VN 100 A Quiz

(Study Guide)

1. **Discuss the following roles of nurses:**
    a. Caregiver
        a. When a nurse accepts a patient care assignment, the nurse-patient relationship is initiated. This relationship, beyond its more personal human component, has a legal basis: the duty to provide professional care.
    b. Advocate
        a. An advocate is one who defends or pleads a cause or issue on behalf of another. A nurse advocate has a legal and ethical obligation to safeguard the patient's interests. (Foundations of Nursing Ch. 2 p. 25)
    c. Educator
        a. An example of an educator would be a physical therapist, instructing a patient how to do their exercises to get better.

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2. **Discuss the steps in abdominal assessment.**
    - inspection, auscultation, percussion, palpation.
        i. examine the abdomen. First inspect the abdomen for shape, contour, lesions, scars, lumps, or rashes. Normally, the abdomen's contour is even, and skin color is the same as that of the thorax. Then auscultate for bowel sounds (NOTE: before palpating; palpating first can alter the bowel sounds) by placing the diaphragm of the stethoscope over the divisions of the abdomen (Fig. 13.9) and listening for the sounds of peristalsis (wavelike movements of the intestine). It is helpful, before beginning, to make sure the room is quiet. If the patient is on a nasogastric suction machine, or if a radio or television is on, turn them off. Light pressure on the stethoscope is sufficient to detect bowel sounds. Because peristalsis is continuous, sounds normally are heard in all quadrants. Bowel sounds occur every 15 to 60 seconds and are classified as active, hyperactive, hypoactive, or absent. The normal rate of bowel sounds is 4 to 32 per minute.

        (Foundations of nursing Ch 13 p. 331)

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3. **Explain the purposes of documentation.**
    - (Foundations of Nursing Ch 1 pp. 17)
    - It helps with communication within the healthcare team.
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- Documentation in any form is the permanent record of the patient's progress and treatment. It constitutes the formal and legal record of care received by the patient and the patient's response to that care (Fig. 1.10). The information recorded during the entire course of treatment serves many purposes. It provides a progress record of treatment so that all the involved health care members are aware of what treatment the patient is receiving. It also provides a chronicle of events, which becomes a valued piece of the patient's health history that may be referenced for future health care needs. (See Chapter 3 for further discussion of documentation.)

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4. Discuss how to assist a weak client to move from the bed to a wheelchair.

