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Priority Nursing Actions

1. CLINICAL JUDGMENT:
PRIORITIZE HYPOTHESES
A client who is homeless comes to the health care clinic for treatment of a painful open foot wound. Priority client needs include the following:
• Provide measures for pain relief.
• Identify the cause of the open foot wound.
• Assess and treat the open foot wound.
• Provide care with a nonjudgmental and nonthreatening approach.
Determine medical history and existing health problems.
• Provide available access to health care resources.
• Establish an emergency contact person if available.
Establish a follow-up plan of care.

2. CLINICAL JUDGEMENT: TAKE ACTION
One hour before a scheduled surgical procedure, the client states to the nurse, "I have changed my mind. I don't want the surgery" Actions to take by the nurse include the following.
• Talk to the client about the request.
• Explore with the client concerns about not wanting the surgery. - - -Withhold further surgical preparation, and contact the surgeon to report the client's request.
• Document the client's request and that the surgeon was notified.

3. CLINICAL JUDGMENT: TAKE ACTION
Assessing a Group of Clients in Order of Priority
The nurse is assigned to the following clients. The order of priority in assessing the clients is as follows:
1. A client with heart failure who has a 4-lb weight gain since yesterday and is experiencing shortness of breath
2. A 24-hour postoperative client who had a wedge resection of the lung and has a closed chest tube drainage system
3. A client admitted to the hospital for observation who has absent bowel sounds
4. A client who is undergoing surgery for a hysterectomy on the following day

4. CLINICAL JUDGMENT: TAKE ACTION
Triaging Victims at the Site of an Accident
The nurse is the first responder at the scene of a school bus accident. The nurse triages the victims from highest to lowest priority as follows:
1. Confused child with bright red blood pulsating from a leg wound
2. Child with a closed head wound and multiple compound fractures of the arms and legs
3. Child with a simple fracture of the arm complaining of arm pain
4. Sobbing child with several minor lacerations on the face, arms, and legs

5. CLINICAL JUDGMENT: ANALYZE CUES
A client with gastroenteritis has been vomiting and having diarrhea for the past 3 days. On admission to the hospital, the client complains of weakness and some leg and abdominal cramping. The client's respirations are shallow and the pulse is thready. The client's cardiac rhythm on the monitor screen shows an additional prominent wave following each T wave, indicating the presence of U waves. The nurse considers the client's health problem, the effects and implications of losing fluid through vomiting and diarrhea for 3 days, analyzes the client cues, and interprets these cues as indicating an electrolyte imbalance, specifically hypokalemia.

6. CLINICAL JUDGMENT: ANALYZE CUES
A client with emphysema is hospitalized because of difficulty breathing. The client complains of headache and dizziness and is lethargic and disoriented. Arterial blood gas (ABG) results reveal the following: pH is 7.21, Paco, is 70 mm Hg, and HCO;- is 23 mEq/L (23 mmol/L). The nurse considers the client's health problem, the effects of the health problem on the respiratory system, analyzes the client cues including the ABG results, and interprets these cues as indicating an acid-base disturbance of respiratory acidosis without compensation.

7. CLINICAL JUDGMENT: ANALYZE CUES
A client arrives from the postanesthesia care unit (PACU) at 1300, and the nurse is monitoring vital signs.
1330. 1300
Temperature 37.2° C (98.9°. Temperature to be 36.8° C (98.2° F) orally
Heart rate 98 beats per minute Heart rate 118 beats per minute Respiratory rate 14 breaths Respiratory rate 18 breaths per minute
BP 142/78 mm Hg. BP 95/54 mm Hg
Oxygen saturation 95% on. Oxygen saturation 92% on
3 Lof oxygen via nasal. 3 L of oxygen via nasal cannula
On analysis of the data, the client's vital signs are showing a significant change, particularly the blood pressure, heart rate. and oxygen saturation levels. Given the significant change and considering the client had surgery, the nurse analyzes these cues as an indication of postoperative bleeding

8. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A client with acute kidney injury exhibiting signs of fluid volume excess has laboratory tests done that reveal decreased renal function and glomerular filtration rate. The nephrologist prescribes a fluid restriction. The nurse determines that a client need will be to alleviate thirst and generates solutions to meet this client need. The nurse includes the following measures in the plan of care to help relieve the client's thirst while adhering to the fluid restriction.
Chewing on gum
Sucking hard candy
Freezing fluids so that they take longer to consume
Adding lemon juice to water to make it more refreshing

Gargling with refrigerated mouthwash

9. CLINICAL JUDGMENT: TAKE ACTION
The nurse is performing a cardiovascular assessment and notes the presence of a blowing, swishing sound over the carotid artery. The nurse would take the following actions based on this finding:
When auscultating the client's carotid arteries, the nurse has noted a bruit, which indicates blood flow turbulence and potentially a blockage. A blockage in the carotid artery could decrease blood flow to the brain. Normally, a bruit is not pre-sent, so this finding necessitates the need for follow-up. The primary health care provider (PHCP) would be notified so that further assessment and testing could be done to determine the cause of this finding. The nurse would monitor the client's vital signs and neurological status for signs of altered blood flow to the brain. The nurse would also document the finding and that the PHCP was notified.

10 CLINICAL JUDGMENT: TAKE ACTION
The nurse leader is conducting an educational session for staff about the response plan in the event of a fire and includes the following priority actions to take.
RACE
1. Rescue and remove clients and staff who are in immediate danger.
2. Activate the fire alarm.
3. Confine the fire.
4. Extinguish the fire.
PASS
5. Pull the pin on the fire extinguisher.
6. Aim at the base of the fire.
7. Squeeze the extinguisher handle.
8. Sweep the extinguisher from side to side to coat the area of the fire evenly.

11. CLINICAL JUDGMENT: PRIORITIZE HYPOTHESES
A client is disoriented and unsteady and continually attempts to climb out of bed. Priority client needs include the followin
• Safety and fall prevention
• Room located near the nurses' station
• Orientation to the surroundings
• Bed or chair alarm activated
• Comfortable and safe position
• Personal belongings in reach
• Pain controlled
• Visual and auditory stimuli appropriate (i.e., clock, calen-dar, television, radio)
• Toileting routine established
• Exercise and ambulation schedule in place
• Nonskid socks or footwear, environment free of clutter and tripping hazards, nurse call system in reach

• Support persons present when possible

12. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse leader is conducting an emergency meeting for staff about the COVID-19 surge response plan and would plan to include the following points:
• Know the emergency response plan of the agency
• In the event of a disaster, the emergency response plan is activated immediately.
• Internal disasters are those that occur within the health care facility.
• External disasters, such as COVID-19, occur in the com. munity, and victims are brought to the health care facility for care.
• When the health care facility is notified of a disaster, the nurse would follow the guidelines specifed in the emer. gency response plan of the facility.
* Resources are allocated to respective units, such as protective equipment, client care equipment, and staff to care for clients with COVID-19.
• As part of the disaster plan, infection prevention and control protocols are instituted to mitigate the spread of the disease.

13. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse reviews the physician's medication orders for a client diagnosed with a seizure disorder.
Physician's Orders
Phenytoin o.2 g orally twice daily
The nurse prepares to administer the medication and reads the medication bottle, which states that each capsule is 100 mg. The nurse converts o. g to mg and determines that oz g is equal to 200 mg and prepares for the administration of 2 capsules.

