



## PN1 Final Exam Review

A comprehensive review of key nursing concepts and practice questions for the PN1 final examination. This presentation covers patient advocacy, clinical decision-making, and essential nursing interventions across various healthcare scenarios.

# Exam Overview

**99**

## Questions

Comprehensive assessment covering multiple nursing domains

**5**

## Key Areas

Patient advocacy, clinical assessment, interventions, ethical considerations, and safety

**100%**

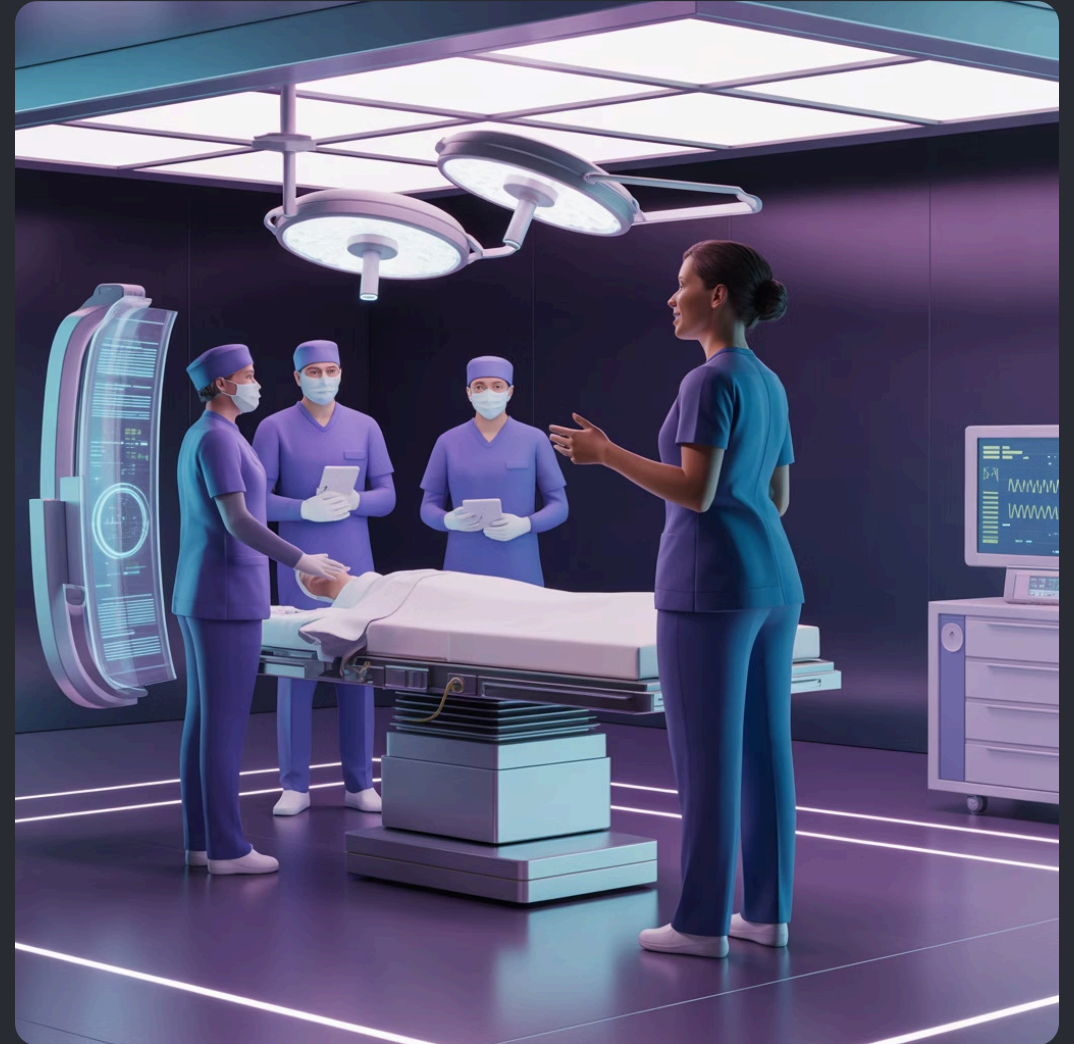
## Pass Goal

Complete understanding of nursing principles and their application

# Patient Advocacy

Patient advocacy is a fundamental nursing responsibility that involves protecting patients' rights and ensuring their needs are met. The circulating nurse in the operating room demonstrates advocacy by:

