NCLEX REVIEWER
NURSING BULLETS:
FUNDAMENTALS OF NURSING

- A blood pressure cuff that's too narrow can cause a falsely elevated blood pressure reading.
- When preparing a single injection for a patient who takes regular and neutral protein Hagedorn insulin, the nurse should draw the regular insulin into the syringe first so that it does not contaminate the regular insulin.
- Rhonchi are the rumbling sounds heard on lung auscultation. They are more pronounced during expiration than during inspiration.
- Gavage is forced feeding, usually through a gastric tube (a tube passed into the stomach through the mouth).
- According to Maslow's hierarchy of needs, physiologic needs (air, water, food, shelter, sex, activity, and comfort) have the highest priority.
- The safest and surest way to verify a patient's identity is to check the identification band on his wrist.
- In the therapeutic environment, the patient's safety is the primary concern.
- Fluid oscillation in the tubing of a chest drainage system indicates that the system is working properly.
- The nurse should place a patient who has a Sengstaken-Blakemore tube in semi-Fowler position.
- The nurse can elicit Trousseau's sign by occluding the brachial or radial artery. Hand and finger spasms that occur during occlusion indicate Trousseau's sign and suggest hypocalcemia.
- For blood transfusion in an adult, the appropriate needle size is 16 to 20G.
- Intractable pain is pain that incapacitates a patient and can't be relieved by drugs.
- In an emergency, consent for treatment can be obtained by fax, telephone, or other telegraphic means.
- Decibel is the unit of measurement of sound.
- Informed consent is required for any invasive procedure.
- A patient who can't write his name to give consent for treatment must make an X in the presence of two witnesses, such as a nurse, priest, or physician.
- The Z-track I.M. injection technique seals the drug deep into the muscle, thereby minimizing skin irritation and staining. It requires a needle that's 1" (2.5 cm) or longer.
- In the event of fire, the acronym most often used is RACE. (R) Remove the patient. (A) Activate the alarm. (C) Attempt to contain the fire by closing the door. (E) Extinguish the fire if it can be done safely.
- A registered nurse should assign a licensed vocational nurse orlicensed practical nurse to perform bedside care, such as suctioning and drug administration.
- If a patient can't void, the first nursing action should be bladder palpation to assess for bladder distention.
- The patient who uses a cane should carry it on the unaffected side and advance it at the same time as the affected extremity.
- To fit a supine patient for crutches, the nurse should measure from the axilla to the sole and add 2" (5 cm) to that measurement.
- Assessment begins with the nurse's first encounter with the patient and continues throughout the patient's stay. The nurse obtains assessment data through the health history, physicalexamination, and review of diagnostic studies.

- The appropriate needle size for insulin injection is 25G and 5/8" long.
- Residual urine is urine that remains in the bladder after voiding. The amount of residual urine is normally 50 to 100 ml.
- The five stages of the nursing process are assessment, nursing diagnosis, planning, implementation, and evaluation.
- Assessment is the stage of the nursing process in which the nurse continuously collects data to identify a patient's actual and potential health needs.
- Nursing diagnosis is the stage of the nursing process in which the nurse makes a clinical judgment about individual, family, or community responses to actual or potential health problems or life processes.
- Planning is the stage of the nursing process in which the nurse assigns priorities to nursing diagnoses, defines short-term and long-term goals and expected outcomes, and establishes thenursing care plan.
- Implementation is the stage of the nursing process in which the nurse puts the nursing care plan into action, delegates specific nursing interventions to members of the nursing team, and charts patient responses to nursing interventions.
- Evaluation is the stage of the nursing process in which the nurse compares objective and subjective data with the outcome criteria and, if needed, modifies the nursing care plan.
- Before administering any "as needed" pain medication, the nurse should ask the patient to indicate the location of the pain.
- Jehovah's Witnesses believe that they shouldn't receive blood components donated by other people.
- To test visual acuity, the nurse should ask the patient to cover each eye separately and to read the eye chart with glasses and without, as appropriate.
- When providing oral care for an unconscious patient, to minimize the risk of aspiration, the nurse should position the patient on the side.
- During assessment of distance vision, the patient should stand 20' (6.1 m) from the chart.
- For a geriatric patient or one who is extremely ill, the ideal room temperature is 66° to 76° F (18.8° to 24.4° C).
- Normal room humidity is 30% to 60%.
- Hand washing is the single best method of limiting the spread of microorganisms. Once gloves are removed after routine contact with a patient, hands should be washed for 10 to 15 seconds.
- To perform catheterization, the nurse should place a woman in the dorsal recumbent position.
- A positive Homans' sign may indicate thrombophlebitis.
- Electrolytes in a solution are measured in milliequivalents per liter (mEq/L). A milliequivalent is the number of milligrams per 100 milliliters of a solution.
- Metabolism occurs in two phases: anabolism (the constructive phase) and catabolism (the destructive phase).
- The basal metabolic rate is the amount of energy needed to maintain essential body functions. It's measured when the patient is awake and resting, hasn't eaten for 14 to 18 hours, and is in a comfortable, warm environment.
- The basal metabolic rate is expressed in calories consumed per hour per kilogram of body weight.

- Dietary fiber (roughage), which is derived from cellulose, supplies bulk, maintains intestinal motility, and helps to establish regular bowel habits.
- Alcohol is metabolized primarily in the liver. Smaller amounts are metabolized by the kidneys and lungs.
- Petechiae are tiny, round, purplish red spots that appear on the skin and mucous membranes as a result of intradermal or submucosal hemorrhage.
- Purpura is a purple discoloration of the skin that's caused by blood extravasation.
- According to the standard precautions recommended by the Centers for Disease Control and Prevention, the nurse shouldn't recap needles after use. Most needle sticks result from missed needle recapping.
- The nurse administers a drug by I.V. push by using a needle and syringe to deliver the dose directly into a vein, I.V. tubing, or a catheter.
- When changing the ties on a tracheostomy tube, the nurse should leave the old ties in place until the new ones are applied.
- A nurse should have assistance when changing the ties on a tracheostomy tube.
- A filter is always used for blood transfusions.
- A four-point (quad) cane is indicated when a patient needs more stability than a regular cane can provide.
- A good way to begin a patient interview is to ask, "What made you seek medical help?"
- When caring for any patient, the nurse should follow standard precautions for handling blood and body fluids.
- Potassium (K+) is the most abundant cation in intracellular fluid.
- In the four-point, or alternating, gait, the patient first moves the right crutch followed by the left foot and then the left crutch followed by the right foot.
- In the three-point gait, the patient moves two crutches and the affected leg simultaneously and then moves the unaffected leg.
- In the two-point gait, the patient moves the right leg and the left crutch simultaneously and then moves the left leg and the right crutch simultaneously.
- The vitamin B complex, the water-soluble vitamins that are essential for metabolism, include thiamine (B1), riboflavin (B2), niacin (B3), pyridoxine (B6), and cyanocobalamin (B12).
- When being weighed, an adult patient should be lightly dressed and shoeless.
- Before taking an adult's temperature orally, the nurse should ensure that the patient hasn't smoked or consumed hot or cold substances in the previous 15 minutes.
- The nurse shouldn't take an adult's temperature rectally if the patient has a cardiac disorder, anal lesions, or bleeding hemorrhoids or has recently undergone rectal surgery.
- In a patient who has a cardiac disorder, measuring temperature rectally may stimulate a vagal response and lead to vasodilation and decreased cardiac output.
- When recording pulse amplitude and rhythm, the nurse should use these descriptive measures: +3, bounding pulse (readily palpable and forceful); +2, normal pulse (easily palpable); +1, thready or weak pulse (difficult to detect); and 0, absent pulse (not detectable).
- The intraoperative period begins when a patient is transferred to the operating room bed and ends when the patient is admitted to the postanesthesia care unit.
- On the morning of surgery, the nurse should ensure that the informed consent form has been signed; that the patient hasn't taken anything by mouth since midnight,

has taken a shower with antimicrobial soap, has had mouth care (without swallowing the water), has removed common jewelry, and has received preoperative medication as prescribed; and that vital signs have been taken and recorded. Artificial limbs and other prostheses are usually removed.

- Comfort measures, such as positioning the patient, rubbing the patient's back, and providing a restful environment, may decrease the patient's need for analgesics or may enhance their effectiveness.
- A drug has three names: generic name, which is used in official publications; trade, or brand, name (such as Tylenol), which is selected by the drug company; and chemical name, which describes the drug's chemical composition.
- To avoid staining the teeth, the patient should take a liquid iron preparation through a straw.
- The nurse should use the Z-track method to administer an I.M. injection of iron dextran (Imferon).
- An organism may enter the body through the nose, mouth, rectum, urinary or reproductive tract, or skin.
- In descending order, the levels of consciousness are alertness, lethargy, stupor, light coma, and deep coma.
- To turn a patient by logrolling, the nurse folds the patient's arms across the chest; extends the patient's legs and inserts a pillow between them, if needed; places a draw sheet under the patient; and turns the patient by slowly and gently pulling on the draw sheet.
- The diaphragm of the stethoscope is used to hear high-pitched sounds, such as breath sounds.
- A slight difference in blood pressure (5 to 10 mm Hg) between the right and the left arms is normal.
- The nurse should place the blood pressure cuff 1" (2.5 cm) above the antecubital fossa.
- When instilling ophthalmic ointments, the nurse should waste the first bead of ointment and then apply the ointment from the inner canthus to the outer canthus.
- The nurse should use a leg cuff to measure blood pressure in an obese patient.
- If a blood pressure cuff is applied too loosely, the reading will be falsely elevated.
- Ptosis is drooping of the eyelid.
- A tilt table is useful for a patient with a spinal cord injury, orthostatic hypotension, or brain damage because it can move the patient gradually from a horizontal to a vertical (upright) position.
- To perform venipuncture with the least injury to the vessel, the nurse should turn the bevel upward when the vessel's lumen is larger than the needle and turn it downward when the lumen is only slightly larger than the needle.
- To move a patient to the edge of the bed for transfer, the nurse should follow these steps: Move the patient's head and shoulders toward the edge of the bed. Move the patient's feet and legs to the edge of the bed (crescent position). Place both arms well under the patient's hips, and straighten the back while moving the patient toward the edge of the bed.
- When being measured for crutches, a patient should wear shoes.
- The nurse should attach a restraint to the part of the bed frame that moves with the head, not to the mattress or side rails.

- The mist in a mist tent should never become so dense that it obscures clear visualization of the patient's respiratory pattern.
- To administer heparin subcutaneously, the nurse should follow these steps: Clean, but don't rub, the site with alcohol. Stretch the skin taut or pick up a well-defined skin fold. Hold the shaft of the needle in a dart position. Insert the needle into the skin at a right (90-degree) angle. Firmly depress the plunger, but don't aspirate. Leave the needle in place for 10 seconds. Withdraw the needle gently at the angle of insertion. Apply pressure to the injection site with an alcohol pad.
- For a sigmoidoscopy, the nurse should place the patient in the knee-chest position or Sims' position, depending on the physician's preference.
- Maslow's hierarchy of needs must be met in the following order: physiologic (oxygen, food, water, sex, rest, and comfort), safety and security, love and belonging, self-esteem and recognition, and self-actualization.
- When caring for a patient who has a nasogastric tube, the nurse should apply a water-soluble lubricant to the nostril to prevent soreness.
- During gastric lavage, a nasogastric tube is inserted, the stomach is flushed, and ingested substances are removed through the tube.
- In documenting drainage on a surgical dressing, the nurse should include the size, color, and consistency of the drainage (for example, "10 mm of brown mucoid drainage noted on dressing").
- To elicit Babinski's reflex, the nurse strokes the sole of the patient's foot with a moderately sharp object, such as a thumbnail.
- A positive Babinski's reflex is shown by dorsiflexion of the great toe and fanning out of the other toes.
- When assessing a patient for bladder distention, the nurse should check the contour of the lower abdomen for a rounded mass above the symphysis pubis.
- The best way to prevent pressure ulcers is to reposition thebedridden patient at least every 2 hours.
- Antiembolism stockings decompress the superficial blood vessels, reducing the risk of thrombus formation.
- In adults, the most convenient veins for venipuncture are the basilic and median cubital veins in the antecubital space.
- Two to three hours before beginning a tube feeding, the nurse should aspirate the patient's stomach contents to verify that gastric emptying is adequate.
- People with type O blood are considered universal donors.
- People with type AB blood are considered universal recipients.
- Hertz (Hz) is the unit of measurement of sound frequency.
- Hearing protection is required when the sound intensity exceeds 84 dB. Double hearing protection is required if it exceeds 104 dB.
- Prothrombin, a clotting factor, is produced in the liver.
- If a patient is menstruating when a urine sample is collected, the nurse should note this on the laboratory request.
- During lumbar puncture, the nurse must note the initial intracranialpressure and the color of the cerebrospinal fluid.
- If a patient can't cough to provide a sputum sample for culture, a heated aerosol treatment can be used to help to obtain a sample.
- If eye ointment and eyedrops must be instilled in the same eye, the eyedrops should be instilled first.

- When leaving an isolation room, the nurse should remove her gloves before her mask because fewer pathogens are on the mask.
- Skeletal traction, which is applied to a bone with wire pins or tongs, is the most effective means of traction.
- The total parenteral nutrition solution should be stored in a refrigerator and removed 30 to 60 minutes before use. Delivery of a chilled solution can cause pain, hypothermia, venous spasm, and venous constriction.
- Drugs aren't routinely injected intramuscularly into edematous tissue because they may not be absorbed.
- When caring for a comatose patient, the nurse should explain each action to the patient in a normal voice.
- Dentures should be cleaned in a sink that's lined with a washcloth.
- A patient should void within 8 hours after surgery.
- An EEG identifies normal and abnormal brain waves.
- Samples of feces for ova and parasite tests should be delivered to the laboratory without delay and without refrigeration.
- The autonomic nervous system regulates the cardiovascular and respiratory systems.
- When providing tracheostomy care, the nurse should insert the catheter gently into the tracheostomy tube. When withdrawing the catheter, the nurse should apply intermittent suction for no more than 15 seconds and use a slight twisting motion.
- A low-residue diet includes such foods as roasted chicken, rice, and pasta.
- A rectal tube shouldn't be inserted for longer than 20 minutes because it can irritate the rectal mucosa and cause loss of sphincter control.
- A patient's bed bath should proceed in this order: face, neck, arms, hands, chest, abdomen, back, legs, perineum.
- To prevent injury when lifting and moving a patient, the nurse should primarily use the upper leg muscles.
- Patient preparation for cholecystography includes ingestion of a contrast medium and a low-fat evening meal.
- While an occupied bed is being changed, the patient should be covered with a bath blanket to promote warmth and prevent exposure.
- Anticipatory grief is mourning that occurs for an extended time when the patient realizes that death is inevitable.
- The following foods can alter the color of the feces: beets (red), cocoa (dark red or brown), licorice (black), spinach (green), andmeat protein (dark brown).
- When preparing for a skull X-ray, the patient should remove all jewelry and dentures.
- The fight-or-flight response is a sympathetic nervous system response.
- Bronchovesicular breath sounds in peripheral lung fields are abnormal and suggest pneumonia.
- Wheezing is an abnormal, high-pitched breath sound that's accentuated on expiration.
- Wax or a foreign body in the ear should be flushed out gently by irrigation with warm saline solution.
- If a patient complains that his hearing aid is "not working," the nurse should check the switch first to see if it's turned on and then check the batteries.
- The nurse should grade hyperactive biceps and triceps reflexes as +4.
- If two eye medications are prescribed for twice-daily instillation, they should be administered 5 minutes apart.

- In a postoperative patient, forcing fluids helps prevent constipation.
- A nurse must provide care in accordance with standards of care established by the American Nurses Association, state regulations, and facility policy.
- The kilocalorie (kcal) is a unit of energy measurement that represents the amount of heat needed to raise the temperature of 1 kilogram of water 1° C.
- As nutrients move through the body, they undergo ingestion, digestion, absorption, transport, cell metabolism, and excretion.
- The body metabolizes alcohol at a fixed rate, regardless of serum concentration.
- In an alcoholic beverage, proof reflects the percentage of alcohol multiplied by 2. For example, a 100-proof beverage contains 50% alcohol.
- A living will is a witnessed document that states a patient's desire for certain types of care and treatment. These decisions are based on the patient's wishes and views on quality of life.
- The nurse should flush a peripheral heparin lock every 8 hours (if it wasn't used during the previous 8 hours) and as needed with normal saline solution to maintain patency.
- Quality assurance is a method of determining whether nursing actions and practices meet established standards.
- The five rights of medication administration are the right patient, right drug, right dose, right route of administration, and right time.
- The evaluation phase of the nursing process is to determine whether nursing interventions have enabled the patient to meet the desired goals.
- Outside of the hospital setting, only the sublingual and translingual forms of nitroglycerin should be used to relieve acute anginal attacks.
- The implementation phase of the nursing process involves recording the patient's response to the nursing plan, putting the nursing plan into action, delegating specific nursing interventions, and coordinating the patient's activities.
- The Patient's Bill of Rights offers patients guidance and protection by stating the responsibilities of the hospital and its staff toward patients and their families during hospitalization.
- To minimize omission and distortion of facts, the nurse should record information as soon as it's gathered.
- When assessing a patient's health history, the nurse should record the current illness chronologically, beginning with the onset of the problem and continuing to the present.
- When assessing a patient's health history, the nurse should record the current illness chronologically, beginning with the onset of the problem and continuing to the present.
- A nurse shouldn't give false assurance to a patient.
- After receiving preoperative medication, a patient isn't competent to sign an informed consent form.
- When lifting a patient, a nurse uses the weight of her body instead of the strength in her arms.
- A nurse may clarify a physician's explanation about an operation or a procedure to a patient, but must refer questions about informed consent to the physician.
- When obtaining a health history from an acutely ill or agitated patient, the nurse should limit questions to those that provide necessary information.
- If a chest drainage system line is broken or interrupted, the nurse should clamp the tube immediately.

- The nurse shouldn't use her thumb to take a patient's pulse rate because the thumb has a pulse that may be confused with the patient's pulse.
- An inspiration and an expiration count as one respiration.
- Eupnea is normal respiration.
- During blood pressure measurement, the patient should rest the arm against a surface. Using muscle strength to hold up the arm may raise the blood pressure.
- Major, unalterable risk factors for coronary artery disease include heredity, sex, race, and age.
- Inspection is the most frequently used assessment technique.
- Family members of an elderly person in a long-term care facility should transfer some personal items (such as photographs, a favorite chair, and knickknacks) to the person's room to provide a comfortable atmosphere.
- Pulsus alternans is a regular pulse rhythm with alternating weak and strong beats. It occurs in ventricular enlargement because the stroke volume varies with each heartbeat.
- The upper respiratory tract warms and humidifies inspired air and plays a role in taste, smell, and mastication.
- Signs of accessory muscle use include shoulder elevation, intercostal muscle retraction, and scalene and sternocleidomastoid muscle use during respiration.
- When patients use axillary crutches, their palms should bear the brunt of the weight.
- Activities of daily living include eating, bathing, dressing, grooming, toileting, and interacting socially.
- Normal gait has two phases: the stance phase, in which the patient's foot rests on the ground, and the swing phase, in which the patient's foot moves forward.
- The phases of mitosis are prophase, metaphase, anaphase, and telophase.
- The nurse should follow standard precautions in the routine care of all patients.
- The nurse should use the bell of the stethoscope to listen for venous hums and cardiac murmurs.
- The nurse can assess a patient's general knowledge by asking questions such as "Who is the president of the United States?
- Cold packs are applied for the first 20 to 48 hours after an injury; then heat is applied. During cold application, the pack is applied for 20 minutes and then removed for 10 to 15 minutes to prevent reflex dilation (rebound phenomenon) and frostbite injury.
- The pons is located above the medulla and consists of white matter (sensory and motor tracts) and gray matter (reflex centers).
- The autonomic nervous system controls the smooth muscles.
- A correctly written patient goal expresses the desired patient behavior, criteria for measurement, time frame for achievement, and conditions under which the behavior will occur. It's developed in collaboration with the patient.
- Percussion causes five basic notes: tympany (loud intensity, as heard over a gastric air bubble or puffed out cheek), hyperresonance (very loud, as heard over an emphysematous lung), resonance (loud, as heard over a normal lung), dullness (medium intensity, as heard over the liver or other solid organ), and flatness (soft, as heard over the thigh).
- The optic disk is yellowish pink and circular, with a distinct border.
- A primary disability is caused by a pathologic process. A secondary disability is caused by inactivity.

- Nurses are commonly held liable for failing to keep an accurate count of sponges and other devices during surgery.
- The best dietary sources of vitamin B6 are liver, kidney, pork, soybeans, corn, and whole-grain cereals.
- Iron-rich foods, such as organ meats, nuts, legumes, dried fruit, green leafy vegetables, eggs, and whole grains, commonly have a low water content.
- Collaboration is joint communication and decision making betweennurses and physicians. It's designed to meet patients' needs by integrating the care regimens of both professions into one comprehensive approach.
- Bradycardia is a heart rate of fewer than 60 beats/minute.
- A nursing diagnosis is a statement of a patient's actual or potential health problem that can be resolved, diminished, or otherwise changed by nursing interventions.
- During the assessment phase of the nursing process, the nurse collects and analyzes three types of data: health history, physical examination, and laboratory and diagnostic test data.
- The patient's health history consists primarily of subjective data, information that's supplied by the patient.
- The physical examination includes objective data obtained by inspection, palpation, percussion, and auscultation.
- When documenting patient care, the nurse should write legibly, use only standard abbreviations, and sign each entry. The nurse should never destroy or attempt to obliterate documentation or leave vacant lines.
- Factors that affect body temperature include time of day, age, physical activity, phase of menstrual cycle, and pregnancy.
- The most accessible and commonly used artery for measuring a patient's pulse rate is the radial artery. To take the pulse rate, the artery is compressed against the radius.
- In a resting adult, the normal pulse rate is 60 to 100 beats/minute. The rate is slightly faster in women than in men and much faster in children than in adults.
- Laboratory test results are an objective form of assessment data.
- The measurement systems most commonly used in clinical practice are the metric system, apothecaries' system, and household system.
- Before signing an informed consent form, the patient should know whether other treatment options are available and should understand what will occur during the preoperative, intraoperative, and postoperative phases; the risks involved; and the possible complications. The patient should also have a general idea of the time required from surgery to recovery. In addition, he should have an opportunity to ask questions.
- A patient must sign a separate informed consent form for each procedure.
- During percussion, the nurse uses quick, sharp tapping of the fingers or hands against body surfaces to produce sounds. This procedure is done to determine the size, shape, position, and density of underlying organs and tissues; elicit tenderness; or assess reflexes.
- Ballottement is a form of light palpation involving gentle, repetitive bouncing of tissues against the hand and feeling their rebound.
- A foot cradle keeps bed linen off the patient's feet to prevent skin irritation and breakdown, especially in a patient who has peripheral vascular disease or neuropathy.

- Gastric lavage is flushing of the stomach and removal of ingested substances through a nasogastric tube. It's used to treat poisoning or drug overdose.
- During the evaluation step of the nursing process, the nurse assesses the patient's response to therapy.
- Bruits commonly indicate life- or limb-threatening vascular disease.
- O.U. means each eye. O.D. is the right eye, and O.S. is the left eye.
- To remove a patient's artificial eye, the nurse depresses the lower lid.
- The nurse should use a warm saline solution to clean an artificial eye.
- A thready pulse is very fine and scarcely perceptible.
- Axillary temperature is usually 1° F lower than oral temperature.
- After suctioning a tracheostomy tube, the nurse must document the color, amount, consistency, and odor of secretions.
- On a drug prescription, the abbreviation p.c. means that the drug should be administered after meals.
- After bladder irrigation, the nurse should document the amount, color, and clarity of the urine and the presence of clots or sediment.
- After bladder irrigation, the nurse should document the amount, color, and clarity of the urine and the presence of clots or sediment.
- Laws regarding patient self-determination vary from state to state. Therefore, the nurse must be familiar with the laws of the state in which she works.
- Gauge is the inside diameter of a needle: the smaller the gauge, the larger the diameter.
- An adult normally has 32 permanent teeth.
- After turning a patient, the nurse should document the position used, the time that the patient was turned, and the findings of skin assessment.
- PERRLA is an abbreviation for normal pupil assessment findings: pupils equal, round, and reactive to light with accommodation.
- When percussing a patient's chest for postural drainage, the nurse's hands should be cupped.
- When measuring a patient's pulse, the nurse should assess its rate, rhythm, quality, and strength.
- Before transferring a patient from a bed to a wheelchair, the nurse should push the wheelchair's footrests to the sides and lock its wheels.
- When assessing respirations, the nurse should document their rate, rhythm, depth, and quality.
- For a subcutaneous injection, the nurse should use a 5/8" 25G needle.
- The notation "AA & O × 3" indicates that the patient is awake, alert, and oriented to person (knows who he is), place (knows where he is), and time (knows the date and time).
- Fluid intake includes all fluids taken by mouth, including foods that are liquid at room temperature, such as gelatin, custard, and ice cream; I.V. fluids; and fluids administered in feeding tubes. Fluid output includes urine, vomitus, and drainage (such as from a nasogastric tube or from a wound) as well as blood loss, diarrhea or feces, and perspiration.
- After administering an intradermal injection, the nurse shouldn't massage the area because massage can irritate the site and interfere with results.
- When administering an intradermal injection, the nurse should hold the syringe almost flat against the patient's skin (at about a 15-degree angle), with the bevel up.

- To obtain an accurate blood pressure, the nurse should inflate the manometer to 20 to 30 mm Hg above the disappearance of the radial pulse before releasing the cuff pressure.
- The nurse should count an irregular pulse for 1 full minute.
- A patient who is vomiting while lying down should be placed in a lateral position to prevent aspiration of vomitus.
- Prophylaxis is disease prevention.
- Body alignment is achieved when body parts are in proper relation to their natural position.
- Trust is the foundation of a nurse-patient relationship.
- Blood pressure is the force exerted by the circulating volume of blood on the arterial walls.
- Malpractice is a professional's wrongful conduct, improper discharge of duties, or failure to meet standards of care that causes harm to another.
- As a general rule, nurses can't refuse a patient care assignment; however, in most states, they may refuse to participate in abortions.
- A nurse can be found negligent if a patient is injured because the nurse failed to perform a duty that a reasonable and prudent person would perform or because the nurse performed an act that a reasonable and prudent person wouldn't perform.
- States have enacted Good Samaritan laws to encourage professionals to provide medical assistance at the scene of an accident without fear of a lawsuit arising from the assistance. These laws don't apply to care provided in a health care facility.
- A physician should sign verbal and telephone orders within the time established by facility policy, usually 24 hours.
- A competent adult has the right to refuse lifesaving medical treatment; however, the individual should be fully informed of the consequences of his refusal.
- Although a patient's health record, or chart, is the health care facility's physical property, its contents belong to the patient.
- Before a patient's health record can be released to a third party, the patient or the patient's legal guardian must give written consent.
- Under the Controlled Substances Act, every dose of a controlled drug that's dispensed by the pharmacy must be accounted for, whether the dose was administered to a patient or discarded accidentally.
- A nurse can't perform duties that violate a rule or regulation established by a state licensing board, even if they are authorized by a health care facility or physician.
- To minimize interruptions during a patient interview, the nurse should select a private room, preferably one with a door that can be closed.
- In categorizing nursing diagnoses, the nurse addresses life-threatening problems first, followed by potentially life-threatening concerns.
- The major components of a nursing care plan are outcome criteria (patient goals) and nursing interventions.
- Standing orders, or protocols, establish guidelines for treating a specific disease or set of symptoms.
- In assessing a patient's heart, the nurse normally finds the point of maximal impulse at the fifth intercostal space, near the apex.
- The S1 heard on auscultation is caused by closure of the mitral and tricuspid valves.
- To maintain package sterility, the nurse should open a wrapper's top flap away from the body, open each side flap by touching only the outer part of the wrapper, and

open the final flap by grasping the turned-down corner and pulling it toward the body.

- The nurse shouldn't dry a patient's ear canal or remove wax with acotton-tipped applicator because it may force cerumen against the tympanic membrane.
- A patient's identification bracelet should remain in place until the patient has been discharged from the health care facility and has left the premises.
- The Controlled Substances Act designated five categories, or schedules, that classify controlled drugs according to their abuse potential.
- Schedule I drugs, such as heroin, have a high abuse potential and have no currently accepted medical use in the United States.
- Schedule II drugs, such as morphine, opium, and meperidine (Demerol), have a high abuse potential, but currently have accepted medical uses. Their use may lead to physical or psychological dependence.
- Schedule III drugs, such as paregoric and butabarbital (Butisol), have a lower abuse potential than Schedule I or II drugs. Abuse of Schedule III drugs may lead to moderate or low physical or psychological dependence, or both.
- Schedule IV drugs, such as chloral hydrate, have a low abuse potential compared with Schedule III drugs.
- Schedule V drugs, such as cough syrups that contain codeine, have the lowest abuse potential of the controlled substances.
- Activities of daily living are actions that the patient must perform every day to provide self-care and to interact with society.
- Testing of the six cardinal fields of gaze evaluates the function of all extraocular muscles and cranial nerves III, IV, and VI.
- The six types of heart murmurs are graded from 1 to 6. A grade 6 heart murmur can be heard with the stethoscope slightly raised from the chest.
- The most important goal to include in a care plan is the patient's goal.
- Fruits are high in fiber and low in protein, and should be omitted from a low-residue diet.
- The nurse should use an objective scale to assess and quantify pain. Postoperative pain varies greatly among individuals.
- Postmortem care includes cleaning and preparing the deceased patient for family viewing, arranging transportation to the morgue or funeral home, and determining the disposition of belongings.
- The nurse should provide honest answers to the patient's questions.
- Milk shouldn't be included in a clear liquid diet.
- When caring for an infant, a child, or a confused patient, consistency in nursing personnel is paramount.
- The hypothalamus secretes vasopressin and oxytocin, which are stored in the pituitary gland.
- The three membranes that enclose the brain and spinal cord are the dura mater, pia mater, and arachnoid.
- A nasogastric tube is used to remove fluid and gas from the small intestine preoperatively or postoperatively.
- Psychologists, physical therapists, and chiropractors aren't authorized to write prescriptions for drugs.
- The area around a stoma is cleaned with mild soap and water.
- Vegetables have a high fiber content.

