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Chapter 01: Overview of Professional Nursing Concepts for Medical-Surgical Nursing

MULTIPLE CHOICE

1. A nurse wishes to provide client-centered care in all interactions. Which action by the nurse best demonstrates this concept?

- a. Assesses for cultural influences affecting health care
- b. Ensures that all the clients basic needs are met
- c. Tells the client and family about all upcoming tests
- d. Thoroughly orients the client and family to the room

ANS: A

Competency in client-focused care is demonstrated when the nurse focuses on communication, culture, respect, compassion, client education, and empowerment. By assessing the effect of the clients culture on health care, this nurse is practicing client-focused care. Providing for basic needs does not demonstrate this competence. Simply telling the client about all upcoming tests is not providing empowering education. Orienting the client and family to the room is an important safety measure, but not directly related to demonstrating client-centered care.

DIF: Understanding/Comprehension REF: 3

KEY: Patient-centered care| culture MSC: Integrated Process: Caring

NOT: Client Needs Category: Psychosocial Integrity

2. A nurse is caring for a postoperative client on the surgical unit. The clients blood pressure was 142/76 mm Hg 30 minutes ago, and now is 88/50 mm Hg. What action by the nurse is best?

- a. Call the Rapid Response Team.
- b. Document and continue to monitor.
- c. Notify the primary care provider.
- d. Repeat blood pressure measurement in 15 minutes.

ANS: A

The purpose of the Rapid Response Team (RRT) is to intervene when clients are deteriorating before they suffer either respiratory or cardiac arrest. Since the client has manifested a significant change, the nurse should call the RRT. Changes in blood pressure, mental status, heart rate, and pain are particularly significant. Documentation is vital, but the nurse must do more than document. The primary care provider should be notified, but this is not the priority over calling the RRT. The clients blood pressure should be reassessed frequently, but the priority is getting the rapid care to the client.

DIF: Applying/Application REF: 3

KEY: Rapid Response Team (RRT)| medical emergencies

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Physiological Integrity: Physiological Adaptation

3. A nurse is orienting a new client and family to the inpatient unit. What information does the nurse provide to help the client promote his or her own safety?

- a. Encourage the client and family to be active partners.
- b. Have the client monitor hand hygiene in caregivers.
- c. Offer the family the opportunity to stay with the client.
- d. Tell the client to always wear his or her armband.

ANS: A

Each action could be important for the client or family to perform. However, encouraging the client to be active in his or her health care as a partner is the most critical. The other actions are very limited in scope and do not provide the broad protection that being active and involved does.

DIF: Understanding/Comprehension REF: 3

KEY: Patient safety

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

4. A new nurse is working with a preceptor on an inpatient medical-surgical unit. The preceptor advises the student that which is the priority when working as a professional nurse?

- a. Attending to holistic client needs
- b. Ensuring client safety
- c. Not making medication errors
- d. Providing client-focused care

ANS: B

All actions are appropriate for the professional nurse. However, ensuring client safety is the priority. Up to 98,000 deaths result each year from errors in hospital care, according to the 2000 Institute of Medicine report. Many more clients have suffered injuries and less serious outcomes. Every nurse has the responsibility to guard the clients safety.

DIF: Understanding/Comprehension REF: 2

KEY: Patient safety

MSC: Integrated Process: Nursing Process: Intervention

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

5. A client is going to be admitted for a scheduled surgical procedure. Which action does the nurse explain is the most important thing the client can do to protect against errors?

- a. Bring a list of all medications and what they are for.
- b. Keep the doctors phone number by the telephone.
- c. Make sure all providers wash hands before entering the room.
- d. Write down the name of each caregiver who comes in the room.

ANS: A

Medication errors are the most common type of health care mistake. The Joint Commissions Speak Up campaign encourages clients to help ensure their safety. One recommendation is for clients to know all their medications and why they take them. This will help prevent medication errors.

DIF: Applying/Application REF: 4

KEY: Speak Up campaign| patient safety MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

6. Which action by the nurse working with a client best demonstrates respect for autonomy?

- a. Asks if the client has questions before signing a consent
- b. Gives the client accurate information when questioned
- c. Keeps the promises made to the client and family
- d. Treats the client fairly compared to other clients

ANS: A

Autonomy is self-determination. The client should make decisions regarding care. When the nurse obtains a signature on the consent form, assessing if the client still has questions is vital, because without full information the client cannot practice autonomy. Giving accurate information is practicing with veracity. Keeping promises is upholding fidelity. Treating the client fairly is providing social justice.

