CHAPTER 1

Terminology

Answers will be individual.

1. An **apprenticeship** in nursing during the Civil War was when a woman learned nursing by doing it.
2. Nursing **theory** is based on relationships among concepts and facts and not on actual knowledge.
3. **Evidence-based nursing** is integrating the best research evidence with clinical expertise and patient values to facilitate clinical decision-making.
4. The **nursing process** is a systematic way to deliver nursing care that combines art and science.

Short Answer: Acronyms

1. The hospital receives a predetermined amount of money for caring for a person with a particular DRG such as pneumonia.
2. An HMO is a type of group medical practice where patients are enrolled for a set monthly fee and then receive the services of a limited network of doctors, hospitals, and other health care providers.
3. It is expected that the emphasis on prevention and coordinated care will produce a shift in nursing from the hospital to the community.

Short Answer

1. Any four of the following:
   a. Stressed a clean environment.
   b. Included good nutrition in her care.
   c. Kept records and statistics to show validity of her nursing practices.
   d. Started nurse training schools.
   e. Felt holistic care was essential (meeting psychosocial as well as physical needs).
   f. Nursing directed at both illness and maintaining health.
   g. Nursing should be taught by nurses.
   h. Continuing education is essential for nurses.
   b. Team nursing—tasks were assigned to team members and the leader coordinated care.
   c. Total patient care—one nurse carried out all nursing tasks for a patient.
   d. Primary nursing—one nurse plans and directs care for a patient over a 24-hour period.
3. Evidence-based practice is using the best scientific evidence from research to guide decision-making.
4. Any four of the following:
   a. Desire and capability to teach
   b. Ability to listen
   c. Belief in holistic care (attention to psychosocial as well as physical care)
   d. Good therapeutic communicator
   e. Able to collaborate with others
   f. Ability to delegate tasks to others
   g. Willing to give basic care to help another (bathing, toileting)
   h. Concern for the patient’s well-being
   i. Ability to give emotional support
   j. Ability to advocate for the patient
   k. Ability to plan care in an organized fashion
   l. Ability to efficiently implement care
5. | LPN/LVN                  | Registered Nurse                                    |
   | 12–18 months of formal training | 2–5 years of formal training |
   | Trained to care for the well or chronically ill | Trained to care for the acutely ill as well as the chronically ill; teach preventive health care |

6. Protect the public and define the legal scope of practice for nurses.

**Review Questions for the NCLEX® Examination**

1. 2
2. practical
3. 2
4. Lillian Wald
5. 2
6. 2
7. 1, 2, 4
8. 3
9. 1
10. 1, 4
11. 1

**Critical Thinking Activities**

1. Definition should include caring for the sick, promoting wellness, providing health teaching, giving emotional support, and attending to psychosocial concerns. Each person’s definition will be different.

2. Make a list of the group’s ideas. Areas to include are assessing patients, choosing nursing diagnoses, stating expected outcomes, planning interventions to meet the outcomes, directly implementing the actions, and evaluating the outcome of the plan. Other ways could be quality assurance activities on the nursing unit; attending continuing education presentations or reading journals; assisting students or new nurses on the unit; maintaining an ethical manner (not divulging confidential information); collaborating with the dietitian, physician, respiratory therapist, or physical therapist on the patient’s plan of care; considering cost-effective ways to implement care; and applying research findings to care.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**

1. delegator
2. foster
3. sought
4. controversy
5. implement
6. criteria
7. prior
8. vigilant
9. skyrocket

**Vocabulary Exercises**

1. Assessment: test evaluation
2. Diagnosis: finding, conclusion drawing
3. Outcome: removal result
4. Implementation: carrying out making equipment
5. Evaluation: measurement analysis
6. Collegiality: education relationship with other workers

**Word Attack Skills**

1. a. He attributed his success to his attributes of hard work and honesty.
   b. The use of the surgical implements was implemented with a training session.

**CHAPTER 2**

**Terminology**

1. g
2. d
3. h
4. f
5. j
6. k
7. i
8. e
9. c
10. a
11. b

**Short Answer**

1. Health is not only the absence of infirmity and disease but also a state of physical, mental, and social well-being.

2. Any three of the following:
   a. Watching dietary intake to prevent weight gain
b. Engaging in a regular exercise program
  c. Obtaining immunization against communicable disease
  d. Examining the breasts or testes monthly

3. a. Monitor the body
   b. Define and interpret symptoms
   c. Seek health care
   d. Follow advice and self-care measures to regain wellness

4. Helping people cope with adverse physiologic, psychosocial, and spiritual responses to illness.

5. a. Perception of the stressor
   b. Degree of health and fitness
   c. Previous life experiences and personality
   d. Social support system available
   e. Personal coping mechanisms

Completion
1. high-level wellness; Dunn
2. an active part
3. cultural
4. unique individual
5. physical, psychological, social, and spiritual
6. coping mechanisms
7. physiologic, safety and security; love and belonging; self-esteem; self-actualization
8. the patient cope
9. adaptation
10. stress
11. sympathetic nervous system; fight or flight
12. hormones

Review Questions for the NCLEX® Examination
1. 1, 2
2. 1, 2, 3, 4
3. 4
4. 3
5. 4
6. 2
7. 1, 3
8. 1

Matching
1. Sympathetic
2. Sympathetic
3. Parasympathetic
4. Parasympathetic
5. Sympathetic
6. Sympathetic

Critical Thinking Activities
1. Psychosocial assessment, calling in a social worker, calling a pastor or priest or other religious leader; attentive listening; exploring concerns.
2. Fatigue makes one want to rest more. Fever may cause one to lie down and rest and it helps eliminate invading organisms. Coughing expels secretions and viral debris. Malaise makes one slow down.
3. Sweaty palms, rapid pulse, muscle tenseness, anxiety, shakiness, (others).
4. a. Obtaining information to decrease fear of the unknown.
   b. Listening to concerns and fears.
   c. Enhancing healthy coping skills such as providing quiet time for meditation.
   d. Meeting needs efficiently.

Steps Toward Better Communication
Completion
1. adverse
2. hygiene
3. noncompliant
4. perception
5. alters
6. intervene
7. emerge
8. deviation
9. maladaptive
10. resolves

Vocabulary Exercises
1. Biologic b, f
2. Psychosocial a, c
3. Spiritual d, e

Word Attack Skills
Opposites
1. minimum, adverse
2. ignore
3. clear, specific
4. dynamic, active
5. atrophy, stagnate
6. good luck, good fortune
7. overreact
8. good health, feel good

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Communication Exercises

Examples:
1. a. Culture Believe in preventive health care
   b. Religion Prayers for better health can be answered
   c. Standard of living Can afford to go to the doctor
   d. Support system Family and friends available to help
   e. Genetic influence Susceptible to heart disease
2. Examples:
   a. Wearing seat belts and helmets for dangerous sports
   b. Obtaining a cancer screening
   c. Eating well-balanced meals
3. Answers will depend on the individual. Verbalization will increase expertise at pronunciation and sentence structure.
4. Answers will depend on the individual.

CHAPTER 3

Terminology

Examples will be individual.
1. Accepting responsibility for one’s actions. Example: A nurse accepts accountability for the care provided by the aide to whom a task was assigned.
2. Communicated in confidence; secret; kept private. Example: The patient’s history is confidential.
4. There is failure to perform in a reasonably prudent manner. Example: A nurse fails to notify the charge nurse or doctor when a patient with a fresh cast complains of pain and numbness.
5. Faulty or improper practice is carried out by a professional person. Example: A licensed nurse fails to heed signs of toxic overdose of medication and continues to administer the drug, causing harm to the patient.
6. Making remarks about a person that are untrue and that damage the person’s reputation. Example: The nurse told a patient that another nurse had been disciplined for taking patient’s medications when this was not true.
7. Physical contact that was against the person’s will or consent. Example: A feeding tube was placed in a patient although no consent was given for its placement.
8. Written defamation of character; untrue and damaging words. Example: The newspaper committed libel in printing untrue statements about the doctor’s treatment of the patient.
9. Violating the right to privacy concerning one’s body and private information without the person’s consent. Example: Two unit secretaries discuss the number of abortions a patient has had.
10. Oral statements that are false or that injure another’s reputation. Example: A nurse makes a false statement to the effect that another nurse forged a license card and is not entitled to be a nurse.
11. Assault is the threat of harm to an individual. Example: When the patient attempts to get out of bed, the nurse pushes him down and straps his arms to the bed rails.
12. Participating states allow nurses to be licensed in one state and practice in any state belonging to the compact. Example: A nurse has her primary residence in Utah near the “four corners” of Utah, Colorado, Arizona, and New Mexico (all of which are participating states). This nurse can drive across the border and practice nursing in any of these compact states without paying any additional licensure fees or application.

Short Answer
1. I Introduction
   S Situation
   B Background
   A Assessment
   R Recommendation
   R Readback
2. (a) the risks and benefits of the proposed treatment, (b) the possible consequences of not having the procedure done, and (c) the name of the health care provider who will perform the procedure
3. the group; membership in the group
4. Being attentive and sincere with each patient, listening to the patient’s needs and complaints, keeping him or her informed of what you will be doing, showing concern and respect.
5. Being charged with practicing medicine without a license. The state board of nursing may take disciplinary action, suspending or revoking the license to practice nursing.
6. Describe the specific functions and activities of nurses as opposed to those of other health care professionals (and to) provide criteria for judging the quality and effectiveness of nursing care.

7. Provide evidence-based and expert-based solutions to areas that have been problematic in terms of patient safety.

8. Educate future nurses in developing the knowledge, skills, and attitudes needed to improve the quality and safety of our future health care systems.

Review Questions for the NCLEX® Examination

1. 3
2. 1, 2, 3, 4
3. 1, 2
4. 3
5. 1
6. 3
7. 1, 2, 3
8. 1, 2, 3
9. 2
10. 2, 4
11. 4

Ethical Situations

These situations require synthesis and application of knowledge.

Situation A

(Giving this information would be a breach of confidentiality.)

1. c
2. lawsuit; loss of employment

Situation B

3. b (Eating the food is against hospital policy and is unethical. It could be considered stealing, even though the food cannot be served to another person.)

Situation C

4. ethics (Taking medication prescribed for another is illegal use of drugs, as well as stealing.)
5. legal

Situation D

6. a (Taking monetary gifts from patients is unethical and is against agency policy. The rationale is that if reward is involved with one patient, he or she may be treated better than another patient.)

7. a (It is unethical to take money for services you have personally rendered to a patient. However, it is acceptable for the patient to contribute to the hospital or to a need for the unit on which the patient stayed.)

Critical Thinking Activities

1. This is a direct threat of false imprisonment. It is unethical, and if carried out, is illegal. Discuss the situation with the person who made the statement to the patient. Suggest alternatives to calm the patient and protect the patient’s safety.

2. Consider stating that all patients are asked to express their preferences for care if certain emergencies occur or health declines to the point of inability to make one’s own decisions any longer. Offer to explain the terms and reasons for the questions on the form. Explain the reasons why it is preferable to most people to make their own decisions about these matters in advance.

3. You are responsible for giving care equal to that of the licensed nurse in all areas in which you have already been trained. You may not legally perform procedures that you have not been sufficiently trained to do yet. You are obligated to tell the person in charge when you do not have the appropriate training to do a procedure or sufficient expertise to care for a group of patients.

4. You should first consult with your clinical instructor and the nurse assigned to the patient. Discuss the situation out of hearing of the child or parents. You could explore the chart for any other evidence of possible child abuse. If a determination is made that the child could be a victim of child abuse, you should report it to the charge nurse and call the social worker or report it directly to the authorities. Find out what the correct protocol of the agency is in this situation. It is your responsibility to see that the authorities are notified.

5. You should call your friend immediately and advise her to take down the posting. Even though no patient name was mentioned, it is both a potential breach of patient confidentiality and unprofessional to post a comment such as that.
**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. a. jeopardize  
   b. escalate  
   c. witness  
   d. resuscitate
2. a. prescribed  
   b. pertinent  
   c. suggestive
3. a. scope  
   b. proxy  
   c. access  
   d. means  
   e. precedent
4. a. seemingly  
   b. gravely

**Vocabulary Exercise**

Ethics: the rules or standards governing the conduct of members of a profession. (Wording of examples may vary.)

**Word Attack Skills**

*Examples:*
1. The doctor will prescribe some medication for the infection.
2. Take the written prescription to the pharmacy.

**Communication Exercises**

*All exercises are individual. Each requires verbalization practice.*

**CHAPTER 4**

**Terminology**
1. b  
2. e  
3. c  
4. g  
5. d  
6. a  
7. f

**Short Answer**
1. a. patient input  
   b. collaboration with other health care team members  
   c. thorough assessment  
   d. prioritization of needs/concerns  
   e. critical thinking
2. a. Define the problem clearly.  
   b. Consider all possible alternatives.  
   c. Consider possible outcomes for each alternative.  
   d. Predict the likelihood of each outcome occurring.  
   e. Choose the alternative with best chance of success and fewest undesirable outcomes.
3. Rather than thinking about something at random, critical thinking is directed and purposeful and requires skills such as effective reading, effective writing, attentive listening, and effective communicating. Critical thinking involves keeping an open mind and looking at an issue from different perspectives. It requires an organized and systematic approach. To think critically, one must be flexible, realistic, creative, humble, honest, curious, and insightful. Clinical reasoning is critical thinking in the clinical setting.
4. Speaking clearly and concisely, considering what has been said and thinking before speaking, attentively listening before responding.
5. Critical thinking skills can be improved by any of the following:
   a. Focusing on main ideas and relevant data while reading.
   b. Writing in an organized manner and expressing each thought coherently and concisely, yet clearly.
   c. Evaluating what has been written.
   d. Consciously practicing attentive listening.
   e. Thinking about what to say and how to state it clearly and concisely in a logical way before beginning to speak.
   f. Taking time to consider a verbal response before making one.
   g. Acquiring the skills and attributes found in the critical thinker as listed in the chapter.
   h. Practicing purposeful thinking.
   Clinical reasoning skills can be improved by practicing any of the above in the clinical setting; also by discussing patient care scenarios and prioritization with your clinical instructor.
6. Patient problems are usually prioritized along the lines of Maslow’s hierarchy of basic needs.
7. What will happen if the task is not done on time.
8. flexible; reprioritize
9. KSA = knowledge, skills, attitudes. Important KSAs in the EBP category that are important for nursing students to acquire include: (Knowledge): Knowledge of the scientific
method; EBPs in use at your clinical facility; the ability to distinguish between opinion and evidence; knowledge of reliable sources of evidence for EBP and clinical practice guidelines. (Skills): Participate in data collection or research activities, implement the individualized plan of care as directed by RN; participate in structuring the work environment when integrating new evidence into standards of practice; consult with clinical experts; question rationale of interventions that lead to adverse outcomes. (Attitudes): Value the concept of EBP; value the need for Quality Improvement; value the need for ethical research; appreciate the need for reading current nursing journals; value the need for continuous improvement in practice based on new knowledge.

Concept Mapping

Each person’s concept map will be different and individual. It should depict the different areas of your life and the responsibilities you have in each of those areas.

Review Questions for the NCLEX® Examination
1. 2, 3
2. consider all possible alternatives
3. 2, 4
4. 4
5. 1
6. 3

Critical Thinking Activity

(Requires synthesis and application of knowledge.)

Priority rating What needs to be done
2 Buy books
1 Get a map and find classrooms
5 Buy a parking permit
4 Call for doctor’s appointment
7 Take daughter to the doctor
8 Buy son’s school supplies
3 Go to first class
6 Go to second class
9 Grocery shop

CHAPTER 5

Terminology
1. h
2. a
3. g
4. e
5. f
6. c
7. b
8. j
9. k
10. i

Completion
1. unforeseen
2. implement
3. concisely
4. overlapping
5. input
6. enhance
7. coherent
8. prognosis

Communication Exercises
1. Example: The man with the chest pain might be having a heart attack (myocardial infarction). That could be life-threatening. The boy with the cut had stopped the bleeding and could wait for treatment of his wound.
2. Individual answers will vary.
   Example: “Marta, when you are finished with the sphygmomanometer, I need to use it. I will be in room 234 or 246. Would you please bring it to me as soon as you have finished taking the blood pressures? I would really appreciate it as there are no wall units in those rooms.”

STEPS TOWARD BETTER COMMUNICATION

Vocabulary Similarities Exercise

correct opinion
14. cues
15. The patient, the family/significant other, the chart, diagnostic test results, the physician's history and physical, and the admission note
16. a. interview  
   b. chart review  
   c. physical assessment
17. Safety: at risk of falling  
   Hygiene/grooming: needs assistance with ADLs  
   Elimination: urinary incontinence  
   Psychosocial and cultural: loss of independence; blow to self-image from stroke  
   Education: instruction in walking with walker; medication instruction; instruction in possible cause of stroke and ways to prevent another one.  
   Rest and activity: left-sided weakness; scheduled rest to prevent fatigue; exercises to strengthen muscles affected on left side and to preserve muscle function on right side
18. Many of the nursing diagnoses in Box 5-4 fit here. Some of the most likely nursing diagnoses are:
   a. Impaired urinary elimination: incontinence  
   b. Impaired physical mobility  
   c. Disturbed thought processes  
   d. Risk of injury  
   e. Self-care deficit
19. Activity-exercise pattern
20. Present function, personal habits, lifestyle and cultural factors, and age-related factors

Review Questions for the NCLEX® Examination
1. 2, 4  
2. data that can be verified by auscultation, palpation, percussion, or inspection  
3. 3  
4. 4  
5. 2  
6. 3, 4  
7. 3  
8. 2  
9. 2  
10. 1, 3

Critical Thinking Activities
1. Relief of pain; assistance with care; reduction of fear; emotional support (in order of priority)
2. Appropriate nursing diagnoses might be:  
   Pain  
   Expected outcome: Pain will be controlled by medication within 6 hours.  
   Self-care deficit, bathing  
   Expected outcome: Assistance with bathing will be provided daily.  
   Self-care deficit, toileting  
   Expected outcome: Assistance with toileting will be provided whenever needed.  
   Anxiety  
   Expected outcome: Anxiety will be decreased within 12 hours.  
   Fear  
   Expected outcome: Fear will be relieved or reduced as pain is controlled and knowledge of what is to happen is gained.
3. Objective data: Cries out when tries to move left leg. Apprehensive facial expression and body language. Bruise present on left forearm, pulse is 92, respirations are 18, winces when left leg is moved.  
   Subjective data: Sustained a fall. States is scared; states that leg really hurts.
   a. O  
   b. O  
   c. O  
   d. S  
   e. O  
   f. O  
   g. S  
   h. O

STEPS TOWARD BETTER COMMUNICATION

Completion
1. significant other  
2. deviate
3. differentiate
4. over-the-counter
5. pertinent
6. alleviate
7. formulate
8. scan
9. correlate
10. concurrent condition
11. prosthesis
12. infer

Word Attack Skills
1. rapport (n)—relation of harmony or accord
2. elicit (v)—to get or bring out
3. affect (v)—have an influence; a change
4. over-the-counter
5. pertinent
6. alleviate
7. formulate
8. scan
9. correlate
10. concurrent condition
11. prosthesis
12. infer

CHAPTER 6

Terminology
1. d
2. j
3. k
4. i
5. b
6. c
7. h
8. f
9. g
10. l
11. a
12. e

Short Answer

A. (Answers require analysis and synthesis of information.)
1. Assessment
2. Planning
3. Implementation
4. Assessment
5. Assessment
6. Assessment
7. Nursing diagnosis
8. Evaluation
9. Nursing diagnosis
10. Evaluation
11. Planning
12. Planning

B. 1. priorities of tasks
2. change-of-shift report
3. a. if visitors will be coming
   b. diagnostic tests are scheduled
   c. time physician may come to see the patient
   d. medication administration schedules
4. introducing microorganisms during an invasive procedure
5. planning; priorities
6. dependent
7. documentation
8. expected outcomes
9. orders, and/or agency policy and procedure manual
10. if interventions have been successful
11. family
12. sterile; invasive
13. the nurse

Sequencing
(Requires synthesis and critical thinking.)
1. 5
2. 7
3. 2
4. 1
5. 3
6. 4
7. 6

Review Questions for the NCLEX® Examination
1. 3 (application of prior knowledge)
2. 1 (application of prior knowledge)
3. 4 (application of prior knowledge)
4. 1
5. 2, 4
6. 4
7. 1
8. 3
9. 1
10. 4
11. independent
12. 3
13. 4
14. 1
15. 2

Critical Thinking Activities
1. The priority of each task; the amount of time available; the ability of the patient to assist with self-care; medication times; procedures to
be done; if the patient will be off the unit for diagnostic tests; when the physician might visit the patient; when visitors might be expected.

2. Some positive aspects are:
   • improvement of nursing care
   • see if care meets current standards of care
   • determine if documentation is occurring
   • determine whether care given is cost-effective

3. Case Study—the nursing care plan should contain the following points:

   **Assessment data:** MVA, splenectomy incision, bruises on right extremities, swollen right knee; pain; cannot walk without pain.

   **Nursing diagnoses:**
   1. *Impaired skin integrity related to surgical incision*
   2. *Risk for infection related to incision and traumatic wounds*
   3. *Impaired physical mobility related to inability to walk without pain*
   4. *Pain related to surgical incision and traumatic wounds*

   **Expected outcomes:**
   1. Incision will heal without signs of infection within 2 weeks.
   2. Systemic infection will not occur during next 4 weeks.
   3. Will be able to walk without pain within 6 weeks.
   4. Pain will be controlled by medication for 4 hours at a time.
   5. Pain will resolve within 4 weeks.

   **Nursing interventions:**
   1. Dressing change daily with aseptic technique. Assess wound for signs of infection.
   2. Monitor vital signs q4h; assess knee for signs of infection q shift. Monitor bruises for signs of infection.
   3. Assist to BR; supervise ROM to other extremities tid. Assist with hygiene and grooming as needed.
   4. Assess for pain q 3–4 hours. Medicate as ordered pm. Provide distraction activities to reduce pain. Monitor for signs of constipation. Increase fluids and roughage to prevent constipation from pain medication.

   **Evaluate after implementation:** Gather data related to wound status, vital signs, pain level, and knee swelling. Determine if actions are helping patient meet the expected outcomes.

4. Concept map. This will vary per the individual making the map. It should include all nursing diagnoses that would be on the patient’s nursing care plan. The appropriate interventions would be linked to each nursing diagnosis.

---

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. deadline
2. imminent
3. collaborative
4. strive
5. impairment
6. adept
7. blame
8. intervening
9. clue
10. sequence
11. incorporated
12. rationale

**Abbreviations**
1. short-term
2. long-term
3. every
4. four hours
5. range of motion
6. physical therapy
7. cerebrovascular accident
8. related to
9. urinalysis
10. outcome-based quality improvement

---

**CHAPTER 7**

**Terminology**

**A.**
1. d
2. c
3. e
4. b
5. f
6. a

**B.**

(Answers may be found in the textbook glossary or in a dictionary.)
1. d
2. c
3. b
4. h
5. j
6. a
7. m
8. i
9. k
10. f
11. g
12. o
13. e
14. n
15. l

Short Answer
1. Any three of the following:
   a. Provide a written record of the history, treatment, care, and response of the patient while under care.
   b. Serve as evidence in a court of law.
   c. Provide data for quality assurance studies.
   d. Guide reimbursement of costs of care.
2. Any of the rules in Box 7-4 that conform to the requirements of a legal record.
   Examples:
   a. Document in ink.
   b. Date and time each entry.
   c. Sign each entry correctly including your title.
   d. Do not leave blank lines in your nurse’s notes.
   e. Correct errors according to protocol.
   f. Chart objective data after completing a task; never chart before doing the task.
   g. Note late entries correctly.
   h. Identify care given by another health care worker.
   i. Document instructions given to the patient.
3. Charting is organized by nursing diagnosis. Assessment data are documented. Implementation of the interventions noted on the nursing care plan is documented along with the patient response. Evaluation of patient progress toward expected outcomes is placed in the nurse’s notes. Evaluation data are documented that indicate expected outcomes have been met.
4. a. Accuracy of what is charted.
   b. Brevity using abbreviations and symbols as accepted.
   c. Completeness of assessments, actions, and results.
5. Answers may include any of the following:
   a. Never share your password.
   b. Chart in a timely manner.
   c. Refresh your screen frequently to check for new medical orders and other entries.
   d. Review your notes for accuracy before hitting “confirm” or “save.”
   e. Do not walk away from your workstation without logging off.

