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Medical-Surgical Nursing

Third Edition

Ray A. Hargrove-Huttel

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Lippincott's MONEY-BACK GUARANTEE

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Medical-Surgical Nursing

Third Edition

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Introduction

Lippincott's Review Series is designed to help you in your study of the key subject areas in nursing. The series consists of six books, one in each core nursing subject area:

Medical-Surgical Nursing
Pediatric Nursing
Maternal-Newborn Nursing
Mental Health and Psychiatric Nursing
Pathophysiology
Fluids and Electrolytes

Lippincott's Review Series was planned and developed in response to your requests for comprehensive outline review books that address each major subject area and also contain a self-test mechanism. These books meet the need for strong and weak areas of knowledge. Each book is a complete source for review and self-assessment of a single core subject—all six together provide an excellent comprehensive review of entry-level nursing.

Each book is all-inclusive of the content addressed in major textbooks. The content outline review uses a consistent nursing process format throughout and addresses nursing care for well and ill clients. Also included, are necessary teaching and other concepts, such as nutrition; pharmacology; body structures and functions, and pathophysiology. Special features include the following:

- **Nursing process overview sections** review each step of the nursing process for the system or group of disorders in discussion. These overviews improve your ability to apply principles to practice by highlighting common assessment findings, diagnoses, goals, interventions, and outcomes.
- **Nursing process overview icons**  remind you to refer back to the nursing process overview section for in-depth discussion of relevant nursing interventions.
- **Nursing Alerts**  are fundamental guidelines you can follow to ensure safe and effective care.
- **Drug charts** provide quick reference for medications that are commonly used in treating the disorders discussed within a given chapter. The drug classification, indications, and selected nursing interventions are provided.
- **Client and family teaching boxes** detail health teaching information, which may be applied in the clinical setting.
- **Chapter study questions** help you chart your progress through each chapter. Answer keys are provided with rationales for correct and incorrect responses.
- **The comprehensive examination** mimics the NCLEX and allows you to assess your strengths and weaknesses. An answer key is provided with rationales for correct and incorrect responses.
- **The glossary,** presented at the end of the book, highlights noteworthy terms not covered in-depth within the text.

- **Accompanying CD-ROM** provides 200 additional NCLEX-style questions so you can practice computer adaptive test-taking skills. Answers are provided with rationales for correct and incorrect responses.

You can use the books in this series in several different ways. Overall, you can use them as subject reviews to augment general study throughout your basic nursing program and as a review to prepare for the National Council Licensure Examination (NCLEX-RN). How you use each book depends on your individual needs and preferences and on whether you review each chapter systematically or concentrate only on those chapters whose subject areas are particularly problematic or challenging. You may instead choose to use the comprehensive examination as a self-assessment opportunity to evaluate your knowledge base before you review the content outline. Likewise, you can use the study questions for pre- or post-testing after study, followed by the comprehensive examination as a means of evaluating your knowledge and competencies of an entire subject area. Regardless of how you use the books, one of the strengths of the series is the self-assessment opportunity it offers in addition to guidance in studying and reviewing content. The chapter study questions and comprehensive examination questions have been carefully developed to cover all topics in the outline review.

Unlike the NCLEX examination that tests the cumulative knowledge needed for safe practice by an entry-level nurse, these practice tests systematically evaluate the knowledge base that serves as the building block for the entire nursing educational process. In this way, you can prepare for the NCLEX examination throughout your course of study. Good study habits throughout your educational program are not only the best way to ensure ongoing success, but also will prove the most beneficial way to prepare for the licensing examination.

Keep in mind that these books are not intended to replace formal learning. They cannot substitute for textbook reading, discussion with instructors, or class attendance. Every effort has been made to provide accurate and current information, but class attendance and interaction with an instructor will provide invaluable information not found in books. Used correctly, these books will help you increase understanding, improve comprehension, evaluate strengths and weakness in areas of knowledge, increase productive study time, and, as a result, help you improve your grades.

