**Chapter 37: Stress and Coping**

**Adventitious crises** – major natural disaster or crime of violence

**Alarm stage** – CNS aroused

**Allostasis** – The concept that the body will attempt to return to a state of balance.

**Allostatic load** – Chronic activation of hormones causes wear and tear on bodily organs

**Appraisal** – how a person interprets the impact of the stressor. A personal evaluation of the meaning of the event to what is happening and a consideration of the resources on hand to help manage the stressor.

**Burnout** – occurs as a result of chronic stress.

**Compassion fatigue** – term used to describe a state of burnout and secondary traumatic stress. Secondary traumatic stress is the stress that health care providers experience when witnessing and care for others who are suffering.

**Coping** – a person’s cognitive and behavioral efforts to manage a stressor

**Crisis** – implies a person is facing a turning point in life.

1. Developmental – occurs as a person moves through different stages of their life.
2. Situational – external. Job change, MVC, severe illness
3. Adventitious – major natural disaster, crime of violence

**Crisis intervention** – specific type of psychotherapy and has two specific goals

1. Patient Safety – use external controls to protect the PT and others if the PT is suicidal or homicidal.
2. Anxiety reduction using techniques that put a patient’s inner resources into effect.

**Developmental crises** – occurs as a person moves through the different stages of their life. i.e., marriage, or birth of a child

**Ego-defense mechanisms** – regulates emotional distress and thus give a person protection from a stressful event.

**Exhaustion stage** – continuous stress causes progressive breakdown of compensatory mechanisms.

**Fight-or-flight response** – body defenses are mobilized

1. Increased blood volume
2. Increased blood glucose levels
3. Increased epinephrine and norepinephrine
4. Increased heart rate
5. Increased blood flow to muscles
6. Increased O2 intake
7. Increased mental alertness

**Flashbacks** – recurrent and intrusive recollections of the event.

**General adaptation syndrome (GAS)** – a three stage set of physiological processes that prepare, or adapt, the body for danger so that the individual is more likely to survive when faced with a threat.

1. Initial Alarm
2. Resistance as a person attempts to compensate for changes induced by the alarm
3. State of exhaustion if the person cannot adapt successfully during the stage of resistance or if stress remains unrelieved.

**Mindfulness** – moment to moment present awareness with an attitude on nonjudgement, acceptance, and openness. Focus on attentiveness on regular activities and truly enjoying pleasant experiences.

**Post-traumatic stress disorder (PTSD)** – begins when a person experiences or witness a traumatic event and responds with intense fear or helplessness.

**Primary appraisal** – evaluating an event in terms of personal meaning

**Resistance stage** – contributes to the fight or flight response, and the body stabilizes, and responds in an attempt to compensate for the changes induced by the alarm stage.

1. Hormone levels, heart rate, blood pressure and cardiac output return to normal
2. The body tries to repair any damage

**Secondary appraisal** – the process by which a person considers possible available coping strategies or resources.

**Situational crises** – external. Job change, MVC, severe illness.

**Stress** – an actual or alleged hazard to the balance of homeostasis.

**Stressors** - Physical, chemical, or emotional factor that produces tension in the body or the mind.

**Trauma** – When symptoms of stress persist beyond the duration of the stressor, a person experiences a trauma.

**Review Questions**

**1. The nurse is interviewing a patient in the community clinic and gathers the following information about her: she is intermittently homeless, a single parent with two children who have developmental delays. She has had asthma since she was a teenager. She does not laugh or smile, does not volunteer any information, and at times appears close to tears. She has no support system and does not work. She is experiencing an allostatic load. As a result, which of the following would be present during complete patient assessment? (Select all that apply.)**

1. Post-traumatic stress disorder

2. Rising hormone levels

3. Chronic illness

4. Insomnia

5. Depression

**2. A patient who is having difficulty managing his diabetes mellitus responds to the news that his hemoglobin A1c, a measure of blood sugar control over the past 90 days, has increased by saying, “The hemoglobin A1c is wrong. My blood sugar levels have been excellent for the last 6 months.” Which defense mechanism is the patient using?**

1. Denial

2. Conversion

3. Dissociation

4. Displacement

**3. When assessing a young woman who was a victim of a home invasion 3 months earlier, the nurse learns that the woman has vivid images of the event whenever she hears loud yelling or a sudden noise. The nurse recognizes this as** \_\_\_\_\_\_\_\_\_\_\_\_.

**4. While assessing an older woman who is recently widowed, the nurse suspects that this woman is experiencing a developmental crisis. Which questions provide information about the impact of this crisis? (Select all that apply.)**

1. With whom do you talk on a routine basis?

2. What do you do when you feel lonely?

3. Tell me what your husband was like.

4. I know this must be hard for you. Let me tell you what might help.

5. Have you experienced any changes in lifestyle habits, such as sleeping, eating, smoking, or drinking?

**5. The nurse plans care for a 16-year-old male, taking into consideration that stressors experienced most commonly by adolescents include which of the following? (Select all that apply.)**

1. Loss of autonomy caused by health problems

2. Physical appearance and body image

3. Accepting one’s personal identity

4. Separation from family

5. Taking tests in school

**6. A 10-year-old girl was playing on a slide at a playground during a summer camp. She fell and broke her arm. The camp notified the parents and took the child to the emergency department according to the camp protocol for injuries. The parents arrive at the emergency department and are stressed and frantic. The 10-year-old is happy in the treatment room, eating a Popsicle and picking out the color of her cast. List in order of priority what the nurse should say to the parents.**

1. “Can I contact someone to help you?”

2. “Your daughter is happy in the treatment room, eating a Popsicle and picking out the color of her cast.”

3. “I’ll have the doctor come out and talk to you as soon as possible.”

4. “I want to be sure you are ok. Let’s talk about what your concerns are about your daughter before we go see her.”

**7. When assessing an older adult who is showing symptoms of anxiety, insomnia, anorexia, and mild confusion, what is the first assessment the nurse conducts?**

1. The amount of family support

2. A 3-day diet recall

3. A thorough physical assessment

4. Threats to safety in her home

**8. A 34-year-old single father who is anxious, tearful, and tired from caring for his three young children tells the nurse that he feels depressed and doesn’t see how he can go on much longer. Which statement would be the nurse’s best response?**

1. “Are you thinking of suicide?”

2. “You’ve been doing a good job raising your children. You can do it!”

3. “Is there someone who can help you during the evenings and weekends?”

4. “Tell me what you mean when you say you can’t go on any longer.”

**9. The nurse is evaluating how well a patient newly diagnosed with multiple sclerosis and psychomotor impairment is coping. Which statements indicate that the patient is beginning to cope with the diagnosis? (Select all that apply.)**

1. “I’m going to learn to drive a car, so I can be more independent.”

2. “My sister says she feels better when she goes shopping, so I’ll go shopping.”

3. “I’m going to let the occupational therapist assess my home to improve efficiency.”

4. “I’ve always felt better when I go for a long walk. I’ll do that when I get home.”

5. “I’m going to attend a support group to learn more about multiple sclerosis.”

**10. A crisis intervention nurse is working with a mother whose child with Down syndrome has been hospitalized with pneumonia and who has lost her child’s disability payment while the child is hospitalized. The mother worries that her daughter will fall behind in her classes during hospitalization. Which strategies are effective in helping this mother cope with these stressors? (Select all that apply.)**

1. Referral to social service process reestablishing the child’s disability payment

2. Sending the child home in 72 hours and having the child return to school

3. Coordinating hospital-based and home-based schooling with the child’s teacher

4. Teaching the mother signs and symptoms of a respiratory tract infection

5. Telling the mother that the stress will decrease in 6 weeks when everything is back to normal

Answers:1.3, 4, 5; 2.1; 3. Post-traumatic stress disorder (PTSD); 4.1, 2, 5; 5.2, 3, 4, 5; 6.2, 4, 3, 1; 7.3; 8.4; 9.3, 5; 10.1, 3, 4.

**ATI Chapter 33 – page 183**

\*Coping describes how an individual deals with problems (illness or stress). Their behavioral and cognitive response to stress. Ability to cope is influenced by number of stressors, support system, and past experiences.

\*Ego defense mechanism regulate emotional distress while stressed.

\*Stress is a person’s response to stressors

 1. situational: job change or MVC

 2. developmental: changes as the person grows from one stage to another: having a baby or getting married or parents dieing.

