MEDICAL NURSING CASE STUDY ANSWERS

Determining the order to see the clients

The first client to be seen by the nurse should be the client who has unexpected or abnormal data. If all of the clients are apparently stable, then the client who has the greatest risk for a complication should be seen first. In this scenario:

1) (C) Mr. Gonzales, diagnosed with chest pain rule out myocardial infarction should be seen first. Chest pain associated with lack of oxygen reaching the cardiac muscle is a high risk for a complication.
2) (D) Ms. Smith, diagnosed with diabetic ketoacidosis, should be seen next to determine blood glucose levels and whether insulin replacement therapy is needed.
3) (A) Mr. Brody or (E) Mr. George can be seen next since both have issues with pain; pain does not kill but should be addressed to make sure that neither is experiencing pain at this time.
4) (A) Mr. Brody or (E) Mr. George can be seen next since both have issues with pain; pain does not kill but should be addressed to make sure that neither is experiencing pain at this time.
5) (B) Ms. White, diagnosed with bacterial pneumonia, should be seen last. Ms. White has been in the facility long enough for the nurse to receive a report. This client should have received at least the first dose of antibiotic by this time.

1. 1) Ensure the client is NPO.
   2) Hold the client’s oral medication.
   3) Administer the intravenous medication.
   4) Make sure the informed consent form is signed.
2. 1) Assess the client’s breath sounds.
   2) Assess the client’s respiratory rate.
   3) Assess the extremities for capillary refill time.
   4) Assess for buccal or circumoral cyanosis.
   5) Assess level of consciousness.
   6) Assess pulse oximeter reading.
   7) Assess the client for productive/non-productive cough.
3. 1) Check the client’s serum potassium level.
   2) Question the medication if the client’s B/P is less than 90/60.
   3) Question the medication if the client is dehydrated.
   4) Check the client’s intake and output.
   5) Assess the client for signs/symptoms of hypokalemia.
4. 1) Check the client’s glucose level.
   2) Check to determine if the client is NPO.
   3) Ensure the client eats breakfast to cover the regular insulin.
   4) Ensure the client eats lunch to cover the intermediate insulin.
   5) Administer the medication in the client’s abdomen.
   6) Assess the client for hypoglycemia throughout the shift.
5. 1) Assess the client’s pain on a scale of 1 to 10.
   2) Rule out any complications prior to administering pain medication (assess urine for blood; strain the client’s urine).
   3) Check the medication administration record (MAR) to determine the last time Mr. George received pain medication.
   4) Sign out narcotic medication from the medication delivery system (PIXYS).
   5) Check MAR against client’s ID band.
   6) Determine if pain medication is compatible with primary IV.
   7) Check patency of client’s IV site.
   8) Push intravenous pain medication slowly over 5 minutes.
   9) Assess client’s respiratory rate.
  10) Document on MAR and in nurse’s notes.
  11) Implement safety issues, bed low position, side rails up, call light within reach.
6. The following should not be delegated:

- **Cut Ms. Smith's toenails.** UAPs and nurses should not cut a client's toenails, especially a client who has diabetes. This presents an opportunity for the client to develop an infection and possibly lose the foot.

- **Rub and massage Ms. Smith's lower extremities.** Nurses and UAPs do not massage the lower extremities because of the risk for dislodging a clot in the extremity.

- **Feed Ms. Smith the breakfast meal.** The UAP should not feed a client who is 24 and can feed herself. The client should be encouraged to be independent.

7. 1) Assess bowel sounds in all four quadrants.
   2) Assess abdomen for firmness and tenderness.
   3) Assess last bowel movement.
   4) Determine type of bowel movement (soft, hard, dark color).
   5) Assess N/G tube output (coffee ground, green bile).
   6) Assess amount of N/G tube output.
   7) Determine if N/G tube is on low intermittent suction.
   8) Assess the client’s nare for irritation.

8. Assess cardiac enzymes including troponin, CPK-MB.

9. 1) Put the calculi (stone) in a sterile lab cup.
   2) Label the cup and send to laboratory.

10. Ms. Teresa should not make assumptions about what Ms. Smith knows:

   1) Ensure client knows how to take insulin injections, correct way and time.
   2) Ensure client knows how to treat hypoglycemia.
   3) Ensure client knows how to treat hyperglycemia and when to call the HCP.
   4) Ensure client knows how to count carbohydrates.
   5) Ensure client knows importance of daily exercise.
   6) Ensure client knows how to assess and care for feet.
   7) Ensure client knows sick day rules.

11. 1) Refer to a dietician.

   2) Provide Mr. George with written handouts.
   3) Limit oxalate to 40 to 50 mg each day.
   4) Drink 8 to 12 cups of fluid each day.

