

临床护理英语

PRACTICAL NURSING ENGLISH

王 霞 张凤军 主编

Authentic Materials and Exercises
for Doctors and Nurses

复旦大学出版社

临床护理英语

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主 编：王 霞 张凤军

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前 言

《临床护理英语》(*Practical Nursing English*)是一本全部用英语讲解护理专业知识的英语护理教材,体现了当今国际流行的整体护理理念和四步护理工作程序。本书第一至第九章分别为护理程序、基础护理、内外科护理、妇产科护理、儿科护理、老年护理、营养学及护理药理学等,最后一章介绍了国外护理学科的最新发展,基本上包括了当今国外护理职业资格考试的全部专业知识内容。

本书正文后附有的练习题都是按照国外护理资格考试的命题原则、理念、样式编写。为方便教师教学及学生学习,本书在每一页底部详加注释。

《临床护理英语》是为英语护理及大学高级护理专业学生编写的专业英语教材,也可以作为临床护理人员学习最新护理知识、理念及护理程序的参考用书,更是准备出国、参加出国护理考试的护理人员考前必备用书。

本书在编写过程中,得到联合国卫生组织专家 Chery Crosby 女士和 Brian Brett 先生的大力支持。Brett 先生为本书提供了大量的参考资料,Crosby 女士审阅了全部书稿。同时,本书的编写还得到了全国英语护理协作会及有关单位领导的大力支持,并提出了许多宝贵意见,在此一并表示衷心的感谢!

编 者

2005 年 6 月

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Section 1

Nursing Process^①

Nursing process is a set of predetermined^② steps used by nurses to identify and to help solve patient problems. It is to communicate problems and approaches among all those providing patient care, and to provide planned, coordinated, and individualized patient care.

Chapter 1 Assessment^③

Assessment is to collect data about patients to aid in the planning, implementation^④ and evaluating^⑤ of patient care. The nurse obtains specific information from patients, through goal directed interviews, participates in the identification of physical, emotional, spiritual, cultural and overt^⑥ learning needs of patients by collecting appropriate data, and analyzes data collected in relation to patients' pathophysiology.

Part 1 Sources of Data

1. Patient, family or significant others, nursing report, and patient's chart. The chart includes laboratory reports, X-ray reports, ECG^⑦ reports, biopsy^⑧ reports, nurses' notes, physician's order sheet, and progress notes of other health care workers. Laboratory reports include CBC^⑨, BS^⑩ or glucose, and blood chemistry. X-ray reports include UGI^⑪, BAE^⑫, GBS^⑬, and chest x-ray examination.
2. Subjective^⑭ data is the information reported by the patient, e. g., pain, anxiety, dizziness, ringing in the ears; objective^⑮ data is the information gathered through

① 程序 ② 预先决定 ③ 评估 ④ 实行 ⑤ 估价 ⑥ 明显的 ⑦ electrocardiogram 心电图

⑧ 活组织检查 ⑨ complete blood count 全血细胞计数 ⑩ blood sugar 血糖

⑪ upper gastrointestinal 上消化道 ⑫ barium enema 钡灌肠剂 ⑬ gallbladder series 胆系造影

⑭ 主观的 ⑮ 客观的

the senses (sight, hearing, smell, and feel) or with a measuring instrument (thermometer^①, sphygmomanometer^②, and scale), e. g., edema^③, cyanosis^④, wheezing, hematuria, vital signs, and weight height.

Part 2 Methods of gathering data

Formal interviewing with patient, listening, observation, physical examination, measurement of vital signs, measurement of weight and height, collection of specimens.

Interview

Formal interviewing with patient or signification others is to gather data on age, occupation, reason for hospitalization, medications, allergies, previous hospitalizations, previous illness, prostheses^⑤, valuables, and special diet, to gather data on difficulty with activities of daily living, sleep, elimination, activity, eating, and any special needs.

