STUDY GUIDE

MEDICAL-SURGICAL NURSING

Concepts for Clinical Judgment and Collaborative Care

11th EDITION

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Study Guide for Medical-Surgical Nursing

Concepts for Clinical Judgment and Collaborative Care

Eleventh Edition

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Preface

The *Study Guide for Medical-Surgical Nursing: Concepts for Clinical Judgment and Collaborative Care,* eleventh edition, is a companion publication for Ignatavicius, Rebar, and Heimgartner's *Medical-Surgical Nursing: Concepts for Clinical Judgment and Collaborative Care,* eleventh edition. This Study Guide, written by Donna Ignatavicius and Cherie Rebar, will help to ensure mastery of the textbook material and help you learn about collaborative practice in the care of the adult medical-surgical patient.

The eleventh edition has been carefully revised and updated for an increased emphasis on utilization of clinical judgment skills.

The overall organization of the *Study Guide for Medical-Surgical Nursing: Concepts for Clinical Judgment and Collaborative Care* directly corresponds to the unit/chapter name and number in the textbook so that you or your instructor can readily select the corresponding learning exercises in the Study Guide. Chapters contain:

- **Learning Outcomes** that mirror those in the textbook
- **Preliminary Reading** to help you focus on knowledge needed to complete the activities in the *Study Guide*
- **Chapter Review** activities geared to provide review of key information in the textbook; examples of activities included are matching terms, fill-in-the-blank phrases, "hot spot" identification on pictures, true and false, and short answer (and others!).
- **Learning Assessment** NCLEX-RN®–style questions that are designed to encourage prioritizing, use of clinical judgment, participation in interprofessional collaboration, and application of the steps of the nursing process. Questions have been created to emphasize the NCLEX-RN® priorities of safety, patient-centered care, and evidence-based practice.

Answers and rationales to the Study/Review Questions are provided for each chapter.

The *Study Guide for Medical-Surgical Nursing: Concepts for Clinical Judgment and Collaborative Care* is a practical tool to help you prepare for classroom examinations and standardized tests as well serve as a review for clinical practice. This improved format will help you review and apply medical-surgical content and help you prepare for the Next-Generation NCLEX® Examination.

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1 CHAPTER

Overview of Professional Nursing Concepts for Medical-Surgical Nursing

LEARNING OUTCOMES

1. Differentiate the six core Quality and Safety Education for Nurses (QSEN) competencies that professional nurses need to provide safe, coordinated patient-centered care.
2. Describe two examples of how nurses can promote effective teamwork and interprofessional collaboration.
3. Explain the relationship between evidence-based practice and clinical judgment.
4. Identify the nurse's role in systems thinking and the quality improvement process to ensure patient safety.
5. State three ways that informatics and technology are used in health care.
6. Explain why selected populations are at risk for health equity issues, including social determinants of health.
7. Identify the major ethics principles that help guide professional nursing practice.
8. Describe how to promote well-being to prevent moral distress in professional nursing practice.

Preliminary Reading

Read and review Chapter 1, pp. 1–20.

Chapter Review

Activity #1

Medical-surgical nurses practice in four "spheres" of health care delivery. Match each sphere in Column A with a health care setting in Column B where medical-surgical nurses may practice.

Sphere of Care (A)	Example of Health Care Setting (B)
___1. Disease prevention/promotion of health	A. Tertiary care center
___2. Chronic disease care	B. Long-term care facility
___3. Regenerative or restorative care	C. Ambulatory care clinic
___4. Hospice/palliative/supportive care	D. Rehabilitation facility

Activity #2

List three examples of common errors nurses make that can jeopardize patient safety.

1. _____

2. _____

3. _____

Activity #3

Match each professional nursing concept with its description/definition.

Professional Nursing Concept

____1. Patient-Centered Care
____2. Safety
____3. Teamwork and Collaboration
____4. Evidence-Based Practice
____5. Informatics
____6. Quality Improvement
____7. Clinical Judgment
____8. Health Equity
____9. Systems Thinking
___10. Ethics

Definition of Concept

A. The observed outcome of critical thinking and decision making
B. A theoretical and reflective domain of human knowledge that addresses issues and questions about morality in human choices, actions, character, and ends
C. The integration of the best current evidence and practices to make decisions about patient care
D. The ability to recognize differences in the resources and/or knowledge needed for individuals to fully participate in health care and achieve optimal outcomes
E. The process of accessing and using information and electronic technology to communicate, manage knowledge, prevent error, and support decision making
F. The ability to recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for the patient's preferences, values, and needs
G. The process in which indicators (data) are used to monitor care outcomes and develop solutions to change and improve care
H. The ability to recognize, understand, and synthesize the interactions and interdependencies in a set of components designed for a specific purpose
I. The ability to keep the patient and staff free from harm and minimize errors in care
J. The ability to function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision making to achieve quality patient care

Activity #4

List at least three issues that affect the health of veterans.

1. _____

2. _____

3. _____

Activity #5

Fill in the blank with one of the appropriate ethical principles that nurses use as a guide for nursing practice.

1. Patient _____ is also referred to as self-determination.

2. _____ emphasizes the importance of preventing harm and ensuring the patient's well-being.

3. _____ refers to the agreement that nurses will keep their obligations or promises to patients to follow through with care.

4. _____ is a principle in which the nurse is obligated to tell the truth to the best of his or her knowledge.

Activity #6

List at least four social determinants of health that can negatively impact health equity.

1. _____

2. _____

3. _____

4. _____

Learning Assessment

NCLEX Examination Challenge #1

The nurse requests analgesia from the primary health care provider for an alert and oriented client experiencing breakthrough cancer pain. Which ethical principle does this nursing action represent?

A. Veracity
B. Fidelity
C. Autonomy
D. Beneficence

NCLEX Examination Challenge #2

The nurse is working with a team to review the evidence about best practices to reduce falls among older clients in a long-term care facility. What is the best source of evidence to include in this review?

A. Facility policies and procedures
B. Research studies
C. Consultant's expert opinion
D. Facility data on the incidence of falls

NCLEX Examination Challenge #3

The nurse checks on an immobile client to determine if the client was turned by the assistive personnel to relieve sacral pressure. Which right of delegation is the nurse demonstrating?

A. Right communication
B. Right circumstance
C. Right supervision
D. Right task

2 CHAPTER

Clinical Judgment and Systems Thinking

LEARNING OUTCOMES

1. Discuss elements of critical thinking, clinical reasoning, and clinical judgment.
2. Identify cognitive skills within the National Council of State Boards of Nursing Clinical Judgment Measurement Model.
3. Differentiate environments of care and roles of health care providers within the health care system.
4. Describe the process of incorporating nursing knowledge into systems thinking.
5. Connect the importance of applying appropriate clinical judgment to systems thinking.