Completion
1. guide
2. communication tool
3. expected outcomes
4. caring directly; access
5. legal record; a court of law
6. chronological
7. baseline condition
8. relevant data
9. problem; event
10. flow sheets; checklists
11. otherwise documented
12. protocols
13. abnormal data; trends
14. interventions
15. computer screen visible
16. legible
17. variance
18. behaviors
19. ordered treatments
20. safety factors; continued care

Abbreviations
(Answers may be found in Appendix H in the section “Abbreviations.”)
1. ADL
2. ERT
3. BE
4. GU
5. DOE
6. CAD
7. CC
8. HTN
9. URI
10. WNL
11. LMP
12. TIA
13. BPH
14. BS
15. CHF
16. RLQ
17. ABD
18. CCU
19. EKG, ECG
20. SOB
21. FHR
22. CRF
23. RLL
Review Questions for the NCLEX® Examination
1. 2, 3, 5  
2. 3  
3. 4  
4. 2  
5. 2  
6. 24-hour intake and output  
7. 1  
8. 2  
9. 2  
10. 2, 4, 5  
11. 2, 3, 5  
12. 3  
13. 4  
14. 2

Critical Thinking Activities
1. Individual answers will vary: charting method preference is a matter of personal choice. Advantages and disadvantages will depend on method of charting chosen.

2. Assessment data: Female, age 22, accident victim, alert, oriented, and able to follow commands. Pupils equal and reactive; fracture of right femur; laceration of right wrist. Pain in leg and wrist.

Nursing diagnosis: Impaired mobility related to fracture of right femur.  
Expected outcome: Patient will regain full mobility within 8 weeks.

STEPS TOWARD BETTER COMMUNICATION

Vocabulary Exercises
1. The adage was ambiguous.
2. The audit showed a need to reimburse the patient’s money.
3. The rule of thumb is that the duration of the office visit should adhere to the rules.
4. The student should jot down the acronyms that she feels are noteworthy and compile a list.
5. The time frame required that the doctor use brevity in talking about the offshoot in the problem.

Pronunciation and Intonation Skills
1. down  
2. up  
3. up  
4. down  
5. up  
6. down

CHAPTER 8

Terminology

A. Matching
1. g  
2. f  
3. e  
4. b  
5. h  
6. d  
7. c  
8. a

B. Completion
1. feedback  
2. body language  
3. communication  
4. patient-centered care  
5. Therapeutic  
6. walking rounds  
7. active listening  
8. Confidentiality

Short Answer
1. A person sending a message and a person who receives the message, processes it, and indicates that the message has been interpreted.  
2. a. Culture  
   b. Past experience  
   c. Emotions and mood  
   d. Attitude  
3. Any three of the following five answers:  
   a. Medications taken today  
   b. Presence of pain  
   c. When last bowel movement occurred  
   d. Allergies  
   e. If previously hospitalized, what year  
4. validated  
5. a. Use of personal space  
   b. Norms for making eye contact  
6. You might say, “That has to be hard for you” or “I can only imagine how difficult this is.”  
7. build trust
8. Any four of the following:
   a. Effective communication skills
   b. Having the quality of empathy
   c. Having a desire to help
   d. A nonjudgmental attitude
   e. Expressing honesty and genuineness
   f. Displaying acceptance and respect for the patient

9. Current vital signs, pertinent laboratory data, intake and output, medications received, patient allergies. Introduction, Situation, Background, Assessment, Recommendation, Readback. Phrase any recommendations very gently. Most physicians don’t like to have the nurse suggest changes in the care of the patient.

10. Any three of the following:
    a. Update the nursing care plan
    b. Charge out supplies
    c. Document nursing care
    d. Transmit orders
    e. Communicate plans for care with another department
    f. Request a consult from another health care professional

11. a. Have the person’s attention before beginning
    b. Eliminate outside distractions
    c. Introduce one idea at a time
    d. Do not rush the person

12. Approach the child at eye level and use a calm, quiet, friendly voice; do not make sudden movements or gestures.

13. Any three actions from Box 8-1.

14. a. Speak very distinctly.
    b. Speak slowly with voice pitch at midrange.
    c. Obtain the person’s attention before beginning.
    d. Face the person at eye level.

15. Any four items from Table E8-1 from Evolve, such as
    a. Understanding patient/family preferences and values.
    b. Knowledge about pain and suffering.
    c. Provide nursing care with sensitivity to the individual patient.
    d. Recognize own attitudes about working with patients from different cultural, ethnic, and social backgrounds.

Review Questions for the NCLEX® Examination
1. 2
2. 3
3. 1, 2, 3, 4
4. 1

Critical Thinking Activities
1. Patient is scheduled for PT, but is experiencing pain (physical therapist); is not eating meals and doesn’t care for the food being served (dietitian); doesn’t like to take medication and
would rather use natural remedies for minor complaints (physician); is awakening every night about 3:00 AM and can’t go to sleep (night shift nurse).

2. Information to include in report: Vicodin given at 8:30 AM with pain relief; IV discontinued; dressing clean and dry; wife visited; walked in hall x 3; taking clear liquid diet without nausea.

3. Consider the culture of the other nurse. It is possible that she comes from a culture where direct eye contact is a sign of disrespect; however, in her nursing education she should have learned the importance of eye contact in communication. It is possible she is tired or distracted; it is less likely (although possible) that she is using subtle disrespect for you as a student. In any event, you want to make sure your verbal information is received. You might briefly pause the report and in a pleasant tone of voice ask, “Is everything OK? I sense that your mind is somewhere else because you’re not making eye contact with me, and I want to be sure I tell you the important information about the patient.” You might also ask for suggestions from her about how, in her opinion, you might give a better ISBAR-R.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. conveyed
2. ambivalent
3. optimal
4. discount
5. judiciously
6. verify
7. lead
8. strive

**CHAPTER 9**

**Terminology**
1. visual
2. auditory
3. kinesthetic
4. behavioral objective
5. return demonstration

**Short Answer**
1. Knowledge of
   a. the disease or disorder
   b. diet
   c. medications
   d. treatment
   e. self-care

2. Poor vision, poor hearing, impaired motor function, illiteracy, or impaired cognition
3. Pain, fatigue, sense of being overwhelmed, and multiple people coming in and out of the unit
4. a. printed material such as books and articles
   b. video- or audiotapes
   c. hands-on equipment
5. a. There is sufficient light for the person to see well and that glasses are on if used.
   b. The person can hear and that the hearing aid is turned on if used.
   c. That outside distractions and noise are minimized.
   d. You proceed slowly and allow time for formulation of questions.

**Completion**
1. value; cultural
2. very small steps
3. Play
4. literate
5. Deficient knowledge
6. consistency
7. questions
8. collaboratively
9. admission
10. readiness; apply
11. kinesthetic
12. processing
13. dexterity
14. knowledge base
15. advantage
16. consistency
17. feedback
18. review
19. return demonstration
20. printed

**Review Questions for the NCLEX® Examination**
1. kinesthetic
2. 4
3. 1, 3
4. 2
5. 3
6. 1
7. 2, 3
8. 4
9. 3
10. 4
11. 1
Critical Thinking Activities
1. Use different modes for an assignment to determine which seems to be the best learning mode for you.
2. Practice using different techniques within your best mode of learning to determine what is most efficient for you.
3. Cover the purpose of the medication, what it should do, potential side effects and their signs and symptoms, when and how to take the medication, and any precautions to be followed while taking the medication.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. dexterity
2. literate
3. deficit
4. teaching moment
5. frame of reference

Vocabulary Exercises
1. Patient is a noun, and means a person treated by a health care provider.
2. Patient is an adjective and means to be calm and willing to take time.
3. Patients is the plural.
4. Patience is a noun meaning the ability to wait calmly for something.

CHAPTER 10

Terminology
1. b
2. c
3. a

Completion
1. control; direction
2. a mistake has been made or something is not known
3. direct, concise; nonthreatening
4. interpersonal relationships
5. accountable
6. Competencies
7. job description
8. clear, concise; attentive listening
9. result; time frame
10. authority
11. feedback
12. privacy
13. feelings; empathy
14. prioritize
15. documentation of specific problems or errors

Short Answer
1. a. know the capabilities and competencies of the person
   b. know whether the task delegated falls within the person’s domain and can be legally delegated
   c. communicate effectively with the person
   d. understand the person’s needs
2. a. coordinate personnel and make work assignments
   b. assist with patient care
   c. help resolve conflicts
   d. assist in writing policies and procedures
   e. contribute information for evaluation of UAPs
   f. collaborate with physicians and other health team members
3. a. Who is your immediate supervisor?
   b. From whom do you take orders?
   c. Who is over your supervisor?
   d. To whom should you report changes in patient condition, signs of complications, etc.?
   e. To whom do you go with concerns or complaints?
   f. Who is in charge of scheduling your hours?
   g. Whom should you call if you are ill and cannot make it to work?
4. a. Define the problem.
   b. Look at alternative solutions.
   c. Estimate possible outcomes for each alternative.
   d. Choose the best alternative to solve the problem.
   e. Try the alternative. (If the alternative does not work, repeat the problem-solving process.)
5. a. Work for 1 year as a staff nurse
   b. Have knowledge and experience in leadership
c. Have training or experience in nursing administration and supervision
d. Have additional training or preparation in the specialized area to which assigned.
6. See Box 10-1 in the textbook or list others that you feel are important.
7. See Box 10-3 in the textbook for possible answers.

Review Questions for the NCLEX® Examination
1. 3
2. 1, 3, 5
3. 2
4. 1, 3, 4, 5
5. 2, 3
6. 3
7. 1, 2, 3
8. 4
9. 2
10. 1

Critical Thinking Activities
1. Considerations would be which tasks legally cannot be delegated, the competencies of the UAP to whom you are assigning, and facility protocols on delegation. You might be able to assign patient baths, bed-making, vital signs, daily weights, and ambulation to a UAP.
2. The time organization sheet should include a row for every hour of the shift and a column for each patient assigned. Include all tasks to be completed, whether they are delegated or not. Remember to include medications, ambulation, ROM, bathing, vital signs, weights, blood sugar determinations, etc. Schedule in time for assessment/data collection and for procedures such as wound care. Remember to include time for patient teaching and time for documentation. Priority items should be entered into the time schedule first. For example, ordered wound care and medications would take precedence over bathing or ROM.

**STEPS TOWARD BETTER COMMUNICATION**

Vocabulary Exercises
1. c
2. e
3. b
4. a
5. d

**Completion**
1. eye contact
2. conflict resolution
3. laissez-faire
4. competent
5. cost-effective
6. reimbursement
7. chain of command
8. active listener
9. feedback
10. domain
11. constructive criticism
12. delegate

**Vocabulary Exercises**

**Word Families**
1. competent
2. compete
3. competently

**Polite and Effective Communication**
4. “LuAnn, I would like you to weigh Mr. Moore, Ms. Garcia, and Ms. Adams before breakfast today. Ask each patient what they were wearing when they were weighed on Monday so that our weights have a consistent basis. For example, if Mr. Moore was wearing his slippers and robe, weigh him with those items on; if Ms. Garcia just had on her gown and slippers, weigh her without her robe. Do you follow what I mean? (LuAnn replies that she does.)

   “Please be sure that the scale is balanced on zero before weighing each patient. When you are finished with all three weights, please write them down on the jot board right away so that they will be available when the physicians make their rounds, which usually start by 8:30 AM. If you have any problems, let me know. I will be making rounds in about 10 minutes and then I will be here at the desk. Can you relate back to me the details of what I’ve asked you to do?” (LuAnn replies and further dialogue occurs if she cannot repeat the instructions correctly.)

**Abbreviations**
1. medication administration record
2. unlicensed assistive personnel
3. immediately
4. as soon as possible (not in the chapter, but widely used throughout the United States in many types of situations)
Completion
1. feedback; collaboration
2. proficient
3. jot; grid
4. instills or fosters

Idiomatic Phrases
1. establish eye contact
2. take precedence over
3. track down

CHAPTER 11

Terminology

A. Matching
1. o
2. j
3. a
4. b
5. k
6. c
7. h
8. l
9. m
10. i
11. d
12. f
13. n
14. g
15. e

B. Completion
1. 18 months; 6
2. libido; pleasure principle
3. Moro
4. right and wrong
5. morals
6. Intelligence
7. social
8. ideology
9. genes
10. time-out
11. early and regular prenatal care
12. double, triple
13. cephalocaudal; head
14. the family

Review of Structure and Function

Answers are in the Overview of Structure and Function section of the chapter in the textbook.
1. amniotic sac
2. It attaches during the second week and is attached by the placenta.
3. The eyes and ears begin to take shape during the fifth week.
4. The heart begins beating at about 3 1/2 weeks.
5. The external genitalia begin to appear during the third month.
6. By the fifth month, the fetus is 10–12 inches in length and weighs about 1 lb.
7. Multiple births are caused by the fertilization of more than one ovum or division of an ovum.
8. Puberty in the female occurs between ages 9–17 with 12 as the average age.
9. 14 years of age for boys; 12 years for girls

Identification
1. b
2. b
3. d
4. b
5. f
6. f
7. c
8. d
9. e
10. d
11. e
12. f
13. b
14. a
15. b

Short Answer
1. a. levels of awareness
   b. components of the personality or mind
   c. psychosexual stages of development
2. a. Organization: we try to make sense of our world
   b. Adaptation: we discover new information and adjust our thinking patterns
3. a. Obey rules to avoid punishment
   b. Conform to social standards to avoid disapproval
   c. Abide by laws and follow one’s conscience
4. a. Growth occurs in orderly and predictable ways.
   b. The rate of growth and development is individual.
   c. Development is lifelong.
   d. Development is multidimensional.
   e. Development is continuous.
5. a. Can delay gratification due to trust. (Table 11-2; individual examples/answers will vary)
b. Practices new skills.
c. Formulates a plan of action and carries it out.
d. Acquires skills of reading, mathematics, and social skills.
e. Investigates and identifies alternatives regarding his or her vocational and personal future.

6. a. Infant should not be left alone on a surface without protection from falls.
b. Infant must be restrained in a car seat in the back seat when the car is moving.
c. Bath water should be tested to see that it is not too hot before putting infant into the bath.
d. Small objects should be kept out of reach to prevent entry into the mouth and choking.
e. Infant should be placed on its back for sleep.
f. No infant should be left in a house or car alone.

7. a. hormonal shifts
b. early adolescence years
8. a. A chronic disease such as diabetes or heart disease
b. Lack of prenatal care
c. Maternal age below 16 or over 35
d. Poor nutritional status of the mother

9. a. Healthy weight gain during pregnancy
b. Decreasing the use of chemicals among pregnant women

Completion
1. more than one ovum is fertilized
2. anal; 1–3 years (Table 11-1)
3. 11
4. predictable
5. physical; cognitive; psychosocial
6. 46 chromosomes
7. 40
8. nourished
9. 30
10. nutrition; oxygen
11. 18 months
12. 16–20
13. 12 to 24
14. 9–11
15. first

Review Questions for the NCLEX® Examination
1. 2
2. 4
3. 8
4. bonding
5. 3
6. 1
7. 2
8. 1, 3, 4
9. 1, 2, 3
10. 2
11. 3
12. 4
13. 1
14. 2
15. 1, 3, 4

Table Activity

(See Overview of Structure and Function section in the chapter.)

Physical Changes of Puberty

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>• ICSH stimulates the testes to produce testosterone.</td>
<td>• FSH stimulates the ovaries to begin producing estrogen hormones.</td>
</tr>
<tr>
<td>• FSH stimulates the testes to begin producing sperm.</td>
<td>• Breast development occurs.</td>
</tr>
<tr>
<td>• Enlargement of the reproductive organs occurs.</td>
<td>• Hips widen.</td>
</tr>
<tr>
<td>• The voice lowers in tone.</td>
<td>• Axillary and pubic hair appears.</td>
</tr>
<tr>
<td>• Growth of facial, pubic, and axillary hair occurs.</td>
<td>• There is growth of the reproductive organs.</td>
</tr>
<tr>
<td>• Bones thicken and skeletal muscles increase in size.</td>
<td>• FSH stimulates the development of ova and menstruation begins.</td>
</tr>
<tr>
<td>• Nocturnal emissions occur.</td>
<td></td>
</tr>
</tbody>
</table>

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Critical Thinking Activities
1. a. Agencies and educational programs available in your community to help combat teen pregnancy.
b. Employers in the area who are tuned in to the needs of adolescents and are interested in their school performance.
c. Books and online resources that help people figure out matches with interests/talents and strengths with career options; i.e. *What Color is Your Parachute*, personality tests, life planning classes, college options, etc.
d. Drug and alcohol education programs available in the community.
e. Assessment parameters for eating disorders.
f. Signs of depression in adolescents.
g. Assessment for high-risk behavior among adolescents.
2. Review normal reflexes, growth patterns, and milestones of physical and mental development. Review the importance of meeting the infant’s needs and what those needs are in areas of safety, nutrition, hygiene, elimination, rest, and stimulation.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. cyanotic
2. erupt
3. resilient
4. baby fat
5. gender stereotype
6. growth spurt

**Vocabulary Exercises**
1. a. vital/necessary/important
   b. helping/aiding/assisting
2. **linguistic:** writing, speaking, learning foreign languages, early speech, talking with others, enjoying word play
   **mathematical:** science, engineering, mathematics, counting, understanding number concepts
   **spatial:** art, architecture, engineering, building blocks, drawing
   **musical:** singing, playing instruments, enjoying music, singing songs, playing instruments, moving to music
   **bodily kinesthetic:** dance, gymnastics, sports, exercise, active play, climbing, dancing, tumbling

**Communication Exercises**
Dialogues will be individual.

**CHAPTER 12**

**Terminology**

**A. Matching**
1. d
2. b
3. h
4. j
5. g
6. a
7. i
8. f
9. e
10. c

**B. Completion**
1. Middle adulthood
2. intimacy
3. 30
4. Executive substage
5. Generativity
6. Stagnation
7. Children
8. Sandwich generation
9. 45
10. 1000; 1200
11. 110/70

**Short Answer**
1. a. Responsibility for members of one’s family or community
   b. Job responsibilities and co-workers
   c. Responsibility for oneself
2. a. Responsible for self
   b. Responsible for family
   c. Responsible for the corporation or the country
3. Any three of the following:
   a. Form close relationships with others
Table Activity

Physical Changes

<table>
<thead>
<tr>
<th>Young Adult</th>
<th>Middle Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Completion of skeletal development</td>
<td></td>
</tr>
<tr>
<td>• High levels of strength, endurance, and energy</td>
<td></td>
</tr>
<tr>
<td>• Dental maturity with eruption of wisdom teeth</td>
<td></td>
</tr>
<tr>
<td>• Physical growth of the brain continues until the mid-20s</td>
<td></td>
</tr>
<tr>
<td>• Prime reproductive/childbearing years</td>
<td></td>
</tr>
<tr>
<td>• Stress-related illness emerges</td>
<td></td>
</tr>
<tr>
<td>• Early disease develops; i.e., cancer</td>
<td></td>
</tr>
<tr>
<td>• Redistribution of body weight</td>
<td></td>
</tr>
<tr>
<td>• Presbyopia</td>
<td></td>
</tr>
<tr>
<td>• Presbycusis</td>
<td></td>
</tr>
<tr>
<td>• Compression of the spinal column and loss of height</td>
<td></td>
</tr>
<tr>
<td>• Loss of muscle tone and elasticity of body tissues</td>
<td></td>
</tr>
<tr>
<td>• Blood pressure increases</td>
<td></td>
</tr>
<tr>
<td>• Skin becomes less resilient</td>
<td></td>
</tr>
<tr>
<td>• Wrinkles appear</td>
<td></td>
</tr>
<tr>
<td>• Graying of the hair</td>
<td></td>
</tr>
<tr>
<td>• Thinning of scalp hair</td>
<td></td>
</tr>
<tr>
<td>• Decreased levels of estrogen in women and decline in testosterone in men</td>
<td></td>
</tr>
</tbody>
</table>

Completion
1. care about and for each other
2. one or two parents and children
3. 28%
4. 40
5. a hot flash
6. garlic
7. patient/family, preferences
8. interests; activities
9. friendships
10. middle years
11. mobility
12. paid caregivers
13. 50%
14. poverty
15. 40
16. cervical
17. 80%
18. loud music
19. Relationships
20. lonely

**Review Questions for the NCLEX® Examination**
1. 4
2. 1, 3
3. 1, 2
4. 3
5. 1, 3
6. 1, 2
7. 3
8. 1
9. 1
10. 2
11. 4
12. 1, 4
13. 3

**Critical Thinking Activities**
1. Answers depend on your age and developmental stage. See Table 11-2.
2. Answers depend on your age and developmental stage.

**Pronunciation and Stress**

<table>
<thead>
<tr>
<th>-tion/-sion</th>
<th>-ic/-ical</th>
<th>-omy</th>
<th>-ogy</th>
<th>-ity</th>
</tr>
</thead>
<tbody>
<tr>
<td>urbanization</td>
<td>pelvic</td>
<td>economy</td>
<td>biology</td>
<td>maturity</td>
</tr>
<tr>
<td>generation</td>
<td>chronic</td>
<td>autonomy</td>
<td>sociology</td>
<td>infidelity</td>
</tr>
<tr>
<td>question</td>
<td>biological</td>
<td>skeptical</td>
<td>gerontology</td>
<td>validity</td>
</tr>
<tr>
<td>maturation</td>
<td>skeptical</td>
<td>physical</td>
<td>flexibility</td>
<td>obesity</td>
</tr>
<tr>
<td>tension</td>
<td>physical</td>
<td>cervical</td>
<td>promiscuity</td>
<td>personality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>-ery</th>
<th>-edy</th>
<th>-istry</th>
</tr>
</thead>
<tbody>
<tr>
<td>delivery</td>
<td>remedy</td>
<td>dentistry</td>
</tr>
<tr>
<td>grocery</td>
<td>tragedy</td>
<td>chemistry</td>
</tr>
<tr>
<td>nursery</td>
<td>comedy</td>
<td></td>
</tr>
<tr>
<td>surgery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Communication Exercises**

1. Group discussion will vary with team member age and developmental stage. This website about reporting child abuse may be helpful as well: www.childwelfare.gov/responding/reporting.cfm
2. Group discussion will vary with team member age and developmental stage.

**Steps Toward Better Communication**

**Completion**
1. depression
2. career, family
3. boomerang
4. menopause
5. mentors
6. sandwich generation

**Vocabulary Exercises**
1. Quiet—boisterous (noisy) or active
2. Blonde—brunette (dark-headed) or dark
3. Athletic—nonathletic, sedentary
4. Tall—short
5. Large—small

**Cultural Points**

1. See online Parenting and Family resources on the Evolve website.
2. The three stages of adulthood in the U.S. include:
a. Young Adulthood, 18-35 years  
b. Middle Adulthood, 35-65 years  
c. Older Adulthood, 65 to death  

Discussion will vary but will likely include Schaie’s and Erikson’s theories.

CHAPTER 13

Terminology

A. Matching
1. f  
2. c  
3. d  
4. b  
5. h  
6. a  
7. g  
8. e  

B. Completion
1. conception  
2. biologic  
3. free radical  
4. activity  
5. elder abuse  
6. life span  
7. 78.9  
8. men  
9. psychosocial  
10. 75  
11. hypertension  
12. 5; 15  

Short Answer
1. a. Biological clock theory: body cells break down after a specific length of time and die.  
b. Free-radical theory: cells are damaged by toxins; free radicals are unstable.  
d. Immune system failure theory: system loses its ability to protect the body.  
e. Autoimmune theory: body no longer recognizes itself and begins to attack its own cells.  
2. a. Stops going to church, withdraws from bridge club.  
b. Takes an adult education class.  
c. Copes with failing eyesight by using the bus rather than driving; adapts to the situation.  
3. a. Education (more education, longer longevity)  
b. Lifestyle (no smoking)  
c. Personality (optimistic people live longer)  
d. Gender (females live longer)  
4. Any one of the changes listed in Table 13-1.  
5. Re-integrative stage. Older adults carefully select how they wish to spend their time. They do not do things just to accommodate other people as easily anymore.  
6. a. Active in the church and/or family events  
b. Proud of well-maintained home appearance and savings for retirement  
7. a. An exercise program  
b. Involvement in service groups, volunteering, hobbies  
c. Staying mentally active (reading, puzzles, computer use, writing)  
8. Any five of the items in Box 13-2.  
9. a. Participation in an exercise program that promotes strength and balance and is an ongoing activity.  
b. Regular physical examinations to monitor health and diet, especially with chronic conditions.  
10. Any items from Box 13-1.  