DIF: Applying/Application REF: 4

KEY: Autonomy| ethical principles MSC: Integrated Process: Caring

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

7. A student nurse asks the faculty to explain best practices when communicating with a person from the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community. What answer by the faculty is most accurate?

- a. Avoid embarrassing the client by asking questions.
- b. Dont make assumptions about their health needs.
- c. Most LGBTQ people do not want to share information.

d. No differences exist in communicating with this population.

ANS: B

Many members of the LGBTQ community have faced discrimination from health care providers and may be reluctant to seek health care. The nurse should never make assumptions about the needs of members of this population. Rather, respectful questions are appropriate. If approached with sensitivity, the client with any health care need is more likely to answer honestly.

DIF: Understanding/Comprehension REF: 4

KEY: LGBTQ| diversity

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Psychosocial Integrity

8. A nurse is calling the on-call physician about a client who had a hysterectomy 2 days ago and has pain that is unrelieved by the prescribed narcotic pain medication. Which statement is part of the SBAR format for communication?

- a. A: I would like you to order a different pain medication.
- b. B: This client has allergies to morphine and codeine.
- c. R: Dr. Smith doesn't like nonsteroidal anti-inflammatory meds.
- d. S: This client had a vaginal hysterectomy 2 days ago.

ANS: B

SBAR is a recommended form of communication, and the acronym stands for Situation, Background, Assessment, and Recommendation. Appropriate background information includes allergies to medications the on-call physician might order. Situation describes what is happening right now that must be communicated; the client's surgery 2 days ago would be considered background. Assessment would include an analysis of the client's problem; asking for a different pain medication is a recommendation. Recommendation is a statement of what is needed or what outcome is desired; this information about the surgeon's preference might be better placed in background.

DIF: Applying/Application REF: 5

KEY: SBAR| communication

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

9. A nurse working on a cardiac unit delegated taking vital signs to an experienced unlicensed assistive personnel (UAP). Four hours later, the nurse notes the client's blood pressure is much higher than previous readings, and the client's mental status has changed. What action by the nurse would most likely have prevented this negative outcome?

- a. Determining if the UAP knew how to take blood pressure
- b. Double-checking the UAP by taking another blood pressure
- c. Providing more appropriate supervision of the UAP
- d. Taking the blood pressure instead of delegating the task

ANS: C

Supervision is one of the five rights of delegation and includes directing, evaluating, and following up on delegated tasks. The nurse should either have asked the UAP about the vital signs or instructed the UAP to report them right away. An experienced UAP should know how to take vital signs and the nurse should not have to assess this at this point. Double-checking the work defeats the purpose of delegation. Vital signs are within the scope of practice for a UAP and are permissible to delegate. The only appropriate answer is that the nurse did not provide adequate instruction to the UAP.

DIF: Applying/Application REF: 6

KEY: Supervision| delegation| unlicensed assistive personnel

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

10. A nurse is talking with a client who is moving to a new state and needs to find a new doctor and hospital there. What advice by the nurse is best?

- a. Ask the hospitals there about standard nurse-client ratios.
- b. Choose the hospital that has the newest technology.
- c. Find a hospital that is accredited by The Joint Commission.
- d. Use a facility affiliated with a medical or nursing school.

ANS: C

Accreditation by The Joint Commission (TJC) or other accrediting body gives assurance that the facility has a focus on safety. Nurse-client ratios differ by unit type and change over time. New technology doesn't necessarily mean the hospital is safe. Affiliation with a health professions school has several advantages, but safety is most important.

DIF: Understanding/Comprehension REF: 2

KEY: The Joint Commission (TJC)| accreditation

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

11. A newly graduated nurse in the hospital states that, since she is so new, she cannot participate in quality improvement (QI) projects. What response by the precepting nurse is best?

- a. All staff nurses are required to participate in quality improvement here.
- b. Even being new, you can implement activities designed to improve care.
- c. It's easy to identify what indicators should be used to measure quality.
- d. You should ask to be assigned to the research and quality committee.

ANS: B

The preceptor should try to reassure the nurse that implementing QI measures is not out of line for a newly licensed nurse. Simply stating that all nurses are required to participate does not help the nurse understand how that is possible and is dismissive. Identifying indicators of quality is not an easy, quick process and would not be the best place to suggest a new nurse to start. Asking to be assigned to the QI committee does not give the nurse information about how to implement QI in daily practice.

DIF: Applying/Application REF: 6

KEY: Quality improvement

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

MULTIPLE RESPONSE

1. A nurse is interested in making interdisciplinary work a high priority. Which actions by the nurse best demonstrate this skill? (Select all that apply.)