Preliminary Reading

Read and review Chapter 2, pp. 21–34.

Chapter Review

Activity #1

Fill in the blank from the Key Term bank below. Not all Key Terms will be used.

clinical judgment
clinical reasoning
critical thinking
Evidence-Based Practice
Informatics
Patient-Centered Care
Quality and Safety Education for Nurses (QSEN)
Quality Improvement (QI)
Safety
systems thinking
Teamwork and Collaboration

1. The use of _____ and _____ leads to _____, which is the observed outcome of these two underlying mental processes.
2. Which term refers the use of best evidence, the nurse's clinical expertise, and patient preferences? _____
3. The key way in which the interprofessional team functions is defined by the QSEN competency of _____.

4. Use of data, information, and technology to develop solutions to improve care based on data is reflected in the QSEN competencies of _____ and _____.
5. The nurse has undergone training at national nursing conference regarding interventions that prevent transmission of COVID-19. After the conference, the nurse returns to the hospital environment. When entering a patient's room, the nurse uses these interventions to prevent transmission of infection to a specific patient. This is an example of _____.

Activity #2

Match the Key Term with its components.

1.	Clinical judgment	A.	Use of logic and reasoning applied to clinical practice
2.	Critical thinking	B.	Observed outcome of critical thinking and decision making
3.	Informatics	C.	Understanding that the patient is in control of their care
4.	Quality Improvement	D.	Synthesis of patterns, interactions, and interdependencies
5.	Systems thinking	E.	Use of technology and information in planning care
6.	Patient-Centered Care	F.	Use of indictors to monitor outcomes and improve care

Activity #3

Match the factors that influence health equity and patient outcomes with their description.

Factors That Influence Health Equity/ Patient Outcomes	Description
Behavioral and social determinants of health	A. Use of new technologies to assess health risks and implement treatment plans based on personal factors
Evolving approaches to population health management	B. Involvement, coordination, and respect of all members of the health care team to provide competent, precise, and personalized care
Policy and health care reform	C. Evidence-based methods to reduce health inequities and improve health using methods of data collection and analysis
Available and emerging technologies	D. Recognition that health care maintenance, activities, and interventions do not occur in isolation and that a systems approach to prevention and care is more likely to have positive health outcomes than actions taken by a single provider
Interprofessional practice with an emphasis on patient-centered care	E. Viewpoint that health care is a right rather than a privilege and that individuals should be active participants in their own health choices and actions
Shift toward systems thinking	F. What "health" means to each person within the context of their culture and what actions they are willing or able to take to achieve or maintain it

Activity #4

Fill in the blank from the Nurse's documentation below to complete each sentence.

1. When documenting components of **Recognize Cues,** the nurse's documentation will say _____.
2. When documenting components of **Analyze Cues,** the nurse's documentation will say _____.
3. When documenting components of **Take Action,** the nurse's documentation will say _____.
4. When documenting components of **Evaluate Outcomes,** the nurse's documentation will say _____.

	Nurse's Documentation
A.	"Fever decreased from 103.4°F to 101.2°F (39.6°C to 38.4°C) in 2 hours post administration of acetaminophen."
B.	"Reports history of hypertension and type 2 diabetes in addition to today's symptoms of sore throat, fever of 103.4°F (39.6°C), and cough. Lung sounds with crackles bilaterally."
C.	"Was exposed to several people at a concert last week that now have tested positive for influenza B."
D.	"Placed in droplet isolation, administered acetaminophen as ordered. Diet order placed."

Learning Assessment

NCLEX Examination Challenge #1

Which barriers to successful implementation of community health care exist? **Select all that apply.**

A. Shortages in the workforce
B. Discrimination against people
C. Insurance coverage maximizes benefits
D. Insufficient personal finances for health care
E. Lack of understanding of social determinants of health

NCLEX Examination Challenge #2

Which individual is recognized as an advanced practice nurse (APRN)?

A. Registered nurse
B. Clinical nurse educator
C. Licensed practical nurse
D. Certified nurse practitioner

3 CHAPTER

Overview of Health Concepts for Medical-Surgical Nursing

LEARNING OUTCOMES

1. Plan collaborative interventions with the interprofessional team to help patients meet basic nutrition, elimination, and tissue integrity needs.
2. Plan nursing interventions to manage pain and promote comfort.
3. Assess risk factors that may result in altered sexuality.
4. Plan nursing interventions to promote cognition, mobility, and sensory perception and to maintain safety.
5. Differentiate the concepts of inflammation, immunity, and infection.
6. Describe common physiologic consequences when a patient has impaired acid-base balance and/or impaired fluid and electrolyte balance.
7. Describe how to determine a patient's perfusion, gas exchange, and clotting status.
8. Plan patient-centered nursing interventions to help patients meet selected physiologic health needs related to cellular regulation and glucose regulation.

Preliminary Reading

Read and review Chapter 3, pp. 35–57.

Chapter Review

Activity #1

The scope of the concept of cognition can be viewed as a continuum with adequate cognition on one end and severe cognitive impairment on the other as shown in the figure below:

Continuum of the Concept of Cognitive

<———————————————————————————————————————>

Adequate Cognition **Severe Impaired Cognition**

For each of these patients below, indicate their cognitive status on the continuum using the number of the patient scenario. Use your personal device to look up any information you don't know.

1. Older adult who has moderate-stage Alzheimer's disease and lives in an assisted living facility
2. Four-week-old full-term healthy newborn baby living at home with parents
3. Adolescent who was recently diagnosed with depression and anxiety and lives with grandparents
4. Middle-aged adult who had a severe hemorrhagic stroke and is unable to communicate
5. Young adult who experienced a severe traumatic brain injury from a motorcycle crash

Activity #2

List at least five complications (physiologic consequences) of impaired mobility or immobility.

1. _____

2. _____

3. _____

4. _____

5. _____

Activity #3

For inflammation in an extremity, best practice interventions include the use of **R-I-C-E**. Fill in the blank with what each of these interventions are.

R = _____
I = _____
C = _____
E = _____

Activity #4

List at least three factors that place individuals at risk for decreased immunity.

1. _____

2. _____

3. _____

Activity #5

Nurses assess and care for patients who have impaired gas exchange. State at least three physical assessment techniques that help to identify a patient's gas exchange status.

1. _____

2. _____

3. _____

Activity #6

Match the risk factor in Column A with the concept for which the risk factor is most associated in Column B.