5) The body may turn extra vitamin C into oxalate. Avoid high doses of vitamin C supplements (more than 2,000 mg of vitamin C per day).

6) Oxalate is found in many foods. Limit foods such as soy cheese, soy milk, soy yogurt, cereal (bran or high fiber), fruitcake, pretzels, wheat bran, wheat germ, whole wheat bread, whole wheat flour, dark or “robust” beer, black tea, chocolate milk, cocoa, instant coffee, and hot chocolate.

12. 1) Discuss use of sublingual nitroglycerin (NTG): take one every 5 minutes; if no pain relief, get to the emergency department (do not drive), keep NTG in dark bottle, medication should burn under tongue.

   2) Instruct Mr. Gonzales to stop any activity if chest pain occurs; then take NTG as above.

   3) Discuss a low-fat, low-cholesterol (no fried foods; instead, boil, bake, and grill meats).

   4) Discuss the importance of walking daily for 30 minutes.

   5) Discuss the importance of not smoking or being around secondhand smoke.

   6) Discuss the need to eat small, frequent meals and avoid large meals.

13. 1) Determine Mr. Brody’s gag reflex has returned prior to giving PO fluids or food.

   2) Assess the client for any abdominal bleeding.

   3) Administer Mr. Brody’s a.m. medications.

   4) Give Mr. Brody water and breakfast or lunch meal.

14. 1) Check Ms. Smith’s blood glucometer reading.

   2) Give Ms. Smith a glass of orange juice.

   3) Give Ms. Smith a complex carbohydrate after feeling better such as graham crackers, peanut butter crackers, or cheese and crackers.

   4) Ensure Ms. Smith stays in bed.

15. 1) Elevate the head of Ms. White’s bed.

   2) Administer or increase oxygen via nasal cannula.

   3) Notify the respiratory therapist.

   4) Stay with Ms. White and attempt to calm her.

   5) Request client to take slow, deep breaths.

   6) Assess Ms. White’s bilateral lung sounds.
CRITICAL CARE NURSING CASE STUDY ANSWERS

1. 1) Check ventilator settings with prescribed settings.
   • Tidal volume
   • Rate
   • Positive-end-expiratory pressure (PEEP)
   • FiO₂ (oxygen concentration)
   • Mode of ventilation—control, assist-control, intermittent mandatory (IMV), synchronized intermittent mandatory ventilation (SIMV), pressure support ventilation (PSV)
2) Check ET tube placement.
3) Maintain proper cuff inflation.
4) Check all ventilator connections.
5) Have manual resuscitative bag at bedside (ambu bag).
6) Ensure all ventilator alarms are on and answered promptly.
7) Empty condensed water from water traps.
8) Assess client’s respiratory status, pulse oximeter, arterial blood gases.
9) Complete respiratory assessment (lung sounds, LOC, etc.).
10) Assess client’s reaction to muscle-paralyzing agents.
11) Ensure upper extremity restraints are on properly and assess for neurovascular compromise.
12) Suction with end-line suction as needed.
13) Collaborate with respiratory therapist.

2. 1) Assess for pallor, petechiae, purpura, oozing blood, hematomas, and occult hemorrhage.
2) Assess PT/PTT (prolonged); fibrinogen and platelets (reduced).
3) Administer blood products: platelets, cryoprecipitate, fresh frozen plasma.
4) Administer heparin or low-molecular-weight heparin.
5) Avoid IV and IM injections.
6) Use soft-bristle toothbrush.
7) Use electric razor.
8) Protect from trauma that may cause bleeding.

3. 1) Administer high liter oxygen and monitor pulse oximeter/arterial blood gases.
2) If pulse oximeter readings/ABG results continue to drop while client is receiving supplemental oxygen, it is ARDS.
3) Prepare to place client on ventilator (only treatment) along with treating underlying cause.

4. 1) See question 1 for care of the client on the ventilator.
2) Some clients respond positively to being placed in the prone position.
3) Address nutritional needs.
4) Assess client’s respiratory status.

5. 1) Assess for spinal shock (decreased reflexes, loss of sensation, flaccid paralysis).
2) Assess for neurogenic shock (hypotension and bradycardia).
3) Assess for respiratory status since C-6 and ascending paralysis.
4) Maintain bowel and bladder integrity.
5) Address immobility issues of the client (pneumonia, pressure ulcers, DVTs, contractures).
6) Maintain appropriate temperature of environment.