Physical examination

Inspection, palpation, percussion^⑥, auscultation^⑦:

1. To assist with the physical examination, be sure that the patient understands the examination and why it is being done, gather equipment, position patient appropriately, drape^⑧ covers to provide for privacy; after the examination, make the patient comfortable and safe, chart the procedure and patient's reactions, note specimens obtained.
2. The nurse explains procedure to the patient and carry out specific requirements: nothing by mouth or special meals, clothing, positioning, medications. Chest X-ray examination: no metal objects in view of X-ray. UGI series: nothing by mouth after midnight, medication or enema^⑨ to eliminate barium after the x-ray examination. BaE: low-residue meal evening before, NPO p MN^⑩, medications or enema to clear colon before and after X-ray examination; uses iodine-based dye; notify physician if patient is allergic to iodine or shellfish^⑪. GBS: fat-free meal evening before, NPO p MN, oral ingestion of dye tablets; dye is iodine based; check patient for iodine^⑫ based; check patient for iodine or shellfish allergy. Lumbar puncture: signed consent form is required; empty bladder and bowel^⑬

① 体温计 ② 脉搏计 ③ 水肿, 浮肿 ④ 发绀 ⑤ 修补物 ⑥ 叩诊 ⑦ 听诊 ⑧ 披上
 ⑨ 灌肠剂 ⑩ NPO 不能用口进食; nothing by mouth after midnight 半夜后不进食 ⑪ 贝 ⑫ 碘
 ⑬ 肠

before procedure; patient lies curled on side with head almost touching knees; nurse faces patient holding shoulders and knees, patient remains flat in bed after procedure.

Vital signs

Measurement of vital signs to assess functioning of cardiovascular^① and respiration systems.

1. Temperature: Normal temperature ranges axillary: 96 to 98. Mercury thermometer held in place 10 minutes, electronic thermometer held in place until final reading is indicated, pat dry the axilla before inserting, hold arm close to side. Orally: 97 to 99. Mercury thermometer left in place 2 to 4 minutes, electronic thermometer left in place until final reading is indicated, wait 10 minutes if the patient has been eating, smoking, drinking a hot or cold beverage, or chewing gum. Rectally^②: 98 to 100. Mercury thermometer held in place 3 to 4 minutes or according to agency policy. Electronic thermometer held in place until final reading is indicated, lubricate^③ before inserting, and insert 3.75cm.
2. Pulse: The beat of the heart heard at the apex^④ or felt at specific sites as a wave of blood flows through an artery. Normal adult range is 60 to 80 bpm, varies greatly among individuals. Rate is more rapid for children. Count for 1 full minute if taking pulse apically, if rhythm is irregular, or if rate is abnormal. Variations: tachycardia (fast heart beat, over 100), bradycardia (slow heart rate, under 60), irregular (intervals between beats uneven), thready (weak pulse, easily obliterated), and bounding (very strong pulse). Pulse can be felt with fingertips at places where an artery^⑤ crosses over muscle or bone close to the skin and at the apex of the heart (temporal^⑥, carotid^⑦, brachia^⑧, radial^⑨, and remoral, political, petal, and apical^⑩). Apical-radial pulse is to detect a difference between rates at the two sites, requires two people one taking the radial pulse and one taking the apical pulse, apical rate can never be lower than the radical rate. Must be counted simultaneously for 1 full minute.
3. Blood pressure:
 - a. BP is the force exerted by the blood against the walls of the arteries; it is measured in millimeters of mercury Hg at brachial artery or popliteal artery. Be sure cuff is proper size for the individual. Normal adult range is 60 to 80 mm Hg diastolic^⑪, 90 to 120 mm Hg systolic^⑫, varies among individuals and

① 心血管的 ② 直肠的 ③ 使润滑 ④ 心尖部 ⑤ 动脉 ⑥ 暂时的 ⑦ 颈动脉 ⑧ 臂状的
⑨ 径向的 ⑩ 顶端的 ⑪ 心脏舒张的 ⑫ 心脏收缩的

with activity.