- Keeping the operating room door closed at all times
- Maintaining patient privacy and dignity
- Ensuring sterile technique is followed
- Speaking up when patient safety is at risk



# Clinical Prioritization

Nurses must prioritize care based on patient needs. When receiving multiple requests for assistance, the nurse should prioritize based on urgency and potential for harm.

1

## Highest Priority

Patient running out of money and cutting insulin dose in half - this represents an immediate health risk that could lead to diabetic crisis

2

## Secondary Priorities

Assess other patient needs based on potential for harm, urgency, and available resources

3

## Appropriate Referrals

Connect patients with social workers or community agencies when needs extend beyond clinical care

# Managing Medication Side Effects

## Constipation with Morphine

Opioid-induced constipation is a common side effect that requires proactive management. Nursing interventions include:

- Ensuring adequate hydration (8 glasses of water daily)
- Promoting sufficient dietary fiber through fruits and vegetables
- Encouraging mobility as tolerated
- Monitoring bowel movements



# Age-Related Physiological Changes

## **Thermoregulation**

Older adults have diminished ability to regulate body temperature due to slower metabolic rates

## **Cardiovascular**

Reduced cardiac output and elasticity of blood vessels

## **Respiratory**

Decreased lung elasticity and vital capacity

## **Renal**

Reduced filtration rate and concentration ability

Understanding these changes helps nurses provide appropriate care and education for older adults.





## Post-Anesthesia Assessment

The PACU nurse must conduct thorough cardiovascular assessments, including monitoring for:

- Atrial fibrillation on cardiac monitor
- Apical pulse rate (92 bpm noted)
- Peripheral pulses (absent dorsal pedal pulse in right foot)
- Blood pressure fluctuations
- Signs of bleeding or fluid imbalance

# Neutropenic Precautions

## Safe Food Choices

Patients with compromised immune systems require special dietary considerations to prevent infection. Safe fruit and vegetable options include:

- Canned pears (commercially processed)
- Cooked corn (heat-treated to kill microorganisms)
- Other thoroughly cooked or processed foods



## Canned Foods

Commercial processing eliminates pathogens



## Cooked Foods

Heat treatment kills microorganisms



## Avoid Raw

Uncooked produce may harbor bacteria



# Managing Opioid-Induced Respiratory Depression

When a patient develops respiratory depression (rate of 6 breaths/minute) after receiving hydromorphone 2mg IV, the nurse should:

1. Immediately notify the prescriber
2. Prepare to administer naloxone (opioid antagonist)
3. Continue to monitor vital signs
4. Have emergency equipment ready



# Types of Pain

## Visceral Pain

Originates from internal organs, described as severe abdominal pain



## Neuropathic Pain

Burning, sharp, shooting pain from nerve damage



## Breakthrough Pain

Pain that occurs despite around-the-clock medication



## Somatic Pain

Localized pain from skin, muscles, and bones



# Anaphylactic Reactions

Anaphylaxis to bee or wasp stings can be life-threatening. Key manifestations include:

## Respiratory

- Respiratory distress
- Bronchospasm
- Laryngeal edema

## Cardiovascular

- Hypotension
- Tachycardia
- Shock

## Neurological

- Deterioration in mental status
- Anxiety
- Loss of consciousness

Immediate intervention with epinephrine is essential for severe reactions.