6. 1) Ensure patent airway.
2) Administer pain medication, including nitroglycerin sublingual and intravenous morphine.
3) Administer oxygen via nasal cannula or non-rebreather mask, and monitor pulse oximetry.
4) Obtain 12-lead EKG.
5) Monitor ECG telemetry readings.
6) Monitor cardiac isoenzymes, including troponin, CPK-MB.
7) Prepare to administer thrombolytic therapy, if appropriate.
8) Provide reassurance and emotional support to client and family.
9) Perform cardiovascular assessment frequently.
10) Bed rest and activity limitation for 12 to 24 hours, with gradual increase of activity.
7. 1) 80% of the clients have dysrhythmias.  
   2) Heart failure.  
   3) Cardiogenic shock.  
   4) Papillary muscle dysfunction.  
   5) Ventricular aneurysm.  
   6) Pericarditis.  
   7) Thromboembolism.  

8. 1) Shout, shake client, and check for carotid pulse.  
   2) Call a code.  
   3) Start CPR/Advanced Cardiac Life Support (ACLS).  
   4) Defibrillate at 360 joules.  
   5) Administer epinephrine IVP.  
   6) Administer lidocaine or amiodarone IVP.  

9. Problem 1: Nutritional problems  
   1) What to feed, when to feed, how to feed (route of administration).  
   2) Collaborate with registered dietician.  
   3) Enteral or parenteral nutrition.  

Problem 2: Anxiety  
   1) Encourage client to calmly verbalize concerns and ask questions.  
   2) Include client and family in all teaching; explain purpose of equipment and procedures.  
   3) Administer anti-anxiety medications cautiously.  

Problem 3: Inability to communicate  
   1) Use alternate methods of communication (picture boards, magic slates).  
   2) Use hand gestures; have client use eye blinks for yes/no questions.  
   3) Assess client for non-verbal communication.  

Problem 4: Intensive care psychosis (sensory-perceptual problems)  
   1) Identify and address factors that may precipitate delirium.  
   2) Use clocks and calendars in the ICU to help orient to time.  
   3) Limit noise in ICU, such as monitoring how many equipment alarms are going off, no paging.  

Problem 5: Sleep disturbances  
   1) Attempt to structure sleep, by creating a wake cycle: cluster activities, schedule rest periods.  
   2) Dim lights at night, and open curtains during the day.  
   3) Administer sleep medications, if needed.  

Problem 6: Pain  
   1) Assess client’s pain on 1 to 10 scale.  
   2) Rule out any complications secondary to pain that require medical interventions.  
   3) Keep client comfortable.  

Problem 7: Include family/significant other in all aspect of client care  
   1) Share pertinent information with family.  
   2) Allow family to be involved in decision making.  
   3) Ms. Paula should discuss what to expect when visiting clients in ICU, such as machines, noise.  
   4) Least restrictive visiting hours.
OUTPATIENT NURSING CASE STUDY ANSWERS

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

2. 1) Tell the client an informed consent form must be signed for this procedure.  
   2) Explain the client cannot eat or drink anything 8 hours prior to the procedure.  
   3) Tell the client an IV will be started and he will be sedated during the procedure.  
   4) Inform the client he will not remember the procedure when he wakes up.  
   5) Tell the client the nurse will be taking vital signs every 15 to 30 minutes after the procedure.  
   6) Explain the client’s gag reflex will have to be intact prior to any food or drink being given, usually 2 to 4 hours.  
   7) Tell the client the throat should not be painful but may experience some discomfort.  
   8) When the client can drink without vomiting, the client will be discharged from outpatient clinic.  
   9) Instruct the client to contact HCP if any bleeding, pain, or vomiting.

3. 1) The client will sign informed consent form.  
   2) A bowel preparation will be prescribed by the HCP the day before the procedure—which could be Golytely, Fleet’s enema—and the bowel must be free of feces prior to the procedure.  
   3) The client will be on a clear liquid diet 24 hours prior to the procedure and NPO 8 hours prior to the procedure (no red fluids).  
   4) Explain that an IV will be started and the client will be sedated during the procedure and should not remember anything.

4. 1) Explain the procedure to the client and gather the needed equipment.  
   2) Perform hand hygiene and don non-sterile gloves.  
   3) Position the client in the high-Fowler’s position.  
   4) Remove the sterile applicator from the culture tube by rotating the cap to break seal.  
   5) Instruct the client to tilt head back and open mouth.  
   6) Use tongue depressor (if desired) to depress tongue.  
   7) Swab the back of the throat along the tonsillar area from left to right.  
   8) Remove the applicator stick and place in the specimen tube.  
   9) Insert the stick into the tube until the swab is saturated with culture medium and the cap reaches black dot.  
   10) Label specimen tube and send to laboratory.