Completion
1. healthier  
2. diet; exercise  
3. personality  
4. 20 to 30  
5. 2.7  
6. frail; active  
7. depression  
8. resistance training  
9. circulatory  
10. physical activity  
11. volunteer  
12. needed  
13. 30

Review Questions for the NCLEX® Examination
1. 4  
2. 2  
3. 3  
4. 1, 3  
5. glasses; hearing aid  
6. 4  
7. 2  
8. 1
9. 2
10. 2

Critical Thinking Activities
1. Consider nutrition, exercise, medications, social activities, and activities that require the active use of the mind.
2. Safety concerns related to confusion; inability to maintain a checkbook and attend to finances; malnutrition from forgetting to eat; poor hygiene; illness from forgetting medications.

Meeting Clinical Objectives
Consult with your clinical instructor.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. irrelevant
2. nest egg
3. myth
4. lifestyle

Vocabulary Exercises

Myth versus Theory versus Fact
1. T Theory
2. M Myth
3. F Fact

Communication Exercise
Answers for stress markings (may vary):

Nurse: “Good morning, Mr. Hernandez. How are you feeling?”
Mr. H.: “Pretty good for an old guy my age.”
Nurse: “Now, what medications are you taking?”
Mr. H.: “Oh, I don’t know. There are some pink ones, and some red ones. There were some big horse pills, too, but I stopped taking them.”
Nurse: “Why? Did the doctor tell you to stop?”
Mr. H.: “No, but they weren’t doing me any good and they stuck in my throat.”
Nurse: “How do you know they weren’t doing you any good?”
Mr. H.: “Well, I don’t feel any different when I take them.”

Nurse: “Mr. H., some medications don’t make any difference in how you feel, but they are doing their job in your body. Your cholesterol and hypertension pills help keep the blood vessels open to your heart and brain so you won’t have a stroke or heart attack. You don’t want your wife to have to take care of you if you can’t talk or feed yourself, do you?”

Mr. H.: “Oh gosh, no! Is that what will happen?”
Nurse: “Well, the medication helps prevent those types of complications. If you have some side effects, or other problems taking those pills, talk to the doctor and maybe he can change the prescription. But you should continue taking them until you talk to the doctor.”

Mr. H.: “Well, OK, but I sure don’t like those horse pills!”
Nurse: “You know the old saying, ‘healthy as a horse.’ Maybe that’s how they stay healthy! Seriously, let’s see if the pills can be cut in half.”

CHAPTER 14

Terminology

A. Matching
1. e
2. d
3. g
4. l
5. b
6. k
7. j
8. c
9. o
10. h
11. i
12. f
13. a
14. m
15. n
16. p

B. Completion
1. sensitivity
2. stereotype
3. dialects
4. culture
5. world view
6. generalization
7. Pacific Islanders
8. Ethnic
9. Chi’i
10. yin; yang
11. curandero
12. shaman
13. offering food
14. personal
15. kosher

**Comparisons**

Answers are from Table 14-3.

<table>
<thead>
<tr>
<th>Cultural Group</th>
<th>Beliefs or Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic Americans</td>
<td>Any of the beliefs or values listed in Table 14-3.</td>
</tr>
<tr>
<td>Asian/Pacific Islander Americans</td>
<td>Any of the beliefs or values listed in Table 14-3.</td>
</tr>
<tr>
<td>American Indians</td>
<td>Any of the beliefs or values listed in Table 14-3.</td>
</tr>
<tr>
<td>African Americans</td>
<td>Any of the beliefs or values listed in Table 14-3.</td>
</tr>
<tr>
<td>European Americans</td>
<td>Any of the beliefs or values listed in Table 14-3.</td>
</tr>
<tr>
<td>Arab Americans</td>
<td>Any of the beliefs or values listed in Table 14-3.</td>
</tr>
</tbody>
</table>

**Short Answer**

1. a. Both have to do with attempting to understand one’s place in the world and life’s meaning or purpose.
   b. Spirituality concerns the spirit, or soul, and is an element of religion.
   c. Religion is a formalized system of belief and worship.
2. a. Shellfish and pork are prohibited/strongly discouraged; meat and fish are avoided by most devout; eggs/dairy are permitted but avoided during certain times.
   b. Do not eat any pork.
   c. If Orthodox, eat only Kosher foods; do not eat pork.
   d. Prefer vegetarian meals.
   e. Meat, fish, and shellfish are avoided by most devout; eggs/dairy are permitted but avoided at some observances.
   f. Meat, eggs/dairy, fish, and shellfish are all permitted but with some restrictions.

3. Develop cultural awareness. Know yourself, examine your own values, attitudes, beliefs, and prejudices. Keep an open mind and try to look at the world through the perspectives of culturally diverse peoples. Learn all you can about other cultures.

4. Learning about a people’s history, appreciating their artistic expressions, foods, and celebrations.

5. a. communication
   b. view of time
   c. organization of the family
   d. foods in the diet
   e. issues related to death and dying
   f. health care beliefs

**Completion**

1. values
2. rejected
3. culture
4. transition
5. equality; brotherhood
6. eighth
7. body; a previous life
8. anxiety
9. yin; yang
10. malnutrition; tuberculosis
11. human caring
12. an open mind
13. authority; older
14. 18 inches
15. European American
16. patriarchal; matriarchal
17. temperature
18. folk or home remedy
19. Hispanic American; African American
20. Hispanic; Native American

**Application of the Nursing Process**

1. Any of the questions from p. 185 in the textbook.
2. a. Impaired verbal communication
   b. Decisional conflict
   c. Spiritual distress
3. Any three of the following:
   a. States he or she feels at peace.
   b. Expresses comfort with relationship to God and significant others.
   c. Identifies and employs spiritual support.
d. Develops or reestablishes spiritual practices that nurture a relationship with God or a higher power.

4. a. Inquire about foods normally consumed within the patient’s culture to include in the diet.
   b. Consult with the dietitian to provide culturally acceptable foods.
   c. Ask the family to bring in acceptable cultural dishes for the patient’s meal.

5. a. You might inquire whether a sense of peace is being achieved.
   b. Determine if prayer and spiritual readings are being used.
   c. Determine whether a religious leader is visiting.

Review Questions for the NCLEX® Examination
1. 2
2. 4
3. 3
4. 1
5. 2
6. 1
7. egalitarian
8. 4
9. 1
10. 2, 3, 4
11. 2
12. 3
13. Chinese
14. African Americans
15. 3
16. 2

Critical Thinking Activities
1. Define what your own cultural beliefs are. Ask a peer about his or her cultural beliefs; list both and compare.
2. Outline what you feel the spiritual needs of the Hindu, the Buddhist, and the Muslim might be; then plan what you would do to meet those needs.

CHAPTER 15

Terminology
A. Matching
1. e
2. g
3. d
4. a
5. f
6. c
7. i
8. j
9. h
10. b

B. Completion
1. loss
2. life changes
3. Anticipatory grieving
4. health care proxy
5. possible
6. validate

Short Answer
1. Person must be declared brain dead by absence of brain waves that indicate life.
2. A program of care to meet the needs of the terminally ill and family in their home or health care facility.
3. Any three of the following:
   a. Fear of pain
   b. Fear of loneliness
   c. Fear of abandonment
   d. Fear of the unknown
   e. Fear of loss of dignity
   f. Fear of loss of control

4. Euthanasia is the act of ending another person’s life to end suffering with or without his consent.

Word Attack Skills
Answers will be individual. Examples are:
1. PREValent, SECond, CATegorized, STEReo-types, CULTure
2. aTIRE, reFRAIN, susTAIN, imPEDE, HisPAN-ic, exTENDeD, nuTRition
3. celeBRation, ethnoLOGical, malnuTRi-tion, ecoNOMic, recogNIZE, circumCISion, curanDERo
4. susceptiBILity, ethnocenTRic, evaluAtion, interpreTAtion, egalITARian, spirituALity
5. Passive euthanasia occurs when a patient chooses to refuse treatment that might prolong life. Active euthanasia is administering a drug or treatment that ends the patient’s life.

6. Assisted suicide is making the means to end life available to the patient when he could not otherwise obtain such means, knowing that suicide is his intent. In active euthanasia, the patient is administered a drug or treatment that ends his life.

7. “The nurse does not act deliberately to terminate the life of any person.” and “Nurses must not participate in assisted suicide.”

8. The right to die with dignity

9. Any of the interventions listed in the section of the chapter on common problems.
   a. Advocate for sufficient pain medication to keep the patient comfortable.
   b. Administering antiemetics.
   c. Obtaining an order for morphine to ease breathing.
   d. Obtaining an order for a sedative.
   e. Obtain a standing laxative order.
   f. Allowing decreased fluid intake when appropriate.
   g. Providing ice chips or hard candy to suck.
   h. Removing unpleasant sights and eliminating odors before mealtime.

10. The purpose of a durable power of attorney for health care is so an appointed person can carry out a person’s wishes as expressed in an advance directive.

11. a. opiate medications
    b. decreased food and fluid intake
    c. decreased mobility

12. a. Administer antiemetic medication.
    b. Provide frequent oral care.
    c. Offer small servings of home-prepared food favorites.

13. reduce secretions, bring breathing back to more normal, and prevent the “death rattle”

14. listen; talk

15. Any of the signs and symptoms listed in Box 15-1.

Correlation

Answers require use of Box 15-1 plus application and synthesis of knowledge.

1. d
2. b
3. e
4. a
5. d

6. b
7. c
8. e
9. a
10. d

Application of the Nursing Process

1. Any four of the items discussed on pp. 197-198.
   a. What the physician has said about their condition
   b. Desires for advance directives and life support
   c. What is hoped for from nursing care
   d. What are the specific concerns
   e. Specifics regarding religious and spiritual needs
   f. Methods of coping and emotional status

2. Any three nursing diagnoses from Box 15-4.
   Examples:
   a. Impaired skin integrity
   b. Self-care deficit
   c. Fear

3. The patient, the family, and all health care professionals involved in the patient’s care.

4. Answers depend on nursing diagnoses listed in question #2. Examples:
   a. Patient will not experience further instances of skin breakdown before death.
   b. Patient’s hygiene needs will be met daily.
   c. Knowledge of what to expect as death approaches will decrease fear.

5. nerve block, implanted pump, or surgery
6. stool softener; laxative
7. small; easily digested
8. Degree of attainment of the expected outcomes

Review Questions for the NCLEX® Examination

1. 4
2. 1
3. 1
4. denial
5. 3
6. 4
7. 2, 3
8. 3
9. 2
10. 2

Critical Thinking Activities

1. You are responsible for approaching the family about organ and tissue donation. This requires tact. Planning an approach will make you more comfortable with this issue.
2. Hope comes in many forms. You might help her to hope for a more pain-free day, for the joy of seeing something beautiful like a bird or flower outside the window, of the joy of watching children happily playing. You could plan ways to decrease discomforts so that there is hope for a more comfortable day. There can be hope for a pleasant time with a loved one.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. anticipatory
2. collaboratively
3. enhance
4. grapple
5. proactive
6. proxy
7. respite
8. validating

**Vocabulary Exercise**

Examples will vary.

**Communication Exercises**
1. Answers will be individual.
2. Example: “Ms. Rodney, I understand you are experiencing many problems and many discomforts. Now that you are in hospice care there are several things we can do to help you. We are going to regulate your medications so that you achieve pain relief, but do not become so constipated. The new medications and in-home oxygen should help with your shortness of breath, and that in turn should help you relax. Our team will be just a phone call away and we will be here at least three times a week. We will work with your family in ways to reposition you that do not cause you so much discomfort. I have ordered a special air mattress to make your bed more comfortable and to relieve pressure on those sore spots. What is your main concern for your care at this time?”

**CHAPTER 16**

**Terminology**

**A. Matching**
1. k
2. j

**B. Completion**
1. hand hygiene
2. normal flora
3. Virus
4. Protozoa
5. Rickettsia; vectors
6. fungi
7. round worms; tapeworms (also hookworm)
8. Endotoxin
9. health care associated (formerly called nosocomial)
10. pathogens
11. culture
12. perform hand hygiene
13. gloving; removing gloves
14. they are dry
15. 1/4, artificial nails, wraps, or nail jewelry
16. jewelry harbors microorganisms
17. sharps
18. biohazard or hazardous waste
19. Creutzfeldt-Jakob’s

**Short Answer**
1. a. adhere to mucosal surfaces or skin  
   b. penetrate mucous membranes  
   c. multiply once in the body  
   d. secrete harmful enzymes or toxins  
   e. resist phagocytosis  
2. Any example from the process of infection is acceptable.  
   a. Causative agent: *Streptococcus* bacteria  
   b. Reservoir: infected wound  
   c. Portal of exit: respiratory tract (mucous membranes)  
   d. Mode of transmission: drinking from a contaminated glass  
   e. Portal of entry: broken skin  
   f. Susceptible host: patient with a surgical incision.
3. Medical asepsis is the practice of reducing the number of organisms present or reducing the risk of transmission of microorganisms. It is
carried out through hand hygiene, Standard Precautions, and disinfection. Surgical asepsis is a way of protecting the patient from exposure to living microorganisms. It involves sterilization of all instruments and inanimate objects used in surgery, use of sterile supplies, and special techniques for procedures that invade the body.

4. a. Direct contact with body excreta or drainage from an infected area.
   b. Indirect contact with contaminated inanimate objects
   c. Vectors that harbor infectious agents and transmit infection through bites and stings
   d. Droplet contamination by the aerosol route through sneezing and coughing
   e. Spread of infection from one part of the body to another by personal touch, infected fluids, or inanimate touch (gown soiled at wound and then a different part of the patient lies on that area)

5. Exposing objects that can withstand heat and moisture to moist heat under pressure in an autoclave

6. a. Any point from Table 16-6, as well as:
   b. poor nutrition
   c. chronic illness
   d. poor hygiene related to immobility
   e. decreased immune function

7. a. Genitourinary tract
   b. Gastrointestinal tract
   c. Skin
   d. Respiratory tract

8. a. fever
   b. leukocytosis
   c. phagocytosis
   d. inflammation
   e. action of interferon

9. interferon

10. a. neutralize and destroy harmful agents
    b. limit the spread of harmful agents to other parts of the body
    c. prepare the damaged tissues for repair

11. Naturally acquired immunity occurs when the body produces antibodies against a microorganism.

12. antitoxin; antiserum; antibodies or antitoxins developed in another person

13. Injection of vaccines or immunizing substances that contain dead or inactive microorganisms or their toxins

14. when there is a possibility of being splashed by body fluids

15. an airborne pathogen; splashed body fluid

16. being splashed in the eyes with any body fluid

17. a. Rinse the object with cold water.
   b. Wash the object in hot soapy water.
   c. Use a stiff-bristled brush or abrasive to clean equipment with grooves or narrow spaces.
   d. Rinse the object well with moderately hot water.
   e. Dry the object.

18. a. Use gloves in appropriate situations.
   b. Do not use gloves for routine tasks where blood, body fluid, or microorganism contamination is unlikely.
   c. Do not “snap” gloves when removing.
   d. Do not use petroleum-based hand lotion before donning gloves.

Review Questions for the NCLEX® Examination
1. 3
2. 2, 3, 5, 6
3. 1
4. 1
5. 2
6. 4
7. 1
8. 2
9. 1
10. 3
11. 4
12. 2
13. 3
14. fungi
15. 1, 2, 4, 5
16. 4
17. 2, 3, 5
18. 3
19. 2
20. 2
21. 1

Critical Thinking Activities
1. **Medical Asepsis:**
   - Handwashing to remove microorganisms
   - Disinfection to prevent transfer of microorganisms
   - Standard Precautions—use of barriers to prevent transfer of microorganisms
   - Containment of microorganisms—plastic bagging contaminated dressings

2. **Surgical Asepsis:**
   - Autoclaving surgical instruments
   - Using only sterile items for invasive procedures
Surgical scrubbing and sterile gloving
Using only sterile supplies and technique for dressing changes

2. Be sure to discuss the first, second, and third line of defense. Use simple examples and common terminology to discuss the defenses of the skin, secretions, cilia, bones, blood cells, liver cells, GI secretions and activity, urination, fever, leukocytosis, phagocytosis, inflammation, action of interferon, immune response.

3. Discuss transmission of pathogens, particularly HIV, hepatitis B and C, and need to prevent such transmission. Explain why different PPEs are used.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. virulent
2. scrupulously
3. impede
4. impermeable
5. render
6. prevalent
7. vector

**Word Attack Skills**
1. b
2. c
3. a

**Communication Exercise**

Example: “Ms. Thierry, you must wash your hands thoroughly after changing your dressing and cleansing the wound. Bacteria from the wound area can get onto your hands and then contaminate anything you touch if you don’t. The bacteria could be transferred from your hands to the telephone or the coffee pot handle and the next person in the house who touches the telephone or the coffee pot would have the bacteria transferred to their hands. The bacteria can infect them if there is a break in the skin on the hands or if they then touch the eye or the mouth where the bacteria can enter the body through the mucous membranes.” (Continue with how to handle the contaminated dressings, how to disinfect surfaces, etc.)
ing catheters, as well as the skin, and mucous membranes.

j. Always cleanse from the urinary meatus toward the rectum.

3. a. Monitor diagnostic test reports related to infection.
b. Continually observe patients for signs of infection.
c. Implement procedures to contain microorganisms when infection is suspected.
d. Properly handle, sterilize, or dispose of contaminated items and equipment.
e. Utilize approved sanitation methods.
f. Recognize individuals at high risk for infection and implement appropriate protection.

4. With airborne precautions a room with negative air pressure is required and a respiratory device mask is essential.

5. Any three of the following:
a. Keep the patient stimulated with appropriate activities.
b. Increase sensory stimulation if signs of sensory deprivation appear.
c. Listen to the patient’s feelings; give encouragement such as positive comments on efforts at grooming or self-amusement.
d. Engage in conversation with the patient about his or her particular interests or hobbies.

6. There is less exposure to health care–acquired infection and strict surgical asepsis is not as necessary. Dirty supplies must be disposed of in sealed plastic bags. Washing in a solution of hot, soapy water with chlorine bleach will kill most organisms. One set of linens is used by the patient. Clean gloves may be used in place of sterile gloves in many instances.

7. Place a special N95 particulate mask on the patient.

8. The older person’s immune system is not as active as the younger person’s. When an older person has one infection, there is greater risk of contracting another because the body’s available defenses are already working to fight the first infection.

9. a. Puncture wounds from contaminated needles or other sharps.
b. Skin contact allowing infectious fluids to enter through damaged or broken skin.
c. Mucous membrane contact where infectious fluids enter through the mucous membranes of the eyes, mouth, and nose.

10. a. Know what is sterile.
b. Know what is not sterile.
c. Separate sterile from unsterile.
d. Remedy contamination immediately.

11. a. Perform hand hygiene each time before touching the patient, the catheter, the IV site, IV line, or dressing. Wear clean gloves when providing care. Cleanse the spout on the catheter bag after emptying it. Inspect the IV site continuously throughout the shift for signs of inflammation. Maintain strict asepsis when changing the IV solution or the IV line. Perform the dressing change using sterile technique. Do not talk while changing the dressing. Handle the catheter gently so that it does not cause undue irritation of the urinary meatus or bladder. Cleanse the catheter according to agency policy when bathing him.
b. Perform hand hygiene before approaching the patient. Use strict sterile technique for insertion of the catheter. Tape the catheter to the abdomen or leg so that there is no pulling on the balloon, which can cause irritation of the bladder when the patient moves. Cleanse the spout of the drainage bag after emptying it. Encourage a high intake of fluid to keep the bladder flushed unless contraindicated.
c. Obtain an order for a condom catheter or other device to prevent urine contamination of the patient’s dressing. Keep his linens clean and dry. Perform hand hygiene before giving care. Perform hand hygiene and change gloves after cleaning up after incontinence. Perform hand hygiene and use gloves when turning the patient.

12. a. A sterile field is only sterile when in constant view. Even when in a sterile gown, the back of the gown is not considered sterile and would expose the field to possible pathogens.
b. Talking over a sterile field is to be avoided because saliva or droplets from the respiratory system may fall on the field.
c. Moisture will carry microorganisms from the outside of the package wrapper to the items on the field.
d. The outside of the unopened sterile packages are not sterile and will contaminate the entire sterile field if placed on it. Packages should be aseptically opened and their contents dropped into the sterile field from its edge.
Matching

All answers can be found in Box 17-1.
1. a, c
2. a, d
3. a, c
4. a, b
5. a, d
6. a, c
7. a, d
8. a, b, d
9. a, c
10. a, c

Application of the Nursing Process
1. a. Signs of wound infection
   b. Fever and malaise
   c. Elevated temperature and increased white blood cell count
   d. Positive culture results
2. Risk for infection related to open wound
3. Carefully planning care and gathering all needed supplies before going to the patient’s room; anticipating patient needs.
4. About the disease process, modes of transmission, and precautions necessary to prevent spread of the infection
5. An N-95 special particulate filter mask must be worn when in the room.
6. a. Determining that all signs and symptoms of the infection are gone
   b. Determining that the infection has not been transmitted to any other patient or a health care worker on the unit or in the hospital

Review Questions for the NCLEX® Examination
1. 3
2. 1, 2, 3, 4, 5
3. 1
4. hand hygiene
5. 4
6. 1, 2, 4
7. 1, 2, 4
8. 3
9. 4
10. 3
11. 1
12. 2
13. 2
14. 3
15. 3

Critical Thinking Activities
1. The patient’s safety is at risk. Everyone in the room is responsible for pointing out breaks in sterility. You must point out the contamination to the surgeon. Think about how you would do this.
2. Determine what activities and hobbies the patient has. Work with the patient to plan activities to prevent boredom and sensory deprivation.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. immunocompromised
2. integrity
3. residual
4. scalding
5. sensory deprivation
6. enhance

Vocabulary Exercises
1. prevents spread of microorganisms/infection
2. identification bracelet
3. elevated temperature
4. people
5. quieter
6. initials
7. intact
8. true
9. body fluids and water
10. director of nurses

Communication Exercises
Answers will be individual. This exercise will help you to become comfortable with patient teaching.

CHAPTER 18

Terminology

A. Matching
1. f
2. d
3. b
4. e
5. c
6. a
7. g
B. Completion
1. supine
2. pivot
3. shearing forces
4. necrosis
5. prone
6. symmetry
7. ambulate
8. gait
9. logrolling
10. dangling
11. transfer (gait) belt
12. contracture

Short Answer
1. a. The biggest cause of injury to health care workers is repetitive lifting.
   b. Back injuries cause loss of work time and are expensive for the employer.
2. a. an erect head centered over the body
   b. buttocks in the same plane as the shoulders with the thighs parallel to the shoulders
   c. weight evenly distributed over the buttocks and thighs
   d. knees flexed at about 90 degrees with the feet resting comfortably on the footrests or floor
   e. arms lying comfortably in the lap or supported by the chair armrests or lapboard
3. a. about shoulder-width apart
   b. coordinated movements
   c. close to your body
   d. level or height as the object to be moved
   e. pivot rather than push or twist
   f. of the movement
4. Any similar example to the following: (Box 18-1)
   a. Use a wide base of support when transferring a patient. Keep feet about shoulder-width apart.
   b. Using the arms as levers placed beneath the patient and rocking back on the heels to move the patient to the side of the bed.
   c. Lifting a box with elbows bent at sides to keep weight of the box close to the body and stabilize the center of gravity.
   d. Raising the bed to waist height before attempting to reposition the patient to reduce back strain.
   e. Pulling, using weight as a counterforce, to reduce the workload. Pivoting during a transfer to prevent twisting the body and possible back injury.
   f. Directly face the object or person to be moved.
5. a. Interference with circulation, which may lead to pressure ulcers
   b. Muscle cramps and possible contracture
   c. Fluid collection in the lungs
6. a. Place pillows lengthwise under the arms from the armpit to the wrist, allowing the hand to fall slightly over the end of the pillow. Place a rolled pillow on the outside of each leg to prevent external rotation. Use a footboard or sneakers to keep the ankles and feet in proper alignment. Place a flat, small pillow at the curvature of the lower spine to prevent excessive straightening of the spine.
   b. Place pillows lengthwise under each arm to prevent undue rotation of the shoulders and to support the joints of the arms. Place a pillow beneath the knees, supporting above and below the joint to help prevent the patient from slipping down in the bed. Place a pillow lengthwise behind the back for comfort as indicated.
7. Lock the wheels of the wheelchair and the bed. Place your arms under the axillae and your hands on the scapulae. Assist to stand while bracing the patient’s legs with your knees. Pivot so that patient’s back is toward the bed. When patient’s legs are against the mattress, lower the body onto the bed. Reposition for correct alignment in the bed.
8. The weight of the object or person is drawn close to the body, stabilizing your own center of gravity.
9. Prone position is used when the patient is on prolonged bed rest and immobilized, when the patient can tolerate the position.
10. Have patient wear sturdy slippers, allow to stand before walking to decrease dizziness; keep tubes and lines from tangling in legs or tripping patient; use gait belt or support patient adequately; ask to keep head up and stand as straight as possible; do not overestimate the distance patient can walk without extreme fatigue or weakness.
11. maximally stretched; flexibility of the joint
12. 3-5
13. extremity
14. The book seems lighter when held close to the body.
15. Lower back strain.
17. muscles; the legs
Matching
1. c
2. e
3. a
4. f
5. d
6. b

Application of the Nursing Process
1. That the head is in alignment with the body, the shoulders and hips are parallel, knees and ankles are slightly flexed, arms hang comfortably at the sides, and the feet have support.
2. Impaired physical mobility
3. The patient will master use of a wheelchair within one month.
4. active; passive
5. logrolling
6. lock the wheels of the wheelchair
7. body mechanics
8. a. Ambulated with assistance half of the length of the hall.
   b. Ambulated length of the hall with the walker.