Column A	**Column B**
___1. Immune compromise	A. Pain
___2. Food insecurity	B. Tissue integrity
___3. Osteoarthritis	C. Infection
___4. Diabetes mellitus	D. Nutrition
___5. Urinary incontinence	E. Perfusion

Learning Assessment

NCLEX Examination Challenge #1

1. The nurse is assessing a client for the risk for increased clotting. Which assessment findings may place the client at risk for this health problem? **Select all that apply.**
   A. Smoking
   B. Diabetes mellitus
   C. Immobility
   D. Advanced age
   E. Pressure injury

NCLEX Examination Challenge #2

The nurse is caring for a postoperative client recently diagnosed with impaired cognition. The client was alert and oriented before surgery. What condition would the nurse suspect as the cause of the client's impaired cognition?

A. Depression
B. Delirium
C. Dementia
D. Delusion

NCLEX Examination Challenge #3

The nurse assesses an older adult's sensory perception status. What normal physiologic change of aging would the nurse expect is related to sensory perception?

A. Presbycusis
B. Increased sense of smell
C. Numbness in feet
D. Minimal sense of taste

4 CHAPTER

Concepts of Care for Older Adults

LEARNING OUTCOMES

1. Describe evidence-based fall risk and prevention interventions for older adults that promote safety and maintain mobility.
2. Plan health teaching about lifestyle practices to promote health in older adults.
3. Discuss how to conduct a medication assessment for all older adults to ensure safety and quality care.
4. Identify social determinants of health that impact health equity within the older-adult population.
5. Differentiate the 3Ds of impaired cognition commonly associated with older adults.
6. Explain factors that contribute to decreased nutrition and elimination changes among older adults in the community and inpatient facilities.
7. Summarize the core elements of the 4Ms of an Age-Friendly Health System that help ensure patient-centered care for older adults in any setting.

Preliminary Reading

Read and review Chapter 4, pp. 58–74.

Chapter Review

Activity #1

During the COVID-19 pandemic, older adults, especially those residing in care facilities, experienced more hospitalizations and deaths than any other group. Within this population, older adults of color were affected more often than Whites because of many contributing factors, particularly social determinants of health (SDOH). List at least four SDOH experienced by older adults of color that help to explain these clinical outcomes when compared with other groups.

1. _____

2. _____

3. _____

4. _____

Activity #2

For each statement below, specify if the statement is **true (T)** or **false (F)**.

_____1. One of the benefits of maintaining physical activity for older adults is to improve their well-being and self-esteem.
_____2. Swimming is an appropriate exercise for older adults to help prevent osteoporosis (bone loss).
_____3. Medicare B pays for inpatient hospital care and skilled care for a limited time for qualifying older adults.
_____4. Older adults usually have more difficulty adapting to major changes when compared with younger and middle-aged adults.
_____5. The Beers criteria help determine the appropriateness of specific medications for older adults.
_____6. Family caregivers are the most frequent abusers of older adults because they feel burdened by the care they need to provide.
_____7. If a court determines that an older adult is not legally competent, a guardian is typically appointed to make health care decisions.
_____8. Depression is one of the most common mental health disorders experienced by older adults.
_____9. Older adults need to keep up to date with their immunizations, including a Tdap every 10 years.
_____10. Older adults need to increase their intake of fiber-containing foods and grain products.
_____11. The Timed Up and Go (TUG) test for older adults should take less than 18 seconds.
_____12. If a home care nurse suspects elder abuse or neglect, Adult Protective Services should be contacted.

Activity #3

Nurses need to assess the medication profile for older adults for whom they provide care. List at least three recommended interview questions related to the medication assessment.

1. _____

2. _____

3. _____

Activity #4

Match the glossary term below with its definition/description.

Glossary Term

___1. Dementia
___2. Neglect
___3. Delirium
___4. Geriatric syndrome
___5. Presbyopia
___6. Depression

Definition/Description of Glossary Terms

A. Farsightedness that worsens with aging
B. Failure of a caregiver to provide for a person's needs
C. Chronic, progressive, and global impairment of intellectual function
D. Major health issue associated with late adulthood
E. Mood disorder that has cognitive, affective, and physical manifestations
F. Acute, fluctuating cognitive disorder that can be hypo- or hyperalert

Activity #5

List the patient-centered elements of the 4Ms of an Age-Friendly Health System used in inpatient health care settings today.

1. _____

2. _____

3. _____

4. _____

Activity #6

List at least five of the eight evidence-based risk factors identified as essential to predicting falls.

1. _____

2. _____

3. _____

4. _____

5. _____

Learning Assessment

NCLEX Examination Challenge #1

The nurse is planning care for a hospitalized older adult who has a history of falls at home. Which nursing action is **most** important to help reduce falls for this client?

A. Inform the family that they need to take turns staying with the client.
B. Place the client in a reclining chair close to the nurses' station.
C. Identify current factors that increase the client's risk for falls.
D. Reorient the client each time when entering the client's room.

NCLEX Examination Challenge #2

The nurse is assessing medications being taken by an older adult who lives in the community. For which medication would the nurse contact the client's primary health care provider?

A. Lorazepam
B. Amlodipine
C. Simvastatin
D. Famotidine

NCLEX Examination Challenge #3

The nurse is assessing an older adult using the Confusion Assessment Method (CAM) and finds that the client meets the required criteria. Which condition would the client **most likely** have?

A. Depression
B. Dementia
C. Anxiety
D. Delirium

5 CHAPTER

Concepts of Care for Transgender and Nonbinary Patients

LEARNING OUTCOMES

1. Plan collaborative care with the interprofessional team to provide evidence-based care to transgender and nonbinary patients.
2. Explain the role of the nurse in providing high-quality care and improving health equity for transgender and nonbinary patients.
3. Discuss appropriate use of culturally sensitive terminology when providing care for transgender and nonbinary patients.
4. Identify major sources of stress that contribute to health issues experienced by transgender and nonbinary patients.
5. Prioritize evidence-based care for transgender and nonbinary patients who are taking hormone therapy and/or are having gender-affirming surgery.
6. Identify appropriate health care resources for transgender and nonbinary patients.

Preliminary Reading

Read and review Chapter 5, pp. 75–92.

Chapter Review

Terminology Review

#1. Match the Key Term in Column A with its definition in Column B.