5. 1) Tell the client to remember the acronym “RICE”—rest, ice, compression, and elevation.  
   2) Rest prevents further injury and avoids stress on the injured ankle. The client should wear a brace or splint provided by the HCP.  
   3) Teach the client how to use crutches so no weight can be placed on the right ankle.  
   4) Tell the client to apply ice to the injury to help decrease pain and edema.  
   5) Instruct client not to apply ice directly to the skin; use a towel between the ice and the skin and apply ice for 20 minutes at a time.
allowing at least 30 minutes to elapse between applications.

6) Apply a compression to support and help prevent inflammation.

7) Show the client or significant other how to apply an ACE bandage by making a figure 8 wrap.

8) Inform the client not to apply it too tightly; toes should not be cold, turn blue, or tingle.

9) Explain elevation helps the body absorb fluid that has leaked into the tissue.

10) Tell the client to elevate the right foot above the level of the heart.

11) Recommend the client use ibuprofen for pain, and take the medication every 4 hours with food; the client can alternate Tylenol to help control pain.

12) Instruct the client to return to outpatient clinic or emergency department if pain is not relieved by ibuprofen/Tylenol, foot becomes numb, the client is unable to move the toes, or they are cold to the touch, or if edema has not decreased in 48 hours.

6. Explanation: Antibiotics are not prescribed for the “common cold” because antibiotics treat bacterial infections and the common cold is caused by a virus.

1) Explain the cold symptoms will usually last about 1 or 2 weeks.

2) Recommend the client drink water, juice, and clear broth, which will help loosen congestion and prevent dehydration.

3) Recommend the client not drink alcohol, coffee, or caffeinated sodas, which will increase possibility of dehydration.

4) Recommend salt water gargle to help relieve scratchy throat—1/2 teaspoon salt in 8 ounces of warm water.

5) Recommend saline nasal drops and sprays for nasal stuffiness and congestion.

6) Zinc products are recommended for a cold and can be purchased over the counter.

7) Recommend chicken noodle soup, which may have anti-inflammatory and mucous-thinning effects which makes the client feel better.

8) Explain there are numerous over-the-counter cold and cough medications; however, they will not prevent a cold or shorten the duration of a cold. Some OTC medication may cause complications; for example, Tylenol can cause liver dysfunction, and many cause drowsiness so the client should not operate machinery or drive a car.

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

8. Question 1: The American Cancer Society Web site recommends the following for detecting breast cancer:

• Yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health.

• Clinical breast exam (CBE) is recommended about every 3 years for women in their 20s and 30s and every year for women 40 and over.

• Women should know how their breasts normally look and feel and report any breast change promptly to their healthcare provider. Breast self-exam (BSE) is an option for women starting in their 20s.

Question 2: The American Cancer Society recommends the following beginning at age 50; both men and women should follow one of these testing schedules:

• Tests that find polyps and cancer
  • Flexible sigmoidoscopy every 5 years, or
  • Colonoscopy every 10 years, or
  • Double-contrast barium enema every 5 years, or
  • CT colonography (virtual colonoscopy) every 5 years

• Tests that primarily find cancer
  • Yearly fecal occult blood test (gFOBT), or
  • Yearly fecal immunochemical test (FIT) every year, or
  • Stool DNA test (sDNA), interval uncertain

Question 3: The American Cancer Society recommends the following to screen for cervical cancer:

• All women should begin cervical cancer screening about 3 years after they begin having vaginal intercourse, but no later than 21 years old. Screening should be done every year with the regular Pap test or every 2 years using the newer, liquid-based Pap test.

• Beginning at age 30, women who have had three normal Pap test results in a row may get screened every 2 to 3 years. Women older than 30 may also get screened every 3 years with either the conventional or liquid-based Pap test, plus the human papillomavirus (HPV) test.
• Women 70 years of age or older who have had three or more normal Pap tests in a row and no abnormal Pap test results in the last 10 years may choose to stop having Pap tests.
• Women who have had a total hysterectomy (removal of the uterus and cervix) may also choose to stop having Pap tests, unless the surgery was done as a treatment for cervical cancer or pre-cancer. Women who have had a hysterectomy without removal of the cervix should continue to have Pap tests.

Question 4: The American Cancer Society recommends men make an informed decision with their doctor about whether to be tested for prostate cancer. Research has not yet proved the potential benefits of testing outweigh the harms of testing and treatment. The American Cancer Society believes men should not be tested without learning about what is known and not known about the risks and possible benefits of testing and treatment.

Starting at age 50, talk to your doctor about the pros and cons of testing so you can decide if testing is the right choice for you. If you are African American or have a father or brother who had prostate cancer before age 65, you should have this talk with your doctor starting at age 45. If you decide to be tested, you should have the PSA blood test with or without a rectal exam.