- The nurse should use a tuberculin syringe to administer a subcutaneous injection of less than 1 ml.
- For adults, subcutaneous injections require a 25G 1" needle; for infants, children, elderly, or very thin patients, they require a 25G to 27G ½" needle.
- Before administering a drug, the nurse should identify the patient by checking the identification band and asking the patient to state his name.
- To clean the skin before an injection, the nurse uses a sterile alcohol swab to wipe from the center of the site outward in a circular motion.
- The nurse should inject heparin deep into subcutaneous tissue at a 90-degree angle (perpendicular to the skin) to prevent skin irritation.
- If blood is aspirated into the syringe before an I.M. injection, the nurse should withdraw the needle, prepare another syringe, and repeat the procedure.
- The nurse shouldn't cut the patient's hair without written consent from the patient or an appropriate relative.
- If bleeding occurs after an injection, the nurse should apply pressure until the bleeding stops. If bruising occurs, the nurse should monitor the site for an enlarging hematoma.
- When providing hair and scalp care, the nurse should begin combing at the end of the hair and work toward the head.
- The frequency of patient hair care depends on the length and texture of the hair, the duration of hospitalization, and the patient's condition.
- Proper function of a hearing aid requires careful handling during insertion and removal, regular cleaning of the ear piece to prevent wax buildup, and prompt replacement of dead batteries.
- The hearing aid that's marked with a blue dot is for the left ear; the one with a red dot is for the right ear.
- A hearing aid shouldn't be exposed to heat or humidity and shouldn't be immersed in water.
- The nurse should instruct the patient to avoid using hair spray while wearing a hearing aid.
- The five branches of pharmacology are pharmacokinetics, pharmacodynamics, pharmacotherapeutics, toxicology, and pharmacognosy.
- The nurse should remove heel protectors every 8 hours to inspect the foot for signs of skin breakdown.
- Heat is applied to promote vasodilation, which reduces pain caused by inflammation.
- A sutured surgical incision is an example of healing by first intention (healing directly, without granulation).
- Healing by secondary intention (healing by granulation) is closure of the wound when granulation tissue fills the defect and allows reepithelialization to occur, beginning at the wound edges and continuing to the center, until the entire wound is covered.
- Keloid formation is an abnormality in healing that's characterized by overgrowth of scar tissue at the wound site.
- The nurse should administer procaine penicillin by deep I.M. injection in the upper outer portion of the buttocks in the adult or in the midlateral thigh in the child. The nurse shouldn't massage the injection site.

- An ascending colostomy drains fluid feces. A descending colostomy drains solid fecal matter.
- A folded towel (scrotal bridge) can provide scrotal support for the patient with scrotal edema caused by vasectomy, epididymitis, or orchitis.
- When giving an injection to a patient who has a bleeding disorder, the nurse should use a small-gauge needle and apply pressure to the site for 5 minutes after the injection.
- Platelets are the smallest and most fragile formed element of the blood and are essential for coagulation.
- To insert a nasogastric tube, the nurse instructs the patient to tilt the head back slightly and then inserts the tube. When the nurse feels the tube curving at the pharynx, the nurse should tell the patient to tilt the head forward to close the trachea and open the esophagus by swallowing. (Sips of water can facilitate this action.)
- Families with loved ones in intensive care units report that their four most important needs are to have their questions answered honestly, to be assured that the best possible care is being provided, to know the patient's prognosis, and to feel that there is hope of recovery.
- Double-bind communication occurs when the verbal message contradicts the nonverbal message and the receiver is unsure of which message to respond to.
- A nonjudgmental attitude displayed by a nurse shows that she neither approves nor disapproves of the patient.
- Target symptoms are those that the patient finds most distressing.
- A patient should be advised to take aspirin on an empty stomach, with a full glass of water, and should avoid acidic foods such as coffee, citrus fruits, and cola.
- For every patient problem, there is a nursing diagnosis; for every nursing diagnosis, there is a goal; and for every goal, there are interventions designed to make the goal a reality. The keys to answering examination questions correctly are identifying the problem presented, formulating a goal for the problem, and selecting the intervention from the choices provided that will enable the patient to reach that goal.
- Fidelity means loyalty and can be shown as a commitment to the profession of nursing and to the patient.
- Administering an I.M. injection against the patient's will and without legal authority is battery.
- An example of a third-party payer is an insurance company.
- The formula for calculating the drops per minute for an I.V. infusion is as follows: (volume to be infused × drip factor) ÷ time in minutes = drops/minute
- On-call medication should be given within 5 minutes of the call.
- Usually, the best method to determine a patient's cultural or spiritual needs is to ask him.
- An incident report or unusual occurrence report isn't part of a patient's record, but is an in-house document that's used for the purpose of correcting the problem.
- Critical pathways are a multidisciplinary guideline for patient care.
- When prioritizing nursing diagnoses, the following hierarchy should be used: Problems associated with the airway, those concerning breathing, and those related to circulation.
- The two nursing diagnoses that have the highest priority that the nurse can assign are Ineffective airway clearance and Ineffective breathing pattern.

- A subjective sign that a sitz bath has been effective is the patient's expression of decreased pain or discomfort.
- For the nursing diagnosis Deficient diversional activity to be valid, the patient must state that he's "bored," that he has "nothing to do," or words to that effect.
- The most appropriate nursing diagnosis for an individual who doesn't speak English is Impaired verbal communication related to inability to speak dominant language (English).
- The family of a patient who has been diagnosed as hearing impaired should be instructed to face the individual when they speak to him.
- Before instilling medication into the ear of a patient who is up to age 3, the nurse should pull the pinna down and back to straighten the eustachian tube.
- To prevent injury to the cornea when administering eyedrops, the nurse should waste the first drop and instill the drug in the lower conjunctival sac.
- After administering eye ointment, the nurse should twist the medication tube to detach the ointment.
- When the nurse removes gloves and a mask, she should remove the gloves first. They are soiled and are likely to contain pathogens.
- Crutches should be placed 6" (15.2 cm) in front of the patient and 6" to the side to form a tripod arrangement.
- Listening is the most effective communication technique.
- Before teaching any procedure to a patient, the nurse must assess the patient's current knowledge and willingness to learn.
- Process recording is a method of evaluating one's communication effectiveness.
- When feeding an elderly patient, the nurse should limit high-carbohydrate foods because of the risk of glucose intolerance.
- When feeding an elderly patient, essential foods should be given first.
- Passive range of motion maintains joint mobility. Resistive exercises increase muscle mass.
- Isometric exercises are performed on an extremity that's in a cast.
- A back rub is an example of the gate-control theory of pain.
- Anything that's located below the waist is considered unsterile; a sterile field becomes unsterile when it comes in contact with any unsterile item; a sterile field must be monitored continuously; and a border of 1" (2.5 cm) around a sterile field is considered unsterile.
- A "shift to the left" is evident when the number of immature cells (bands) in the blood increases to fight an infection.
- A "shift to the right" is evident when the number of mature cells in the blood increases, as seen in advanced liver disease and pernicious anemia.
- Before administering preoperative medication, the nurse should ensure that an informed consent form has been signed and attached to the patient's record.
- A nurse should spend no more than 30 minutes per 8-hour shift providing care to a patient who has a radiation implant.
- A nurse shouldn't be assigned to care for more than one patient who has a radiation implant.
- Long-handled forceps and a lead-lined container should be available in the room of a patient who has a radiation implant.
- Usually, patients who have the same infection and are in strict isolation can share a room.

- Diseases that require strict isolation include chickenpox, diphtheria, and viral hemorrhagic fevers such as Marburg disease.
- For the patient who abides by Jewish custom, milk and meat shouldn't be served at the same meal.
- Whether the patient can perform a procedure (psychomotor domain of learning) is a better indicator of the effectiveness of patient teaching than whether the patient can simply state the steps involved in the procedure (cognitive domain of learning).
- According to Erik Erikson, developmental stages are trust versus mistrust (birth to 18 months), autonomy versus shame and doubt (18 months to age 3), initiative versus guilt (ages 3 to 5), industry versus inferiority (ages 5 to 12), identity versus identity diffusion (ages 12 to 18), intimacy versus isolation (ages 18 to 25), generativity versus stagnation (ages 25 to 60), and ego integrity versus despair (older than age 60).
- When communicating with a hearing impaired patient, the nurse should face him.
- An appropriate nursing intervention for the spouse of a patient who has a serious incapacitating disease is to help him to mobilize a support system.
- Hyperpyrexia is extreme elevation in temperature above 106° F (41.1° C).
- Milk is high in sodium and low in iron.
- When a patient expresses concern about a health-related issue, before addressing the concern, the nurse should assess the patient's level of knowledge.
- The most effective way to reduce a fever is to administer an antipyretic, which lowers the temperature set point.
- When a patient is ill, it's essential for the members of his family to maintain communication about his health needs.
- Ethnocentrism is the universal belief that one's way of life is superior to others'.
- When a nurse is communicating with a patient through an interpreter, the nurse should speak to the patient and the interpreter.
- In accordance with the "hot-cold" system used by some Mexicans, Puerto Ricans, and other Hispanic and Latino groups, most foods, beverages, herbs, and drugs are described as "cold."
- Prejudice is a hostile attitude toward individuals of a particular group.
- Discrimination is preferential treatment of individuals of a particular group. It's usually discussed in a negative sense.
- Increased gastric motility interferes with the absorption of oral drugs.
- The three phases of the therapeutic relationship are orientation, working, and termination.
- Patients often exhibit resistive and challenging behaviors in the orientation phase of the therapeutic relationship.
- Abdominal assessment is performed in the following order: inspection, auscultation, palpation, and percussion.
- When measuring blood pressure in a neonate, the nurse should select a cuff that's no less than one-half and no more than two-thirds the length of the extremity that's used.
- When administering a drug by Z-track, the nurse shouldn't use the same needle that was used to draw the drug into the syringe because doing so could stain the skin.
- Sites for intradermal injection include the inner arm, the upper chest, and on the back, under the scapula.

- When evaluating whether an answer on an examination is correct, the nurse should consider whether the action that's described promotes autonomy (independence), safety, self-esteem, and a sense of belonging.
- When answering a question on the NCLEX examination, the student should consider the cue (the stimulus for a thought) and the inference (the thought) to determine whether the inference is correct. When in doubt, the nurse should select an answer that indicates the need for further information to eliminate ambiguity. For example, the patient complains of chest pain (the stimulus for the thought) and the nurse infers that the patient is having cardiac pain (the thought). In this case, the nurse hasn't confirmed whether the pain is cardiac. It would be more appropriate to make further assessments.
- Veracity is truth and is an essential component of a therapeutic relationship between a health care provider and his patient.
- Beneficence is the duty to do no harm and the duty to do good. There's an obligation in patient care to do no harm and an equal obligation to assist the patient.
- Nonmaleficence is the duty to do no harm.
- Frye's ABCDE cascade provides a framework for prioritizing care by identifying the most important treatment concerns.
- A = Airway. This category includes everything that affects a patent airway, including a foreign object, fluid from an upper respiratory infection, and edema from trauma or an allergic reaction.
- B = Breathing. This category includes everything that affects the breathing pattern, including hyperventilation or hypoventilation and abnormal breathing patterns, such as Korsakoff's, Biot's, or Cheyne-Stokes respiration.
- C = Circulation. This category includes everything that affects thecirculation, including fluid and electrolyte disturbances and disease processes that affect cardiac output.
- D = Disease processes. If the patient has no problem with the airway, breathing, or circulation, then the nurse should evaluate the disease processes, giving priority to the disease process that poses the greatest immediate risk. For example, if a patient has terminal cancer and hypoglycemia, hypoglycemia is a more immediate concern.
- E = Everything else. This category includes such issues as writing an incident report and completing the patient chart. When evaluating needs, this category is never the highest priority.
- When answering a question on an NCLEX examination, the basic rule is "assess before action." The student should evaluate each possible answer carefully. Usually, several answers reflect the implementation phase of nursing and one or two reflect the assessment phase. In this case, the best choice is an assessment response unless a specific course of action is clearly indicated.
- Rule utilitarianism is known as the "greatest good for the greatest number of people" theory.
- Egalitarian theory emphasizes that equal access to goods and services must be provided to the less fortunate by an affluent society.
- Active euthanasia is actively helping a person to die.
- Brain death is irreversible cessation of all brain function.
- Passive euthanasia is stopping the therapy that's sustaining life.

- A third-party payer is an insurance company.
- Utilization review is performed to determine whether the care provided to a patient was appropriate and cost-effective.
- A value cohort is a group of people who experienced an out-of-the-ordinary event that shaped their values.
- Voluntary euthanasia is actively helping a patient to die at the patient's request.
- Bananas, citrus fruits, and potatoes are good sources of potassium.
- Good sources of magnesium include fish, nuts, and grains.
- Beef, oysters, shrimp, scallops, spinach, beets, and greens are good sources of iron.
- Intrathecal injection is administering a drug through the spine.
- When a patient asks a question or makes a statement that's emotionally charged, the nurse should respond to the emotion behind the statement or question rather than to what's being said or asked.
- The steps of the trajectory-nursing model are as follows:
  - Step 1: Identifying the trajectory phase
  - Step 2: Identifying the problems and establishing goals
  - Step 3: Establishing a plan to meet the goals
  - Step 4: Identifying factors that facilitate or hinder attainment of the goals
  - Step 5: Implementing interventions
  - Step 6: Evaluating the effectiveness of the interventions
- A Hindu patient is likely to request a vegetarian diet.
- Pain threshold, or pain sensation, is the initial point at which a patient feels pain.
- The difference between acute pain and chronic pain is its duration.
- Referred pain is pain that's felt at a site other than its origin.
- Alleviating pain by performing a back massage is consistent with the gate control theory.
- Romberg's test is a test for balance or gait.
- Pain seems more intense at night because the patient isn't distracted by daily activities.
- Older patients commonly don't report pain because of fear of treatment, lifestyle changes, or dependency.
- No pork or pork products are allowed in a Muslim diet.
- Two goals of Healthy People 2010 are:
  - Help individuals of all ages to increase the quality of life and the number of years of optimal health
  - Eliminate health disparities among different segments of the population.
- A community nurse is serving as a patient's advocate if she tells a malnourished patient to go to a meal program at a local park.
- If a patient isn't following his treatment plan, the nurse should first ask why.
- Falls are the leading cause of injury in elderly people.
- Primary prevention is true prevention. Examples are immunizations, weight control, and smoking cessation.
- Secondary prevention is early detection. Examples include purified protein derivative (PPD), breast self-examination, testicular self-examination, and chest X-ray.
- Tertiary prevention is treatment to prevent long-term complications.
- A patient indicates that he's coming to terms with having a chronic disease when he says, "I'm never going to get any better."

- On noticing religious artifacts and literature on a patient's night stand, a culturally aware nurse would ask the patient the meaning of the items.
- A Mexican patient may request the intervention of a curandero, or faith healer, who involves the family in healing the patient.
- In an infant, the normal hemoglobin value is 12 g/dl.
- The nitrogen balance estimates the difference between the intake and use of protein.
- Most of the absorption of water occurs in the large intestine.
- Most nutrients are absorbed in the small intestine.
- When assessing a patient's eating habits, the nurse should ask, "What have you eaten in the last 24 hours?"
- A vegan diet should include an abundant supply of fiber.
- A hypotonic enema softens the feces, distends the colon, and stimulates peristalsis.
- First-morning urine provides the best sample to measure glucose, ketone, pH, and specific gravity values.
- To induce sleep, the first step is to minimize environmental stimuli.
- Before moving a patient, the nurse should assess the patient's physical abilities and ability to understand instructions as well as the amount of strength required to move the patient.
- To lose 1 lb (0.5 kg) in 1 week, the patient must decrease his weekly intake by 3,500 calories (approximately 500 calories daily). To lose 2 lb (1 kg) in 1 week, the patient must decrease his weekly caloric intake by 7,000 calories (approximately 1,000 calories daily).
- To avoid shearing force injury, a patient who is completely immobile is lifted on a sheet.
- To insert a catheter from the nose through the trachea for suction, the nurse should ask the patient to swallow.
- Vitamin C is needed for collagen production.
- Only the patient can describe his pain accurately.
- Cutaneous stimulation creates the release of endorphins that block the transmission of pain stimuli.
- Patient-controlled analgesia is a safe method to relieve acute pain caused by surgical incision, traumatic injury, labor and delivery, or cancer.
- An Asian American or European American typically places distance between himself and others when communicating.
- The patient who believes in a scientific, or biomedical, approach to health is likely to expect a drug, treatment, or surgery to cure illness.
- Chronic illnesses occur in very young as well as middle-aged and very old people.
- The trajectory framework for chronic illness states that preferences about daily life activities affect treatment decisions.
- Exacerbations of chronic disease usually cause the patient to seek treatment and may lead to hospitalization.
- School health programs provide cost-effective health care for low-income families and those who have no health insurance.
- Collegiality is the promotion of collaboration, development, and interdependence among members of a profession.
- A change agent is an individual who recognizes a need for change or is selected to make a change within an established entity, such as a hospital.

- The patients' bill of rights was introduced by the American Hospital Association.
- Abandonment is premature termination of treatment without the patient's permission and without appropriate relief of symptoms.
- Values clarification is a process that individuals use to prioritize their personal values.
- Distributive justice is a principle that promotes equal treatment for all.
- Milk and milk products, poultry, grains, and fish are good sources of phosphate.
- The best way to prevent falls at night in an oriented, but restless, elderly patient is to raise the side rails.
- By the end of the orientation phase, the patient should begin to trust the nurse.
- Falls in the elderly are likely to be caused by poor vision.
- Barriers to communication include language deficits, sensory deficits, cognitive impairments, structural deficits, and paralysis.
- The three elements that are necessary for a fire are heat, oxygen, and combustible material.
- Sebaceous glands lubricate the skin.
- To check for petechiae in a dark-skinned patient, the nurse should assess the oral mucosa.
- To put on a sterile glove, the nurse should pick up the first glove at the folded border and adjust the fingers when both gloves are on.
- To increase patient comfort, the nurse should let the alcohol dry before giving an intramuscular injection.
- Treatment for a stage 1 ulcer on the heels includes heel protectors.
- Seventh-Day Adventists are usually vegetarians.
- Endorphins are morphinelike substances that produce a feeling of well-being.
- Pain tolerance is the maximum amount and duration of pain that an individual is willing to endure.
- A blood pressure cuff that's too narrow can cause a falsely elevated blood pressure reading.
- When preparing a single injection for a patient who takes regular and neutral protein Hagedorn insulin, the nurse should draw the regular insulin into the syringe first so that it does not contaminate the regular insulin.
- Rhonchi are the rumbling sounds heard on lung auscultation. They are more pronounced during expiration than during inspiration.
- Gavage is forced feeding, usually through a gastric tube (a tube passed into the stomach through the mouth).
- According to Maslow's hierarchy of needs, physiologic needs (air, water, food, shelter, sex, activity, and comfort) have the highest priority.
- The safest and surest way to verify a patient's identity is to check the identification band on his wrist.
- In the therapeutic environment, the patient's safety is the primary concern.
- Fluid oscillation in the tubing of a chest drainage system indicates that the system is working properly.
- The nurse should place a patient who has a Sengstaken-Blakemore tube in semi-Fowler position.
  ϖ The nurse can elicit Trousseau's sign by occluding the brachial or radial artery. Hand and finger spasms that occur during occlusion indicate Trousseau's sign and suggest hypocalcemia.

ϖ For blood transfusion in an adult, the appropriate needle size is 16 to 20G.

ϖ Intractable pain is pain that incapacitates a patient and can't be relieved by drugs.

ϖ In an emergency, consent for treatment can be obtained by fax, telephone, or other telegraphic means.
ϖ Decibel is the unit of measurement of sound.

ϖ Informed consent is required for any invasive procedure.

ϖ A patient who can't write his name to give consent for treatment must make an X in the presence of two witnesses, such as a nurse, priest, or physician.

ϖ The Z-track I.M. injection technique seals the drug deep into the muscle, thereby minimizing skin irritation and staining. It requires a needle that's 1" (2.5 cm) or longer.

ϖ In the event of fire, the acronym most often used is RACE. (R) Remove the patient. (A) Activate the alarm. (C) Attempt to contain the fire by closing the door. (E) Extinguish the fire if it can be done safely.

ϖ A registered nurse should assign a licensed vocational nurse or licensed practical nurse to perform bedside care, such as suctioning and drug administration.

ϖ If a patient can't void, the first nursing action should be bladder palpation to assess for bladder distention.
ϖ The patient who uses a cane should carry it on the unaffected side and advance it at the same time as the affected extremity.

ϖ To fit a supine patient for crutches, the nurse should measure from the axilla to the sole and add 2" (5 cm) to that measurement.

ϖ Assessment begins with the nurse's first encounter with the patient and continues throughout the patient's stay. The nurse obtains assessment data through the health history, physical examination, and review of diagnostic studies.

ϖ The appropriate needle size for insulin injection is 25G and 5/8" long.

ϖ Residual urine is urine that remains in the bladder after voiding. The amount of residual urine is normally 50 to 100 ml.

ϖ The five stages of the nursing process are assessment, nursing diagnosis, planning, implementation, and evaluation.

ϖ Assessment is the stage of the nursing process in which the nurse continuously collects data to identify a patient's actual and potential health needs.

ϖ Nursing diagnosis is the stage of the nursing process in which the nurse makes a

clinical judgment about individual, family, or community responses to actual or potential health problems or life processes.

ϖ Planning is the stage of the nursing process in which the nurse assigns priorities to nursing diagnoses, defines short-term and long-term goals and expected outcomes, and establishes the nursing care plan.

ϖ Implementation is the stage of the nursing process in which the nurse puts the nursing care plan into action, delegates specific nursing interventions to members of the nursing team, and charts patient responses to nursing interventions.

ϖ Evaluation is the stage of the nursing process in which the nurse compares objective and subjective data with the outcome criteria and, if needed, modifies the nursing care plan.

ϖ Before administering any "as needed" pain medication, the nurse should ask the patient to indicate the location of the pain.

ϖ Jehovah's Witnesses believe that they shouldn't receive blood components donated by other people.

ϖ To test visual acuity, the nurse should ask the patient to cover each eye separately and to read the eye chart with glasses and without, as appropriate.

ϖ When providing oral care for an unconscious patient, to minimize the risk of aspiration, the nurse should position the patient on the side.

ϖ During assessment of distance vision, the patient should stand 20' (6.1 m) from the chart.
ϖ For a geriatric patient or one who is extremely ill, the ideal room temperature is 66° to 76° F (18.8° to 24.4° C).

ϖ Normal room humidity is 30% to 60%.

ϖ Hand washing is the single best method of limiting the spread of microorganisms. Once gloves are removed after routine contact with a patient, hands should be washed for 10 to 15 seconds.

ϖ To perform catheterization, the nurse should place a woman in the dorsal recumbent position.

ϖ A positive Homans' sign may indicate thrombophlebitis.

ϖ Electrolytes in a solution are measured in milliequivalents per liter (mEq/L). A milliequivalent is the number of milligrams per 100 milliliters of a solution.

ϖ Metabolism occurs in two phases: anabolism (the constructive phase) and catabolism (the destructive phase).

ϖ The basal metabolic rate is the amount of energy needed to maintain essential body functions. It's measured when the patient is awake and resting, hasn't eaten for 14 to 18 hours, and is in a comfortable, warm environment.

ϖ The basal metabolic rate is expressed in calories consumed per hour per kilogram of body weight.

ϖ Dietary fiber (roughage), which is derived from cellulose, supplies bulk, maintains intestinal motility, and helps to establish regular bowel habits.

ϖ Alcohol is metabolized primarily in the liver. Smaller amounts are metabolized by the kidneys and lungs.

ϖ Petechiae are tiny, round, purplish red spots that appear on the skin and mucous membranes as a result of intradermal or submucosal hemorrhage.

ϖ Purpura is a purple discoloration of the skin that's caused by blood extravasation.

ϖ According to the standard precautions recommended by the Centers for Disease Control and Prevention, the nurse shouldn't recap needles after use. Most needle sticks result from missed needle recapping.

ϖ The nurse administers a drug by I.V. push by using a needle and syringe to deliver the dose directly into a vein, I.V. tubing, or a catheter.

ϖ When changing the ties on a tracheostomy tube, the nurse should leave the old ties in place until the new ones are applied.

ϖ A nurse should have assistance when changing the ties on a tracheostomy tube.

ϖ A filter is always used for blood transfusions.

ϖ A four-point (quad) cane is indicated when a patient needs more stability than a regular cane can provide.

ϖ A good way to begin a patient interview is to ask, "What made you seek medical help?"

ϖ When caring for any patient, the nurse should follow standard precautions for handling blood and body fluids.
ϖ Potassium (K+) is the most abundant cation in intracellular fluid.

ϖ In the four-point, or alternating, gait, the patient first moves the right crutch followed by the left foot and then the left crutch followed by the right foot.

ϖ In the three-point gait, the patient moves two crutches and the affected leg

simultaneously and then moves the unaffected leg.

ϖ In the two-point gait, the patient moves the right leg and the left crutch simultaneously and then moves the left leg and the right crutch simultaneously.

ϖ The vitamin B complex, the water-soluble vitamins that are essential for metabolism, include thiamine (B1), riboflavin (B2), niacin (B3), pyridoxine (B6), and cyanocobalamin (B12).

ϖ When being weighed, an adult patient should be lightly dressed and shoeless.

ϖ Before taking an adult's temperature orally, the nurse should ensure that the patient hasn't smoked or consumed hot or cold substances in the previous 15 minutes.

ϖ The nurse shouldn't take an adult's temperature rectally if the patient has a cardiac disorder, anal lesions, or bleeding hemorrhoids or has recently undergone rectal surgery.

ϖ In a patient who has a cardiac disorder, measuring temperature rectally may stimulate a vagal response and lead to vasodilation and decreased cardiac output.

ϖ When recording pulse amplitude and rhythm, the nurse should use these descriptive measures: +3, bounding pulse (readily palpable and forceful); +2, normal pulse (easily palpable); +1, thready or weak pulse (difficult to detect); and 0, absent pulse (not detectable).

ϖ The intraoperative period begins when a patient is transferred to the operating room bed and ends when the patient is admitted to the postanesthesia care unit.

ϖ On the morning of surgery, the nurse should ensure that the informed consent form has been signed; that the patient hasn't taken anything by mouth since midnight, has taken a shower with antimicrobial soap, has had mouth care (without swallowing the water), has removed common jewelry, and has received preoperative medication as prescribed; and that vital signs have been taken and recorded. Artificial limbs and other prostheses are usually removed.

ϖ Comfort measures, such as positioning the patient, rubbing the patient's back, and providing a restful environment, may decrease the patient's need for analgesics or may enhance their effectiveness.

ϖ A drug has three names: generic name, which is used in official publications; trade, or brand, name (such as Tylenol), which is selected by the drug company; and chemical name, which describes the drug's chemical composition.

ϖ To avoid staining the teeth, the patient should take a liquid iron preparation through a straw.

ϖ The nurse should use the Z-track method to administer an I.M. injection of iron dextran (Imferon).

ϖ An organism may enter the body through the nose, mouth, rectum, urinary or reproductive tract, or skin.

ϖ In descending order, the levels of consciousness are alertness, lethargy, stupor, light coma, and deep coma.

ϖ To turn a patient by logrolling, the nurse folds the patient's arms across the chest; extends the patient's legs and inserts a pillow between them, if needed; places a draw sheet under the patient; and turns the patient by slowly and gently pulling on the draw sheet.

ϖ The diaphragm of the stethoscope is used to hear high-pitched sounds, such as breath sounds.

ϖ A slight difference in blood pressure (5 to 10 mm Hg) between the right and the left arms is normal.

ϖ The nurse should place the blood pressure cuff 1" (2.5 cm) above the antecubital fossa.

ϖ When instilling ophthalmic ointments, the nurse should waste the first bead of ointment and then apply the ointment from the inner canthus to the outer canthus.

ϖ The nurse should use a leg cuff to measure blood pressure in an obese patient.

ϖ If a blood pressure cuff is applied too loosely, the reading will be falsely elevated.

ϖ Ptosis is drooping of the eyelid.
ϖ A tilt table is useful for a patient with a spinal cord injury, orthostatic hypotension, or brain damage because it can move the patient gradually from a horizontal to a vertical (upright) position.

ϖ To perform venipuncture with the least injury to the vessel, the nurse should turn the bevel upward when the vessel's lumen is larger than the needle and turn it downward when the lumen is only slightly larger than the needle.

ϖ To move a patient to the edge of the bed for transfer, the nurse should follow these steps: Move the patient's head and shoulders toward the edge of the bed. Move the patient's feet and legs to the edge of the bed (crescent position). Place both arms well under the patient's hips, and straighten the back while moving the patient toward the edge of the bed.

ϖ When being measured for crutches, a patient should wear shoes.

ϖ The nurse should attach a restraint to the part of the bed frame that moves with the head, not to the mattress or side rails.

ϖ The mist in a mist tent should never become so dense that it obscures clear visualization of the patient's respiratory pattern.

ϖ To administer heparin subcutaneously, the nurse should follow these steps: Clean, but don't rub, the site with alcohol. Stretch the skin taut or pick up a well-defined skin fold. Hold the shaft of the needle in a dart position. Insert the needle into the skin at a right (90-degree) angle. Firmly depress the plunger, but don't aspirate. Leave the needle in place for 10 seconds. Withdraw the needle gently at the angle of insertion. Apply pressure to the injection site with an alcohol pad.

ϖ For a sigmoidoscopy, the nurse should place the patient in the knee-chest position or Sims' position, depending on the physician's preference.

ϖ Maslow's hierarchy of needs must be met in the following order: physiologic (oxygen, food, water, sex, rest, and comfort), safety and security, love and belonging, self-esteem and recognition, and self-actualization.

ϖ When caring for a patient who has a nasogastric tube, the nurse should apply a water-soluble lubricant to the nostril to prevent soreness.

ϖ During gastric lavage, a nasogastric tube is inserted, the stomach is flushed, and ingested substances are removed through the tube.

ϖ In documenting drainage on a surgical dressing, the nurse should include the size, color, and consistency of the drainage (for example, "10 mm of brown mucoid drainage noted on dressing").

ϖ To elicit Babinski's reflex, the nurse strokes the sole of the patient's foot with a moderately sharp object, such as a thumbnail.

ϖ A positive Babinski's reflex is shown by dorsiflexion of the great toe and fanning out of the other toes.

ϖ When assessing a patient for bladder distention, the nurse should check the contour of the lower abdomen for a rounded mass above the symphysis pubis.

ϖ The best way to prevent pressure ulcers is to reposition the bedridden patient at least every 2 hours.