Column A	Column B
____1. Cisgender	A. Distress caused by an incongruence between someone's sex assigned at birth and gender identity
____2. Gender dysphoria	B. Adjective used to describe persons who self-identify as the opposite gender or another gender
____3. Gender identity	C. Adjective used to describe people who have a chromosomal pattern, reproductive system, or sexual anatomy that does not fit the sex assigned at birth binary
____4. Genderfluid	D. Steps a person takes to bring congruence in their gender
____5. Intersex	E. Adjective used to describe people whose gender identity is in alignment with their sex assigned at birth
____6. MtF	F. Physical, emotional, romantic, or sexual attraction to another person
____7. Nonbinary	G. Adjective describing people whose gender changes dynamically rather than remaining static
____8. Sex	H. Person's genital anatomy present at birth
____9. Sexual orientation	I. A synonym for transwomen
___10. Transgender	J. Umbrella term for gender identities that are not male or female, that are between or beyond genders, or that are agender
___11. Transition	K. Person's inner sense of being male, female, neither, or an alternative gender

Review of Nursing Care for Transgender and Nonbinary Patients

#2. For each statement below, specify if the statement is **true (T)** or **false (F).**

____1. Nonbinary people have gender identities that are not exclusively male or female or that are between and beyond genders or they are without a gender.
____2. Gender identity is always related to reproductive anatomy.
____3. Transition is a process that must include surgical alteration of the patient's genitalia.
____4. The population of people who are transgender is extremely diverse.
____5. Gender is a social construct that helps people to explain the world around them.
____6. It is appropriate to ask patients which pronouns they use.
____7. Vaginoplasties are uncomplicated surgical procedures with few adverse effects.
____8. The patient using transdermal estrogen should remove one patch before applying another.
____9. Allow patients to identify the people who they consider to be part of their family.
___10. Monitor the patient taking spironolactone carefully for signs of hypertension.

Activities

Activity #1

List three ways that the nurse can provide a safe environment of care for a patient who is transgender or nonbinary.

1. _____

2. _____

3. _____

Activity #2

A MtF patient has just been prescribed the drugs listed. After the nurse has completed teaching, the client is asked to restate the purpose of these drugs. Which client statements indicate an understanding of these drugs?

1. Estrogen _____

_____

2. Spironolactone _____

_____

3. Cyproterone acetate _____

_____

4. Finasteride _____

_____

Activity #3

Match the surgical terminology in Column A with the procedure description in Column B.

Column A		Column B	
____1.	Labiaplasty	A.	Creation of a small penis
____2.	Penectomy	B.	Removal of the penis
____3.	Vaginoplasty	C.	Fatty tissue removal
____4.	Scrotectomy	D.	Creation of a small scrotum
____5.	Mammoplasty	E.	Urethra creation
____6.	Liposuction	F.	Vocal feminizing surgery
____7.	Reduction thyroid chondroplasty	G.	Creation of a vagina and surrounding parts
____8.	Scrotoplasty	H.	Removal of the testes
____9.	Ureteroplasty	I.	Removal of the vagina
___10.	Metoidioplasty	J.	Genital area contouring
___11.	Vaginectomy	K.	Creation of labia minora
___12.	Monsplasty	L.	Removal of scrotal tissue
___13.	Orchiectomy	M.	Changing appearance of breast tissue

Activity #4: Fill in the blank from the choices below to complete the sentence. Not all choices will be used.

Review the nurse's documentation below and assign a number to each phrase.

1. A client tells the nurse, "I recently transitioned from male to female."
   - o The nurse will document this information by recording, "client states they are _____, having recently transitioned from male to female."
2. The nurse has assessed a client who says, "I don't have a gender."
   - o When documenting the client's gender identity, the nurse will use the term _____.
3. The nurse is caring for a client who says, "Some days I feel very masculine and other days I feel more feminine."
   - o When documenting the client's gender identity, the nurse will use the word _____.
4. A client tells the nurse, "I was born with reproductive anatomy that has characteristics that are both male and female."
   - o The nurse will use the term _____ to document this information.
5. When taking a sexual history, a client reports having intercourse with people assigned male at birth and people assigned female at birth.
   - o The nurse will use the term _____ to document this information.

Word Bank	
A.	Agender
B.	Androgynous
C.	Asexual
D.	Bisexual
E.	Cisgender
F.	Genderfluid
G.	Genderqueer
H.	Intersex
I.	Nonbinary
J.	Transgender

Learning Assessment

NCLEX Examination Challenge #1

A client who is being seen at the primary health care provider's office tells the nurse, "My name is Shawn." When the client's health record shows "Mary" as the first name, which nursing response is appropriate?

A. "Hello, Shawn, it is nice to see you today."
B. "Mary, we need to bring your name up to date."
C. "I'm confused because your health record says your name is Mary."
D. "Why did you change your name from Mary to Shawn?"

NCLEX Examination Challenge #2

Which health teaching will the nurse include when caring for a FtM client who has had no surgical intervention? **Select all that apply.**

A. Schedule a prostate examination.
B. Routine Pap examinations are recommended.
C. Use condoms when having sexual intercourse.
D. Talk with your provider about having mammograms.
E. Oocyte freezing is available if you are interested in this option.

NCLEX Examination Challenge #3

The nurse is caring for a MtF client who has just had a vaginoplasty. Which action will the nurse take when the client returns to the floor from the postanesthesia care unit (PACU)? **Select all that apply.**

A. Begin daily dilation regimen.
B. Remove the urinary catheter.
C. Check capillary refill in extremities.
D. Monitor for the return of movement in the legs.
E. Assess the surgical dressing for bright red blood.

NCLEX Examination Challenge #4

When a client who is nonbinary asks if surgical procedures are available, which response will the nurse provide? **Select all that apply**.

A. "Why do you want to have surgery?"
B. "Nullifying surgery can be done to flatten the chest."
C. "There are no procedures available for nonbinary clients."
D. "Have you considered asking your provider about a phalloplasty?"
E. "Modified genital surgery is something you may wish to consider."

6 CHAPTER

Assessment and Concepts of Care for Patients with Pain

LEARNING OUTCOMES

1. Identify the role of the nurse as an advocate for patients with acute pain or persistent (chronic) pain.
2. Plan collaborative care with the interprofessional team to promote comfort in patients with pain.
3. Teach the patient and caregiver(s) about drug therapy and complementary and integrative therapies for pain management.
4. Plan patient- and family-centered nursing interventions to decrease the psychosocial impact caused by pain.
5. Use knowledge of anatomy and physiology to perform an evidence-based assessment for a patient with pain.
6. Organize care coordination and transition management for patients with pain.
7. Use clinical judgment to plan evidence-based nursing care to promote comfort and prevent complications in patients with pain.
8. Incorporate factors that affect health equity into the plan of care for patients with pain.

Preliminary Reading

Read and review Chapter 6, pp. 93–119.

Chapter Review

Activity #1

Define each type of pain.

1. Acute pain _____

_____

2. Breakthrough pain _____

_____

3. Nociceptive pain _____

_____

4. Persistent pain _____

_____

Activity #2

For each scenario, specify if the patient most likely has:

A. Acute pain
B. Breakthrough pain
C. Persistent pain

_____1. Patient with joint pain for 7 years related to rheumatoid arthritis
_____2. Patient who just fell in a ski accident and has a broken ankle
_____3. Patient with a new onset of severe back pain who has been taking oxycodone for chronic back pain
_____4. Patient who experienced a second-degree burn earlier this evening while cooking
_____5. Patient with ongoing pain for the past 6 months due to metastatic breast cancer
_____6. Patient with abdominal pain following bariatric surgery
_____7. Patient taking acetaminophen regularly for headaches who has a more severe headache this afternoon
_____8. Patient with the onset of chest pain radiating into their shoulder
_____9. Patient whose finger was bent backward playing basketball earlier today
____10. Patient with ongoing pain following an injury to their neck 9 months ago

Activity #3

Explain five ways in which you, as the nurse, can minimize bias when assessing the pain of your patients.