14. CLINICAL JUDGMENT: TAKE ACTION
The nurse is assisting the surgeon in obtaining informed consent from a client for a scheduled surgical procedure.
The client signs the consent, but after the surgeon leaves the nursing unit, the client informs the nurse about being unclear about certain aspects of the surgical procedure. As it is a responsibility of the nurse to ensure that the client has understood the surgeon's explanation of the procedure, the nurse takes action and notifies the surgeon about the need for clarification before moving forward with surgical preparation.

15. CLINICAL JUDGMENT: TAKE ACTION
A client who had a right colectory calls the nurse and reports a popping feeling in the incisional area. The nurse removes the abdominal dressing to assess the wound and

notes that the incision line has opened and a loop of bowel is protruding from the wound. The nurse takes action and implements the following interventions:
Calls for help; asks that the surgeon be notified and that needed supplies be brought to the client's room.
• Stays with the client.
a Places the client in a low-Fowler's position with the knees bent.
• Covers the wound with a sterile normal saline dressing and keeps the dressing moist.
• Takes vital signs and monitors the client closely for signs of shock.
Prepares the client for surgery as necessary.
• Documents the occurrence, actions taken, and the client's response.

16. CLINICAL JUDGMENT: EVALUATE OUTCOMES
The client is being discharged from the emergency department after treatment for a severe sprain in the right ankle.
The client requires crutches for walking and has been instructed on the three-point gait. The nurse observes the client walking and determines that the client safely uses the crutches because the client is bearing weight on both crutches and then on the left leg, repeating the sequence.

17. CLINICAL JUDGMENT: TAKE ACTION
The nurse is performing an assessment on a postoperative client following creation of a colostomy. The client's vital signs are 99.6° F (37.5° C), heart rate 72 beats per minute, respirations 18 breaths per minute, blood pressure 122/78 mm Hg, oxygen saturation 93%. The client's abdomen is slightly distended, and bowel sounds are absent. A collection bag is attached to the client's skin. The nurse assesses the stoma and notes that it is dark blue in color. The nurse would take action and contact the surgeon because a stoma that is dark blue in color indicates a lack of blood supply and possible necrosis.

18. CLINICAL JUDGMENT:
GENERATE SOLUTIONS
A parent of a 3-year-old tells the clinic nurse that the child is rebelling constantly and having temper tantrums and that as parents they do not know what to do about it. Using Erik son's psychosocial development theory, the nurse generates solutions for the parents and plans to provide the following recommendations;
• Set limits on the child's behavior.
• Address the child's behavior when the child has a temper tantrum.
• Provide a simple explanation of why the behavior is unacceptable.

19. CLINICAL JUDGMENT: TAKE ACTION
The nurse is caring for a hospitalized preschool child who is very apprehensive. To promote comfort for the child, the nurse would take the following actions:

• Provide a safe and secure environment.
Take time to communicate with the child.
• Allow the child to express feelings such as anxiety, fear, or anger.
• Accept any regressive behavior.
Assist the preschooler with moving from regressive to appropriate behaviors.
• Encourage rooming-in with parents or leaving a favorite toy with the child.
• Allow mobility and provide play and diversional activities.
• Encourage interaction for the preschooler with other children of the same age if possible.
• Encourage the preschooler to be independent.
• Explain procedures simply on the preschooler's level.
• Avoid intrusive procedures when possible.

20. CLINICAL JUDGMENT: TAKE ACTION
The home care nurse is caring for an older dient who lives with her son and is physically and financially dependent on her son. The nurse notes multiple bruises on the chient's arms and asks the client how these bruises occurred. The de ent confides in the nurse that her son takes out anger on her sometimes. The nurse takes the following actions.
• Performs a thorough assessment of physical injuries.
• Provides confidentiality during the assessment with an empathetic and nonjudgrental approach.
Reports the abuse to the appropriate authorities and fol lows state and agency guidelines.
"Reassures the victim that they have done nothing wrong
* Assists the victim in developing self-protective and problem-solving skills.
Encourages the victim to develop a specific plan for safety (a fast escape if the violence returns) and for where to obtain help (hotlines, safe houses, and shelters) or to call the police (an abused person is usually reluctant to call the police).

21. CLINICAL JUDGMENT: TAKE ACTION
The nurse is performing an initial assessment on a pregnant adolescent, and the adolescent reports consuming small amounts of alcohol on a daily basis. The nurse would take the following actions:
• Consider that an adolescent pregnancy is high risk because of the immaturity of the reproductive system and the high-risk behaviors that some adolescents engage in.
• Provide information to the adolescent regarding the risks associated with drug and alcohol consumption during pregnancy.
• Explain to the adolescent that bacteria, nutrients, drugs, antibodies, and viruses can pass through the placenta to the fetus.
• Discuss measures that need to be taken to minimize exposure to substances such as alcohol that can cross the placental barrier and affect the health of the fetus. m Decide on an immediate and follow-up plan to address the high-risk behavior of consuming alcohol.

22. CLINICAL JUDGMENT: EVALUATE OUTCOMES
A client who is 6 weeks pregnant is having episodes of morning sickness. The clinic nurse provides information to the client about measures to take to alleviate the episodes of nausea and vomiting. The nurse determines that the client understands these measures when the client makes the following statements:
• "I should keep dry crackers at my bedside and eat them before I get up in the morning."
" "t would be best to eat smali, frequent meals through the
day."
• "I need to try to eat low-fat foods and especially avoid any fried foods or spicy foods."
• "Eating a protein snack at bedtime may help me."
" "I should try to drink fluids between meals. Drinking liquids at meals may fill my stomach too much and make me sick."
" * know that I can try sucking on hard candy, That might help."
• "If i feel I need to, I can ask my doctor about some medication that might help or other herbal remedies."

23. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse creates a plan of care for a client with preeclamp. sia with severe features who is receiving magnesium sulfate by intravenous infusion. The plan of care focuses on interventions if the client experiences an eclampsic event. The nurse includes the following interventions in the plan:
Remains with the client and calls for help
• Ensures an open airway, turns the client on the side, and administers oxygen by face mask at 8 to 10 L/minute
• Monitors fetal heart rate patterns
• Administers medications to control the seizures as prescribed
• After the seizure has ended, inserts an oral airway and suctions the client's mouth as needed
Prepares for delivery of the fetus after stabilization of the
client, if warranted
• Documents occurrence, client's response, and outcome

24. CLINICAL JUDGMENT: TAKE ACTION
The nurse is caring for a client in labor who is receiving an outocin infusion to induce labor. The nurse notes on the fetal monitor that the fetal heart rate repeatedly declines to 20 beats fr minute and persists at that level for at least 60 seconds before returning to taseline. The nurse identifies this pattern as variable decelerations and takes the following actions:
* Discontinues oxytocin infusion.
Changes the client's position,

Administers ovygen by face mask at $ to 10 L/minute and infuses intravenous (IV) fluids as prescribed.
• Identifes the cause of the variable decelerations.
• Prepares to initiate continuous electronic fetal monitoring with internal devices if not contraindicated.
• Prepares for cesarean delivery if necessary.
Documents the event, actions taken, and the client's response.