- b. Systolic: pressure in the arteries during contraction of the heart. Diastolic: pressure in the arteries during relaxation of the heart. Hypotension^①: lower than normal BP, under 100/60. Hypertension^②: higher than normal BP, over 140/90. Pulse pressure: difference between systolic and diastolic pressure.
- 4. Respiration^③: The process of inhaling^④ and exhaling air into and out of the lungs; one inhalation plus one exhalation equals one respiration. When observe rate, rhythm, and depth, patient must not be aware that respiration is being observed.
 - a. Normal adult range is 14 to 20 respirations per minute. Varies greatly with activity level; rate is higher for children.
 - b. Dyspnea^⑤: Difficulty breathing. Stertorous: noisy breathing, snoring.
 - c. Cheyne-Stokes: rhythmic repeated cycles in depth and rate, then gradually becoming slower and shallow, followed by a period of apnea^⑥; often precedes death.
 - d. Apnea: absence of breathing.
 - e. Tachypnea: rapid breathing.
 - f. Kussmaul's: paroxysms^⑦ of dyspnea of ten proceeding diabetic^⑧ comas.
 - g. Orthopnea: breathing is possible only while in an upright position.

Weight and height

- 1. The result of measuring weight is used to establish medication dosages, gain or loss of body fluid, and nutritional status. Weight should be measured in same amount of clothing each day, before breakfast, shoes be off, be sure scale is balanced.
- 2. Height is used in determining some medication dosages and anesthesia^⑨ requirements. Have patient be in bare feet, standing on a paper towel stand tall.

Specimens^⑩

Follow your agency's procedure for collection, container, labels, requisitions, and recording. Label all specimen containers correctly and send with a laboratory requisition. Send specimens to the laboratory promptly. Wear protective gloves. Wash hands thoroughly after handling specimen.

- 1. Urine specimens: Urinalysis; routine examination of urine, Patient and container need only be clean, often collected as part of admission procedure. Culture^⑪ and

① 低血压 ② 高血压 ③ 呼吸 ④ 吸气 ⑤ 发声困难 ⑥ 窒息 ⑦ 发作 ⑧ 糖尿病的
⑨ 麻醉 ⑩ 标本 ⑪ 培养

sensitivity; clean-catch, midstream, genitalia and meatus are cleaned, specimen is taken after stream has started but before voiding is completed. Gather specimen by using sterile technique and equipment. 24-hour specimens; first voiding is discarded and time is noted; all urine for the next 24 hours is collected.

2. Sugar and acetone testing; urine obtained 30 to 60 minutes before meal or at designated time, double-voided^① specimen gives more accurate results. Test specimen with tes-tape clinitest, clinistix, or Keto-diaistix; follow manufacturer's directions precisely for accurate results. Report results immediately to medication nurse. Record results in proper place.
3. Stool specimens; Collect in clean bedpan, use tongue^② depressor^③ or wooden spatula^④ to transfer stool to specimen container. For blood occult^⑤ patient may be on a red meat-free diet 3 days before test. For culture and sensitivity; sterile container. For ova and parasites; stool must still be warm when it reaches the laboratory.
4. Blood specimen; Capillary^⑥ puncture for blood glucose testing usually requires agency certification. Explain procedure to patient, assemble equipment; gloves, alcohol swab^⑦, lancet^⑧, collector, gauze or cotton ball, and adhesive^⑨ bandage. Wash hands, enhance blood supply to puncture site by milking or applying warmth, with gloved hands, swab site with alcohol; let alcohol dry, puncture with lancet; collect blood, apply pressure to site; apply adhesive bandage.
5. Sputum^⑩ specimens; Patient first rinses mouth with water, take deep breath, cough deeply, and expectorate^⑪ into container. Specimen must be from the lung, not just mouth saliva^⑫, best collected in the morning before breakfast.

Chapter 2 Planning

1. Planning is to set reasonable goals and priorities designed to meet client needs. The nurse determines priorities and plans care accordingly, formulates^⑬ and collaborates^⑭ in developing written nursing care plans, and participates in developing preventative or long-term health plans for patients and families.
2. The process of setting priorities, determining patient-centered goals, and deciding on nursing actions to achieve the goals; ends with writing of the nursing care plan.