1. _____

2. _____

3. _____

4. _____

5. _____

Activity #4

For each scenario, specify how the nurse will document the type of pain the patient reports.

A. Localized
B. Projected
C. Referred
D. Radiating

_____ 1. Patient with a second-degree burn on the hand
_____ 2. Patient with shoulder pain following a laparoscopic hysterectomy
_____ 3. Patient with a broken ankle whose leg and foot also hurt
_____ 4. Patient with flank pain who also reports abdominal discomfort
_____ 5. Patient with a finger laceration following an accident with a kitchen knife
_____ 6. Patient who reports a tingling sensation from their back down their buttock into the leg
_____ 7. Patient with herpes zoster (“shingles”) rash on one side of the body

Activity #5

List 10 ways that unrelieved pain can affect a patient. Include physiological, quality-of-life, and financial impacts that may occur.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Activity #6

Explain how the nurse interprets findings according to the **Pasero Opioid-Induced Sedation Scale (POSS) with Interventions**. First, explain what the finding listed means, and then list appropriate interventions that match that finding. The first finding is done for you.

1. **S**
   a. Finding: *Sleep, easy to arouse* _____
   b. Interventions: _____
   _____
2. **1**
   a. Finding: _____
   b. Interventions: _____
   _____
3. **2**
   a. Finding: _____
   b. Interventions: _____
   _____
4. **3**
   a. Finding: _____
   b. Interventions: _____
   _____
5. **4**
   a. Finding: _____
   b. Interventions: _____
   _____

Learning Assessment

NCLEX Examination Challenge #1

The nurse is caring for a client with ongoing low back pain for 6 years who just underwent surgery for appendicitis. When the client reports continuing back pain and incisional pain, which kind of pain does the nurse document? **Select all that apply.**

A. Somatic
B. Visceral
C. Radiating
D. Nociceptive
E. Neuropathic

NCLEX Examination Challenge #2

The emergency nurse is caring for a client who fell 7 feet from a ladder and is reporting severe back and hip pain. The client has been seen repeatedly for unrelieved back pain over the past year and takes oxycodone regularly. Which nursing action is appropriate? **Select all that apply.**

A. Advocate for adequate pain control for the client.
B. Assume the client is reporting more pain than is truly experienced.
C. Ask the client to describe the pain and rate the intensity on a 0 to 10 scale.
D. Assess how the client's current pain is the same or different as existing pain.
E. Collaborate with the health care provider to convey that they client is overreacting to pain.

NCLEX Examination Challenge #3

The nurse is caring for a client residing in a skilled nursing facility who is nonverbal. Which action will the nurse take to assess for pain? **Select all that apply.**

A. Assume there is no pain unless the client cries or attempts to vocalize.
B. Use an evidence-based pain assessment tool when examining the client.
C. Review the electronic health record to assess for potential causes of pain.
D. Collaborate with other nursing staff who have recently cared for the client.
E. Observe trended client behaviors, looking for grimacing, moaning, or guarding.

7 CHAPTER

Concepts of Rehabilitation for Chronic and Disabling Health Conditions

LEARNING OUTCOMES

1. Plan collaborative care with the interprofessional rehabilitation team for patients with chronic and disabling health problems.
2. Explain how to use safe patient-handling practices based on current evidence to prevent self-injury.
3. Plan care coordination and transition management for patients with chronic and disabling health problems.
4. Teach patients with chronic and disabling health problems how to prevent complications associated with decreased mobility.
5. Plan patient and family-centered nursing interventions to decrease the psychosocial impact of living with a chronic and disabling health problem.
6. Interpret health assessment findings associated with conditions that require acute or long-term rehabilitation.
7. Use clinical judgment to plan nursing care to promote health and function in patients in rehabilitative care settings.
8. Incorporate factors that affect health equity into the plan of care for patients with chronic and disabling health problems.

Preliminary Reading

Read and review Chapter 7, pp. 120–139.

Chapter Review

Activity #1

Identify five conditions that can contribute to the need for rehabilitation care.

1. _____

2. _____

3. _____

4. _____

5. _____

Activity #2

For each statement, specify if the statement is **true (T)** or **false (F).**

___1. Cognitive therapists diagnose mental health/behavioral health disorders.
___2. Physical assessment data should be collected on residents at least daily.
___3. Acute confusion may be the only sign of a urinary tract infection in an older adult.

____4. Residents in wheelchairs should be repositioned at least every 1 to 2 hours.
____5. Pressure-reducing devices should only be used at the first sign of a pressure injury.
____6. Residents should be toileted every 4 hours during the day and every 6 to 8 hours at night.
____7. A person who needs mild support with ADLs is best served by being in a skilled nursing facility.
____8. The Valsalva and Credé maneuvers are used when a patient has bowel problems.
____9. Telehealth can be used to assist with care coordination in the home setting.
___10. Bisacodyl is only available in suppository form.

Activity #3

Briefly explain the role of each type of therapist who works in the rehabilitation setting.

1. Physical therapist _____

_____

2. Occupational therapist _____

_____

3. Recreational therapist _____

_____

4. Cognitive therapist _____

_____

Activity #4

Match the glossary term with its definition/description.

Glossary Term

___1. Aphasia
___2. Credé maneuver
___3. Dysphasia
___4. Paresis
___5. Physiatrist
___6. Rehabilitation assistant
___7. Rehabilitation therapists
___8. Resident

Definition/Description of Glossary Terms

A. Weakness
B. Slurred speech
C. Technique used to assist in urination
D. A person who assists the rehabilitation therapist
E. A physician who specializes in rehabilitative medicine
F. Person living in an inpatient facility with rights of anyone living in their home
G. Inability to use or comprehend spoken or written language because of brain injury or disease
H. Collective group of physical therapists, occupational therapists, and speech-language pathologists

Activity #5

List five rights a resident has while living in an assisted-living facility.

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

Activity #6

List 10 people who are part of the interprofessional health care team in a rehabilitation setting.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Learning Assessment

NCLEX Examination Challenge #1

The nurse is planning care for a client in a rehabilitation setting. To avoid patient constipation, which dietary choices will the nurse include in the plan of care? **Select all that apply.**

A. Apples
B. Green peas
C. Baked beans
D. Bran muffins
E. Whole grain bread

NCLEX Examination Challenge #2

The nurse is caring for a client in a rehabilitation setting who has a urinary tract infection with burning and urgency. Which drug does the nurse anticipate will be prescribed?