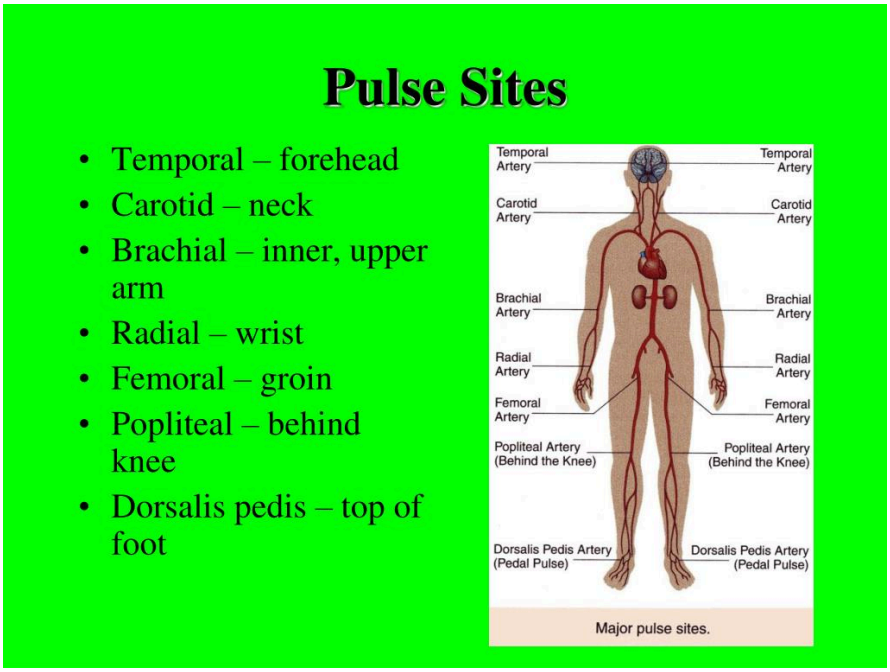
- (Foundations of Nursing Ch. 8 pp. 180)
- Transferring the patient from bed to straight chair or wheelchair:
    i. a. Lower bed to lowest position. (Provides patient safety when getting up.)
    ii. b. Raise head of bed. (Patient can more easily swing around to sitting position.)
    iii. c. Support patient's shoulders and help swing legs around and off bed; perform all in one motion (see Step 11e). (Prevents strain on patient, especially if patient has incision.)
    iv. d. Help patient don robe and slippers (or do this before beginning procedure). (Prevents chilling.)
    v. e. Have chair positioned beside bed with seat facing foot of bed. (Provides easy access to chair.)
    vi. (1) Place wheelchair at right angle to bed and lock wheels after bed is lowered. (Provides safety.)
    vii. (2) Place straight chair against wall or have another nurse hold the chair. (Provides safety.)
    viii. f. Stand in front of patient and place hands at patient's waist level or below; allow patient to use his or her arms and shoulder muscles to push down on the mattress to facilitate the move. (Prepares the patient for movement to chair.)
    ix. g. Assist patient to stand and swing around with back toward seat of chair. Keep the strong side toward the chair. (Provides safety.)
    x. h. Help patient to sit down as the nurse bends his or her knees to assist process. (Prevents patient from slipping and falling. If patient begins to fall, prevent patient injury by holding patient and allowing patient to sit down gently on floor; see Box 8.2, Step 3.)
    xi.
    xii. i. Apply blanket to legs. (Provides extra warmth.)
    xiii. j. If transfer belt is used, apply after patient is sitting on side of bed and follow these guidelines:
    xiv. (1) Stand in front of the patient. (Permits excellent view of patient.)
    xv. (2) Have the patient hold on to the mattress, or ask the patient to place his or her fists on the bed by the thighs. (Any assistance from the patient minimizes strain on you.)

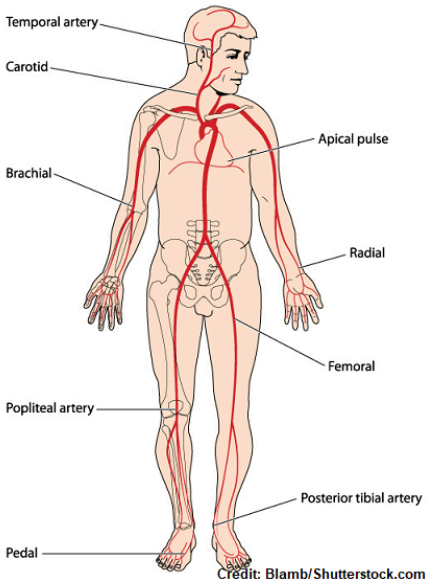
xvi. (3) Be sure the patient's feet are flat on the floor. (Provides balance and stability for patient.)
xvii. (4) Have the patient lean forward.
xviii. (5) Instruct the patient to place his or her hands on the nurse's shoulders, not around the nurse's neck or at the side as shown. (Arms around the neck could result in neck injury to nurse.)
xix. (6) Grasp the transfer belt at each side. (Offers stability of patient for the nurse.)
xx. (7) Brace knees against the patient's knees. Block the patient's feet with the nurse's feet. (Provides safety and prevents patient's foot from slipping.)
xxi.
xxii. (8) Ask the patient to push down on the mattress and to stand on the count of 3. Pull the patient into a standing position as you straighten your knees. (Provides for less strain on your back.)
xxiii.
xxiv. (9) Pivot the patient so that he or she is able to grasp the far arm of the chair. Back of the legs will be touching the chair. (Enables patient to assist in the transfer.)
xxv. (10) Continue to turn the patient until the other arm rest is grasped.
xxvi. (11) Gradually lower the patient into the chair as you bend your hips and knees. The patient assists if able by leaning forward and bending his or her elbows and knees. (Encourages patient to assist in transfer and increases muscle strength and a sense of control.)
xxvii. (12) Ensure buttocks are to the back of the chair. (Ensures patient safety.)
xxviii. (13) Cover patient's lap and legs. (Promotes patient's comfort and privacy.)