Review Questions for the NCLEX® Examination
1. 3
2. 2, 3
3. Sims’
4. 3
5. 3
6. 4
7. 2
8. 3, 4
9. 1
10. 2, 3

Critical Thinking Activities
1. If allowed, raise and lower the head of the bed slightly frequently to redistribute the weight over the sacral area. Provide a trapeze so that the patient can reposition and lift the buttocks off the mattress from time to time.
2. All areas against the mattress: anterior hip, lateral knees, ankles, right elbow, left ear.
3. Hand and foot splints or footboard, pillows or sandbags of various sizes.

STEPS TOWARD BETTER COMMUNICATION

Vocabulary Exercise
The striated muscle works to move the extremities. Inertia for long periods tends to make the muscles atrophy. When muscles are not exercised and joints are not moved, the joints are predisposed to contractures. Exercising the joints also alleviates the pain that can occur with inactivity. Proper positioning ensures that the weight of the body is dispersed over a broad area. When performing ROM exercises, it is best not to hyperflex a joint, as that may cause injury. When transferring a patient from the bed to a chair, a wide base of support is used so that you do not sway while moving the patient.

Pronunciation of Difficult Terms
prognosis prog NO sis
design de SIGN
aligned a LIGNED
magnificent mag NIF i cent

Communication Exercise
Dialogue will be individual. Here is an example:

Nurse: “Good morning, Mr. Brown. Are you ready for your walk today?”
Mr. B.: “Uh-huh.”
Nurse: “First, I am going to raise the head of your bed, to let you get oriented, and I will lower the bed so your feet can reach the floor. Let me help you sit up and swing your legs over the side of the bed, that’s it! Does that feel OK?”
Mr. B.: (Waves his hand.) “Uh-uh!”
Nurse: “Are you dizzy? Just sit there for a minute, while I get your slippers on. OK. Do you feel better now?”
Mr. B.: (Nods.) “Uh-huh. OK.”
Nurse: “All right, if you are ready now, we will stand up. Put your arms around my shoulders.”
Nurse: “I’m going to help you up now; one, two, three.”
Mr. B.: “Uhhhh…”
Nurse: “Let’s just stand here until you are stable and then we will walk around the room.”
Mr. B.: “OK.”
CHAPTER 19

Terminology

A. Matching
1. g
2. a
3. i
4. d
5. j
6. b
7. f
8. e
9. h
10. c
11. k

B. Completion
1. reactive hyperemia
2. diaphoresis
3. epidermis
4. caries
5. integumentary
6. melanin
7. maceration
8. syncope

Review of Structure and Function

All answers may be found in the Overview of Structure and Function of the Integumentary System section in the textbook.
1. Melanin
2. keratin
3. Sebaceous glands
4. Sebum
5. Sweat glands
6. Mucous membranes
7. dermis; corium
8. Skin

Short Answer
1. Any four of the following:
   a. Loss of elastic fibers and adipose tissue leads to wrinkles and sagging.
   b. Loss of collagen fibers makes the skin more fragile and slower to heal.
   c. Decreased sebaceous gland activity causes dryness and itching.
   d. Temperature control is altered due to loss of density of the skin and decreased sebaceous gland activity.
   e. The number of hair follicles decreases, leading to slowed growth and thinning hair.
   f. Nail growth decreases and nails thicken.
2. (See Box 19-1)
   a. Bed or chair confinement: Continuous pressure may occur at a particular area if position is not changed.
   b. Inability to move: Cannot alter pressure over dependent areas even slightly.
   c. Loss of bowel or bladder control: Moisture contributes to maceration of skin and colonization of bacteria.
   d. Poor nutrition: Protein and vitamins are needed for skin cell regeneration and to maintain skin health.
   e. Lowered mental awareness: Unaware of how long has remained in one position causing pressure over same areas for long periods.
3. Dehydration, obesity, excessive diaphoresis, extreme age (fragile skin), and edema
4. Any five interventions from Safety Alert on p. 292. Examples:
   a. Change the patient’s position at least q2h.
   b. Use pressure-reducing devices as appropriate.
   c. Minimize skin injury caused by friction and shear forces when repositioning.
   d. Keep the patient clean and dry.
   e. Provide adequate nutrition and fluid intake.
5. See Figure 19-3; requires critical thinking.
   a. Wheelchair: buttocks, sacral area, elbows, heels
   b. Semi-Fowler’s: buttocks, sacral area, backs of thighs, heels, thoracic spine, back of head
   c. Sims’: left anterior hip, outside of left knee and ankle, left inner elbow, left shoulder, left ear
   d. Prone: front of hips, anterior aspect of shoulder areas, chin (or side of face if head is turned)
6. the bath
7. 1/2 to 3/4 the amount of time that pressure was present to cause the redness
8. Any three characteristics listed.
   a. Suspected deep tissue injury: localized discolored intact skin that is maroon or purple or a blood-filled blister resulting from damage to underlying soft tissue from pressure or shearing. The area may be painful, firm, mushy, boggy, warmer, or cooler when compared to adjacent tissue.
   b. Stage I: red, deep pink, or mottled skin; no blanching; warmth, edema, or induration
   c. Stage II: partial-thickness skin loss; surrounding area warm, reddening
   d. Stage III: full-thickness skin loss; damaged or necrotic subcutaneous tissue; bacterial infection; drainage
   e. Stage IV: full-thickness skin loss with extensive tissue necrosis, sinus tracts, infection, black eschar present, wet and oozing
   f. Unstageable: loss of full-thickness of tissue. The base of the ulcer is covered by eschar (tan, brown, or black) in the wound bed, or the base of the ulcer contains slough (yellow, tan, gray, green, or brown)

9. the location of the abnormality, its color and size, and reaction to the blanch test
10. a. Cleanse the skin
    b. Promote comfort
    c. Stimulate circulation to all areas of the body
    d. Remove waste products secreted through the skin
11. Face, hands, axillae, and perineal area
12. a. Cleanse
    b. Stimulate peripheral circulation
    c. Provide comfort
13. healing
14. rectal; perineal
15. confined to bed
16. 8
17. a container with normal saline or water
18. diabetes; vascular insufficiency
19. Basin of water or a stoppered sink with some water in the bottom
20. submerging
21. 18 or below

Application of the Nursing Process
1. a. Cultural views regarding hygiene practices
    b. Self-care abilities
2. Self-care deficit, hygiene
3. Patient will maintain normal hygiene practices with assistance.
4. Make certain that the room is sufficiently warm with no drafts; the patient is adequately covered with a bath blanket; skin is adequately rinsed of soap; water is changed as it cools or becomes too soapy; attention to perineal care is paid unless patient can easily reach these areas; moisturizing lotion is applied immediately after the bath.

5. Skin over all bony prominences is without redness or break.

Review Questions for the NCLEX® Examination
1. 3
2. 2
3. 2
4. 3
5. 3
6. 1, 4
7. 1
8. 1
9. constantly moist skin
10. 3

Critical Thinking Activities
1. Patients have a right to refuse any procedure. Inquire why the bath is refused. See if there is a better time for bathing.
2. See if there is an electric razor on the unit that is sterile and that can be resterilized for the next patient. Have a family member bring his razor from home. Inquire if it is all right to shave him with a disposable safety razor.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. exacerbation
2. nick
3. mottled
4. don
5. débridement

Vocabulary Exercises
1. e
2. d
3. b
4. c
5. a

Word Attack Skills
1. outer, on
2. skin
3. hard
Communication Exercise

Yes you should talk, but be sensitive to the patient’s feelings. He may just want to relax, and enjoy the pleasure of having someone take care of him, especially during the backrub.

Talk about the weather, the seasons, ask about family, or visitors, tell something about your activities. During the bath is a good time to gather further assessment data, explore learning needs, and begin patient teaching.

CHAPTER 20

Terminology
1. environment
2. ventilation
3. acute radiation sickness
4. humidity
5. poison
6. bioterrorism

Short Answer
1. a. temperature  
   b. ventilation  
   c. lighting  
   d. odor  
   e. noise  
2. 68°–74° F (20°–23° C)  
3. safety; comfortable  
4. Negative airflow: air flows into the room; positive airflow: air flows out of the room.  
5. a. Refrain from putting odorous items in the patient unit trash.  
   b. Refrain from wearing perfumes, scented lotions, or scented cosmetics while at work.  
6. Avoiding long conversations on the intercom and limiting staff conversation in the hallway; speak in a lowered voice.  
7. glare; soft and diffuse  
8. the far side rail; the bed to working height  
9. a. Use good body alignment.  
    b. Maintain a wide base of support.  
    c. Face toward the direction of movement.  
    d. Bend at the knees rather than bending the back.  
    e. Raise the bed to the proper working height.  
10. Toileting the patient on a regular schedule to prevent the need for getting up without assistance.  
11. Ventilation  
12. Always knock gently and identify yourself before entering the room. In multiple-patient rooms, close the curtain around the patient for personal tasks such as using a bedpan and bathing. Post a sign on the door informing others of such tasks to discourage them from entering the room.
    b. Improve the effectiveness of communication among caregivers.  
    c. Improve the safety of using medications.  
    d. Reduce the risk of health care–associated infections.  
    e. Reduce the risk of patient harm resulting from falls.  
    f. Prevent health care–associated pressure ulcers (decubitus ulcers).
14. Any four measures from Box 20-3. Individual judgment dictates what is most important.
15. a. Patient with diabetes  
    b. Patient with impaired circulation  
    c. Paralyzed patient without sensory feeling  
    d. Patient receiving drugs that alter mental awareness
16. any equipment that could cause a spark
17. a. Location of fire alarms  
    b. Location of fire extinguishers  
    c. Escape routes from the unit  
    d. Techniques for rescuing patients
18. Rescue the patient quickly.  
   Activate the fire alarm system.  
   Contain the fire by closing doors and windows.  
   Extinguish the flames.
19. the release of pathogenic microorganisms into the community
20. a. gas  
    b. liquid  
    c. solid
21. 21
22. convulsions, paralysis, and death
23. time, distance, and shielding
24. nausea, vomiting, diarrhea, loss of appetite, fatigue, fever, skin damage, hair loss, seizures, and coma
25. b, a, c, d, although some would say b, c, a, d. It takes experience to triage accurately.
26. decontamination with removal of clothing and jewelry and scrubbing down
27. who will most likely live if they receive treatment
28. Name of the product, patient’s age, amount you believe is involved, and any symptoms and/or complaints you observe.
29. childproof latches
30. last resort
31. to bring in items from home that are familiar such as photographs, a quilt, pillow, etc.
32. a sudden change in mental status or behavior
33. index and middle fingers
34. knots that are easy to undo
35. 2 hours; exercises

Review Questions for the NCLEX® Examination
1. 1
2. 1, 3
3. 2
4. 2
5. 1, 3
6. 1
7. 3
8. 2
9. 3
10. cardiovascular
11. 3
12. 1, 4
13. 4
14. 2
15. 4
16. 2
17. 2

Critical Thinking Activities
1. Have someone sit with him. Use a bed alarm. Remind him where he is and why. Try to determine why he wants to get up.
2. A fire safety inventory is required; answer will depend on what deficiencies are found.
3. A poison safety inspection is needed; answer will depend on what is found.
4. Instruct patient to change positions slowly. Instruct patient to sit on edge of bed and dangle her feet before standing. Instruct patient to perform dorsiflexion before standing.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. diffuse
2. noxious
3. frayed
4. tact
5. neat and tidy

Vocabulary Exercises

<table>
<thead>
<tr>
<th>Word</th>
<th>Physical/Tangible</th>
<th>Emotional/Intangible</th>
</tr>
</thead>
<tbody>
<tr>
<td>frayed</td>
<td>worn at the edges</td>
<td>irritated, annoyed</td>
</tr>
<tr>
<td>glare</td>
<td>a strong reflected light</td>
<td>to look hard at someone with anger or hatred</td>
</tr>
<tr>
<td>miter</td>
<td>tall, pointed bishop’s hat</td>
<td>making a corner with two pieces at an angle</td>
</tr>
<tr>
<td>prone</td>
<td>lying face down</td>
<td>likely to happen</td>
</tr>
<tr>
<td>slump</td>
<td>to slide or bend into a low position</td>
<td>to fall or sink down</td>
</tr>
<tr>
<td>stifle</td>
<td>preventing or restricting from getting air</td>
<td>prevent someone from doing something</td>
</tr>
</tbody>
</table>

2. a. I hate clutter; I like to keep my work area neat and tidy.
   b. That light produces too much glare, and I would like you to do something to diffuse the light.

Communication Exercises
1. I am putting your bed rails up for your safety so you won’t fall out.
2. Could you please lower your voices or move into the lounge area? Some patients are trying to rest.
3. We do this for her own safety. We check them regularly to be sure she is comfortable.
4. Be careful, the tea is hot.

Grammar Points
1. in the role of
2. because
3. to the same amount
4. for example
CHAPTER 21

Terminology

A. Matching
1. f
2. b
3. h
4. a
5. i
6. e
7. d
8. j
9. c
10. g

B. Completion
1. eupnea
2. dyspnea
3. diastolic
4. defervescence
5. auscultatory gap
6. basal metabolic rate (BMR)
7. metabolism
8. hypothalamus; feedback
9. the volume of blood pushed into the aorta with each heartbeat

Review of Structure and Function

All answers for this section are in Overview of the Structures and their Functions that Regulate the Vital Signs in the textbook.
1. a pyrogen causes the body to conserve and manufacture heat
2. the thyroid, epinephrine, norepinephrine, and testosterone hormones, and muscle movement that produces heat
3. diaphoresis
4. stroke volume
5. sinoatrial node
6. stroke volume
7. 5 liters
8. between the lungs and the atmosphere
9. alveolar membrane
10. the nose, pharynx, larynx, trachea, bronchi, lungs, diaphragm, and respiratory muscles
11. surfactant
12. pons; medulla
13. carotid bodies; aortic body
14. maximum pressure exerted on the arteries during left ventricular contraction (systole)
15. the heart is at rest and pressure in the arteries is lowest
16. stroke
17. peripheral vascular
18. decreases
19. increase
20. metabolic rate
21. increased

Short Answer
1. metabolic rate, environmental temperature, hormone levels, muscle movement from exercise, shivering
2. 97.5°–99.5° F; 36°–37.5° C
3. 60–100 bpm
4. Rhythm and volume
5. Over the radial artery, temporal artery, carotid artery, femoral artery, popliteal artery, posterior tibial artery, and dorsalis pedis artery
6. Apex of the heart [fifth intercostal space (ICS) at mid-clavicular line]; a full minute
7. a. Bradycardia (synthesis of information)
   b. Tachycardia
   c. Arrhythmia
   d. Unable to palpate (name the pulse site)
8. 101.3° F, or 38.5° C
9. brain; hypothalamus
10. 120/70
11. Any five of the following factors helpful for accurate BP determination:
   a. Have the patient rest for at least 5 minutes before taking the blood pressure.
   b. Position the arm at heart level and support it.
   c. Attach the cuff over the bare arm.
   d. Center the bladder of the cuff over the brachial artery.
   e. Inflate the cuff while palpating the artery, noting the level at which the pulse disappears. Inflate the cuff 30 mm Hg over the level at which the pulse disappeared when auscultating the pressure.
   f. Place the diaphragm of the stethoscope firmly but lightly over the artery with all edges of the diaphragm in contact with the skin.
   g. Deflate the cuff at about 2 mm Hg per second and deflate to zero.
12. dizziness; faintness
13. orthostatic or postural
14. count the apical pulse rate at exactly the same time as another nurse counts the radial pulse using the same watch for both of you. Subtract the radial pulse from the apical pulse to obtain the pulse deficit.
**Application of the Nursing Process**

1. A temporal artery or tympanic thermometer would be best. The tympanic thermometer should be used in the ear canal pointing toward the tympanic membrane. Pull the earlobe upward gently to straighten the canal.

2. You can count the brachial pulse while the parent is holding the child securely.

3. If the radial pulse is irregular, tell the patient you are having trouble feeling the pulse and take an apical pulse rate for a full minute.

4. A large adult blood pressure cuff should be used with the sphygmomanometer and stethoscope. A normal adult cuff will not fit most patients with this weight and will give a falsely high reading.

5. You might place a hand on the chest and measure the rise of the chest on inspiration, or use a stethoscope on the chest to listen to the breaths.

6. a. *Hyperthermia related to unknown cause*
   b. *Ineffective breathing pattern related to impaired respiration*
   c. *Decreased cardiac output related to rapid heart rate*
   d. *Ineffective tissue perfusion related to decreased systemic blood flow associated with increased vascular resistance* (Other possible nursing diagnoses might be: Risk for injury related to consistently elevated blood pressure; Deficient knowledge regarding disease process and therapeutic regimen; Risk for ineffective management of therapeutic regimen)

7. a. Temperature will return to normal with administration of antipyretic within 8 hours.
   b. Breathing will return to normal pattern with 1 hour of use of bronchodilator medication.
   c. Heart rate will return to normal within 8 hours after initiating beta-blocker therapy.
   d. Blood pressure will return to normal level within 1 week after beginning antihypertensive therapy.

8. a. Temperature 98.6°F (37.0°C) at 4 PM (6 hours later)
   b. Respirations 20, 1 hour after nebulizer treatment with albuterol
   c. Heart rate 94 bpm at 4 PM (8 hours after medication)
   d. BP 136/86 mm Hg at clinic visit 1 week after initiating antihypertensive therapy

**Priority Setting**

1. 2

**Review Questions for the NCLEX® Examination**

1. 2
2. 2
3. 1
4. 5
5. 4

**Critical Thinking Activities**

1. The respiratory rate will vary when a lower respiratory infection is present. Causes include secretions in the lungs interfering with oxygen and carbon dioxide dispersion, narrowing of bronchioles and bronchi, or obstruction of airways, causing the body to increase the rate to obtain sufficient oxygen.

2. Tries to conserve and manufacture heat to raise the set point for core temperature. Because the person feels cold, clothes or covers are used to conserve heat and the person huddles with extremities held curled close to the body, environmental heat may be turned up. Chills may occur that increase body metabolism, thereby increasing heat production.

3. A major examination causes some degree of anxiety. Anxiety stimulates the sympathetic nervous system, which in turn raises the heart rate.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**

1. abatement
2. alter
3. contraindicated
4. propelled
5. flared
6. simultaneously
7. distract
8. clockwise
9. blunt
10. peripheral

Vocabulary Exercises

<table>
<thead>
<tr>
<th>Text</th>
<th>Conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blunt</td>
<td>Short, stubby, or flat</td>
</tr>
<tr>
<td>Superficial</td>
<td>Close to the surface</td>
</tr>
</tbody>
</table>

Word Attack Skills

1. he mo/dy NAM ics, blood/movement = movement of the blood and pressures within the body
2. an te/CUB ital space, above/the elbow = surface of the arm in front of the elbow

Pronunciation Skills

- ap ne a
- eup ne a
dyp ne a
eup ne a
dysp ne a
hy po x i a
ar ry th mi a
tach y car di a
di as to l ic
a su cul ta tory
feb rile
py re x i a
def er ves ence
di a phor g sis
sphyg mo man om e ter

Communication Exercises

Sample Dialogue B

Nurse: “Slip this probe under your tongue. The thermometer will beep when it is done. Turn your arm over for me, so I can feel your pulse more easily. (Places fingers over artery.) There it is. It is regular at 76 beats per minute.”

CHAPTER 22

Terminology

A. Matching
1. g
2. k
3. i
4. b
5. c
6. f
7. e
8. l
9. m
10. h
11. j
12. d
13. a

B. Completion
1. bronchovesicular
2. vesicular
3. stridor
4. palpation
5. wheeze
6. Rinne
7. Weber
8. ascites
9. crackles
10. olfaction

Identification

1. a
2. d
3. d
4. b
5. e
6. a, b
7. e, a
8. b
9. a, b
10. b

Short Answer

1. a. Female genitalia, pelvic exam
   b. Rectal exam
   c. Flexible sigmoidoscopy
2. a. Mentation and level of consciousness (Skill 22-2)
   b. Pupil reflexes and extraocular movements; size, equality, reaction, and accommodation to light
   c. Motor movements to command, and muscle strength
   d. Vital signs
3. a. Health history factors
   b. Current health problems
   c. Psychosocial/cultural data
4. a. Rest and activity
   b. Nutritional, fluid, and electrolytes
   c. Safety and security
d. Hygiene and grooming  
e. Oxygenation and circulation needs  
f. Psychosocial needs  
g. Elimination and education needs  

5. a. Need for and timing of regular physical examination  
   b. Recommended periodic diagnostic tests  
   c. Need and schedule for immunizations  
   d. Warning signs of cancer  
   e. How to perform breast self-exam  
   f. How to perform testicular self-exam  

Priority Setting  
The physical assessment should be performed from head to toe. There can be some variation. The following would be appropriate:  

6, 5, 3, 4, 1, 7, 8, 2, 9  

Completion  
1. sweetish  
2. a hand  
3. dialysis shunt; mastectomy  
4. bell  
5. mucous membranes  
6. compared bilaterally  
7. tibia; ankle  
8. expected outcomes  
9. RNS HOPE  
10. head-to-toe  
11. diagnostic tests  
12. unnecessary exposure  
13. neurologic exam  
14. 12  

Application of the Nursing Process  
1. the patient, the family, the chart, other health care workers involved in the patient’s care, and diagnostic test results  
2. an individualized plan of care can be formulated  
3. sight is the most helpful method (observation and inspection)  
4. data indicating problems that are defining characteristics for the various nursing diagnoses are used to support the choice of the diagnoses for that patient  
5. setting priorities of care and incorporating all tasks and assessments needed for the shift into the work organization plan  
6. at the beginning of each shift and whenever there appears to be a change in the patient’s condition  
7. implementing the plan’s interventions and then evaluating whether the interventions helped the patient reach the expected outcomes  

Review Questions for the NCLEX® Examination  
1. 3  
2. compare  
3. 3  
4. 4  
5. 1, 3  
6. 1, 4  
7. 4  
8. 3  
9. 1  
10. 1, 2, 3  

Critical Thinking Activities  
1. Auscultate the heart and lungs, including heart valve sounds. Check all peripheral pulses and compare bilaterally.  
2. Blood work—laboratory tests  
   Mammogram, Pap smear  
   Stool for occult blood  
   Digital rectal exam; PSA test  
   Proctosigmoidoscopy  
   Urinalysis  
3. See Box 22-6.  

STEPS TOWARD BETTER COMMUNICATION  

Completion  
1. appraising  
2. opacity  
3. holistic  
4. ascertaining  
5. subsides  
6. acronym  
7. patent  
8. astute  

Vocabulary Exercises  
1. abnormal  
2. a word made from the initials of other words  
3. occluded  
4. sluggish  

Word Attack Skills  

Pronunciation of Difficult Terms  
A. Requires practice pronouncing the words.  
B. 1. sphyg/mo/ma/nom/e/ter  
   2. oph/thal/mo/scope
**Abbreviations**

1. Point of maximal impulse
2. Pupils equal, round, reactive to light, and accommodation
3. Breast self-exam
4. Patient-controlled analgesia
5. Activities of daily living
6. Testicular self-exam
7. Extraocular movements
8. Gastrointestinal
9. Digital rectal exam

**Communication Exercise**

A. Requires practice with a partner.
B. Who can you count on when you are having a problem or an emergency?
   - Are you ever depressed or really feeling blue?
   - Will you be able to have someone care for you at home while you recover, or would you like to speak with the social worker to arrange your convalescence?
   - Will you be able to obtain your medications and dressing supplies without a problem?
   - What are your fears or concerns at this point in time?
   - Let’s wait and see what the pathology report and prognosis are to see if there is a further problem.
   - How will you change your dressing and care for your incision?
C. Each dialogue will be different depending on your personality and knowledge level. Share your dialog with a peer or your instructor for comments.