A. Oxybutynin
B. Solifenacin
C. Tolterodine
D. Trimethoprim

NCLEX Examination Challenge #3

The nurse is assessing a new resident in a rehabilitation setting. When the client's Functional Independence Measure (FIM) is 6, which action will the nurse take? **Select all that apply.**

A. Raise all bed rails at night to prevent falls.
B. Encourage dressing self as much as possible.
C. Assign assistive personnel (AP) to provide bathing.
D. Assure there is a clear path from the bed to bathroom.
E. Coordinate full-time care among nursing staff each shift.

8 CHAPTER

Concepts of Care for Patients at End-of-Life

LEARNING OUTCOMES

1. Collaborate within the interprofessional health care team to promote high-quality care for the patient at the end-of-life, including family or other caregivers.
2. Discuss the ethical and legal obligations of the nurse regarding end-of-life care.
3. Explain the purpose of and procedures for advance directives to patients and their families.
4. Assess the ability of the patient and family to cope with the dying process.
5. Incorporate the patient's cultural and spiritual practices and beliefs when providing care during the dying process and death.
6. Assess patients for signs and symptoms related to the end-of-life.
7. Plan evidence-based end-of-life nursing care for the dying patient.

Preliminary Reading

Read and review Chapter 8, pp. 140–155.

Chapter Review

Activity #1

Match the Key Term in Column A with its definition in Column B.

Column A	Column B
___1. Advance care planning	A. Process of reflecting on life's memories
___2. Advance directive (AD)	B. Care management approach to decrease patient suffering by administration of medications that lower consciousness
___3. Bereavement	C. Legal document in which a person has appointed another person to make health care decisions for them if incapacitated
___4. Do-not-resuscitate (DNR)	D. Compassionate and supportive approach to caring for patients and families living with life-threatening conditions
___5. Durable power of attorney for health care (DPOAHC)	E. Written document prepared by a competent person to specify which actions are to be taken or avoided if the patient cannot make personal decisions
___6. Living will	F. Legal document instructing health care providers and others about which life-sustaining treatment is wanted or is to be avoided if the patient cannot make decisions for themselves
___7. Palliative care	G. Grief and mourning of survivors before and after a death
___8. Palliative sedation	H. Process in which patients and families discuss end-of-life care
___9. Reminiscence	I. Order from physician or authorized health care provider instructing that CPR not be performed in the event of cardiac or respiratory arrest

Activity #2

For each statement below, specify if the statement is **true (T)** or **false (F)** regarding the nature of death of people living in the United States.

____1. Most deaths of patients occur suddenly and unexpectedly.
____2. Most people die after a long period of chronic illness.
____3. Most people die after the age of 65 years.
____4. The most common cause of death is heart disease.
____5. Medicare covers hospice care for recipients with a prognosis of 6 months or less to live.
____6. Cheyne-Stokes respirations are one symptom that death is near.
____7. The nurse must contact a spiritual representative to meet with each patient who is dying.
____8. Patient needs at the end-of-life can vary based on cultural and spiritual beliefs.
____9. Family members should be encouraged to refrain from saying "goodbye" when speaking with a dying loved one.
___10. Cannabinoid-based medications can be used in some states for end-of-life care.

Activity #3

List 10 signs and symptoms that may be noted or that a patient may experience when they are near death.

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

6. _____

7. _____

8. _____

9. _____

10. _____

Activity #4

Briefly explain the how the nurse intervenes to contribute to a patient's "good death."

_____

_____

_____

_____

_____

_____

Activity #5

Explain how each of the complementary and integrative interventions below can help with pain management of a patient who is dying.

1. Massage _____

   _____

2. Music therapy _____

   _____

3. Guided imagery _____

   _____

4. Aromatherapy/use of essential oils _____

   _____

Activity #6

List several ways in which hospice care differs from palliative care.

1. _____

2. _____

3. _____

Learning Assessment

NCLEX Examination Challenge #1

The hospice nurse is planning care for a client who has been given 3 months to live. Which intervention will the nurse include in the plan of care? **Select all that apply.**

A. Apply oxygen via nasal cannula if dyspnea occurs.
B. Involve family in the caring process if the client and family desire.
C. Discourage friends and family from using the terms "death" and "dying".
D. Withhold opioid drugs so the patient with pain does not develop tolerance.
E. Explain each nursing action to the client and family before they occur.

NCLEX Examination Challenge #2

The nurse is talking with a family member of a dying client who states, "I am afraid to say goodbye to my mother." Which nursing response is appropriate?

A. "Why do you think it is hard for you to say goodbye?"
B. "It is important that you say goodbye before your mother dies."
C. "Your mother may not die with peace unless she hears you say it."
D. "You can choose to express other thoughts, such as 'I love you.'"

NCLEX Examination Challenge #3

The nurse is preparing to assess the spirituality of a client who is dying. Which component will the nurse plan to consider? **Select all that apply.**

A. Client's sources of strength and hope
B. Whether the client subscribes to an organized religion
C. The degree to which religion (if any) is important to the client
D. Personal practices the client engages in that are personally meaningful
E. The effect of spirituality and religion on the client's end-of-life decisions

NCLEX Examination Challenge #4

The nurse has assessed a client who is dying. Which action will the nurse take when cool extremities that are mottled and cyanotic are noted?

A. Administer warmed IV fluids.
B. Place a warm blanket over the client.
C. Gently rub the client's extremities to stimulate circulation.
D. Reposition the client so that the lower extremities are dependent.

9 CHAPTER

Concepts of Care for Perioperative Patients

LEARNING OUTCOMES

1. Plan collaborative care with the interprofessional team to promote favorable outcomes in perioperative patients.
2. Teach the patient and caregiver(s) about preoperative preparations and how to decrease the risk for postoperative complications.
3. Plan patient- and family-centered nursing interventions to decrease the psychosocial impact of surgery.
4. Use clinical judgment to plan evidence-based nursing care to minimize pain, protect patients from injury and infection, and prevent complications of surgery during the postoperative phase.

Preliminary Reading

Read and review Chapter 9, pp. 156–193.

Chapter Review

Activity #1

Provide a brief definition of each of the following terms.

