situation.

References:

Ross-Kerr, J. C., & Wood, M. J. (2006). *Canadian fundamentals of nursing* (3rd ed.). Toronto: Elsevier, p. 116.

Canadian Nurses Association (2002). *Code of ethics for registered nurses.* Ottawa: CNA.

Question 72

72

**Which of the following statements should the nurse include when teaching parents of a 5-month-old infant about child safety?**

1) Ensure that electrical outlets are covered or plugged.

   *Rationale:* Incorrect: Although this is an important safety consideration, it is not relevant for infants. Motor development for an infant at this stage would be sitting on a lap and grasp objects.

2) **Remove drapery cords that may dangle close to the crib.**

   *Rationale:* Correct: Infants may be able to reach drapery cords and could strangle themselves. Motor development for a 5 month old would be to grasp objects.

3) Have prescriptions dispensed in containers with childproof caps.

*Rationale:* Incorrect: This is more of a consideration in toddlers. Infants cannot do more that grasp objects at this age.

4) Install safety latches on cabinets that contain cleaning products.

*Rationale:* Incorrect: This is more of a consideration in toddlers. An infant at this age may not be crawling let alone opening cupboards.

References:

Kail, R. V., & Cavanaugh, J. C. (2000). *Human development: A lifespan view* (2nd ed.). Scarborough: Nelson/Thomson Learning, p. 99.

Smith, C. M. & Maurer, F. A. (2000). *Community health nursing: Theory and practice* (2nd ed.) Philadelphia: Saunder, p. 760-761.

Question 73

Amy Carter, 4 years old, is scheduled for a cardiac catheterization.

**What should the nurse do to prepare Amy for the procedure?**

1) Describe the procedure to Amy and her parents.

*Rationale:* Incorrect: Amy will not understand what the procedure is about. It is more important to familiarize Amy to what will happen with the aid of a prop or visual aids.

2) Give Amy a tour of the procedure room and let her handle the equipment to be used.

*Rationale:* Incorrect: Showing the equipment to a pre-schooler is not appropriate.

73 3) **Use a doll to help explain the procedure to Amy.**

*Rationale:* Correct: Using a doll can help the child visualize the procedure. A doll is something that the child can relate to. Teaching is enhanced by meeting the child's developmental needs.

4) Show Amy a model of the heart and explain how the catheter is inserted.

*Rationale:* Incorrect: This is not appropriate for a client of this age. Amy will not understand what the models are all about. Pre-schoolers have limitations in thought.

References:

Ball, J. W. & Bindler, R. (2003). *Pediatric Nursing: Caring for children* (3rd ed.). Upper Saddle River, NJ: Prentice Hall, p. 73-78.

Pilliterri A. (2007). *Maternal & child health nursing: Care of the childbearing and childrearing family.* Philadelphia: Lippincott, Williams & Wilkins, p. 1048, 1228.

Question 74

Mrs. Poole, 66 years old, goes into cardiac arrest. The physician asks the nurse who is a recent graduate to defibrillate Mrs. Poole.

**Why is the nurse justified in refusing to defibrillate Mrs. Poole?**

1) The nurse wishes to comply with the wishes of Mrs. Poole's spouse who does not want her resuscitated.

*Rationale:* Incorrect: The graduate nurse has not been taught this skill or certified in it. According to the code of ethics the nurse must practice within their own level of competence.

2) Cardiac defibrillation goes against the nurse's personal values.

*Rationale:* Incorrect: Same answer as 1. Even if a procedure is against the nurse's personal values the nurse is responsible to care for the client. Nurses must give primary consideration to the welfare of clients.

74 3) **The nurse must not perform any act outside the nurse's level of competence.**

*Rationale:* Correct: According to the Code of Ethics the nurse must practice within their own level of competence. Since this is not a skill that the new graduate would have upon completion of a nursing program it is appropriate for the nurse to refuse.

4) A colleague who is very familiar with defibrillation must guide the nurse in the technique.

*Rationale:* Incorrect: Having a colleague guide the nurse is not acceptable. The code of ethics states the nurse base their practice on relevant knowledge, and acquire new skills and knowledge in their area of practice. The nurse must practice within their own level of competence.

References:

Canadian Nurses Association (2002). *Code of ethics for registered nurses.* Ottawa: CNA.

Du Gas, B. W., Esson, L., & Ronaldson, S. E. (1999). *Nursing foundations: A Canadian perspective* (2nd ed.). Scarborough, ON: Prentice Hall, p. 1274.

Question 75

75

For several years, student nurses have come to the campus health nurse with disturbing levels of stress. They typically complain about an

overwhelming workload. The nurse has raised the issue with faculty but has seen no changes.

**What should the nurse do?**

1) Work with the students to assist them with time management skills.