\*Stress weakens the immune system

\*General Adaption Syndrome – Stress Syndrome

 1. Alarm stage – fight or flight. Hormones released.

 2. Resistance Stage – the body attempts to get back to homeostasis

 3. Exhaustion Stage – body can no longer keep up fight or flight or adapt to stressor.

**Flashcards**

**1. What are some of the symptoms that a client might experience if coping is a problem? PG. 767**

Sleep disturbance, difficulty falling asleep, excessive sleeping, fatigue, inappropriate laughing or crying, poor grooming, lack of interest in food.

**2. What are the 2 priority goals when someone is in crises? PG. 772**

Safety and anxiety reduction.

**3. What is a crisis? PG. 772**

Occurs when stress overwhelms a person’s usual coping mechanisms and demands mobilization of all available resources.

**4. Give an example of a developmental crises? PG. 763**

Marriage, baby, death of a parent.

**5. What is compassion fatigue? PG. 765**

Caregivers burning out when taking care of patients. i.e., oncology nurse.

**6. Name 5 interventions that can enhance a client’s ability to cope with a stressor? PG. 772**

Regular exercise, support system, time management, guided imagery, journal writing, mindfulness

**7. Explain PTSD? PG. 763**

When a person experiences a traumatic event and responds with intense fear or helplessness.

**8. How does stress relate to coping? PG. 763**

Coping is the ability to deal with stress.

**9. What physiological changes take place in the body during fight or flight response? PG. 762**

 1. increased heart rate

 2. increased blood volume

 3. increased glucose

 4. increased blow flow to muscles

 5. increased mental alertness

**10. What are the 3 stages of GAS? PG. 761**

 1. Alarm stage – fight or flight. Increased blood volume, glucose, epinephrine, norepinephrine, heart rate, O2 intake, blood flow to muscles, and mental alertness

 2. Resistance stage – body tries to return to normal

 3. Exhaustion stage – body cannot maintain fight or flight

**11. Define 4 of the ego defense mechanisms? PG. 763**

Compensation – making up for deficiency by focusing on a strength

Conversion – repressing anxiety producing emotional conflict

Denial – refusing to acknowledge anything that causes intolerable emotional pain

Displacement – transferring ideas, emotions, or wishes from a stressful situation to less stressful

Identification – assuming another person’s qualities, characteristics, and actions

Dissociation – reduced sense of surroundings

Regression – actions associated with earlier developmental period.

**Chapter 44: Pain Management**

**Acupressure** – influences nerve pathways

**Acute pain** – protective, usually has an identifiable cause, is of short duration, and has limited tissue damage and emotional response.

**Addiction** – A primary chronic neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Addictive behaviors include one or more of the following:

1. Impaired control over drug use
2. Compulsive use
3. Continued use despite harm
4. Craving

**Adjuvants** – co analgesics. Enhance analgesics or have analgesic properties.

**Analgesics** – most common and effective method of pain relief.

1. Non opioids – acetaminophen and NSAID
2. Opioids – usually narcotics
3. Adjuvants – enhance analgesics or have analgesic properties

**Biofeedback** – a type of therapy initiated by nurses.

**Breakthrough cancer pain** – transitory increase in pain in someone who has relatively stable and an adequately controlled baseline level of pain.

**Chronic pain** – not protective. Ongoing or recurrent pain that lasts beyond the usual course of acute illness. More than 3 – 6 months.

**Cutaneous stimulation** – it may cause the release of endorphins thus blocking painful stimuli.

**Drug tolerance** – a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more effects of the drug over time.

**Epidural analgesia** – a form of regional analgesia. Preservative free opioids are often administered as single agents or in combination with local anesthetics into a patient’s epidural space.

**Guided imagery** – allow patients to alter affective – motivational and cognitive pain perception.

**Idiopathic pain** – chronic pain in the absence of an identifiable physical or psychological cause or pain perceived as excessive for the extent of an organic pathological condition.

**Local anesthesia** – local infiltration of an anesthetic medication to induce loss of sensation to a body part.

**Modulation** – inhibition of pain pulse

**Multimodal analgesia** – combines drugs with at least two different mechanisms of action to optimize pain control. Allows for lower-than-normal doses of each medication.

**Nociception** – observable activity in the nervous system in response to adequate stimulus. 4 physiological processes.

1. Transduction – energy converted to action potential
2. Transmission – impulse begins
3. Perception – awareness of pain
4. Modulation – blocking of pain

**Opioids** – narcotics

**Pain threshold** – tolerance for pain.

**Pain tolerance** – level of pain a person is willing to accept.

**Patient-controlled analgesia (PCA)** – drug delivery system that allows patients to self-administer opioids with minimal risk of overdose.

**Perineural infusions** – reduce total dosage of oral analgesics needed.

**Physical dependence** – a state of adaptation that is manifested by a drug class specific withdrawal syndrome produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and / or administration of an antagonist.

**Placebos** – pharmacologically inactive preparations or procedures that produce no beneficial or therapeutic effect.

**Pseudo addiction** – patients who consult with numerous health care providers may be labeled as drug seekers when they are actually seeking adequate pain relief. Nurses should discourage doctor shopping and refer patients to pain specialists.

**Regional anesthesia** – injection of infusion of local anesthetics to block a group or sensory fibers. Produce temporary loss of sensation by inhibiting nerve conduction.

**Relaxation** – mental and physical freedom from tension or stress that provides a person with a sense of self control.

**Transcutaneous electrical nerve stimulation (TENS)** – may reduce pain perception.

**Transduction** – the process whereby an activated nociceptor converts energy produced by stimuli into an action potential.

**Transmission** – impulse begins

**Review Questions**

**1. Which of the following signs or symptoms in a patient who is opioid-naïve is of greatest concern to the nurse when assessing the patient 1 hour after administering an opioid?**

1. Oxygen saturation of 95%

2. Difficulty arousing the patient

3. Respiratory rate of 12 breaths/min

4. Pain intensity rating of 5 on a scale of 0 to 10

**2. A health care provider writes the following order for a patient who is opioid-naïve who returned from the operating room following a total hip replacement: “Fentanyl patch 100 mcg, change every 3 days.” On the basis of this order, the nurse takes the following action:**

1. Calls the health care provider and questions the order

2. Applies the patch the third postoperative day

3. Applies the patch as soon as the patient reports pain

4. Places the patch as close to the hip dressing as possible

**3. A patient is being discharged home on an around-the-clock (ATC) opioid for postoperative pain. Because of this order, the nurse anticipates an additional order for which class of medication?**

1. Opioid antagonists

2. Antiemetics

3. Stool softeners

4. Muscle relaxants

**4. A new medical resident writes an order for oxycodone CR 10 mg PO q2h prn. Which part of the order does the nurse question?**

1. The drug

2. The time interval

3. The dose

4. The route

**5. The nurse reviews a patient’s medical administration record (MAR) and finds that the patient has received oxycodone/acetaminophen (5/325), two tablets PO every 3 hours for the past 3 days. What concerns the nurse the most?**

1. The patient’s level of pain

2. The potential for addiction

3. The amount of daily acetaminophen

4. The risk for gastrointestinal bleeding

**6. When using ice massage for pain relief, which of the following is correct? (Select all that apply.)**

1. Apply ice using firm pressure over the skin.

2. Apply ice for 5 minutes or until numbness occurs.

3. Apply ice no more than 3 times a day.

4. Limit application of ice to no longer than 10 minutes.

5. Use a slow, circular steady massage.

**7. A patient with a 3-day history of a stroke that left her confused and unable to communicate returns from interventional radiology following placement of a gastrostomy tube. The patient had been taking hydrocodone/APAP 5/325 up to four tablets/day before her stroke for the past year to manage her arthritic pain. The health care provider’s order reads as follows: “Hydrocodone/APAP 5/325 1 tab, per gastrostomy tube, q4h, prn.” Which action by the nurse is most appropriate?**

1. No action is required by the nurse because the order is appropriate.

2. Request to have the order changed to around the clock (ATC) for the first 48 hours.

3. Ask for a change of medication to meperidine (Demerol) 50 mg IVP, q3h, prn.

4. Begin the hydrocodone/APAP when the patient shows nonverbal symptoms of pain.

**8. Place the following steps in the correct order for administration of patient-controlled analgesia:**

1. Insert drug cartridge into infusion device and prime tubing.

2. Wipe injection port of maintenance IV line vigorously with antiseptic swab for 15 seconds and allow to dry.

3. Demonstrate to patient how to push medication demand button.

4. Secure connection and anchor PCA tubing with tape.

5. Instruct patient to notify a nurse for possible side effects or changes in the severity or location of pain.

6. Insert needleless adapter into injection port nearest patient.

7. Apply clean gloves. Check infuser and patient-control module for accurate labeling or evidence of leaking.

8. Program computerized PCA pump as ordered to deliver prescribed medication dose and lockout interval.

9. Attach needleless adapter to tubing adapter of patient-controlled module.

**9. When teaching a patient about transcutaneous electrical nerve stimulation (TENS), which of the following represent an accurate description of the nonpharmacological therapy? (Select all that apply.)**

1. Turn TENS on before patient feels discomfort.

2. TENS works peripherally and centrally on nerve receptors.

3. TENS does not require a health care provider order.

4. Remove any skin preparations before attaching TENS electrodes.

5. Placing electrodes directly over or near the pain site works best.

**10. Match the characteristics on the left with the appropriate pain category on the right.**



Answers: 1.2; 2.1; 3.3; 4.2; 5.3; 6.1, 2, 5; 7.2; 8. 3, 5, 7, 1, 9, 2, 6, 4, 8; 9.2, 4, 5; 10.Acute pain: A, C, F; Chronic pain: B, D, E.