1. Autologous donation _____
2. Carboxyhemoglobin _____
3. Dehiscence _____
4. Evisceration _____
5. Malignant hyperthermia _____
6. Morbidity _____
7. Myoglobinuria _____

8. Perioperative _____

9. Pulse deficit _____

10. Sanguineous _____

11. Serosanguineous _____

12. Serous _____

Activity #2

For each statement, specify if the statement is **true (T)** or **false (F).**

____1. In the case of evisceration, use clean gloves to provide immediate care.
____2. The intranasal route of naloxone administration has the most rapid onset.
____3. Music and breathing exercises are examples of nonpharmacologic pain management.
____4. Acute cholecystitis is an example of surgery that needs to be performed urgently.
____5. Use of herbal preparations does not have an effect on surgical procedures or outcomes.
____6. A patient identified as ASA I under the American Society of Anesthesiologists Physical Status Classification System is a normal, healthy, nonsmoking person.
____7. Loss of lung elasticity and decreased cardiac output are age-related surgical risk factors.
____8. Following surgery with general anesthesia, the sense of pain is the first conscious function to return.
____9. Constipation is a common side effect of opioid drug therapy used to manage pain after surgery.
___10. Patients who do not want blood transfusions during surgery have no other options.

Activity #3

Place the steps in order that the nurse will take when caring for a client with respirations of 8 breaths/min and is suspected of experiencing a benzodiazepine overdose.

A. Apply oxygen.
B. Obtain IV access.
C. Administer flumazenil.
D. Assess IV site every shift.
E. Repeat administration of flumazenil.
F. Do not leave the client unattended until fully responsive.

Order: _____

Activity #4

Identify which phase the nursing actions below are most likely to occur within.

Phase
A. Preoperative
B. Postoperative
C. Both preoperative and postoperative

___1. Determine if bloodless surgery is preferred.
___2. Assess respiratory effort, rate, rhythm, and depth.
___3. Ask if there is a personal or family history of malignant hyperthermia.
___4. Determine if feeling has returned as anesthesia clears the body.

____5. Apply antiembolism stockings.
____6. Collect vital signs.
____7. Continually monitor pulse oximetry.
____8. Assess for sanguineous, serosanguineous, or serous drainage.
____9. Provide teaching about how to care for self at home.
___10. Teach and encourage deep breathing exercises.

Activity #5

Identify things the nurse will assess for when collecting a health history and performing a general review of systems.

1. General (constitutional)_____

_____

2. Eyes _____

_____

3. Ears, nose, mouth, and throat_____

_____

4. Cardiovascular_____

_____

5. Respiratory _____

_____

6. Gastrointestinal_____

_____

7. Genitourinary_____

_____

8. Musculoskeletal_____

_____

9. Integumentary (including skin and breasts) _____

_____

10. Neurologic_____

_____

11. Psychiatric_____

_____

12. Endocrine_____

_____

13. Hematologic and lymphatic_____

_____

14. Allergic and immunologic_____

_____

Activity #6

Match the purpose of surgery in Column A with the most likely example of this type of procedure in Column B.

Column A	Column B
___1. Cosmetic	A. Total hip replacement
___2. Curative	B. Facelift
___3. Diagnostic	C. Knee arthroscopy
___4. Palliative	D. Prophylactic mastectomy
___5. Preventive	E. Removal of malignant tumor on lung
___6. Reconstructive	F. Pancreas transplant
___7. Transplantation	G. Stent placement following vessel blockage

Learning Assessment

NCLEX Examination Challenge #1

A client with Crohn's disease who will have a colectomy is having which type of surgical procedure?

A. Curative
B. Diagnostic
C. Preventative (preventive)
D. Transplantation

NCLEX Examination Challenge #2

Which statement describes the role of the nurse in the process of a client's informed consent for surgery?

A. The nurse provides the client with the benefits and risks associated with surgery.
B. The nurse serves as witness that the surgeon fully informed the client before surgery.
C. The nurse collects informed consent after the surgical procedure has been successful.
D. The nurse's only duty is to ensure that signed informed consent is in the health record.

NCLEX Examination Challenge #3

The caregiver of a usually healthy 77-year-old client who had a knee replacement this morning states that they are concerned. The client knows the caregiver's name and that they have had surgery but does not know the day or time. Which nursing response is appropriate?

A. Notify the surgeon and request a consultation with a geriatrician.
B. Go to the client's bedside and perform a full mental status assessment.
C. Explain that drugs and anesthesia used in surgery take time to exit the body.
D. Ask the caregiver if there is a family history of dementia or Alzheimer's disease.

NCLEX Examination Challenge #4

How will the nurse interpret laboratory results of a postoperative client when an increase in band cells is noted?

A. It is likely that infection is present.
B. This result is normal following surgery.
C. Anemia is present, so a transfusion may be needed.
D. Clotting factors are impaired, so the risk for bleeding increases.

10 CHAPTER

Concepts of Emergency and Trauma Nursing

LEARNING OUTCOMES

1. Describe the emergency department (ED) environment, including vulnerable populations served.
2. Engage in teamwork and collaboration with interprofessional team members to maintain staff and patient safety.
3. Explain selected core competencies required of ED nurses.
4. Prioritize order of ED care delivery via triage and assessment of the injured patient.
5. Implement nursing interventions to support survivors after the death of a loved one.
6. Describe the expected sequence of events from admission through disposition of a patient treated in the ED with trauma or emergent needs.

Preliminary Reading

Read and review Chapter 10, pp. 194–212.

Chapter Review

Activity #1

Match the Key Term in Column A with its definition in Column B.

Column A		Column B	
____1.	Acceleration-deceleration	A.	Category of patients who can wait several hours
____2.	Blast effect	B.	Comprehensive head-to-toe assessment
____3.	Blunt trauma	C.	Force involving rapid movement forward then backward
____4.	Mechanism of injury	D.	Type of trauma resulting from explosive force
____5.	Nonurgent triage	E.	Category of patients who need treatment quickly
____6.	Penetrating trauma	F.	System used to sort or classify patients for care
____7.	Primary survey	G.	Priorities of care based on the *ABCDE* mnemonic
____8.	Secondary survey	H.	Injuries caused by piercing
____9.	Triage	I.	Method by which a traumatic event occurred
___10.	Urgent triage	J.	Type of trauma resulting from impact forces

Activity #2

For each statement below, specify if the statement is **true (T)** or **false (F)** regarding emergency care in the United States.

___1. Older adults are considered a vulnerable population.
___2. Contact precautions are required when caring for all patients.
___3. A sexual assault nurse examiner is a type of forensic nurse.
___4. Emergency medical technicians (EMTs) are a type of prehospital care provider.

_____5. SBAR communication is only used if a patient has a life-threatening condition.
_____6. Family members are preferred translators instead of telephone language lines.
_____7. A patient who fell ice skating and has a suspected arm fracture is triaged as urgent.
_____8. Skin is not cleaned on a patient whose death is under forensic investigation if it could damage evidence.
_____9. Trauma nursing encompasses a continuum of care from prevention to reintegration.
____10. Practicing trauma-informed care is a method of ensuring patient safety.

Activity #3

List ways the nurse can intervene when receiving a patient in the ED who is unconscious and cannot provide their identity or a health history.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Activity #4

Identify which trauma center is most likely represented by the descriptions here.