*Rationale:* Incorrect: Inappropriate response. The student may have excellent time management skills, but the workload is the problem. This response reinforces that the students cannot manage their workload.

2) Bring the problem to the attention of the student body and faculty again.

*Rationale:* Incorrect: Not the best answer. The campus health nurse has tried this already.

3) Set up an after-hours class to teach them relaxation techniques.

*Rationale:* Incorrect: Inappropriate response. This is not helping to get to the cause of the stress as it is the workload that is a problem. This may reinforce to the students that they cannot manage their workload and does not support the students claim.

4) **Work with students to lobby nursing faculty for changes in student workload.**

*Rationale:* Correct answer: There is evidence in the literature that student nurses have the highest levels of stress when compared with students in other health professions. It is time to lobby for change because there has been no action and the problem persists.

References:

Wright, L. M. & Leahy, M. (2000). *Nurses and families: A guide to family assessment and intervention* (3rd ed.) Philadelphia: F.A. Davis.

## Question 76

76

The nurse wants to evaluate her performance as a caregiver.

**What should she do as a first step?**

1) **Conduct a self-assessment.**

*Rationale:* Correct: The nurse needs to conduct a self-assessment to determine what other actions she should take next. This is the initial step in self awareness.

2) Validate her perceptions with her immediate supervisor.

*Rationale:* Incorrect: This is not the first step. A self assessment needs to be done prior to the nurse verifying her perceptions with a supervisor. However, it is important to validate to decrease bias.

3) Ask the opinion of the health care team members.

*Rationale:* Incorrect: The health care team members may not be able to accurately give an evaluation of the nurse's performance.

4) Question the clients for whom she is responsible.

*Rationale:* Incorrect: This imposes upon the client. The client may feel that they will not be cared for as well if there opinion of the nurse's care is not optimal. The nurse may be creating an undue influence.

References:

Austin, W. & Boyd, M. A. (1998). *Psychiatric nursing for Canadian practice.* Philadelphia: Lippincott Williams & Wilkins, p. 101

Stuart, G. W. & Laraia, M. T. (2005). *Principles and practice of psychiatric nursing.* St. Louis: Mosby, p. 17, 320.

## Question 77

77

**When teaching a parent from a specific ethnic background about family nutrition, what is the most appropriate nursing action?**

1) Discuss the possible need to alter traditional cooking practices.

*Rationale:* Incorrect: This assumes prior judgment of their dietary practices. It does not allow for respect of cultural specific practices. It does not incorporate client choice.

2) Reassure the parent that foods in Canada are of a high standard.

*Rationale:* Incorrect: This is not consistently accurate. It infers that the parents' choice of following traditional cooking practices is not appropriate.

3) **Ask the parent about the family's nutritional preferences.**

*Rationale:* Correct: Asking for client input shows respect and helps assess if there is a need for teaching. This shows value of client choice.

4) Tell the parent to document the family's dietary habits for one week.

*Rationale:* Incorrect: It is directive and an unnecessarily long time.

References:

Clark, M. J. (1996). *Nursing in the community* (2nd ed.) Stamford, CN: Appleton & Lange, p. 278.

Boyd, M. A. (2002). *Psychiatric nursing: Contemporary practice.* Philadelphia: Lippincott, p. 278.

Question 78

78

A 65-year-old male client arrives at the local clinic. On examination, his colour is pink, but he states that he has been having increasing dyspnea on exertion which has now progressed to difficulty breathing while at rest. He does not have a cough or sputum production. He has an increased anterior-posterior chest diameter, decreased breath sounds, and decreased oxygen saturation.

**Which one of the following questions would be appropriate for the nurse to ask based on these findings?**

1) **"Do you have a family history of emphysema?"**

   *Rationale:* Correct: These are the characteristic presenting symptoms of a client with emphysema and this condition has a familial predisposition.

2) "Have you ever had any teaching on normal respiratory changes with aging?"

   *Rationale:* Incorrect: These symptoms are not normal changes associated with aging. Further subjective questions need to be asked to gather a complete health history.

3) "Did you recently receive the flu vaccine?"

   *Rationale:* Incorrect: These are not the presenting side effects of the flu vaccine. Also, these symptoms are respiratory in nature and further questioning is needed.

4) "Have you recently been in contact with a person with Tuberculosis?"

   *Rationale:* Incorrect: These are not the findings of TB. Clinical manifestations of TB include cough, night sweats, fatigue, weight loss.

References:

Jarvis, C. (2004). *Physical Examination and Health Assessment* (4th ed.) St. Louis, MO: W.B. Saunders, p. 447.

Smeltzer, S. C. & Bare, B G. (2000). *Brunner & Suddarth's textbook of medical-surgical nursing* (9th ed.) Philadelphia, PA: Lippincott, p.453.