ϖ Antiembolism stockings decompress the superficial blood vessels, reducing the risk of thrombus formation.

ϖ In adults, the most convenient veins for venipuncture are the basilic and median cubital veins in the antecubital space.

ϖ Two to three hours before beginning a tube feeding, the nurse should aspirate the patient's stomach contents to verify that gastric emptying is adequate.

ϖ People with type O blood are considered universal donors.

ϖ People with type AB blood are considered universal recipients.

ϖ Hertz (Hz) is the unit of measurement of sound frequency.

ϖ Hearing protection is required when the sound intensity exceeds 84 dB. Double hearing protection is required if it exceeds 104 dB.

ϖ Prothrombin, a clotting factor, is produced in the liver.

ϖ If a patient is menstruating when a urine sample is collected, the nurse should note this on the laboratory request.

ϖ During lumbar puncture, the nurse must note the initial intracranial pressure and the color of the cerebrospinal fluid.

ϖ If a patient can't cough to provide a sputum sample for culture, a heated aerosol treatment can be used to help to obtain a sample.

ϖ If eye ointment and eyedrops must be instilled in the same eye, the eyedrops should be instilled first.

ϖ When leaving an isolation room, the nurse should remove her gloves before her mask because fewer pathogens are on the mask.

ϖ Skeletal traction, which is applied to a bone with wire pins or tongs, is the most effective means of traction.

ϖ The total parenteral nutrition solution should be stored in a refrigerator and removed 30 to 60 minutes before use. Delivery of a chilled solution can cause pain, hypothermia, venous spasm, and venous constriction.

ϖ Drugs aren't routinely injected intramuscularly into edematous tissue because they may not be absorbed.

ϖ When caring for a comatose patient, the nurse should explain each action to the patient in a normal voice.

ϖ Dentures should be cleaned in a sink that's lined with a washcloth.

ϖ A patient should void within 8 hours after surgery.

ϖ An EEG identifies normal and abnormal brain waves.

ϖ Samples of feces for ova and parasite tests should be delivered to the laboratory without delay and without refrigeration.

ϖ The autonomic nervous system regulates the cardiovascular and respiratory systems.

ϖ When providing tracheostomy care, the nurse should insert the catheter gently into the tracheostomy tube. When withdrawing the catheter, the nurse should apply intermittent suction for no more than 15 seconds and use a slight twisting motion.

ϖ A low-residue diet includes such foods as roasted chicken, rice, and pasta.

ϖ A rectal tube shouldn't be inserted for longer than 20 minutes because it can irritate the rectal mucosa and cause loss of sphincter control.

ϖ A patient's bed bath should proceed in this order: face, neck, arms, hands, chest, abdomen, back, legs, perineum.

ϖ To prevent injury when lifting and moving a patient, the nurse should primarily use the upper leg muscles.

ϖ Patient preparation for cholecystography includes ingestion of a contrast medium and a low-fat evening meal.

ϖ While an occupied bed is being changed, the patient should be covered with a bath blanket to promote warmth and prevent exposure.

ϖ Anticipatory grief is mourning that occurs for an extended time when the patient realizes that death is inevitable.
ϖ The following foods can alter the color of the feces: beets (red), cocoa (dark red or brown), licorice (black), spinach (green), and meat protein (dark brown).

ϖ When preparing for a skull X-ray, the patient should remove all jewelry and dentures.

ϖ The fight-or-flight response is a sympathetic nervous system response.

ϖ Bronchovesicular breath sounds in peripheral lung fields are abnormal and suggest pneumonia.

ϖ Wheezing is an abnormal, high-pitched breath sound that's accentuated on expiration.

ϖ Wax or a foreign body in the ear should be flushed out gently by irrigation with warm saline solution.

ϖ If a patient complains that his hearing aid is "not working," the nurse should check the switch first to see if it's turned on and then check the batteries.

ϖ The nurse should grade hyperactive biceps and triceps reflexes as +4.

ϖ If two eye medications are prescribed for twice-daily instillation, they should be administered 5 minutes apart.

ϖ In a postoperative patient, forcing fluids helps prevent constipation.

ϖ A nurse must provide care in accordance with standards of care established by the American Nurses Association, state regulations, and facility policy.

ϖ The kilocalorie (kcal) is a unit of energy measurement that represents the amount of heat needed to raise the temperature of 1 kilogram of water 1° C.

ϖ As nutrients move through the body, they undergo ingestion, digestion, absorption, transport, cell metabolism, and excretion.

ϖ The body metabolizes alcohol at a fixed rate, regardless of serum concentration.

ϖ In an alcoholic beverage, proof reflects the percentage of alcohol multiplied by 2. For example, a 100-proof beverage contains 50% alcohol.

ϖ A living will is a witnessed document that states a patient's desire for certain types of care and treatment. These decisions are based on the patient's wishes and views on quality of life.

ϖ The nurse should flush a peripheral heparin lock every 8 hours (if it wasn't used during the previous 8 hours) and as needed with normal saline solution to maintain patency.

ϖ Quality assurance is a method of determining whether nursing actions and practices meet established standards.

ϖ The five rights of medication administration are the right patient, right drug, right dose, right route of administration, and right time.

ϖ The evaluation phase of the nursing process is to determine whether nursing interventions have enabled the patient to meet the desired goals.

ϖ Outside of the hospital setting, only the sublingual and translingual forms of nitroglycerin should be used to relieve acute anginal attacks.

ϖ The implementation phase of the nursing process involves recording the patient's response to the nursing plan, putting the nursing plan into action, delegating specific

nursing interventions, and coordinating the patient's activities.

ϖ The Patient's Bill of Rights offers patients guidance and protection by stating the responsibilities of the hospital and its staff toward patients and their families during hospitalization.

ϖ To minimize omission and distortion of facts, the nurse should record information as soon as it's gathered.

ϖ When assessing a patient's health history, the nurse should record the current illness chronologically, beginning with the onset of the problem and continuing to the present.

ϖ When assessing a patient's health history, the nurse should record the current illness chronologically, beginning with the onset of the problem and continuing to the present.

ϖ A nurse shouldn't give false assurance to a patient.

ϖ After receiving preoperative medication, a patient isn't competent to sign an informed consent form.

ϖ When lifting a patient, a nurse uses the weight of her body instead of the strength in her arms.

ϖ A nurse may clarify a physician's explanation about an operation or a procedure to a patient, but must refer questions about informed consent to the physician.

ϖ When obtaining a health history from an acutely ill or agitated patient, the nurse should limit questions to those that provide necessary information.

ϖ If a chest drainage system line is broken or interrupted, the nurse should clamp the tube immediately.

ϖ The nurse shouldn't use her thumb to take a patient's pulse rate because the thumb has a pulse that may be confused with the patient's pulse.

ϖ An inspiration and an expiration count as one respiration.

ϖ Eupnea is normal respiration.

ϖ During blood pressure measurement, the patient should rest the arm against a surface. Using muscle strength to hold up the arm may raise the blood pressure.

ϖ Major, unalterable risk factors for coronary artery disease include heredity, sex, race, and age.

ϖ Inspection is the most frequently used assessment technique.

ϖ Family members of an elderly person in a long-term care facility should transfer some personal items (such as photographs, a favorite chair, and knickknacks) to the person's room to provide a comfortable atmosphere.

ϖ Pulsus alternans is a regular pulse rhythm with alternating weak and strong beats. It occurs in ventricular enlargement because the stroke volume varies with each heartbeat.

ϖ The upper respiratory tract warms and humidifies inspired air and plays a role in taste, smell, and mastication.
ϖ Signs of accessory muscle use include shoulder elevation, intercostal muscle retraction, and scalene and sternocleidomastoid muscle use during respiration.

ϖ When patients use axillary crutches, their palms should bear the brunt of the weight.

ϖ Activities of daily living include eating, bathing, dressing, grooming, toileting, and interacting socially.

ϖ Normal gait has two phases: the stance phase, in which the patient's foot rests on the ground, and the swing phase, in which the patient's foot moves forward.

ϖ The phases of mitosis are prophase, metaphase, anaphase, and telophase.

ϖ The nurse should follow standard precautions in the routine care of all patients.

ϖ The nurse should use the bell of the stethoscope to listen for venous hums and cardiac murmurs.

ϖ The nurse can assess a patient's general knowledge by asking questions such as "Who is the president of the United States?"

ϖ Cold packs are applied for the first 20 to 48 hours after an injury; then heat is applied. During cold application, the pack is applied for 20 minutes and then removed for 10 to 15 minutes to prevent reflex dilation (rebound phenomenon) and frostbite injury.
ϖ The pons is located above the medulla and consists of white matter (sensory and motor tracts) and gray matter (reflex centers).

ϖ The autonomic nervous system controls the smooth muscles.

ϖ A correctly written patient goal expresses the desired patient behavior, criteria for measurement, time frame for achievement, and conditions under which the behavior will occur. It's developed in collaboration with the patient.

ϖ Percussion causes five basic notes: tympany (loud intensity, as heard over a gastric air bubble or puffed out cheek), hyperresonance (very loud, as heard over an emphysematous lung), resonance (loud, as heard over a normal lung), dullness

(medium intensity, as heard over the liver or other solid organ), and flatness (soft, as heard over the thigh).

ϖ The optic disk is yellowish pink and circular, with a distinct border.

ϖ A primary disability is caused by a pathologic process. A secondary disability is caused by inactivity.

ϖ Nurses are commonly held liable for failing to keep an accurate count of sponges and other devices during surgery.

ϖ The best dietary sources of vitamin B6 are liver, kidney, pork, soybeans, corn, and whole-grain cereals.

ϖ Iron-rich foods, such as organ meats, nuts, legumes, dried fruit, green leafy vegetables, eggs, and whole grains, commonly have a low water content.

ϖ Collaboration is joint communication and decision making between nurses and physicians. It's designed to meet patients' needs by integrating the care regimens of both professions into one comprehensive approach.

ϖ Bradycardia is a heart rate of fewer than 60 beats/minute.

ϖ A nursing diagnosis is a statement of a patient's actual or potential health problem that can be resolved, diminished, or otherwise changed by nursing interventions.

ϖ During the assessment phase of the nursing process, the nurse collects and analyzes three types of data: health history, physical examination, and laboratory and diagnostic test data.

ϖ The patient's health history consists primarily of subjective data, information that's supplied by the patient.

ϖ The physical examination includes objective data obtained by inspection, palpation, percussion, and auscultation.

ϖ When documenting patient care, the nurse should write legibly, use only standard abbreviations, and sign each entry. The nurse should never destroy or attempt to obliterate documentation or leave vacant lines.

ϖ Factors that affect body temperature include time of day, age, physical activity, phase of menstrual cycle, and pregnancy.

ϖ The most accessible and commonly used artery for measuring a patient's pulse rate is the radial artery. To take the pulse rate, the artery is compressed against the radius.

ϖ In a resting adult, the normal pulse rate is 60 to 100 beats/minute. The rate is slightly faster in women than in men and much faster in children than in adults.

ϖ Laboratory test results are an objective form of assessment data.

ϖ The measurement systems most commonly used in clinical practice are the metric system, apothecaries' system, and household system.

ϖ Before signing an informed consent form, the patient should know whether other treatment options are available and should understand what will occur during the preoperative, intraoperative, and postoperative phases; the risks involved; and the possible complications. The patient should also have a general idea of the time required from surgery to recovery. In addition, he should have an opportunity to ask questions.

ϖ A patient must sign a separate informed consent form for each procedure.

ϖ During percussion, the nurse uses quick, sharp tapping of the fingers or hands against body surfaces to produce sounds. This procedure is done to determine the size, shape, position, and density of underlying organs and tissues; elicit tenderness; or assess reflexes.

ϖ Ballottement is a form of light palpation involving gentle, repetitive bouncing of tissues against the hand and feeling their rebound.

ϖ A foot cradle keeps bed linen off the patient's feet to prevent skin irritation and breakdown, especially in a patient who has peripheral vascular disease or neuropathy.

ϖ Gastric lavage is flushing of the stomach and removal of ingested substances through a nasogastric tube. It's used to treat poisoning or drug overdose.

ϖ During the evaluation step of the nursing process, the nurse assesses the patient's response to therapy.

ϖ Bruits commonly indicate life- or limb-threatening vascular disease.

ϖ O.U. means each eye. O.D. is the right eye, and O.S. is the left eye.

ϖ To remove a patient's artificial eye, the nurse depresses the lower lid.

ϖ The nurse should use a warm saline solution to clean an artificial eye.

ϖ A thready pulse is very fine and scarcely perceptible.

ϖ Axillary temperature is usually 1° F lower than oral temperature.

ϖ After suctioning a tracheostomy tube, the nurse must document the color,

amount, consistency, and odor of secretions.

ϖ On a drug prescription, the abbreviation p.c. means that the drug should be administered after meals.

ϖ After bladder irrigation, the nurse should document the amount, color, and clarity of the urine and the presence of clots or sediment.

ϖ After bladder irrigation, the nurse should document the amount, color, and clarity of the urine and the presence of clots or sediment.

ϖ Laws regarding patient self-determination vary from state to state. Therefore, the nurse must be familiar with the laws of the state in which she works.

ϖ Gauge is the inside diameter of a needle: the smaller the gauge, the larger the diameter.

ϖ An adult normally has 32 permanent teeth.

ϖ After turning a patient, the nurse should document the position used, the time that the patient was turned, and the findings of skin assessment.

ϖ PERRLA is an abbreviation for normal pupil assessment findings: pupils equal, round, and reactive to light with accommodation.

ϖ When percussing a patient's chest for postural drainage, the nurse's hands should be cupped.

ϖ When measuring a patient's pulse, the nurse should assess its rate, rhythm, quality, and strength.

ϖ Before transferring a patient from a bed to a wheelchair, the nurse should push the wheelchair's footrests to the sides and lock its wheels.

ϖ When assessing respirations, the nurse should document their rate, rhythm, depth, and quality.
ϖ For a subcutaneous injection, the nurse should use a 5/8" 25G needle.

ϖ The notation "AA & O × 3" indicates that the patient is awake, alert, and oriented to person (knows who he is), place (knows where he is), and time (knows the date and time).

ϖ Fluid intake includes all fluids taken by mouth, including foods that are liquid at room temperature, such as gelatin, custard, and ice cream; I.V. fluids; and fluids administered in feeding tubes. Fluid output includes urine, vomitus, and drainage (such as from a nasogastric tube or from a wound) as well as blood loss, diarrhea or feces, and perspiration.

ϖ After administering an intradermal injection, the nurse shouldn't massage the area because massage can irritate the site and interfere with results.

ϖ When administering an intradermal injection, the nurse should hold the syringe almost flat against the patient's skin (at about a 15-degree angle), with the bevel up.

ϖ To obtain an accurate blood pressure, the nurse should inflate the manometer to 20 to 30 mm Hg above the disappearance of the radial pulse before releasing the cuff pressure.

ϖ The nurse should count an irregular pulse for 1 full minute.

ϖ A patient who is vomiting while lying down should be placed in a lateral position to prevent aspiration of vomitus.

ϖ Prophylaxis is disease prevention.

ϖ Body alignment is achieved when body parts are in proper relation to their natural position.

ϖ Trust is the foundation of a nurse-patient relationship.

ϖ Blood pressure is the force exerted by the circulating volume of blood on the arterial walls.

ϖ Malpractice is a professional's wrongful conduct, improper discharge of duties, or failure to meet standards of care that causes harm to another.

ϖ As a general rule, nurses can't refuse a patient care assignment; however, in most states, they may refuse to participate in abortions.

ϖ A nurse can be found negligent if a patient is injured because the nurse failed to perform a duty that a reasonable and prudent person would perform or because the nurse performed an act that a reasonable and prudent person wouldn't perform.

ϖ States have enacted Good Samaritan laws to encourage professionals to provide medical assistance at the scene of an accident without fear of a lawsuit arising from the assistance. These laws don't apply to care provided in a health care facility.

ϖ A physician should sign verbal and telephone orders within the time established by facility policy, usually 24 hours.

ϖ A competent adult has the right to refuse lifesaving medical treatment; however, the individual should be fully informed of the consequences of his refusal.

ϖ Although a patient's health record, or chart, is the health care facility's physical property, its contents belong to the patient.

ϖ Before a patient's health record can be released to a third party, the patient or the patient's legal guardian must give written consent.

ϖ Under the Controlled Substances Act, every dose of a controlled drug that's dispensed by the pharmacy must be accounted for, whether the dose was administered to a patient or discarded accidentally.

ϖ A nurse can't perform duties that violate a rule or regulation established by a state licensing board, even if they are authorized by a health care facility or physician.

ϖ To minimize interruptions during a patient interview, the nurse should select a private room, preferably one with a door that can be closed.

ϖ In categorizing nursing diagnoses, the nurse addresses life-threatening problems first, followed by potentially life-threatening concerns.

ϖ The major components of a nursing care plan are outcome criteria (patient goals) and nursing interventions.

ϖ Standing orders, or protocols, establish guidelines for treating a specific disease or set of symptoms.

ϖ In assessing a patient's heart, the nurse normally finds the point of maximal impulse at the fifth intercostal space, near the apex.

ϖ The S1 heard on auscultation is caused by closure of the mitral and tricuspid valves.

ϖ To maintain package sterility, the nurse should open a wrapper's top flap away from the body, open each side flap by touching only the outer part of the wrapper, and open the final flap by grasping the turned-down corner and pulling it toward the body.

ϖ The nurse shouldn't dry a patient's ear canal or remove wax with a cotton-tipped applicator because it may force cerumen against the tympanic membrane.

ϖ A patient's identification bracelet should remain in place until the patient has been discharged from the health care facility and has left the premises.

ϖ The Controlled Substances Act designated five categories, or schedules, that classify controlled drugs according to their abuse potential.
ϖ Schedule I drugs, such as heroin, have a high abuse potential and have no currently accepted medical use in the United States.

ϖ Schedule II drugs, such as morphine, opium, and meperidine (Demerol), have a high abuse potential, but currently have accepted medical uses. Their use may lead to physical or psychological dependence.
ϖ Schedule III drugs, such as paregoric and butabarbital (Butisol), have a lower abuse potential than Schedule I or II drugs. Abuse of Schedule III drugs may lead to

moderate or low physical or psychological dependence, or both.

ϖ Schedule IV drugs, such as chloral hydrate, have a low abuse potential compared with Schedule III drugs.

ϖ Schedule V drugs, such as cough syrups that contain codeine, have the lowest abuse potential of the controlled substances.

ϖ Activities of daily living are actions that the patient must perform every day to provide self-care and to interact with society.

ϖ Testing of the six cardinal fields of gaze evaluates the function of all extraocular muscles and cranial nerves III, IV, and VI.

ϖ The six types of heart murmurs are graded from 1 to 6. A grade 6 heart murmur can be heard with the stethoscope slightly raised from the chest.

ϖ The most important goal to include in a care plan is the patient's goal.

ϖ Fruits are high in fiber and low in protein, and should be omitted from a low-residue diet.

ϖ The nurse should use an objective scale to assess and quantify pain. Postoperative pain varies greatly among individuals.

ϖ Postmortem care includes cleaning and preparing the deceased patient for family viewing, arranging transportation to the morgue or funeral home, and determining the disposition of belongings.

ϖ The nurse should provide honest answers to the patient's questions.

ϖ Milk shouldn't be included in a clear liquid diet.

ϖ When caring for an infant, a child, or a confused patient, consistency in nursing personnel is paramount.

ϖ The hypothalamus secretes vasopressin and oxytocin, which are stored in the pituitary gland.

ϖ The three membranes that enclose the brain and spinal cord are the dura mater, pia mater, and arachnoid.

ϖ A nasogastric tube is used to remove fluid and gas from the small intestine preoperatively or postoperatively.

ϖ Psychologists, physical therapists, and chiropractors aren't authorized to write prescriptions for drugs.

ϖ The area around a stoma is cleaned with mild soap and water.

ϖ Vegetables have a high fiber content.

ϖ The nurse should use a tuberculin syringe to administer a subcutaneous injection of less than 1 ml.

ϖ For adults, subcutaneous injections require a 25G 1" needle; for infants, children, elderly, or very thin patients, they require a 25G to 27G ½" needle.

ϖ Before administering a drug, the nurse should identify the patient by checking the identification band and asking the patient to state his name.

ϖ To clean the skin before an injection, the nurse uses a sterile alcohol swab to wipe from the center of the site outward in a circular motion.

ϖ The nurse should inject heparin deep into subcutaneous tissue at a 90-degree angle (perpendicular to the skin) to prevent skin irritation.

ϖ If blood is aspirated into the syringe before an I.M. injection, the nurse should withdraw the needle, prepare another syringe, and repeat the procedure.

ϖ The nurse shouldn't cut the patient's hair without written consent from the patient or an appropriate relative.

ϖ If bleeding occurs after an injection, the nurse should apply pressure until the bleeding stops. If bruising occurs, the nurse should monitor the site for an enlarging hematoma.

ϖ When providing hair and scalp care, the nurse should begin combing at the end of the hair and work toward the head.

ϖ The frequency of patient hair care depends on the length and texture of the hair, the duration of hospitalization, and the patient's condition.

ϖ Proper function of a hearing aid requires careful handling during insertion and removal, regular cleaning of the ear piece to prevent wax buildup, and prompt replacement of dead batteries.

ϖ The hearing aid that's marked with a blue dot is for the left ear; the one with a red dot is for the right ear.

ϖ A hearing aid shouldn't be exposed to heat or humidity and shouldn't be immersed in water.

ϖ The nurse should instruct the patient to avoid using hair spray while wearing a hearing aid.

ϖ The five branches of pharmacology are pharmacokinetics, pharmacodynamics, pharmacotherapeutics, toxicology, and pharmacognosy.
ϖ The nurse should remove heel protectors every 8 hours to inspect the foot for signs of skin breakdown.

ϖ Heat is applied to promote vasodilation, which reduces pain caused by inflammation.

ϖ A sutured surgical incision is an example of healing by first intention (healing directly, without granulation).

ϖ Healing by secondary intention (healing by granulation) is closure of the wound when granulation tissue fills the defect and allows reepithelialization to occur, beginning at the wound edges and continuing to the center, until the entire wound is covered.
ϖ Keloid formation is an abnormality in healing that's characterized by overgrowth of scar tissue at the wound site.

ϖ The nurse should administer procaine penicillin by deep I.M. injection in the upper outer portion of the buttocks in the adult or in the midlateral thigh in the child. The nurse shouldn't massage the injection site.

ϖ An ascending colostomy drains fluid feces. A descending colostomy drains solid fecal matter.

ϖ A folded towel (scrotal bridge) can provide scrotal support for the patient with scrotal edema caused by vasectomy, epididymitis, or orchitis.

ϖ When giving an injection to a patient who has a bleeding disorder, the nurse should use a small-gauge needle and apply pressure to the site for 5 minutes after the injection.

ϖ Platelets are the smallest and most fragile formed element of the blood and are essential for coagulation.

ϖ To insert a nasogastric tube, the nurse instructs the patient to tilt the head back slightly and then inserts the tube. When the nurse feels the tube curving at the pharynx, the nurse should tell the patient to tilt the head forward to close the trachea and open the esophagus by swallowing. (Sips of water can facilitate this action.)

ϖ Families with loved ones in intensive care units report that their four most important needs are to have their questions answered honestly, to be assured that the best possible care is being provided, to know the patient's prognosis, and to feel that there is hope of recovery.

ϖ Double-bind communication occurs when the verbal message contradicts the nonverbal message and the receiver is unsure of which message to respond to.

ϖ A nonjudgmental attitude displayed by a nurse shows that she neither approves nor disapproves of the patient.

ϖ Target symptoms are those that the patient finds most distressing.

ϖ A patient should be advised to take aspirin on an empty stomach, with a full glass of water, and should avoid acidic foods such as coffee, citrus fruits, and cola.

ϖ For every patient problem, there is a nursing diagnosis; for every nursing diagnosis, there is a goal; and for every goal, there are interventions designed to make the goal a reality. The keys to answering examination questions correctly are identifying the problem presented, formulating a goal for the problem, and selecting the intervention from the choices provided that will enable the patient to reach that goal.

ϖ Fidelity means loyalty and can be shown as a commitment to the profession of nursing and to the patient.

ϖ Administering an I.M. injection against the patient's will and without legal authority is battery.

ϖ An example of a third-party payer is an insurance company.

ϖ The formula for calculating the drops per minute for an I.V. infusion is as follows: (volume to be infused × drip factor) ÷ time in minutes = drops/minute

ϖ On-call medication should be given within 5 minutes of the call.

ϖ Usually, the best method to determine a patient's cultural or spiritual needs is to ask him.

ϖ An incident report or unusual occurrence report isn't part of a patient's record, but is an in-house document that's used for the purpose of correcting the problem.

ϖ Critical pathways are a multidisciplinary guideline for patient care.

ϖ When prioritizing nursing diagnoses, the following hierarchy should be used: Problems associated with the airway, those concerning breathing, and those related to circulation.
ϖ The two nursing diagnoses that have the highest priority that the nurse can assign are Ineffective airway clearance and Ineffective breathing pattern.

ϖ A subjective sign that a sitz bath has been effective is the patient's expression of decreased pain or discomfort.

ϖ For the nursing diagnosis Deficient diversional activity to be valid, the patient must state that he's "bored," that he has "nothing to do," or words to that effect.

ϖ The most appropriate nursing diagnosis for an individual who doesn't speak English is Impaired verbal communication related to inability to speak dominant language (English).

ϖ The family of a patient who has been diagnosed as hearing impaired should be instructed to face the individual when they speak to him.

ϖ Before instilling medication into the ear of a patient who is up to age 3, the nurse should pull the pinna down and back to straighten the eustachian tube.

ϖ To prevent injury to the cornea when administering eyedrops, the nurse should waste the first drop and instill the drug in the lower conjunctival sac.

ϖ After administering eye ointment, the nurse should twist the medication tube to detach the ointment.

ϖ When the nurse removes gloves and a mask, she should remove the gloves first. They are soiled and are likely to contain pathogens.

ϖ Crutches should be placed 6" (15.2 cm) in front of the patient and 6" to the side to form a tripod arrangement.

ϖ Listening is the most effective communication technique.

ϖ Before teaching any procedure to a patient, the nurse must assess the patient's current knowledge and willingness to learn.

ϖ Process recording is a method of evaluating one's communication effectiveness.

ϖ When feeding an elderly patient, the nurse should limit high-carbohydrate foods because of the risk of glucose intolerance.

ϖ When feeding an elderly patient, essential foods should be given first.

ϖ Passive range of motion maintains joint mobility. Resistive exercises increase muscle mass.

ϖ Isometric exercises are performed on an extremity that's in a cast.

ϖ A back rub is an example of the gate-control theory of pain.

ϖ Anything that's located below the waist is considered unsterile; a sterile field becomes unsterile when it comes in contact with any unsterile item; a sterile field must be monitored continuously; and a border of 1" (2.5 cm) around a sterile field is considered unsterile.

ϖ A "shift to the left" is evident when the number of immature cells (bands) in the blood increases to fight an infection.

ϖ A "shift to the right" is evident when the number of mature cells in the blood increases, as seen in advanced liver disease and pernicious anemia.

ϖ Before administering preoperative medication, the nurse should ensure that an informed consent form has been signed and attached to the patient's record.

ϖ A nurse should spend no more than 30 minutes per 8-hour shift providing care to a patient who has a radiation implant.

ϖ A nurse shouldn't be assigned to care for more than one patient who has a radiation implant.

ϖ Long-handled forceps and a lead-lined container should be available in the room of a patient who has a radiation implant.

ϖ Usually, patients who have the same infection and are in strict isolation can share a room.

ϖ Diseases that require strict isolation include chickenpox, diphtheria, and viral hemorrhagic fevers such as Marburg disease.

ϖ For the patient who abides by Jewish custom, milk and meat shouldn't be served at the same meal.

ϖ Whether the patient can perform a procedure (psychomotor domain of learning) is a better indicator of the effectiveness of patient teaching than whether the patient can simply state the steps involved in the procedure (cognitive domain of learning).

ϖ According to Erik Erikson, developmental stages are trust versus mistrust (birth to 18 months), autonomy versus shame and doubt (18 months to age 3), initiative versus guilt (ages 3 to 5), industry versus inferiority (ages 5 to 12), identity versus identity diffusion (ages 12 to 18), intimacy versus isolation (ages 18 to 25), generativity versus stagnation (ages 25 to 60), and ego integrity versus despair (older than age 60).

ϖ When communicating with a hearing impaired patient, the nurse should face him.

ϖ An appropriate nursing intervention for the spouse of a patient who has a serious incapacitating disease is to help him to mobilize a support system.

ϖ Hyperpyrexia is extreme elevation in temperature above 106° F (41.1° C).

ϖ Milk is high in sodium and low in iron.

ϖ When a patient expresses concern about a health-related issue, before addressing the concern, the nurse should assess the patient's level of knowledge.

ϖ The most effective way to reduce a fever is to administer an antipyretic, which lowers the temperature set point.

ϖ When a patient is ill, it's essential for the members of his family to maintain communication about his health needs.

ϖ Ethnocentrism is the universal belief that one's way of life is superior to others'.

ϖ When a nurse is communicating with a patient through an interpreter, the nurse should speak to the patient and the interpreter.

ϖ In accordance with the "hot-cold" system used by some Mexicans, Puerto Ricans, and other Hispanic and Latino groups, most foods, beverages, herbs, and drugs are described as "cold."

ϖ Prejudice is a hostile attitude toward individuals of a particular group.

ϖ Discrimination is preferential treatment of individuals of a particular group. It's usually discussed in a negative sense.

ϖ Increased gastric motility interferes with the absorption of oral drugs.

ϖ The three phases of the therapeutic relationship are orientation, working, and termination.

ϖ Patients often exhibit resistive and challenging behaviors in the orientation phase of the therapeutic relationship.

ϖ Abdominal assessment is performed in the following order: inspection, auscultation, palpation, and percussion.

ϖ When measuring blood pressure in a neonate, the nurse should select a cuff that's no less than one-half and no more than two-thirds the length of the extremity that's used.

ϖ When administering a drug by Z-track, the nurse shouldn't use the same needle that was used to draw the drug into the syringe because doing so could stain the skin.

ϖ Sites for intradermal injection include the inner arm, the upper chest, and on the back, under the scapula.

ϖ When evaluating whether an answer on an examination is correct, the nurse should consider whether the action that's described promotes autonomy (independence), safety, self-esteem, and a sense of belonging.