25. CLINICAL JUDGMENT: TAKE ACTION
The nurse is caring for a client who is in stager labor, trans tion phase, and is 8 cm dilated. The client tells the nurse de it feels as if something is coming out through the vagina.
The nurse notes on the fetal monitor that the fetal heart rate is slow and irregular, The nurse checks the client and sees the umbilical cord protruding from the vagina and takes the following actions.
Elevates the fetal presenting part that is lying on the cond by applying finger pressure with a sterile gloved hand to relieve cord pressure
•Places the client into extreme Trendelenburg's or mod-fied left lateral position or a knee-chest position
Stays with the client
Calls for assistance and asks another person to notify the obstetrical health care provider immediately
Administers oxygen, 8 to 10 L/minute, by face mask to
the client
• Wraps the umbilical cord loosely in a sterile towel saturated with warm sterile normal saline
• Monitors fetal heart rate and assesses the fetus for hy poxia
.
Prepares to start intravenous Aluids or increase the rate of administration of an existing appropriate solution
• Prepares for immediate birth via cesarean section
Documents the event, actions taken, and the client's response

26. CLINICAL JUDGMENT: ANALYZE CUES
The nurse is monitoring a postpartum client. The client appears pale and restless and the blood pressure is 100/60 mm Hg and pulse rate is 110 beats per min-ute. Baseline postpartum blood pressure was 122/80 mm Hg with pulse rate of 84 beats per minute. The nurse checks the lochial flow and notes that the perineal pad applied 15 minutes ago was saturated with blood that contained several small clots. The nurse analyzes these cues as indicating excessive bleeding.
If this occurred, the nurse would check the uterus for atony, massage it if necessary, and contact the obstetrician.

27. CLINICAL JUDGMENT: TAKE ACTION
A nurse is monitoring a client in the postpartum period
Three hours after the delivery of the newborn, the nurse notes that the client is restless and difficult to rouse. The client's color is ashen and skin feels cool and clammy. The nurse notes that the client's peripad and the underpad are saturated with bright red blood. The nurse calls for assistance and takes vital signs, which reveal a pulse of 128 beats per minute, shallow respirations at 24 breaths per minute, a blood pressure of 88/50 mm Hg, and a pulse oximetry reading of 90%. The nurse takes the following actions:
• Ensures a patent airway.
• Administers oxygen by nonrebreather face mask at 8 to 10
L/min.
• Notifies the obstetrician (OB); stays with the client and asks another nurse to contact the OB.
• Elevates the client's legs to at least a 3o-degree angle.
• Checks the uterus. If atonic, massages firmly to cause it to contract.
Starts an intravenous infusion per standing orders.
• Administers uterotonic medications (e.g., oxytocin, pros-taglandins) as prescribed to increase uterine tone.
• Provides additional or maintains an existing intravenous
(IV) infusion of lactated Ringer's solution or normal saline solution to restore circulatory volume (the client should have two patent IV lines; the second IV line should be a 16- to 18-gauge IV catheter).
* Monitors vital signs and inserts an indwelling urinary catheter to monitor perfusion of kidneys.
Administers blood or blood products as prescribed.
Administers emergency medications as prescribed
• Prepares for possible surgery or other emergency treatments or procedures.
• Records event, interventions instituted, and the client's response to interventions.
• Prepares for transfer to a critical care unit for stabilization and ongoing care and monitoring if required.

28. CLINICAL JUDGMENT: TAKE ACTION
The nurse is performing an initial assessment on a newborn and notes that the newborn is experiencing tremors. The nurse would take the following actions:
• Swaddle the newborn.
• Determine the cause immediately.
■Check for hypothermia or hyperthermia.
• Check for hypoglycemia and check other laboratory val. ues, specifically for hypocalcemia.
• Check for possible drug withdrawal.
• Contact the primary health care provider, and initiate treatment as prescribed.

29. CLINICAL JUDGMENT: EVALUATE OUTCOMES
The nurse has provided instructions to the parents of an infant about measures to take if the infant demonstrates signs of choking and cannot relieve the episode with cough. ing. The nurse asks the parents to demonstrate the procedure on an infant manikin. The nurse determines that the parents can safely and correctly relieve an obstruction based on the following observations of the parents working with the infant manikin.
• Sits or kneels with the manikin in the lap.
•Removes clothing from the manikin's chest if easily removed.
a Holds the manikin face down with the head lower than the chest while resting the manikin on the forearm. The manikin's head and jaw are supported with the hand. The forearm is rested on the thigh to support the manikin (Fig. 28.8).
• Delivers five back slaps between the manikin's shoulder blades using the heel of the other hand with sufficient force. Places the free hand on manikin's back while supporting the back of the manikin's head with the palm of the hand. Cradles the manikin between the two forearms.
Turns the manikin as a unit while supporting the head and neck.
Rests the forearm on the thigh while holding the manikin face up. Delivers five chest thrusts in the middle of the chest over the lower half of the sternum at a rate of 1 per second with enough force to relieve the obstruction.
Repeats the sequence until the obstruction is relieved.
Note: if the infant becomes unresponsive, the parents need to call for help and activate the emergency response system. Cardiopulmonary resuscitation (CPR) is initiated as necessary. Parents are taught not to perform blind finger sweeps.

30. CLINICAL JUDGMENT: TAKE ACTION
A maternity nurse is caring for a pregnant client who is receiving oxytocin to induce labor. The nurse notes absent variability on the fetal heart monitor and takes the following
actions
• Stops the oxytocin infusion,
• Turns the client on the side, stays with the client, and asks another nurse to contact the PHCP,
* Increases the flow rate of the intravenous (IV) solution that does not contain the oxytocin.
• Administers oxygen, 8 to 10 L/minute, by snug face mask.
Assesses client's vital signs; fetal heart rate and patterns; and frequency, duration, and force of contractions.
Documents the event, actions taken, and the response.

31. CLINICAL JUDGMENT: TAKE ACTION
A nurse is called to a neighbor's house when the neighbor frantically screams that their toddler climbed on a chair and spilled a bowl of hot soup on their chest. The actions that the nurse would take include the following:
a Protect the child from further harm and stop the burning

process.
• Assess for a patent airway.
Begin resuscitation measures if necessary using CAB-compressions, airway, and breathing.
Remove burned clothing and other restrictive items if not stuck to the skin.
• Cool the burned area under cool (not cold) running water or apply a clean cool, wet compress until the pain eases. a Cover the wound with a clean cloth (sterile dressings are
used on arrival to the health care facility).
Keep the child warm.
• Call emergency medical services as soon as possible for transporting the child to the emergency department.

32. CLINICAL JUDGMENT: TAKE ACTION
A child with hemophilia who has been in a motor vehicle crash is admitted to the pediatric unit. The nurse would take the following actions in the care of the child:
• Assess injuries.
• Check for bleeding
• Apply pressure for at least 15 minutes to any superficial bleeding areas.
m Monitor vital signs for indications of internal bleeding and hypovolemic shock.
• Place the child on bleeding precautions.
• Monitor for joint pain or joint bleeding.
• Treat joint bleeding with immobilization, elevation, and application of ice.
• Monitor the neurological status for signs of intracranial hemorrhage.
Monitor the urine for hematuria.
• Administer blood replacement factors as prescribed.

33. CLINICAL JUDGMENT: RECOGNIZE CUES
The nurse reviews the physical examination in the medical record of a 10-year-old child who has Hodgkin's disease with advanced lymph node and extralymphatic involvement. The nurse would recognize the following physical assessment findings as characteristic cues of this disease.
Physical Examination
Child complains of loss of appetite and nausea and abdominal pain. Parent states that the child has intermittent low-grade fevers with night sweats. Weight loss of 4 pounds in 1 month. Painless, firm, movable adenopathy in the cervical and supraclavicular areas. Hepatosplenomegaly present. Lymph node biopsy shows presence of Reed-Sternberg cells.

34. CLINICAL JUDGMENT: EVALUATE OUTCOMES
The nurse is evaluating the parents' understanding of treatment for their child who has phenylketonuria. The nurse determines that the parents understand the treatment based on the following statements.