**ATI Chapter 41 – page 235**

\*Undertreatment of pain is a serious healthcare problem.

 1. Acute chronic pain can cause anxiety, fear and depression

 2. Poorly managed acute pain can lead to chronic pain syndrome.

\*Acute Pain is temporary and protective.

 1. physiological response: tachycardia, hypertension, anxiety, diaphoresis, muscle tension

 2. behavioral response: grimacing, moaning, flinching, and guarding

\*Chronic pain is not protective. It lasts more than 6 months and persists beyond tissue healing.

 1. physiological responses are not altered, but PT have depression, fatigue, and decreased levels of functioning.

 2. Idiopathic pain is chronic pain without a reason or pain that is higher than expected for a condition.

\*Nociceptive pain arises from damage to tissue.

 1. Throbbing, aching or localized.

 2. Responds to opioids and non-opioids.

 \*Physiology of nociceptive pain

 1. Transduction – conversion of painful stimuli to an electrical impulse through peripheral nerve fibers.

 2. Transmission – occurs as electrical impulses travel along nerve fibers

 3. Perception – awareness of pain

 Pain threshold – the point at which a person feels pain

 Pain tolerance – the amount of pain a person is willing to bear

 4. Modulation – occurs in the spinal cord, causing muscles to contract reflexively, moving the body away from painful stimuli.

\*Neuropathic pain is caused by abnormal or damaged pain nerves.

 1. Examples: phantom limb pain, pain below spinal cord injury, diabetic neuropathy.

 2. Quality: shooting, burning, pins and needles

 3. Respond to adjuvant medication.

**Flashcards**

**1. Identify 5 nonverbal indications of possible pain. PG. 1074**

Vocalizations: moaning, crying, gasping, and grunting

Facial expressions: grimace, clenched teeth, wrinkled forehead, tightly closed eyes, lip biting

Body movement: restlessness, immobilization, muscle tension, pacing, grabbing, or holding a body part

Social interaction: avoidance of conversation, focus on pain relief activities, reduced attention span.

**2. What is meant by visceral pain? PG. 1071**

Pain resulting from stimulation of visceral organs.

**3. Name 3 nonpharmacological interventions for pain management? PG. 1079**

Acupuncture, acupressure, massage, osteopathic and chiropractic manipulation, meditative movement, and mind body interventions.

**4. What is the difference between referred pain and radiating pain? PG. 1071**

Referred pain is common with visceral pain b/c many organs do not have pain receptors. Pain is in part of body separate from source of pain and assumes any characteristic.

Radiating pain is a sensation of pain extending from initial site of injury to another body part.

**5. What is idiopathic pain? PG. 1064**

Chronic pain with no known cause or greater than expected pain for a particular condition.

**6. Name 3 things that happen in sympathetic reaction to pain? 1063**

Increased RR, increased HR, Elevated BP, increased glucose, diaphoresis, dilation of pupils, decreased gastrointestinal motility, increased muscle tension.

**7. Name 3 parasympathetic reactions to pain? PG. 1063**

Pallor, nausea, vomiting, decreased BP and HR, rapid and irregular breathing.

**8. What is neuropathic pain? PG. 1064**

Caused by a lesion or disease of the somatosensory nervous system. Typically uses adjuvant analgesics.

**9. What is the difference between acute and chronic pain? PG. 1063**

Acute: short term. Usually ends with tissue healing. Protective.

Chronic: 6+ months. Not protective. Affects quality of life.

**10. Identify 2 scales for rating pain. PG. 1073**

Numeric rating scale, verbal descriptive scale (line with 2 – 6 word descriptors), visual analog scale

**11. Identify 2 types of nociceptive pain. PG. 1064**

Somatic: comes from bone, join, muscle, skin, or connective tissue. Aching or throbbing. Localized.

Visceral: arises from visceral organ

**12. What are the 4 physiological processes involved in pain? PG. 1061**

Transduction, transmission, perception, and modulation.

**Chapter 48 – Skin Integrity and Wound Care**

**Abrasion** – superficial with little bleeding and is considered a partial thickness wound.

**Approximated** – skin edges are close or closed

**Blanching** – normal red tones of the light skinned patient are absent. Dark skin patients may not show the blanch response.

**Blanchable hyperemia** – press a finger into affected area. It should blanch and then returns to erythema meaning the hyperemia is transient and trying to overcome ischemic episode.

**Debridement** – removal of nonviable, necrotic tissue. Removal of necrotic tissue is necessary to rid the wound of a source of infection, enable visualization of the wound bed, and provide a clean base necessary for healing.

**Dehiscence** – partial or total separation of wound layers.

**Drainage evacuators** – convenient portable units that connect to tubular drains lying within a wound bed and exert safe, constant low-pressure vacuum to remove and collect drainage.

**Epithelialization** – a process where epithelial cells migrate upwards and repair the wounded area.

**Eschar** – black, brown, tan, or necrotic tissue. Must be removed before healing can occur.

**Evisceration** – total separation of wound layers. Protrusion of visceral organs though a wound opening.

**Exudate** – secretions from blood vessels or organs

**Fluctuance** – tense area of skin with a wave-like or boggy feeling upon palpation. This is the pus which has accumulated beneath the epidermis.

**Friction** – the force of two surfaces moving across one another such as the mechanical force exerted when skin is dragged across a coarse surface such as bed linens.

**Granulation tissue** – red, moist tissue composed of new blood vessels, the presence of which indicates progression toward healing.

**Hemostasis** – injured blood vessels constrict, and platelets gather to stop bleeding.

**Induration** – localized hardening of soft tissue of the body. The area becomes firm, but not as hard as bone.

**Laceration** – may bleed more profusely than an abrasion depending on depth and location of the wound.

Negative pressure wound therapy, p. 1263

**Non blanchable erythema** – skin doesn’t blanch when pressure is applied meaning possible deep tissue damage.

**Pressure injury** – impaired skin integrity related to unrelieved prolonged pressure. Localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical device or other device.

**Primary intention** – a wound with little tissue loss. Usually from a clean surgical incision.

**Puncture wound** – bleed in relation to the depth, size, and location of the wound. Usually small, circular wound with the edges coming together toward the center. Primary dangers are internal bleeding and infection.

**Purulent** – thick, yellow, green, or brown drainage.

**Reactive hyperemia** – increase in organ blood flow that occurs after a brief period of ischemia

**Sanguineous** – bright red; indicates active bleeding

**Secondary intention** – a wound with some loss of tissue such as a burn, stage 2 pressure injury or severe laceration.

**Serosanguineous** – pale, pink, watery: mixture of clear and red fluid.

**Serous** – clear, thin, and watery

**Shearing force** – unaligned forces pushing one part of a body in one specific direction, and another part of the body in the opposite direction.

**Slough** – Soft yellow or white tissues. Stringy substance attached to wound bed.

**Tissue ischemia** – pressure applied over a capillary exceeds the normal capillary pressure and the vessel for a prolonged period reducing O2 and nutrients to a tissue.

**Vacuum-assisted closure** – device that helps in would closure by applying localized negative pressure to draw the edges of a wound together.