Question 79

79

The nurse at an elementary school has observed a trend of pedestrian-vehicle accidents and wishes to promote a school safety patrol program.

**How will the nurse best gain support for this program?**

1) Write a letter to all the students of the school inviting them to participate in the program.

   *Rationale:* Incorrect: This would not be the initial step in promoting this program and not all students would be of an appropriate age to act as school patrols.

2) Collect data on the traffic patterns in the community and submit the findings to the local health department.

   *Rationale:* Incorrect: This strategy may provide supportive data for a trend that has been observed but the data should be directed to the school not the health department. The nurse would like to see changes at the school.

3) **Make an appointment with the school principal and parent council to discuss a safety patrol program.**

   *Rationale:* Correct: Addressing key stakeholders and leaders in the school would inform them of the health risk and assist them in understanding the benefits of a safety program.

4) Submit a proposal to the school board requesting that a safety patrol program be mandated.

   *Rationale:* Incorrect: This is a top down approach that does not allow community involvement.

References:

Stewart, M. J. (2000). *Community nursing: Promoting Canadians' health.* Toronto: W.B. Saunders.

Hitchcock, J. E., Schubert, P.E. & Thomas, S. A. (2003). *Community health nursing: Caring in action.* New York: Thomson Delmar Learning.

Question 80

80

A client is receiving palliative care at home. During a biweekly visit, the nurse finds that the client has begun to experience occasional nausea and retching.

**Which of the following nursing actions is most appropriate?**

1) Contact the physician to order an oral antiemetic.

   *Rationale:* Incorrect: An oral antiemetic would not be effective in this case as the client has nausea and retching. The client may not be absorbing the medication.

2) **Sit with the client and assist in identifying triggers.**

*Rationale:* Correct: The treatment of nausea and vomiting is based on the cause. Keeping a journal will assist in identifying the cause.

3) Recommend that the client rest an hour after each meal in side-lying position.

*Rationale:* Incorrect: Resting after meals is suggested, but with head elevated.

4) Encourage adequate hydration by adding more fruit juices.

*Rationale:* Incorrect: Adequate hydration is appropriate, but nonacidic juices should be used rather than those which are acidic. The fluids may be one of the causes of the nausea. Identification of cause is important.

References:

Kemp, C. (1999). *Terminal illness: A guide to nursing care* (2nd ed.) Philadelphia: Lippincott, p. 184-185.

Smeltzer, S. C. & Bare, B. G. (2004). *Brunner and Suddarth's textbook of medical surgical nursing.* Philadelphia: Lippincott, p. 285-286.

Question 81

81

Mr. Scott is a 37-year-old homeless person. The community health nurse finds him huddled in a doorway shaking. The nurse notes a large infected ulcer over his left lower leg and suggests he go to the nearest treatment facility.

**What should the nurse do when Mr. Scott refuses?**

1) **Speak with Mr. Scott's homeless friends and ask them to encourage him to seek treatment.**

*Rationale:* Incorrect: This may involve a breach of confidentiality and the nurse should not be discussing his health needs without his permission.

2) Contact the community police and request that they escort Mr. Scott to a treatment facility.

*Rationale:* Incorrect: Mr. Scott has the right to choose whether he wishes to seek treatment or not. This is not a matter for the police.

3) Offer to buy Mr. Scott some coffee and a sandwich if he will agree to go for treatment.

*Rationale:* Incorrect: This is coercive. There is a fine line between encouragement and bribery.

4) **Assess Mr. Scott's mental status to make sure that he is able to understand the need for treatment.**

*Rationale:* Correct: Mentally competent adults have the right to refuse treatment. Nurses must support informed decision-making.

References:

Canadian Nurses Association (2002). *Code of ethics for registered nurses.* Ottawa: CNA.

Keatings, M & Smith, O. B. (2000). *Ethical and legal issues in Canadian nursing.* Toronto: W. B. Saunders.

Question 82

82

Ms. Benoit is recovering from orthopaedic surgery 3 days ago. She requests acetaminophen (Tylenol) plain instead of her ordered dosage of acetaminophen with codeine 30 mg (Tylenol 3).

**What should the nurse base her action on?**

1) It is appropriate to give a lower dosage of analgesic than ordered.

*Rationale:* Incorrect: Giving an unordered dosage of medication without prescribing authority would be outside the nurse's scope of practice.

2) **Ms. Benoit should have her pain medication re-evaluated by her doctor.**

*Rationale:* Correct: The prescriber should be the person to adjust the pharmacological pain relief regimen.

3) At this level of pain, non-pharmacological interventions will be sufficient.

*Rationale:* Incorrect: This is a subjective decision that should only be made with the client. At 2 days post operative for orthopedic surgery it is unlikely that the client does not need pharmacological intervention for pain. Also, Ms. Benoit recognizes that she needs an analgesic. She just wants a reduced dosage.