Question 5: There is no standard or routine screening test for testicular cancer. Teach the client to perform self-testicular exams monthly to feel for lumps in the testes. This cancer is often found accidently by the client.
CHAPTER 14 CASE STUDIES: CARE OF CLIENTS IN VARIOUS SETTINGS

HOME HEALTH CASE STUDY ANSWERS

1. 1) Perform hand hygiene and provide privacy for the client.
2) Explain the procedure to the client and ensure all equipment is within reach.
3) Open sterile catheter set package.
4) Place sterile absorbent pad under the client’s buttocks.
5) Don sterile gloves from package on dominant hand.
6) Remove sterile articles from tray and arrange on sterile field.
7) Pour antiseptic solution over cotton balls or open swabs with stick end up.
8) Lubricate end of catheter, replace in sterile sleeve, and place between the client’s legs on sterile field.

[NOTE: It is controversial to check inflation of balloon—follow hospital policy.]
9) Cleanse the client’s urinary meatus, separate the client’s labia and keep separated during procedure.
10) Use sterile gloved hand with forceps (cotton balls) or swabs to cleanse meatus; one downward stroke only and discard in non-sterile area or bag; repeat 3 or 4 times.
11) Using sterile gloved hand insert lubricated catheter 2 inches or until urine enters tube.
12) Inject entire contents of prefilled syringe (10 mL) into side arm of the catheter.
13) Retract the catheter until resistance is felt.

[NOTE: If client experiences pain, deflate balloon and insert further and reinflate.]
9) Secure tubing to client’s clothing.
10) Dispose of soiled dressing and equipment in separate trash bag.

3. 1) Perform hand hygiene and provide privacy for client.
2) Explain procedure to client and ensure all equipment is within reach.
3) Cuff the top of disposable waterproof bag and place in reach of work area.
4) Don non-sterile gloves and place waterproof pad under client.
5) Remove old dressing, and do not apply water if dressing is adhering to the wound. Inform the client of possible discomfort or pre-medicate 30 minutes prior to procedure if needed.
6) Assess the drainage of dressing and dispose in the waterproof bag and remove non-sterile gloves.
7) Prepare sterile dressing supplies; pour prescribed solution over non-mesh gauze.
8) Don sterile gloves.
9) Assess the wound color, character of drainage, presence of type of sutures, and presence of any drainage.
10) Cleanse wound from least to most contaminated area.
11) Apply fine mesh gauze into wound in a single layer; be sure to crunch gauze.
12) Apply dry sterile 4x4 gauze over wet gauze.
13) Cover with ABD pad and secure firmly to abdomen with tape.
14) Remove sterile gloves and put old dressing and equipment in separate trash bag.

4. 1) Perform hand hygiene and provide privacy for client.
2) Explain procedure to the client and ensure all equipment is within reach.
3) Open specimen container and place cap sterile inside service up; do not touch inside of container.
4) Give client antiseptic wipe and instruct the client to hold penis with one hand; using a circular motion, cleanse area with antiseptic wipe from center outside.
5) Tell the client to urinate into commode then place sterile container under urine stream and collect 30 to 60 mL of urine in the cup.
6) Remove specimen container before flow of urine stops and before releasing the penis.
7) Replace specimen cap on the cup, and cleanse urine from external surface of container.
8) Discard gloves and wash hands.
9) Label specimen container with the client’s name and pertinent data.

5. 1) Perform hand hygiene, provide privacy for the client, and place protection (towels) under the client.
2) Explain the procedure to the client, ensure all equipment is within reach, and determine if the client can make it to the bathroom or obtain a bed pan.
3) Fill water container with 750 to 1,000 mL of lukewarm solution.
4) Prime the tubing with water.
5) Hang the enema bag on IV pole at bedside 18 inches above the rectum.
6) Don non-sterile gloves.
7) Place client on left side in Sims position.
8) Lubricate tip of tubing with water-soluble lubricant.
9) Gently spread buttocks; instruct the client to take slow breaths, and insert tubing 3 to 4 inches.
10) Open regulating clamp and allow solution to flow slowly.
11) Hold tubing in place and instruct client to take slow, deep breaths.
12) After solution has infused, gently remove tubing.

6. 1) Instruct the home health aide to perform hand hygiene and provide privacy for the client.
2) Tell the home health aide to explain the procedure to the client and ensure all equipment is within reach but the client does not have to wear gloves when performing irrigation.
Teach the home health aide the following:
3) Position the client on a chair in front of the toilet.
4) Remove used pouch gently and dispose of in separate trash bag.
5) Apply irrigation sleeve over stoma and allow the end to be in the commode water.
6) Fill irrigation bag with 1,000 mL of tap water and clear tubing of air.
7) Hang irrigation bag no higher than shoulder height.