**Wound** – disruption of the integrity and function of tissues in the body.

**Review Questions**

**1. When repositioning an immobile patient, the nurse notices redness over the hip bone. What is indicated when a reddened area blanches on fingertip touch?**

1. A local skin infection requiring antibiotics

2. Sensitive skin that requires special bed linen

3. A stage 3 pressure injury needing the appropriate dressing

4. Blanching hyperemia, indicating the attempt by the body to overcome the ischemic episode

**2. Match the pressure injury stages with the correct definition.**



**3. After surgery the patient with a closed abdominal wound reports a sudden “pop” after coughing. When the nurse examines the surgical wound site, the sutures are open, and pieces of small bowel are noted at the bottom of the now-opened wound. Which are the priority nursing interventions? (Select all that apply.)**

1. Notify the health care provider.

2. Allow the area to be exposed to air until all drainage has stopped.

3. Place several cold packs over the area, protecting the skin around the wound.

4. Cover the area with sterile, saline-soaked towels immediately.

5. Cover the area with sterile gauze and apply an abdominal binder.

**4. What is the correct sequence of steps when performing wound irrigation to a large open wound?**

1. Use slow, continuous pressure to irrigate wound.

2. Attach 19-gauge angiocatheter to syringe.

3. Fill syringe with irrigation fluid.

4. Place biohazard bag near bed.

5. Position angiocatheter over wound.

**5. Which skin-care measures are used to manage a patient who is experiencing fecal and/or urinary incontinence? (Select all that apply.)**

1. Frequent position changes

2. Keeping the buttocks exposed to air at all times

3. Using a large absorbent diaper, changing when saturated

4. Using an incontinence cleaner

5. Applying a moisture barrier ointment

**6. Which of the following describes a hydrocolloid dressing?**

1. A seaweed derivative that is highly absorptive

2. Premoistened gauze placed over a granulating wound

3. A debriding enzyme that is used to remove necrotic tissue

4. A dressing that forms a gel that interacts with the wound surface

**7. Which of the following is an indication for a binder to be placed around a surgical patient with a new abdominal wound? (Select all that apply.)**

1. Collection of wound drainage

2. Providing support to abdominal tissues when coughing or walking

3. Reduction of abdominal swelling

4. Reduction of stress on the abdominal incision

5. Stimulation of peristalsis (return of bowel function) from direct pressure

**8. When is the application of a warm compress to an ankle muscle sprain indicated? (Select all that apply.)**

1. To relieve edema

2. To reduce shivering

3. To improve blood flow to an injured part

4. To protect bony prominences from pressure injuries

5. To immobilize area

**9. What is the removal of devitalized tissue from a wound called?**

1. Debridement

2. Pressure distribution

3. Negative-pressure wound therapy

4. Sanitization

**10. Which of the following are measures to reduce tissue damage from shear? (Select all that apply.)**

1. Use a transfer device (e.g., transfer board)

2. Have head of bed elevated when transferring patient

3. Have head of bed flat when repositioning patient

4. Raise head of bed 60 degrees when patient positioned supine

5. Raise head of bed 30 degrees when patient positioned supine

Answers:

1. 4; 2. Stage 1 is b, stage 2 is a, stage 3 is d, and stage 4 is c; 3. 1, 4; 4. 4, 3, 2, 5, 1; 5. 1, 4, 5; 6. 4; 7. 2, 4; 8. 1, 3; 9. 1; 10. 1, 3, 5.

**ATI Chapter 55 – page 341**

**Flashcards**

1. Identify 3 things to assess before administering hot or cold therapies: PG. 1268

**2. In what direction should you clean a wound? PG. 1254**

Inside out.

3. What is a negative pressure wound therapy? PG. 1263

4. Name 4 interventions to prevent pressure ulcer formation? PG. 1258

5. Can you identify a Jackson Pratt and Penrose Drain? PG. 1250

**6. Give an example of healing by primary intention? PG. 1239**

Clean incision from a surgery. No wound.

7. What is the difference between dehiscence and evisceration? PG. 1242

Dehiscence: wound opens up

Evisceration:

8. What 4 processes are involved in the healing of full thickness wound? PG. 1241

9. What are the 6 categories on the Braden Scale? PG. 1243

10. Can you identify serous, sero sanguineous and purulent drainage? PG. 1242

Serous: thin, clear

Sero sanguineous: pink, watery

Purulent: yellow or brown

11. What is the difference between friction and shear? PG. 1237

12. What is the difference between stage 1 pressure and deep tissue injury? PG. 1238

Stage 1: red but epidermis is intact

13. Can a stage 3 pressure ulcer become a stage 2 as it heals?

No.

14. What is the difference between a stage 3 and stage 4 pressure ulcer? PG. 1238

Stage 3: sub q showing

Stage 4: bone showing

15. What is the difference between stage 1 and 2 pressure ulcers? PG. 1238

Stage 1: red but epidermis showing

Stage 2: epidermis missing

**Chapter 50: Perioperative Nursing**

**Ambulatory surgery** – outpatient surgery. Patient goes home right away, and family assumes responsibility for caregiving.

**American Society of Anesthesiologists (ASA)** – assign classifications to patient’s based on their physiological condition

**American Society of Peri Anesthesia Nurses (ASPAN)** – develop standards for perioperative management and evaluation of processes and outcomes.

**Association of Perioperative Registered Nurses (AORN)** – develop standards for perioperative management and evaluation of processes and outcomes.

**Atelectasis** – lung collapse

**Bariatric** – treatment of obesity

**Circulating nurse** – does not scrub in. Manages care of the patient. Ensures that all necessary supplies are available and patient is positioned properly.

**Co-morbid** – one or more diseases in addition to primary disease.

**Conscious sedation** – IV moderate sedation for short procedures that do not require complete anesthesia just a depressed level of consciousness.

**General anesthesia** – patient loses all sensation, consciousness, and reflex including gag and blink reflex. They also have amnesia, so they don’t remember anything unpleasant about the surgery.

**Intermittent pneumatic compression (IPC) stockings** – stockings connected to a pump that inflate and deflate the stockings allowing for intermittent pressure from knee to ankle. Mimics walking.

**Informed consent** – after the surgeon informs the patient about the surgery and all of their options, they sign a form consenting to the procedure with the nurse as the witness.

**Laparoscopy** – minimally invasive surgery that allows access to the abdomen and pelvis without a major incision.

**Latex sensitivity** – allergy. Reaction to certain proteins in the natural rubber latex.

**Local anesthesia** – loss of sensation at a particular site by inhibiting peripheral nerve conduction.

**Malignant hyperthermia** – life threatening complication of anesthesia. Characterized by high CO2 levels, metabolic and respiratory acidosis, increased O2 consumption, production of heat, high serum K+ levels, multiple organ dysfunction and failure.

**Moribund** – a patient who won’t survive without the surgery

**Never event** – a mistake that should never happen in the medical field and one that CMS will not pay for.

**Obstructive sleep apnea (OSA)** – chronic sleep disorder characterized by narrowing or collapse of upper airway.

**Oxygen desaturation** – percentage of O2 lower than it should be. Can be caused when airway is collapsed for too long.

**Paralytic ileus** – motor activity of the bowel is impaired.

**Perioperative nursing** – RN planned patient care approach in providing care to patients preoperatively, intraoperatively, and post operatively.

**Post anesthesia recovery score (PARS)** – a scoring system used to determine if a patient is ready for discharge from the PACU.

**Preanesthesia care unit (PCU)** – presurgical unit. Where preoperative preparations are done.

**Preoperative teaching plan** – a comprehensive plan to teach the patient about nursing diagnosis

**Regional anesthesia** – loss of sensation to a body part by anesthetizing sensory pathways.

**Scrub nurse** – must have complete knowledge of procedure and be able to anticipate when tools are needed.

**Review Questions**

**1. The nurse prepares a patient with type 2 diabetes for a surgical procedure. The patient weighs 112.7 kg (248 lb) and is 5 feet, 2 inches in height. Which factors increase this patient’s risk for surgical complications? (Select all that apply.)**

1. Obesity

2. Prolonged bleeding time

3. Delayed wound healing

4. Ineffective vital capacity

5. Immobility secondary to height

**2. Which assessment questions should the nurse ask a preoperative patient preparing for surgery? (Select all that apply.)**

1. “Are you experiencing any pain?”

2. “Do you exercise on a daily basis?”

3. “When do you regularly take your medications?”

4. “Do you have any medication allergies?”

5. “Do you use drugs and/or tobacco products?”