- a. Consults with other disciplines on client care
- b. Coordinates discharge planning for home safety
- c. Participates in comprehensive client rounding
- d. Routinely asks other disciplines about client progress
- e. Shows the nursing care plans to other disciplines

ANS: A, B, C, D

Collaborating with the interdisciplinary team involves planning, implementing, and evaluating client care as a team with all other disciplines included. Simply showing other caregivers the nursing care plan is not actively involving them or collaborating with them.

DIF: Applying/Application REF: 4

KEY: Collaboration| interdisciplinary team

MSC: Integrated Process: Communication and Documentation

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

2. A nurse manager wishes to ensure that the nurses on the unit are practicing at their highest levels of competency. Which areas should the manager assess to determine if the nursing staff demonstrate competency according to the Institute of Medicine (IOM) report *Health Professions Education: A Bridge to Quality*? (Select all that apply.)

- a. Collaborating with an interdisciplinary team
- b. Implementing evidence-based care
- c. Providing family-focused care
- d. Routinely using informatics in practice
- e. Using quality improvement in client care

ANS: A, B, D, E

The IOM report lists five broad core competencies that all health care providers should practice. These include collaborating with the interdisciplinary team, implementing evidence-based practice, providing client-focused care, using informatics in client care, and using quality improvement in client care.

DIF: Remembering/Knowledge REF: 3

KEY: Competencies| Institute of Medicine (IOM)

MSC: Integrated Process: Nursing Process: Assessment

NOT: Client Needs Category: Safe and Effective Care Environment: Safety and Infection Control

3. The nurse utilizing evidence-based practice (EBP) considers which factors when planning care? (Select all that apply.)

- a. Cost-saving measures
- b. Nurses expertise
- c. Client preferences
- d. Research findings
- e. Values of the client

ANS: B, C, D, E

EBP consists of utilizing current evidence, the clients values and preferences, and the nurses expertise when planning care. It does not include cost-saving measures.

DIF: Remembering/Knowledge REF: 6

KEY: Evidence-based practice (EBP)

MSC: Integrated Process: Nursing Process: Planning

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

4. A nurse manager wants to improve hand-off communication among the staff. What actions by the manager would best help achieve this goal? (Select all that apply.)

- a. Attend hand-off rounds to coach and mentor.
- b. Conduct audits of staff using a new template.
- c. Create a template of topics to include in report.
- d. Encourage staff to ask questions during hand-off.
- e. Give raises based on compliance with reporting.

ANS: A, B, C, D

A good tool for standardizing hand-off reports and other critical communication is the SHARE model. SHARE stands for standardize critical information, hardwire within your system, allow opportunities to ask questions, reinforce quality and measurement, and educate and coach. Attending hand-off report gives the manager opportunities to educate and coach. Conducting audits is part of reinforcing quality. Creating a template is hardwiring within the system. Encouraging staff to ask questions and think critically about the information is allowing opportunities to ask questions. The manager may need to tie raises into compliance if the staff is resistive and other measures have failed, but this is not part of the SHARE model.

DIF: Applying/Application REF: 5

KEY: SHARE| hand-off communication

MSC: Integrated Process: Nursing Process: Intervention

NOT: Client Needs Category: Safe and Effective Care Environment: Management of Care

Chapter 02: Overview of Health Concepts for Medical-Surgical Nursing

MULTIPLE CHOICE

1. Acid-base balance occurs when the pH level of the blood is between:

- a. 7.3 and 7.5
- b. 7.35 and 7.45
- c. 7.4 and 7.5
- d. 7.25 and 7.35

ANS: B

Acid-base balance is the maintenance of arterial blood pH between 7.35 and 7.45 through hydrogen ion production and elimination.

DIF: Understanding/Comprehension REF: 13

KEY: Assessment

MSC: Physiological Adaptation | Fluid and Electrolyte Imbalances

NOT: Describe common fluid, electrolyte, and acid-base imbalances.

2. The nurse would expect a patient with respiratory acidosis to have an excessive amount of

- a. Hydrogen ions.
- b. Bicarbonate.
- c. Oxygen.
- d. Phosphate.

ANS: A

Respiratory acidosis occurs when the arterial blood pH level falls below 7.35 and is caused by either too many hydrogen ions in the body (respiratory acidosis) or too little bicarbonate (metabolic acidosis). Excessive oxygen and phosphate are not characteristic of respiratory acidosis.