• "The correct diet is the primary treatment for this prob-lem."
"We need to avoid giving our child foods high in protein, such as meats and dairy products, because they contain high levels of phenylalanine."
"Cereals, pastas and rice, fruits and vegetables are great for my child to eat."
"We need to read food labels closely because some foods contain aspartame, an artificial sweetener, and this contains phenylalanine."
• "Follow-up doctor appointments are really important for our child."

35. CLINICAL JUDGMENT: TAKE ACTION
A child who has gastroenteritis has experienced several episodes of diarrhea, developed fluid and electrolyte imbal. ances, and is lethargic. The child suddenly vomits. The nurse would take the following actions to prevent aspiration:
• Maintain a patent airway.
• Turn the child on the side (or sit the child upright).
• Ask another health care team member to obtain suctioning equipment.
• Check respiratory status and lung sounds.
• Check the character and amount of vomitus.
• Document the episode, including assessment findings and characteristics of the vomitus.
Notify the primary health care provider if aspiration is
suspected.

36. CLINICAL JUDGMENT: TAKE ACTION
A child is brought to the emergency department, and the parents tell the emergency department nurse that they think the child drank some cleaning fluid from a bottle that was under the kitchen sink. The emergency department nurse would take the following actions:
• Assess the child's airway, breathing, and circulation;
begin resuscitation measures as necessary.
• Terminate exposure to the poison.
• Identify the type and amount of poison ingested.
• Prepare to take measures as prescribed to prevent ab. sorption of the poison; measures depend on the type and amount of poison ingested and the time of the ingestion.
• Monitor the child closely, including vital signs and res-piratory, cardiovascular, and renal status.
• Document the occurrence, assessment findings, poison ingested, treatment measures, and the child's response.

37. CLINICAL JUDGMENT: TAKE ACTION

A nurse is attending a school-aged child's soccer game when a child is hit in the nose area with the soccer ball and is bleeding from the nose. The nurse takes the following actions to stop the bleeding:
• Approaches the child calmly
• Remains calm and keeps the child calm and quiet
• Assists the child to sit up and lean forward
• Applies continuous pressure to the nose with the thumb and forefinger for at least 10 minutes
• Inserts cotton or wadded tissue into each nostril, and applies ice or a cold cloth to the bridge of the nose if bleeding persists
• Arranges for transport of the child to the emergency department if the bleeding cannot be controlled; packing or cauterization of the bleeding vessel may be indicated

38. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A parent comes to the emergency department with a 10-year-old child. The parent reports that over the last 3 days the child has had difficulty breathing, a cough, and wheezing. The child has a history of asthma and is using a short-acting inhaled bronchodilator at home. The child reports using the inhaler more fre. quently these past few days than in the past and says it has not helped much at all. The child reports feeling some respiratory congestion symptoms; otherwise, the child denies exposure to any precipitants. The nurse assesses airway patency and respiratory status. Initial respiratory assessment findings reveal an oxygen saturation of 85% and a respiratory rate of 40 breaths/ min. The child is dyspneic, and wheezing is heard in the upper lobes of the lungs bilaterally. The nurse notifies the emergency department physician and plans for the following actions:
• Administering humidified oxygen by face mask
• Administering quick-relief (rescue) medications
• Initiating an intravenous (IV) line
• Administering corticosteroids
• Preparing the child for a chest radiograph
• Preparing to obtain a blood sample for determining arterial blood gas levels

39. CLINICAL JUDGMENT: TAKE ACTION
The nurse is assisting with a blood draw on an infant with tetralogy of Fallot. The infant is crying uncontrollably because of the trauma. Respirations become deep and rapid, and the infant becomes cyanotic. The nurse recognizes that the infant is experiencing a hypercyanotic episode and takes the following actions:
• Calms the infant and minimizes stimuli
• Places the infant in a knee-chest position
Contacts the primary health care provider or cardiologist
• Administers 100% oxygen as prescribed
• Administers morphine sulfate as prescribed

• Administers fluids intravenously as prescribed
• Documents the occurrence, actions taken, and the infant's response

40. CLINICAL JUDGMENT: ANALYZE CUES
The nurse arrives at 0700, performs an assessment on an
8-year-old child with glomerulonephritis, and notes the fol-lowing:
Nurse's Notes
Periorbital and facial edema, generalized edema
Hand and neck veins distended
Weight 37.2 kg (82 lb) increased from 34.5 kg (76 lb) recorded 24 hrs ago
Reports anorexia and some abdominal discomfort; not wanting to eat breakfast
Urinary output 30 mL since last evening; cloudy and cola-colored
Pale and sleepy
Temperature 99.2° F (37.3 C), pulse 122 beats per minute and bounding, dyspneic, respirations 24 breaths per min-ute, blood pressure 140/98 mm Hg
The nurse analyzes the assessment findings, determines that the child is experiencing fluid volume overload, and notifies the primary health care provider for prescriptions, which may include fluid and sodium restriction and the administration of diuretics.

41. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse is caring for a 10-year-old child who sustained a blunt head injury when accidentally hit with a baseball bat.
The child exhibits a significant decrease in level of conscious-ness, bradycardia, and decorticate posturing. The child is at risk for seizures, and the nurse creates a plan of care to initiate seizure precautions; the plan includes the following actions:
• Have suction equipment and oxygen available.
Raise the side rails on the bed.
• Pad the side rails and other hard objects.
• Clear the area of any hazards or hard objects.
• Place a waterproof mattress or pad on the bed.
• Alert caregivers to the need for seizure precautions or any other special precautions.

42. CLINICAL JUDGMENT: TAKE ACTION
A 12-year-old child falls off a trampoline in the school play-ground. The school nurse quickly arrives at the scene of the accident. The child is alert but crying and moaning in pain. The child states "I didn't hit my head but twisted my leg badly and it is really hurting, and I cannot move it." On assessment of the extent of the injury, the nurse notes an obvious deformity of the lower right leg, swelling, and the presence of bone protruding from an open wound. The nurse takes the following actions:
• Immobilizes the extremity
• Checks neurovascular status of the extremity
• Covers the wound with a sterile dressing (clean dressing if a sterile dressing is unavailable)
Elevates the injured extremity if possible

•Applies cold to the area
• Arranges for immediate transport to the nearest emergency department

43. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A hospitalized 7-year-old child is diagnosed with mumps.
The nurse would prepare for the following in the care of the child:
• Arrange for the child to be moved to a private room.
Ensure that standard precautions and droplet and contact precautions are instituted.
•Ensure that all health care personnel in contact with the child wear an Ngs respirator mask.
Ensure that all health care personnel in contact with the child wear gowns and gloves and perform hand hygiene before and after client contact.
• Ensure that the child rests.
• Provide soft foods that will not require chewing to alleviate parotid gland discomfort.
Apply hot or cold compresses to the neck to promote comfort.
•Apply warmth and local support with snug-fitting underpants to relieve orchitis.
•Monitor for signs of aseptic meningitis and report them to the primary health care provider if they occur.
• Instruct the parents in measures to prevent the transmission of the communicable disease.

44. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse is preparing to administer a medication that has an unpleasant taste to a hospitalized infant. To minimize ths unpleasant effect, the nurse plans to administer the mexica tion with the following method:
Draw the required dose into a syringe without the needie
• Place the infant sideways on the lap, placing the infants closest arm under the nurse's arm and behind the nurses back cradle the infant's head, and hold the infant's hand
* Place the syringe into the side and toward the back of the infant's mouth.
• Administer the medication slowis allowing the infant to swallow

45. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse is preparing to teach a client with an allergy to bee stings about how to respond in case of a sting. The nurse plans to include the following teaching points:
• Individuals who are allergic need to carry an epinephrine autoinjector for self-administration of intramuscular epinephrine if a bee or wasp sting occurs.
"After use of the epinephrine autoinjector, the individual needs to seek emergency medical attention.
• Individuals need to have two injectors available and obtain a replacement as soon as possible.