MONEY-BACK GUARANTEE—Lippincott's Review Series will help you study more effectively during coursework throughout your educational program, and help you prepare for quizzes and tests, including the NCLEX exam. If you buy and use any of the six volumes in Lippincott's Review Series and fail the NCLEX exam, simply send us verification of your exam results and your copy of the review book to the address below. We will promptly send you a check for our suggested list price.

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Contents

1 Nursing Health Assessment

I. Overview of nursing health assessment

A. Definition

1. Assessment, the first step of the nursing process, refers to systematic appraisal of all factors relevant to a client's health.
2. Health assessment components
   a. Collecting information through the health history, physical examination, records and reports, and laboratory and diagnostic studies
   b. Analyzing information by comparing client data with baseline data
   c. Synthesizing information from all sources to form a complete clinical picture and discover relationships among data

B. Purposes

1. Surveying the client's health status and risk factors for particular health problems
2. Identifying latent or occult (undetected) disease
3. Screening for a specific disease such as diabetes or hypertension (ie, case finding)
4. Identifying risks for particular health problems
5. Determining functional impact of disease (ie, human response to actual or potential health problems)
6. Evaluating the effectiveness of the health care plan

II. Health history

A. Purposes

1. Through the health history, the nurse elicits a detailed, accurate, and chronologic health record as seen from the client's perspective.
2. The health history helps the nurse connect with a client and develop good rapport, provides insight into the client's functional status, and helps focus and guide subsequent physical examinations.

B. Data collection techniques

1. Provide privacy and comfort for the client.
2. Greet the client, and introduce yourself.
3. Establish a verbal contract with the client that delineates the purpose of the history-taking session, the client's role, and a time limit for the interview.
4. Ask open-ended questions to explore problem area (eg, "Tell me what made you seek answers about questions you may have with your breathing.").

5. Ask progressively more specific questions after identifying a particular problem (ie, symptom analysis).
6. Guide the interview to obtain essential information without discouraging the client's discussion.

C. Reliability of data

1. During the health history interview, it is important to observe and document behaviors that lead you to believe the client is a reliable, partially reliable, or unreliable source of information (eg, "responded promptly to all questions, maintained eye contact, and dates consistent: client reliable").
2. Reliability may come into question for clients who change their minds about their history, cannot recall certain events, do not know why they take certain medications, and are generally uncertain about their responses.

D. Components

1. **Biographic information.** Document the following information, but do not repeat it if the information is already in the client's record.
   a. Date and time of interview
   b. Client's name, address, telephone number, and Social Security number
   c. Name, address, and telephone number of person to contact in case of emergency or other situation
   d. Gender, race, ethnic origin, and religious preference
   e. Age, birth date, birthplace, and marital status
   f. Occupation and level of education
   g. Health insurance, usual sources of health care, and source of referral
   h. **Information regarding Advance Directive, Living Will, and Durable Power of Attorney for Health Care.**
      (1) Determine whether the client has these documents, ascertain where the originals are located, and obtain copies for the client's chart.
      (2) If the client does not have these documents, encourage the client to obtain them and provide information about how to obtain these vital documents.
2. **Chief complaint.** Identify the client's reason for seeking health care and obtain the following:
   a. A brief statement, usually in the client's own words, of the overriding problem for which she is seeking help.
   b. A description of onset and duration of the problem.
3. **Current health history.** Elicit a detailed description of the chief complaint, including the following:
   a. A detailed chronologic statement of the problem, beginning with when the client last felt well and ending with a description of the current condition
   b. An individual description of each health problem (in cases of multiple problems)
   c. A symptom analysis of each problem that includes the following:
      (1) Bodily location and radiation of pain (eg, pain in the lower right abdomen)
      (2) Quality (eg, sharp pain)
      (3) Quantity (eg, pain of about 6 on a 10-point scale)
      (4) Chronology, including onset, duration, and constant or intermittent nature
      (5) Setting, including precipitating circumstances, place, activity, and persons present
      (6) Aggravating and alleviating factors (eg, "When I stand up straight, the pain is worse; when I curl up, it goes away.")
      (7) Associated manifestations (eg, vomiting, headache)
   d. Information on possible exposure or incubation period in case of acute infections

e. Observations about whether and when the client stopped working or went to bed or about any change of activity level
f. The client's perception about whether the problem is getting better or worse
g. Information on previous treatments, including medications (eg, prescribed, over the counter), the prescribing practitioner, and treatment setting (eg, hospital, clinic)
h. Information on current medication status, including prescription drugs, over-the-counter remedies, folk remedies, and any type of alternative health care (eg, herbs)
i. Identification of the problem as acute, chronic, or an acute exacerbation of a chronic problem