DIF: Understanding/Comprehension REF: 13

KEY: Assessment

MSC: Physiological Adaptation | Fluid and Electrolyte Imbalances

NOT: Describe common fluid, electrolyte, and acid-base imbalances.

3. The best way for an individual to maintain acid-base balance is to

- a. avoid or quit smoking.
- b. exercise regularly.
- c. eat healthy and well-balanced meals.
- d. All of the above.

ANS: D

Maintaining a healthy lifestyle is the best way to maintain acid-base balance. For example, most cases of COPD can be prevented by avoiding or quitting smoking, while regular exercise and a healthy diet can decrease the incidence of type-2 diabetes.

DIF: Patient education REF: 14

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

4. The process to control cellular growth, replication, and differentiation to maintain homeostasis is called:

- a. cellular regulation.
- b. cellular impairment.
- c. cellular reproduction.
- d. cellular tumor.

ANS: A

Cellular Regulation is the term used to describe both the positive and negative aspects of cellular function

within the body.

DIF: Understanding/Comprehension REF: 14

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

5. A defining characteristic of malignant (cancerous) cells is:

- a. they cannot spread to other tissues or organs.
- b. they can invade healthy cells, tissues, and organs.
- c. they are not usually a health risk.
- d. none of the above.

ANS: B

Malignant (cancerous) cells have no comparison to the original cells from which they are derived, and they have the ability to invade healthy cells, tissues, and other organs through tumor formation and invasion. On the other hand, Benign cells do not have the ability to spread to other tissues or organs.

DIF: Understanding/Comprehension REF: 14

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

6. Specialized cells that circulate in the body to promote clotting are called:

- a. anticoagulants.
- b. proteins.
- c. emboli.
- d. platelets.

ANS: D

Clotting is a complex, multi-step process through which blood forms a protein-based clot to prevent excessive bleeding. Platelets (thrombocytes) are the specialized cells that circulate in the blood and are activated when an injury occurs. Once activated, these cells become sticky, causing them to clump together to form a temporary, localized, solid plug.

DIF: Understanding/Comprehension REF: 15

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

7. An increase in platelet stickiness can lead to:

- a. hypercoagulability
- b. thrombocytopenia
- c. embolus
- d. atrial fibrillation

ANS: A

Hypercoagulability refers to an increase in clotting ability caused by an excess of platelets or excessive platelet stickiness, which can impair blood flow. The opposite end of the spectrum involves an inability to form adequate clots, which often occurs when there is an inadequate number of circulating platelets or a reduction in platelet stickiness.

DIF: Understanding/Comprehension REF: 15

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

8. Signs and symptoms of _____ thrombosis include localized redness, swelling, and warmth:

- a. arterial

- b. venous
- c. partial
- d. atrial

ANS: B

Venous thrombosis is a clot formation in either superficial or deep veins, usually in the leg, and can be observed locally.

DIF: Understanding/Comprehension REF: 16

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

9. A serious condition which is not locally observable and is typically manifested by decreased blood flow to a distal extremity is known as _____ thrombosis.

- a. arterial
- b. venous
- c. partial
- d. atrial

ANS: A

Arterial thrombosis is manifested by decreased blood flow (perfusion) to a distal extremity or internal organ. For example, the distal leg can become pale and cool in the case of a femoral arterial clot due to blockage of blood to the leg. This is an emergent condition and requires immediate intervention.

DIF: Understanding/Comprehension REF: 16

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Health Promotion and Maintenance

10. A high-level thinking process that allows an individual to make decisions and judgments is known as:

- a. amnesia
- b. personality
- c. reasoning
- d. memory

ANS: C

Reasoning is the high-level cognitive thinking process that helps individuals make decisions and judgments. Personality is the way an individual feels and behaves, while Memory is the ability of an individual to retain and recall information. Amnesia refers to a loss of memory caused by brain trauma, congenital disorders, or acute health problems.

DIF: Understanding/Comprehension REF: 16

KEY: Assessment

MSC: Integrated Process: Teaching/Learning

NOT: Client Needs Category: Psychosocial Integrity

11. A form of inadequate cognition in older adults which is manifested by an acute, fluctuating confusional state is known as:

- a. dementia
- b. delirium
- c. amnesia
- d. depression

ANS: B

Delirium is the form of acute, fluctuating confusion which lasts from a few hours to less than 1 month and that may be treatable. Dementia is a chronic state of confusion that may last from a few months to many years and that may not be reversible. Amnesia refers to a loss of memory caused by brain trauma, congenital disorders, or acute health problems.