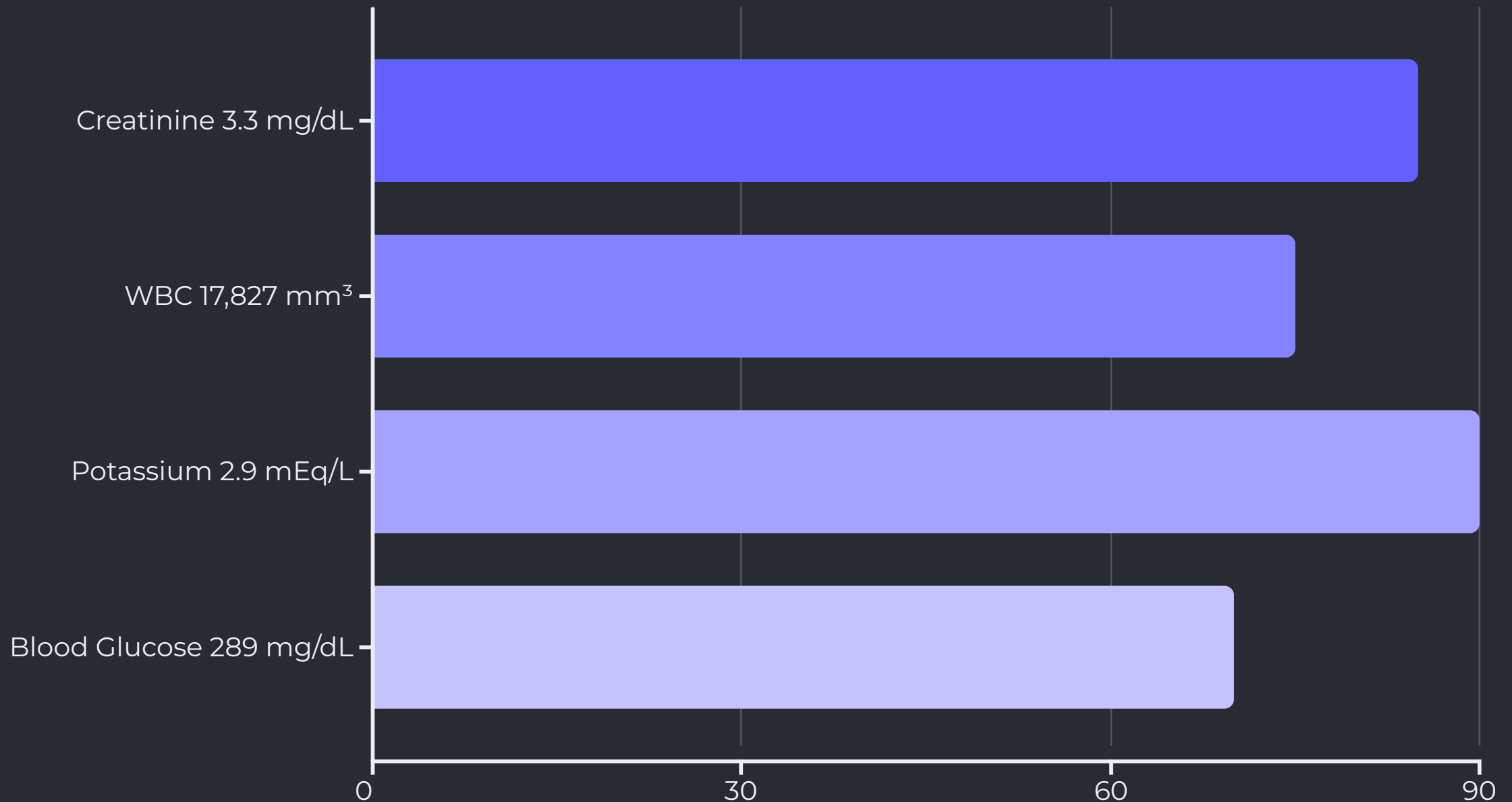
## EMTALA Compliance

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to:

- Provide medical screening examinations to all patients seeking emergency care
- Stabilize emergency medical conditions before considering financial status
- Transfer patients only when medically appropriate

Proper compliance example: A patient with chest pain is triaged directly to a room for evaluation, with registration information obtained after stabilization.