**3. Communication between a nurse caring for a patient in the preoperative holding area and the circulating nurse in the operating room (OR) can best be enhanced by which of the following? (Select all that apply.)**

1. Documenting assessment findings in the medical record

2. Using a standardized SBAR tool

3. Being responsive in using nonverbal communication techniques

4. Giving specific information to a transport technician

5. Listening to the OR nurse’s questions

**4. Which postoperative intervention best prevents atelectasis?**

1. Use of intermittent compression stockings

2. Heel-toe flexion

3. Use of the incentive spirometer

4. Abdominal splinting when coughing

**5. An 85-year-old patient returns to the inpatient surgical unit after leaving the PACU. Which of the following place the patient at risk during surgery? (Select all that apply.)**

1. Stiffened lung tissue

2. Reduced diaphragmatic excursion

3. Increased laryngeal reflexes

4. Reduced blood flow to kidneys

5. Increased cholinergic transmission

**6. A postoperative patient experiences tachypnea during the first hour of recovery. Which nursing intervention is a priority?**

1. Elevate the head of the patient’s bed.

2. Give ordered oxygen through a mask at 4 L/min.

3. Ask the patient to use an incentive spirometer.

4. Position the patient on one side with the face down and the neck slightly extended so that the tongue falls forward.

**7. Which is the best intervention the nurse should implement to promote bowel function?**

1. Early ambulation

2. Deep-breathing exercises

3. Repositioning on the left side

4. Lowering the head of the patient’s bed

**8. Match the nursing interventions on the left with the complication to be prevented on the right. An intervention may apply to more than one complication.**



**9. A nurse cares for a postoperative patient in the PACU. Upon assessment, the nurse finds the surgical dressing is saturated with serosanguineous drainage. Which interventions are a priority? (Select all that apply.)**

1. Notify surgeon.

2. Maintain the intravenous fluid infusion.

3. Provide 2 L/min of oxygen via nasal cannula.

4. Monitor the patient’s vital signs every 5 to 10 minutes.

5. Reinforce the dressing.

**10. A patient who returned from surgery 3 hours ago following a kidney transplant is reporting pain at a 7 on a scale of 0 to 10. The nurse has tried repositioning with no improvement in the patient’s pain report. Unmanaged surgical pain can lead to which of the following problems? (Select all that apply.)**

1. Delayed ambulation

2. Reduced ventilation

3. Catheter-associated urinary tract infection

4. Retained pulmonary secretions

5. Reduced appetite

Answers: 1. 1, 3; 2. 1, 4, 5; 3. 2, 3, 5; 4. 3; 5. 1, 2, 4; 6. 1; 7. 1; 8. 1 c, 2 a and c, 3 b, 4 d, 5 a and d; 9. 1, 5; 10. 1, 2, 4, 5.

**Flashcards**

**1. What is a PCA? PG. 1355**

Patient controlled analgesia.

**2. How can you identify sterile items in the operating room?**

In a sealed packaged, that is dry and valid expiration date.

**3. What are the roles of the circulating and scrub nurse? PG. 1343**

Circulating: manages patient care activities in the OR including positioning, meds, warming

Scrub: most know the procedure and anticipate instrument and supply needs

**4. What is a paralytic ileus? PG. 1350**

After surgery bowels are working.

**5. What is moderate sedation? PG. 1344**

IV moderate sedation. Used when general isn’t required just a depressed level of consciousness.

**6. What technique should be used for hand off communication?**

SBAR. In person

**7. What is a time out for surgery? PG. 1341**

Everything stops everyone identifies right patient, right procedure, right site, and any implants.

**8. ID 5 things the nurse needs to monitor in the initial postoperative period: PG. 1347**

Vital signs, respiratory status, I&O, pain, level of consciousness, drainage, Fluid therapy

**9. Name 2 anti-embolism devices. PG. 1341**

Anti-embolic stockings and intermittent pneumatic compression stockings

**10. ID 7 postoperative complications: PG. 1353**

Atelectasis, pneumonia, hypoxemia, pulmonary embolism, hemorrhage, hypovolemic shock, thrombophlebitis, thrombus, embolus, hospital associated deconditioning, paralytic ileus, abdominal distention, nausea and vomiting, urinary retention, UTI, wound infection, wound dehiscence, wound evisceration, skin breakdown, malignant hyperthermia, intractable pain.

**11. What is the difference between general and regional anesthesia? PG. 1344**

General is the whole body. Loss of sensation, reflexes, and consciousness

Regional loss of sensation to a particular body part by anesthetizing sensory pathways.

**12. Name 3 different purposes for surgery: pg. 1322**

Diagnostic, ablative, restorative, palliative, transplant, constructive, cosmetic.

**13. Name 3 category of labs that the nurse should review for surgical patient? PG 1334**

Complete CBC: hemoglobin, hematocrit, platelet count, and WBC.

Blood chemistry: Na, K, Cl, CO2, BUN, creatinine, Glucose

Coagulation studies: INR, PTT, APTT, PT

**14. Name 5 risk factors associated with surgery? PG. 1323**

Smoking, age, nutrition, obesity, obstructive sleep apnea, immunosuppression, fluid and electrolyte imbalance, post operative nausea and vomiting, venous thromboembolism.

**15. What is perioperative nursing? PG. 1321**

Care of the patient preoperatively, intraoperatively, and postoperatively.

**Chapter 11: Developmental Theories**

Conventional reasoning, p. 140

**Erikson’s theory of psychosocial development** – individuals need to accomplish a particular task before successfully mastering the stage and progressing to the next one.

 **Trust vs Mistrust** (Birth – 12 to 18 months): requires consistent care from a caregiver to build trust

**Autonomy vs Sense of Shame and Doubt** (18 months – 3 years): decision making. Limiting choices or harsh punishment bring shame and doubt. Mastering this stage achieves self-control and will power.

**Initiative vs Guilt** (3 – 6 years):

**Freud’s psychoanalytical model of personality development** – individuals go through 5 stages of psychosexual development and that each stage is characterized by sexual pleasure in parts of the body: the mouth, the anus, and the genitals

**Stage 1:** Oral (Birth – 12 to 18 months): sucking and oral satisfaction are vital to life. The infant begins to realize that the mother/parent is separate from themselves.

**Stage 2:** Anal (12 to 18 months – 3 years): Toilet training

**Stage 3:** Phallic or Oedipal (3 – 6 years): child becomes interested in genitals. Identification with parent of same sex

**Stage 4:** Latency (6 – 12 years): repression and channeling of sexual urges into educational and social worlds. Much to learn and much to accomplish

**Stage 5:** Genital (Puberty – Adulthood): Sexual urges reawaken and directed outside of family.

Kohlberg’s theory of moral development, p. 140

Piaget’s theory of cognitive development, p. 138

Postconventional reasoning, p. 140

Temperament, p. 138

**Review Questions**

**1. The nurse is aware that preschoolers often display a developmental characteristic that makes them treat dolls or stuffed animals as if they have thoughts and feelings. This is an example of:**

1. Logical reasoning.

2. Egocentrism.

3. Concrete thinking.

4. Animism.

**2. A 9-year-old child has a difficult time making friends at school and being chosen to play on the team. He also has trouble completing his homework and, as a result, receives little positive feedback from his parents or teacher. According to Erikson’s theory, failure at this stage of development results in: (Select all that apply.)**

1. Feelings of inadequacy.

2. A sense of guilt.

3. A poor sense of self.

4. Feelings of inferiority.

5. Mistrust.

**3. The nurse teaches parents how to have their children learn impulse control and cooperative behaviors. This would be during which of Erikson’s stages of development?**

1. Trust versus mistrust

2. Initiative versus guilt

3. Industry versus inferiority

4. Autonomy versus sense of shame and doubt

**4. When Ryan was 3 months old, he had a toy train; when his view of the train was blocked, he did not search for it. Now that he is 9 months old, he looks for it, reflecting the presence of:**

1. Object permanence.

2. Sensorimotor play.

3. Schemata.

4. Magical thinking.

**5. When preparing a 4-year-old child for a procedure, which method is developmentally most appropriate for the nurse to use?**

1. Allowing the child to watch another child undergoing the same procedure

2. Showing the child pictures of what he or she will experience

3. Talking to the child in simple terms about what will happen

4. Preparing the child through play with a doll and toy medical equipment

**6. A nurse is caring for a man who is recently retired and who appears withdrawn. He says he is “bored with life.” The nurse helps this individual find meaning in life by:**

1. Encouraging him to reflect on his relationships with others.

2. Encouraging relocation to a new city.

3. Explaining the need to simplify life.

4. Encouraging him to adopt a new pet.

**7. According to Piaget’s cognitive theory, a 12-year-old child is most likely to engage in which of the following activities? (Select all that apply.)**

1. Using building blocks to determine how houses are constructed

2. Writing a story about a clown who wants to leave the circus

3. Drawing pictures of a family using stick figures

4. Writing an essay about patriotism

5. Hanging out with a best friend

**8. Elizabeth, who is having unprotected sex with her boyfriend, comments to her friends, “Did you hear about Kathy? You know, she fools around so much; I heard she was pregnant. That would never happen to me!” This is an example of adolescent:**

1. Imaginary audience.

2. False-belief syndrome.

3. Personal fable.

4. Sense of invulnerability.

**9. Which of the following are examples of the conventional reasoning form of cognitive development? (Select all that apply.)**

1. A 35-year-old woman is speaking with you about her recent diagnosis of a chronic illness. She is concerned about her treatment options in relation to her ability to continue to care for her family. As she considers the options and alternatives, she incorporates information, her values, and emotions to decide which plan will be the best fit for her.