ϖ When answering a question on the NCLEX examination, the student should

consider the cue (the stimulus for a thought) and the inference (the thought) to determine whether the inference is correct. When in doubt, the nurse should select an answer that indicates the need for further information to eliminate ambiguity. For example, the patient complains of chest pain (the stimulus for the thought) and the nurse infers that the patient is having cardiac pain (the thought). In this case, the nurse hasn't confirmed whether the pain is cardiac. It would be more appropriate to make further assessments.

ϖ Veracity is truth and is an essential component of a therapeutic relationship between a health care provider and his patient.

ϖ Beneficence is the duty to do no harm and the duty to do good. There's an obligation in patient care to do no harm and an equal obligation to assist the patient.

ϖ Nonmaleficence is the duty to do no harm.

ϖ Frye's ABCDE cascade provides a framework for prioritizing care by identifying the most important treatment concerns.

ϖ A = Airway. This category includes everything that affects a patent airway, including a foreign object, fluid from an upper respiratory infection, and edema from trauma or an allergic reaction.

ϖ B = Breathing. This category includes everything that affects the breathing pattern, including hyperventilation or hypoventilation and abnormal breathing patterns, such as Korsakoff's, Biot's, or Cheyne-Stokes respiration.

ϖ C = Circulation. This category includes everything that affects the circulation, including fluid and electrolyte disturbances and disease processes that affect cardiac output.

ϖ D = Disease processes. If the patient has no problem with the airway, breathing, or circulation, then the nurse should evaluate the disease processes, giving priority to the disease process that poses the greatest immediate risk. For example, if a patient has terminal cancer and hypoglycemia, hypoglycemia is a more immediate concern.

ϖ E = Everything else. This category includes such issues as writing an incident report and completing the patient chart. When evaluating needs, this category is never the highest priority.

ϖ When answering a question on an NCLEX examination, the basic rule is "assess before action." The student should evaluate each possible answer carefully. Usually, several answers reflect the implementation phase of nursing and one or two reflect

the assessment phase. In this case, the best choice is an assessment response unless a specific course of action is clearly indicated.

ϖ Rule utilitarianism is known as the "greatest good for the greatest number of people" theory.

ϖ Egalitarian theory emphasizes that equal access to goods and services must be provided to the less fortunate by an affluent society.

ϖ Active euthanasia is actively helping a person to die.

ϖ Brain death is irreversible cessation of all brain function.

ϖ Passive euthanasia is stopping the therapy that's sustaining life.

ϖ A third-party payer is an insurance company.

ϖ Utilization review is performed to determine whether the care provided to a patient was appropriate and cost-effective.
ϖ A value cohort is a group of people who experienced an out-of-the-ordinary event that shaped their values.

ϖ Voluntary euthanasia is actively helping a patient to die at the patient's request.
ϖ Bananas, citrus fruits, and potatoes are good sources of potassium.

ϖ Good sources of magnesium include fish, nuts, and grains.

ϖ Beef, oysters, shrimp, scallops, spinach, beets, and greens are good sources of iron.

ϖ Intrathecal injection is administering a drug through the spine.

ϖ When a patient asks a question or makes a statement that's emotionally charged, the nurse should respond to the emotion behind the statement or question rather than to what's being said or asked.

ϖ The steps of the trajectory-nursing model are as follows:
– Step 1: Identifying the trajectory phase
– Step 2: Identifying the problems and establishing goals
– Step 3: Establishing a plan to meet the goals
– Step 4: Identifying factors that facilitate or hinder attainment of the goals
– Step 5: Implementing interventions
– Step 6: Evaluating the effectiveness of the interventions

ϖ A Hindu patient is likely to request a vegetarian diet.

ϖ Pain threshold, or pain sensation, is the initial point at which a patient feels pain.

ϖ The difference between acute pain and chronic pain is its duration.

ϖ Referred pain is pain that's felt at a site other than its origin.

ϖ Alleviating pain by performing a back massage is consistent with the gate control theory.

ϖ Romberg's test is a test for balance or gait.

ϖ Pain seems more intense at night because the patient isn't distracted by daily activities.

ϖ Older patients commonly don't report pain because of fear of treatment, lifestyle changes, or dependency.
ϖ No pork or pork products are allowed in a Muslim diet.

ϖ Two goals of Healthy People 2010 are:
– Help individuals of all ages to increase the quality of life and the number of years of optimal health
– Eliminate health disparities among different segments of the population.

ϖ A community nurse is serving as a patient's advocate if she tells a malnourished patient to go to a meal program at a local park.

ϖ If a patient isn't following his treatment plan, the nurse should first ask why.

ϖ Falls are the leading cause of injury in elderly people.

ϖ Primary prevention is true prevention. Examples are immunizations, weight control, and smoking cessation.

ϖ Secondary prevention is early detection. Examples include purified protein derivative (PPD), breast self-examination, testicular self-examination, and chest X-ray.

ϖ Tertiary prevention is treatment to prevent long-term complications.

ϖ A patient indicates that he's coming to terms with having a chronic disease when he says, "I'm never going to get any better."

ϖ On noticing religious artifacts and literature on a patient's night stand, a culturally aware nurse would ask the patient the meaning of the items.

ϖ A Mexican patient may request the intervention of a curandero, or faith healer, who involves the family in healing the patient.

ϖ In an infant, the normal hemoglobin value is 12 g/dl.

ϖ The nitrogen balance estimates the difference between the intake and use of protein.

ϖ Most of the absorption of water occurs in the large intestine.

ϖ Most nutrients are absorbed in the small intestine.

ϖ When assessing a patient's eating habits, the nurse should ask, "What have you eaten in the last 24 hours?"

ϖ A vegan diet should include an abundant supply of fiber.

ϖ A hypotonic enema softens the feces, distends the colon, and stimulates peristalsis.

ϖ First-morning urine provides the best sample to measure glucose, ketone, pH, and specific gravity values.

ϖ To induce sleep, the first step is to minimize environmental stimuli.

ϖ Before moving a patient, the nurse should assess the patient's physical abilities and ability to understand instructions as well as the amount of strength required to move the patient.

ϖ To lose 1 lb (0.5 kg) in 1 week, the patient must decrease his weekly intake by 3,500 calories (approximately 500 calories daily). To lose 2 lb (1 kg) in 1 week, the patient must decrease his weekly caloric intake by 7,000 calories (approximately 1,000 calories daily).

ϖ To avoid shearing force injury, a patient who is completely immobile is lifted on a sheet.

ϖ To insert a catheter from the nose through the trachea for suction, the nurse should ask the patient to swallow.

ϖ Vitamin C is needed for collagen production.

ϖ Only the patient can describe his pain accurately.

ϖ Cutaneous stimulation creates the release of endorphins that block the transmission of pain stimuli.

ϖ Patient-controlled analgesia is a safe method to relieve acute pain caused by surgical incision, traumatic injury, labor and delivery, or cancer.

ϖ An Asian American or European American typically places distance between himself and others when communicating.

ϖ The patient who believes in a scientific, or biomedical, approach to health is likely to expect a drug, treatment, or surgery to cure illness.

ϖ Chronic illnesses occur in very young as well as middle-aged and very old people.

ϖ The trajectory framework for chronic illness states that preferences about daily life activities affect treatment decisions.

ϖ Exacerbations of chronic disease usually cause the patient to seek treatment and may lead to hospitalization.

ϖ School health programs provide cost-effective health care for low-income families and those who have no health insurance.

ϖ Collegiality is the promotion of collaboration, development, and interdependence among members of a profession.

ϖ A change agent is an individual who recognizes a need for change or is selected to make a change within an established entity, such as a hospital.

ϖ The patients' bill of rights was introduced by the American Hospital Association.

ϖ Abandonment is premature termination of treatment without the patient's permission and without appropriate relief of symptoms.

ϖ Values clarification is a process that individuals use to prioritize their personal values.

ϖ Distributive justice is a principle that promotes equal treatment for all.

ϖ Milk and milk products, poultry, grains, and fish are good sources of phosphate.

ϖ The best way to prevent falls at night in an oriented, but restless, elderly patient is to raise the side rails.

ϖ By the end of the orientation phase, the patient should begin to trust the nurse.

ϖ Falls in the elderly are likely to be caused by poor vision.

ϖ Barriers to communication include language deficits, sensory deficits, cognitive impairments, structural deficits, and paralysis.

ϖ The three elements that are necessary for a fire are heat, oxygen, and combustible material.

ϖ Sebaceous glands lubricate the skin.

ϖ To check for petechiae in a dark-skinned patient, the nurse should assess the oral mucosa.

ϖ To put on a sterile glove, the nurse should pick up the first glove at the folded

border and adjust the fingers when both gloves are on.

ϖ To increase patient comfort, the nurse should let the alcohol dry before giving an intramuscular injection.

ϖ Treatment for a stage 1 ulcer on the heels includes heel protectors.

ϖ Seventh-Day Adventists are usually vegetarians.

ϖ Endorphins are morphinelike substances that produce a feeling of well-being.

ϖ Pain tolerance is the maximum amount and duration of pain that an individual is willing to endure.

MATERNAL AND CHILD:

- Unlike false labor, true labor produces regular rhythmic contractions, abdominal discomfort, progressive descent of the fetus, bloody show, and progressive effacement and dilation of the cervix.
- To help a mother break the suction of her breast-feeding infant, the nurse should teach her to insert a finger at the corner of the infant's mouth.
- Administering high levels of oxygen to a premature neonate can cause blindness as a result of retrolental fibroplasia.
- Amniotomy is artificial rupture of the amniotic membranes.
- During pregnancy, weight gain averages 25 to 30 lb (11 to 13.5 kg).
- Rubella has a teratogenic effect on the fetus during the first trimester. It produces abnormalities in up to 40% of cases without interrupting the pregnancy.
- Immunity to rubella can be measured by a hemagglutination inhibition test (rubella titer). This test identifies exposure to rubella infection and determines susceptibility in pregnant women. In a woman, a titer greater than 1:8 indicates immunity.
- When used to describe the degree of fetal descent during labor, floating means the presenting part isn't engaged in the pelvic inlet, but is freely movable (ballotable) above the pelvic inlet.
- When used to describe the degree of fetal descent, engagement means when the largest diameter of the presenting part has passed through the pelvic inlet.
- Fetal station indicates the location of the presenting part in relation to the ischial spine. It's described as –1, –2, –3, –4, or –5 to indicate the number of centimeters above the level of the ischial spine; station –5 is at the pelvic inlet.
- Fetal station also is described as +1, +2, +3, +4, or +5 to indicate the number of centimeters it is below the level of the ischial spine; station 0 is at the level of the ischial spine.
- During the first stage of labor, the side-lying position usually provides the greatest degree of comfort, although the patient may assume any comfortable position.
- During delivery, if the umbilical cord can't be loosened and slipped from around the neonate's neck, it should be clamped with two clamps and cut between the clamps.
- An Apgar score of 7 to 10 indicates no immediate distress, 4 to 6 indicates moderate distress, and 0 to 3 indicates severe distress.

- To elicit Moro's reflex, the nurse holds the neonate in both hands and suddenly, but gently, drops the neonate's head backward. Normally, the neonate abducts and extends all extremities bilaterally and symmetrically, forms a C shape with the thumb and forefinger, and first adducts and then flexes the extremities.
- Pregnancy-induced hypertension (preeclampsia) is an increase in blood pressure of 30/15 mm Hg over baseline or blood pressure of 140/95 mm Hg on two occasions at least 6 hours apart accompanied by edema and albuminuria after 20 weeks' gestation.
- Positive signs of pregnancy include ultrasound evidence, fetal heart tones, and fetal movement felt by the examiner (not usually present until 4 months' gestation
- Goodell's sign is softening of the cervix.
- Quickening, a presumptive sign of pregnancy, occurs between 16 and 19 weeks' gestation.
- Ovulation ceases during pregnancy.
- Any vaginal bleeding during pregnancy should be considered a complication until proven otherwise.
- To estimate the date of delivery using Nägele's rule, the nurse counts backward 3 months from the first day of the last menstrual period and then adds 7 days to this date.
- At 12 weeks' gestation, the fundus should be at the top of the symphysis pubis.
- Cow's milk shouldn't be given to infants younger than age 1 because it has a low linoleic acid content and its protein is difficult for infants to digest.
- If jaundice is suspected in a neonate, the nurse should examine the infant under natural window light. If natural light is unavailable, the nurse should examine the infant under a white light.
- The three phases of a uterine contraction are increment, acme, and decrement.
- The intensity of a labor contraction can be assessed by the indentability of the uterine wall at the contraction's peak. Intensity is graded as mild (uterine muscle is somewhat tense), moderate (uterine muscle is moderately tense), or strong (uterine muscle is boardlike).
- Chloasma, the mask of pregnancy, is pigmentation of a circumscribed area of skin (usually over the bridge of the nose and cheeks) that occurs in some pregnant women.
- The gynecoid pelvis is most ideal for delivery. Other types include platypelloid (flat), anthropoid (apelike), and android (malelike).
- Pregnant women should be advised that there is no safe level of alcohol intake.
- The frequency of uterine contractions, which is measured in minutes, is the time from the beginning of one contraction to the beginning of the next.
- Vitamin K is administered to neonates to prevent hemorrhagic disorders because a neonate's intestine can't synthesize vitamin K.
- Before internal fetal monitoring can be performed, a pregnant patient's cervix must be dilated at least 2 cm, the amniotic membranes must be ruptured, and the fetus's presenting part (scalp or buttocks) must be at station –1 or lower, so that a small electrode can be attached.
- Fetal alcohol syndrome presents in the first 24 hours after birth and produces lethargy, seizures, poor sucking reflex, abdominal distention, and respiratory difficulty.
- Variability is any change in the fetal heart rate (FHR) from its normal rate of 120 to 160 beats/minute. Acceleration is increased FHR; deceleration is decreased FHR.

- In a neonate, the symptoms of heroin withdrawal may begin several hours to 4 days after birth.
- In a neonate, the symptoms of methadone withdrawal may begin 7 days to several weeks after birth.
- In a neonate, the cardinal signs of narcotic withdrawal include coarse, flapping tremors; sleepiness; restlessness; prolonged, persistent, high-pitched cry; and irritability.
- The nurse should count a neonate's respirations for 1 full minute.
- Chlorpromazine (Thorazine) is used to treat neonates who are addicted to narcotics.
- The nurse should provide a dark, quiet environment for a neonate who is experiencing narcotic withdrawal.
- In a premature neonate, signs of respiratory distress include nostril flaring, substernal retractions, and inspiratory grunting.
- Respiratory distress syndrome (hyaline membrane disease) develops in premature infants because their pulmonary alveoli lack surfactant.
- Whenever an infant is being put down to sleep, the parent or caregiver should position the infant on the back. (Remember back to sleep.)
- The male sperm contributes an X or a Y chromosome; the female ovum contributes an X chromosome.
- Fertilization produces a total of 46 chromosomes, including an XY combination (male) or an XX combination (female).
- The percentage of water in a neonate's body is about 78% to 80%.
- To perform nasotracheal suctioning in an infant, the nurse positions the infant with his neck slightly hyperextended in a "sniffing" position, with his chin up and his head tilted back slightly.
- Organogenesis occurs during the first trimester of pregnancy, specifically, days 14 to 56 of gestation.
- After birth, the neonate's umbilical cord is tied 1" (2.5 cm) from the abdominal wall with a cotton cord, plastic clamp, or rubber band.
- Gravida is the number of pregnancies a woman has had, regardless of outcome.
- Para is the number of pregnancies that reached viability, regardless of whether the fetus was delivered alive or stillborn. A fetus is considered viable at 20 weeks' gestation.
- An ectopic pregnancy is one that implants abnormally, outside the uterus.
- The first stage of labor begins with the onset of labor and ends with full cervical dilation at 10 cm.
- The second stage of labor begins with full cervical dilation and ends with the neonate's birth.
- The third stage of labor begins after the neonate's birth and ends with expulsion of the placenta.
- In a full-term neonate, skin creases appear over two-thirds of the neonate's feet. Preterm neonates have heel creases that cover less than two-thirds of the feet.
- The fourth stage of labor (postpartum stabilization) lasts up to 4 hours after the placenta is delivered. This time is needed to stabilize the mother's physical and emotional state after the stress of childbirth.
- At 20 weeks' gestation, the fundus is at the level of the umbilicus.
- At 36 weeks' gestation, the fundus is at the lower border of the rib cage.
- A premature neonate is one born before the end of the 37th week of gestation.

- Pregnancy-induced hypertension is a leading cause of maternal death in the United States.
- A habitual aborter is a woman who has had three or more consecutive spontaneous abortions.
- Threatened abortion occurs when bleeding is present without cervical dilation.
- A complete abortion occurs when all products of conception are expelled.
- Hydramnios (polyhydramnios) is excessive amniotic fluid (more than 2,000 ml in the third trimester).
- Stress, dehydration, and fatigue may reduce a breast-feeding mother's milk supply.
- During the transition phase of the first stage of labor, the cervix is dilated 8 to 10 cm and contractions usually occur 2 to 3 minutes apart and last for 60 seconds.
- A nonstress test is considered nonreactive (positive) if fewer than two fetal heart rate accelerations of at least 15 beats/minute occur in 20 minutes.
- A nonstress test is considered reactive (negative) if two or more fetal heart rate accelerations of 15 beats/minute above baseline occur in 20 minutes.
- A nonstress test is usually performed to assess fetal well-being in a pregnant patient with a prolonged pregnancy (42 weeks or more), diabetes, a history of poor pregnancy outcomes, or pregnancy-induced hypertension.
- A pregnant woman should drink at least eight 8-oz glasses (about 2,000 ml) of water daily.
- When both breasts are used for breast-feeding, the infant usually doesn't empty the second breast. Therefore, the second breast should be used first at the next feeding.
- A low-birth-weight neonate weighs 2,500 g (5 lb 8 oz) or less at birth.
- A very-low-birth-weight neonate weighs 1,500 g (3 lb 5 oz) or less at birth.
- When teaching parents to provide umbilical cord care, the nurse should teach them to clean the umbilical area with a cotton ball saturated with alcohol after every diaper change to prevent infection and promote drying.
- Teenage mothers are more likely to have low-birth-weight neonates because they seek prenatal care late in pregnancy (as a result of denial) and are more likely than older mothers to have nutritional deficiencies.
- Linea nigra, a dark line that extends from the umbilicus to the mons pubis, commonly appears during pregnancy and disappears after pregnancy.
- Implantation in the uterus occurs 6 to 10 days after ovum fertilization.
- Placenta previa is abnormally low implantation of the placenta so that it encroaches on or covers the cervical os.
- In complete (total) placenta previa, the placenta completely covers the cervical os.
- In partial (incomplete or marginal) placenta previa, the placenta covers only a portion of the cervical os.
- Abruptio placentae is premature separation of a normally implanted placenta. It may be partial or complete, and usually causes abdominal pain, vaginal bleeding, and a boardlike abdomen.
- Cutis marmorata is mottling or purple discoloration of the skin. It's a transient vasomotor response that occurs primarily in the arms and legs of infants who are exposed to cold.
- The classic triad of symptoms of preeclampsia are hypertension, edema, and proteinuria. Additional symptoms of severe preeclampsia include hyperreflexia, cerebral and vision disturbances, and epigastric pain.

- Ortolani's sign (an audible click or palpable jerk that occurs with thigh abduction) confirms congenital hip dislocation in a neonate.
- The first immunization for a neonate is the hepatitis B vaccine, which is administered in the nursery shortly after birth.
- If a patient misses a menstrual period while taking an oral contraceptive exactly as prescribed, she should continue taking the contraceptive.
- If a patient misses two consecutive menstrual periods while taking an oral contraceptive, she should discontinue the contraceptive and take a pregnancy test.
- If a patient who is taking an oral contraceptive misses a dose, she should take the pill as soon as she remembers or take two at the next scheduled interval and continue with the normal schedule.
- If a patient who is taking an oral contraceptive misses two consecutive doses, she should double the dose for 2 days and then resume her normal schedule. She also should use an additional birth control method for 1 week.
- Eclampsia is the occurrence of seizures that aren't caused by a cerebral disorder in a patient who has pregnancy-induced hypertension.
- In placenta previa, bleeding is painless and seldom fatal on the first occasion, but it becomes heavier with each subsequent episode.
- Treatment for abruptio placentae is usually immediate cesarean delivery.
- Drugs used to treat withdrawal symptoms in neonates include phenobarbital (Luminal), camphorated opium tincture (paregoric), and diazepam (Valium).
- Infants with Down syndrome typically have marked hypotonia, floppiness, slanted eyes, excess skin on the back of the neck, flattened bridge of the nose, flat facial features, spadelike hands, short and broad feet, small male genitalia, absence of Moro's reflex, and a simian crease on the hands.
- The failure rate of a contraceptive is determined by the experience of 100 women for 1 year. It's expressed as pregnancies per 100 woman-years.
- The narrowest diameter of the pelvic inlet is the anteroposterior (diagonal conjugate).
- The chorion is the outermost extraembryonic membrane that gives rise to the placenta.
- The corpus luteum secretes large quantities of progesterone.
- From the 8th week of gestation through delivery, the developing cells are known as a fetus.
- In an incomplete abortion, the fetus is expelled, but parts of the placenta and membrane remain in the uterus.
- The circumference of a neonate's head is normally 2 to 3 cm greater than the circumference of the chest.
- After administering magnesium sulfate to a pregnant patient for hypertension or preterm labor, the nurse should monitor the respiratory rate and deep tendon reflexes.
- During the first hour after birth (the period of reactivity), the neonate is alert and awake.
- When a pregnant patient has undiagnosed vaginal bleeding, vaginal examination should be avoided until ultrasonography rules out placenta previa.
- After delivery, the first nursing action is to establish the neonate's airway.

- Nursing interventions for a patient with placenta previa include positioning the patient on her left side for maximum fetal perfusion, monitoring fetal heart tones, and administering I.V. fluids and oxygen, as ordered.
- The specific gravity of a neonate's urine is 1.003 to 1.030. A lower specific gravity suggests overhydration; a higher one suggests dehydration.
- The neonatal period extends from birth to day 28. It's also called the first 4 weeks or first month of life.
- A woman who is breast-feeding should rub a mild emollient cream or a few drops of breast milk (or colostrum) on the nipples after each feeding. She should let the breasts air-dry to prevent them from cracking.
- Breast-feeding mothers should increase their fluid intake to 2½ to 3 qt (2,500 to 3,000 ml) daily.
- After feeding an infant with a cleft lip or palate, the nurse should rinse the infant's mouth with sterile water.
- The nurse instills erythromycin in a neonate's eyes primarily to prevent blindness caused by gonorrhea or chlamydia.
- Human immunodeficiency virus (HIV) has been cultured in breast milk and can be transmitted by an HIV-positive mother who breast-feeds her infant.
- A fever in the first 24 hours postpartum is most likely caused by dehydration rather than infection.
- Preterm neonates or neonates who can't maintain a skin temperature of at least 97.6° F (36.4° C) should receive care in an incubator (Isolette) or a radiant warmer. In a radiant warmer, a heat-sensitive probe taped to the neonate's skin activates the heater unit automatically to maintain the desired temperature.
- During labor, the resting phase between contractions is at least 30 seconds.
- Lochia rubra is the vaginal discharge of almost pure blood that occurs during the first few days after childbirth.
- Lochia serosa is the serous vaginal discharge that occurs 4 to 7 days after childbirth.
- Lochia alba is the vaginal discharge of decreased blood and increased leukocytes that's the final stage of lochia. It occurs 7 to 10 days after childbirth.
- Colostrum, the precursor of milk, is the first secretion from the breasts after delivery.
- The length of the uterus increases from 2½" (6.3 cm) before pregnancy to 12½" (32 cm) at term.
- To estimate the true conjugate (the smallest inlet measurement of the pelvis), deduct 1.5 cm from the diagonal conjugate (usually 12 cm). A true conjugate of 10.5 cm enables the fetal head (usually 10 cm) to pass.
- The smallest outlet measurement of the pelvis is the intertuberous diameter, which is the transverse diameter between the ischial tuberosities.
- Electronic fetal monitoring is used to assess fetal well-being during labor. If compromised fetal status is suspected, fetal blood pH may be evaluated by obtaining a scalp sample.
- In an emergency delivery, enough pressure should be applied to the emerging fetus's head to guide the descent and prevent a rapid change in pressure within the molded fetal skull.
- After delivery, a multiparous woman is more susceptible to bleeding than a primiparous woman because her uterine muscles may be overstretched and may not contract efficiently.

- Neonates who are delivered by cesarean birth have a higher incidence of respiratory distress syndrome.
- The nurse should suggest ambulation to a postpartum patient who has gas pain and flatulence.
- Massaging the uterus helps to stimulate contractions after the placenta is delivered.
- When providing phototherapy to a neonate, the nurse should cover the neonate's eyes and genital area.
- The narcotic antagonist naloxone (Narcan) may be given to a neonate to correct respiratory depression caused by narcotic administration to the mother during labor.
- In a neonate, symptoms of respiratory distress syndrome include expiratory grunting or whining, sandpaper breath sounds, and seesaw retractions.
- Cerebral palsy presents as asymmetrical movement, irritability, and excessive, feeble crying in a long, thin infant.
- The nurse should assess a breech-birth neonate for hydrocephalus, hematomas, fractures, and other anomalies caused by birth trauma.
- When a patient is admitted to the unit in active labor, the nurse's first action is to listen for fetal heart tones.
- In a neonate, long, brittle fingernails are a sign of postmaturity.
- Desquamation (skin peeling) is common in postmature neonates.
- A mother should allow her infant to breast-feed until the infant is satisfied. The time may vary from 5 to 20 minutes.
- Nitrazine paper is used to test the pH of vaginal discharge to determine the presence of amniotic fluid.
- A pregnant patient normally gains 2 to 5 lb (1 to 2.5 kg) during the first trimester and slightly less than 1 lb (0.5 kg) per week during the last two trimesters.
- Neonatal jaundice in the first 24 hours after birth is known as pathological jaundice and is a sign of erythroblastosis fetalis.
- A classic difference between abruptio placentae and placenta previa is the degree of pain. Abruptio placentae causes pain, whereas placenta previa causes painless bleeding.
- Because a major role of the placenta is to function as a fetal lung, any condition that interrupts normal blood flow to or from the placenta increases fetal partial pressure of arterial carbon dioxide and decreases fetal pH.
- Precipitate labor lasts for approximately 3 hours and ends with delivery of the neonate.
- Methylergonovine (Methergine) is an oxytocic agent used to prevent and treat postpartum hemorrhage caused by uterine atony or subinvolution.
- As emergency treatment for excessive uterine bleeding, 0.2 mg of methylergonovine (Methergine) is injected I.V. over 1 minute while the patient's blood pressure and uterine contractions are monitored.
- Braxton Hicks contractions are usually felt in the abdomen and don't cause cervical change. True labor contractions are felt in the front of the abdomen and back and lead to progressive cervical dilation and effacement.
- The average birth weight of neonates born to mothers who smoke is 6 oz (170 g) less than that of neonates born to nonsmoking mothers.
- Culdoscopy is visualization of the pelvic organs through the posterior vaginal fornix.
- The nurse should teach a pregnant vegetarian to obtain protein from alternative sources, such as nuts, soybeans, and legumes.

- The nurse should instruct a pregnant patient to take only prescribed prenatal vitamins because over-the-counter high-potency vitamins may harm the fetus.
- High-sodium foods can cause fluid retention, especially in pregnant patients.
- A pregnant patient can avoid constipation and hemorrhoids by adding fiber to her diet.
- If a fetus has late decelerations (a sign of fetal hypoxia), the nurse should instruct the mother to lie on her left side and then administer 8 to 10 L of oxygen per minute by mask or cannula. The nurse should notify the physician. The side-lying position removes pressure on the inferior vena cava.
- Oxytocin (Pitocin) promotes lactation and uterine contractions.
- Lanugo covers the fetus's body until about 20 weeks' gestation. Then it begins to disappear from the face, trunk, arms, and legs, in that order.
- In a neonate, hypoglycemia causes temperature instability, hypotonia, jitteriness, and seizures. Premature, postmature, small-for-gestational-age, and large-for-gestational-age neonates are susceptible to this disorder.
- Neonates typically need to consume 50 to 55 cal per pound of body weight daily.
- Because oxytocin (Pitocin) stimulates powerful uterine contractions during labor, it must be administered under close observation to help prevent maternal and fetal distress.
- During fetal heart rate monitoring, variable decelerations indicate compression or prolapse of the umbilical cord.
- Cytomegalovirus is the leading cause of congenital viral infection.
- Tocolytic therapy is indicated in premature labor, but contraindicated in fetal death, fetal distress, or severe hemorrhage.
- Through ultrasonography, the biophysical profile assesses fetal well-being by measuring fetal breathing movements, gross body movements, fetal tone, reactive fetal heart rate (nonstress test), and qualitative amniotic fluid volume.
- A neonate whose mother has diabetes should be assessed for hyperinsulinism.
- In a patient with preeclampsia, epigastric pain is a late symptom and requires immediate medical intervention.
- After a stillbirth, the mother should be allowed to hold the neonate to help her come to terms with the death.
- Molding is the process by which the fetal head changes shape to facilitate movement through the birth canal.
- If a woman receives a spinal block before delivery, the nurse should monitor the patient's blood pressure closely.
- If a woman suddenly becomes hypotensive during labor, the nurse should increase the infusion rate of I.V. fluids as prescribed.
- The best technique for assessing jaundice in a neonate is to blanch the tip of the nose or the area just above the umbilicus.
- During fetal heart monitoring, early deceleration is caused by compression of the head during labor.
- After the placenta is delivered, the nurse may add oxytocin (Pitocin) to the patient's I.V. solution, as prescribed, to promote postpartum involution of the uterus and stimulate lactation.
- Pica is a craving to eat nonfood items, such as dirt, crayons, chalk, glue, starch, or hair. It may occur during pregnancy and can endanger the fetus.