8) Lubricate tube tip and hold snuggly against stoma opening (do not force cone into stoma) and start inflow of water.
9) Allow water to flow in over 5 to 10 minutes; if cramping starts, stop the flow until cramping stops; encourage the client to take deep breaths.
10) After fluid has entered colostomy, clamp tubing and wait 15 minutes to prevent sudden backflow of water from stoma.
11) Allow 15 minutes for initial evacuation of stool from colostomy, then dry tip of sleeve and clamp irrigation sleeve and leave in place for 30 minutes to allow more stool to be evacuated.
12) Encourage the client to ambulate while sleeve is on.
13) After 30 minutes, unclamp sleeve, empty fecal content, and remove the sleeve and rinse with liquid cleanser and cool water; hang sleeve to dry.
14) Rinse stoma site with water, note if any rash or irritation around stoma (contact HCP if needed); stoma should be pink and moist. If dark purple or dry, contact HCP.
15) Apply new colostomy pouch over stoma.

7. 1) Perform hand hygiene and don non-sterile gloves.
2) Explain procedure to the client and ensure all equipment is within reach.
3) Place arm straight in dependent position and place towel under arm.
4) Place tourniquet 4 to 6 inches above client’s elbow; instruct client to open and close hand.
5) Cleanse antecubital fossa with antimicrobial wipe, starting at vein site and cleanse in circular motion and let dry.
6) Hold skin taut and insert needle with bevel up at 30° angle.
7) Lower needle toward skin and thread needle along path of vein.
8) When blood is obtained, pull syringe plunger back gently and then transfer blood to appropriate tube. For vacutainer system, insert blood collection tube into plastic holder while holding plastic adapter steady.
9) Fill syringe to desired amount.
10) Remove needle from vein; cover venipuncture site with a sterile sponge to stop bleeding.

8. 1) Perform hand hygiene and don non-sterile gloves.
2) Explain procedure to the client and ensure all equipment is within reach.
3) Elevate the client’s head of bed.  
4) Ask the client if nose has been fractured or has a deviated septum. Check for nares patency.  
5) Place towel on chest and provide emesis basin.  
6) Measure N/G tube from tip of the client’s nose to earlobe to xiphoid process then mark tube.  
7) Coil end of N/G tube over fingers.  
8) Lubricate end of tube with water-soluble lubricant.  
9) Have client slightly extend head, then insert tube through nostril to back of throat.  
10) Ask the client to flex head forward.  
11) Have the client sip water while inserting tube until predetermined mark is reached.  
12) Aspirate gastric contents to determine correct tube placement.  
9. 1) Teach the client to pull plunger down to 20 units of air.  
2) Insert air into 70/30 bottle in upright position.  
3) Flip bottle to downward position and withdraw 20 units of 70/30 insulin.  
4) Have the client expose abdomen and identify an area 2 inches from umbilicus (belly button) and instruct to rotate sites (right side to left side).  
5) Instruct the client to hold syringe like a dart between the thumb and forefinger.  
6) Insert needle into skin at a 45° or 90° angle. client does not have to cleanse skin.  
7) Slowly insert 70/30 insulin (client does not have to aspirate for blood).  
8) Remove needle and apply a swab to injection site.  
9) Discard needle safely so no one else can use needle (plastic milk carton).  
10. 1) Instruct significant other to place chair with arms at side of bed.  
2) Assist the client to dangle legs on side of bed until stable.  
3) Ensure the client has nonslip shoes on.  
4) Have the client scoot to side of bed, and instruct significant other how to place gait belt on client, if necessary.  
5) Instruct significant other to place his or her foot closest to chair between the client’s feet.  
6) Rock the client and on the count of three assist client to standing position.  
7) Grasp gait belt and pivot the client to chair.  
8) Instruct the client to place hands on the arms of and slowly lower the client into the chair.  
9) Tell the client to scoot back in the chair so the client’s back is flush with back of the chair.
1. 1) d  
   2) i  
   3) l  
   4) f  
   5) a  
   6) m  
   7) o  
   8) b  
   9) h  
   10) n  
   11) e  
   12) k  
   13) g  
   14) c  

2. 1) Initial phase—usually the first one or two meetings in which the client’s anxiety is high; during these meetings address the reason for the group and group rules, and establish a trusting relationship with the nurse leader along with appropriate interactions with group members.  
   2) Working phase—these are meetings in which problems are identified, clients begin problem solving, and the group develops a sense of “we-ness”; these meetings allow the clients to accomplish goals.  
   3) Termination phase—this is usually the last one or two meetings; the clients should evaluate the group experience; some clients may be anxious about ending the group, but others may be glad to disband the group.  