2. A young father is considering whether or not to return to school for a graduate degree. He considers the impact the time commitment may have on the needs of his wife and infant son.

3. A teenage girl is encouraged by her peers to engage in shoplifting. She decides not to join her peers in this activity because she is afraid of getting caught in the act.

4. A single mother of two children is unhappy with her employer. She has been unable to secure alternate employment but decides to quit her current job.

5. A young man drives over the speed limit regularly because he thinks he is an excellent driver and will not get into a car accident.

**10. Dave reports being happy and satisfied with his life. What do we know about him?**

1. He is in one of the later developmental periods, concerned with reviewing his life.

2. He is atypical, since most people in any of the developmental stages report significant dissatisfaction with their lives.

3. He is in one of the earlier developmental periods, concerned with establishing a career and satisfying long-term relationships.

4. It is difficult to determine Dave’s developmental stage since most people report overall satisfaction with their lives in all stages.

**Answers: 1. 4; 2. 1, 4; 3. 2; 4. 1; 5. 4; 6. 1; 7. 2, 5; 8. 4; 9. 1, 2; 10. 4.**

**Chapter 14: Older Adults**

Ageism, p. 176

Delirium, p. 181

Dementia, p. 181

Depression, p. 181

Elder mistreatment, p. 190

Gerontological nursing, p. 177

Gerontology, p. 176

Reality orientation, p. 191

Reminiscence, p. 192

Validation therapy, p. 191

**Review Questions**

**1. A patient’s family member is considering having her mother placed in a nursing center. The nurse has talked with the family before and knows that this is a difficult decision. Which of the following criteria does the nurse recommend in choosing a nursing center? (Select all that apply.)**

1. The center needs to be clean, and rooms should look like a hospital room.

2. Adequate staffing is available on all shifts.

3. Social activities are available for all residents.

4. The center provides three meals daily with a set menu and serving schedule.

5. Staff encourage family involvement in care planning and assisting with physical care.

**2. A nurse conducted an assessment of a new patient who came to the medical clinic. The patient is 82 years old and has had osteoarthritis for 10 years and diabetes mellitus for 20 years. He is alert but becomes easily distracted during the assessment. He recently moved to a new apartment, and his pet beagle died just 2 months ago. He is most likely experiencing:**

1. Dementia.

2. Depression.

3. Delirium.

4. Anxiety.

**3. A nurse is completing a health history with the daughter of a newly admitted patient who is confused and agitated. The daughter reports that her mother was diagnosed with Alzheimer’s disease 1 194year ago but became extremely confused last evening and was hallucinating. She was unable to calm her, and her mother thought she was a stranger. On the basis of this history, the nurse suspects that the patient is experiencing:**

1. Normal aging.

2. Delirium.

3. Depression.

4. Worsening dementia.

**4. Older adults frequently experience a change in sexual activity. Which best explains this change?**

1. The need to touch and be touched is decreased.

2. The sexual preferences of older adults are not as diverse.

3. Medication side effects often impact sexual functioning.

4. Frequency and opportunities for sexual activity may decline.

**5. A nurse sees a 76-year-old woman in the outpatient clinic. She states that she recently started to notice a glare in the lights at home. Her vision is blurred, and she is unable to play cards with her friends, read, or do her needlework. Which of the following nursing interventions are appropriate? (Select all that apply.)**

1. Refer her to an ophthalmologist.

2. Suggest large-print books and playing cards.

3. Reassure her that this is part of normal aging.

4. Suggest lower-wattage light bulbs to decrease glare.

5. Assess her home environment for safety.

**6. A 63-year-old patient is retiring from his job at an accounting firm where he was in a management role for the past 20 years. He has been with the same company for 42 years and was a dedicated employee. His wife is a homemaker. She raised their five children, babysits for her grandchildren as needed, and belongs to numerous church committees. What are the major concerns for this patient? (Select all that apply.)**

1. The loss of his work role

2. The risk of social isolation

3. A determination on whether the wife will need to start working

4. How the wife expects household tasks to be divided in the home in retirement

5. The age the patient chose to retire

**7. A nurse is assessing an older adult brought to the emergency department following a fall and wrist fracture. The patient is very thin and unkempt, has a stage 3 pressure injury on her coccyx, and has old bruising to the extremities in addition to her new bruises from the fall. She defers all of the questions to her caregiver son, who accompanied her to the hospital. What is the nurse’s next step?**

1. Call social services to begin nursing home placement.

2. Ask the son to step out of the room so that she can complete her assessment.

3. Call adult protective services because you suspect elder mistreatment.

4. Assess the patient’s cognitive status.

**8. A nurse is participating in a health and wellness event at the local community center. A woman approaches and relates that she is worried that her widowed father is becoming more functionally impaired and may need to move in with her. The nurse asks about his ability to complete activities of daily living (ADLs). ADLs include independence with: (Select all that apply.)**

1. Driving.

2. Toileting.

3. Bathing.

4. Daily exercise.

5. Eating.

**9. During a home health visit a nurse talks with a patient and his family caregiver about the patient’s medications. The patient has hypertension and renal disease. Which of the following findings place him at risk for an adverse drug event? (Select all that apply.)**

1. Taking two medications for hypertension

2. Taking a total of eight different medications during the day

3. Having one physician who reviews all medications

4. Patient’s health history of renal disease

5. Involvement of the caregiver in helping with medication administration

**10. A 71-year-old patient enters the emergency department after falling down stairs at church. The nurse is conducting a fall history with the patient and his wife. They live in a one-level ranch home. He has had diabetes for over 15 years and experiences some numbness in his feet. He wears bifocal glasses. His blood pressure is stable at 130/70. The patient does not exercise regularly and states that he experiences weakness in his legs when climbing stairs. He is alert, oriented, and able to answer questions clearly. What are the fall risk factors for this patient? (Select all that apply.)**

1. Impaired vision

2. Residence design

3. Blood pressure

4. Leg weakness

5. Exercise history

**Answers:1.2, 3, 5; 2.2; 3.2; 4.4; 5.1, 2, 5; 6. 1, 4; 7.2; 8.2, 3, 5; 9.2, 4; 10.1, 4, 5.**

**Chapter 49: Sensory alterations**

Aphasia, p. 1306

Auditory, p. 1300

Conductive hearing loss, p. 1313

Expressive aphasia, p. 1306

Gustatory, p. 1300

Hyperesthesia, p. 1313

Kinesthetic, p. 1300

Olfactory, p. 1300

Otolaryngologist, p. 1304

Ototoxic, p. 1307

Proprioceptive, p. 1303

Receptive aphasia, p. 1306

Refractive error, p. 1309

Sensory deficit, p. 1301

Sensory deprivation, p. 1301

Sensory overload, p. 1302

Stereognosis, p. 1300

Strabismus, p. 1309

Tactile, p. 1300

**Review Questions**

**1. A patient has been on contact isolation for 4 days because of a hospital-acquired infection. He has had few visitors and few opportunities to leave his room. His ambulation is also still limited. Which are the correct nursing interventions to reduce sensory deprivation? (Select all that apply.)**

1. Teaching how activities such as reading and using crossword puzzles provide stimulation

2. Moving him to a room away from the nurses’ station

3. Turning on the lights and opening the room blinds

4. Sitting down, speaking, touching, and listening to his feelings and perceptions

5. Providing auditory stimulation for the patient by keeping the television on continuously

**2. The home care nurse is instructing an assistive personnel about interventions to facilitate location of items for patients with vision impairment. Which are effective strategies for enhancing a patient’s impaired vision? (Select all that apply.)**

1. Use of fluorescent lighting

2. Use of warm incandescent lighting

3. Use of yellow or amber lenses to decrease glare

4. Use of adjustable blinds, sheer curtains, or draperies

5. Indirect lighting to reduce glare

**3. An older adult patient with bilateral hearing loss wears a hearing aid in her left ear. Which of the following approaches best facilitates communication with her? (Select all that apply.)**

1. Talk to the patient at a distance so he or she may read your lips.

2. Keep your arms at your side; speak directly into the patient’s left ear.

3. Face the patient when speaking; demonstrate ideas you wish to convey.

4. Position the patient so that the light is on his or her face when speaking.

5. Verify that the information that has been given has been clearly understood.

**4. A patient is returning to an assisted-living apartment following a diagnosis of declining, progressive visual loss. Although she is familiar with her apartment and residence, she reports feeling a little uncertain about walking alone. There is one step into her apartment. Her children are scheduling themselves to be available to their mom for the next 2 weeks. Which of the following approaches will you teach the children to assist ambulation? (Select all that apply.)**