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5. Discuss the different pulse sites.

- Major pulses include temporal, facial, carotid, brachial, radial, femoral, popliteal, posterior tibial, and dorsalis pedis; the pulses provide both general and specific information.
- Access bilateral pulses.

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6. **Discuss performing oral hygiene in an unconscious patient.**
    - Lay the patient in Lateral (On their Side) having aspiration precautions.
    - Or place head to the side, to prevent aspirations.
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    - For conscious patients, sit them up and watch out for aspiration.

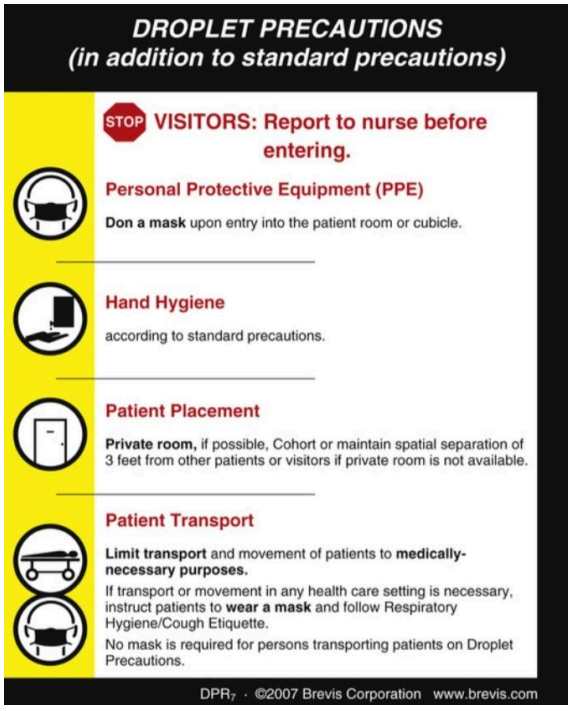
7. **Discuss the use of tea in Chinese culture.**
    - In Chinese culture: It helps with food digestion.
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8. **Discuss the PPE required for a patient with pneumonia.**
    - In addition to standard precautions, use droplet precautions for patients known or suspected to have serious illness transmitted by large particle droplets. Examples of such illnesses include the following:
        i. Invasive Haemophilus influenzae, including meningitis, pneumonia, epiglottitis, and sepsis

        (Foundations of Nursing ch. 7 pp. 136)

        Required PPE : surgical mask / gloves (Standard Precautions)



(per book)

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9. **Explain ownership of medical records.**

- The original health care record or chart is the property of the institution or the health care provider.
- Patients need to ask the hospital by filling out a form.
- A nurse has access to the system via computer log in. Don't share passwords.
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- (Foundations of nursing ch. 3 pp. 56)

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10. Discuss leaving against medical advice.

- (Foundations of Nursing Ch 11 pp. 273)
  Going AMA.

  Patients that leave without being discharged / Patients who refuse further treatment against medical advice.

  Patients who go AMA are required to sign an AMA form before leaving for legal reason.

Discharge: against medical advice (AMA)

- This is when a patient leaves a health care facility without a provider's order for discharge
- Notify the provider immediately
- If the provider fails to convince the patient to remain in the facility, the provider will ask the patient to sign an AMA form, releasing the facility from legal responsibility for any medical problems the patient may experience after discharge
- Do not detain the patient; this violates his or her legal rights

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11. Discuss and provide examples of the following:

a. Subjective data
   a. things a person tells you about that you cannot observe through your senses; symptoms
   b. What the patient states. "I am feeling anxious." or feeling pain.

b. Objective data
   a. Output Data. (Like numbers,)
   b. information that is seen, heard, felt, or smelled by an observer; signs
   c. Example : vital signs / bowel movement / numbers / lab results

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12. List the interpersonal variables affecting the communication process.