4) Ms. Benoit's request to have her analgesic reduced indicates concern about addiction.

*Rationale:* Incorrect: It is normal to need narcotic intervention up to at least 72 hours postoperative following orthopedic surgery. Ms. Benoit may feel that she does not need the same strength of analgesic as before.

References:

Eisenhauer L. A., Nichols L. W., Bergon F. W. (1998). *Clinical pharmacology and nursing management* (5th ed.) New York: Lippincott, p. 89.

Lemone, P. & Burke, K. M. (2003). *Medical-surgical nursing: Critical thinking in client care* (3rd ed.) Upper Saddle River, NJ: Prentice Hall, p. 61-71.

Question 83

83

Mr. Davis, 73 years old, is a palliative client who has requested that he be allowed to die at home. Mrs. Davis tells the home care nurse that she is tired, and does not know how much longer she can cope with the responsibility of providing total care for her husband.

**What course of action should the nurse take?**

1) Offer to stay with Mr. Davis for a few hours while Mrs. Davis rests.

*Rationale:* Incorrect: This provides only a temporary solution to the wife's concerns, and does not look at other possible alternative.

2) Discuss with her the necessity of Mr. Davis being admitted to the hospital.

*Rationale:* Incorrect: This would go against the client's wishes. This does not explore other options with Mrs. Davis that would provide support while Mr. Davis is at home.

3) Suggest that Mrs. Davis involve her family with her husband's care.

*Rationale:* Incorrect: The family should be encouraged to provide assistance. This may be too forceful as the family may be unable or unwilling to help.

4) **Discuss with Mrs. Davis possible options for respite care.**

*Rationale:* Correct: Respite care provides time away from the client for the caregiver and helps relieve care-giver burn-out. This would allow Mr. Davis to remain at home while Mrs. Davis has some rest.

References:

Lubkin, I. M., Larsen, P. D. (2006). *Chronic illness: Impact and interventions.* Toronto: Jones and Bartlett Publishers.

Cookfair, J. M. (1996). *Nursing care in the community.* St. Louis: Mosby, p. 481-485.

Question 84

84

The registered nurse (RN) in charge of a long-term care agency from midnight to 0800 is confronted with a clinical situation concerning a resident. She is the only RN on duty and is unsure about how to handle the situation. She is unable to find a written agency policy, protocol or procedure.

**Which of the following would best guide her decision-making?**

1) The client's wishes

*Rationale:* Incorrect: The client's wishes may conflict with professional practice standards or with agency policy.

2) Consultation with other night staff

*Rationale:* Incorrect: Other staff may not be professional, or may not have correct information. The nurse needs to refer to her professional practice standards.

3) **Professional standards of practice**

*Rationale:* Correct: Standards of practice provide objective criteria for nurses to provide care.

4) The client's health record

*Rationale:* Incorrect: Resource limited to information about client only. This would not provide information regarding professional standards of practice.

References:

Du Gas, B. W., Esson, L., Ronaldson, S. E. (1999). *Nursing foundations: A Canadian perspective.* (2nd ed.) Scarborough: Prentice Hall, p. 106.

Potter, P. A., Perry, A. G., Kerr, J. C. & Sirotnik, M K. (1997). *Canadian fundamentals for nursing.* St. Louis, MI: Mosby-Year Book, p. 218.

Question 85

85

**What is the best advice a nurse can give to a day-care supervisor who wishes to decrease the incidence of bacterial conjunctivitis (pink eye)?**

1) Improve waste disposal techniques in the classrooms.

*Rationale:* Incorrect: A good health promotion idea, but will not necessarily decrease bacterial cross-contamination between children.

2) Sterilize all visibly soiled toys at the end of each day.

*Rationale:* Incorrect: Sterilization is the complete elimination of all microorganisms. While it is a good idea to routinely clean or disinfect toys and surface areas, it is not necessary nor possible to sterilize them within a daycare centre. Also, assumes that the microorganisms are visible.

3) **Increase the frequency of handwashing by staff and children.**

*Rationale:* Correct: Pinkeye is bacterial conjunctivitis spread by direct contact. The most important technique in preventing and controlling the transmission of infection is handwashing. Contaminated hands are a prime source of cross-infection.

4) Ensure proper ventilation throughout the building.

*Rationale:* Incorrect: Important in preventing the spread of airborne pathogens. Ventilation is not relevant to decrease incidence of pinkeye as this is spread through contact.

References:

Heymann, D. L. (2004). *Control of communicable diseases manual* (18th ed.) Washington, DC: American Public Health Association, p. 124-126.

Smith, C. M. & Maurer, F. A (1995). *Community health nursing: Theory and practice.* Philadelphia: W.B. Saunders Company, p. 503, 659.

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