4. **Past health status.** Obtain a description of the client's health history. Elicit information not specifically associated with the current problem, which is usually considered to be any problem occurring more than 6 months to 1 year earlier. Ask the client to describe the following factors:
   a. General health and strength compared with 1 year ago; consider the stability of weight and appetite
   b. Past illnesses, including childhood illnesses, acute infectious diseases, illnesses not requiring hospitalization, and illness requiring hospitalization or surgery
   c. Accidents and injuries
   d. Sexual history, including sexual performance, sexual preference (ie, heterosexual, homosexual, or bisexual), menstrual history, and pregnancies (*Note:* This information may also appear in the review of systems.)
   e. Immunizations
   f. Allergies, including eczema, hives, and itching (with a description of the reaction) and allergy treatments
   g. Geographic exposure, including areas of residence and foreign travel
   h. Psychiatric history, including a history of "nervous breakdown," anxiety, and depression
5. **Family health history.** Obtain information regarding grandparents, parents, brothers, sisters, spouse, and children. Collect the following data:
   a. Age and health status or age at death and cause of death of relatives and adopted relatives (eg, adoptive parents who smoked may help identify problems related to smoking)
   b. Family history of heart disease, hypertension, stroke, diabetes, gout, kidney disease or calculi, thyroid disease, asthma or other allergic disorders, blood problems, cancer, epilepsy, mental illness, arthritis, alcoholism, and obesity
   c. Hereditary diseases such as hemophilia or sickle cell disease
   d. Family history presented as a genogram (Fig. 1-1) or diagram of the "family tree" with added notation regarding family negatives (eg, diseases not present in the family)
6. **Review of body systems.** Elicit subjective information on the client's perceptions of major body system functions. Note current status, any related past symptoms (ie, positives) or lack of symptoms (ie, negatives), and add a symptom analysis of any positive findings. The important information collected for each body part or system is subsequently described, and the physical examination section (see Section III) offers more detail.
   a. **General:** weakness, fatigue, malaise, fever, chills, and recent weight loss or gain
   b. **Integument:** pruritus, pigmentary and other color changes, bleeding and bruising tendencies, lesions, excessive dryness, change in texture or character of hair or nails, and use of hair dyes or any possibly toxic agent
   c. **Head:** headache, head injury, scope, and dizziness

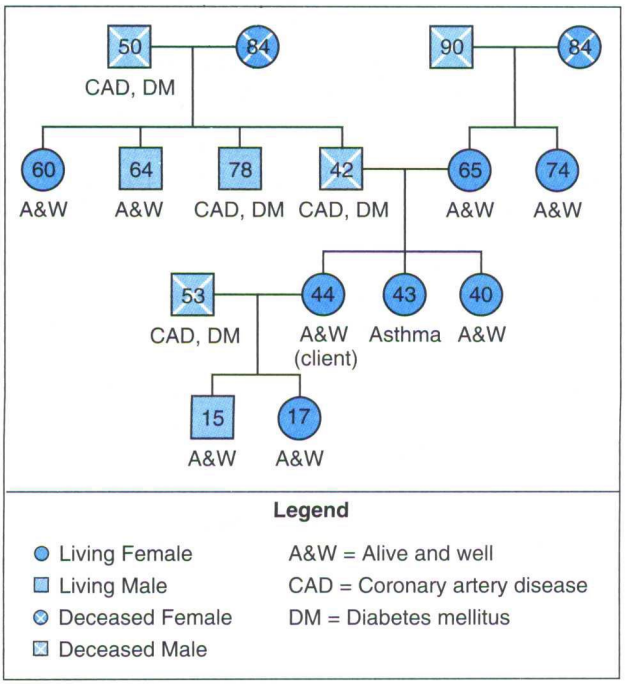

FIGURE 1-1
Genogram.