- Possible interpersonal variable to affect communication process is a persons grade level Speak to people in simple language, Don't speak to family members with the use of medical terminology.

Examples:

Patient can't speak english.
Perceived Body Language
Culture

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13. Discuss incident report and provide examples.

- (Foundations of Nursing Ch 3 pp. 49)
- Examples: Patient Falling, Medication errors, Getting hurt at work,
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- An incident report (form used to document any event not consistent with the routine operation of a health care unit or the routine care of a patient, Fig. 3.10) is sometimes necessary in response to an unplanned occurrence within a health care facility. For example, if a nurse neglects to give a medication or treatment or gives an incorrect dose of a drug, an incident report must be filed. Either of these events has the potential to cause injury. Incident reports also are filled out for any unusual event in a hospital (e.g., injuries to a patient, visitor, hospital personnel). Many staff members are reluctant to fill out these forms, but this information helps the facility risk manager and unit managers to track occurrences of incidents is to prevent future problems through education and other corrective measures.incidents. One of the benefits of tracking particular.
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- On the form, only facts may be written in. Do not write in opinions.

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14. Discuss privacy.

- Protection of patient information. HIPAA.
- Example ; When performing ADL ensure privacy by covering blinds / Do not discuss patient info unless consented or needed by healthcare workers.

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15. Discuss ways to communicate with a client who has aphasia.

- (Foundations of Nursing Ch 4 pp. 76)
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- Aphasia : DIfficulty in speaking.
- Expressive:
    i. Unable to send desired verbal message
- Receptive:
    i. Inability to recognize or interpret the verbal message being received
- Global:
    i. Patients with global aphasia can only produce a few recognizable words. They can understand very little or no spoken language. However, they may have fully

preserved cognitive and intellectual abilities that are not related to language or speech.

- Aphasia is a deficient or absent language function that results from ischemic insult to the brain, such as stroke (cerebrovascular accident), brain trauma, or anoxia.
- Examples of communication: Picture, Body language, boards

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16. Explain advance directives.

- Advance directives are signed and witnessed documents that provide specific instructions for health care treatment if a person is unable to make these decisions personally at the time they are needed.
- Example: A living will,

(Foundations of Nursing ch. 2, pp. 33)

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17. Discuss temperature taking using an oral thermometer.

- Temperature measurements are obtained by several methods
- Obtaining an oral temperature reading with an electronic thermometer.

(Foundations of Nursing Ch. 12 pp. 284)

i. a. Follow Steps 1 through 6.

ii. b. Perform hand hygiene and don disposable gloves (optional). (Reduces spread of microorganisms.)

iii. c. Remove thermometer pack from charging unit. (Adds maneuverability; battery power is available.) Remove probe from storage well of recording unit. Grasp top of stem, being careful not to apply pressure to eject button. (Ensures proper working order.)

iv. d. Insert probe snugly into probe cover: red probe for rectal readings, blue probe for oral and axillary readings (see Fig. 12.3). (Using probe cover helps reduce spread of microorganisms.)

v. e. Inspect digital display. (Ensures that unit is ready for use.)

vi. f. Request patient to open the mouth; gently insert probe into the posterior sublingual pocket. Request patient to hold thermometer in place with lips closed. (Ensures an accurate reading.)

vii. g. Wait for audible signal. (Indicates temperature reading is complete.)

viii. h. Remove probe from patient's mouth and remove probe cover by pressing the eject button, directing probe cover into trash receptacle. (Reduces spread of microorganisms.)

ix. i. Provide for patient comfort.

x. j. Read and write down reading from digital display before reinserting probe into holder. (Ensures accurate recording.)

xi. k. Perform hand hygiene. (Reduces spread of microorganisms.) Return electronic unit to charger. (Maintains battery charge.)

xii. l. Complete procedure by following Step 12, a through d.

Pedal push.

Extra Notes

DROPLET PRECAUTIONS
(in addition to standard precautions)

STOP VISITORS: Report to nurse before entering.