• Monitor for rebound anaphylaxis, because the reaction is not always a single one. In some cases, symptoms of the reaction return hours or days after one receives an epinephrine injection.
• Diphenhydramine can be taken to assist in alleviating symptoms.

46. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse is creating a plan of care for a client who had a topical glucocorticold prescribed to treat an inflammatory skin condition scattered over various skin areas. The nurse plans to avoid the following skin areas with the understanding that topical glucocorticoids can be absorbed greater in these permeable skin areas.
- Scalp
- Axilla
• Face
- Neck
- Eyelids
- Perineum
The nurse also includes in the plan of care to wash the area just before application of the topical glucocorticoid and to apply the medication sparingly in a thin film, rubbing the area gently. Lastly, the nurse plans to monitor for signs of systemic absorption of the medication.

47. CLINICAL JUDGMENT: TAKE ACTION
The nurse is caring for a hospitalized client who has a sealed radiation implant to treat cervical cancer. During morning care, the nurse turns the client to the side and sees the radiation seed lying under the client. The nurse takes the following actions:
m Encourages the client to lie still.
• Uses a long-handled forceps to retrieve the radioactive source.
• Deposits the radioactive source in a lead container.
• Contacts the radiation oncologist.
• Does not allow others to enter the room until the source is secured.
Documents the occurrence and the actions taken.

47. CLINICAL JUDGMENT: ANALYZE CUES
A dient with breast cancer had bilateral mastectomies 3 years ago. Since then the dient has been receiving radiation and chemotherapy treatments to treat the cancer. Over the past year diagnostic studes revealed metastasis to the lungs, bones and pelvis, and the liver. The client has been experiencing a great deal of pain and is receiving pain medi cation to control it. Today the client calls the clinic nurse and reports severe pain in the back, inability to sit up or move around, and that the pain medication is ineffective. The client is also experiencing muscle weakness and numbness and tingling in the legs. The nurse analyzes the cues and suspects that the client has spinal

cord compression. This is an oncological emergency, and the client needs medical attention immediately.

49. CLINICAL JUDGMENT: TAKE ACTION
The nurse in the chemotherapy department of an oncology center notes that a client who needs to receive a scheduled antineoplastic medication has an absolute neutrophil count
(ANC) of goo. The nurse recognizes this value as low, indi cating moderate neutropenia. Knowing that the client with neutropenia is at risk for infection, the nurse would contact the oncologist for further prescriptions before initiating the chemotherapy infusion. The chemotherapy infusion will probably be withheld and rescheduled after another follow-up ANC evaluation. The client needs to be instructed on neutropenic precautions to protect self from infection.

50. CLINICAL JUDGMENT: TAKE ACTION
A 35 year old client with ovarian cancer is receiving the first scheduled chemotherapy treatment with paclitazel at the cancer center. Thirty minutes after the infusion is started the client complains of severe shortness of breath, dizziness and a feeling of passing out, chest pain, and feeling itchy. The nurse recognizes these symptoms as an acute allergic response to the pacitaxel and immediately takes the following actions.
• Stops the medication
Contacts the Rapid Response Team and the oncologist
Administers oxygen
Raises the client's feet and legs, if not contraindicated
• Monitors respiratory status and vital signs
• Maintains the intravenous (IV) access with normal saline
Prepares for intubation if severe respiratory distress
develops
• Administers prescribed emergency medications, such as epinephrine
• Documents the event, actions taken, and the client's response

51. CLINICAL JUDGMENT: TAKE ACTION
A client with pheochromocytoma suddenly develops a severe headache, dizziness, and blurred vision. The nurse checks the client's vital signs and notes that the client's respiratory rate is 28 breaths per minute and the client is dyspneic. The blood pressure is 220/140 mm Hg. The nurse analyzes these cues, determines that the client is developing hypertensive crisis, and takes the following actions:
• Places the client in a semi-Fowler's position
" Notifies the primary health care provider
• Prepares to administer oxygen
• Starts an intravenous infusion of o.9% normal saline

(NS) solution and infuses it slowly to prevent fluid overload (which would further increase blood pressure)
• Administers intravenous medications to lower blood pressure
• Monitors the blood pressure frequently for a response, and monitors for complications

52. CLINICAL JUDGMENT: TAKE ACTION
A hospitalized client with diabetes mellitus complains of sweating and hunger, and the nurse notes that the client is pale and shaking. The nurse recognizes these cues as a hypoglycemic reaction. Using the 15/15 rule, the nurse takes the following actions:
• Checks the client's blood glucose level
• If the blood glucose is below 70 mg/dL. (3.9 mmol/L)
administers 15 g of a simple carbohydrate such as ½ cup of fruit juice or 15 g of glucose gel
Rechecks the blood glucose level in 15 minutes
If the blood glucose remains below 70 mg/dL. (3.9 mmol/L) administers another 15 g of a simple carbohydrate
Rechecks the blood glucose level in 15 minutes; if still below 70 mg/dL. (3.9 mmol/L), treats with an additional 15 g of a simple carbohydrate
Rechecks the blood glucose level in 15 minutes; if still below 70 mg/dL (3.9 mmol/L), treats with 25 to 50 ml of 50% dextrose intravenously or with 1 mg of glucagon subcutaneously or intramuscularly
After the blood glucose level has recovered, has the client ingest a snack that includes a complex carbohydrate and a protein
Documents the client's complaints, actions taken, and
outcome
• Explores the precipitating cause of the hypoglycemia with
the client
• If the client is experiencing an altered level of conscious-ness, bypasses oral treatment and starts with injectable glucagon or 50% dextrose

53. CLINICAL JUDGMENT: GENERATE SOLUTIONS
The nurse is reviewing the medical record of a hospitalized client scheduled later that day for a computerized tomography (CT) scan with an intravenous contrast dye. On review of the record the nurse notes that the client has diabetes mellitus and is taking metformin. The nurse prepares to take the following actions:
• Contact the radiology department to inform them that the client is taking metformin and for rescheduling the scan.
" Check with the primary health care provider about the time for withholding the metformin after the scan is com-pleted.
• Encourage fluid intake after the scan is completed.
• Check the serum creatinine level before resuming the metformin.

54. CLINICAL JUDGMENT: TAKE ACTION BOX
A 59-year-old client with ascites is scheduled to have a paracentesis. The nurse would take the following actions to prepare the client for the procedure:
Ensure that the client understands the procedure and that informed consent has been obtained.
- Obtain vital signs.
• Obtain weight.
• Assist the client to void and empty the bladder.
• Measure abdominal girth.
Position the client upright.

55. CLINICAL JUDGMENT: TAKE ACTION
The nurse is preparing a client for a liver biopsy. During review of the client's laboratory results, the nurse notes that the client's prothrombin time is 35 seconds and platelet count is 100,000 mm} (100 × 109 /L). Based on these find-ings, the nurse would take the following action:
• The client's prothrombin time is prolonged and the platelet count is low, placing the client at risk for bleeding.
Therefore, the nurse must immediately notify the primary health care provider of these abnormal laboratory values and place the client on bleeding precautions.