1. Walk one-half step behind and slightly to her side.

2. Have her grasp your arm just above the elbow and walk at a comfortable pace.

3. Stand next to your mom at the top and bottom of stairs.

4. Stand one step ahead of mom at the top of the stairs.

5. Place yourself alongside your mom and hold onto her waist.

**5. A new nurse is going to help a patient walk down the corridor and sit in a chair. The patient has an eye patch over the left eye and poor vision in the right eye. What is the correct order of steps to help the patient safely walk down the hall and sit in the chair?**

1. Tell patient when you are approaching the chair.

2. Walk at a relaxed pace.

3. Guide patient’s hand to nurse’s arm, resting just above the elbow.

4. Position yourself one-half step in front of patient.

5. Position patient’s hand on back of chair.

**6. A patient with progressive vision impairments had to surrender his driver’s license 6 months ago. He comes to the medical clinic for a routine checkup. He is accompanied by his son. His wife died 2 years ago, and he admits to feeling lonely much of the time. Which of the following interventions reduce loneliness? (Select all that apply.)**

1. Sharing information about senior transportation services

2. Reassuring the patient that loneliness is a normal part of aging

3. Maintaining distance while talking to avoid overstimulating the patient

4. Providing information about local social groups in the patient’s neighborhood

5. Recommending that the patient consider making living arrangements that will put him closer to family or friends

**7. A nurse is performing an assessment on a patient admitted to the unit following treatment in the emergency department for severe bilateral eye trauma. During patient admission the nurse’s priority interventions include which of the following? (Select all that apply.)**

1. Conducting a home-safety assessment and identifying hazards in the patient’s living environment

2. Reinforcing eye safety at work and in activities that place the patient at risk for eye injury

3. Placing necessary objects such as the nurse call system and water in front of the patient to prevent falls caused by reaching

4. Orienting the patient to the environment to reduce anxiety and prevent further injury to the eye

5. Alerting other nurses and health care providers about patient’s visual status during hand-off reports

**8. An older adult is admitted from a skilled nursing home to a medical unit with pneumonia. A review of the medical record reveals that he had a stroke affecting the right hemisphere of the brain 6 months ago and was placed in the skilled nursing home because he was unable to care for himself. Which of these assessment findings does the nurse expect to find? (Select all that apply.)**

1. Slow, cautious behavioral style

2. Inattention and neglect, especially to the left side

3. Cloudy or opaque areas in part of the lens or the entire lens

4. Visual spatial alterations such as loss of half of a visual field

5. Loss of sensation and motor function on the right side of the body

**9. A nurse is performing a home care assessment on a patient with a hearing impairment. The patient reports, “I think my hearing aid is broken. I can’t hear anything.” After determining that the patient’s hearing aid works and that the patient is having trouble managing the hearing aid at home, which of the following teaching strategies does the nurse implement? (Select all that apply.)**

1. Demonstrate hearing aid battery replacement.

2. Review method to check volume on hearing aid.

3. Demonstrate how to wash the earmold and microphone with hot water.

4. Discuss the importance of having wax buildup in the ear canal removed.

5. Recommend a chemical cleaner to remove difficult buildup.

**10. Identify the measures to ensure safety for a patient who has no sensation on one side of the body.**

**Answers: 1. 1, 3, 4; 2. 2, 3, 4; 3. 3, 5; 4. 2, 3; 5. 3, 4, 2, 1, 5; 6. 1, 4, 5; 7. 3, 4, 5; 8. 2, 4; 9. 1, 2, 4; 10. See Evolve.**

**Chapter 9: Cultural Competence**

**Acculturation, p. 111**

**Assimilation, p. 111**

**Core measures, p. 111**

**Culture, p. 107**

**Cultural assessment, p. 113**

**Cultural awareness, p. 111**

**Cultural competence, p. 107**

**Cultural desire, p. 112**

**Cultural encounter, p. 112**

**Cultural knowledge, p. 112**

**Cultural respect, p. 111**

**Cultural skill, p. 112**

**Culturally congruent care, p. 107**

**Emic world view, p. 108**

**Ethnic/cultural identity, p. 110**

**Etic world view, p. 108**

**Health disparity, p. 108**

**Health literacy p. 115**

**Intersectionality, p. 110**

**Linguistic competence, p. 114**

**Marginalized groups, p. 109**

**Oppression, p. 110**

**Racial identity, p. 110**

**Social determinants of health, p. 109**

**Stereotype, p. 108**

**Unconscious/implicit bias, p. 107**

**Review Questions**

**1. Which of the following is an example of a patient with a health disparity? (Select all that apply.)**

1. A patient who has a homosexual sexual preference

2. A patient unable to access primary care services

3. A patient living with a chronic disease

4. A family who relies on public transportation

5. A patient who has had a history of smoking for 10 years

**2. A 35-year-old woman has Medicaid coverage for herself and two young children. She missed an appointment at the local health clinic to get an annual mammogram because she has no transportation. She gets the annual screening because her mother had breast cancer. Which of the following are social determinants of this woman’s health? (Select all that apply.)**

1. Medicaid insurance

2. Annual screening

3. Mother’s history of breast cancer

4. Lack of transportation

5. Woman’s age

**3. During a nursing assessment a patient displayed several behaviors. Which behavior suggests the patient may have a health literacy problem?**

1. Patient has difficulty completing a registration form at a medical office

2. Patient asks for written information about a health topic

3. Patient speaks Spanish as primary language

4. Patient states unfamiliarity with a newly ordered medicine

**4. A nurse desires to communicate with a young woman who is Serbian and who has limited experience with being in a hospital. The nurse has 10 years of experience caring for Serbian women. The patient was admitted for a serious pregnancy complication. Apply the LEARN model and match the nurse’s behaviors with each step of the model.**



**5. Health care organizations must provide which of the following based on federal civil rights laws? (Select all that apply.)**

1. Provide language assistance services at all points of contact free of charge.

2. Provide auxiliary aids and services, such as interpreters, note takers, and computer-aided transcription services.

3. Use patients’ family members to interpret difficult topics.

4. Ensure that interpreters are competent in medical terminology.

5. Provide language assistance to all patients who speak limited English or are deaf.

**6. A nurse working in a large occupational health clinic knows that many of the workers at her company are marginalized and at risk for poor health outcomes. Which of the following individuals are most likely to be marginalized?**

1. Wives of the employees

2. The head supervisors of the company

3. Workers who have a high school education

4. Workers employed for less than a year at the company

**7. A mother is concerned about her child’s flulike symptoms. You learn from the health assessment that the mother practices use of “hot” and “cold” foods to treat ailments. Which of the following foods do you expect the mother to use to treat her child?**

1. Chicken

2. Yogurt

3. Fresh fruits

4. Eggs

**8. Which explanation provided by the nurse is the most accurate meaning for “providing culturally congruent care”?**

1. It fits the patient’s valued life patterns and set of meanings.

2. It is the same set of values as those of the health care team member providing daily care.

3. It holds one’s own way of life as superior to those of others.

4. It redirects the patient to a more socially expected set of values.

**9. Which statement made by a new graduate nurse about the teach-back technique requires intervention and further instruction by the nurse’s preceptor?**

1. “After teaching a patient how to use an inhaler, I need to use the teach-back technique to test my patient’s technique.”

2. “The teach-back technique is an ongoing process of asking patients for feedback.”

3. “Using teach-back will help me identify explanations and communication strategies that my patients will most commonly understand.”

4. “Using pictures, drawings, and models can enhance the effectiveness of the teach-back technique.”

**10. Match the cultural concepts on the left with the correct definitions on the right**.



**Answers: 1.** 2, 3, 5; **2.** 1, 4, 5; **3.** 1; **4.** 1d, 2b, 3a, 4e, 5c; **5.** 1, 2, 4, 5; **6.** 3; **7.** 4; **8.** 1; **9.** 1; **10.** 1d, 2a, 3e, 4c, 5b.

**Chapter 35 – Spiritual Health**

**Agnostic, p. 723**

**Atheist, p. 723**

**Connectedness, p. 724**

**Faith, p. 724**

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**Hope, p. 724**

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**Spiritual distress, p. 725**

**Spirituality, p. 723**

**Spiritual well-being, p. 724**

**Transcendence, p. 724**

**Inner strength and peace, p. 724**

**Meaning and purpose in life, p. 724**

Review Questions

**1. The nurse is caring for a patient who has just had a near-death experience (NDE) following a cardiac arrest. Which intervention by the nurse best promotes the spiritual well-being of the patient after the NDE?**

1. Allowing the patient to discuss the experience

2. Referring the patient to pastoral care

3. Having the patient talk to another patient who had an NDE

4. Offering to pray for the patient

**2. The nurse is caring for a patient who is very depressed and decides to complete a spiritual assessment using the FICA tool. Using the FICA assessment tool, match the criteria on the left with the appropriate assessment question on the right.**



**3. Which statement made by a patient who is recovering after recently experiencing third-degree burns shows connectedness?**

1. “My pain medicine helps me feel better.”