3. 1) Hallucinations (auditory and visual).  
   2) Delusions.  
   3) Disorganized speech.  
   4) Disorganized behavior.  

4. 1) Flight of ideas.  
   2) Continuous activity, and does not respect boundaries.  
   3) Sexually acting out.  
   4) Talkative and pressured speech.  
   5) Easily distracted.  
   6) Bizarre dress and grooming.  
   7) Agitated or explosive.  
   8) Delusions of grandeur.  

5. 1) Loss of pleasure in life.  
   2) Change in appetite that may cause weight loss or gain.  
   3) Inability to sleep.  
   4) Listless, no energy, or easily fatigued.  
   5) Feelings of hopelessness or worthlessness.  
   6) Inability to concentrate or think clearly.  
   7) May have suicidal tendencies.  

6. First, Mr. Aaron must ask Mrs. Jones directly if she is thinking of killing herself.  
   Second, if Mrs. Jones says yes then Mr. Aaron must ask if she has a plan (the more specific the plan, the more serious the threat).  
   Third, see if Mrs. Jones has the method available (such as sleeping pills, a gun).  
   Mr. Aaron should determine if Mrs. Jones has ever attempted suicide before; this is a risk factor for attempting suicide.  

7. 1) Set limits on intrusive behavior and help the client respect boundaries.  
   2) Be calm, non-judgmental, and do not get “feelings” hurt.  
   3) Encourage the client to walk, throw basketball, and tear rags—any type of physical activity.  
   4) Discourage the client from playing competitive games such as cards, ping pong.  
   5) Do not argue or become defensive with the client interpreting the nurse as being intrusive.  
   6) Administer anti-mania medication (which will take up to 3 weeks to be effective).  

8. 1) Do not fight Mr. Chandler’s delusion.  
   2) Use distraction and involve client in reality-based topics.  
   3) Ask Mr. Chandler what the hallucinations are saying.  
   4) Mr. Aaron must take action if Mr. Chandler is having command hallucinations (which may cause harm to self or others).  
   5) Do not pretend to understand what Mr. Chandler is saying.  
   6) Give short, simple directions.  
   7) Orient the client by using unit orientation board (has date, month, season, and next holiday).
9. 1) Assess Mr. Jones for delirium tremens (seizure activity).
2) Administer benzodiazepines (anti-anxiety) medications to prevent seizures, e.g., chlordiazepoxide (Librium), diazepam (Valium), clonazepam (Klonopin).
3) Provide high-protein diet.
4) Increase client’s oral fluid intake.
5) Monitor intravenous fluids, which may include vitamins (known as “banana boat”).
6) Keep environmental stimuli to a minimum.
7) Monitor Mr. Jones’s vital signs.

10. 1) Axis I—psychiatric diagnosis.
2) Axis II—personality disorder.
3) Axis III—medical or physical problems.
4) Axis IV—psychological issues affecting the client such as being homeless or jobless, having no family, is divorced.
5) Axis V—Global Assessment Functioning (GAF) tool; the higher the number (1–100), the more apt it will be that the client can live independently.

WALKING (STEPPING REFLEX) IS ELICITED WHEN THE SOLES OF THE FEET TOUCH A FLAT SURFACE. THE INFANT WILL ATTEMPT TO “WALK” BY PLACING ONE FOOT IN FRONT OF THE OTHER. THIS REFLEX DISAPPEARS AT 6 WEEKS DUE TO AN INCREASED RATIO OF LEG WEIGHT TO STRENGTH.

ROOTING REFLEX IS ELICITED WHEN THE INFANT’S CHEEK OR MOUTH SEARCHES FOR THE OBJECT BY MOVING HIS HEAD IN STEADILY DECREASING ARCS UNTIL THE OBJECT IS FOUND. AFTER BECOMING USED TO RESPONDING IN THIS WAY (IF BREASTFED, APPROXIMATELY 3 WEEKS AFTER BIRTH), THE INFANT WILL MOVE DIRECTLY TO THE OBJECT WITHOUT SEARCHING.

SUCCING REFLEX IS ELICITED BY THE ROOF OF THE INFANT’S MOUTH AND THE INFANT WILL SUDDENLY START TO SUCK, SIMULATING THE WAY THE INFANT NATURALLY EATS.