- A pregnant patient should take folic acid because this nutrient is required for rapid cell division.
- A woman who is taking clomiphene (Clomid) to induce ovulation should be informed of the possibility of multiple births with this drug.
- If needed, cervical suturing is usually done between 14 and 18 weeks' gestation to reinforce an incompetent cervix and maintain pregnancy. The suturing is typically removed by 35 weeks' gestation.
- During the first trimester, a pregnant woman should avoid all drugs unless doing so would adversely affect her health.
- Most drugs that a breast-feeding mother takes appear in breast milk.
- The Food and Drug Administration has established the following five categories of drugs based on their potential for causing birth defects: A, no evidence of risk; B, no risk found in animals, but no studies have been done in women; C, animal studies have shown an adverse effect, but the drug may be beneficial to women despite the potential risk; D, evidence of risk, but its benefits may outweigh its risks; and X, fetal anomalies noted, and the risks clearly outweigh the potential benefits.
- A patient with a ruptured ectopic pregnancy commonly has sharp pain in the lower abdomen, with spotting and cramping. She may have abdominal rigidity; rapid, shallow respirations; tachycardia; and shock.
- A patient with a ruptured ectopic pregnancy commonly has sharp pain in the lower abdomen, with spotting and cramping. She may have abdominal rigidity; rapid, shallow respirations; tachycardia; and shock.
- The mechanics of delivery are engagement, descent and flexion, internal rotation, extension, external rotation, restitution, and expulsion.
- A probable sign of pregnancy, McDonald's sign is characterized by an ease in flexing the body of the uterus against the cervix.
- Amenorrhea is a probable sign of pregnancy.
- A pregnant woman's partner should avoid introducing air into the vagina during oral sex because of the possibility of air embolism.
- The presence of human chorionic gonadotropin in the blood or urine is a probable sign of pregnancy.
- Radiography isn't usually used in a pregnant woman because it may harm the developing fetus. If radiography is essential, it should be performed only after 36 weeks' gestation.
- A pregnant patient who has had rupture of the membranes or who is experiencing vaginal bleeding shouldn't engage in sexual intercourse.
- Milia may occur as pinpoint spots over a neonate's nose.
- The duration of a contraction is timed from the moment that the uterine muscle begins to tense to the moment that it reaches full relaxation. It's measured in seconds.
- The union of a male and a female gamete produces a zygote, which divides into the fertilized ovum.
- The first menstrual flow is called menarche and may be anovulatory (infertile).
- Spermatozoa (or their fragments) remain in the vagina for 72 hours after sexual intercourse.
- Prolactin stimulates and sustains milk production.
- Strabismus is a normal finding in a neonate.

- A postpartum patient may resume sexual intercourse after the perineal or uterine wounds heal (usually within 4 weeks after delivery).
- A pregnant staff member shouldn't be assigned to work with a patient who has cytomegalovirus infection because the virus can be transmitted to the fetus.
- Fetal demise is death of the fetus after viability.
- Respiratory distress syndrome develops in premature neonates because their alveoli lack surfactant.
- The most common method of inducing labor after artificial rupture of the membranes is oxytocin (Pitocin) infusion.
- After the amniotic membranes rupture, the initial nursing action is to assess the fetal heart rate.
- The most common reasons for cesarean birth are malpresentation, fetal distress, cephalopelvic disproportion, pregnancy-induced hypertension, previous cesarean birth, and inadequate progress in labor.
- Amniocentesis increases the risk of spontaneous abortion, trauma to the fetus or placenta, premature labor, infection, and Rh sensitization of the fetus.
- After amniocentesis, abdominal cramping or spontaneous vaginal bleeding may indicate complications.
- To prevent her from developing Rh antibodies, an Rh-negative primigravida should receive Rho(D) immune globulin (RhoGAM) after delivering an Rh-positive neonate.
- If a pregnant patient's test results are negative for glucose but positive for acetone, the nurse should assess the patient's diet for inadequate caloric intake.
- If a pregnant patient's test results are negative for glucose but positive for acetone, the nurse should assess the patient's diet for inadequate caloric intake.
- Rubella infection in a pregnant patient, especially during the first trimester, can lead to spontaneous abortion or stillbirth as well as fetal cardiac and other birth defects.
- A pregnant patient should take an iron supplement to help prevent anemia.
- Direct antiglobulin (direct Coombs') test is used to detect maternal antibodies attached to red blood cells in the neonate.
- Nausea and vomiting during the first trimester of pregnancy are caused by rising levels of the hormone human chorionic gonadotropin.
- Before discharging a patient who has had an abortion, the nurse should instruct her to report bright red clots, bleeding that lasts longer than 7 days, or signs of infection, such as a temperature of greater than 100° F (37.8° C), foul-smelling vaginal discharge, severe uterine cramping, nausea, or vomiting.
- When informed that a patient's amniotic membrane has broken, the nurse should check fetal heart tones and then maternal vital signs.
- The duration of pregnancy averages 280 days, 40 weeks, 9 calendar months, or 10 lunar months.
- The initial weight loss for a healthy neonate is 5% to 10% of birth weight.
- The normal hemoglobin value in neonates is 17 to 20 g/dl.
- Crowning is the appearance of the fetus's head when its largest diameter is encircled by the vulvovaginal ring.
- A multipara is a woman who has had two or more pregnancies that progressed to viability, regardless of whether the offspring were alive at birth.
- In a pregnant patient, preeclampsia may progress to eclampsia, which is characterized by seizures and may lead to coma.

- The Apgar score is used to assess the neonate's vital functions. It's obtained at 1 minute and 5 minutes after delivery. The score is based on respiratory effort, heart rate, muscle tone, reflex irritability, and color.
- Because of the anti-insulin effects of placental hormones, insulin requirements increase during the third trimester.
- Gestational age can be estimated by ultrasound measurement of maternal abdominal circumference, fetal femur length, and fetal head size. These measurements are most accurate between 12 and 18 weeks' gestation.
- Skeletal system abnormalities and ventricular septal defects are the most common disorders of infants who are born to diabetic women. The incidence of congenital malformation is three times higher in these infants than in those born to nondiabetic women.
- Skeletal system abnormalities and ventricular septal defects are the most common disorders of infants who are born to diabetic women. The incidence of congenital malformation is three times higher in these infants than in those born to nondiabetic women.
- The patient with preeclampsia usually has puffiness around the eyes or edema in the hands (for example, "I can't put my wedding ring on.").
- Kegel exercises require contraction and relaxation of the perineal muscles. These exercises help strengthen pelvic muscles and improve urine control in postpartum patients.
- Symptoms of postpartum depression range from mild postpartum blues to intense, suicidal, depressive psychosis.
- The preterm neonate may require gavage feedings because of a weak sucking reflex, uncoordinated sucking, or respiratory distress.
- Acrocyanosis (blueness and coolness of the arms and legs) is normal in neonates because of their immature peripheral circulatory system.
- To prevent ophthalmia neonatorum (a severe eye infection caused by maternal gonorrhea), the nurse may administer one of three drugs, as prescribed, in the neonate's eyes: tetracycline, silver nitrate, or erythromycin.
- Neonatal testing for phenylketonuria is mandatory in most states.
- The nurse should place the neonate in a 30-degree Trendelenburg position to facilitate mucus drainage.
- The nurse may suction the neonate's nose and mouth as needed with a bulb syringe or suction trap.
- To prevent heat loss, the nurse should place the neonate under a radiant warmer during suctioning and initial delivery-room care, and then wrap the neonate in a warmed blanket for transport to the nursery.
- The umbilical cord normally has two arteries and one vein.
- When providing care, the nurse should expose only one part of an infant's body at a time.
- Lightening is settling of the fetal head into the brim of the pelvis.
- If the neonate is stable, the mother should be allowed to breast-feed within the neonate's first hour of life.
- The nurse should check the neonate's temperature every 1 to 2 hours until it's maintained within normal limits.

- At birth, a neonate normally weighs 5 to 9 lb (2 to 4 kg), measures 18" to 22" (45.5 to 56 cm) in length, has a head circumference of 13½" to 14" (34 to 35.5 cm), and has a chest circumference that's 1" (2.5 cm) less than the head circumference.
- In the neonate, temperature normally ranges from 98° to 99° F (36.7° to 37.2° C), apical pulse rate averages 120 to 160 beats/minute, and respirations are 40 to 60 breaths/minute.
- The diamond-shaped anterior fontanel usually closes between ages 12 and 18 months. The triangular posterior fontanel usually closes by age 2 months.
- In the neonate, a straight spine is normal. A tuft of hair over the spine is an abnormal finding.
- Prostaglandin gel may be applied to the vagina or cervix to ripen an unfavorable cervix before labor induction with oxytocin (Pitocin).
- Supernumerary nipples are occasionally seen on neonates. Theyusually appear along a line that runs from each axilla, through the normal nipple area, and to the groin.
- Meconium is a material that collects in the fetus's intestines and forms the neonate's first feces, which are black and tarry.
- The presence of meconium in the amniotic fluid during labor indicates possible fetal distress and the need to evaluate the neonate for meconium aspiration.
- To assess a neonate's rooting reflex, the nurse touches a finger to the cheek or the corner of the mouth. Normally, the neonate turns his head toward the stimulus, opens his mouth, and searches for the stimulus.
- Harlequin sign is present when a neonate who is lying on his side appears red on the dependent side and pale on the upper side.
- Mongolian spots can range from brown to blue. Their color depends on how close melanocytes are to the surface of the skin. They most commonly appear as patches across the sacrum, buttocks, and legs.
- Mongolian spots are common in non-white infants and usuallydisappear by age 2 to 3 years.
- Vernix caseosa is a cheeselike substance that covers and protects the fetus's skin in utero. It may be rubbed into the neonate's skin or washed away in one or two baths.
- Caput succedaneum is edema that develops in and under the fetal scalp during labor and delivery. It resolves spontaneously and presents no danger to the neonate. The edema doesn't cross the suture line.
- Nevus flammeus, or port-wine stain, is a diffuse pink to dark bluish red lesion on a neonate's face or neck.
- The Guthrie test (a screening test for phenylketonuria) is most reliable if it's done between the second and sixth days after birth and is performed after the neonate has ingested protein.
- To assess coordination of sucking and swallowing, the nurse should observe the neonate's first breast-feeding or sterile water bottle-feeding.
- To establish a milk supply pattern, the mother should breast-feed her infant at least every 4 hours. During the first month, she should breast-feed 8 to 12 times daily (demand feeding).
- To avoid contact with blood and other body fluids, the nurse should wear gloves when handling the neonate until after the first bath is given.

- If a breast-fed infant is content, has good skin turgor, an adequate number of wet diapers, and normal weight gain, the mother's milk supply is assumed to be adequate.
- In the supine position, a pregnant patient's enlarged uterus impairs venous return from the lower half of the body to the heart, resulting in supine hypotensive syndrome, or inferior vena cava syndrome.
- Tocolytic agents used to treat preterm labor include terbutaline (Brethine), ritodrine (Yutopar), and magnesium sulfate.
- A pregnant woman who has hyperemesis gravidarum may require hospitalization to treat dehydration and starvation.
- Diaphragmatic hernia is one of the most urgent neonatal surgical emergencies. By compressing and displacing the lungs and heart, this disorder can cause respiratory distress shortly after birth.
- Common complications of early pregnancy (up to 20 weeks' gestation) include fetal loss and serious threats to maternal health.
- Fetal embodiment is a maternal developmental task that occurs in the second trimester. During this stage, the mother may complain that she never gets to sleep because the fetus always gives her a thump when she tries.
- Visualization in pregnancy is a process in which the mother imagines what the child she's carrying is like and becomes acquainted with it.
- Hemodilution of pregnancy is the increase in blood volume that occurs during pregnancy. The increased volume consists of plasma and causes an imbalance between the ratio of red blood cells to plasma and a resultant decrease in hematocrit.
- Mean arterial pressure of greater than 100 mm Hg after 20 weeks of pregnancy is considered hypertension.
- The treatment for supine hypotension syndrome (a condition that sometimes occurs in pregnancy) is to have the patient lie on her left side.
- A contributing factor in dependent edema in the pregnant patient is the increase of femoral venous pressure from 10 mm Hg (normal) to 18 mm Hg (high).
- Hyperpigmentation of the pregnant patient's face, formerly called chloasma and now referred to as melasma, fades after delivery.
- The hormone relaxin, which is secreted first by the corpus luteum and later by the placenta, relaxes the connective tissue and cartilage of the symphysis pubis and the sacroiliac joint to facilitate passage of the fetus during delivery.
- Progesterone maintains the integrity of the pregnancy by inhibiting uterine motility.
- Ladin's sign, an early indication of pregnancy, causes softening of a spot on the anterior portion of the uterus, just above the uterocervical juncture.
- During pregnancy, the abdominal line from the symphysis pubis to the umbilicus changes from linea alba to linea nigra.
- In neonates, cold stress affects the circulatory, regulatory, and respiratory systems.
- Obstetric data can be described by using the F/TPAL system:
- F/T: Full-term delivery at 38 weeks or longer
- P: Preterm delivery between 20 and 37 weeks
- A: Abortion or loss of fetus before 20 weeks
- L: Number of children living (if a child has died, further explanation is needed to clarify the discrepancy in numbers).
- Parity doesn't refer to the number of infants delivered, only the number of deliveries.

- Women who are carrying more than one fetus should be encouraged to gain 35 to 45 lb (15.5 to 20.5 kg) during pregnancy.
- The recommended amount of iron supplement for the pregnant patient is 30 to 60 mg daily.
- Drinking six alcoholic beverages a day or a single episode of binge drinking in the first trimester can cause fetal alcohol syndrome.
- Chorionic villus sampling is performed at 8 to 12 weeks of pregnancy for early identification of genetic defects.
- In percutaneous umbilical blood sampling, a blood sample is obtained from the umbilical cord to detect anemia, genetic defects, and blood incompatibility as well as to assess the need for blood transfusions.
- The period between contractions is referred to as the interval, or resting phase. During this phase, the uterus and placenta fill with blood and allow for the exchange of oxygen, carbon dioxide, and nutrients.
- In a patient who has hypertonic contractions, the uterus doesn't have an opportunity to relax and there is no interval between contractions. As a result, the fetus may experience hypoxia or rapid delivery may occur.
- Two qualities of the myometrium are elasticity, which allows it to stretch yet maintain its tone, and contractility, which allows it to shorten and lengthen in a synchronized pattern.
- During crowning, the presenting part of the fetus remains visible during the interval between contractions.
- Uterine atony is failure of the uterus to remain firmly contracted.
- The major cause of uterine atony is a full bladder.
- If the mother wishes to breast-feed, the neonate should be nursed as soon as possible after delivery.
- A smacking sound, milk dripping from the side of the mouth, and sucking noises all indicate improper placement of the infant's mouth over the nipple.
- Before feeding is initiated, an infant should be burped to expel air from the stomach.
- Most authorities strongly encourage the continuation of breast-feeding on both the affected and the unaffected breast of patients with mastitis.
- Neonates are nearsighted and focus on items that are held 10" to 12" (25 to 30.5 cm) away.
- In a neonate, low-set ears are associated with chromosomal abnormalities such as Down syndrome.
- Meconium is usually passed in the first 24 hours; however, passage may take up to 72 hours.
- Boys who are born with hypospadias shouldn't be circumcised at birth because the foreskin may be needed for constructive surgery.
- In the neonate, the normal blood glucose level is 45 to 90 mg/dl.
- Hepatitis B vaccine is usually given within 48 hours of birth.
- Hepatitis B immune globulin is usually given within 12 hours of birth.
- HELLP (hemolysis, elevated liver enzymes, and low platelets) syndrome is an unusual variation of pregnancy-induced hypertension.
- Maternal serum alpha-fetoprotein is detectable at 7 weeks of gestation and peaks in the third trimester. High levels detected between the 16th and 18th weeks are associated with neural tube defects. Low levels are associated with Down syndrome.

- An arrest of descent occurs when the fetus doesn't descend through the pelvic cavity during labor. It's commonly associated with cephalopelvic disproportion, and cesarean delivery may be required.
- A late sign of preeclampsia is epigastric pain as a result of severe liver edema.
- In the patient with preeclampsia, blood pressure returns to normal during the puerperal period.
- To obtain an estriol level, urine is collected for 24 hours.
- An estriol level is used to assess fetal well-being and maternal renal functioning as well as to monitor a pregnancy that's complicated by diabetes.
- A pregnant patient with vaginal bleeding shouldn't have a pelvic examination.
- In the early stages of pregnancy, the finding of glucose in the urine may be related to the increased shunting of glucose to the developing placenta, without a corresponding increase in the reabsorption capability of the kidneys.
- A patient who has premature rupture of the membranes is at significant risk for infection if labor doesn't begin within 24 hours.
- Infants of diabetic mothers are susceptible to macrosomia as a result of increased insulin production in the fetus.
- To prevent heat loss in the neonate, the nurse should bathe one part of his body at a time and keep the rest of the body covered.
- A patient who has a cesarean delivery is at greater risk for infection than the patient who gives birth vaginally.
- The occurrence of thrush in the neonate is probably caused by contact with the organism during delivery through the birth canal.
- The nurse should keep the sac of meningomyelocele moist with normal saline solution.
- If fundal height is at least 2 cm less than expected, the cause may be growth retardation, missed abortion, transverse lie, or false pregnancy.
- Fundal height that exceeds expectations by more than 2 cm may be caused by multiple gestation, polyhydramnios, uterine myomata, or a large baby.
- A major developmental task for a woman during the first trimester of pregnancy is accepting the pregnancy.
- Unlike formula, breast milk offers the benefit of maternal antibodies.
- Spontaneous rupture of the membranes increases the risk of a prolapsed umbilical cord.
- A clinical manifestation of a prolapsed umbilical cord is variable decelerations.
- During labor, to relieve supine hypotension manifested by nausea and vomiting and paleness, turn the patient on her left side.
- If the ovum is fertilized by a spermatozoon carrying a Y chromosome, a male zygote is formed.
- Implantation occurs when the cellular walls of the blastocyte implants itself in the endometrium, usually 7 to 9 days after fertilization.
- Implantation occurs when the cellular walls of the blastocyte implants itself in the endometrium, usually 7 to 9 days after fertilization.
- Heart development in the embryo begins at 2 to 4 weeks and is complete by the end of the embryonic stage.
- Methergine stimulates uterine contractions.
- The administration of folic acid during the early stages of gestation may prevent neural tube defects.

- With advanced maternal age, a common genetic problem is Down syndrome.
- With early maternal age, cephalopelvic disproportion commonly occurs.
- In the early postpartum period, the fundus should be midline at the umbilicus.
- A rubella vaccine shouldn't be given to a pregnant woman. The vaccine can be administered after delivery, but the patient should be instructed to avoid becoming pregnant for 3 months.
- A 16-year-old girl who is pregnant is at risk for having a low-birth-weight neonate.
- The mother's Rh factor should be determined before an amniocentesis is performed.
- Maternal hypotension is a complication of spinal block.
- After delivery, if the fundus is boggy and deviated to the right side, the patient should empty her bladder.
- Before providing a specimen for a sperm count, the patient should avoid ejaculation for 48 to 72 hours.
- The hormone human chorionic gonadotropin is a marker for pregnancy.
- Painless vaginal bleeding during the last trimester of pregnancy may indicate placenta previa.
- During the transition phase of labor, the woman usually is irritable and restless.
- Because women with diabetes have a higher incidence of birth anomalies than women without diabetes, an alpha-fetoprotein level may be ordered at 15 to 17 weeks' gestation.
- To avoid puncturing the placenta, a vaginal examination shouldn't be performed on a pregnant patient who is bleeding.
- A patient who has postpartum hemorrhage caused by uterine atony should be given oxytocin as prescribed.
- Laceration of the vagina, cervix, or perineum produces bright red bleeding that often comes in spurts. The bleeding is continuous, even when the fundus is firm.
- Hot compresses can help to relieve breast tenderness after breast-feeding.
- The fundus of a postpartum patient is massaged to stimulate contraction of the uterus and prevent hemorrhage.
- A mother who has a positive human immunodeficiency virus test result shouldn't breast-feed her infant.
- Dinoprostone (Cervidil) is used to ripen the cervix.
- Breast-feeding of a premature neonate born at 32 weeks' gestation can be accomplished if the mother expresses milk and feeds the neonate by gavage.
- If a pregnant patient's rubella titer is less than 1:8, she should be immunized after delivery.
- The administration of oxytocin (Pitocin) is stopped if the contractions are 90 seconds or longer.
- For an extramural delivery (one that takes place outside of a normal delivery center), the priorities for care of the neonate include maintaining a patent airway, supporting efforts to breathe, monitoring vital signs, and maintaining adequate body temperature.
- Subinvolution may occur if the bladder is distended after delivery.
- The nurse must place identification bands on both the mother and the neonate before they leave the delivery room.
- Erythromycin is given at birth to prevent ophthalmia neonatorum.
- Pelvic-tilt exercises can help to prevent or relieve backache during pregnancy.

- Before performing a Leopold maneuver, the nurse should ask thepatient to empty her bladder

PSYCHIATRIC NURSING:

- According to Kübler-Ross, the five stages of death and dying are denial, anger, bargaining, depression, and acceptance.
- Flight of ideas is an alteration in thought processes that's characterized by skipping from one topic to another, unrelated topic.
- La belle indifférence is the lack of concern for a profound disability, such as blindness or paralysis that may occur in a patient who has a conversion disorder.
- Moderate anxiety decreases a person's ability to perceive and concentrate. The person is selectively inattentive (focuses on immediate concerns), and the perceptual field narrows.
- A patient who has a phobic disorder uses self-protective avoidance as an ego defense mechanism.
- In a patient who has anorexia nervosa, the highest treatment priority is correction of nutritional and electrolyte imbalances.
- A patient who is taking lithium must undergo regular (usually once a month) monitoring of the blood lithium level because the margin between therapeutic and toxic levels is narrow. A normal laboratory value is 0.5 to 1.5 mEq/L.
- Early signs and symptoms of alcohol withdrawal include anxiety, anorexia, tremors, and insomnia. They may begin up to 8 hours after the last alcohol intake.
- Al-Anon is a support group for families of alcoholics.
- The nurse shouldn't administer chlorpromazine (Thorazine) to a patient who has ingested alcohol because it may cause oversedation and respiratory depression.
- Lithium toxicity can occur when sodium and fluid intake are insufficient, causing lithium retention.
- An alcoholic who achieves sobriety is called a recovering alcoholic because no cure for alcoholism exists.
- According to Erikson, the school-age child (ages 6 to 12) is in the industry-versus-inferiority stage of psychosocial development.
- When caring for a depressed patient, the nurse's first priority is safety because of the increased risk of suicide.
- Echolalia is parrotlike repetition of another person's words or phrases.
- According to psychoanalytic theory, the ego is the part of the psyche that controls internal demands and interacts with the outside world at the conscious, preconscious, and unconscious levels.
- According to psychoanalytic theory, the superego is the part of the psyche that's composed of morals, values, and ethics. It continually evaluates thoughts and actions, rewarding the good and punishing the bad. (Think of the superego as the "supercop" of the unconscious.)
- According to psychoanalytic theory, the id is the part of the psyche that contains instinctual drives. (Remember i for instinctual and d for drive.)
- Denial is the defense mechanism used by a patient who denies the reality of an event.
- In a psychiatric setting, seclusion is used to reduce overwhelming environmental stimulation, protect the patient from self-injury or injury to others, and prevent damage to hospital property. It's used for patients who don't respond to less

restrictive interventions. Seclusion controls external behavior until the patient can assume self-control and helps the patient to regain self-control.

- Tyramine-rich food, such as aged cheese, chicken liver, avocados, bananas, meat tenderizer, salami, bologna, Chianti wine, and beer may cause severe hypertension in a patient who takes a monoamine oxidase inhibitor.
- A patient who takes a monoamine oxidase inhibitor should be weighed biweekly and monitored for suicidal tendencies.
- If the patient who takes a monoamine oxidase inhibitor has palpitations, headaches, or severe orthostatic hypotension, the nurse should withhold the drug and notify the physician.
- Common causes of child abuse are poor impulse control by the parents and the lack of knowledge of growth and development.
- The diagnosis of Alzheimer's disease is based on clinical findings of two or more cognitive deficits, progressive worsening of memory, and the results of a neuropsychological test.
- Memory disturbance is a classic sign of Alzheimer's disease.
- Thought blocking is loss of the train of thought because of a defect in mental processing.
- A compulsion is an irresistible urge to perform an irrational act, such as walking in a clockwise circle before leaving a room or washing the hands repeatedly.
- A patient who has a chosen method and a plan to commit suicide in the next 48 to 72 hours is at high risk for suicide.
- The therapeutic serum level for lithium is 0.5 to 1.5 mEq/L.
- Phobic disorders are treated with desensitization therapy, which gradually exposes a patient to an anxiety-producing stimulus.
- Dysfunctional grieving is absent or prolonged grief.
- During phase I of the nurse-patient relationship (beginning, or orientation, phase), the nurse obtains an initial history and the nurse and the patient agree to a contract.
- During phase II of the nurse-patient relationship (middle, or working, phase), the patient discusses his problems, behavioral changes occur, and self-defeating behavior is resolved or reduced.
- During phase III of the nurse-patient relationship (termination, or resolution, phase), the nurse terminates the therapeutic relationship and gives the patient positive feedback on his accomplishments.
- According to Freud, a person between ages 12 and 20 is in the genital stage, during which he learns independence, has an increased interest in members of the opposite sex, and establishes an identity.
- According to Erikson, the identity-versus-role confusion stage occurs between ages 12 and 20.
- Tolerance is the need for increasing amounts of a substance to achieve an effect that formerly was achieved with lesser amounts.
- Suicide is the third leading cause of death among white teenagers.
- Most teenagers who kill themselves made a previous suicide attempt and left telltale signs of their plans.
- In Erikson's stage of generativity versus despair, generativity (investment of the self in the interest of the larger community) is expressed through procreation, work, community service, and creative endeavors.
- Alcoholics Anonymous recommends a 12-step program to achieve sobriety.

- Signs and symptoms of anorexia nervosa include amenorrhea, excessive weight loss, lanugo (fine body hair), abdominal distention, and electrolyte disturbances.
- A serum lithium level that exceeds 2.0 mEq/L is considered toxic.
- Public Law 94-247 (Child Abuse and Neglect Act of 1973) requires reporting of suspected cases of child abuse to child protection services.
- The nurse should suspect sexual abuse in a young child who has blood in the feces or urine, penile or vaginal discharge, genital trauma that isn't readily explained, or a sexually transmitted disease.
- An alcoholic uses alcohol to cope with the stresses of life.
- The human personality operates on three levels: conscious, preconscious, and unconscious.
- Asking a patient an open-ended question is one of the best ways to elicit or clarify information.
- The diagnosis of autism is often made when a child is between ages 2 and 3.
- Defense mechanisms protect the personality by reducing stress and anxiety.
- Suppression is voluntary exclusion of stress-producing thoughts from the consciousness.
- In psychodrama, life situations are approximated in a structured environment, allowing the participant to recreate and enact scenes to gain insight and to practice new skills.
- Psychodrama is a therapeutic technique that's used with groups to help participants gain new perception and self-awareness by acting out their own or assigned problems.
- A patient who is taking disulfiram (Antabuse) must avoid ingesting products that contain alcohol, such as cough syrup, fruitcake, and sauces and soups made with cooking wine.
- A patient who is admitted to a psychiatric hospital involuntarily loses the right to sign out against medical advice.
- "People who live in glass houses shouldn't throw stones" and "Arolling stone gathers no moss" are examples of proverbs used during a psychiatric interview to determine a patient's ability to think abstractly. (Schizophrenic patients think in concrete terms and might interpret the glass house proverb as "If you throw a stone in a glass house, the house will break.")
- Signs of lithium toxicity include diarrhea, tremors, nausea, muscle weakness, ataxia, and confusion.
- A labile affect is characterized by rapid shifts of emotions and mood.
- Amnesia is loss of memory from an organic or inorganic cause.
- A person who has borderline personality disorder is demanding and judgmental in interpersonal relationships and will attempt to split staff by pointing to discrepancies in the treatment plan.
- Disulfiram (Antabuse) shouldn't be taken concurrently with metronidazole (Flagyl) because they may interact and cause a psychotic reaction.
- In rare cases, electroconvulsive therapy causes arrhythmias and death.
- A patient who is scheduled for electroconvulsive therapy should receive nothing by mouth after midnight to prevent aspiration while under anesthesia.
- Electroconvulsive therapy is normally used for patients who have severe depression that doesn't respond to drug therapy.

- For electroconvulsive therapy to be effective, the patient usually receives 6 to 12 treatments at a rate of 2 to 3 per week.
- During the manic phase of bipolar affective disorder, nursing care is directed at slowing the patient down because the patient may die as a result of self-induced exhaustion or injury.
- For a patient with Alzheimer's disease, the nursing care plan should focus on safety measures.
- After sexual assault, the patient's needs are the primary concern, followed by medicolegal considerations.
- Patients who are in a maintenance program for narcotic abstinence syndrome receive 10 to 40 mg of methadone (Dolophine) in a single daily dose and are monitored to ensure that the drug is ingested.
- Stress management is a short-range goal of psychotherapy.
- The mood most often experienced by a patient with organic brain syndrome is irritability.
- Creative intuition is controlled by the right side of the brain.
- Methohexital (Brevital) is the general anesthetic that's administered to patients who are scheduled for electroconvulsive therapy.
- The decision to use restraints should be based on the patient's safety needs.
- Diphenhydramine (Benadryl) relieves the extrapyramidal adverse effects of psychotropic drugs.
- In a patient who is stabilized on lithium (Eskalith) therapy, blood lithium levels should be checked 8 to 12 hours after the first dose, then two or three times weekly during the first month. Levels should be checked weekly to monthly during maintenance therapy.
- The primary purpose of psychotropic drugs is to decrease the patient's symptoms, which improves function and increases compliance with therapy.
- Manipulation is a maladaptive method of meeting one's needs because it disregards the needs and feelings of others.
- If a patient has symptoms of lithium toxicity, the nurse should withhold one dose and call the physician.
- A patient who is taking lithium (Eskalith) for bipolar affective disorder must maintain a balanced diet with adequate salt intake.
- A patient who constantly seeks approval or assistance from staff members and other patients is demonstrating dependent behavior.
- Alcoholics Anonymous advocates total abstinence from alcohol.
- Methylphenidate (Ritalin) is the drug of choice for treating attention deficit hyperactivity disorder in children.
- Setting limits is the most effective way to control manipulative behavior.
- Violent outbursts are common in a patient who has borderline personality disorder.
- When working with a depressed patient, the nurse should explore meaningful losses.
- An illusion is a misinterpretation of an actual environmental stimulus.
- Anxiety is nonspecific; fear is specific.
- Extrapyramidal adverse effects are common in patients who take antipsychotic drugs.
- The nurse should encourage an angry patient to follow a physical exercise program as one of the ways to ventilate feelings.