**CHAPTER 23**

**Terminology**

**A. Matching**

1. f
2. e
3. c
4. a
5. d
6. b

**B. Completion**

1. discharge planner
2. emergency admission
3. Medicare
4. TRICARE
5. pre-authorization
6. Managed care

**Short Answer**

1. make sure that all admission criteria are met and verify authorization for admission and insurance coverage.
2. a. Location of call bell and its operation.
   b. Location of bathroom and its call bell.
   c. How to operate the television and telephone.
   d. Explain visiting hours.
   e. Explain NPO if necessary or tell meal times.
   f. Explain services available; i.e., chaplain, social worker, etc.
   g. Answer questions.
3. a. primary and secondary diagnoses
   b. current orders
   c. list of medications including dosage, route, frequency, and time of last dose given
   d. physician names and phone numbers
   e. brief synopsis of the hospital stay
4. a. rest and activity directions and restrictions
   b. diet instructions
   c. wound care
   d. medications and when to take them
   e. signs and symptoms of problems to report to the physician
   f. name and phone number of the physician
5. Immediately notify the physician. After the death is pronounced, the nurse prepares the body for viewing by the family, and then the body is given postmortem care.
6. Sent home with the family; placed within a valuables envelope, listed, sealed, and placed in the hospital safe
7. RN; LVN/LPN
8. on the front of the chart, on the admission assessment, on the MAR, and on a patient arm band per agency policy
9. physician; business office and the family
10. adequate communication between caregivers
11. discharge planner
12. nurse who signs off on the order sheet
13. Wound care, diabetic care and teaching, IV medication administration
14. physical therapy, occupational therapy, speech therapy, respiratory care, personal care
15. notify the physician
16. listen to what the patient has to say, answer questions, offer to ask the physician or supervising nurse to talk with the patient; ask the patient to sign the AMA form
17. not pay for the treatment that has been received
18. a. Simply sit with the bereaved, listen, and offer quiet comfort.
   b. Offer to call the priest, rabbi, or religious leader.
   c. Provide privacy for grieving.
   d. Tell the person you are sorry for the loss of the loved one.
19. a. Death is from unknown causes.
   b. Death is at the hands of another.
   c. Patient has not been under the care of a physician within a specific time.

**Review Questions for the NCLEX® Examination**
1. 2
2. 3
3. 1, 3, 4
4. 4
5. 1
6. 4
7. 3
8. 4
9. 3
10. 1, 2, 4
11. 1
12. AMA (against medical advice)

**Critical Thinking Activities**
1. Answers will be individual.
2. Seek out relatives, his employer, and friends to supply the needed information.
3. Seek the assistance of the social worker; enlist the aid of a relative or neighbor to look in on her if she is self-sufficient.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. significant other
2. protocols
3. verified
4. synopsis
5. alleviate
6. devastating
7. lethargic
8. In general

**Word Attack Skills**
1. drowsy
2. active
3. rectal
4. easy

**Communication Exercise**
Each role play will be individual.

**CHAPTER 24**

**Terminology**
1. aspiration
2. biopsy
3. endoscope
4. hematoma
5. jaundice
6. panel
7. polyps
8. smear
9. transducer
10. tonsilar

**Matching**
1. f
2. c
3. g
4. b
5. h
6. e
7. i
8. d
9. j
10. a
11. l
12. k

**Completion**
1. diagnosis
2. noninvasive
3. ultrasonic waves
4. hematology; components
5. leukocytosis; infection
6. prothrombin time
7. sedimentation
8. 8–12
9. Standard Precautions
10. glucometer
11. kidney
12. deteriorates quickly
13. pathologist
14. movement
15. nuclear medicine
16. kidneys, ureters, bladder
17. metal
18. electrical activity
19. heart; valves; coronary
20. pulmonary; capacity; diffusion
21. upper GI; barium enema
22. drink; water
23. GI
24. large intestine
25. endoscopic retrograde cholangiopancreatography; stricture; cyst; stones
26. immediately
27. in a preservative solution

Review Questions for the NCLEX® Examination
1. lithotomy
2. 1, 2
3. 1
4. 2
5. 1
6. 3
7. 4
8. 1
9. 1, 3
10. 4

Application of the Nursing Process
1. a. Assess what the patient knows about the test.
   b. Assess what concerns the patient has about the test.
   c. Assess for safety measures that need to be implemented before or after the test.
   d. Assess for allergy to medication used for the test or to skin preparation solutions to be used.
2. Deficient knowledge related to unfamiliarity with diagnostic test
3. Patient will verbalize purpose of the test and what will be experienced during and after the test.
4. Patient teaching regarding the test
5. Implementing safety measures such as frequent vital signs, forcing fluids, or other measures to protect the patient
6. Compare the result with the previous test result

Critical Thinking Activities
1. • what exactly is done
   • purpose
   • sensations patient will feel
   • how long it takes
   • pretest sedation
   • posttest routine
2. • describe machine and sensations
   • need for keeping still
   • methods of dealing with claustrophobia
   • amount of time it takes
3. Describe how ultrasound waves reflect structures.

Steps Toward Better Communication

Completion
1. diagnostic
2. titer
3. deteriorates
4. troubleshoot

Word Attack Skills
1. endoscope, microscope, fluoroscope, gastroscope, sigmoidoscope, cystoscope, stethoscope
2. cystoscopy, gastroscopy, proctosigmoidoscopy, sigmoidoscopy, fluoroscopy, colonoscopy
3. arteriograph
4. angiography, ultrasonography, sonography, radiography, cineradiography, tomography, arteriography, cholangiopancreatography, electroencephalography

Pronunciation of Difficult Terms
1. AN gi OG ra phy
2. cho LAN gi o PAN cre a TOG ra phy
3. cys TOS co py
4. e LEC tro en CEPH al o gram
5. gas TROS co py
6. my o CAR di al in FARC tion
7. PAR a cen TE sis
8. PROC to sig moid QS co py
9. RA di o PAQUE
10. RA di o IM mu no AS says
11. THO ra cen TE sis

Communication Exercise
Practice increases pronunciation and intonation ability.

Chapter 25

Terminology

A. Matching
1. d
2. c
3. g
4. f
5. h
6. a
7. j
8. k
9. i
10. e
11. l
12. b

B. Completion
1. hypovolemia
2. hypokalemia
3. hypocalcemia
4. diffusion
5. Osmosis
6. isotonic
7. hypertonic
8. edema
9. filtration
10. active transport
11. hypernatremia
12. hyperkalemia
13. hypermagnesemia
14. hyperventilation
15. diabetic

Identification

A.
1. Slightly low—hypokalemia
2. Normal
3. High—hypercalcemia
4. Normal
5. Normal
6. Low—hyponatremia

B.
1. Respiratory acidosis
2. Respiratory alkalosis
3. Metabolic acidosis
4. Metabolic alkalosis

Short Answer
1. a. be a vehicle for the transportation of substances to and from the cells
   b. aid heat regulation by providing perspiration that evaporates
   c. assist maintenance of hydrogen ion balance in the body
   d. serve as a medium for the enzymatic action of digestion
2. a. extracellular fluid
   b. intracellular fluid
3. plasma proteins and plasma colloid osmotic pressure
4. fluid excess or fluid deficit
5. daily weight
6. a pulse rate over 100 bpm
7. neuromuscular irritability
8. tap the facial nerve about an inch in front of the earlobe

Application of the Nursing Process
1. Diarrhea, fatigue, nausea or anorexia, palpitations, muscle weakness or paresthesias
2. Mucous membranes, urine output, and appearance of eyes
3. Ineffective tissue perfusion
4. Patient’s weight will decrease by 1.5 lb. by tomorrow; pedal edema will subside before discharge.
5. take in only clear liquids; take small sips of electrolyte solution such as Gatorade every hour; give an antidiarrheal drug; encourage intake of water and other liquids; attempt to determine cause of diarrhea; provide antinausea medication if needed, keep the room free from odors
6. weight, intake and output 24-hour total, electrolyte lab values, state of pedal edema, and lung sounds

Review Questions for the NCLEX® Examination
1. 4
2. 3
3. 1
4. 1
5. 2, 3
6. 450 mL
7. 4
8. 1
9. 3
10. 4
11. 1, 2
12. 3
13. 1, 2, 3, 5, 6
14. 3
15. 1
16. 3

Critical Thinking Activities
1. Cover kidney’s role in potassium regulation in the blood. Review foods containing potassium. Meats must be decreased; see Patient Teaching on p. 439.
2. Present how sodium affects blood pressure. Refer to Patient Teaching Table on p. 437 and work with the patient’s food preferences to
devise an appropriate diet. Refer to the low-sodium diet in Appendix G of the textbook.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**
1. considerable
2. compensatory
3. tracking
4. twitch
5. lethargic
6. buffer
7. ingestion

**Vocabulary Exercises**
1. Lung sounds: moist
2. Pulse: weak, full, bounding, thready, faint, slow, rapid
3. Blood pressure: elevated
4. Mucous membranes: moist, dry, sticky
5. Urine: scanty
6. Skin: moist, dry, sticky, pale

**Word Attack Skills**
1. shallow—deep
2. rapid—slow
3. passive—active
4. moist—dry
5. attraction—repellent
6. gain—loss
7. increase—decrease
8. deficit—excess

**Communication Exercise**

Dialogue written will vary among individuals. Here is an example.

Nurse: “Mr. Jones, we will be monitoring all the fluids that you take into your body and all that are excreted. We do this any time a patient is receiving IV fluids to make certain that he is not receiving more fluid than the body can handle.”

Mr. J.: “So what will I have to do?”

Nurse: “You will need to write down on this sheet all the fluids that you drink. You can just note 1/2 glass water or 1 cup of coffee and I will translate that amount into milliliters.”

Mr. J.: “I think I can manage to do that.”

Nurse: “You will also need to be certain you use this container when you empty your bladder. Set it aside and turn on the call light. Someone will come and empty the container and record the amount of urine that was in it.”

Mr. J.: “I can’t do that myself? I hate to leave that for someone else to do.”

Nurse: “We really need to look at the urine when we measure it as well, so I’d prefer that you just let us handle that task.”

Mr. J.: “OK, if you say so. I want to do what is best.”

Nurse: “Thank you, Mr. J.”

**CHAPTER 26**

**Terminology**

**A. Matching**
1. o
2. k
3. d
4. b
5. j
6. i
7. g
8. a
9. h
10. m
11. e
12. n
13. c
14. f
15. l

**B. Completion**
1. complete protein
2. incomplete protein
3. complementary proteins
4. essential
5. nonessential
6. Middle Eastern
7. kwashiorkor
8. vegan
9. vegetable oils
10. saturated
11. toxicity
12. Kosher
13. Kwashiorkor
14. Obesity
Review of Structure and Function

All answers are found in the Overview of Structure and Function section of the chapter.

1. h
2. d
3. b
4. a
5. e
6. g
7. c
8. f

Short Answer

1. a. fruits, vegetables, whole grains, and fat-free or 1% low-fat milk and milk products
   b. a diet with lean meats, poultry, fish, beans, eggs, and nuts
   c. a diet low in saturated fats, trans fats, cholesterol, sodium, and added sugars
2. linoleic acid, oleic acid, and linolenic acid
3. provide a concentrated supply of energy and spare protein from being burned for energy
4. Cells; tissues; play a role in maintaining fluid balance, assist with transportation of nutrients, and are necessary for antibody and hormone production
5. 10–15
6. 50–60%; 4
7. metabolism; cellular
8. breads, pasta, cereal, potatoes, and rice
9. a. Provide a quick source of energy
    b. Regulate protein and fat metabolism
    c. Help fight infection
    d. Promote growth of body tissues
    e. Provide fiber for bulk in the stool, aiding waste elimination
10. 500 mL
11. Examples will be of individual choice. Some examples are:
    a. Age: Older adults may receive inadequate nutrition because of difficulty obtaining or preparing food.
    b. Illness: Nausea may cause inadequate nutrient intake.
    c. Emotional status: Severe stress may cause either anorexia or overeating and weight gain.
    d. Economic status: Inadequate funds may lead to a diet deficient in protein.
    e. Religion: Food may need to be prepared in a certain way in order to be acceptable.
    f. Culture: Appetite is usually better when foods are familiar.
12. 6; double; triple
13. 4 to 6 months
14. sweets
15. fast foods
16. evening; obesity
17. older adults
18. 5; 3
19. 48
20. complete protein, vitamins, and minerals
21. 24.9
22. 300

Identification

A. Function of Vitamins

All answers are in Table 26-4.

1. A
2. D
3. A
4. B (niacin)
5. K
6. B
7. Folic acid
8. E
9. C
10. B

B. Function of Minerals

All answers may be found in Table 26-4. Any one answer is correct.

1. Calcium: muscle action, coagulation, building of strong bones and teeth
   Deficiency causes: poor bone growth, poor blood clotting
2. Chloride: maintenance of fluid and acid-base balance, activation of gastric enzymes
   Deficiency causes: acid-base imbalance
3. Magnesium: build strong teeth and bones; protein synthesis; regulation of heartbeat
   Deficiency causes: cardiac arrhythmia; possible confusion or poor memory
4. Phosphorus: build strong bones and teeth; maintain acid-base balance
   Deficiency causes: weakness, stiff joints, anorexia
5. Potassium: maintain acid-base balance; transmission of nerve impulses; helps control muscle contractions; helps regulate heartbeat
   Deficiency causes: cardiac arrhythmia; hypertension; possible impaired growth
6. Sodium: maintain acid-base and fluid balance
   Deficiency causes: hyponatremia; edema of lower extremities
7. Chromium: activates enzymes; contributes to removal of glucose from the blood
   Deficiency causes: central nervous system dysfunction; weight loss; aggravation of diabetes mellitus
8. Fluoride: contributes to formation of bones and teeth; decreases cavities
   Deficiency causes: risk of dental caries
9. Iodine: helps regulate metabolism; contributes to healthy skin, hair, and nails
   Deficiency causes: goiter; cretinism in children if mother was deficient during pregnancy
10. Iron: formation of hemoglobin
    Deficiency causes: iron-deficiency anemia
11. Zinc: immune function; protein synthesis; normal growth and sexual development; wound healing
    Deficiency causes: depressed immune function; poor growth; delayed sexual maturation

**Application of the Nursing Process**
1. BMI=24.44
2. Risk for imbalanced nutrition: less than body requirements
3. a. Patient will stabilize body weight after surgery within 2 months.
   b. Patient will not develop diarrhea when feeding is resumed.
4. Any two of the following:
   a. Weigh patient three times per week.
   b. Ask family to bring in favorite foods to tempt appetite.
   c. Start small, bland, frequent feedings as tolerated and slowly increase amounts.
   d. Monitor closely for diarrhea, nausea, or abdominal distention.
5. a. Weight is stabilized at 128 lbs.
   b. Diarrhea minimal and stopped after 3 days.
6. Refusing most of diet due to anorexia.
   Weight loss of 0.5 lb. this week.
   Loose stools occurred after first three feedings.
   Continues to experience nausea.
7. Revise the plan of care in attempt to find interventions that will assist the patient to meet the expected outcomes.

**Review Questions for the NCLEX® Examination**

(Answers require synthesis and application of knowledge.)
1. 2
2. 1, 4
3. 1, 2, 3
4. 3
5. 2
6. 3
7. 1
8. 3
9. 2
10. 1, 2, 3, 4
11. 4
12. 3
13. 3
14. 3
15. 1
16. 2, 4
17. 2, 4
18. 1
19. 4
20. thyroid gland

**Critical Thinking Activities**
1. See Table 26-4 for problems of deficiency of the various B vitamins.
2. Plan choices using the food pyramid and calorie and fat charts for various fast foods. Consider Jackie’s likes and dislikes. Suggest take-along foods such as fresh fruit and snack packs of carrots. Discuss nutrition bars.
3. Recommend finger foods such as high-quality hot dog pieces or low-fat sausage pieces, chunks of cheese cut into fun shapes. Raw vegetable pieces may be more appealing than cooked vegetables. Refrain from sweet foods as much as possible. Use 100% juice rather than juice drinks. Try a variety of foods. Offer small rewards such as a story if all food is eaten. Feed more frequently throughout the day.
4. Individual answers will indicate changes needed.

**STEPS TOWARD BETTER COMMUNICATION**

**Vocabulary Exercises**
1. Child rearing is comprised of feeding, clothing, nourishing, training, loving, and educating a child.
2. Finicky eaters consume some foods sparingly.
3. The lack of green vegetables in his diet compromised his health.
4. Many volunteers for the Meals on Wheels program are retired and enjoy helping their peers.

**Communication Exercise**

Nurse: (1) Morning, Ms. Andrews. How’re you today?
Ms. A.: I’m OK, but I wish (2) they’d gimme a better breakfast!
Nurse: (3) Whaddaya mean? What’d you have?
Ms. A.: Just some lukewarm watery tea, (4) and cold oatmeal and milk—with no salt. And the toast was dry and cold.
Nurse: (5) Doesn’t sound very appetizing. I’ll speak to dietary. Didya call the nurse and ask fer hot tea?
Ms. A.: (7) Naw. ‘t wasn’t worth it. I’m goin’ home today anyway.
Nurse: That’s good news. But (8) ya’know you’re on a low-sodium diet. That means you’re not (9) sposed ta have salt added to your food.
Ms. A.: Not even a little in cooking?
Nurse: Not if (10) ya want to follow doctor’s orders and keep your blood pressure down. We don’t want to see you back in here again.
Ms. A.: No offense, but I (11) don’ wanna BE back here again.
(12) I’ll jus’hafta try ta get usta it, I guess.
Nurse: That’s the spirit. Now let me take your vital signs.

1. Good Morning, Ms. Andrews. How are you today?
2. they would give me
3. What do you mean? What did you have?
4. and cold oatmeal and milk. And the toast was dry and cold.
5. That doesn’t
6. Did you call the nurse and ask for hot tea?
7. No. It wasn’t worth it. I am going home today, anyway.
8. You know you are
9. supposed to
10. you
11. don’t want
12. I’ll just have to try to get used to it

**CHAPTER 27**

**Terminology**

A. Completion
1. atherosclerosis
2. CHF (congestive heart failure)
3. glycosuria
4. dysphagia
5. mild obesity
6. bulimia
7. hypertension
8. parenteral
9. PEG (percutaneous endoscopic gastrostomy)
10. hyperosmolality
11. residue

**Identification**

Answers may be found in Box 27-1.
1. N (unless it is strained)
2. B
3. F
4. B
5. F
6. N
7. B
8. B
9. F
10. F
11. B
12. F

**Short Answer**

1. a. have paralysis or immobilization of an arm
   b. are visually impaired
   c. have an intravenous line in their hand or arm
   d. are severely weak or impaired from surgery or illness
   e. problems with breathing or swallowing (dysphagia)
2. 6–8
3. psychological; nutritional
4. 25 to 35 lbs.; 1 lb.
5. thiamin
6. cardiovascular disease, diabetes, hypertension, gallbladder disease, and colon and breast cancer
7. fat; cholesterol; sodium
8. fruits, vegetables, nuts, seeds, legumes, and low-fat dairy products
9. secreted in normal amounts but receptor sites won’t let it into the cells
10. a. cardiovascular disease  
b. hypertension  
c. kidney disease  
d. stroke  
e. blindness  
11. 70–120  
12. a. Maintaining high calorie intake  
b. Increasing protein intake to maintain or increase muscle mass  
c. Offering bland, soft, or puréed foods when the mouth is painful  
d. Adding thickening agents to liquids if swallowing is difficult  
e. Adding seasoning to help food taste more appealing  
f. Encouraging small, frequent meals  
13. a. dysphagia from a stroke  
b. inflammatory bowel disease  
c. HIV/AIDS  
d. cancer treatment/chemotherapy  
e. massive burns  
f. intestinal obstruction  
14. at least every shift and before administering each feeding or giving a medication  
15. More freedom of ambulation, easier to administer own feedings, no need for general anesthesia for surgical placement, less harmful to body image  
16. Measure the tube length from skin level to the end of the placement adapter. Compare the measurements to the initial measurements right after placement. High measurement indicates outward movement of tube. Notify charge nurse and physician if dislodged.  
17. 8–12  
18. glycosuria; diarrhea  
19. Any four of the principles listed in Box 27-3.  
20. speed up the rate to catch up on the amount that should have been infused, and do not use hydrogen peroxide around gastrostomy or jejunostomy tubes because it is corrosive to skin.  

Application of the Nursing Process  

Any four of the following from Table 27-4.  
1. a. Monitor IV site every 4 hours for signs redness, swelling, or drainage  
b. Monitor blood glucose levels every 6–8 hours until stable.  
c. Assess rate of flow every 4 hours to determine that solution is flowing no faster than rate ordered.  

d. Track intake and output every shift to prevent excessive diuresis from glycosuria caused by the TPN.  
e. Monitor vital signs every 4–8 hours to detect any sign of infection or complication from the TPN line or solution.  
f. Monitor weight, albumin levels, and muscle mass to determine nutritional status.  
2. Nutrition, imbalanced, less than body requirements related to anorexia and difficulty eating. Deficient fluid volume, related to diarrhea. Risk for injury related to possible aspiration related to tube feeding.  
3. Expected outcomes will depend on the nursing diagnoses chosen. For the nursing diagnoses in #1 above, the expected outcomes might be:  
a. Caloric intake will be 2500 calories per day.  
b. Fluid intake and output will be balanced within 48 hours.  
c. No injury from aspiration of tube feeding will occur while feeding tube is in place.  
d. The patient will tolerate food and fluids without vomiting.  
e. The patient will consume at least 90% of all meals.  
f. The patient’s breath sounds will remain clear without evidence of aspiration of food or fluids.  
g. The patient will gain 2 lbs. by time of discharge.  
h. The patient’s stools will be formed.  
4. a. Sit the patient upright 30 to 90 degrees before feeding and leave up for 30 to 60 minutes after feeding to prevent reflux and aspiration.  
b. Check the placement of the tube to be certain it is in the stomach or intestinal tract before initiating the feeding.  
c. Check for amount of residual feeding at least every 4 hours or before initiating an intermittent feeding to be certain emptying and absorption are occurring.  
d. Give the solution slowly to prevent too rapid a carbohydrate load, upsetting blood glucose levels and causing diarrhea and electrolyte imbalance.  
5. Correct order is:  
a. 5 Unclamp the tube.  
b. 7 Flush the tube with water.  
c. 3 Check the placement of the tube.  
d. 2 Elevate the patient’s head and upper body.  
e. 1 Prepare the feeding bag.  
f. 4 Check for residual feeding in the stomach.
6. Start the feeding.
7. Reclamp the tube.
8. Evaluation statements might be:
   a. Patient demonstrates no nausea or diarrhea.
   b. Weight has remained the same or there is weight gain.
   c. No evidence of muscle wasting or abnormal serum albumin level.

Review Questions for the NCLEX® Examination
1. 100
2. 2
3. 2
4. 3
5. 2, 3
6. 2
7. 2
8. 5
9. 2
10. 3, 4

Critical Thinking Activities
1. Consider ways to decrease cholesterol, saturated fat, trans fat and sodium-containing foods; no added salt at the table or in cooking. Should include menus for several days.
2. Frequent, small meals; experiment with seasonings to enhance taste. Add powdered milk to solids such as meatloaf, mashed potatoes, casseroles, etc. Make high-powered milkshakes using fruits and protein powder. Add extra egg to casseroles and dishes such as meatloaf.
3. Decrease sodium-containing foods; substitute broiled or baked foods for deep-frying. Switch from use of lard and saturated oils to unsaturated oils for cooking.

Meeting Clinical Objectives
1. See Box 27-3.
2. See Table 27-4.
3. See Nursing Care Plan 27-1.
4. Reference labs from clinical text and consider patient diagnosis and medications.

CHAPTER 28

Terminology

A. Matching
1. m
2. h
3. e
4. g
5. i
6. j
7. c
8. d
9. k
10. f
11. b
12. l
13. n
14. o
15. a

B. Completion
1. apnea
2. tracheostomy
3. obturator
4. inspiration
5. expiration
6. hypoxemia
7. anoxia
8. Respiration

Review of Structure and Function
1. Central nervous system
2. Cilia
3. Alveolar macrophages
4. Chemoreceptors
5. Mucous membranes
6. Alveolar membrane
7. Trachea
8. Upper airway passages

Short Answer
1. See Skill 28-2. Ask if the person can speak and verify person is choking. If unable to speak and coughing is ineffective, stand behind the person and place arms around the person halfway between the umbilicus and the xiphoid process with one hand forming a fist and the other over the fist. With an upward motion forcefully
thrust the hands into the abdomen at an upward angle.