Trauma Center Level
Level I
Level II
Level III
Level IV

_____1. Focuses on initial injury stabilization and transfer if necessary
_____2. Provides total collaborative care to a dense population
_____3. Offers life support care in a rural area where other access is unavailable
_____4. Meets needs of most patients, excluding complex or multisystem injury management

Activity #5

A family arrives and wants to see the body of a client who died in the ED following a motor vehicle crash in which no forensic investigation is required. Describe specific actions the nurse will take before the family enters the room.

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

Activity #6

List signs associated with human trafficking that require the nurse to assess further.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Learning Assessment

NCLEX Examination Challenge #1

In which situation would the triage ED nurse, who is working alone, activate the panic button? **Select all that apply.**

A. The line for clients waiting to be triaged becomes overwhelmingly long.
B. A hospital overhead announcement says someone has abducted an infant.
C. A person walks in and starts threatening the registration staff with a weapon.
D. Emergency medical services call on their way to the ED with a client in full arrest.
E. Several clients who have been in the waiting room for a long time begin to complain.

NCLEX Examination Challenge #2

Which statement would the nurse use **first** when giving a hand-off report to the next shift nurse using the SBAR method?

A. "You will need to contact the hospitalist on call for admission."
B. "The client is a 65-year-old who came to the ED for a severe headache."
C. "Vital signs are T 98.6°F (37°C), HR 98 beats/min, RR 22 breaths/min, BP 190/100 mm Hg."
D. "Medical history includes hypertension; the client stopped taking medications 3 months ago."

NCLEX Examination Challenge #3

Five clients enter the emergency department at 0600. Which client will the triage nurse classify as emergent? **Select all that apply.**

A. Client from a long-term care facility with ongoing dysuria
B. Client with potential internal injuries following a motor vehicle crash
C. Client with a dislocated shoulder sustained while playing football
D. Client with back pain and hematuria with a history of kidney stones
E. Client with a generalized skin rash who had shellfish for breakfast two days ago

11 CHAPTER

Concepts of Care for Patients with Common Environmental Emergencies

LEARNING OUTCOMES

1. Plan collaborative care with the interprofessional team to promote perfusion and tissue integrity in patients with environmental emergencies.
2. Teach adults how to decrease the risk for exposure to environmental emergencies.
3. Apply knowledge of anatomy, physiology, and pathophysiology to provide evidence-based care for patients with an environmental emergency affecting perfusion, tissue integrity, and pain.
4. Analyze assessment and diagnostic findings to generate solutions and to prioritize nursing care for patients with an environmental emergency.
5. Organize care coordination and transition management for patients with environmental emergencies.
6. Use clinical judgment to plan evidence-based nursing care to promote perfusion, tissue integrity, and pain management and to prevent complications in patients with environmental emergencies.
7. Describe the expected sequence of events from first aid and prehospital interventions through disposition of a patient following an environmental emergency.

Preliminary Reading

Read and review Chapter 11, pp. 213–230.

Chapter Review

Activity #1

Match the Key Term in Column A with its definition in Column B.

Column A		Column B	
____1.	Acclimatization	A.	Global phenomenon resulting from burning of fossil fuels
____2.	Climate action	B.	Medical emergency from failure of heat regulatory mechanisms
____3.	Climate change	C.	Process of adapting top high altitude
____4.	Frostbite	D.	Decreased arterial carbon dioxide levels
____5.	Frostnip	E.	Breakdown of muscle tissue
____6.	Heat stroke	F.	Marks that appear on the skin after a lightning strike
____7.	Hyperemia	G.	Increased blood flow to an area
____8.	Hypocapnia	H.	Cold injury that is a form of superficial frostbite
____9.	Lichtenberg figures	I.	Taking active measures to mitigate and adapt to circumstances that are a result of climate change
___10.	Rhabdomyolysis	J.	Cold injury in which tissues freezes

Activity #2

For each statement, specify if the statement is **true (T)** or **false (F).**

____1. Air and water quality can create or contribute to health concerns.
____2. Nonexertional heat stroke occurs suddenly with exposure to a hot environment.
____3. Bites from deer ticks can result in Lyme disease.
____4. A patient who is struck by lightning is electrically charged following the injury.
____5. Core rewarming for patients with moderate hypothermia includes warm IV fluids.
____6. Patients diagnosed with frostnip are likely to lose the body part that is affected.
____7. Acute mountain sickness may be accompanied by high-altitude cerebral edema.
____8. Pulmonary edema can result from aspiration of fresh or salt water.
____9. After rescue, any patient who has drowned should undergo spine stabilization.
___10. Bee stings can result in anaphylaxis or in localized skin reactions.

Activity #3

List important teaching points the nurse will include when providing education to a community group about avoiding lightning injuries.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

Activity #4

Identify which organism is most likely represented by the descriptions.

Organism
A. Pit viper
B. Coral snake
C. Brown recluse spider
D. Black widow spider
E. Scorpion
F. Honeybee

____1. Retractable curved fangs
____2. Fiddle-shaped mark from eyes down the back
____3. Red hourglass pattern on torso of shiny black body
____4. Pattern of red bands that touch white or yellow bands
____5. Small, fixed maxillary fangs

____6. Stinger on the tail that falls off after stinging
____7. Triangular head
____8. Single row of subcaudal scales
____9. Stinger must be removed by tweezers
___10. Injects venom from a stinging apparatus on the tail; effects are neurotoxic

Activity #5

List appropriate actions for the nurse to take when a client with heat stroke has been admitted to the ED.

1. _____

2. _____

3. _____

4. _____

5. _____

Activity #6

Explain *planetary health* and why the nurse must understand this concept.

_____

_____

_____

_____

_____

_____

Learning Assessment

NCLEX Examination Challenge #1

Which task will the nurse assign to AP when the ED team is preparing for the arrival of a client who is a drowning victim?

A. Insert a nasogastric tube and attach to suction.
B. Take, report, and record vital signs every 15 minutes.
C. Advise the victim's family of the resuscitation status.
D. Assist with the bag-valve-mask device during intubation.

NCLEX Examination Challenge #2

Which nursing action is appropriate when providing care for a client with white, waxy skin on the nose, cheeks, and ears?

A. Administer warmed IV fluids.
B. Massage the body parts briskly.
C. Place warm hands over the affected areas.
D. Apply cool water compresses to the waxy areas.

NCLEX Examination Challenge #3

The telehealth nurse receives a call from a client who reports being stung by a bee. Which statement prompts the nurse to refer the client to call 911 right away?

A. "I was stung multiple times by a swarm of bees."
B. "I'm a little bit anxious, but I am not short of breath."
C. "The site where I was stung is red, swollen, and painful."
D. "The last two times I was stung, my provider gave me cortisone cream."