d. **Eyes:** pain, recent change in appearance or vision, eyeglasses or contact lenses and recent change in prescription, diplopia, photophobia, blind spots, itching, burning, discharge, conjunctivitis, infection, glaucoma, cataracts, diabetes, and hypertension
e. **Ears:** hearing acuity, earaches, tinnitus, vertigo, discharge, infection, and mastoiditis
f. **Nose and sinuses:** sense of smell, sinus pain, epistaxis, nasal obstruction, discharge, postnasal drip, frequency of head colds, sneezing, and use of nose drops or sprays
g. **Oral cavity:** toothache, recent extractions, state of dental repair; dry mouth, soreness or bleeding of lips, gums, mouth, tongue, or throat; disturbed taste sensation; hoarseness; and tonsillectomy
h. **Neck:** pain, limitation of motion, and thyroid enlargement
i. **Lymph nodes:** tenderness or enlargement of neck, axillary, epitrochlear, or inguinal nodes; and duration and progress of abnormality
j. **Breasts:** pain, lumps, and nipple discharge; surgery; any change in appearance of a breast; mammography and breast self-examination; timing of self-examination with regard to menstrual cycle; and estrogen replacement therapy
k. **Respiratory system:** chest pain and its relationship to respiration, pleurisy, frequent sneezing, cough, sputum production (character and amount), hemoptysis, wheezing and its location in the chest, stridor, asthma, bronchitis, pneumonia, tuberculosis or contact therewith, night sweats, date of recent chest radiograph, and smoking history
l. **Cardiovascular system:** precordial or retrosternal pain or discomfort, palpitations, dyspnea, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, edema, cyanosis; history of heart murmur, rheumatic fever (and its manifestations), hypertension (and usual blood pressure, if known), or coronary artery disease; and most recent electrocardiogram and results

m. **Gastrointestinal system:** appetite, food intolerance, dysphagia (with solids and liquids), heartburn, postprandial pain or distress, biliary colic, jaundice, other abdominal pain or distress, belching, nausea, vomiting, hematemesis or flatulence; change in character or color of stools (eg, bleeding, melena, clay colored, diarrhea, constipation) or change in bowel habits; use of laxatives (type and frequency); rectal conditions (eg, pruritus, hemorrhoids, fissures, fistula); ulcers; gallbladder disease; hepatitis; appendicitis; colitis; parasites; hernia; and radiographs (where and when obtained and results)

n. **Renal and urinary systems:** renal colic, frequency of urination, nocturia, polyuria, oliguria, urine retention, hesitancy, urgency, dysuria, narrowing of urine stream, dribbling, incontinence, hematuria, albuminuria, pyuria, kidney disease, facial edema, renal calculi, and results of cystoscopy if indicated

o. **Male reproductive system:** testicular pain and change in scrotum; puberty (eg, onset, voice change, erections, emissions); libido and satisfaction with sexual relations; and history of sexually transmitted disease such as gonorrhea, syphilis, herpes, and human immunodeficiency virus infection or acquired immunodeficiency syndrome, including date of onset, treatments and their effectiveness, and any complications

p. **Female reproductive system:** menstrual history (eg, menarche, last period, cycle and duration, amount of flow, premenstrual pain, dysmenorrhea, intermenstrual bleeding), vaginal discharge, dyspareunia, obstetric history (eg, gravida/para, miscarriages, abortions, complications), menopause and associated symptoms, contraceptive methods used, libido, satisfaction with sexual relations, and history of sexually transmitted diseases as described in the previous section

q. **Peripheral vascular system:** intermittent claudication, varicose veins, and thrombophlebitis

r. **Musculoskeletal system:** joint pain, stiffness, swelling (eg, location, migratory nature, relation to known cardiac involvement); rheumatoid arthritis, gout, or bursitis; limitations in function or range of motion; flat feet, osteomyelitis, or fractures; muscle pain or cramps; and back pain (ie, location and radiation, especially to extremities), stiffness, limitation of motion, and sciatica or disk disease