Personal Protective Equipment (PPE)

Don a mask upon entry into the patient room or cubicle.

Hand Hygiene

according to standard precautions.

Patient Placement

Private room, if possible, Cohort or maintain spatial separation of 3 feet from other patients or visitors if private room is not available.

Patient Transport

Limit transport and movement of patients to **medically-necessary purposes.**

If transport or movement in any health care setting is necessary, instruct patients to **wear a mask** and follow Respiratory Hygiene/Cough Etiquette.

No mask is required for persons transporting patients on Droplet Precautions.

AIRBORNE PRECAUTIONS
(in addition to standard precautions)

VISITORS: Report to nurse before entering.

Use Airborne Precautions as recommended for patients known or suspected to be infected with infectious agents transmitted person-to-person by the airborne route (e.g., *M. tuberculosis*, measles, chickenpox, disseminated herpes zoster).

Patient Placement

Place patients in an **AIIR** (Airborne Infection Isolation Room). **Monitor air pressure** daily with visual indicators (e.g., flutter strips).

Keep door closed when not required for entry and exit.

In ambulatory settings instruct patients with a known or suspected airborne infection to wear a surgical mast and observe Respiratory Hygiene/Cough Etiquette. Once in an AIIR, the mask may be removed.

Patient Transport

Limit transport and movement of patients to **medically-necessary purposes.**

If transport or movement outside an AIIR is necessary, instruct patients to **wear a surgical mask,** if possible, and observe Respiratory Hygiene/Cough Etiquette.

Hand Hygiene

Hand hygiene according to standard precautions.

Personal Protective Equipment (PPE)

Wear a fit-tested NIOSH-approved N-95 or higher level respirator for respiratory protection when entering the room of a patient when the following diseases are suspected or confirmed: Listed on back.

CONTACT PRECAUTIONS
(in addition to standard precautions)

STOP VISITORS: Report to nurse before entering.

Gloves

Don gloves upon entry into the room or cubicle.

Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient.

Remove gloves before leaving patient room.

Hand Hygiene

Hand Hygiene according to Standard Precautions.

Gowns

Don gown upon entry into the room or cubicle.

Remove gown and observe hand hygiene before leaving the patient care environment.

Patient Transport

Limit transport of patients to **medically-necessary purposes.**

Ensure that infected or colonized areas of the patient's body are contained and covered.

Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions.

Don clean PPE to handle the patient at the transport destination.

Patient Care Equipment

Use disposable noncritical patient care equipment or implement patient-dedicated use of such equipment.

Possible book references

Cooper, K. Gosnell, K. (2019). ***Foundation of Nursing, 8th Edition;*** **Elsevier**
Chapter 1 The Evolution of Nursing pp 1-21
Chapter 2 Legal and Ethical Aspects of Nursing pp 22-39
Chapter 4 Communication pp 60-79
Chapter 6 Cultural and Ethnic Considerations pp 95-116
Chapter 5 Nursing Process and Critical Thinking pp 80-94

Assessment Technologies Institute, LLC (2016). Fundamentals for Nursing Edition 9.0
Chapter 3 Ethical Responsibilities pp 11-14
Chapter 4 Legal Responsibilities pp 15-20
Chapter 32 Therapeutic Communication pp 173-178
Chapter 7 Nursing Process pp 29-32

Cooper, K. Gosnell, K. (2019). ***Foundation of Nursing, 8th Edition;*** **Elsevier**
Chapter 5 Nursing Process and Critical Thinking pp 80-94
Chapter 12 Vital Signs pp 278-310
Chapter 13 Physical Assessment pp 311-337

Assessment Technologies Institute, LLC (2016). Fundamentals for Nursing Edition 9.0
Chapter 8 Critical Thinking and Clinical Judgment pp 33-36
Chapter 27 Vital Signs pp 133-142
Chapter 28 Head and Neck pp 143-150
Chapter 29 Thorax, heart, and Abdomen pp 151-160
Chapter 30 Integumentary and Peripheral Vascular Systems pp 161-164
Chapter 31 Musculoskeletal and Neurosensory Systems pp 165-172