

Fundamentals of Nursing Study Guide

Assessment: - ANSWER>>collecting vital signs, pain levels, other signs/ symptoms

Diagnosis: - ANSWER>>nurse makes a nursing diagnosis based on assessment of patient; not a medical diagnosis

Planning: - ANSWER>>nurse comes up with client-centered goals; need to be measurable (client will ambulate 10 meters 3x daily for 2 wks)

Implementing: - ANSWER>>following through with plan that was developed for the patient

Evaluation: - ANSWER>>goal was met, partially met, not met; how effective the plan was for the patient and what should be changed for the patient

Normal range for temperature - ANSWER>>96.8-100.4

Normal range for pulse - ANSWER>>60-100

Normal range for respirations - ANSWER>>12-20

Normal range for BP - ANSWER>>100/60-140/90

Normal range for pulse ox. - ANSWER>>>95%

SOLER - ANSWER>>sit close, observe, lean forward, eye contact, relax

Types of pain - ANSWER>>acute, chronic, cancer, by inferred pathology, idiopathic

Pain threshold - ANSWER>>level of stimulus needed to produce the perception of pain

Pain tolerance - ANSWER>>amount of pain a patient endures without its interference of ADLs

Factors influencing pain - ANSWER>>age, fatigue, genes, neurological functions, social factors, spiritual factors, psychological factors, cultural factors

Behavioral responses to pain - ANSWER>>clenching teeth, holding painful part, bent posture, grimaces, cries or moans, restlessness, frequent requests of the nurse; confused patient may not show reaction

Pharmacological pain relief - ANSWER>>analgesics (NSAIDS & non-opioids, opioids, adjuvants)

Answer Key 36 Fundamentals Nursing Study Guide

SJ Ball



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students care plans have been expanded to more clearly explain assessment findings leading to nursing diagnoses as well as evaluation of outcomes

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