① 空隙 ② 舌 ③ 压舌板 ④ 压舌片 ⑤ 神秘之事 ⑥ 毛细血管 ⑦ 牙签 ⑧ 刺血针
⑨ 黏着的 ⑩ 痰,唾液 ⑪ 咳出 ⑫ 唾液 ⑬ 制定 ⑭ 合作

Problems are that life threatening is of highest priority, when no single problem seems more important than the others do, the patient may help determine priorities. The expected nursing goals are stated in terms of patient behavior so that achievement can easily be evaluated. Whenever possible patient should be involved in setting goals, long-term goals are those hoped for in the future, usually set by the registered nurse, short-term goals are those sought immediately or in the near future. Decisions about which nursing measures to use are based on sound knowledge of current nursing practice, principles, rationales^①, and judgment. The written nursing care plan provides continuity of patient care.

Example: Nursing plan for 39-year-old woman 4 days after cesarean section.

Problem: constipation 4 days.

Goal: will have a stool today and at least every other day thereafter.

Nursing actions: encourage walking, encourage fluids to at least 2,500ml/day, encourage eating roughage^② and fruits, give pm laxative^③, record bowel movements (BMs) in nurse's notes every shift, teach patient relationship of activity, fluids, and fiber to stool elimination.

Chapter 3 Implementation

1. It is to carry out the nursing actions to accomplish the goals and solve the problem.

The nurse uses basic communication skills in a structured care setting, safely performs therapeutic and preventative nursing procedures, incorporating^④ fundamental biologic^⑤ and psychological^⑥ principles in giving individualized care, observes patients and communicates significant findings to the health care team, does incidental^⑦ teaching and supports and reinforces the teaching plan for a specific patient and family.

2. Principles: nurse must know how, when and why measure is to be performed, checking for a physician's order when necessary. To reduce anxiety, patients need to know what measure is to be performed and why as well as what is expected of them. Special preparation needed for special measure (medications, positioning, attire^⑧ etc.). All necessary equipment ready in working order.

3. Performance: nurse must have knowledge of and ability to perform measure and to

① 合理的 ② 粗粮 ③ 轻泻剂 ④ 合并 ⑤ 生物的 ⑥ 心理学的 ⑦ 附带的 ⑧ 服装

seek help when necessary. Medical asepsis is always followed; surgical asepsis and universal precautions are followed as required, work must be organized to conserve nurse's patient's energy and to meet patient's need for security, assessment of patient's response to the measure is ongoing.

4. Aftercare: patient made safe and comfortable, equipment cleaned and returned to proper place or disposed of, evaluation of results of the measure and whether it helped achieve the goal.
5. Report & record: report and record significant observations immediately, when the measure was performed and the results.

Chapter 4 Evaluation

1. It is to determine whether the goal was accomplished and the problems solved. The nurse evaluates, with guidance if necessary, the care given and makes necessary adjustments, records evaluations of the results nursing actions.
2. Criteria: has the need been met? Is the problem solved or being solved? Has the goal expected outcome been achieved?
3. Revision of the plan: Based on evaluation of effectiveness, practical nurse collaborates with the registered nurse in revising problem list, goals, and nursing measures.

Section 2

Basic Concepts and Skills

Chapter 1 Basic Concepts

Nursing is an ongoing^① relationship with patients in various stages of the health-illness continuum^② and growth and development. Basic skills include the knowledge of the patient as a person, factor contributing to health and illness, ability to use problem-solving techniques, and ability to perform nursing skills.

Part 1 What is health and illness?

Health is a state of complete physical, mental, and social well-being and not merely an absence of disease or infirmity^③. Illness is a state of disturbance^④ of body structure or function or emotional or sociologic^⑤ functioning. It exists when disease is present, when an individual believes he or she is ill, when signs of illness are detected by the individual or the professional, or when all basic human needs are not satisfied. The individual's position on the health-illness continuum is determined by need satisfaction, the stage of disease progression, and his or her perception^⑥ of relative health or illness. The position is constantly changing in the balance between health and illness. A person is rarely either totally healthy or totally ill.

Part 2 Stages and tasks of adult development

Young adulthood

It is the time of an individual who is from 18 to 40 years old. Characteristics of the period are: a generally healthy period of life, reproductive capacity is at its height

① 不间断的 ② 连续统一体 ③ 虚弱 ④ 不安 ⑤ 社会的 ⑥ 感觉

and the prime^① of biologic^② life. Tasks of the time are: establishing a personal identity and life-style, intimate relationships outside the family, a career and own family unit; developing a set of personal moral values and achieving independence.