2. “I know I will get better if I just keep trying.”

3. “I see God’s grace and become relaxed when I watch the sun set at night.”

4. “I feel so much closer to God after I read my Bible and pray.”

**4. A nurse is caring for a patient who is Muslim and has diabetes. Which of the following items does the nurse need to remove from the meal tray when it is delivered to the patient?**

**1. Small container of vanilla ice cream**

**2. A dozen red grapes**

**3. Bacon and eggs**

**4. Garden salad with ranch dressing**

**5. A 44-year-old male patient has just been told that his wife and child were killed in an auto accident while coming to visit him in the hospital. Which of the following statements are assessment findings that support a nursing diagnosis of *Spiritual Distress related to loss of family members*? (Select all that apply.)**

1. “I need to call my sister for support.”

2. “I have nothing to live for now.”

3. “Why would my God do this to me?”

4. “I need to pray for a miracle.”

5. “I want to be more involved in my church.”

**6. A patient has just learned she has been diagnosed with a malignant brain tumor. She is alone; her family will not be arriving from out of town for an hour. The nurse has been caring for her for only 2 hours but has a good relationship with her. What is the most appropriate intervention for support of her spiritual well-being at this time?**

1. Make a referral to a professional spiritual care adviser.

2. Sit down and talk with the patient; have her discuss her feelings and listen attentively.

3. Move the patient’s Bible from her bedside cabinet drawer to the top of the over-bed table.

4. Ask the patient whether she would like to learn more about the implications of having this type of tumor.

**7. A nurse is preparing to teach an older adult who has chronic arthritis how to practice meditation. Which of the following strategies are appropriate? (Select all that apply.)**

1. Encourage family members to participate in the exercise.

2. Have patient identify a quiet room in the home that has minimal interruptions.

3. Suggest the use of a quiet fan running in the room.

4. Explain that it is best to meditate about 5 minutes 4 times a day.

5. Show the patient how to sit comfortably with the limitation of his arthritis and focus on a prayer.

**8. A nursing student is developing a plan of care for a 74-year-old-female patient who has spiritual distress over losing a spouse. As the nurse develops appropriate interventions, which characteristics of older adults should be considered? (Select all that apply.)**

1. Older adults do not routinely use complementary medicine to cope with illness.

2. Older adults dislike discussing the afterlife and what might have happened to people who have passed on.

3. Older adults achieve spiritual resilience through frequent expressions of gratitude.

4. Have the patient determine whether her husband left a legacy behind.

5. Offer the patient her choice of rituals or participation in exercise.

**9. A nurse used spiritual rituals as an intervention in a patient’s care. Which of the following questions is most appropriate to evaluate its efficacy?**

1. Do you feel the need to forgive your wife over your loss?

2. What can I do to help you feel more at peace?

3. Did either prayer or meditation prove helpful to you?

4. Should we plan on having your family try to visit you more often in the hospital?

**10. The nurse is caring for a 50-year-old woman visiting the outpatient medicine clinic. The patient has had type 1 diabetes since age 13. She has numerous complications from her disease, including reduced vision, heart disease, and severe numbness and tingling of the extremities. Knowing that spirituality helps patients cope with chronic illness, which of the following principles should the nurse apply in practice? (Select all that apply.)**

1. Pay attention to the patient’s spiritual identity throughout the course of her illness.

2. Select interventions that you know scientifically support spiritual well-being.

3. Listen to the patient’s story each visit to the clinic and offer a compassionate presence.

4. When the patient questions the reason for her long-time suffering, try to provide answers.

5. Consult with a spiritual care adviser, and have the adviser recommend useful interventions.

**Answers:1.1; 2.1a, 2d, 3c, 4b; 3.4; 4.3; 5.2, 3; 6.2; 7.2, 3, 5; 8.3, 4, 5; 9.3; 10.1, 3;**

**Chapter 36: Loss and Grief**

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**Ambiguous loss, p. 742**

**Anticipatory grief, p. 742**

**Autopsy, p. 755**

**Bereavement, p. 742**

**Complicated grief, p. 742**

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**Grief, p. 741**

**Hope, p. 744**

**Hospice, p. 751**

**Maturational loss, p. 741**

**Mourning, p. 741**

**Necessary loss, p. 741**

**Normal (uncomplicated) grief, p. 742**

**Organ and tissue donation, p. 755**

**Palliative care, p. 751**

**Postmortem care, p. 756**

**Perceived loss, p. 741**

**Situational loss, p. 741**

**Review Questions**

**1. To best assist a patient in the grieving process, which factors are most important for the nurse to assess? (Select all that apply.)**

1. Previous experiences with grief and loss

2. Religious affiliation and denomination

3. Ethnic background and cultural practices

4. Current financial status

5. Current medications

**2. Which interventions does a nurse implement to help a patient at the end of life maintain autonomy while in a hospital? (Select all that apply.)**

1. Use therapeutic techniques when communicating with the patient.

2. Allow the patient to determine timing and scheduling of interventions.

3. Allow patients to have visitors at any time.

4. Provide the patient with a private room close to the nurses’ station.

5. Encourage the patient to eat whenever he or she is hungry.

**3. The nurse recognizes that which factors influence a person’s approach to death? (Select all that apply.)**

1. Culture

2. Spirituality

3. Personal beliefs

4. Previous experiences with death

5. Gender

6. Level of education

**4. A nurse has the responsibility of managing a patient’s postmortem care. What is the proper order for postmortem care when there is no autopsy ordered?**

1. Bathe the body of the deceased.

2. Collect any needed specimens.

3. Remove all tubes and indwelling lines.

4. Position the body for family viewing.

5. Speak to the family members about their possible participation.

6. Ensure that the request for organ/tissue donation and/or autopsy was completed.

7. Notify support person (e.g., spiritual care provider, bereavement specialist) for the family.

8. Accurately tag the body, including the identity of the deceased and safety issues regarding infection control.

9. Elevate the head of the bed.

**5. Which comments to a patient by a new nurse regarding palliative care needs are correct? (Select all that apply.)**

1. “Even though you’re continuing treatment, palliative care is something we might want to talk about.”

2. “Palliative care is appropriate for people with any diagnosis.”

3. “Only people who are dying can receive palliative care.”

4. “Children are able to receive palliative care.”

5. Palliative care is only for people with uncontrolled pain.

**6. A patient is receiving palliative care for symptom management related to anxiety and pain. A family member asks whether the patient is dying and now in “hospice.” What does the nurse tell the family member about palliative care? (Select all that apply.)**

1. Palliative care and hospice are the same thing.

2. Palliative care is for any patient, any time, any disease, in any setting.

3. Palliative care strategies are primarily designed to treat the patient’s illness.

4. Palliative care relieves the symptoms of illness and treatment.

5. Palliative care selects home health care services.

**7. When planning care for a dying patient, which interventions promote the patient’s dignity? (Select all that apply.)**

1. Providing respect

2. Viewing the patient as a whole

3. Providing symptom management

4. Showing interest

5. Being present

6. Inserting a straight catheter when the patient has difficulty voiding

**8. What are the physical circulatory changes that occur as death approaches?**

1. Skin irritation

2. Mottling

3. Increased urine output

4. Weakness

**9. When providing postmortem care, which actions are necessary for the nurse to complete?**

1. Locating the patient’s clothing

2. Calling the funeral home

3. Providing culturally and religiously sensitive care in body preparation

4. Providing postmortem care to protect the family of the deceased from having to view the body

**10. Which actions by the nurse help grieving families? (Select all that apply.)**

1. Encourage involvement in nonthreatening group social activities.

2. Follow up with the family in their home.

3. Remind them that feelings of sadness or pain can return around anniversaries.

4. Encourage survivors to ask for help.

5. Look for overuse of alcohol, sleeping aids, or street drugs.

**Answers:1.1, 2, 3;**

**2.2, 3, 5;**

 **3.1, 2, 3, 4;**

**4. 6, 9, 2, 5, 7, 3, 1, 4, 8;**

**5.1, 2, 4;**

**6. 2, 4;**

**7. 1, 2, 4, 5;**

 **8. 2;**

**9.3;**

**10.1, 3, 4, 5.**