56. CLINICAL JUDGMENT: TAKE ACTION
The nurse is caring for a 6a-rear-old client with cirrhosis and encephalopathy. The physician prescribes lactulose for the dient. The nurse monitors the client for an effective response to the medication, notes that the client is hav. ing diarrhea, and notes that the ammonia laboratory result reveals a value of 75 mcg/dL (45 mcmol/Lj. The nurse takes the following actions:
• Reports the normal ammonia level
• Documents the effectiveness of the lactulose
• Monitors the status of diarrhea
• Monitors intake and output
Assesses the client for signs of dehydration
Assists the client with getting to the commode or bath.
room
" Assists the client with perineal care and personal hygiene
care after a bowel movement

57. CLINICAL JUDGMENT: TAKE ACTION
The nurse is caring for a client 2 days postoperative. The dent has a history of deep vein thrombosis and heart failure.
The dient also has difficulty with mobility and is obese.

The client calls the nurse and reports sudden chest pain, acough, and difficulty breathing. The client is anxious and restless. Respirations are 26 breaths per minute and shallow.
Pulse is 120 beats per minute. Blood pressure is go/66 mm Hg. Pulse oximetry reading is 89%. Crackles are heard on auscultation of the lungs. The nurse suspects the development of pulmonary embolism and takes the following actions:
Reassures the client and elevates the head of the bed
Notifies the Rapid Response Team and the PHCP
• Administers oxygen
• Prepares to obtain an arterial blood gas
• Prepares for laboratory studies to be drawn and diagnos-tie scanning
• Prepares for the administration of heparin therapy or other therapies
a Monitors vital signs and checks lung sounds
• Provides comfort and emotional support
• Documents the event, interventions taken, and the client's response to treatment

58. CLINICAL JUDGMENT: EVALUATE OUTCOMES
The nurse is monitoring a client who has been taking isoniazid for the past 4 months to treat tuberculosis for a response to the medication. The nurse determines that the client is experiencing nonviral hepatitis as an adverse effect based on the following client manifestations:
• Anorexia
• laundice
• Dark-colored urine
• Nausea
• Fatigue
- Weakness

59. CLINICAL JUDGMENT: ANALYZE CUES
The nurse is caring for a client who had cardiac surgery 24 hours ago. The client has had a urine output averaging 20 mL/hr for 2 hours. The client received a single bolus of 500 mL of intravenous fluid. Urine output for the subsequent hour was 25 ml. Daily laboratory results indicate that the blood urea nitrogen level is 45 mg/dL (16 mmol/L) and the serum creatinine level is 2.2 mg/dL (194 mcmol/L).
The nurse analyzes these findings and interprets that the client is experiencing acute kidney injury and notifies the surgeon.

60. CLINICAL JUDGMENT: ANALYZE CUES BOX
The nurse is caring for clients in the telemetry unit and notes that a client with sinus rhythm has a premature ventricular contraction that falls on the T wave of the preceding beat. The client's rhythm suddenly changes to one with no P waves, no definable QRS complexes, and coarse wavy lines of varying amplitude. The nurse

analyzes these findings and determines that the client is experiencing ventricular fibrillation. The nurse would immediately initiate
CPR, call the Rapid Response Team, and prepare for defibrillation.

61. CLINICAL JUDGMENT: TAKE ACTION
The nurse is monitoring a hospitalized client who is being rested for a diagnosis of heart failure. The client is on a andac monitor and oxygen at 2 L/minute via nasal cannula the dent calls the nurse and reports severe dyspnea. On assessment the nurse notes that the client's heart rate is 128 beats per minute and respirations are 24 breaths per minute.
The dient is anious and restless, is sweating profusely, and the dent's sion is cool and clammy. Wheezing and crackles are heard on auscultation of the lungs, and the client is expectorating blood tinged frothy sputum. Pulse oximetry mading is 89%. The nurse takes the following actions:
* Places the client in a high-Fowler's position.
Says with the client and asks another person to contact the primary health care provider.
Ensures orygen administration and increases flow rate or method of administration as prescribed.
Ensures that an intravenous (IV) access device is in place.
Prepares for the administration of a diuretic and mor-shine sallate.
Inserts a Foley catheter as prescribed.
• Prepares for intubation and ventilator support, if required.
* Documents the event, actions taken, and the client's response

62. CLINICAL JUDGMENT: EVALUATE OUTCOMES
The nurse is evaluating the condition of a client after peri-cardiocentesis performed to treat cardiac tamponade. The nurse determines that the procedure was effective when noting the following, when comparing preprocedure and postprocedure assessment findings.
• Clear breath sounds
• Increased blood pressure
• Normal jugular veins
• Decreased central venous pressure
• Signs of increased cardiac output (blood pressure and pulse rate and rhythm normal for the client, strong peripheral pulses; no chest pain, dyspnea, or syncope)

63. CLINICAL JUDGMENT: TAKE ACTION
The nurse is caring for a hospitalized client with coronary ar. tery disease. The client calls the nurse and reports substernal crushing chest pain that radiates to the left arm. The nurse takes the following actions:

• Quickly assesses the client, specifically characteristics of pain, heart rate and rhythm, and blood pressure (BP)
• Administers a nitroglycerin tablet sublingually
• Stays with the client
• Reassesses the client in 5 minutes
• Administers another nitroglycerin tablet sublingually if pain is not relieved and the BP is stable
• Reassesses the client in 5 minutes
• Administers a third nitroglycerin tablet sublingually if pain is not relieved and the BP is stable
• Reassesses in 5 minutes; contacts the PHCP if the third nitroglycerin tablet does not relieve the pain Documents the event, actions taken, and the client's response to treatment

64. CLINICAL JUDGMENT: ANALYZE CUES
The nurse is caring for a hospitalized client with a history of heart failure and a diagnosis of urinary tract infection. On assessment, the nurse notes that the client's urine output has decreased to 15 mL/hour and that the blood pressure has increased to 190/110 mm Hg. Auscultation of lung sounds reveal fine crackles and wheezes in the lung bases bilaterally. The client is dyspneic and has jugular vein distention and peripheral edema. The nurse analyzes the cues and interprets the findings as indicating possible acute kidney injury and fluid overload.

65. CLINICAL JUDGMENT: TAKE ACTION
The nurse is monitoring a client during a hemodialysis treat. ment when the client complains of chest pain and difficulty breathing. The nurse notes that the client's pulse rate is 110 beats per minute and the blood pressure is 98/60 mm Hg.
Cyanosis is noted around the lips and the pulse oximetry reading is 88%. The nurse suspects an air embolism and takes the following actions:
• Stops the hemodialysis, and does not reinfuse blood
• Turns the client on the left side, with the head down (Trendelenburg's position).
• Stays with the client and asks another person to notify the
PHCP and the Rapid Response Team
• Administers oxygen
Assesses vital signs and pulse oximetry
•Documents the event, actions taken, and the client's response

66. CLINICAL JUDGMENT: RECOGNIZE CUES
A client with acute cystitis has been prescribed cip rofloxacin. The client calls the nurse at the health care clinic to report dizziness and light headedness and that vision is blurred. The client tells the nurse about feeling really depressed and needing to keep all

of the shades and curtains closed in the house because the light is really bothering the eyes. The nurse recognizes that the client may be experiencing central nervous system effects from the medication. The nurse would instruct the client to withhold the medication and contact the primary health care provider (PHCP).

67. CLINICAL JUDGMENT: TAKE ACTION
A client arrives in the emergency department after sustaining a chernical splash to the eye. The client tells the nurse that a bottle of nail polish remover fell off the counter when tending over to open a cabinet and that the polish remover splashed into the right eye. The client reports that the eye was inmediately flushed for about 15 minutes with tap water; men the client was brought immediately to the emergency denartment. On arrival to the emergency department, the nurse takes the following actions:
* Quickly assesses the client and visual acuity.
Checks the pit of the eye. Normal ph is approximately
Imigates the eye continuously, until the pH is at an ac-castable level.
Cantacts the ophthalmologist.
Documents the event, actions taken, and the client's response.

68. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A 79-year-old client who requires the instillation of eye drops 3 times daily tells the nurse about living alone and concern about the ability to administer the drops because of shaky hands. The nurse creates a plan of care and generates solutions that include the following;
a Assist with the arrangement of a home care nurse to as-
sess the client and the home situation,
• Explore the possibility that a friend, neighbor, or family member can be taught the technique and administer the dient's eye drops.
• Explore potential adaptive equipment that positions the bottle of eye drops directly over the eye to facilitate ease for the client to instill the eye drops.

69. CLINICAL JUDGMENT: ANALYZE CUES
Health History
The nurse is monitoring a client who sustained a head injury after being hit in the side of the head with a baseball bat. The client was admitted to the neurological unit at 1300.
Nurses' Notes
1300: Alert and oriented and complaining of a headache as
3/10 on a 1 to 10 pain intensity scale.
Moving all extremities, pupils are equal and reactive, PER.
RLA. Glasgow Coma Scale is 15.
1400: Restless. Pupils: slow to react. Glasgow Coma Scale is 11.
Vital Signs

1300: Temperature 98.8° F (37.1° C), pulse 82 beats per minute, respirations 20 breaths per minute and regular, blood pressure 130/88 mmHg.
1400: Temperature 100.8° F (38.2° C), pulse 60 beats per minute, respirations 18 breaths per minute and irregular, blood pressure 150/68 mmg.
The nurse analyzes the cues and notes the changes in the client. The nurse determines that the client's condition has deteriorated and is indicative of increased intracranial pressure

70. CLINICAL JUDGMENT: TAKE ACTION
The nurse notes that a hospitalized client who experienced a stroke is sitting in a chair and is leaning to the left with one arm caught in the side of the chair seat. The nurse suspects that the client is experiencing unilateral neglect syndrome and takes the following actions:
• Checks the dient for signs of injury and repositions the dient
*Provides for a safe environment for the client
• Teaches the client to use both sides of the body and to attend to the affected side first
Asks the client if there is difficulty with sight and if so, teaches the client to turn the head from side to side to expand the visual field

71. CLINICAL JUDGMENT: TAKE ACTION
A client with a traumatic brain injury experiencing restless. ness and agitation because of pain is receiving morphine sulfate. On assessment of the client the nurse measures the respiratory rate and notes it to be 10 breaths/ min. The nurse takes the following actions:
• Withholds the morphine sulfate
• Stays with the client
• Monitors pulse oximetry reading and vital signs frequent-ly, especially respirations
• Administers oxygen
• Administers naloxone per protocol prescription
• Contacts the primary health care provider
• Documents assessment findings and actions taken

72. CLINICAL JUDGMENT: ANALYZE CUES
The nurse is caring for a hospitalized client who sustained a femur fracture in a motor vehicle crash and is placed in balanced suspension traction to approximate the fracture. The client calls the nurse and complains of sudden chest pain and difficulty breathing. The client is restless and confused, is coughing, and the nurse hears bilateral crackles in the lungs. The nurse analyzes these cues and suspects a fat embolism.

CLINICAL JUDGMENT: TAKE ACTION

The nurse employed in an industrial plant is called to an accident site in the plant in which an employee amputated an index finger on an electric saw. The nurse takes the following
actions:
• Obtains emergency medical assistance (calls 911)
• Stays with the victim
• Checks the amputation site and applies direct pressure with gauze or cloth. (Do not remove applied pressure dressing to prevent dislodgment of a formed clot.)
• Flevates the extremity above heart level
• If a finger (or fingers) was amputated, places it in a water-tight, sealed plastic bag; places the bag in ice water (not directly on ice); and transports the bag to the emergency department with the victim

73. CLINICAL JUDGMENT: TAKE ACTION
A client is seen in the health care clinic complaining of muscle spasms following a back injury that occurred when moving furniture at home. The primary health care provider suggests cyclobenzaprine to relieve the muscle spasms. The nurse reviews the client's medical record and notes that the client is currently taking phenelzine to treat depression. The nurse would take the following actions:
• Seek health information from the client and confirm that the client is currently taking phenelzine
• Notify the primary health care provider that the client is taking a monoamine oxidase inhibitor, a contraindication to taking cyclobenzaprine
• Document the information and that the primary health care provider was notified

74. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A client visits the health care clinic and tells the nurse that the family is planning a backpacking camping up to the mountains for the weekend. The dient is concerned about the possibility of exposure to ticks, getting bit by a tick, and dew aping Lyme disease. The nurse develops a disease prevent plan with the client and includes the following in the plan:
* Reduce exposure to ticks as much as possible because this is the best way to prevent Lyme disease
• Spray insect repellent containing DEET sparingly on stin or clothing.
Avoid wearing darker clothing because lighter-colored clothing makes spotting ticks easier.
Wear long-sleeved tops and long pants, closed shoes, and a hat or cap.
• Pull socks up and over the pant legs to prevent ticks from entering under clothing.
" Apply permethrin to camping gear such as tents because
it will protect from ticks for several hours.
*If possible, avoid heavily wooded areas or areas with thick underbrush.
Walk in the center of trails.
Bring fine-tipped tweezers if tick removal is necessary and antiseptic solution for cleaning the bite area.

Examine clothes and the body frequently for the presence of ticks. If a tick is seen, remove it before it attaches to the skin. If it has attached, remove it with fine-tipped tweezers and clean the area with an antiseptic. Grasp the tick as close to the skin's surface as possible, and pull upward with a steady, even pressure Avoid burning a tid from the skin because this could spread infection.
from the skin because this could spread infection.
• If bringing a pet, check the pet for ticks. Have pets wear tick collars, and inspect them frequently. Avoid sleeping closely with a pet.

75. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A hospitalized client who is receiving ceftriaxone to treat an infection develops severe diarrhea. The nurse prepares a plan of care for the client and includes the following in the plan:
• Place the client on contact precautions.
- Assess and monitor for signs of fluid and electrolyte imbalances
•Encourage the intake of fluids such as water, broth, sugarless fruit juices, or oral rehydration drinks, avoiding beverages high in added sugars and those that contain caffeine such as coffee, tea, and colas because they will worsen the condition.
- Avoid fatty and spicy foods because they will worsen the condition.
•Contact the primary health care provider (PHCP) for a prescription for an antidiarrheal medication: some PHCPs prefer not to use antidiarrheals because they can interfere with the body's ability to eliminate toxins and lead to complications.
interfere with the body sability to eliminate toxins and lead to complications.
• Ask the PHCP about the use of probiotics because they can rebalance the healthy bacteria in the client's digestive tract.
- Monitor intake and output, and document the client's response to treatment.

76. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A nurse is assisting a client to apply learned coping mecha nisms to decrease anxiety, and is discussing how these skills should be applied in order of priority. The nurse would instruct the client, as a priority, to first identify the source of the anxiety. Next, the nurse would explore with the client the various methods to reduce the anxiety, such as relaxation methods.

77. CLINICAL JUDGMENT: EVALUATE OUTCOMES
A nurse is working with a client and evaluating the client's constructive use of defense mechanisms as a coping mecha. nism. A defense mechanism is a coping mechanism used in an effort to protect oneself from feelings of anxiety. The client may use a defense mechanism as a protection from anxiety. As anxiety increases and becomes overwhelming for the client, the defense mechanism protects the ego, thereby decreasing the anxiety. The nurse would facilitate appropriate and constructive use of the defense mechanism that the client uses to protect self, and would evaluate whether the mechanism used by the client is effective or creates additional distress, never criticizing the client's behavior during the encounter.