Middle adulthood

It is the time of an individual who is from 40 to 65 years old. Characteristics are that: physical changes develop gradually (diminishing strength, energy, and endurance, wrinkles, graying^③ and loss of hair, changes in vision, menopause^④, and weight increases), beginning of chronic^⑤ illness (cancer and heart disease), expected period of work and financial success, increased demands of aged parent, decreased demands of parenthood^⑥ with children achieving independence, a period involving crisis (realization that lifelong dreams are yet unmet); Tasks: recognizing own mortality^⑦, adjusting to changes (family, social and physical), developing concern beyond the family.

Older adulthood

Characteristics of an individual over 65 years are that: retirement often bring fixed income, much variation in levels of functioning and health, most are undergoing the normal physical changes of the aging process, most maintain active lifestyles; Tasks are that adapting to psychosocial changes and to the physical changes of the aging process, adjusting to loss of friends and family members, review life and prepare for death.

Part 3 Environmental Factors

Infectious agents: Microorganisms^① is small living organism that can only be seen with a microscope. There are four kinds of microorganisms: bacteria^②, viruses^③, fungi^④ and protozoa^⑤. Pathogens^⑥ are disease-producing organisms, nonpathogens are those that do not usually cause disease and normal flora^⑦ are those that normally live on or in an individual's body.

Chemical agents: taken by ingestion, such as medicine overdose or taken accidentally or intentionally and inhaled, such as gases, insecticide sprays^⑧, and factory emissions.

Physical agents: heat, cold, ultraviolet rays^⑨ of the sun and electric current.

① 全盛期 ② 生物的 ③ (使)变灰色 ④ 慢性的 ⑤ 父母身份 ⑥ 必死的命运 ⑦ 微生物
⑧ 细菌 ⑨ 病毒 ⑩ 真菌 ⑪ 原生生物 ⑫ 致病菌 ⑬ 菌群、菌丛 ⑭ 杀虫剂 ⑮ 紫外线

Heat may lead to heat exhaustion or heat stroke. Cold may cause hypothermia^①, frostbite^②, or even death. Ultraviolet rays can produce sunburn and electric current may cause shock, burn, or death.

Economic level may influence accessibility of health care. Lack of social and economic resources may contribute to disturbed mental health and substandard living accommodations and sanitation may predispose^③ to diseases like tuberculosis^④.

The nurse needs to be aware of patient's cultural practices and beliefs to meet needs in a way most beneficial to the patient. The cultural background means the beliefs and practices common to a group of people and passed down from generation to generation. Cultural practices influence food habits, reactions to illness, family interactions, and health practices.

The nurse must know the practices of the major religions and learn about others when the occasion arises to best meet the patient's needs. Religious practices may affect health practices, the patient may follow all, some, or none of the religious practices; may turn to or completely away from them while ill. That she must comply with a patient's religious practices^⑤ may reduce anxiety during illness.

Part 4 Internal Factors

Congenital^⑥ and hereditary factors^⑦ immunity, defense mechanisms^⑧, tissue and wound healing, and fluid and electrolyte balance.

Body defense mechanisms are methods used by the body to protect itself from invasion by disease-producing substances. First barriers are unbroken skin and mucous membranes; tears, the acid secretions of the vagina, hairlike projections in the nose, trachea, and bronchi, and reflexes are some others. Coughing and sneezing rid the body of pathogens, the acid secretions usually destroy pathogens, and Cilia sweep pathogens out of the respiratory tract and tears wash foreign particles from the eyes.

A local reaction (such as redness, heat, pain, swelling, and limited movement) occurs when tissue is injured by physical agents, chemical agents, or microorganisms injure tissue. After an injury the inflammatory process begins: increased blood flow to the injured part; leukocytes move to the area; phagocytes begin to engulf and digest bacteria; pus forms from dead pathogens and dead tissue. The suffix -itis means inflammation.

① 低体温 ② 冻伤 ③ 使预先有倾向 ④ 肺结核 ⑤ 宗教习惯 ⑥ 先天的 ⑦ 遗传因素
⑧ 机理