- Depression is clinically significant if it's characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, and hopelessness that are inappropriate or out of proportion to reality.
- Free-floating anxiety is anxiousness with generalized apprehension and pessimism for unknown reasons.
- In a patient who is experiencing intense anxiety, the fight-or-flight reaction (alarm reflex) may take over.
- Confabulation is the use of imaginary experiences or made-up information to fill missing gaps of memory.
- When starting a therapeutic relationship with a patient, the nurse should explain that the purpose of the therapy is to produce a positive change.
- A basic assumption of psychoanalytic theory is that all behavior has meaning.
- Catharsis is the expression of deep feelings and emotions.
- According to the pleasure principle, the psyche seeks pleasure and avoids unpleasant experiences, regardless of the consequences.
- A patient who has a conversion disorder resolves a psychological conflict through the loss of a specific physical function (for example, paralysis, blindness, or inability to swallow). This loss of function is involuntary, but diagnostic tests show no organic cause.
- Chlordiazepoxide (Librium) is the drug of choice for treating alcohol withdrawal symptoms.
- For a patient who is at risk for alcohol withdrawal, the nurse should assess the pulse rate and blood pressure every 2 hours for the first 12 hours, every 4 hours for the next 24 hours, and every 6 hours thereafter (unless the patient's condition becomes unstable).
- Alcohol detoxification is most successful when carried out in a structured environment by a supportive, nonjudgmental staff.
- The nurse should follow these guidelines when caring for a patientwho is experiencing alcohol withdrawal: Maintain a calm environment, keep intrusions to a minimum, speak slowly and calmly, adjust lighting to prevent shadows and glare, call the patient by name, and have a friend or family member stay with the patient, if possible.
- The therapeutic regimen for an alcoholic patient includes folic acid, thiamine, and multivitamin supplements as well as adequate food and fluids.
- A patient who is addicted to opiates (drugs derived from poppy seeds, such as heroin and morphine) typically experiences withdrawal symptoms within 12 hours after the last dose. The most severe symptoms occur within 48 hours and decrease over the next 2 weeks.
- Reactive depression is a response to a specific life event.
- Projection is the unconscious assigning of a thought, feeling, or action to someone or something else.
- Sublimation is the channeling of unacceptable impulses into socially acceptable behavior.
- Repression is an unconscious defense mechanism whereby unacceptable or painful thoughts, impulses, memories, or feelings are pushed from the consciousness or forgotten.
- Hypochondriasis is morbid anxiety about one's health associated with various symptoms that aren't caused by organic disease.

- Denial is a refusal to acknowledge feelings, thoughts, desires, impulses, or external facts that are consciously intolerable.
- Reaction formation is the avoidance of anxiety through behavior and attitudes that are the opposite of repressed impulses anddrives.
- Displacement is the transfer of unacceptable feelings to a more acceptable object.
- Regression is a retreat to an earlier developmental stage.
- According to Erikson, an older adult (age 65 or older) is in the developmental stage of integrity versus despair.
- Family therapy focuses on the family as a whole rather than the individual. Its major objective is to reestablish rational communication between family members.
- When caring for a patient who is hostile or angry, the nurse should attempt to remain calm, listen impartially, use short sentences, and speak in a firm, quiet voice.
- Ritualism and negativism are typical toddler behaviors. They occur during the developmental stage identified by Erikson as autonomy versus shame and doubt.
- Circumstantiality is a disturbance in associated thought and speech patterns in which a patient gives unnecessary, minute details and digresses into inappropriate thoughts that delay communication of central ideas and goal achievement.
- Idea of reference is an incorrect belief that the statements or actions of others are related to oneself.
- Group therapy provides an opportunity for each group member to examine interactions, learn and practice successful interpersonal communication skills, and explore emotional conflicts.
- Korsakoff's syndrome is believed to be a chronic form of Wernicke's encephalopathy. It's marked by hallucinations, confabulation, amnesia, and disturbances of orientation.
- A patient with antisocial personality disorder often engages in confrontations with authority figures, such as police, parents, and school officials.
- A patient with paranoid personality disorder exhibits suspicion, hypervigilance, and hostility toward others.
- Depression is the most common psychiatric disorder.
- Adverse reactions to tricyclic antidepressant drugs include tachycardia, orthostatic hypotension, hypomania, lowered seizure threshold, tremors, weight gain, problems with erections or orgasms, and anxiety.
- The Minnesota Multiphasic Personality Inventory consists of 550 statements for the subject to interpret. It assesses personality and detects disorders, such as depression and schizophrenia, in adolescents and adults.
- Organic brain syndrome is the most common form of mental illness in elderly patients.
- A person who has an IQ of less than 20 is profoundly retarded and is considered a total-care patient.
- Reframing is a therapeutic technique that's used to help depressed patients to view a situation in alternative ways.
- Fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil) are serotonin reuptake inhibitors used to treat depression.
- The early stage of Alzheimer's disease lasts 2 to 4 years. Patients have inappropriate affect, transient paranoia, disorientation to time, memory loss, careless dressing, and impaired judgment.

- The middle stage of Alzheimer's disease lasts 4 to 7 years and is marked by profound personality changes, loss of independence, disorientation, confusion, inability to recognize family members, and nocturnal restlessness.
- The last stage of Alzheimer's disease occurs during the final year of life and is characterized by a blank facial expression, seizures, loss of appetite, emaciation, irritability, and total dependence.
- Threatening a patient with an injection for failing to take an oral drug is an example of assault.
- Reexamination of life goals is a major developmental task during middle adulthood.
- Acute alcohol withdrawal causes anorexia, insomnia, headache, and restlessness and escalates to a syndrome that's characterized by agitation, disorientation, vivid hallucinations, and tremors of the hands, feet, legs, and tongue.
- In a hospitalized alcoholic, alcohol withdrawal delirium most commonly occurs 3 to 4 days after admission.
- Confrontation is a communication technique in which the nurse points out discrepancies between the patient's words and his nonverbal behaviors.
- For a patient with substance-induced delirium, the time of drug ingestion can help to determine whether the drug can be evacuated from the body.
- Treatment for alcohol withdrawal may include administration of I.V. glucose for hypoglycemia, I.V. fluid containing thiamine and other B vitamins, and antianxiety, antidiarrheal, anticonvulsant, and antiemetic drugs.
- The alcoholic patient receives thiamine to help prevent peripheral neuropathy and Korsakoff's syndrome.
- Alcohol withdrawal may precipitate seizure activity because alcohol lowers the seizure threshold in some people.
- Paraphrasing is an active listening technique in which the nurse restates what the patient has just said.
- A patient with Korsakoff's syndrome may use confabulation (made up information) to cover memory lapses or periods of amnesia.
- People with obsessive-compulsive disorder realize that their behavior is unreasonable, but are powerless to control it.
- When witnessing psychiatric patients who are engaged in a threatening confrontation, the nurse should first separate the two individuals.
- Patients with anorexia nervosa or bulimia must be observed during meals and for some time afterward to ensure that they don't purge what they have eaten.
- Transsexuals believe that they were born the wrong gender and may seek hormonal or surgical treatment to change their gender.
- Fugue is a dissociative state in which a person leaves his familiar surroundings, assumes a new identity, and has amnesia about his previous identity. (It's also described as "flight from himself.")
- In a psychiatric setting, the patient should be able to predict the nurse's behavior and expect consistent positive attitudes and approaches.
- When establishing a schedule for a one-to-one interaction with a patient, the nurse should state how long the conversation will last and then adhere to the time limit.
- Thought broadcasting is a type of delusion in which the person believes that his thoughts are being broadcast for the world to hear.
- Lithium should be taken with food. A patient who is taking lithium shouldn't restrict his sodium intake.

- A patient who is taking lithium should stop taking the drug and call his physician if he experiences vomiting, drowsiness, or muscle weakness.
- The patient who is taking a monoamine oxidase inhibitor for depression can include cottage cheese, cream cheese, yogurt, and sour cream in his diet.
- Sensory overload is a state in which sensory stimulation exceeds the individual's capacity to tolerate or process it.
- Symptoms of sensory overload include a feeling of distress and hyperarousal with impaired thinking and concentration.
- In sensory deprivation, overall sensory input is decreased.
- A sign of sensory deprivation is a decrease in stimulation from the environment or from within oneself, such as daydreaming, inactivity, sleeping excessively, and reminiscing.
- The three stages of general adaptation syndrome are alarm, resistance, and exhaustion.
- A maladaptive response to stress is drinking alcohol or smoking excessively.
- Hyperalertness and the startle reflex are characteristics of posttraumatic stress disorder.
- A treatment for a phobia is desensitization, a process in which the patient is slowly exposed to the feared stimuli.
- Symptoms of major depressive disorder include depressed mood, inability to experience pleasure, sleep disturbance, appetite changes, decreased libido, and feelings of worthlessness.
- Clinical signs of lithium toxicity are nausea, vomiting, and lethargy.
- Asking too many "why" questions yields scant information and may overwhelm a psychiatric patient and lead to stress and withdrawal.
- Remote memory may be impaired in the late stages of dementia.
- According to the DSM-IV, bipolar II disorder is characterized by at least one manic episode that's accompanied by hypomania.
- The nurse can use silence and active listening to promote interactions with a depressed patient.
- A psychiatric patient with a substance abuse problem and a major psychiatric disorder has a dual diagnosis.
- When a patient is readmitted to a mental health unit, the nurse should assess compliance with medication orders.
- Alcohol potentiates the effects of tricyclic antidepressants.
- Flight of ideas is movement from one topic to another without any discernible connection.
- Conduct disorder is manifested by extreme behavior, such as hurting people and animals.
- During the "tension-building" phase of an abusive relationship, the abused individual feels helpless.
- In the emergency treatment of an alcohol-intoxicated patient, determining the blood-alcohol level is paramount in determining the amount of medication that the patient needs.
- Side effects of the antidepressant fluoxetine (Prozac) include diarrhea, decreased libido, weight loss, and dry mouth.
- Before electroconvulsive therapy, the patient is given the skeletal muscle relaxant succinylcholine (Anectine) by I.V. administration.

- When a psychotic patient is admitted to an inpatient facility, the primary concern is safety, followed by the establishment of trust.
- An effective way to decrease the risk of suicide is to make a suicide contract with the patient for a specified period of time.
- A depressed patient should be given sufficient portions of his favorite foods, but shouldn't be overwhelmed with too much food.
- The nurse should assess the depressed patient for suicidal ideation.
- Delusional thought patterns commonly occur during the manic phase of bipolar disorder.
- Apathy is typically observed in patients who have schizophrenia.
- Manipulative behavior is characteristic of a patient who has passive– aggressive personality disorder.
- When a patient who has schizophrenia begins to hallucinate, the nurse should redirect the patient to activities that are focused on the here and now.
- When a patient who is receiving an antipsychotic drug exhibits muscle rigidity and tremors, the nurse should administer an antiparkinsonian drug (for example, Cogentin or Artane) as ordered.
- A patient who is receiving lithium (Eskalith) therapy should report diarrhea, vomiting, drowsiness, muscular weakness, or lack of coordination to the physician immediately.
- The therapeutic serum level of lithium (Eskalith) for maintenance is 0.6 to 1.2 mEq/L.
- Obsessive-compulsive disorder is an anxiety-related disorder.
- Al-Anon is a self-help group for families of alcoholics.
- Desensitization is a treatment for phobia, or irrational fear.
- After electroconvulsive therapy, the patient is placed in the lateral position, with the head turned to one side.
- A delusion is a fixed false belief.
- Giving away personal possessions is a sign of suicidal ideation. Other signs include writing a suicide note or talking about suicide.
- Agoraphobia is fear of open spaces.
- A person who has paranoid personality disorder projects hostilities onto others.
- To assess a patient's judgment, the nurse should ask the patient what he would do if he found a stamped, addressed envelope. An appropriate response is that he would mail the envelope.
- After electroconvulsive therapy, the patient should be monitored for post-shock amnesia.
- A mother who continues to perform cardiopulmonary resuscitation after a physician pronounces a child dead is showing denial.
- Transvestism is a desire to wear clothes usually worn by members of the opposite sex.
- Tardive dyskinesia causes excessive blinking and unusual movement of the tongue, and involuntary sucking and chewing.
- Trihexyphenidyl (Artane) and benztropine (Cogentin) are administered to counteract extrapyramidal adverse effects.
- To prevent hypertensive crisis, a patient who is taking a monoamine oxidase inhibitor should avoid consuming aged cheese, caffeine, beer, yeast, chocolate, liver, processed foods, and monosodium glutamate.
- Extrapyramidal symptoms include parkinsonism, dystonia, akathisia ("ants in the pants"), and tardive dyskinesia.

- One theory that supports the use of electroconvulsive therapy suggests that it "resets" the brain circuits to allow normal function.
- A patient who has obsessive-compulsive disorder usually recognizes the senselessness of his behavior but is powerless to stop it (ego-dystonia).
- In helping a patient who has been abused, physical safety is the nurse's first priority.
- Pemoline (Cylert) is used to treat attention deficit hyperactivity disorder (ADHD).
- Clozapine (Clozaril) is contraindicated in pregnant women and in patients who have severe granulocytopenia or severe central nervous system depression.
- Repression, an unconscious process, is the inability to recall painful or unpleasant thoughts or feelings.
- Projection is shifting of unwanted characteristics or shortcomings to others (scapegoat).
- Hypnosis is used to treat psychogenic amnesia.
- Disulfiram (Antabuse) is administered orally as an aversion therapy to treat alcoholism.
- Ingestion of alcohol by a patient who is taking disulfiram (Antabuse) can cause severe reactions, including nausea and vomiting, and may endanger the patient's life.
- Improved concentration is a sign that lithium is taking effect.
- Behavior modification, including time-outs, token economy, or a reward system, is a treatment for attention deficit hyperactivity disorder.
- For a patient who has anorexia nervosa, the nurse should provide support at mealtime and record the amount the patient eats.
- A significant toxic risk associated with clozapine (Clozaril) administration is blood dyscrasia.
- Adverse effects of haloperidol (Haldol) administration include drowsiness; insomnia; weakness; headache; and extrapyramidal symptoms, such as akathisia, tardive dyskinesia, and dystonia.
- Hypervigilance and déjà vu are signs of posttraumatic stress disorder (PTSD).
- A child who shows dissociation has probably been abused.
- Confabulation is the use of fantasy to fill in gaps of memory.
- According to Kübler-Ross, the five stages of death and dying are denial, anger, bargaining, depression, and acceptance.
- Flight of ideas is an alteration in thought processes that's characterized by skipping from one topic to another, unrelated topic
- .La belle in difference is the lack of concern for a profound disability, such as blindness or paralysis that may occur in a patient who has a conversion disorder.
- Moderate anxiety decreases a person's ability to perceive and concentrate. The person is selectively inattentive (focuses on immediate concerns), and the perceptual field narrows
- .A patient who has a phobic disorder uses self-protective avoidance as an ego defense mechanism.
- In a patient who has anorexia nervosa, the highest treatment priority is correction of nutritional and electrolyte imbalances
- .A patient who is taking lithium must undergo regular (usually once a month) monitoring of the blood lithium level because the margin between therapeutic and toxic levels is narrow.
- A normal laboratory value is 0.5 to 1.5 mEq/L.
- Early signs and symptoms of alcohol withdrawal include anxiety, anorexia, tremors, and insomnia.
- They may begin up to 8 hours after the last alcohol intake.

- Al-Anon is a support group for families of alcoholics.
- The nurse shouldn't administer chlorpromazine (Thorazine) to a patient who has ingested alcohol because it may cause over sedation and respiratory depression

PEDIATRIC NURSING:

- A child with HIV-positive blood should receive inactivated poliovirus vaccine (IPV) rather than oral poliovirus vaccine (OPV) immunization.
- To achieve postural drainage in an infant, place a pillow on the nurse's lap and lay the infant across it.
- A child with cystic fibrosis should eat more calories, protein, vitamins, and minerals than a child without the disease.
- Infants subsisting on cow's milk only don't receive a sufficient amount of iron (ferrous sulfate), which will eventually result in iron deficiency anemia.
- A child with an undiagnosed infection should be placed in isolation.
- An infant usually triples his birth weight by the end of his first year.
- Clinical signs of a dehydrated infant include lethargy, irritability, dry skin decreased tearing, decreased urinary output, and increased pulse.
- Appropriate care of a child with meningitis includes frequent assessment of neurologic signs (such as decreasing levels of consciousness, difficulty to arouse) and measuring the circumference of the head because subdural effusions and obstructive hydrocephalus can develop.
- Expected clinical findings in a newborn with cerebral palsy include reflexive hypertonicity and criss-crossing or scissoring leg movements.
- Papules, vesicles, and crust are all present at the same time in the early phase of chickenpox.
- Topical corticosteroids shouldn't be used on chickenpox lesions.
- A serving size of a food is usually 1 tablespoon for each year of age.
- The characteristic of fifth disease (erythema infectiosum) is erythema on the face, primarily the cheeks, giving a "slapped face" appearance.
- Adolescents may brave pain, especially in front of peers. Therefore, offer analgesics if pain is suspected or administer the medication if the client asks for it.
- Signs that a child with cystic fibrosis is responding to pancreatic enzymes are the absence of steatorrhea, improved appetite, and absence of abdominal pain.
- Roseola appears as discrete rose-pink macules that first appear on the trunk and that fade when pressure is applied.
- A ninety degree-ninety degree traction is used for fracture of a child's femur or tibia.
- One sign of developmental dysplasia is limping during ambulation.
- Circumcision wouldn't be performed on a male child with hypospadias because the foreskin may be needed during surgical reconstruction.
- Neonatal abstinence syndrome is manifested in central nervous system hyperirritability (for example, hyperactive Moro reflex) and gastrointestinal symptoms (watery stools).
- Classic signs of shaken baby syndrome are seizures, slow apical pulse difficulty breathing, and retinal hemorrhage.
- An infant born to an HIV-positive mother will usually receive AZT (zidovudine) for the first 6 weeks of life.
- Infants born to an HIV-positive mother should receive all immunizations of schedule.
- Blood pressure in the arms and legs is essentially the same in infants.

- When bottle-feeding a newborn with a cleft palate, hold the infant's head in an upright position.
- Because of circulating maternal antibodies that will decrease the immune response, the measles, mumps, and rubella (MMR) vaccine shouldn't be given until the infant has reached 1 year of age.
- Before feeding an infant any fluid that has been warmed, test a drop of the liquid on your own skin to prevent burning the infant.
- A newborn typically wets 6 to 10 diapers per day.
- Although microwaving food and fluids isn't recommend for infants, it's commonplace in the United States. Therefore the family should be toughs to test the temperature of the food or fluid against their own skin before allowing it to be consumed by the infant.
- The most adequate diet for an infant in the first 6 months of life is breast milk.
- An infant can usually chew food by 7 months, hold spoon by 9 month, and drink fluid from a cup by 1 year of age.
- Choking from mechanical obstruction is the leading cause of death (by suffocation) for infants younger than 1 year of age.
- Failure to thrive is a term used to describe an infant who falls below the fifth percentile for weight and height on a standard measurement chart.
- Developmental theories include Havighurst's age periods and developmental tasks; Freud's five stages of development; Kohlberg's stages of moral development; Erikson's eight stages of development; and Piaget's phases ofcognitive development.
- The primary concern with infusing large volumes of fluid is circulatory overload. This is especially true in children and infants, and in clients with renal disease.
- Certain hazards present increased risk of harm to children and occur more often at different ages. For infants, more falls, burns, and suffocation occur; for toddlers, there are more burns, poisoning, and drowning for preschoolers, more playground equipment accidents, choking, poisoning, and drowning; and for adolescents, more automobile accidents, drowning, fires, and firearm accidents.
- A child in Bryant's traction who's younger than age 3 or weighs less than 30 lb (13.6 kg) should have the buttocks slightly elevated and clear or the bed. The knees should be slightly flexed, and the legs should be extended at a right angle to the body. The body provides the traction mechanism.
- In an infant, a bulging fontanel is the most significant sign of increasing intracranial pressure

MEDICAL SURGICAL NURSING:

PART1

1. Bone scan is done by injecting radioisotope per IV & X-rays are taken.
2. To prevent edema edema on the site of sprain, apply cold compress on the area for the 1st 24 hrs
3. To turn the client after lumbar Laminectomy, use logrolling technique
4. Carpal tunnel syndrome occurs due to the injury of median nerve.

5. Massaging the back of the head is specifically important for the client w/ Crutchfield tong.
6. A 1 yr old child has a fracture of the L femur. He is placed in Bryant's traction. The reason for elevation of his both legs at 90 deg. angle is his weight isn't adequate to provide sufficient countertraction, so his entire body must be used.
7. Swing-through crutch gait is done by advancing both crutches together & the client moves both legs past the level of the crutches.
8. The appropriate nursing measure to prevent displacement of the prosthesis after a right total hip replacement for arthritis is to place the patient in the position of right leg abducted.
9. Pain on non-use of joints, subcutaneous nodules & elevated ESR are characteristic manifestations of rheumatoid arthritis.
10. Teaching program of a patient w/ SLE should include emphasis on walking in shaded area.
11. Otosclerosis is characterized by replacement of normal bones by spongy & highly vascularized bones.
12. Use of high pitched voice is inappropriate for the client w/ hearing impairment.
13. Rinne's test compares air conduction w/ bone conduction.
14. Vertigo is the most characteristic manifestation of Meniere's disease.
15. Low sodium is the diet for a client w/ Meniere's disease.
16. A client who had cataract surgery should be told to call his MD if he has eye pain.
17. Risk for Injury takes priority for a client w/ Meniere's disease.
18. Irrigate the eye w/ sterile saline is the priority nursing intervention when the client has a foreign body protruding from the eye.
19. Snellen's Test assesses visual acuity.
20. Presbyopia is an eye disorder characterized by lessening of the effective powers of accommodation.
21. The primary problem in cataract is blurring of vision.
22. The primary reason for performing iridectomy after cataract extraction is to prevent secondary glaucoma.
23. In acute glaucoma, the obstruction of the flow of aqueous humor is caused by displacement of the iris.
24. Glaucoma is characterized by irreversible blindness.
25. Hyperopia is corrected by convex lens.
26. Pterygium is caused primarily by exposure to dust.
27. A sterile chronic granulomatous inflammation of the meibomian gland is chalazion.
28. The surgical procedure w/c involves removal of the eyeball is enucleation.
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39. The client is for EEG this morning. Prepare him for the procedure by rendering hair shampoo, excluding caffeine from his meal & instructing the client to remain still during the procedure.
40. If the client w/ increased ICP demonstrates decorticate posturing, observe for flexion of elbows, extension of the knees, plantar flexion of the feet,
41. The nursing diagnosis that would have the highest priority in the care of the client who has become comatose following cerebral hemorrhage is Ineffective Airway Clearance.
42. The initial nursing action—for a client who is in the clonic phase of a tonic-clonic seizure—is to obtain equipment for orotracheal suctioning.
43. The first nursing intervention in a quadriplegic client who is experiencing autonomic dysreflexia is to elevate his head as high as possible.
44. Following surgery for a brain tumor near the hypothalamus, the nursing assessment should include observing for inability to regulate body temp.
45. Post-myelogram (using metrizamide (Amipaque) care includes keeping head elevated for at least 8 hrs.
46. Homonymous hemianopsia is described by a client had CVA & can only see the nasal visual field on one side & the temporal portion on the opposite side.
47. Ticlopidine may be prescribed to prevent thromboembolic CVA.
48. To maintain airway patency during a stroke in evolution, have orotracheal suction available at all times.
49. For a client w/ CVA, the gag reflux must return before the client is fed.
50. Clear fluids draining from the nose of a client who had a head trauma 3 hrs ago may indicate basilar skull fracture.
51. An adverse effect of gingival hyperplasia may occur during Phenytoin (DIlantin) therapy.
52. Urine output increased: best shows that the mannitol is effective in a client w/ increased ICP.
53. A client w/ C6 spinal injury would most likely have the symptom of quadriplegia.
54. Falls are the leading cause of injury in elderly people.
55. Primary prevention is true prevention. Examples are immunizations, weight control, and smoking cessation.
56. Secondary prevention is early detection. Examples include purifiedv protein derivative (PPD), breast self-examination, testicular self-examination, and chest X-ray.

57. Tertiary prevention is treatment to prevent long-term complications.
58. A patient indicates that he's coming to terms with having a chronic disease when he says, "I'm never going to get any better."
59. On noticing religious artifacts and literature on a patient's nightv stand, a culturally aware nurse would ask the patient the meaning of the items.
60. A Mexican patient may request the intervention of a curandero, orv faith healer, who involves the family in healing the patient.
61. In an infant, the normal hemoglobin value is 12 g/dl.
62. The nitrogen balance estimates the difference between the intake and use of protein.
63. Most of the absorption of water occurs in the large intestine.
64. Most nutrients are absorbed in the small intestine.
65. When assessing a patient's eating habits, the nurse should ask, "What have you eaten in the last 24 hours?"
66. A vegan diet should include an abundant supply of fiber.
67. A hypotonic enema softens the feces, distends the colon, and stimulates peristalsis.
68. First-morning urine provides the best sample to measure glucose, ketone, pH, and specific gravity values.
69. To induce sleep, the first step is to minimize environmental stimuli.
70. Before moving a patient, the nurse should assess the patient'sv physical abilities and ability to understand instructions as well as the amount of strength required to move the patient.
71. To lose 1 lb (0.5 kg) in 1 week, the patient must decrease his weeklyv intake by 3,500 calories (approximately 500 calories daily). To lose 2 lb (1 kg) in 1 week, the patient must decrease his weekly caloric intake by 7,000 calories (approximately 1,000 calories daily).
72. To avoid shearing force injury, a patient who is completely immobile is lifted on a sheet.
73. To insert a catheter from the nose through the trachea for suction, the nurse should ask the patient to swallow.
74. Vitamin C is needed for collagen production.
75. Only the patient can describe his pain accurately.
76. Cutaneous stimulation creates the release of endorphins that block the transmission of pain stimuli.
77. Patient-controlled analgesia is a safe method to relieve acute painv caused by surgical incision, traumatic injury, labor and delivery, or cancer.
78. An Asian American or European American typically places distance between himself and others when communicating.
79. Active euthanasia is actively helping a person to die.
80. Brain death is irreversible cessation of all brain function.
81. Passive euthanasia is stopping the therapy that's sustaining life.
82. A third-party payer is an insurance company.
83. Utilization review is performed to determine whether the care provided to a patient was appropriate and cost-effective.

84. A value cohort is a group of people who experienced an out-of-the-ordinary event that shaped their values.
85. Voluntary euthanasia is actively helping a patient to die at the patient's request.
86. Bananas, citrus fruits, and potatoes are good sources of potassium.
87. Good sources of magnesium include fish, nuts, and grains.
88. Beef, oysters, shrimp, scallops, spinach, beets, and greens are good sources of iron.
89. Intrathecal injection is administering a drug through the spine.
90. When a patient asks a question or makes a statement that'sv emotionally charged, the nurse should respond to the emotion behind the statement or question rather than to what's being said or asked.
91. The steps of the trajectory-nursing model are as follows:
92. – Step 1: Identifying the trajectory phase
93. – Step 2: Identifying the problems and establishing goals
94. – Step 3: Establishing a plan to meet the goals
95. – Step 4: Identifying factors that facilitate or hinder attainment of the goals
96. – Step 5: Implementing interventions
97. – Step 6: Evaluating the effectiveness of the interventions
98. A Hindu patient is likely to request a vegetarian diet.
99. Pain threshold, or pain sensation, is the initial point at which a patient feels pain.
100. The difference between acute pain and chronic pain is its duration.
101. Referred pain is pain that's felt at a site other than its origin.
102. Alleviating pain by performing a back massage is consistent with the gate control theory.
103. Romberg's test is a test for balance or gait.
104. Pain seems more intense at night because the patient isn't distracted by daily activities.
105. Older patients commonly don't report pain because of fear of treatment, lifestyle changes, or dependency.
106. No pork or pork products are allowed in a Muslim diet.
107. Two goals of Healthy People 2010 are:
108. – Help individuals of all ages to increase the quality of life and the number of years of optimal health
109. – Eliminate health disparities among different segments of the population.
110. A community nurse is serving as a patient's advocate if she tells av malnourished patient to go to a meal program at a local park.
111. If a patient isn't following his treatment plan, the nurse should first ask why.
112. When a patient is ill, it's essential for the members of his family to maintain communication about his health needs.
113. Ethnocentrism is the universal belief that one's way of life is superior to others'.
114. When a nurse is communicating with a patient through an interpreter,v the nurse should speak to the patient and the interpreter.

115. In accordance with the "hot-cold" system used by some Mexicans,v Puerto Ricans, and other Hispanic and Latino groups, most foods, beverages, herbs, and drugs are described as "cold."
116. Prejudice is a hostile attitude toward individuals of a particular group.
117. Discrimination is preferential treatment of individuals of a particular group. It's usually discussed in a negative sense.
118. Increased gastric motility interferes with the absorption of oral drugs.
119. The three phases of the therapeutic relationship are orientation, working, and termination.
120. Patients often exhibit resistive and challenging behaviors in the orientation phase of the therapeutic relationship.
121. Abdominal assessment is performed in the following order: inspection, auscultation, palpation, and percussion.
122. When measuring blood pressure in a neonate, the nurse should select a cuff that's no less than one-half and no more than two-thirds the length of the extremity that's used.
123. When administering a drug by Z-track, the nurse shouldn't use thev same needle that was used to draw the drug into the syringe because doing so could stain the skin.
124. Sites for intradermal injection include the inner arm, the upper chest, and on the back, under the scapula.
125. When evaluating whether an answer on an examination is correct, thev nurse should consider whether the action that's described promotes autonomy (independence), safety, self-esteem, and a sense of belonging.
126. Veracity is truth and is an essential component of a therapeutic relationship between a health care provider and his patient.
127. Beneficence is the duty to do no harm and the duty to do good.v There's an obligation in patient care to do no harm and an equal obligation to assist the patient.
128. Nonmaleficence is the duty to do no harm.
129. Frye's ABCDE cascade provides a framework for prioritizing care by identifying the most important treatment concerns.
130. A = Airway. This category includes everything that affects a patentv airway, including a foreign object, fluid from an upper respiratory infection, and edema from trauma or an allergic reaction.
131. B = Breathing. This category includes everything that affects thev breathing pattern, including hyperventilation or hypoventilation and abnormal breathing patterns, such as Korsakoff's, Biot's, or Cheyne-Stokes respiration.
132. C = Circulation. This category includes everything that affects thev circulation, including fluid and electrolyte disturbances and disease processes that affect cardiac output.
133. D = Disease processes. If the patient has no problem with the airway,v breathing, or circulation, then the nurse should evaluate the disease processes, giving priority to

the disease process that poses the greatest immediate risk. For example, if a patient has terminal cancer and hypoglycemia, hypoglycemia is a more immediate concern.