78. CLINICAL JUDGMENT: TAKE ACTION
The nurse working at a mental health care facility is assisting a dient with managing an acute anxiety attack, and takes the following actions to ensure safety:
• Provides a calm environment, decreases environmental stimuli, and stays with the client
• Asks the client to identify what and how they feel
Encourages the client to describe and discuss their feelings
Helps the client identify the causes of the feelings if they are having difficulty in doing so
" Listens to the client for expressions of helplessness and hopelessness
" Documents the event, significant information, actions taken and follow-up actions, and the client's response

79. CLINICAL JUDGMENT: TAKE ACTION
A client with schizophrenia is experiencing visual hallucina tions. The nurse takes the following actions:
• Monitors for hallucination cues and assesses content of hallucinations
• Intervenes with one-on-one contact
• Decreases stimuli or moves the client to another area
Avoids conveying to the client that others also are experi encing the hallucination
Responds verbally to anything real that the client talks about
• Avoids touching the client
• Encourages the client to express feelings
• During a hallucination, attempts to engage the client's attention through a concrete activity
• Accepts and does not joke about or judge the client's behavior
• Provides easy activities and a structured environment with routine activities of daily living
• Monitors for signs of increasing fear, anxiety, or agitation
• Decreases stimuli as needed
• Administers medications as prescribed

80. CLINICAL JUDGMENT: RECOGNIZE CUES
The nurse is monitoring a client in a psychiatric mental health facility. The client is receiving treatment for opioid addiction, and the nurse monitors for signs of withdrawal.
The nurse recognizes cues associated with opioid withdrawal when the following assessment findings are noted: tachycardia, diaphoresis, restlessness, dilated pupils, bone and joint aches, rhinorrhea and lacrimation, diarrhea and vomiting, tremors, yawning, anxiety or irritability, and piloerection.

81. CLINICAL JUDGMENT: TAKE ACTION
The nurse working in the emergency department suspects physical abuse of an 84 year-old client by the client's sig. nificant other. To ensure client safety, the nurse takes the following actions:
• Assesses and treats the wounds.
* Ensures that the victim is removed from the threatening environment.
Adheres to mandatory abuse reporting laws
• Notifies the caseworker of the situation,
• Documents the occurrence, findings, actions taken, and the victim's response.

82. CLINICAL JUDGMENT: TAKE ACTION
A victim of rape has just arrived at the emergency depart ment. The emergency department nurse takes the following actions:
Performs the victim's assessment in a quiet, private area Makes a referral to the sexual assault/domestic violence (SADV) nurse as appropriate
Stays with the victim and provides client safety
Assesses the victim for physical injuries and treats as ap propriate
Assesses the victim's stress level before performing treat ments and procedures
Explains to the victim why showering, bathing, douching. or changing clothing cannot be done until an examination is performed
Obtains written consent from the victim for the examina-tion, photographs, laboratory tests, release of informa. tion, and laboratory samples
Assists with the pelvic or other examination and obtains specimens to detect bodily fluids of another (the pelvic examination may trigger a flashback of the attack: offers a shower and fresh clothing to the victim after the examination
Preserves any evidence
Treats physical injuries and provides client safe
Administers prescribed medications
• Documents all events in the care of the victim
• Reinforces to the victim that surviving the assault is most important; if the victim survived the rape, then the victim did exactly what was necessary to stay alive
• Refers the victim to crisis intervention and support groups

83. CLINICAL JUDGMENT: TAKE ACTION
The nurse receives a report from the emergency medical service (EMS) technicians. The EMS technicians inform the emergency department nurse that the client is suspected of a tricyclic antidepressant overdose. Based on this information, the nurse takes the following actions:
• Checks airway and maintains a patent airway.
• Administers oxygen and ventilation (as required)
• Checks vital signs and initiates cardiac monitoring.
• Obtains an electrocardiogram.
• Prepares for gastric lavage with activated charcoal if within 2 hours of ingestion.
• Administers intravenous fluids as prescribed

• Prepares to administer medications as prescribed to reverse the effects of the tricyclic antidepressant.
* Documents the event, actions taken, and the client's response.

84. CLINICAL JUDGMENT: GENERATE SOLUTIONS
A client has been taking alprazolam on a long-term basis for the treatment of anxiety. The psychiatric mental health nurse practitioner (PMHNP) has informed the nurse that the medication will be discontinued and that the client needs instructions about tapering off the medication. The nurse plans to include the following instructional points in the teaching plan:
• To taper the dose gradually over 2 to 6 weeks
• That abrupt or too rapid withdrawal can result in restlessness, irritability, insomnia, hand tremors, abdominal muscle cramps, sweating, vomiting, or seizures
• That if any manifestations occur during tapering, to notify the PMHNP immediately

85. CLINICAL JUDGMENT: TAKE ACTION
The nurse is changing a client's central venous catheter dressing. After removal of the dressing, the nurse notes redness at the insertion site and some white drainage. The nurse takes the following actions in the care of the client:
• Checks vital signs
• Checks the most recent white blood cell count
• Notifies the primary health care provider
• Prepares to remove the catheter and for possible restart at a different location
• Cuts the tip of the catheter off after removal and sends it to the laboratory for culture
• Prepares the client for obtaining blood cultures
• Prepares for antibiotic administration
• Documents the occurrence, the actions taken, and the client's response

86. CLINICAL JUDGMENT: TAKE ACTION
A client receiving a unit of packed red blood cells suddenly complains of chills and a backache. The client also tells the nurse about feeling itchy, and the nurse notes a neck and chest rash. The nurse takes the following actions in the care of the client:
Stops the transfusion
• Changes the intravenous (IV) tubing down to the IV site and keeps the IV line open with normal saline
• Checks vital signs
• Notifies the primary health care provider and blood bank
• Stays with the client, observing signs and symptoms and monitoring vital signs as often as every 5 minutes
• Prepares to administer emergency medications as prescribed and performs cardiopulmonary resuscitation if needed
• Obtains a urine specimen for laboratory studies and obtains specimens for any other laboratory studies as prescribed

• Returns blood bag, tubing, attached labels, and transfusion record to the blood bank
Documents the occurrence, actions taken, and the client's response

87. CLINICAL JUDGMENT: ANALYZE CUES
A client who sustained a spinal cord injury above the level of
T6 suddenly complains of a severe throbbing headache. The nurse notes that the client's blood pressure is 190/120 mm Hg and the heart rate is 54 beats per minute. The client's face is flushed and the client is sweating and has goose bumps.
The nurse considers the client's health problem, a spinal cord injury, and the complications associated with an injury above the level of T6. The nurse analyzes the client's presentation and connects these cues to the complication, autonomic dysreflexia.

88. CLINICAL JUDGMENT: TAKE ACTION
A dient is brought to the emergency department by the spouse, who reports that the two were visiting family when the client began to have difficulty breathing and felt that the throat was closing. The spouse reports that the client is allergic to cats and that the family members they were visiting have three cats. The spouse notes that although the cats were in the cellar during their visit, the cat dander presented a problem. The emergency department nurse takes the following actions in the care of the client:
• Quickly assesses respiratory status and ensures a patent airway
• Administers resuscitation measures as necessary
• Seeks out the emergency department physician and calls the Rapid Response Team
" Administers oxygen
• Initiates an intravenous (IV) line and infuses normal saline
a Prepares to administer diphenhydramine, epinephrine, and possibly corticosteroids
Documents the event, actions taken, and the client's response