# Critical Lab Values



These abnormal values should be reported to the provider immediately as they indicate significant physiological disturbances that could affect surgical outcomes.

# Psychosocial Needs of Immobilized Patients

Immobilization can significantly impact a patient's psychological well-being. Nurses should address these needs through:

- Collaborative care planning: "Let's discuss the routine to see if there are any changes we can make"
- Providing meaningful activities and social interaction
- Ensuring environmental stimulation
- Maintaining dignity and autonomy



# Types of Immunity



## Active Immunity

Body produces its own antibodies after exposure to antigens (through infection or vaccination)



## Passive Immunity

Antibodies are transferred from another source (IV immunoglobulin G provides temporary passive immunity)



## Natural Passive

Antibodies transferred from mother to infant through placenta or breast milk



# Infant Safety

Parents must understand developmental milestones and associated safety risks. A mother demonstrates understanding of infant safety when she states:

"My baby loves to play with his crib gym but I took it away from him."

This shows awareness that as infants develop mobility skills, previously safe items may become hazards.



# Advance Directives and Legal Authority

## Legal Precedence

When a male client with terminal illness is unconscious, his sister who is the durable power of attorney and healthcare proxy has legal authority over his wife regarding code status.

## Healthcare Proxy

A legally appointed individual who makes healthcare decisions when the patient is unable to do so.

## Durable Power of Attorney

Legal document that designates an agent to make healthcare decisions when the patient lacks capacity.

# Emergency Interventions: Hypothermia

## Priority Nursing Intervention

For a patient suspected to be hypothermic, the priority nursing intervention is to:

- Remove wet clothes immediately
- Prevent further heat loss
- Begin passive rewarming
- Monitor core temperature