2. See Table 28-3.
   a. Nasal cannula: patient can move, talk, and eat while receiving oxygen.
   b. Simple mask: allows higher delivery of oxygen than cannula.
   d. Non-rebreathing mask: Can deliver 80–95% oxygen in an emergency situation.
   e. Venturi mask: Accurate delivery: provides consistent FiO₂ regardless of breathing pattern.
   f. Tracheostomy collar: Adds humidity to oxygen flow for a tracheostomy.
   g. T-bar: Adds humidity to oxygen flow for a tracheostomy.

3. a. Preoxygenate the patient.
   b. Maintain sterility of the suction catheter and supplies.
   c. Be certain suction is turned on before inserting the catheter.
   d. Do not suction for more than 10 seconds.

4. Any five of the following:
   a. restlessness and irritability
   b. increasing anxiety
   c. confusion, decreased concentration
   d. tachypnea
   e. stridor
   f. retractions
   g. cardiac arrhythmia
   h. cyanosis
   i. does not seem right
   j. combative
   k. headache
   l. lethargic

5. Making certain that the sensor is attached and functioning properly, the machine is properly set, that a trend of decreasing oxygen saturation is reported promptly to the physician, adjusting oxygen flow to physician orders based on SpO₂ levels, and documenting readings at intervals.

6. a. To relieve an airway obstruction
   b. To protect the airway
   c. To facilitate suctioning
   d. To provide artificial ventilation

Sequencing
4 Check the carotid pulse (which is absent).
2 Call for help.
1 Shake and shout name or “Are you OK?” (No)
9 Give two breaths.

5 Position hands for chest compressions.
3 Position supine.
6 Give 30 chest compressions.
7 Tilt head and open airway.
8 Form seal around nose and mouth with your mouth.

10 Continue CPR sequence until relieved or unable to continue.

Application of the Nursing Process
1. Auscultate her lungs, take her vital signs, check skin and mucous membrane color, assess shortness of breath with activity, check mentation.
2. Impaired gas exchange related to retained secretions in right lower lobe.
3. Gas exchange will improve within 2 days.
4. Turn, cough, and deep-breathe at least every 2 hours; use incentive spirometer; ambulate frequently; increase fluid intake to thin secretions; administer oxygen as ordered; monitor lung status and respiratory rate; provide postural drainage if ordered.
5. Actions are effective if lungs are clear to auscultation and there is no shortness of breath; respiratory rate is within normal limits.

Review Questions for the NCLEX® Examination
1. 2-3
2. 1
3. 1, 2, 3
4. 4
5. 1, 2, 4
6. 3
7. 3
8. 3
9. 3
10. 1
11. 2–12
12. 2

Critical Thinking Activities
1. Medicate for pain; assist to splint ribs to cough; teach forced exhalation coughing.
   2. — When it will be done
      — Pain medication beforehand
      — How it will feel
      — Need for occlusive dressing
3. — Monitor oxygen saturation of the blood in noninvasive fashion
   — Explain mechanics of light probe
   — Meaning of readout on screen
   — Alarms
   — How readings are used
STEPS TOWARD BETTER COMMUNICATION

Completion
1. copious
2. brink
3. intertwined
4. combustion

CHAPTER 29

Terminology

A. Matching
1. e
2. f
3. i
4. h
5. a
6. g
7. j
8. b
9. c
10. d

B. Completion
1. commode chair
2. 40%
3. residual urine
4. retention
5. denies
6. urostomy
7. catheterization
8. condom catheter

Review of Structure and Function
1. c
2. f
3. d
4. b
5. a
6. e

Identification
1. ___ Color: dark amber
2. ___ Character: slightly cloudy
3. ___X Specific gravity: 1.008
4. ___ pH: 6.0
5. ___X Glucose: 1+
6. ___X Protein: 1+
7. ___ Ketones: 0
8. ___X Leukocytes: moderate
9. ___ Erythrocytes: 0
10. ___X Bilirubin: slight
11. ___X Pyuria: trace

Short Answer
1. frequency of urination, urgency, dysuria, burning, malaise, foul-smelling urine, a slight temperature elevation
2. Any three of the following:
   a. Run water in a basin while the patient attempts to urinate.
   b. Pour warm water over the perineum while patient attempts to urinate.
   c. Have male patient stand at the side of the bed to urinate.
   d. Have the patient blow into a straw placed in a glass of water while attempting to urinate.
3. discard the catheter and use a sterile one in order to avoid introducing bacteria into the bladder
4. regularly experience urinary retention or incontinence such as those who have a neuromuscular problem that prevents them from emptying the bladder normally
5. Any three of the following:
   a. Wash out residual urine or sediment from the bladder.
   b. Remove clots and stop oozing of blood after prostate or bladder surgery.
   c. Soothe irritated bladder tissues and promote healing.
   d. Ensure that the lumen of the indwelling catheter is open and draining.
   e. Instill medication into the bladder.
6. Encourage a large fluid intake unless contraindicated, include cranberry juice in the diet, provide supplemental vitamin C, maintain sterility when emptying the collection bag, clean around the urinary meatus and rinse well at least once a day.
7. always maintain aseptic technique
8. bladder retraining program; use of a condom catheter; teaching Kegel exercises; toileting every 2 hours while awake; using adult briefs or absorbent pads; surgical correction of the problem; drug therapy
9. label the specimen correctly with the patient’s name, room number, physician’s name, date and time; place the container in a biohazard transport bag; transport it to the lab within 15 minutes of collection or refrigerate it until specimen pick-up time

Completion
1. 5–10 times
2. infection
3. 8
4. 15 minutes
5. discard
6. strained
7. dehydration
8. get onto/sit
9. Coudé
10. clamped and released
11. dilute
12. beneath the buttocks
13. urinary meatus; the vaginal opening
14. bladder tone
15. gently

Application of the Nursing Process
1. Is there any burning? Do you have trouble initiating the stream? Is there a foul smell to the urine? What color is the urine? How much fluid are you drinking? Do you have get up a lot at night? What medications are you taking?
2. Impaired urinary elimination
   *Urinary retention
   Risk for infection
3. a. Urine elimination will be maintained with use of catheter or drugs.
   b. Normal urinary pattern will be reestablished after 2 months of drug therapy.
4. He is at risk for urinary tract infection because of the retention. Decreasing fluid volume will increase that risk. He should drink normal amounts of fluid.
5. Palpate the bladder after he voids to determine if there is still retention. Assess output and compare it to input to see if there is a balance. Assess if voidings are becoming less frequent and of more volume.

Review Questions for the NCLEX® Examination
1. urine specific gravity
2. 1
3. 1, 3, 4
4. 2, 3
5. 1, 2, 3
6. 2
7. 3, 4
8. 2
9. 4
10. 1
11. 2
12. 1

Priority Setting
1. 2
2. 4
3. 3
4. 1

Critical Thinking Activities
1. Base the plan on the individual and Patient Teaching on p. 558.
2. Use Health Promotion Points “How to Prevent Cystitis” and adjust teaching to the individual.
3. Explain dangers of urine backing up into the kidney. Explain the functions of the kidney and how they can be damaged.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. bulbous
2. impede
3. stasis
4. instillation
5. prone
6. pucker
7. patent

Vocabulary Exercises
Answers will be individual. Examples are:
1. The patient with the fractured hip and a Foley catheter was dependent on the nurse to help him turn in bed.
2. The tubing leading to the Foley catheter drainage bag should not be dependent; it should be kept above the level of the bag.
3. The preoperative order is invalid because the patient has had surgery. New orders are needed.
4. While recovering from kidney surgery, the patient is considered an invalid.
5. When stasis of urine occurs regularly, the patient is prone to urinary tract infection.
6. After placement of the urostomy tube, the patient was more comfortable on his side or in a prone position.

CHAPTER 30

Terminology

A. Matching
1. k
2. e
3. a
4. c
5. j
6. i  
7. f  
8. g  
9. b  
10. h  
11. l  
12. d  

**B. Completion**  
1. fecal impaction  
2. borborygmi  
3. incontinence  
4. 50  
5. vagal response  
6. Valsalva maneuver  
7. colostomy  
8. atrophy  
9. rubber baby nipple  
10. periostomal  
11. effluent  
12. black or occult  

**Review of Structure and Function**  
1. g  
2. a  
3. c  
4. j  
5. h  
6. d  
7. i  
8. b  
9. f  
10. e  

**Short Answer**  
1. *Any four of the following:*  
   a. Dehydration  
   b. Narcotic pain medication  
   c. Diet lacking fiber and sufficient fluid  
   d. Decreased exercise or immobility  
   e. Hypoactive bowel  
   f. Injury or disease affecting abdominal muscles  
   g. Small serving of stewed or dried prunes  
2. a. Melena: bleeding in the stomach or small intestine  
   b. Occult blood: small amount of bleeding in the intestines  
   c. Pale-colored stool: blockage of bile flow into the intestine  
   d. Mucus: Irritation or inflammation of the bowel  
   e. Foul-smelling stool that floats in water: too much undigested fat in the stool; lack of digestive enzymes and bile  
   f. Liquid stool; gastrointestinal infection or toxicity causing diarrhea  
   g. Hard, dry stool: lack of fluid and fiber or lack of peristalsis  

3. a. Loss of body function and change in body image  
   b. Possibility of rejection by others  
   c. Loss of physical or sexual attractiveness  
   d. Death from underlying disease  

4. A visit from a member of the United Ostomy Association  

5. a. Colostomy  
   b. Ileostomy  
   c. Continent diversion (pouch) (Figure 30-6)  

6. a. Increase dietary fiber  
   b. Increase fluid intake  
   c. Exercise regularly  
   d. Heed the urge to defecate  

7. a. Testing the fluid temperature to be sure it isn’t too hot  
   b. Keeping the height of the enema bag no more than 18 inches above the rectum  
   c. Controlling the flow of the fluid so that it doesn’t run in too fast  
   d. Stopping the flow if the patient experiences severe cramping  

8. a. Stimulating the inner surface of the rectum  
   b. Forming gas that expands the rectum  
   c. Melting to lubricate the stool for easier passage from the rectum  

**Application of the Nursing Process**  
1. Obtain a history of usual bowel function, diet, and medications; characteristics of the stool; changes in appearance of stool or pattern of bowel movements; auscultate bowel sounds; palpate and percuss abdomen  

2. *Risk for constipation related to inactivity and narcotic pain medication*  

3. Patient will have normal bowel movements before discharge.  

4. Increase fluid intake; add fiber to the diet; give a stool softener or bulk-forming laxative; provide privacy for defecation; assess abdominal status and bowel pattern  

5. Bowel movements and appearance of stool (intake and output; dietary intake; and tolerance of stool softener or bulk-forming laxative would be assessed also)
**Review Questions for the NCLEX® Examination**

1. left Sims’
2. 3
3. 1
4. 4
5. 4
6. 3
7. 1, 4
8. 2
9. 3
10. 3
11. 4

**Priority Setting**

2, 3, 1, 4, 5

**Critical Thinking Activities**

1. Teach basics of how bowel works. Cover points of bowel dietary and exercise intervention and the importance of paying attention to the urge to defecate. Individualize the plan to accommodate eating in restaurants most of the time.
2. How to collect the stool—Saran Wrap™ over toilet bowl, paper plate, etc.; How much stool to place on the test window.
3. See Steps 30-2 and individualize to the patient as needed.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**

1. heed
2. distention
3. triggering
4. wafer
5. oblique
6. commode
7. scanty

**Word Attack Skills**

1. Colostomy is located along the colon.
2. Ileostomy is located along the ileum of the small intestine.
3. Urostomy is located on the abdominal wall where the ureter is attached to discharge urine from the kidney.

**Communication Exercises**

2B. Dialogue will be individual for each student.
3. Dialogue with the enterostomal therapist will be individual.

**CHAPTER 31**

**Terminology**

1. f
2. d
3. h
4. l
5. c
6. b
7. i
8. e
9. k
10. g
11. a
12. j

**Short Answer**

1. Biofeedback: use of a machine that measures the degree of muscular tension to teach the patient to relax particular muscles.
2. Distraction technique: patient focuses on a word or object and the concentration blocks out the pain sensations.
3. Epidural analgesia: catheter is placed in epidural space and opioid analgesic is administered via a pump.
4. Guided imagery: patient is assisted to form pleasant mental images of another place that takes focus off of pain sensations.
5. Hypnosis: inducing a trance-like state using focusing and relaxing techniques to alter consciousness.
6. Meditation technique: patient concentrates on a focal point such as a visual point, a sound, a repeated phrase, or on his or her own breathing, which turns attention away from pain.
7. Patient-controlled analgesia: intravenous opioid medication administered from a pump by the patient.
8. Relaxation technique: Techniques to relax muscle groups that decrease muscle tension, thereby reducing pain.
9. Transcutaneous electrical nerve stimulation: small electrical stimulator delivers pulses of electrical current that block the transmission of pain sensations.
10. stimulating large-diameter nerve fibers, closing the gate.
11. a. Transduction: NSAIDs to block substances that trigger the nociceptors.
   b. Transmission: opioids to interfere with the transmission of impulses from nociceptors.
   c. Perception: distraction or guided imagery to divert perception away from the pain.
d. Modulation: drugs that block neurotransmitter uptake.

12. providing distraction
13. the cerebral cortex and thalamus to open the gate

14. a. nonopioid medications
   b. narcotics or opioids
   c. adjuvant analgesics

15. cause nerve damage
16. 16; brain development
17. tolerance; analgesia

18. a. Fear
   b. Pain
   c. Stress
   d. Medication side effects

19. 10–11

20. Non-rapid eye movement sleep (NREM)
21. a. Stage 1: a light sleep with relaxed muscles lasting only a few minutes
   b. Stage 2: a deeper sleep with more brain wave activity and bursts of electrical activity lasting about 10–20 minutes
   c. Stage 3: delta sleep with slow brain waves; respirations and heart rate slow and the body becomes immobile; lasts 20–40 minutes
   d. Stage 4: deepest stage of sleep with person difficult to arouse; lasts about 30 minutes
   e. REM sleep: brain waves become active as if awake; dreams occur; lasts 20 minutes or longer

22. a. Too much caffeine
   b. Nicotine from smoking
   c. Alcohol consumption can cause nocturnal awakenings
   d. Regular exercise promotes sleep, but not too close to bedtime
   e. Napping during the day may disrupt nighttime sleep

23. a. Environment is too noisy.
   b. Room is too hot or too cold.
   c. Room is too brightly lit.

24. use of a continuous positive airway pressure (CPAP) machine while sleeping

25. a. physical structural obstruction of air passages
   b. obstruction due to allergy or cold

26. a. warm water compresses
   b. warm blankets
   c. Aquathermia pads
   d. tub and whirlpool baths
   e. chemical self-heating packs
   f. heat-producing equipment or patches

27. sudden-onset, recurrent, uncontrollable brief episodes of sleep during hours of wakefulness

28. clinical evaluation, sleep logs, and sleep laboratory tests

29. a. Reducing swelling
   b. Calming muscle spasm
   c. Reducing pain in joints and muscles

30. a. Use a barrier between the ice pack and the skin.
   b. Limit duration of use to 15–20 minutes at a time.

**Application of the Nursing Process**

1. Look for changes in his vital signs; develop a system of communication in writing or by pointing to pictures. Use a pain scale by pointing to the options and have him blink or move his head for “yes” and “no” answers. Study his body language for clues to the degree of pain.

2. Nursing diagnoses chosen will vary. Examples are:
   - Risk for injury related to potential for fat embolus from fracture
   - Risk for infection related to multiple trauma and intubation
   - Impaired mobility related to trauma and ventilation
   - Self-care deficit related to immobility

3. Expected outcomes will vary depending on choice of nursing diagnoses. Examples: (synthesis and application of knowledge)
   a. Patient will not suffer injury from a fat embolus.
   b. Patient will not develop wound or respiratory infection while immobilized.
   c. Patient will not develop muscle atrophy while immobilized.
   d. Patient will resume self-care activities when no longer immobilized.

4. a. Administration of analgesia via PCA pump
   b. Use of distraction in the form of video games or TV
   c. Use of guided relaxation exercises or imagery
   d. Use of cold packs over injured joints

5. Statements will vary depending on the expected outcomes written. Examples: (NCP 31-I)
   a. Indicates PCA pump is controlling pain.
   b. Did not use PCA while engaged in playing videogame.
   c. Indicated guided relaxation helps decrease pain.
   d. Indicates cold packs feel good and reduce pain.
Review Questions for the NCLEX® Examination
1. 3
2. 1
3. 2
4. FLACC
5. 4
6. 1, 2, 3, 4
7. 2
8. 3
9. 1, 2, 4
10. 2, 4

Critical Thinking Activities
1. Consult Patient Teaching on p. 599.
2. Use Table 31-2 and a drug handbook.
3. Use progressive relaxation starting at the toes or head and going steadily up or down the body relaxing the muscles in each area. Use slow, deep breaths between each set of muscle relaxations.

STEPS TOWARD BETTER COMMUNICATION

Completion

A.
1. adjuvant
2. stress
3. distraction
4. pantomime
5. divert
6. enhanced
7. perception
8. stoic
9. complementary
10. phantom

B.

Examples are:
1. During the course of the night the patient experienced severe phantom pain.
2. On occasion, over-the-counter pain medication is effective for most patients.
3. During the course of an illness, over-the-counter medication may be used before seeking the help of a health care professional.
4. Most nurses on occasion get tired of the hours of shift work.
5. Many nurses are likely to suffer from the effects of shift work if they continuously have to work the night shift.

6. Patients who are on prescription medications and also take over-the-counter medications are likely to suffer from some drug interactions.
7. Nurses do adjust to shift work to a fair degree rather quickly.

Communication Exercises

Answers depend on individual responses.

CHAPTER 32

Terminology
1. Accupressure
2. aromatherapy
3. chiropractic
4. Reiki
5. Folk medicine

Short Answer
1. a. The use of relaxation therapy along with pain medication to increase comfort.
   b. Chiropractic treatment along with muscle relaxant and pain medication to treat a back strain.
2. a. Relaxation techniques
   b. Imagery
   c. Meditation
   d. Biofeedback
3. check for contraindications to the use of herbal therapies, considering other medications the patient is taking and the total health status of the patient. The patient should be directed to reliable information available about the herbals being considered.
4. a. like cures like
   b. the greater the dilution of the remedy, the greater its potency
   c. illness is specific to the individual

Completion
1. bodily functions; symptoms
2. National Center for Complementary and Alternative Medicine (NCCAM)
3. Homeopathic medicine, naturopathic medicine, traditional Chinese medicine, and Ayurveda
4. pulsed, magnetic, alternating current, direct current
5. Acupuncture
6. redirecting mental focus; controlling breathing; improving coordination; promoting relaxation
7. Ayurveda
Review Questions for the NCLEX® Examination
1. 2
2. 2, 3
3. 1, 3
4. 2, 4
5. 2
6. heart and respiratory rates
7. 1
8. 4

Critical Thinking Activities
1. Answers will vary according to which sites are visited. Saw palmetto is most frequently used to treat benign prostatic hypertrophy. It is used to decrease the size of the prostate. It is also a mild diuretic. Its effectiveness is in question.
2. Chiropractic medicine is used mainly to treat muscle and skeletal problems. It is often combined with massage, electrostimulation of muscle, and specific exercises. Back strain and whiplash injury are two commonly treated maladies. It is based on the belief that correct spinal alignment leads to healing of muscle strains and impingement of nerves.

Completion
1. inherently
2. alignment
3. wafted
4. comprised
5. medium/conduit

Vocabulary Exercises
1. Alternative means to do or use one thing instead of another. EXAMPLE: Use relaxation instead of giving a painkiller.
   Complementary means to do or use in addition to, to complete. EXAMPLE: Use relaxation as well as giving a painkiller.
2. Compliment is a positive comment about something; complimentary is a remark that does that. EXAMPLE: That was a very good report you gave in class.
   Note: Complimentary can also mean free, or without charge.
3. Medium can mean a method or way of distribution. EXAMPLE: Television is a medium for advertising.
   Medium can mean being in the middle. EXAMPLE: What size do you wear—small, medium, or large?

Word Attack Skills
- Bioelectromagnetic-based (13)
- Bio/electro/magnet/ic-based
- Contraindications (11)
- Contra/indications
- Polarities (4)
- Polar/ities
- Polarities

Communication Exercise
Patient: I think I will skip my radiation treatments and just eat a macrobiotic diet. My friend knows someone who did that and is doing very well.

Nurse: You should talk to your doctor about that. He can tell you the pros and cons of each.

Patient: What do you think about using St. John’s wort to help my child?

Nurse: Be sure you ask the pharmacist about that when you leave your prescription. Inform the pharmacist of any medications your child is taking, your child’s age, and why you wish to use St. John’s wort. That way the pharmacist can let you know whether there are any contraindications to giving your child that herb.

CHAPTER 33
Terminology

A. Matching
1. f
2. i
3. c
4. a
5. g
6. d
7. b
8. e
9. h

B. Completion
1. agonist
2. antagonist
3. drug interaction
4. pharmacokinetics
5. nursing implications
6. synergistic effect
7. therapeutic effect
8. toxic effect

Short Answer
1. a. stimulation or depression
   b. replacement
   c. Inhibition or killing of organisms or abnormal cells
   d. irritation
2. safe and therapeutic effect of the drugs
3. they do not comprehend how the drug works, why they are taking it, or that they need to take it to maintain a steady blood level of the drug so it can work
4. the blood level of the drug increases above the therapeutic range and unintended damage to normal cells occurs
5. Any five of the items in the textbook under “Considerations for the Elderly”
   Be certain that the patient understands what each medication is for, when to take it, what the potential side effects are, and what adverse effects to report. Should be certain patient can manage the pill containers or use a medication planner box.
6. be certain the patient can open the medication vials, uses a medication organizer if needed, has written instructions as to when to take the medications and what each medication is for, and instruct family members about the medications
7. how drugs affect cellular physiology, biology, and their mechanism of action
8. never to take the drug again; each time the drug produces an allergic reaction, it will be worse and can be life-threatening.
9. a. Give the right drug
   b. Give the right dose of the drug
   c. Give the drug by the right route
   d. Give the drug at the right time
   e. Give the drug to the right person
   f. Document drug administration
10. a. What the drug is for
    b. The effect the drug is supposed to have
    c. When and how to take the drug
    d. Precautions for taking the drug (with or without food, etc.)
    e. Expected possible side effects
    f. Adverse effects to report
11. every other day
12. check with the pharmacist and/or the physician
13. heparin, insulin, IV potassium, IV cardiac drugs, and chemotherapy drugs

Identification
Answers are from Table 33-1.
1. ACE inhibitor; antihypertensive that relaxes arterial vessels
2. Beta blocker; antihypertensive/antianginal that blocks beta adrenergic receptors in vascular smooth muscle
3. Blocks histamine-2 receptors; inhibits histamine at H₂ receptor sites, decreasing gastric secretions
4. Antilipemic; inhibits HMG-COA reductase enzyme, reducing cholesterol synthesis
5. Broad-spectrum antiinfective; inhibits bacteria by interfering with DNA

Drug Knowledge
Answers can be found in any drug handbook or pharmacology textbook.
1. Diuretic, antihypertensive
2. 25–100 mg PO
3. PO
4. Presence of anuria, or hypersensitivity to sulfonamides or thiazide diuretics, renal decompensation
5. Take in the evening.

Drug Calculations and Conversions
1. 4
2. 2.2
3. 600
4. 45
5. 750
6. 2 oz.
7. 4 capsules
8. 10 mL
9. 2 caps
10. 0.66 mL

Application of the Nursing Process
1. “Mrs. Murano, may I see the medication vials for those medications you are taking now? I also need to see any other drugstore medicines you are using even occasionally.”
   For each drug, ask:
   “How long have you been taking ________?”
   “Have you noticed any problems with it?”
   (Ask specific questions regarding very common side effects of the drug.)
“Do you remember to take each drug as you are supposed to take it? How do you remember to do that?”

2. You need to know:
   a. any drug allergies she has.
   b. how she plans to manage her drug regimen.
   c. if any of the drugs interact.
   d. nursing precautions and implications for each drug.
   e. usual and safe dosage range for each drug.
   f. any side effects that she has suffered currently or in the past from the drugs she is taking.
   g. whether periodic laboratory testing is needed for any of the drugs she is taking.