134. E = Everything else. This category includes such issues as writing anv incident report and completing the patient chart. When evaluating needs, this category is never the highest priority.

135. Rule utilitarianism is known as the "greatest good for the greatest number of people" theory.

136. Egalitarian theory emphasizes that equal access to goods and servicesv must be provided to the less fortunate by an affluent society.

137. Before teaching any procedure to a patient, the nurse must assess the patient's current knowledge and willingness to learn.

138. Process recording is a method of evaluating one's communication effectiveness.

139. When feeding an elderly patient, the nurse should limit high-carbohydrate foods because of the risk of glucose intolerance.

140. When feeding an elderly patient, essential foods should be given first.

141. Passive range of motion maintains joint mobility. Resistive exercises increase muscle mass.

142. Isometric exercises are performed on an extremity that's in a cast.

143. A back rub is an example of the gate-control theory of pain.

144. Anything that's located below the waist is considered unsterile; av sterile field becomes unsterile when it comes in contact with any unsterile item; a sterile field must be monitored continuously; and a border of 1" (2.5 cm) around a sterile field is considered unsterile.

145. A "shift to the left" is evident when the number of immature cells (bands) in the blood increases to fight an infection.

146. A "shift to the right" is evident when the number of mature cells inv the blood increases, as seen in advanced liver disease and pernicious anemia.

147. Before administering preoperative medication, the nurse should ensurev that an informed consent form has been signed and attached to the patient's record.

148. A nurse should spend no more than 30 minutes per 8-hour shift providing care to a patient who has a radiation implant.

149. A nurse shouldn't be assigned to care for more than one patient who has a radiation implant.

150. Long-handled forceps and a lead-lined container should be available in the room of a patient who has a radiation implant.

151. Usually, patients who have the same infection and are in strict isolation can share a room.

152. Diseases that require strict isolation include chickenpox, diphtheria, and viral hemorrhagic fevers such as Marburg disease.

153. For the patient who abides by Jewish custom, milk and meat shouldn't be served at the same meal.

154. Whether the patient can perform a procedure (psychomotor domain ofv learning) is a better indicator of the effectiveness of patient teaching than whether the patient can simply state the steps involved in the procedure (cognitive domain of learning).
155. According to Erik Erikson, developmental stages are trust versusv mistrust (birth to 18 months), autonomy versus shame and doubt (18 months to age 3), initiative versus guilt (ages 3 to 5), industry versus inferiority (ages 5 to 12), identity versus identity diffusion (ages 12 to 18), intimacy versus isolation (ages 18 to 25), generativity versus stagnation (ages 25 to 60), and ego integrity versus despair (older than age 60).
156. When communicating with a hearing impaired patient, the nurse should face him.
157. An appropriate nursing intervention for the spouse of a patient whov has a serious incapacitating disease is to help him to mobilize a support system.
158. Hyperpyrexia is extreme elevation in temperature above 106° F (41.1° C).
159. Milk is high in sodium and low in iron.
160. When a patient expresses concern about a health-related issue, beforev addressing the concern, the nurse should assess the patient's level of knowledge.
161. The most effective way to reduce a fever is to administer an antipyretic, which lowers the temperature set point.
162. Unlike false labor, true labor produces regular rhythmic contractions, abdominal discomfort, progressive descent of the fetus, bloody show, and progressive effacement and dilation of the cervix.
163. To help a mother break the suction of her breast-feeding infant, the nurse should teach her to insert a finger at the corner of the infant's mouth.
164. Administering high levels of oxygen to a premature neonate can cause blindness as a result of retrolental fibroplasia.
165. Amniotomy is artificial rupture of the amniotic membranes.
166. During pregnancy, weight gain averages 25 to 30 lb (11 to 13.5 kg).
167. Rubella has a teratogenic effect on the fetus during the first trimester. It produces abnormalities in up to 40% of cases without interrupting the pregnancy.
168. Immunity to rubella can be measured by a hemagglutination inhibition test (rubella titer). This test identifies exposure to rubella infection and determines susceptibility in pregnant women. In a woman, a titer greater than 1:8 indicates immunity.
169. When used to describe the degree of fetal descent during labor, floating means the presenting part isn't engaged in the pelvic inlet, but is freely movable (ballotable) above the pelvic inlet.
170. When used to describe the degree of fetal descent, engagement means when the largest diameter of the presenting part has passed through the pelvic inlet.
171. Fetal station indicates the location of the presenting part in relation to the ischial spine. It's described as –1, –2, –3, –4, or –5 to indicate the number of centimeters above the level of the ischial spine; station –5 is at the pelvic inlet.

172. Fetal station also is described as +1, +2, +3, +4, or +5 to indicate the number of centimeters it is below the level of the ischial spine; station 0 is at the level of the ischial spine.
173. During the first stage of labor, the side-lying position usually provides the greatest degree of comfort, although the patient may assume any comfortable position.
174. During delivery, if the umbilical cord can't be loosened and slipped from around the neonate's neck, it should be clamped with two clamps and cut between the clamps.
175. An Apgar score of 7 to 10 indicates no immediate distress, 4 to 6 indicates moderate distress, and 0 to 3 indicates severe distress.
176. To elicit Moro's reflex, the nurse holds the neonate in both hands and suddenly, but gently, drops the neonate's head backward. Normally, the neonate abducts and extends all extremities bilaterally and symmetrically, forms a C shape with the thumb and forefinger, and first adducts and then flexes the extremities.
177. Pregnancy-induced hypertension (preeclampsia) is an increase in blood pressure of 30/15 mm Hg over baseline or blood pressure of 140/95 mm Hg on two occasions at least 6 hours apart accompanied by edema and albuminuria after 20 weeks' gestation.
178. Positive signs of pregnancy include ultrasound evidence, fetal heart tones, and fetal movement felt by the examiner (not usually present until 4 months' gestation)
179. Goodell's sign is softening of the cervix.
180. Quickening, a presumptive sign of pregnancy, occurs between 16 and 19 weeks' gestation.
181. Ovulation ceases during pregnancy.
182. Any vaginal bleeding during pregnancy should be considered a complication until proven otherwise.
183. To estimate the date of delivery using Nägele's rule, the nurse counts backward 3 months from the first day of the last menstrual period and then adds 7 days to this date.
184. At 12 weeks' gestation, the fundus should be at the top of the symphysis pubis.
185. Cow's milk shouldn't be given to infants younger than age 1 because it has a low linoleic acid content and its protein is difficult for infants to digest.
186. If jaundice is suspected in a neonate, the nurse should examine the infant under natural window light. If natural light is unavailable, the nurse should examine the infant under a white light.
187. The three phases of a uterine contraction are increment, acme, and decrement.
188. The intensity of a labor contraction can be assessed by the indentability of the uterine wall at the contraction's peak. Intensity is graded as mild (uterine muscle is somewhat tense), moderate (uterine muscle is moderately tense), or strong (uterine muscle is boardlike).

189. Chloasma, the mask of pregnancy, is pigmentation of a circumscribed area of skin (usually over the bridge of the nose and cheeks) that occurs in some pregnant women.
190. The gynecoid pelvis is most ideal for delivery. Other types include platypelloid (flat), anthropoid (apelike), and android (malelike).
191. Pregnant women should be advised that there is no safe level of alcohol intake.
192. The frequency of uterine contractions, which is measured in minutes, is the time from the beginning of one contraction to the beginning of the next.
193. Vitamin K is administered to neonates to prevent hemorrhagic disorders because a neonate's intestine can't synthesize vitamin K.
194. Before internal fetal monitoring can be performed, a pregnant patient's cervix must be dilated at least 2 cm, the amniotic membranes must be ruptured, and the fetus's presenting part (scalp or buttocks) must be at station –1 or lower, so that a small electrode can be attached.
195. Fetal alcohol syndrome presents in the first 24 hours after birth and produces lethargy, seizures, poor sucking reflex, abdominal distention, and respiratory difficulty.
196. Variability is any change in the fetal heart rate (FHR) from its normal rate of 120 to 160 beats/minute. Acceleration is increased FHR; deceleration is decreased FHR.
197. In a neonate, the symptoms of heroin withdrawal may begin several hours to 4 days after birth.
198. In a neonate, the symptoms of methadone withdrawal may begin 7 days to several weeks after birth.
199. In a neonate, the cardinal signs of narcotic withdrawal include coarse, flapping tremors; sleepiness; restlessness; prolonged, persistent, high-pitched cry; and irritability.
200. The nurse should count a neonate's respirations for 1 full minute.
201. Chlorpromazine (Thorazine) is used to treat neonates who are addicted to narcotics.
202. The nurse should provide a dark, quiet environment for a neonate who is experiencing narcotic withdrawal.
203. In a premature neonate, signs of respiratory distress include nostril flaring, substernal retractions, and inspiratory grunting.
204. Respiratory distress syndrome (hyaline membrane disease) develops in premature infants because their pulmonary alveoli lack surfactant.
205. Whenever an infant is being put down to sleep, the parent or caregiver should position the infant on the back. (Remember back to sleep.)
206. The male sperm contributes an X or a Y chromosome; the female ovum contributes an X chromosome.
207. Fertilization produces a total of 46 chromosomes, including an XY combination (male) or an XX combination (female).
208. The percentage of water in a neonate's body is about 78% to 80%.

209. To perform nasotracheal suctioning in an infant, the nurse positions the infant with his neck slightly hyperextended in a "sniffing" position, with his chin up and his head tilted back slightly.
210. Organogenesis occurs during the first trimester of pregnancy, specifically, days 14 to 56 of gestation.
211. After birth, the neonate's umbilical cord is tied 1" (2.5 cm) from the abdominal wall with a cotton cord, plastic clamp, or rubber band.
212. Gravida is the number of pregnancies a woman has had, regardless of outcome.
213. Para is the number of pregnancies that reached viability, regardless of whether the fetus was delivered alive or stillborn. A fetus is considered viable at 20 weeks' gestation.
214. An ectopic pregnancy is one that implants abnormally, outside the uterus.
215. The first stage of labor begins with the onset of labor and ends with full cervical dilation at 10 cm.
216. The second stage of labor begins with full cervical dilation and ends with the neonate's birth.
217. The third stage of labor begins after the neonate's birth and ends with expulsion of the placenta.
218. In a full-term neonate, skin creases appear over two-thirds of the neonate's feet. Preterm neonates have heel creases that cover less than two-thirds of the feet.
219. The fourth stage of labor (postpartum stabilization) lasts up to 4 hours after the placenta is delivered. This time is needed to stabilize the mother's physical and emotional state after the stress of childbirth.
220. At 20 weeks' gestation, the fundus is at the level of the umbilicus.
221. At 36 weeks' gestation, the fundus is at the lower border of the rib cage.
222. A premature neonate is one born before the end of the 37th week of gestation.
223. Pregnancy-induced hypertension is a leading cause of maternal death in the United States.
224. A habitual aborter is a woman who has had three or more consecutive spontaneous abortions.
225. Threatened abortion occurs when bleeding is present without cervical dilation.
226. A complete abortion occurs when all products of conception are expelled.
227. Hydramnios (polyhydramnios) is excessive amniotic fluid (more than 2,000 ml in the third trimester).
228. Stress, dehydration, and fatigue may reduce a breast-feeding mother's milk supply.
229. During the transition phase of the first stage of labor, the cervix is dilated 8 to 10 cm and contractions usually occur 2 to 3 minutes apart and last for 60 seconds.
230. A nonstress test is considered nonreactive (positive) if fewer than two fetal heart rate accelerations of at least 15 beats/minute occur in 20 minutes.

231. A nonstress test is considered reactive (negative) if two or more fetal heart rate accelerations of 15 beats/minute above baseline occur in 20 minutes.
232. A nonstress test is usually performed to assess fetal well-being in a pregnant patient with a prolonged pregnancy (42 weeks or more), diabetes, a history of poor pregnancy outcomes, or pregnancy-induced hypertension.
233. A pregnant woman should drink at least eight 8-oz glasses (about 2,000 ml) of water daily.
234. When both breasts are used for breast-feeding, the infant usually doesn't empty the second breast. Therefore, the second breast should be used first at the next feeding.
235. A low-birth-weight neonate weighs 2,500 g (5 lb 8 oz) or less at birth.
236. A very-low-birth-weight neonate weighs 1,500 g (3 lb 5 oz) or less at birth.
237. When teaching parents to provide umbilical cord care, the nurse should teach them to clean the umbilical area with a cotton ball saturated with alcohol after every diaper change to prevent infection and promote drying.
238. Teenage mothers are more likely to have low-birth-weight neonates because they seek prenatal care late in pregnancy (as a result of denial) and are more likely than older mothers to have nutritional deficiencies.
239. Linea nigra, a dark line that extends from the umbilicus to the mons pubis, commonly appears during pregnancy and disappears after pregnancy.
240. Implantation in the uterus occurs 6 to 10 days after ovum fertilization.
241. Placenta previa is abnormally low implantation of the placenta so that it encroaches on or covers the cervical os.
242. In complete (total) placenta previa, the placenta completely covers the cervical os.
243. In partial (incomplete or marginal) placenta previa, the placenta covers only a portion of the cervical os.
244. Abruptio placentae is premature separation of a normally implanted placenta. It may be partial or complete, and usually causes abdominal pain, vaginal bleeding, and a boardlike abdomen.
245. Cutis marmorata is mottling or purple discoloration of the skin. It's a transient vasomotor response that occurs primarily in the arms and legs of infants who are exposed to cold.
246. The classic triad of symptoms of preeclampsia are hypertension, edema, and proteinuria. Additional symptoms of severe preeclampsia include hyperreflexia, cerebral and vision disturbances, and epigastric pain.
247. Ortolani's sign (an audible click or palpable jerk that occurs with thigh abduction) confirms congenital hip dislocation in a neonate.
248. The first immunization for a neonate is the hepatitis B vaccine, which is administered in the nursery shortly after birth.
249. If a patient misses a menstrual period while taking an oral contraceptive exactly as prescribed, she should continue taking the contraceptive.

250. If a patient misses two consecutive menstrual periods while taking an oral contraceptive, she should discontinue the contraceptive and take a pregnancy test.
251. If a patient who is taking an oral contraceptive misses a dose, she should take the pill as soon as she remembers or take two at the next scheduled interval and continue with the normal schedule.
252. If a patient who is taking an oral contraceptive misses two consecutive doses, she should double the dose for 2 days and then resume her normal schedule. She also should use an additional birth control method for 1 week.
253. Eclampsia is the occurrence of seizures that aren't caused by a cerebral disorder in a patient who has pregnancy-induced hypertension.
254. In placenta previa, bleeding is painless and seldom fatal on the first occasion, but it becomes heavier with each subsequent episode.
255. Treatment for abruptio placentae is usually immediate cesarean delivery.
256. Drugs used to treat withdrawal symptoms in neonates include phenobarbital (Luminal), camphorated opium tincture (paregoric), and diazepam (Valium).
257. Infants with Down syndrome typically have marked hypotonia, floppiness, slanted eyes, excess skin on the back of the neck, flattened bridge of the nose, flat facial features, spadelike hands, short and broad feet, small male genitalia, absence of Moro's reflex, and a simian crease on the hands.
258. The failure rate of a contraceptive is determined by the experience of 100 women for 1 year. It's expressed as pregnancies per 100 woman-years.
259. The narrowest diameter of the pelvic inlet is the anteroposterior (diagonal conjugate).
260. The chorion is the outermost extraembryonic membrane that gives rise to the placenta.
261. The corpus luteum secretes large quantities of progesterone.
262. From the 8th week of gestation through delivery, the developing cells are known as a fetus.
263. In an incomplete abortion, the fetus is expelled, but parts of the placenta and membrane remain in the uterus.
264. The circumference of a neonate's head is normally 2 to 3 cm greater than the circumference of the chest.
265. After administering magnesium sulfate to a pregnant patient for hypertension or preterm labor, the nurse should monitor the respiratory rate and deep tendon reflexes.
266. During the first hour after birth (the period of reactivity), the neonate is alert and awake.
267. When a pregnant patient has undiagnosed vaginal bleeding, vaginal examination should be avoided until ultrasonography rules out placenta previa.
268. After delivery, the first nursing action is to establish the neonate's airway.
269. Nursing interventions for a patient with placenta previa include positioning the patient on her left side for maximum fetal perfusion, monitoring fetal heart tones, and administering I.V. fluids and oxygen, as ordered.

270. The specific gravity of a neonate's urine is 1.003 to 1.030. A lower specific gravity suggests overhydration; a higher one suggests dehydration.
271. The neonatal period extends from birth to day 28. It's also called the first 4 weeks or first month of life.
272. A woman who is breast-feeding should rub a mild emollient cream or a few drops of breast milk (or colostrum) on the nipples after each feeding. She should let the breasts air-dry to prevent them from cracking.
273. Breast-feeding mothers should increase their fluid intake to 2½ to 3 qt (2,500 to 3,000 ml) daily.
274. After feeding an infant with a cleft lip or palate, the nurse should rinse the infant's mouth with sterile water.
275. The nurse instills erythromycin in a neonate's eyes primarily to prevent blindness caused by gonorrhea or chlamydia.
276. Human immunodeficiency virus (HIV) has been cultured in breast milk and can be transmitted by an HIV-positive mother who breast-feeds her infant.
277. A fever in the first 24 hours postpartum is most likely caused by dehydration rather than infection.
278. Preterm neonates or neonates who can't maintain a skin temperature of at least 97.6° F (36.4° C) should receive care in an incubator (Isolette) or a radiant warmer. In a radiant warmer, a heat-sensitive probe taped to the neonate's skin activates the heater unit automatically to maintain the desired temperature.
279. During labor, the resting phase between contractions is at least 30 seconds.
280. Lochia rubra is the vaginal discharge of almost pure blood that occurs during the first few days after childbirth.
281. Lochia serosa is the serous vaginal discharge that occurs 4 to 7 days after childbirth.
282. Lochia alba is the vaginal discharge of decreased blood and increased leukocytes that's the final stage of lochia. It occurs 7 to 10 days after childbirth.
283. Colostrum, the precursor of milk, is the first secretion from the breasts after delivery.
284. The length of the uterus increases from 2½" (6.3 cm) before pregnancy to 12½" (32 cm) at term.
285. To estimate the true conjugate (the smallest inlet measurement of the pelvis), deduct 1.5 cm from the diagonal conjugate (usually 12 cm). A true conjugate of 10.5 cm enables the fetal head (usually 10 cm) to pass.
286. The smallest outlet measurement of the pelvis is the intertuberous diameter, which is the transverse diameter between the ischial tuberosities.
287. Electronic fetal monitoring is used to assess fetal well-being during labor. If compromised fetal status is suspected, fetal blood pH may be evaluated by obtaining a scalp sample.

288. In an emergency delivery, enough pressure should be applied to the emerging fetus's head to guide the descent and prevent a rapid change in pressure within the molded fetal skull.
289. After delivery, a multiparous woman is more susceptible to bleeding than a primiparous woman because her uterine muscles may be overstretched and may not contract efficiently.
290. Neonates who are delivered by cesarean birth have a higher incidence of respiratory distress syndrome.
291. The nurse should suggest ambulation to a postpartum patient who has gas pain and flatulence.
292. Massaging the uterus helps to stimulate contractions after the placenta is delivered.
293. When providing phototherapy to a neonate, the nurse should cover the neonate's eyes and genital area.
294. The narcotic antagonist naloxone (Narcan) may be given to a neonate to correct respiratory depression caused by narcotic administration to the mother during labor.
295. In a neonate, symptoms of respiratory distress syndrome include expiratory grunting or whining, sandpaper breath sounds, and seesaw retractions.
296. Cerebral palsy presents as asymmetrical movement, irritability, and excessive, feeble crying in a long, thin infant.
297. The nurse should assess a breech-birth neonate for hydrocephalus, hematomas, fractures, and other anomalies caused by birth trauma.
298. When a patient is admitted to the unit in active labor, the nurse's first action is to listen for fetal heart tones.
299. In a neonate, long, brittle fingernails are a sign of postmaturity.
300. Desquamation (skin peeling) is common in postmature neonates.
301. A mother should allow her infant to breast-feed until the infant is satisfied. The time may vary from 5 to 20 minutes.
302. Nitrazine paper is used to test the pH of vaginal discharge to determine the presence of amniotic fluid.
303. A pregnant patient normally gains 2 to 5 lb (1 to 2.5 kg) during the first trimester and slightly less than 1 lb (0.5 kg) per week during the last two trimesters.
304. Neonatal jaundice in the first 24 hours after birth is known as pathological jaundice and is a sign of erythroblastosis fetalis.
305. A classic difference between abruptio placentae and placenta previa is the degree of pain. Abruptio placentae causes pain, whereas placenta previa causes painless bleeding.
306. Because a major role of the placenta is to function as a fetal lung, any condition that interrupts normal blood flow to or from the placenta increases fetal partial pressure of arterial carbon dioxide and decreases fetal pH.

307. Precipitate labor lasts for approximately 3 hours and ends with delivery of the neonate
308. Methylergonovine (Methergine) is an oxytocic agent used to prevent and treat postpartum hemorrhage caused by uterine atony or subinvolution.
309. As emergency treatment for excessive uterine bleeding, 0.2 mg of methylergonovine (Methergine) is injected I.V. over 1 minute while the patient's blood pressure and uterine contractions are monitored.
310. Braxton Hicks contractions are usually felt in the abdomen and don't cause cervical change. True labor contractions are felt in the front of the abdomen and back and lead to progressive cervical dilation and effacement.
311. The average birth weight of neonates born to mothers who smoke is 6 oz (170 g) less than that of neonates born to nonsmoking mothers.
312. Culdoscopy is visualization of the pelvic organs through the posterior vaginal fornix.
313. The nurse should teach a pregnant vegetarian to obtain protein from alternative sources, such as nuts, soybeans, and legumes.
314. The nurse should instruct a pregnant patient to take only prescribed prenatal vitamins because over-the-counter high-potency vitamins may harm the fetus.
315. High-sodium foods can cause fluid retention, especially in pregnant patients.
316. A pregnant patient can avoid constipation and hemorrhoids by adding fiber to her diet.
317. If a fetus has late decelerations (a sign of fetal hypoxia), the nurse should instruct the mother to lie on her left side and then administer 8 to 10 L of oxygen per minute by mask or cannula. The nurse should notify the physician. The side-lying position removes pressure on the inferior vena cava.
318. Oxytocin (Pitocin) promotes lactation and uterine contractions.
319. Lanugo covers the fetus's body until about 20 weeks' gestation. Then it begins to disappear from the face, trunk, arms, and legs, in that order.
320. In a neonate, hypoglycemia causes temperature instability, hypotonia, jitteriness, and seizures. Premature, postmature, small-for-gestational-age, and large-for-gestational-age neonates are susceptible to this disorder.
321. Neonates typically need to consume 50 to 55 cal per pound of body weight daily.
322. Because oxytocin (Pitocin) stimulates powerful uterine contractions during labor, it must be administered under close observation to help prevent maternal and fetal distress.
323. During fetal heart rate monitoring, variable decelerations indicate compression or prolapse of the umbilical cord.
324. Cytomegalovirus is the leading cause of congenital viral infection.
325. Tocolytic therapy is indicated in premature labor, but contraindicated in fetal death, fetal distress, or severe hemorrhage.

326. Through ultrasonography, the biophysical profile assesses fetal well-being by measuring fetal breathing movements, gross body movements, fetal tone, reactive fetal heart rate (nonstress test), and qualitative amniotic fluid volume.
327. A neonate whose mother has diabetes should be assessed for hyperinsulinism.
328. In a patient with preeclampsia, epigastric pain is a late symptom and requires immediate medical intervention.
329. After a stillbirth, the mother should be allowed to hold the neonate to help her come to terms with the death.
330. Molding is the process by which the fetal head changes shape to facilitate movement through the birth canal.
331. If a woman receives a spinal block before delivery, the nurse should monitor the patient's blood pressure closely.
332. If a woman suddenly becomes hypotensive during labor, the nurse should increase the infusion rate of I.V. fluids as prescribed.
333. The best technique for assessing jaundice in a neonate is to blanch the tip of the nose or the area just above the umbilicus.
334. During fetal heart monitoring, early deceleration is caused by compression of the head during labor.
335. After the placenta is delivered, the nurse may add oxytocin (Pitocin) to the patient's I.V. solution, as prescribed, to promote postpartum involution of the uterus and stimulate lactation.
336. Pica is a craving to eat nonfood items, such as dirt, crayons, chalk, glue, starch, or hair. It may occur during pregnancy and can endanger the fetus.
337. A pregnant patient should take folic acid because this nutrient is required for rapid cell division.
338. A woman who is taking clomiphene (Clomid) to induce ovulation should be informed of the possibility of multiple births with this drug.
339. If needed, cervical suturing is usually done between 14 and 18 weeks' gestation to reinforce an incompetent cervix and maintain pregnancy. The suturing is typically removed by 35 weeks' gestation.
340. During the first trimester, a pregnant woman should avoid all drugs unless doing so would adversely affect her health.
341. Most drugs that a breast-feeding mother takes appear in breast milk.
342. The Food and Drug Administration has established the following five categories of drugs based on their potential for causing birth defects: A, no evidence of risk; B, no risk found in animals, but no studies have been done in women; C, animal studies have shown an adverse effect, but the drug may be beneficial to women despite the potential risk; D, evidence of risk, but its benefits may outweigh its risks; and X, fetal anomalies noted, and the risks clearly outweigh the potential benefits.
343. A patient with a ruptured ectopic pregnancy commonly has sharp pain in the lower abdomen, with spotting and cramping. She may have abdominal rigidity; rapid, shallow respirations; tachycardia; and shock.

344. A patient with a ruptured ectopic pregnancy commonly has sharp pain in the lower abdomen, with spotting and cramping. She may have abdominal rigidity; rapid, shallow respirations; tachycardia; and shock.
345. The mechanics of delivery are engagement, descent and flexion, internal rotation, extension, external rotation, restitution, and expulsion.
346. A probable sign of pregnancy, McDonald's sign is characterized by an ease in flexing the body of the uterus against the cervix.
347. Amenorrhea is a probable sign of pregnancy.
348. A pregnant woman's partner should avoid introducing air into the vagina during oral sex because of the possibility of air embolism.
349. The presence of human chorionic gonadotropin in the blood or urine is a probable sign of pregnancy.
350. Radiography isn't usually used in a pregnant woman because it may harm the developing fetus. If radiography is essential, it should be performed only after 36 weeks' gestation.

PART2

1. A pregnant patient who has had rupture of the membranes or who is experiencing vaginal bleeding shouldn't engage in sexual intercourse.
2. Milia may occur as pinpoint spots over a neonate's nose.
3. The duration of a contraction is timed from the moment that the uterine muscle begins to tense to the moment that it reaches full relaxation. It's measured in seconds.
4. The union of a male and a female gamete produces a zygote, which divides into the fertilized ovum.
5. The first menstrual flow is called menarche and may be anovulatory (infertile).
6. Spermatozoa (or their fragments) remain in the vagina for 72 hours after sexual intercourse.
7. Prolactin stimulates and sustains milk productions
8. Strabismus is a normal finding in a neonate.
9. A postpartum patient may resume sexual intercourse after the perineal or uterine wounds heal (usually within 4 weeks after delivery).
10. A pregnant staff member shouldn't be assigned to work with a patient who has cytomegalovirus infection because the virus can be transmitted to the fetus.
11. Fetal demise is death of the fetus after viability.
12. Respiratory distress syndrome develops in premature neonates because their alveoli lack surfactant
13. The most common method of inducing labor after artificial rupture of the membranes is oxytocin (Pitocin) infusion.
14. After the amniotic membranes rupture, the initial nursing action is to assess the fetal heart rate.

15. The most common reasons for cesarean birth are malpresentation, fetal distress, cephalopelvic disproportion, pregnancy-induced hypertension, previous cesarean birth, and inadequate progress in labor.
16. Amniocentesis increases the risk of spontaneous abortion, trauma to the fetus or placenta, premature labor, infection, and Rh sensitization of the fetus.
17. After amniocentesis, abdominal cramping or spontaneous vaginal bleeding may indicate complications.
18. To prevent her from developing Rh antibodies, an Rh-negative primigravida should receive Rho(D) immune globulin (RhoGAM) after delivering an Rh-positive neonate.
19. If a pregnant patient's test results are negative for glucose but positive for acetone, the nurse should assess the patient's diet for inadequate caloric intake.
20. If a pregnant patient's test results are negative for glucose but positive for acetone, the nurse should assess the patient's diet for inadequate caloric intake.
21. Rubella infection in a pregnant patient, especially during the first trimester, can lead to spontaneous abortion or stillbirth as well as fetal cardiac and other birth defects.
22. A pregnant patient should take an iron supplement to help prevent anemia.
23. Direct antiglobulin (direct Coombs') test is used to detect maternal antibodies attached to red blood cells in the neonate.
24. Nausea and vomiting during the first trimester of pregnancy are caused by rising levels of the hormone human chorionic gonadotropin.
25. Before discharging a patient who has had an abortion, the nurse should instruct her to report bright red clots, bleeding that lasts longer than 7 days, or signs of infection, such as a temperature of greater than 100° F (37.8° C), foul-smelling vaginal discharge, severe uterine cramping, nausea, or vomiting.
26. When informed that a patient's amniotic membrane has broken, the nurse should check fetal heart tones and then maternal vital signs.
27. The duration of pregnancy averages 280 days, 40 weeks, 9 calendar months, or 10 lunar months.
28. The initial weight loss for a healthy neonate is 5% to 10% of birth weight.
29. The normal hemoglobin value in neonates is 17 to 20 g/dl.
30. Crowning is the appearance of the fetus's head when its largest diameter is encircled by the vulvovaginal ring.
31. A multipara is a woman who has had two or more pregnancies that progressed to viability, regardless of whether the offspring were alive at birth.
32. In a pregnant patient, preeclampsia may progress to eclampsia, which is characterized by seizures and may lead to coma.
33. The Apgar score is used to assess the neonate's vital functions. It's obtained at 1 minute and 5 minutes after delivery. The score is based on respiratory effort, heart rate, muscle tone, reflex irritability, and color.
34. Because of the anti-insulin effects of placental hormones, insulin requirements increase during the third trimester.