TONIC-NECK REFLEX, KNOWN AS ASYMMETRIC TONIC-NECK REFLEX OR “FENCING POSTURE,” IS INITIATED WHEN THE CHILD’S HEAD IS TURNED TO THE SIDE. THE ARM ON THAT SIDE WILL STRAIGHTEN AND THE OPPOSITE ARM WILL BEND (SOMETIMES THE MOTION WILL BE VERY SUBTLE OR SLIGHT).

PALMAR GRASP REFLEX IS ELICITED WHEN AN OBJECT IS PLACED IN THE INFANT’S HAND AND STROKES THE PALM. THE FINGERS WILL CLOSE AND THE INFANT WILL GRASP IT; THE GRIP IS STRONG BUT UNPREDICTABLE. ALTHOUGH IT MAY BE ABLE TO SUPPORT THE INFANT’S WEIGHT, HE OR SHE MAY ALSO RELEASE THE GRIP SUDDENLY AND WITHOUT WARNING.

PLANTAR REFLEX IS A NORMAL REFLEX THAT INVOLVES PLANTAR FLEXION OF THE FOOT IN WHICH TOES MOVE AWAY FROM THE SHIN, AND CURL DOWN.

BABINSKI’S SIGN IS INITIATED WHEN THE FOOT IS STROKED AND THERE IS DORSIFLEXION OF THE FOOT (FOOT ANGLES TOWARD THE SHIN, BIG TOE CURLS UP).

FOR AN A PGAR SCORE, A NEWBORN IS ASSESSED AT 1 MINUTE AND 5 MINUTES AND EACH AREA CAN HAVE A SCORE OF 0, 1, OR 2, WITH 10 POINTS AS THE MAXIMUM. A TOTAL SCORE OF 10 MEANS A BABY IS IN THE BEST POSSIBLE CONDITION; A PGAR SCORES OF 3 OR LESS OFTEN MEAN A BABY NEEDS IMMEDIATE ATTENTION AND CARE. HOWEVER, ONLY 1.4% OF BABIES HAVE A PGAR SCORES LESS THAN 7 AT 5 MINUTES AFTER BIRTH.
3. Assess the general health including sleep, feeding, elimination, cry, alertness, respiration, temperature, and apical pulse. A complete newborn screening includes movement, muscle tone, symmetry, and also assesses for jaundice, hydration, and umbilicus.

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

5. Stage 1—latent phase—this is the first phase and is the longest and least intense; contractions become more frequent, helping the cervix to dilate so the baby can pass through the birth canal; the cervix will dilate approximately 3 or 4 centimeters and efface.

   Stage 1—active phase—the cervix dilates from 4 to 7 centimeters; the mother may feel intense pain or pressure in the back or abdomen during each contraction; she may feel the urge to push or bear down but must wait until the cervix is completely dilated.

   Stage 1—transition phase—the cervix fully dilates to 10 centimeters; contractions are very strong, painful, and frequent, coming every 3 to 4 minutes and lasting from 60 to 90 seconds. Stage 1 is complete when the cervix is fully dilated and effaced.

   Stage 2—this stage begins when the cervix is completely opened; the doctor will instruct the mother to push; the force of contractions will propel the baby through the birth canal; the fontanels on the baby’s head allow it to fit through the narrow canal; the baby’s head crowns when the widest part of it reaches the vaginal opening; pushing helps to deliver the baby’s shoulders and body.

   Stage 3—this is the final stage of labor after the baby has been delivered; the placenta is delivered.

6. 1) Hygiene—shower and wash hair at any time, change pads frequently and cleanse with warm water using peri-bottle at every change, wipe from front to back, and do not douche or use internal tampons for 4 to 6 weeks. Perineal stitches are absorbable and do not need to be removed. Take a sitz bath three times a day and use perineal wipes on your perineum or hemorrhoids.

   2) Constipation—avoid constipation by eating a well-balanced diet including fruits and vegetables and drink plenty of fluids. Stool softeners or mild laxatives may be used.

   3) Exercise/rest—take frequent rest periods, especially when the baby is sleeping, avoid lifting anything heavier than the baby for 3 to 4 weeks, and do not start vigorous exercises until approved by your provider. Perineal exercises can be started when at home.

   4) Call the physician immediately if your temperature is above 100°F; you experience severe cramping or abdominal pains with chills and fever; have heavy bleeding and/or pass large blood clots; have foul-smelling vaginal discharge; have increased tenderness, redness, drainage, or separation of stitches; have pain, burning, or difficulty urinating.

   5) It is normal to feel tired or overwhelmed or have “postpartum blues” after going home; this is because of the many physical, hormonal, and emotional changes that occur after delivery. If these feelings continue for more than a few days, notify your provider.