3. Noncompliance with drug regimen related to forgetfulness.

4. Patient will use a medication planner to take all prescribed doses of medication on time.

5. a. Assist Mrs. Murano to obtain a medication planner and to set it up with the medications.
   b. Make arrangements with a relative or friend to help her refill her medication planner each week.
   c. Verify that therapeutic action of each drug is occurring.
   d. If needed, try to set up a telephone reminder system for Mrs. Murano.
   e. Be certain Mrs. Murano understands the importance of and reason for taking each drug to increase compliance.

6. Check the medication planner and pill vials at each home visit to see that pills are indeed being taken. Question Mrs. Murano about when she is taking her pills and how she is remembering to use the planner. Speak with a relative or friend who is helping Mrs. Murano to obtain information about her medication compliance. Evaluation statements might be:

Medication planner set up with prescribed medications for one week. (Wed.) Medication planner bins empty for Monday, Tuesday, and Wednesday AM. States has been remembering to take medications. Sister states that Mrs. Murano has been responsive to reminder calls and has usually taken the medications already when she calls.

Review Questions for the NCLEX® Examination
1. 3
2. liver

3. 4
4. 2
5. 1
6. 1, 2, 3, 4
7. 1
8. 1

Critical Thinking Activities
1. Use a drug handbook or a pharmacology book to locate the information needed to devise a teaching plan. Cover action, side effects, adverse effects to report, and nursing implications.

2. Review the laws governing the dispensing and prescribing of scheduled drugs. Also cover potential problems when taking a drug not prescribed by physician (other drug interactions and effects on chronic health conditions).

3. Health and health problems, allergies, why patient is receiving the drug, other drugs and over-the-counter medications being taken, diagnostic tests scheduled on which the drug might have an effect, side effects from previous doses, what patient knows about the drug and taking it.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. incompatible
2. compliant; tactful
3. readily
4. erroneously
5. categorize

Communication Exercises
1. For this exercise, have the partner choose three drugs that the patient might be taking. Drugs will vary with the scenario.

2. For this exercise, use three other drugs. Atenolol (Tenormin), alprazolam (Xanax), Vicodin (acetaminophen with hydrocodone), and pravastatin sodium (Pravachol) are other commonly prescribed drugs, but any other drug may be used.

3. Points to cover are:
   a. what the drug is supposed to do.
   b. how to take the drug.
   c. when to take the drug and whether it must be taken with or without food.
   d. possible side effects of the drug.
e. adverse reactions to report to the physician.
f. what to do if a dose is forgotten.
g. what might happen if the medication is stopped.

CHAPTER 34

Terminology

A. Matching
1. e
2. a
3. d
4. f
5. h
6. g
7. j
8. b
9. i
10. c

B. Abbreviations

Helen Warren is being treated for asthma. Her medications are not adequately controlling her symptoms. The doctor orders a nebulizer treatment for her immediately (stat) to relieve her bronchospasm. He tells her to discontinue the antihistamine she has been taking as it does not seem to be helping. He prescribes oral (PO) montelukast sodium (Singulair) to be taken with water in the evening. He puts her on another metered-dose inhaler (MDI), triamcinolone acetonide (Azmacort) and tells her to use the new inhaler three times a day.

Short Answer
1. Patient’s name orally and on the name band; ID# on the MAR and on the patient’s ID bracelet; date of birth, social security number, address, phone number
2. a. the correct dose (within range of normal dose)
b. the route by which it may be given (appropriate route for this patient)
c. desired effects of the medication
d. potential side effects of the medication
e. interactions with other medications
f. any contraindications for giving this drug to the patient
3. a. name of the patient
b. the full name of the drug
c. the dosage to be given
d. the route of administration
e. how often it is to be given
f. date the prescription was written
g. signature of the prescriber
4. a. antihypertensive
b. antihistamine
c. sedative hypnotic
d. bronchodilator
e. antibiotic
f. antidepressant
g. antiarrythmic
h. antiinflammatory

5. Protocol orders are used in the emergency department, ICU, CCU, labor and delivery, and occasionally on regular nursing units. They are used for common emergency situations.

6. a. sublingual tablets
b. enteric-coated tablets
c. sustained-release caplets

7. Any three of the following: (See Elder Care Points in chapter.)
   a. Whether patient is receiving another med from another doctor for the same problem
   b. Whether special caution is needed if the patient has difficulty swallowing pills or capsules
   c. Whether the pill was swallowed after administration or has ended up in the buccal cavity
   d. Whether there are liver or kidney problems that require a reduced dosage of the drug so that toxicity does not develop

8. The LPN/LVN must know the action, normal dosage, adverse effects, interactions, and nursing implications of each drug administered; professionally the nurse must follow the 6 rights of medication administration and should know the patient’s allergies. Ethically the nurse must report any medication error. The nurse must handle all medications safely and should safeguard all narcotics, following procedures for checking out controlled drugs and administering them. The nurse must assess the patient following drug administration for any side effects or adverse effects.

9. To take a sip of water and swallow it; place the pill toward the back of the tongue. Have the person take a large sip of water, place the tongue on the roof of the mouth and with the chin tilted slightly downward, swallow; follow with more water.
Completion
1. questioned
2. metric
3. another colleague
4. skin; mucous membranes
5. 48–72 hours
6. surgery; general anesthesia
7. as quickly as possible
8. be certain the old patch is removed and the skin cleansed of any remaining medication. The new patch is placed in a different location on the skin.
9. medication administration record (MAR)
10. controlled substances (drugs)
11. patted onto
12. vaginal
13. unwrapped
14. meniscus
15. ineffective

Application of the Nursing Process
1. Assessment: Any three of the following:
   a. Determine that the order is still valid (within date).
   b. Assess for patient allergies.
   c. Determine why the patient is receiving the drug.
   d. Assess for therapeutic effect of previous doses of the drug.
   e. Assess for contraindications to taking the drug.
   f. Assess for side effects of previous doses of the drug.
   g. Assess for drug interactions with food or other drugs.
   h. Assess the patient’s knowledge about the drug.
2. a. All medications will be safely administered to each patient on time.
   b. Serious side effects of medication will be identified quickly.
   c. The medications will be effective.
   d. No allergic reaction to the medication will occur.
   e. The patient will understand why the drug is prescribed, adhere to the medication schedule, and report serious side effects.
3. three times
4. Any one of the following:
   a. Wound is clean and dry without inflammation or tenderness.
   b. Wound culture after 5 days of antibiotic treatment is negative.
   c. Temperature and WBC are within normal limits.
   d. Area of inflammation and tenderness around wound is decreased.

Priority Setting
It is most important to give the drugs that must be maintained at a therapeutic blood level as close to the ordered time as possible. Antiarrhythmics, anticonvulsants, and antianginals should always be given as close to the ordered time as possible. Vitamins and minerals can usually be given within an hour of the ordered time according to agency policy.

Review Questions for the NCLEX® Examination
1. 2, 3, 5
2. 3
3. 2
4. 1, 2, 4
5. 2, 3
6. 1, 2, 3
7. 3
8. 1
9. Erythromycin 250 mg PO qid
10. 2

Critical Thinking Activities
1. Discard the medication and chart that it was not given and why.
2. Verify the physician’s actual order, determine that the pill in question is actually that medication; determine why the patient is to receive this pill, and why, if it is a continuing order, he has received a different medication than this one.
3. Technically, the pill should be replaced by a new one. However, most nurses allow the patient to pick up the tablet and take it, as it is contaminated with the patient’s own microorganisms.
**STEPS TOWARD BETTER COMMUNICATION**

**Completion**

This is a very potent drug. The directions for using it are ambiguous, so we had better check with the doctor. I don’t want to make any deviation from his plans.

**CHAPTER 35**

**Terminology**

**A. Matching**

1. g  
2. n  
3. d  
4. m  
5. j  
6. b  
7. c  
8. e  
9. h  
10. i  
11. k  
12. f  
13. a  
14. l

**B. Completion**

1. intradermal  
2. anaphylactic shock  
3. parenteral  
4. Z-track  
5. tuberculin  
6. subcutaneous  
7. compatibility  
8. intramuscular

**Short Answer**

1. a. When the patient cannot take medication by mouth  
b. To hasten the action of the drug  
c. When digestive juices would counteract the effects of the drug if given by the oral route  
2. a. Ensure that the dose is accurate.  
b. Select the correct site to prevent damage to tissues.  
c. Use sterile equipment and aseptic technique to prevent infection.  
3. lateral surfaces of the upper arm or the anterior and lateral aspects of the thigh  
4. abdominal  
5. aspirate  
6. a. Mid-deltoid muscle  
b. Ventrogluteal site  
c. Vastus lateralis site in thigh  
d. Rectus femoris site in the adult thigh  
7. rotate sites  
8. an air lock  
9. emotional support  
10. irritating  
11. urticaria (hives), bronchiolar constriction (wheezing, difficulty breathing), and circulatory collapse.  
12. 25-, 27-, or 29-gauge  
13. 45 degrees  
14. 3 mL  
15. filter  
16. tenths  
17. sterile water; sterile saline  
18. allergies  
19. aqueous; oil  
20. needle sticks; blood-borne  
21. the size of muscle mass and possible decreased circulation in the area; a smaller-length needle may need to be used

**Correlation**

1. c  
2. a  
3. a  
4. a  
5. b  
6. c  
7. c  
8. b  
9. b  
10. a

**Application of the Nursing Process**

1. d, c, f, e, b, a  
2. Deficient fluid volume related to vomiting  
3. Vomiting will be controlled by antiemetic medication within 1 hour.  
4. Any three of the following:  
a. Move him as little as possible.  
b. Apply a cool cloth to the forehead, back of neck, or under the chin.  
c. Keep food and other odors out of the room.  
d. Decrease environmental stimuli.  
e. Give nothing by mouth.  
5. Statement chosen will be individual. States nausea has eased since injection of medication.  
No vomiting after injection of antiemetic.
**Review Questions for the NCLEX® Examination**

1. 3
2. abdomen; 45-degree
3. 4
4. 3
5. 2
6. 2, 3, 4
7. 1, 2, 4, 5
8. 4
9. rapidly
10. 1, 2, 3

**Critical Thinking Activities**

1. Discuss how to prevent a needle stick; “scoop” up the cap; take a small biohazard sharps container with you. Use a safety needle and syringe.
2. Waste the medication; if it is narcotic, have someone witness the wasting and document it on the narcotic checkout sheet. Document in the chart that the medication was not given. Seek an order change to a PO medication. Note on the MAR that the medication was not taken.
3. First check—after taking the medication from stock.
   Second check—just before drawing it up.
   Third check—just after drawing it up.
4. Review which type of insulin to draw up first. Discuss adding air to both vials first then beginning drawing of insulin.

**STEPS TOWARD BETTER COMMUNICATION**

**Completion**

**A.**
1. aqueous
2. reconstituted
3. beveled
4. dexterity
5. compatible
6. vial
7. apprehensive
8. needle stick

**B.**
1. sloughed off, with dexterity, vial
2. apprehensive, aqueous, reconstituted
3. scored, calibrated
4. hastened, induration
5. beveled, were compatible

**Time Clauses**

**A.**
1. When I fell, I was walking up the stairs.
2. While he was in the hospital, Donald Moore learned to give himself injections.
3. When her sister arrived, Margaret Smith was eating.
4. After she received the injection, the patient felt better.
5. Before the nurse gave her the injection, she was having a lot of pain.

**B.**

Answers will vary.

**CHAPTER 36**

**Terminology**

**A. Matching**
1. h
2. g
3. b
4. f
5. i
6. a
7. e
8. d
9. c

**B. Completion**
1. hypertonic; will pull
2. hypotonic
3. isotonic
4. infiltrated
5. Macrodrop
6. microdrop; 60
7. vascular access device

**Short Answer**

1. Any four of the following:
   a. Supply hydration when fluids cannot be taken by mouth.
   b. Deliver medication directly to the bloodstream.
   c. Quickly replenish and balance electrolytes.
   d. Supply nutrients when the patient cannot absorb them from the intestinal tract or needs supplementation.
   e. Replenish blood, plasma, or particular blood components.
2. Order of last two items will be individual. Priority is based on potential for threat to the patient’s life from a serious complication (Box 36-3).
   a. Keep IV tubing clear of air.
   b. Observe closely for transfusion reactions.
   c. Keep IV fluid sterile.
   d. Carefully regulate the rate of flow.
   e. Protect the cannula site from contamination to avoid possible infection.
   f. Assess the site frequently for signs of complications.
   g. Track intake and output when a patient is receiving IV fluids or blood.

3. a. Be certain the IV fluid to be administered is the one actually ordered.
   b. Be certain that fluid infuses at the prescribed rate.
   c. Maintain sterility of the system.
   d. Observe for complications.

4. edema around the site and cool, pale tissue

5. a. Infiltration: remove IV catheter and restart at site in other extremity.
   b. Phlebitis: remove IV catheter, notify physician, apply warm soaks to the site.
   c. Speed shock: stop the infusion, monitor vital signs closely, notify the physician.
   d. Circulatory overload: slow infusion, elevate the head of the bed, keep patient warm, notify the physician, assess for edema.
   e. Air embolus: place on left side and lower head of bed; inspect IV system for leak, notify physician.

6. chills, back pain, itching, shortness of breath, rash, apprehension, fever, tachycardia, nausea and vomiting, hematuria (Skill 36-6)

7. Turn off the blood and start the saline; give oxygen as needed; stay with the patient; notify the physician.

8. 1500–2000

9. 200

10. clarity, leaks, or particulate matter

11. needleless

12. when it is finished infusing, the main IV begins infusing again at the set rate

13. normal saline

14. a. small amounts of fluid are required
   b. extreme care must be used to measure the exact amount, such as when giving IV fluids to infants, children, and older adults

15. flushed

16. 1–2 hours

17. a. Butterfly needles

b. Over-the-needle catheters

18. superior vena cava; atrium

19. high blood flow vessel

20. take blood pressure

21. no fluid is to be infused until placement is confirmed by x-ray

22. non-coring, Huber

23. 80–250

24. pack the area with hot packs to distend the vein

25. distal site

26. potassium

27. check the alarm to be certain it can be heard outside the room or away from the patient’s bedside if in an intensive care unit

Application of the Nursing Process
1. a. The correct IV solution is hanging.
   b. The site is patent and the solution is infusing.
   c. The flow rate is that which is ordered.
   d. No complications are occurring.

2. a. The patient is not allergic to the medication.
   b. The medication is not incompatible with the fluid that is infusing.

3. Risk of infection related to invasive procedure

4. Deficient fluid volume will not occur.

5. a. 17 gtt/minute
   b. 31 gtt/minute
   c. 31–32 gtt/minute
   d. 21 gtt/minute
   e. 20 gtt/minute

6. a. The level of fluid remaining in the container
   b. The flow of the solution (that it is running)
   c. The rate of the flow of the solution
   d. The condition of the IV site

7. good skin turgor, moist mucous membranes, and adequate urine output

8. laboratory data indicating that the blood count has increased for the type of blood product infused

Review Questions for the NCLEX® Examination
1. 3
2. 2
3. 31
4. 3
5. 2
6. 1, 3, 4
7. 4
8. 3
Critical Thinking Activities
1. Pull the skin taut distal to the projected site. Use only a 5- to 15-degree angle to approach the vessel with the IV catheter. Use as small a gauge catheter as possible.
2. First, make certain the patient is not lying on the tubing. Next, raise the IV bag. Detach the tubing from the cannula and attempt to aspirate blood from the cannula. Reposition the cannula by rotating it slightly. Try aspirating again. If nothing works, discontinue the cannula and restart the IV at another site.
3. Attempt to aspirate blood. Untape the cannula and rotate it slightly to move the opening away from the vessel wall. Attempt to aspirate blood again. See if you can gently irrigate the cannula now. If not, discontinue the cannula and place a new one in a different location.

STEPS TOWARD BETTER COMMUNICATION

Completion

A.
1. piggyback
2. ascertain
3. discrepancy
4. rule of thumb
5. runaway

B.
1. rule of thumb, criss-crosses and chevrons, ascertain, discrepancies
2. mimicked, piggyback
3. runaway, taut

Grammar Points
1. The nurse observed the patient while checking the IV.
2. She checked the level of fluid remaining in the bag before disconnecting it.
3. The intravenous solution was leaking out of the bag when the patient pushed the call button.
4. Before making the subcutaneous pocket, the surgeon entered the subclavian vessel.

CHAPTER 37

Terminology

A. Matching
1. f
2. e
3. a
4. d
5. b
6. c
7. g
8. h

B. Completion
1. Collapse of the alveoli in the lungs restricting air flow.
2. Surgery to relieve symptoms rather than to cure.
3. Clot (thrombus) that breaks off and travels and lodges in a blood vessel. (Solid, liquid, or gaseous mass of undissolved matter present in a blood or lymphatic vessel.)
4. Extrusion of the viscera through the surgical incision resulting from wound dehiscence.
5. Loss of an extensive amount of blood, which may lead to shock; escape of blood from a ruptured vessel.
6. Inflammation and consolidation of the lung from retained secretions.
7. Inflammation and irritation due to entry of gastric or oropharyngeal food or fluids into tracheobronchial passages from dysfunction or absence of normal protective mechanisms.
8. Stoppage of flow or movement of blood or secretions.
9. Inflammation of a blood vessel from the irritation of a clot (thrombus) on the vessel wall.

C. Combining
1. colostomy
2. thoracotomy
3. cholecystectomy
4. orchiopexy
5. fibroma
6. mammoplasty

Short Answer
1. a. The preoperative checklist is used to ensure that appropriate records and imaging studies are in the OR.
   b. The surgical site is marked with the patient alert.
c. A “time-out” is called in the OR to verify that the correct patient, correct site, and correct body part is to be operated upon.

2. a. General—major surgical procedure such as a colon resection
   b. Regional—obstetrical procedures
   c. Conscious sedation—short procedures such as a dilatation and curettage or breast biopsy
   d. Local—minor surgical procedure such as skin cyst removal

3. Any five of the factors listed in Table 37-1.

4. Allow time for voicing concerns and fears, make adjustments for cultural beliefs, allow time for questions, explain what to expect preoperatively and postoperatively

5. a. Lasers and fiberoptics have allowed ability to operate through much smaller incisions.
   b. Operating microscopes and robotics have made surgical procedures more precise.

6. Check to see that the surgical consent form is signed, lab work is on the chart, patient has been NPO for allotted time, preoperative checklist is complete, allergies have been noted, patient is bathed and gowned for surgery, bladder is emptied, preoperative teaching is complete, and preoperative medications have been given.

7. Anxiety related to the surgical experience and outcome or Anxiety related to the threat to self-concept and threat of death
   Fear related to risk of death and loss of control due to anesthesia
   Deficient knowledge related to postoperative care
   Ineffective coping related to threat to self and multiple stressors

8. Anxiety will be reduced by voicing concerns. Fear will be reduced by speaking with anesthesiologist.
   Learning related to self-care will be obtained through postoperative teaching.

9. a. Patient is prepared physically and emotionally.
   b. Patient is able to demonstrate turning, deep-breathing, coughing, and leg exercises.
   c. Patient is able to verbalize understanding of the procedure and expectations for the postoperative period.
   d. Fluid and electrolyte balance will be maintained throughout the perioperative period.

10. Any three of the following:
    a. Sets up the sterile instruments and supplies.
    b. Counts sponges, needles, scalpel blades, and instruments with the circulating nurse.
    c. Gowns and gloves the surgeon.
    d. Hands instruments to the operating team.
    e. Anticipates needs of the operating team.
    f. Monitors use of sterile technique.

11. Any three of the following:
    a. Maintains the safety of the patient.
    b. Supervises activities of scrub person.
    c. Observes for breaks in sterile technique.
    d. Counts sponges, needles, scalp blades, and instruments with the scrub nurse.
    e. Records the events of surgery.
    f. Provides further instruments and supplies.
    g. Assists with gownsing and gloving of surgical team.
    h. Checks function of all equipment to be used.
    i. Makes certain equipment is properly grounded.
    j. Handles disposition of specimens, obtains blood from blood bank, and fetches IV solutions as needed.

12. Vital signs are stable and the patient is awake and able to respond to stimuli.

**Table Activity**

See Table 37-5. Any one of the signs or symptoms listed for each complication is acceptable.

**Short Answer**

1. Any five of the following:
   a. diet
   b. activity and rest
   c. wound care
   d. use of equipment
   e. signs and symptoms of complications to report
   f. when to see the doctor after discharge

2. written instructions

**Priority Setting**

1. 3
2. 1
3. 2
4. 5
5. 4
Application of the Nursing Process

1. Take vital signs, check the chest tube to be certain it is not kinked and that the suction is functioning, mark the amount of drainage in the chamber, check the oxygen setting, check the IV solution and flow rate, auscultate the lungs, assess level of consciousness, assess level of pain using a pain scale, check the Foley catheter and make certain the tubing is not crimped, note the amount of drainage in the bag, check all areas of the chest dressing and mark any drainage showing, check what pain medication—if any—was given in the PACU and when it was given, check what medications the patient received preoperatively and during surgery as well.

2. Impaired oxygen exchange related to partially collapsed lung and anesthesia
   Pain related to surgical procedure
   Activity intolerance related to tubes, pain, and anesthesia
   Risk for injury related to decreased level of awareness

3. Patient will have a normal oxygen saturation level on room air by postoperative day three. Pain will be controlled by oral analgesia by discharge. Patient will ambulate independently before discharge.

4. Assisting the patient to the chair safely and as painlessly as possible will require an assistant. Assistance will be needed from the nurse for ambulation. The nurse will need to attend to tubes and lines as the patient turns from side to side. Assistance with splinting the chest will be needed for effective coughing initially. Regular assessment of pain level should be done to keep pain under control so the patient will turn, cough, deep-breathe, and move around.

5. Turn, cough, deep-breathe (TCDB; assessment of chest drainage; assessment of urine flow; checking IV flow rate and IV site; checking the dressing; assessment for pain level; ambulation or sitting up in the chair)

6. Turn, cough, and deep-breathe q2h while awake. Splint chest incision while coughing. Monitor oxygen saturation level q2h. Auscultate lungs q shift. Oxygen via cannula at ____L/min. Monitor chest drainage and suction.

7. Lung sound status, oxygen saturation level, amount of chest drainage, result of last chest x-ray.

8. a. Oxygen saturation increased to 98%.
   b. Lungs sounds present in all fields of lungs.
   c. Chest drainage ceased.

Review Questions for the NCLEX® Examination

1. 1, 4, 5
2. 4
3. 3
4. 2
5. 2
6. 1, 3, 5
7. 3
8. 2
9. 1
10. 3 mL

Critical Thinking Activities

1. The correct order of priority would be:
   1. Check the physician’s orders.
   2. Check for a signed surgical consent form.
   3. Check that lab work is complete and on the chart.
   4. Have the patient shower.
   5. Check to see that preoperative medications ordered are available on the unit.
   6. Complete the preoperative checklist.
   7. Have the patient empty the bladder.
   8. Give the preoperative medications.
   9. Document the patient’s readiness for the OR.
   10. Transfer the patient to the OR.
   11. Prepare the unit for the postoperative return of the patient.

2. Possibilities include dehydration, loss of blood and decreased perfusion to the kidneys, hemorrhagic shock, kidney toxicity from anesthesia or drugs.

3. Continue to give the patient nothing but small ice chips that are allowed to melt in the mouth. Encourage ambulation, auscultate bowel sounds every 4 hours, ask patient to report the passing of any flatus.