s. **Neurologic system:** loss of consciousness, convulsions, meningitis, encephalitis, stroke, seizures, or other neurologic problems; use of medication for seizure control; cognitive disturbances (eg, recent or remote memory loss, hallucinations, disorientation, speech and language dysfunction, inability to concentrate); change in sleep pattern; motor problems (eg, gait, balance, coordination), tics, twitching, or tremors; muscle weakness or spasms; paralysis, muscle wasting, or activity intolerance; sensory disturbances (eg, pain, insensitivity to temperature or touch, paresthesias); and neuralgic pain in the head, neck, trunk, and extremities

t. **Hematopoietic and immune systems:** bleeding tendencies of skin or mucous membranes; anemia; blood type; transfusions and reactions; blood dyscrasias, low platelet count, exposure to toxic agents or radiation; and unexplained systemic infections and lymph node swelling

u. **Endocrine and metabolic systems:** nutritional and growth history; thyroid dysfunction (eg, goiter), adrenal problems, or diabetes; changes in tolerance to heat and cold; relationship between appetite and weight; excessive voiding or excessive thirst; change in skin (ie, pigmentation, texture); changes in body contour, hair distribution, and shoe or glove size; and unexplained weakness

7. **Developmental considerations.** Obtain an overview of the client's growth history, including pertinent physical and cognitive developmental milestones and factors.

8. **Lifestyle practices.** Obtain information about the client's activities of daily living and ability to care for self and family, including the following:
   a. Status of client's mobility in relation to activities and demands of daily living (eg, Shanas Index of Incapacity: "Can you go out of doors? Can you walk up and down stairs? Can you get out of the house? Can you wash and bathe yourself? Can you dress yourself? Can you put on your shoes? Can you cut your toenails?")
   b. Client's preferred lifestyle (eg, "Is there anything you cannot do now compared with last year? Do you travel now? Did you in the past? Where did you travel?")
   c. Client's home and neighborhood environment (eg, "Who buys and carries the groceries? Who cooks? Who does the housekeeping? Do you feel safe in and around your home?")
9. **Health promotion and maintenance activities.** Obtain information concerning the client's practices that promote healthy living. Take this opportunity to provide client and family teaching relative to health promotion and maintenance (Client and Family Teaching 1-1).
   a. Health beliefs
      (1) Expectations of health care
      (2) Promotive, preventive, and restorative practices (eg, breast self-examination, use of safety devices, seat belt use)
      (3) The meaning of illness
      (4) Cultural implications of health and illness
      (5) Alternative health care (eg, use of herbs, massage therapy, aroma therapy)

CLIENT AND FAMILY TEACHING 1-1

Guidelines for Health Promotion

1. Explain to the client that taking responsibility for oneself is the key to successful health promotion.
2. Discuss the necessity of ensuring an adequate amount of sleep; this is individualized, but 6 to 8 hours are recommended.
3. Discuss the importance of a properly balanced diet that supplies all of the essential nutrients and an awareness of the relationship between diet and disease.
4. Encourage the necessity of managing stress appropriately to include techniques such as relaxation training, exercise, and modification of stress-producing situations. Always include quality family time and recreational time.
5. Explain that a regular exercise program can promote health by improving the function of the circulatory system and the lungs, decreasing cholesterol and low-density lipoproteins, and lowering body weight by increasing calorie expenditure.
6. Discuss the importance of using safety devices such as seat belts or helmets and of following precautions when using pesticides or fertilizers.
7. Discuss the importance of obtaining examinations to include annual health checkups, eye examinations, gynecologic checkups, mammograms, prostate examinations, and digital rectal examinations.
8. Discuss the importance of self-examinations, including breast self examinations, testicular examinations, and skin examinations.
9. Discuss the importance of avoiding smoking, excessive alcohol intake, and substance abuse of any kind.
10. Discuss the importance of safety and conditions in the home setting, work setting, and community setting.