35. Gestational age can be estimated by ultrasound measurement of maternal abdominal circumference, fetal femur length, and fetal head size. These measurements are most accurate between 12 and 18 weeks' gestation.
36. Skeletal system abnormalities and ventricular septal defects are the most common disorders of infants who are born to diabetic women. The incidence of congenital malformation is three times higher in these infants than in those born to nondiabetic women.
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38. The patient with preeclampsia usually has puffiness around the eyes or edema in the hands (for example, "I can't put my wedding ring on.").
39. Kegel exercises require contraction and relaxation of the perineal muscles. These exercises help strengthen pelvic muscles and improve urine control in postpartum patients.
40. Symptoms of postpartum depression range from mild postpartum blues to intense, suicidal, depressive psychosis.
41. The preterm neonate may require gavage feedings because of a weak sucking reflex, uncoordinated sucking, or respiratory distress.
42. Acrocyanosis (blueness and coolness of the arms and legs) is normal in neonates because of their immature peripheral circulatory system.
43. To prevent ophthalmia neonatorum (a severe eye infection caused by maternal gonorrhea), the nurse may administer one of three drugs, as prescribed, in the neonate's eyes: tetracycline, silver nitrate, or erythromycin.
44. Neonatal testing for phenylketonuria is mandatory in most states.
45. The nurse should place the neonate in a 30-degree Trendelenburg position to facilitate mucus drainage.
46. The nurse may suction the neonate's nose and mouth as needed with a bulb syringe or suction trap.
47. To prevent heat loss, the nurse should place the neonate under a radiant warmer during suctioning and initial delivery-room care, and then wrap the neonate in a warmed blanket for transport to the nursery.
48. The umbilical cord normally has two arteries and one vein.
49. When providing care, the nurse should expose only one part of an infant's body at a time.
50. Lightening is settling of the fetal head into the brim of the pelvis.
51. The nurse must place identification bands on both the mother and the neonate before they leave the delivery room.
52. Erythromycin is given at birth to prevent ophthalmia neonatorum.
53. Pelvic-tilt exercises can help to prevent or relieve backache during pregnancy.

54. Before performing a Leopold maneuver, the nurse should ask the patient to empty her bladder.
55. If the neonate is stable, the mother should be allowed to breast-feed within the neonate's first hour of life.
56. The nurse should check the neonate's temperature every 1 to 2 hours until it's maintained within normal limits.
57. At birth, a neonate normally weighs 5 to 9 lb (2 to 4 kg), measures 18" to 22" (45.5 to 56 cm) in length, has a head circumference of 13½" to 14" (34 to 35.5 cm), and has a chest circumference that's 1" (2.5 cm) less than the head circumference.
58. In the neonate, temperature normally ranges from 98° to 99° F (36.7° to 37.2° C), apical pulse rate averages 120 to 160 beats/minute, and respirations are 40 to 60 breaths/minute.
59. The diamond-shaped anterior fontanel usually closes between ages 12 and 18 months. The triangular posterior fontanel usually closes by age 2 months.
60. In the neonate, a straight spine is normal. A tuft of hair over the spine is an abnormal finding.
61. Prostaglandin gel may be applied to the vagina or cervix to ripen an unfavorable cervix before labor induction with oxytocin (Pitocin)
62. Supernumerary nipples are occasionally seen on neonates. They usually appear along a line that runs from each axilla, through the normal nipple area, and to the groin.
63. Meconium is a material that collects in the fetus's intestines and forms the neonate's first feces, which are black and tarry.
64. The presence of meconium in the amniotic fluid during labor indicates possible fetal distress and the need to evaluate the neonate for meconium aspiration.
65. To assess a neonate's rooting reflex, the nurse touches a finger to the cheek or the corner of the mouth. Normally, the neonate turns his head toward the stimulus, opens his mouth, and searches for the stimulus.
66. Harlequin sign is present when a neonate who is lying on his side appears red on the dependent side and pale on the upper side.
67. Mongolian spots can range from brown to blue. Their color depends on how close melanocytes are to the surface of the skin. They most commonly appear as patches across the sacrum, buttocks, and legs.
68. Mongolian spots are common in non-white infants and usually disappear by age 2 to 3 years.
69. Vernix caseosa is a cheeselike substance that covers and protects the fetus's skin in utero. It may be rubbed into the neonate's skin or washed away in one or two baths.
70. Caput succedaneum is edema that develops in and under the fetal scalp during labor and delivery. It resolves spontaneously and presents no danger to the neonate. The edema doesn't cross the suture line.
71. Nevus flammeus, or port-wine stain, is a diffuse pink to dark bluish red lesion on a neonate's face or neck.

72. The Guthrie test (a screening test for phenylketonuria) is most reliable if it's done between the second and sixth days after birth and is performed after the neonate has ingested protein.
73. To assess coordination of sucking and swallowing, the nurse should observe the neonate's first breast-feeding or sterile water bottle-feeding.
74. To establish a milk supply pattern, the mother should breast-feed her infant at least every 4 hours. During the first month, she should breast-feed 8 to 12 times daily (demand feeding).
75. To avoid contact with blood and other body fluids, the nurse should wear gloves when handling the neonate until after the first bath is given.
76. If a breast-fed infant is content, has good skin turgor, an adequate number of wet diapers, and normal weight gain, the mother's milk supply is assumed to be adequate.
77. In the supine position, a pregnant patient's enlarged uterus impairs venous return from the lower half of the body to the heart, resulting in supine hypotensive syndrome, or inferior vena cava syndrome.
78. Tocolytic agents used to treat preterm labor include terbutaline (Brethine), ritodrine (Yutopar), and magnesium sulfate.
79. A pregnant woman who has hyperemesis gravidarum may require hospitalization to treat dehydration and starvation.
80. Diaphragmatic hernia is one of the most urgent neonatal surgical emergencies. By compressing and displacing the lungs and heart, this disorder can cause respiratory distress shortly after birth.
81. Common complications of early pregnancy (up to 20 weeks' gestation) include fetal loss and serious threats to maternal health.
82. Fetal embodiment is a maternal developmental task that occurs in the second trimester. During this stage, the mother may complain that she never gets to sleep because the fetus always gives her a thump when she tries.
83. Visualization in pregnancy is a process in which the mother imagines what the child she's carrying is like and becomes acquainted with it.
84. Hemodilution of pregnancy is the increase in blood volume that occurs during pregnancy. The increased volume consists of plasma and causes an imbalance between the ratio of red blood cells to plasma and a resultant decrease in hematocrit.
85. Mean arterial pressure of greater than 100 mm Hg after 20 weeks of pregnancy is consideredhypertension.
86. The treatment for supine hypotension syndrome (a condition that sometimes occurs in pregnancy) is to have the patient lie on her left side.
87. A contributing factor in dependent edema in the pregnant patient is the increase of femoral venous pressure from 10 mm Hg (normal) to 18 mm Hg (high).
88. An estriol level is used to assess fetal well-being and maternal renal functioning as well as to monitor a pregnancy that's complicated by diabetes.
89. A pregnant patient with vaginal bleeding shouldn't have a pelvic examination.

90. In the early stages of pregnancy, the finding of glucose in the urine may be related to the increased shunting of glucose to the developing placenta, without a corresponding increase in the reabsorption capability of the kidneys.
91. A patient who has premature rupture of the membranes is at significant risk for infection if labor doesn't begin within 24 hours.
92. Infants of diabetic mothers are susceptible to macrosomia as a result of increased insulin production in the fetus.
93. To prevent heat loss in the neonate, the nurse should bathe one part of his body at a time and keep the rest of the body covered.
94. A patient who has a cesarean delivery is at greater risk for infection than the patient who gives birth vaginally.
95. The occurrence of thrush in the neonate is probably caused by contact with the organism during delivery through the birth canal.
96. The nurse should keep the sac of meningomyelocele moist with normal saline solution.
97. If fundal height is at least 2 cm less than expected, the cause may be growth retardation, missed abortion, transverse lie, or false pregnancy.
98. Fundal height that exceeds expectations by more than 2 cm may be caused by multiple gestation, polyhydramnios, uterine myomata, or a large baby.
99. A major developmental task for a woman during the first trimester of pregnancy is accepting the pregnancy.
100. Unlike formula, breast milk offers the benefit of maternal antibodies.
101. Spontaneous rupture of the membranes increases the risk of a prolapsed umbilical cord.
102. A clinical manifestation of a prolapsed umbilical cord is variable decelerations.
103. During labor, to relieve supine hypotension manifested by nausea and vomiting and paleness, turn the patient on her left side.
104. If the ovum is fertilized by a spermatozoon carrying a Y chromosome, a male zygote is formed.
105. Implantation occurs when the cellular walls of the blastocyte implants itself in the endometrium, usually 7 to 9 days after fertilization.
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107. Heart development in the embryo begins at 2 to 4 weeks and is complete by the end of the embryonic stage.
108. Methergine stimulates uterine contractions.
109. The administration of folic acid during the early stages of gestation may prevent neural tube defects.
110. With advanced maternal age, a common genetic problem is Down syndrome.
111. With early maternal age, cephalopelvic disproportion commonly occurs.
112. In the early postpartum period, the fundus should be midline at the umbilicus.

113. A rubella vaccine shouldn't be given to a pregnant woman. The vaccine can be administered after delivery, but the patient should be instructed to avoid becoming pregnant for 3 months.
114. A 16-year-old girl who is pregnant is at risk for having a low-birth-weight neonate.
115. The mother's Rh factor should be determined before an amniocentesis is performed.
116. Maternal hypotension is a complication of spinal block.
117. After delivery, if the fundus is boggy and deviated to the right side, the patient should empty her bladder.
118. Before providing a specimen for a sperm count, the patient should avoid ejaculation for 48 to 72 hours.
119. The hormone human chorionic gonadotropin is a marker for pregnancy.
120. Painless vaginal bleeding during the last trimester of pregnancy may indicate placenta previa.
121. During the transition phase of labor, the woman usually is irritable and restless.
122. Because women with diabetes have a higher incidence of birth anomalies than women without diabetes, an alpha-fetoprotein level may be ordered at 15 to 17 weeks' gestation.
123. To avoid puncturing the placenta, a vaginal examination shouldn't be performed on a pregnant patient who is bleeding.
124. A patient who has postpartum hemorrhage caused by uterine atony should be given oxytocin as prescribed.
125. Laceration of the vagina, cervix, or perineum produces bright red bleeding that often comes in spurts. The bleeding is continuous, even when the fundus is firm.
126. Hot compresses can help to relieve breast tenderness after breast-feeding.
127. The fundus of a postpartum patient is massaged to stimulate contraction of the uterus and prevent hemorrhage
128. A mother who has a positive human immunodeficiency virus test result shouldn't breast-feed her infant.
129. Dinoprostone (Cervidil) is used to ripen the cervix.
130. Breast-feeding of a premature neonate born at 32 weeks' gestation can be accomplished if the mother expresses milk and feeds the neonate by gavage.
131. If a pregnant patient's rubella titer is less than 1:8, she should be immunized after delivery.
132. The administration of oxytocin (Pitocin) is stopped if the contractions are 90 seconds or longer.
133. For an extramural delivery (one that takes place outside of a normal delivery center), the priorities for care of the neonate include maintaining a patent airway, supporting efforts to breathe, monitoring vital signs, and maintaining adequate body temperature.
134. Subinvolution may occur if the bladder is distended after delivery.

135. A patient who has a chosen method and a plan to commit suicide in the next 48 to 72 hours is at high risk for suicide.
136. The therapeutic serum level for lithium is 0.5 to 1.5 mEq/L.
137. Phobic disorders are treated with desensitization therapy, which gradually exposes a patient to an anxiety-producing stimulus.
138. Dysfunctional grieving is absent or prolonged grief.
139. During phase I of the nurse-patient relationship (beginning, or orientation, phase), the nurse obtains an initial history and the nurse and the patient agree to a contract.
140. During phase II of the nurse-patient relationship (middle, or working, phase), the patient discusses his problems, behavioral changes occur, and self-defeating behavior is resolved or reduced.
141. During phase III of the nurse-patient relationship (termination, or resolution, phase), the nurse terminates the therapeutic relationship and gives the patient positive feedback on his accomplishments.
142. According to Freud, a person between ages 12 and 20 is in the genital stage, during which he learns independence, has an increased interest in members of the opposite sex, and establishes an identity.
143. According to Erikson, the identity-versus-role confusion stage occurs between ages 12 and 20.
144. Tolerance is the need for increasing amounts of a substance to achieve an effect that formerly was achieved with lesser amounts.
145. Suicide is the third leading cause of death among white teenagers.
146. Most teenagers who kill themselves made a previous suicide attempt and left telltale signs of their plans.
147. In Erikson's stage of generativity versus despair, generativity (investment of the self in the interest of the larger community) is expressed through procreation, work, community service, and creative endeavors.
148. Alcoholics Anonymous recommends a 12-step program to achieve sobriety.
149. Signs and symptoms of anorexia nervosa include amenorrhea, excessive weight loss, lanugo (fine body hair), abdominal distention, and electrolyte disturbances.
150. A serum lithium level that exceeds 2.0 mEq/L is considered toxic.
151. Public Law 94-247 (Child Abuse and Neglect Act of 1973) requires reporting of suspected cases of child abuse to child protection services.
152. The nurse should suspect sexual abuse in a young child who has blood in the feces or urine, penile or vaginal discharge, genital trauma that isn't readily explained, or a sexually transmitted disease.
153. An alcoholic uses alcohol to cope with the stresses of life.
154. The human personality operates on three levels: conscious, preconscious, and unconscious.
155. Asking a patient an open-ended question is one of the best ways to elicit or clarify information.

156. The diagnosis of autism is often made when a child is between ages 2 and 3.
157. Defense mechanisms protect the personality by reducing stress and anxiety.
158. Suppression is voluntary exclusion of stress-producing thoughts from the consciousness.
159. In psychodrama, life situations are approximated in a structured environment, allowing the participant to recreate and enact scenes to gain insight and to practice new skills.
160. Psychodrama is a therapeutic technique that's used with groups to help participants gain new perception and self-awareness by acting out their own or assigned problems.
161. A patient who is taking disulfiram (Antabuse) must avoid ingesting products that contain alcohol, such as cough syrup, fruitcake, and sauces and soups made with cooking wine.
162. A patient who is admitted to a psychiatric hospital involuntarily loses the right to sign out against medical advice.
163. "People who live in glass houses shouldn't throw stones" and "A rolling stone gathers no moss" are examples of proverbs used during a psychiatric interview to determine a patient's ability to think abstractly. (Schizophrenic patients think in concrete terms and might interpret the glass house proverb as "If you throw a stone in a glass house, the house will break.")
164. Signs of lithium toxicity include diarrhea, tremors, nausea, muscle weakness, ataxia, and confusion.
165. A labile affect is characterized by rapid shifts of emotions and mood.
166. Amnesia is loss of memory from an organic or inorganic cause.
167. A person who has borderline personality disorder is demanding and judgmental in interpersonal relationships and will attempt to split staff by pointing to discrepancies in the treatment plan.
168. Disulfiram (Antabuse) shouldn't be taken concurrently with metronidazole (Flagyl) because they may interact and cause a psychotic reaction.
169. In rare cases, electroconvulsive therapy causes arrhythmias and death.
170. A patient who is scheduled for electroconvulsive therapy should receive nothing by mouth after midnight to prevent aspiration while under anesthesia.
171. Electroconvulsive therapy is normally used for patients who have severe depression that doesn't respond to drug therapy.
172. For electroconvulsive therapy to be effective, the patient usually receives 6 to 12 treatments at a rate of 2 to 3 per week.
173. During the manic phase of bipolar affective disorder, nursing care is directed at slowing the patient down because the patient may die as a result of self-induced exhaustion or injury.
174. For a patient with Alzheimer's disease, the nursing care plan should focus on safety measures.

175. After sexual assault, the patient's needs are the primary concern, followed by medicolegal considerations.
176. Patients who are in a maintenance program for narcotic abstinence syndrome receive 10 to 40 mg of methadone (Dolophine) in a single daily dose and are monitored to ensure that the drug is ingested.
177. Stress management is a short-range goal of psychotherapy.
178. The mood most often experienced by a patient with organic brain syndrome is irritability.
179. Creative intuition is controlled by the right side of the brain.
180. Methohexital (Brevital) is the general anesthetic that's administered to patients who are scheduled for electroconvulsive therapy.
181. The decision to use restraints should be based on the patient's safety needs.
182. Diphenhydramine (Benadryl) relieves the extrapyramidal adverse effects of psychotropic drugs.
183. In a patient who is stabilized on lithium (Eskalith) therapy, blood lithium levels should be checked 8 to 12 hours after the first dose, then two or three times weekly during the first month. Levels should be checked weekly to monthly during maintenance therapy.
184. The primary purpose of psychotropic drugs is to decrease the patient's symptoms, which improves function and increases compliance with therapy.
185. Manipulation is a maladaptive method of meeting one's needs because it disregards the needs and feelings of others.
186. If a patient has symptoms of lithium toxicity, the nurse should withhold one dose and call the physician.
187. A patient who is taking lithium (Eskalith) for bipolar affective disorder must maintain a balanced diet with adequate salt intake.
188. A patient who constantly seeks approval or assistance from staff members and other patients is demonstrating dependent behavior.
189. Alcoholics Anonymous advocates total abstinence from alcohol.
190. Methylphenidate (Ritalin) is the drug of choice for treating attention deficit hyperactivity disorder in children.
191. Setting limits is the most effective way to control manipulative behavior.
192. Violent outbursts are common in a patient who has borderline personality disorder.
193. When working with a depressed patient, the nurse should explore meaningful losses.
194. An illusion is a misinterpretation of an actual environmental stimulus.
195. Anxiety is nonspecific; fear is specific.
196. Extrapyramidal adverse effects are common in patients who take antipsychotic drugs.
197. The nurse should encourage an angry patient to follow a physical exercise program as one of the ways to ventilate feelings.

198. Depression is clinically significant if it's characterized by exaggerated feelings of sadness, melancholy, dejection, worthlessness, and hopelessness that are inappropriate or out of proportion to reality.
199. Free-floating anxiety is anxiousness with generalized apprehension and pessimism for unknown reasons.
200. In a patient who is experiencing intense anxiety, the fight-or-flight reaction (alarm reflex) may take over.
201. Confabulation is the use of imaginary experiences or made-up information to fill missing gaps of memory.
202. When starting a therapeutic relationship with a patient, the nurse should explain that the purpose of the therapy is to produce a positive change.
203. A basic assumption of psychoanalytic theory is that all behavior has meaning.
204. Catharsis is the expression of deep feelings and emotions.
205. According to the pleasure principle, the psyche seeks pleasure and avoids unpleasant experiences, regardless of the consequences.
206. A patient who has a conversion disorder resolves a psychological conflict through the loss of a specific physical function (for example, paralysis, blindness, or inability to swallow). This loss of function is involuntary, but diagnostic tests show no organic cause.
207. Chlordiazepoxide (Librium) is the drug of choice for treating alcohol withdrawal symptoms.
208. For a patient who is at risk for alcohol withdrawal, the nurse should assess the pulse rate and blood pressure every 2 hours for the first 12 hours, every 4 hours for the next 24 hours, and every 6 hours thereafter (unless the patient's condition becomes unstable).
209. Alcohol detoxification is most successful when carried out in a structured environment by a supportive, nonjudgmental staff.
210. The nurse should follow these guidelines when caring for a patient who is experiencing alcohol withdrawal: Maintain a calm environment, keep intrusions to a minimum, speak slowly and calmly, adjust lighting to prevent shadows and glare, call the patient by name, and have a friend or family member stay with the patient, if possible.
211. The therapeutic regimen for an alcoholic patient includes folic acid, thiamine, and multivitamin supplements as well as adequate food and fluids.
212. A patient who is addicted to opiates (drugs derived from poppy seeds, such as heroin andmorphine) typically experiences withdrawal symptoms within 12 hours after the last dose. The most severe symptoms occur within 48 hours and decrease over the next 2 weeks.
213. Reactive depression is a response to a specific life event.
214. Projection is the unconscious assigning of a thought, feeling, or action to someone or something else.

215. Sublimation is the channeling of unacceptable impulses into socially acceptable behavior.
216. Repression is an unconscious defense mechanism whereby unacceptable or painful thoughts, impulses, memories, or feelings are pushed from the consciousness or forgotten.
217. Hypochondriasis is morbid anxiety about one's health associated with various symptoms that aren't caused by organic disease.
218. The Minnesota Multiphasic Personality Inventory consists of 550 statements for the subject to interpret. It assesses personality and detects disorders, such as depression and schizophrenia, in adolescents and adults.
219. Organic brain syndrome is the most common form of mental illness in elderly patients.
220. A person who has an IQ of less than 20 is profoundly retarded and is considered a total-care patient.
221. Reframing is a therapeutic technique that's used to help depressed patients to view a situation in alternative ways.
222. Fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil) are serotonin reuptake inhibitors used to treat depression.
223. The early stage of Alzheimer's disease lasts 2 to 4 years. Patients have inappropriate affect, transient paranoia, disorientation to time, memory loss, careless dressing, and impaired judgment.
224. The middle stage of Alzheimer's disease lasts 4 to 7 years and is marked by profound personality changes, loss of independence, disorientation, confusion, inability to recognize family members, and nocturnal restlessness.
225. The last stage of Alzheimer's disease occurs during the final year of life and is characterized by a blank facial expression, seizures, loss of appetite, emaciation, irritability, and total dependence.
226. Threatening a patient with an injection for failing to take an oral drug is an example of assault.
227. Reexamination of life goals is a major developmental task during middle adulthood.
228. Acute alcohol withdrawal causes anorexia, insomnia, headache, and restlessness and escalates to a syndrome that's characterized by agitation, disorientation, vivid hallucinations, and tremors of the hands, feet, legs, and tongue.
229. In a hospitalized alcoholic, alcohol withdrawal delirium most commonly occurs 3 to 4 days after admission.
230. Confrontation is a communication technique in which the nurse points out discrepancies between the patient's words and his nonverbal behaviors.
231. For a patient with substance-induced delirium, the time of drug ingestion can help to determine whether the drug can be evacuated from the body.

232. Treatment for alcohol withdrawal may include administration of I.V. glucose for hypoglycemia, I.V. fluid containing thiamine and other B vitamins, and antianxiety, antidiarrheal, anticonvulsant, and antiemetic drugs.
233. The alcoholic patient receives thiamine to help prevent peripheral neuropathy and Korsakoff's syndrome.
234. Alcohol withdrawal may precipitate seizure activity because alcohol lowers the seizure threshold in some people.
235. Paraphrasing is an active listening technique in which the nurse restates what the patient has just said.
236. A patient with Korsakoff's syndrome may use confabulation (made up information) to cover memory lapses or periods of amnesia.
237. People with obsessive-compulsive disorder realize that their behavior is unreasonable, but are powerless to control it.
238. When witnessing psychiatric patients who are engaged in a threatening confrontation, the nurse should first separate the two individuals.
239. Patients with anorexia nervosa or bulimia must be observed during meals and for some time afterward to ensure that they don't purge what they have eaten.
240. Transsexuals believe that they were born the wrong gender and may seek hormonal or surgical treatment to change their gender.
241. Fugue is a dissociative state in which a person leaves his familiar surroundings, assumes a new identity, and has amnesia about his previous identity. (It's also described as "flight from himself.")
242. In a psychiatric setting, the patient should be able to predict the nurse's behavior and expect consistent positive attitudes and approaches.
243. When establishing a schedule for a one-to-one interaction with a patient, the nurse should state how long the conversation will last and then adhere to the time limit.
244. Thought broadcasting is a type of delusion in which the person believes that his thoughts are being broadcast for the world to hear.
245. Lithium should be taken with food. A patient who is taking lithium shouldn't restrict his sodium intake.
246. A patient who is taking lithium should stop taking the drug and call his physician if he experiences vomiting, drowsiness, or muscle weakness.
247. The patient who is taking a monoamine oxidase inhibitor for depression can include cottage cheese, cream cheese, yogurt, and sour cream in his diet.
248. Sensory overload is a state in which sensory stimulation exceeds the individual's capacity to tolerate or process it.
249. Symptoms of sensory overload include a feeling of distress and hyperarousal with impaired thinking and concentration.
250. In sensory deprivation, overall sensory input is decreased.
251. A sign of sensory deprivation is a decrease in stimulation from the environment or from within oneself, such as daydreaming, inactivity, sleeping excessively, and reminiscing.

252. The three stages of general adaptation syndrome are alarm, resistance, and exhaustion.
253. A maladaptive response to stress is drinking alcohol or smoking excessively.
254. Hyperalertness and the startle reflex are characteristics of posttraumatic stress disorder.
255. A treatment for a phobia is desensitization, a process in which the patient is slowly exposed to the feared stimuli.
256. Symptoms of major depressive disorder include depressed mood, inability to experience pleasure, sleep disturbance, appetite changes, decreased libido, and feelings of worthlessness.
257. Clinical signs of lithium toxicity are nausea, vomiting, and lethargy.
258. Asking too many "why" questions yields scant information and may overwhelm a psychiatric patient and lead to stress and withdrawal.
259. Remote memory may be impaired in the late stages of dementia.
260. According to the DSM-IV, bipolar II disorder is characterized by at least one manic episode that's accompanied by hypomania.
261. The nurse can use silence and active listening to promote interactions with a depressed patient.
262. A psychiatric patient with a substance abuse problem and a major psychiatric disorder has a dual diagnosis.
263. When a patient is readmitted to a mental health unit, the nurse should assess compliance with medication orders.
264. Alcohol potentiates the effects of tricyclic antidepressants.
265. Flight of ideas is movement from one topic to another without any discernible connection.
266. Conduct disorder is manifested by extreme behavior, such as hurting people and animals.
267. During the "tension-building" phase of an abusive relationship, the abused individual feels helpless.
268. In the emergency treatment of an alcohol-intoxicated patient, determining the blood-alcohol level is paramount in determining the amount of medication that the patient needs.
269. Side effects of the antidepressant fluoxetine (Prozac) include diarrhea, decreased libido, weight loss, and dry mouth.
270. Before electroconvulsive therapy, the patient is given the skeletal muscle relaxant succinylcholine (Anectine) by I.V. administration.
271. When a psychotic patient is admitted to an inpatient facility, the primary concern is safety, followed by the establishment of trust.
272. An effective way to decrease the risk of suicide is to make a suicide contract with the patient for a specified period of time.
273. A depressed patient should be given sufficient portions of his favorite foods, but shouldn't be overwhelmed with too much food.

274. The nurse should assess the depressed patient for suicidal ideation.
275. Delusional thought patterns commonly occur during the manic phase of bipolar disorder.
276. Apathy is typically observed in patients who have schizophrenia.
277. Manipulative behavior is characteristic of a patient who has passive– aggressive personality disorder.
278. When a patient who has schizophrenia begins to hallucinate, the nurse should redirect the patient to activities that are focused on the here and now.
279. When a patient who is receiving an antipsychotic drug exhibits muscle rigidity and tremors, the nurse should administer an antiparkinsonian drug (for example, Cogentin or Artane) as ordered.
280. A patient who is receiving lithium (Eskalith) therapy should report diarrhea, vomiting, drowsiness, muscular weakness, or lack of coordination to the physician immediately.
281. The therapeutic serum level of lithium (Eskalith) for maintenance is 0.6 to 1.2 mEq/L.
282. Obsessive-compulsive disorder is an anxiety-related disorder.
283. Al-Anon is a self-help group for families of alcoholics.
284. Desensitization is a treatment for phobia, or irrational fear.
285. After electroconvulsive therapy, the patient is placed in the lateral position, with the head turned to one side.
286. A delusion is a fixed false belief.
287. Giving away personal possessions is a sign of suicidal ideation. Other signs include writing a suicide note or talking about suicide.
288. Agoraphobia is fear of open spaces.
289. A person who has paranoid personality disorder projects hostilities onto others.
290. To assess a patient's judgment, the nurse should ask the patient what he would do if he found a stamped, addressed envelope. An appropriate response is that he would mail the envelope.
291. After electroconvulsive therapy, the patient should be monitored for post-shock amnesia.
292. A mother who continues to perform cardiopulmonary resuscitation after a physician pronounces a child dead is showing denial.
293. Transvestism is a desire to wear clothes usually worn by members of the opposite sex.
294. Tardive dyskinesia causes excessive blinking and unusual movement of the tongue, and involuntary sucking and chewing.
295. Trihexyphenidyl (Artane) and benztropine (Cogentin) are administered to counteract extrapyramidal adverse effects.
296. To prevent hypertensive crisis, a patient who is taking a monoamine oxidase inhibitor should avoid consuming aged cheese, caffeine, beer, yeast, chocolate, liver, processed foods, and monosodium glutamate.

297. Extrapyramidal symptoms include parkinsonism, dystonia, akathisia ("ants in the pants"), and tardive dyskinesia.
298. One theory that supports the use of electroconvulsive therapy suggests that it "resets" the brain circuits to allow normal function.
299. A patient who has obsessive-compulsive disorder usually recognizes the senselessness of his behavior but is powerless to stop it (ego-dystonia).
300. In helping a patient who has been abused, physical safety is the nurse's first priority.
301. Pemoline (Cylert) is used to treat attention deficit hyperactivity disorder (ADHD).
302. Clozapine (Clozaril) is contraindicated in pregnant women and in patients who have severe granulocytopenia or severe central nervous system depression.
303. Repression, an unconscious process, is the inability to recall painful or unpleasant thoughts or feelings.
304. Projection is shifting of unwanted characteristics or shortcomings to others (scapegoat).
305. Hypnosis is used to treat psychogenic amnesia.
306. Disulfiram (Antabuse) is administered orally as an aversion therapy to treat alcoholism.
307. Ingestion of alcohol by a patient who is taking disulfiram (Antabuse) can cause severe reactions, including nausea and vomiting, and may endanger the patient's life.
308. Improved concentration is a sign that lithium is taking effect.
309. Behavior modification, including time-outs, token economy, or a reward system, is a treatment for attention deficit hyperactivity disorder.
310. For a patient who has anorexia nervosa, the nurse should provide support at mealtime and record the amount the patient eats.
311. A significant toxic risk associated with clozapine (Clozaril) administration is blood dyscrasia.
312. Adverse effects of haloperidol (Haldol) administration include drowsiness; insomnia; weakness; headache; and extrapyramidal symptoms, such as akathisia, tardive dyskinesia, and dystonia.
313. Hypervigilance and déjà vu are signs of posttraumatic stress disorder (PTSD).
314. A child who shows dissociation has probably been abused.
315. Confabulation is the use of fantasy to fill in gaps of memory.