STEPS TOWARD BETTER COMMUNICATION

Completion

1. allayed
2. sharps
3. groggy
4. grounded
5. prior

Communication Exercises
1. Example: “What concerns you most about undergoing anesthesia, Mr. Jones?”
   “The surgeon should be able to give you an idea of what you might be facing as soon as you wake up after surgery.”
   “Tell me more about your wife, Mr. Jones. Have you been married a very long time?”
   “We’ll help you learn to cope if you have to have a colostomy. We have specially trained nurses who can teach you all you need to know to care for yourself. It might be good to wait and see if you even need a colostomy before you start worrying about it.”
2. Example: “Mr. Stevens, it is time to get you ready for surgery. Here are the towels and special soap for your shower. Soap your chest and abdomen twice. I’ll be back in 15 minutes to give you the preoperative medications.”
   “Mr. Stevens, I have your preoperative medication. Would you please empty your bladder before I give it to you?”
   “OK, first state your name and then I need to check your armband to verify you are the right patient for these medications. Good, that’s correct. if you will turn on your side I will give you these two injections. You stated you are not allergic to any medications, is that correct? Here is the first injection. Now I will put the second one right here. That’s it, Mr. Stevens. You are all ready to go to surgery. These medications may make you a little groggy and I’m putting up the side rails as I don’t want you to get out of bed. The orderly will be here shortly to transport you to surgery. I’ll be back then.”
3. “Mr. Jones, you must stick to a soft diet for the next few days. Once your bowel movements are normal, you can slowly go back to your usual diet. I want you to continue to do your foot and leg exercises at least six times a day at home. You should get plenty of rest and just take it easy for the next week. Do not lift anything weighing more than 5 pounds. I want you to walk around the house today and then increase the distance and time you walk until you are walking around the block without any stiffness or problem. Take the antibiotics in this vial as the directions say. This vial is your pain medication and you may take it every 4–6 hours as you need for the discomfort. Remember to drink plenty of water as this medicine can make you constipated. Change the dressing every day. Wash your hands thoroughly and remove the dressing. Cleanse the area with the saline solution, pat it dry and apply new gauze pads. Tape it crosswise as it is now. Report any redness, new pain, fever, or other problems immediately to your surgeon. Call tomorrow to make your follow-up appointment with her.”

CHAPTER 38

Terminology

A. Completion
1. approximation
2. débridement
3. abscess
4. adhesion
5. exudate
6. collagen
7. infection
8. eschar
9. necrosis
10. fistula
11. phagocytosis
12. contracture
13. hematoma
14. Cellulitis
15. second intention
16. sanguineous
17. serosanguineous
18. sinus
19. purulent

B. Matching
1. f
2. g
3. c
4. a
5. i
6. e
7. d
8. b
9. h

Short Answer
1. a. Swelling or edema
   b. Erythema
   c. Heat
   d. Pain
   e. Loss of function
2. exposed organs, exposed blood vessels or nerves, and malignant (cancerous) tissue
3. Injury—fibrin formation—leukocytes remove debris—granulation tissue forms—connective tissue and capillaries become taut—scar formation

4. Any of the examples mentioned in the section on “Factors Affecting Wound Healing” are acceptable.
   a. Age—an 80-year-old with peripheral vascular disease
   b. Nutrition—the homeless person suffering from malnutrition
   c. Lifestyle—the pack-a-day smoker
   d. Medications—the asthmatic who is on prednisone (a steroid)
   e. Infection—the cancer chemotherapy patient who is immunocompromised
   f. Chronic illness—the diabetic patient, especially with poorly controlled blood glucose

5. A decline in immune function occurs, reduced liver function impairs synthesis of blood factors, decreased lung function reduces available oxygen needed for synthesis of collagen, skin becomes fragile and easily damaged, there may be chronic disease present

6. Fall in blood pressure; rapid, thready pulse; increased rate of respirations; restlessness; diaphoresis; and cold, clammy skin

7. A piece of wide, flat rubber tubing; provide an exit for blood and fluids that accumulate from the inflammatory process so that the wound may heal

8. a. redness, warmth, and pain
    b. purulent drainage
    c. fever
    d. increased WBCs

9. Place the patient supine, cover the area with large sterile dressings or towels soaked in normal saline, reassure the patient, notify the surgeon, and prepare the patient for a return to surgery

10. a. relieve pain
    b. reduce congestion
    c. reduce inflammation or swelling
    d. relieve muscle spasm
    e. provide comfort
    f. elevate body temperature

11. a heating pad, warm moist packs, heated gel pack, heat lamp, hot water bottle, Aquathermia pad

12. Decreasing cellular metabolism and numbing the area

13. Causing vasoconstriction and diminishing blood flow and fluid accumulation in the area

14. Attempting to create heat to bring up the temperature

15. Older adults may have decreased sensation in the affected part and can’t detect something that is too hot. The skin of older adults is much more fragile and may sustain a burn more easily.

Completion

1. Inflammation
2. Secondary
3. Tertiary
4. Contracture
5. *Staphylococcus aureus*
6. Asepsis; wound
7. Hydrocolloid, foam, or hydrogel
8. Compress it; close
9. Shiny
10. Moist
11. Montgomery straps
12. Growth factors; VAC

Application of the Nursing Process

1. Inspect the surgical wound for approximation of the edges; whether sutures/staples are intact; degree of redness; warmth of area; presence of swelling, drainage, or bleeding; and degree of pain in the area.

2. Inspect it visually, smell it, palpate the surrounding area. Measure its dimensions.

3. VAC involves applying a suction device to a special wound dressing to institute negative pressure at the wound site, drawing the edges together. VAC can be useful for treating wounds that are difficult to heal.

4. Analyze the patient’s temperature trend and check the blood count for WBC trend. Inquire how the patient is feeling.

5. Impaired tissue integrity related to traumatic loss of tissue (there is no NANDA nursing diagnosis for actual infection)

6. Answer may vary. Example: Wound will be free from infection within 7 days.


8. Appearance of wound that indicates absence of infection and growth of new tissue. Absence of redness, swelling, or pain in wound area. Absence of temperature elevation; normal WBC.
Review Questions for the NCLEX® Examination

1. 1
2. 4
3. 4
4. 1
5. 1, 2
6. 3
7. 4
8. 1, 2
9. 4
10. 3
11. 1
12. 3, 4
13. 2
14. 2
15. serosanguineous

Critical Thinking Activities

1. This ulcer is defined as unstageable. The eschar needs to be débrided either mechanically or enzymatically before staging and before healing will take place. Treat with physician-prescribed débriding agent and an absorbent dressing.

2. Sterile gloves, sterile dressings—4 x 4s, ABDs, sterile normal saline for cleansing the skin, sterile forceps, discard bag, tape, disposable clean gloves for removing the outer old dressing.

3. Apply a gel hot pack after checking the temperature to make certain it is not so hot it will burn. Could use moist hot packs—again check the temperature. For moist packs, cover with plastic to maintain heat longer. Use for 20 minutes 3–6 times a day.

STEPS TOWARD BETTER COMMUNICATION

Completion

1. hydrate
2. frayed
3. friable
4. cardinal
5. nonadherent
6. shearing forces
7. binder
8. hospital-acquired
9. numbing
10. cessation

Vocabulary Exercise

Examples: frayed = worn—My nerves are so frayed I yelled at her for nothing.

Binder = notebook—Put this paper in your binder, please.

Radiant = glowing—Her smile was radiant.

CHAPTER 39

Terminology

A. Matching

1. f
2. c
3. g
4. h
5. i
6. j
7. d
8. k
9. e
10. b
11. a

B. Completion

1. bivalve
2. quadriplegic
3. isometric
4. paraplegic
5. immobilization
6. spica
7. hemiparesis
8. hemiplegia
9. moleskin
10. trapeze bar
11. hypostatic pneumonia
12. gastrointestinal system complications

Short Answer

1. Prolonged immobility leads to a reduction in blood volume and limits the effectiveness of venous return. In addition, certain patient conditions (fracture, trauma, or debilitating illness) and treatments (casts, traction, or bed rest) can impair general circulation and blood flow to the affected areas of the body.

2. Inspect the skin distal to the injury; palpate the temperature of the skin, compare to the opposite extremity. Check movement distal to the injury, inquire about tingling or numbness, check sensation bilaterally; palpate pulses dis-
tal to the injury and compare bilaterally. Check capillary refill and inquire about the degree, location, and nature of pain.

3. Performing active or passive ROM exercises to maintain joint mobility and muscle integrity.

4. The cast should be supported by pillows with the extremity elevated above the level of the heart. The patient and cast should be turned periodically to promote even drying of the cast. Use the flat part of the palms to handle the cast when turning or repositioning.

5. Assume that the patient can hear you and treat him or her as a valuable person. Talk to the patient in a kind and caring voice. Explain what is being done before and as it is done, and apologize for any unavoidable pain the care may be causing. Talk to the patient about what is going on in the world. If cards or letters arrive, read them to the patient.

6. Blowing cool air under the cast with a can of electronic air cleaner may help decrease itching. Discomfort can sometimes be relieved by directing the air of a hair dryer set on “cool” into the cast. “Castblast” is a commercial product that delivers a soothing layer of talc under the cast.

7. a. Air-fluidized bed: has tiny silicone beads in an air-permeable filter sheet. Warmed air sets the particles in motion so that they act like a fluid, causing the patient to float. Prevents occlusion of blood vessels and shearing of tissues. The heat keeps the skin dry. Used for patients at high risk for skin breakdown.

b. Low air-loss bed: air is distributed through multiple cushions connected in a series to provide pressure relief for the patient. Eliminates shear and friction.

c. Continuous lateral-rotation bed: bed moves slowly from side to side, decreasing the respiratory complications of immobility and promoting normal urine flow. Reduces the risk for thrombosis. Reduces pressure on patient. Patient is wedged into the bed. May be used with spinal traction.

d. CircOlectric bed: Allows change of position of the patient while in bed by moving the bed around the arc of the circle. Often used for burn patients.

8. a. Foam and gel pads

b. Sheepskin pads

c. Pulsating air pads

d. Water mattresses

e. Heel or elbow protectors

9. (Any four of the principles/guidelines listed in the textbook.)

a. Elevate the limb and support it while applying the bandage.

b. Wrap from the distal to the proximal area.

c. Overlap turns of the bandage evenly.

d. Secure the end of the bandage.

e. Check color and sensation of the areas distal and proximal when finished and at frequent intervals.

f. Remove the bandage for bathing and assess the skin; rewrap at least twice a day.

10. Any of the following interventions:

a. Thrombus formation: encourage exercise; increase fluids; apply elastic stockings.

b. Atelectasis: have patient deep-breathe or use incentive spirometer.

c. Constipation: increase fluid intake and fiber intake; give stool softener.

d. Joint contracture: perform active or passive exercise; position joints in anatomical alignment, splinting as needed.

e. Renal stone: increase fluid intake to 3000 mL/day

f. Skin breakdown: reposition at least every 2 hours, pad bony prominences when positioning, keep clean and dry.

g. Boredom: encourage visitors at intervals; provide diversional games and books, TV, videogames, or use of computer.

11. Give frequent, small feedings and bedtime nourishment. Have family and friends bring in favorite foods. Encourage family or friends to visit and eat with the patient.

12. more active; immobilization

13. restore joint function

14. shearing

15. swinging free; good alignment

16. before it becomes severe

17. move freely in the pulleys

18. stability

19. elevated above heart level

20. brace

21. pressure; necrosis

22. uneven

23. immobilize a joint; reduce swelling; apply pressure

24. palms of the hands

25. spreader bar

26. unattended

27. weak; their balance

28. 15–30; hip

29. rest the body weight on the axillary bar

30. overall length; the axillary bar; handgrip
31. freedom of movement
32. paresthesia

Application of the Nursing Process
1. Determining if the weights are swinging free, the ropes are moving freely, the patient is in proper alignment and pulled up in the bed to provide countertraction. Are the pin insertion sites clean and dry? Does she need pain medication? Are her vital signs normal? Are there any signs of infection? Are there any signs of complications of immobility? Are the lungs clear? Is intake and output normal? Is the urine clear? Are bowel sounds present? Does the patient have any complaints?
2. Impaired physical mobility related to fractured leg in traction
3. Risk for injury related to pressure on nerves
4. Patient will not experience nerve damage while cast is present.
5. a. Coordinate visitors so they come at intervals rather than all at once.
   b. Have family bring in materials for activities she does at home such as knitting, cross-stitch, etc.
   c. Supply a jigsaw puzzle for her to work on.
6. Effectiveness of treatment is shown by x-ray that shows proper healing of the fracture with no evidence of infection. Normal temperature and normal WBC would be two parameters for evaluation.
7. a. Performing quadricep setting exercises to prepare muscles for walking.
   b. Working with PT on weight bearing in preparation for ambulation (after traction is discontinued).

Review Questions for the NCLEX® Examination
1. 1, 2
2. 3
3. 1
4. 1
5. 2, 4
6. 1, 2, 3, 4
7. 3
8. 2
9. 2, 3
10. 4
11. 2
12. pad bony prominences
13. 4
14. 2
15. 3

Critical Thinking Activities
1. Assess his interests and develop the program around them if possible. Plan some activities for fun and some that will make him use his brain.
2. Allow ventilation of feelings. Explain what you are doing each time you wrap the stump. Explain what will happen if the stump is not cared for properly and the pain that can occur.
3. Allow ventilation of feelings regarding loss of a body function and the change in body image. Explain what can happen if ambulation is attempted without the walker (fractures or head injury). Review the activities that can be performed independently using the walker.
4. Increase fluid and fiber intake. Perform active and passive range of motion exercises. Administer stool softeners.

STEPS TOWARD BETTER COMMUNICATION

Completion
1. diversionary
2. longitudinally
3. regress
4. disintegrate
5. gait
6. debilitating

Vocabulary Exercises
Individual answers will vary; Examples:
1. a. (Noun) Put the dirty clothes in the hamper.
   b. (Verb) An arm cast can hamper ability for self-care.
2. a. (Noun) The dictate is that no children are allowed.
   b. (Verb) She would like to dictate what I do.
3. a. (Noun) Exams cause me a lot of stress.
   b. (Verb) I can’t stress the importance of practice enough.

Communication Exercise
Each partner should ask the questions and then answer them when the other partner asks the questions.
CHAPTER 40

Terminology

A. Matching
1. g  2. f  3. b  4. e  5. h  6. d  7. i  8. a  9. c  10. j

B. Completion
1. hormone replacement therapy (HRT)  2. bladder retraining  3. over-the-counter  4. habit (timed) voiding  5. fecal impaction  6. walking speed (also known as gait velocity)

Short Answer
1. a. Impaired mobility  
b. Alteration in elimination  
c. Alteration in nutrition  
d. Sensory deficits  
e. Polypharmacy
2. Physically, incontinence can lead to constantly wet skin and skin breakdown. It contributes to the formation of pressure ulcers. Psychologically, it may cause embarrassment, social withdrawal, depression, and low self-esteem.
3. Any of the following:  
a. decreased risk of osteoporosis  
b. decreased muscle wasting  
c. decreased low back pain  
d. decreased incidence of diabetes  
e. improved ability to perform activities of daily living  
f. improved balance and walking endurance
4. a. Improper footwear  
b. Cluttered walkways  
c. Poor lighting  
d. Moving too quickly after arising
5. risk factors, targeted nursing interventions
6. a. assistive devices  
b. hip protectors  
c. personal alarms
7. a. They often have multiple health problems.  
b. They often see more than one physician.  
c. They often use more than one pharmacy.
   d. They sometimes are forgetful and repeat a dose of medicine.  
e. They do not metabolize and excrete drugs efficiently.
8. A chronic respiratory disorder may decrease lung capacity or oxygen diffusion and thereby reduce available oxygen in the blood. This in turn causes fatigue with activity and decreases mobility.
9. Decreased activity causes loss of muscle strength, decreased joint mobility, loss of bone mass, decreased balance and coordination, and thereby interferes with mobility.
10. Any of the factors in Health Promotion Points: Preventing Falls are acceptable. Individual priority will vary.
   a. Using nonslip mats underneath rugs.  
b. Wiping up spills immediately.  
c. Installing sturdy handrails for stairs and steps.  
d. Keeping light cords and telephone cords out of pathways.  
e. Using a night-light in bedroom, hall, and bathroom.
11. gait belt
12. Answers will vary and may include:
   a. gardening  
b. dancing  
c. home maintenance  
d. swimming
13. weight bearing; calcium and vitamin D
14. a fall; wheelchair
15. third
16. medication
17. climbing on a ladder; standing on a chair
18. safety hazards
19. above head
20. reason
21. increase fluid intake
22. fecal impaction
23. sugar; fat; roughage
24. Answers may include any of the following:
   a. Sit the patient upright or in a high Fowler’s position  
b. Feed small amounts to avoid aspiration.  
c. Thicken fluids if recommended by the swallowing evaluation.  
d. Have the person tuck the chin when swallowing.  
e. Assess the patient for adequate hydration.  
f. Maintain the patient upright for 45–60 minutes after eating.  
g. Provide a stress-free environment for eating.
25. a. decreased peripheral vision
   b. decreased night vision
   c. decreased depth perception
26. entering; leaving
27. rearranging
28. physicians
29. impacted cerumen
30. 45% to 65%

**Table Activity**

<table>
<thead>
<tr>
<th>Physical Care Problem</th>
<th>Contributing Factors</th>
</tr>
</thead>
</table>
| Impaired mobility             | Osteoporosis
|                               | Falls
|                               | Obesity
|                               | Arthritis
|                               | Cardiac or respiratory disease that limits activity
|                               | Neurologic disorder affecting mobility
|                               | Severe depression

| Alteration in elimination     | Nervous system disorder (stroke)
|                               | Immobility
|                               | Urinary tract infection
|                               | Insufficient fluid and fiber in diet
|                               | Poor abdominal muscle tone
|                               | Pain medications; other medications

| Alteration in nutrition       | Neurologic deficit (stroke)
|                               | Impaired vision
|                               | Impaired mobility
|                               | Activity intolerance
|                               | Anorexia
|                               | Lack of income
|                               | Lack of transportation
|                               | Alcohol abuse
|                               | Alzheimer’s disease
|                               | Anxiety or depression
|                               | Lack of kitchen facilities

| Sensory deficit—vision        | Lack of money for eye care
|                               | Arteriosclerosis; arthritis
|                               | Diabetes
|                               | Long-term corticosteroid use
|                               | Macular degeneration

| Sensory deficit—hearing       | Heredity
|                               | Ménière’s disease; labyrinthitis
|                               | Long-term exposure to loud noise

| Polypharmacy                  | Multiple chronic disorders
|                               | Impaired vision
|                               | Multiple physicians prescribing
|                               | Use of multiple pharmacies
|                               | Forgetfulness
|                               | Impaired judgment
|                               | Borrowing drugs from others
|                               | Miscommunication
|                               | Use of OTC medications

**Review Questions for the NCLEX® Examination**

1. 3
2. 2
3. 3
4. 2, 3, 4
5. mobility
6. 1
7. 3
8. 1, 2
9. 1, 3
10. 2
11. 3
12. 3
13. 1
14. urinary incontinence
15. 1
16. 2
17. 4
18. 4
19. 2
20. 1, 3, 4

**Critical Thinking Activities**

1. Assess the situation completely; i.e., shopping, food preparation, appetite, etc. Explore available meal resources; explore family’s ability to help. Assess patient’s ability to use a microwave oven. Assess freezer space. Enlist the help of the social worker.
2. Assess for all safety hazards that could cause fire or a fall.
3. Explore all aids available for a visually impaired person.
STEPS TOWARD BETTER COMMUNICATION

Completion

A.
1. address
2. imperative
3. cueing
4. clutter
5. enhance
6. engaged

B.
Coupled with the mud from the inclement weather we were having, cleaning up the clutter was quite a chore. Prudently, I addressed the problem by engaging help to clean up the odoriferous mess. The situation was enhanced by cueing my helper that it was imperative to finish early.

Communication Exercises

Answers will vary per individual. Each exercise should be practiced with a peer, paying close attention to each other’s pronunciation.

CHAPTER 41

Terminology

A. Matching
1. d
2. h
3. c
4. a
5. e
6. b
7. f
8. g

B. Completion
1. age-associated memory impairment
2. benign senescent forgetfulness
3. Confusion; dementia
4. Beers Criteria of Potentially Inappropriate Medications for the Elderly
5. psychosocial interventions and medication
6. validation

Identification
1. Delirium, depression
2. Delirium, dementia
3. Dementia
4. Delirium
5. Depression
6. Depression
7. Dementia
8. Dementia, delirium
9. Delirium, dementia
10. Depression, dementia
11. Dementia, depression
12. Depression
13. Delirium
14. Dementia

Short Answer
1. Any four of the items listed in Box 41-3.
2. Medication effects, a new environment, disease processes such as pneumonia or a urinary tract infection, fluid and electrolyte imbalance, or psychosocial stressors.
3. They are interrelated in that they have similar risk factors associated with multiple losses. Loss contributes to feelings of despair and hopelessness, leading to a distorted outlook wherein alcohol may seem a good solution to avoid the problems. Alcohol combined with depression may lead to suicide when defenses are down and coping mechanisms are impaired.
4. a. Elder abuse: explore conflicting explanation about older person’s condition.
b. Household theft: obtain and verify ID of all workers entering the home.
c. Mail theft: use direct deposit of social security funds.
d. White collar crime: do not give information to strangers on the phone.
e. Vehicular theft: lock vehicle doors and never leave the keys in the car.
5. a. Physical: using drugs to keep older person docile.
b. Psychological: threatening physical violence to control behavior.
c. Material: misuse of older person’s funds.
d. Neglect: not assisting with ADLs as needed or providing inadequate care.
6. Any two of the issues discussed in the text. Examples:
a. Adequate health care including the cost of prescriptions
b. Adequate public transportation to keep older people in their own homes without having to drive
7. First obtain a detailed and accurate medical history and perform a thorough physical examination. Then perform a mental status exam.
8. Patience; respond to questions
9. Functional limitations
10. a. Medication effects
    b. A new environment
    c. Disease process
    d. Fluid and electrolyte imbalance
    e. Psychosocial stressors
11. Dignity, independence, personality, and support system and complicate diagnosis and treatment of an illness
12. Impaired mental status, dehydration, fatigue, low lighting or increased shadows, and disruption in the internal body clock
13. Manage anxiety, agitation, hostility, paranoia, and depression
14. Dealing with grief over a long period of time and physical and mental exhaustion from providing care round-the-clock, 7 days a week
15. Day care and respite care
16. a. Preclinical AD: No obvious symptoms of memory loss or confusion, measurable biologic changes (biomarkers); specific biomarkers (yet to be named) may include brain imaging studies and protein in spinal fluid
    b. Mild cognitive impairment: Mild changes in memory, reasoning, and visual perception noticeable to person affected, friends, and family; capable of carrying out everyday activities
    c. Dementia: Memory impairment, behavioral symptoms, impaired ability to function in daily life
17. Art, music, and humor
18. All other types of nursing interventions have been tried and are unsuccessful
19. Trust
20. a. Observing for factors that trigger the behavior
    b. Diverting attention (focusing attention on one activity)
    c. Maintaining a regular activity program
21. A lifelong psychological pattern, an organic condition, or an adverse reaction to multiple drugs
22. Any of the strategies listed in Patient Teaching Box on p. 835. Examples:
    a. Serve one food at a time to decrease confusion.
    b. Remind patient to open mouth, chew, and swallow.
    c. Avoid hurrying the patient to eat.
23. Complaining of anorexia, sleep disturbance, lack of energy, and loss of interest and enjoyment in life
24. Develop trust; be consistent and reliable; do not make promises you cannot keep
25. Depression, insomnia, mental confusion, frequent falls, self-neglect, uncontrollable hypertension or diabetes, gastritis, or anemia
26. Giving positive feedback for desired behaviors and negative feedback for undesired behaviors
27. Distraction
28. Meticulous planning of personal affairs, giving away treasured possessions, sudden euphoria, or stated death wishes
29. Coma or death

### Table Activity

<table>
<thead>
<tr>
<th>Alzheimer Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alzheimer Disease</strong></td>
</tr>
<tr>
<td><strong>Cause</strong></td>
</tr>
<tr>
<td><strong>Signs and symptoms</strong></td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
</tr>
</tbody>
</table>
Review Questions for the NCLEX® Examination

1.  2
2.  1
3.  3
4.  3
5.  4
6.  infection
7.  1
8.  3
9.  2
10.  4
11.  1
12.  2, 3
13.  2
14.  3
15.  1, 3, 4
16.  3
17.  neglect
18.  MMSE, SPMSQE
19.  2
20.  3
21.  3
22.  1
23.  pet

Critical Thinking Activities

1. Intervention should include increasing social contact, activities that will increase her self-esteem (volunteering, etc.), increase physical activity, obtain social atmosphere for meals, possible attendance in a grief support group, antidepressant medication.

2. List the signs and symptoms of elder abuse. Approach will be individual but should begin with establishing a trusting, confidential relationship. The social worker should be consulted.

3. Individual answers; consider means for older people to obtain transportation for food and physician appointments as well as social activity. How could an inexpensive chore service be provided for seniors?

4. Provide a safe, consistent environment. Stick to routines, do not make changes if possible, make sure patient has a name tag, provide assistance as needed with ADLs, post clearly labeled signs.

STEPS TOWARD BETTER COMMUNICATION

Completion

1. unkempt
2. Advocacy
3. pose
4. condescending
5. implication

Communication Exercise

Dialogue will be individual.