# Acid-Base Balance

**7.49**

**pH**

Elevated pH indicates alkalosis

**32**

**PaCO<sub>2</sub> (mmHg)**

Low PaCO<sub>2</sub> indicates respiratory alkalosis

**21**

**HCO<sub>3</sub> (mEq/L)**

Normal bicarbonate indicates partial compensation

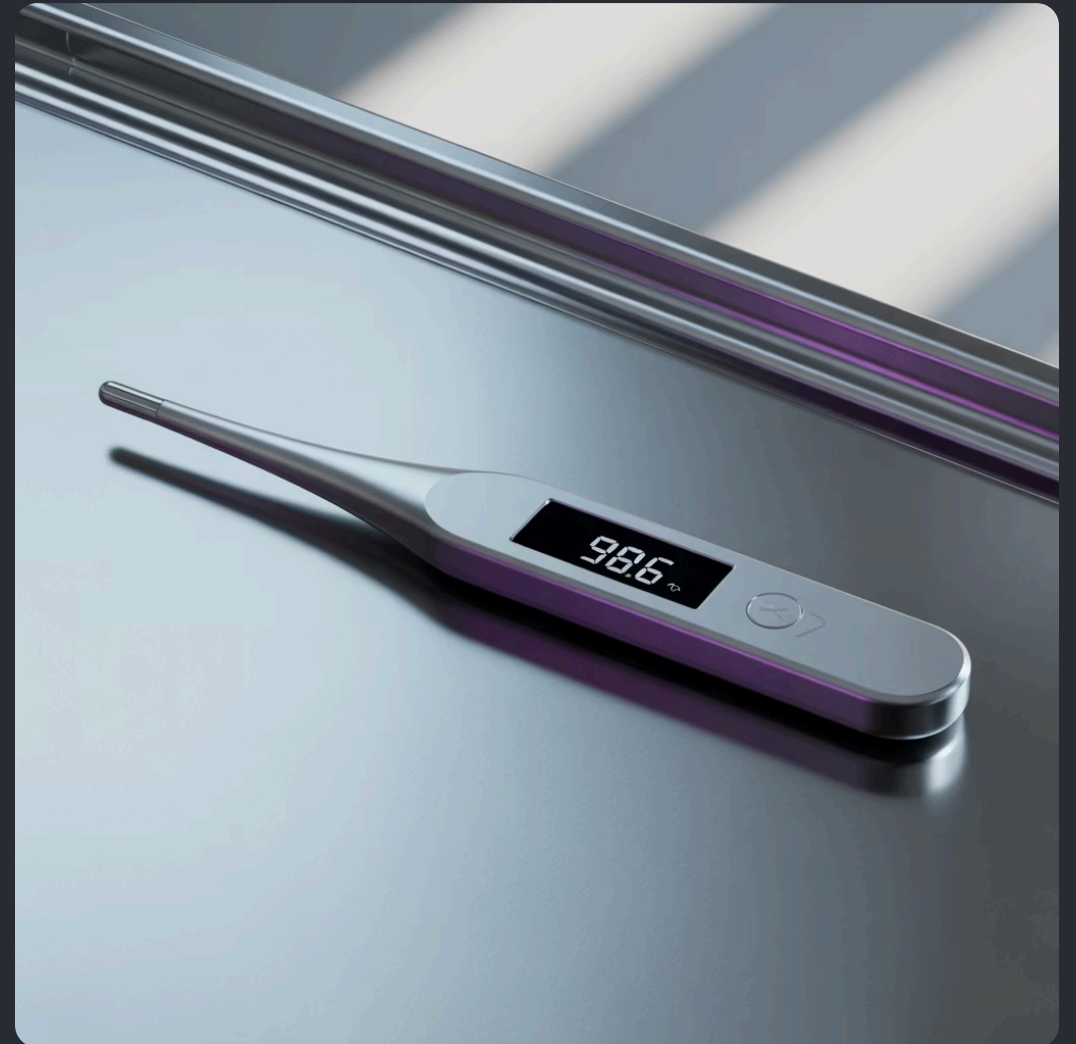
These values validate a partially compensated respiratory alkalosis, where the primary disturbance is respiratory (low PaCO<sub>2</sub>) with some metabolic compensation beginning.

# Core Temperature Assessment

When assessing core body temperature for suspected thermoregulation problems, the most appropriate method is:

## Rectal Temperature

This provides the most accurate core temperature reading when thermoregulation is compromised, as it's less affected by environmental factors than oral or axillary measurements.



# Electrolyte Imbalances



## Hypocalcemia

When caring for a client with respiratory muscle weakness resulting in shallow respirations, the nurse should suspect hypocalcemia, which can cause:

- Neuromuscular irritability
- Muscle weakness
- Tetany
- Respiratory compromise



## Hypokalemia

A critical electrolyte imbalance in clients on diuretic therapy for CHF that can cause:

- Cardiac arrhythmias
- Muscle weakness
- Fatigue



# Infection Control: Airborne Precautions

When caring for a client on airborne precautions, the nurse must maintain proper isolation techniques. The statement requiring charge nurse intervention is:

"I will leave the door propped open to increase auditory and visual stimulation"

This violates airborne precautions, as the door must remain closed to maintain negative pressure and prevent pathogen spread.



# Medication Effects on Acid-Base Balance

## Metabolic Alkalosis Risk

A client who frequently uses calcium carbonate (Tums) is at risk for developing metabolic alkalosis because:

- Calcium carbonate is an antacid that neutralizes stomach acid
- Excessive use can increase blood pH
- May lead to symptoms like confusion, muscle twitching, and nausea



# Medication Considerations in Ulcerative Colitis



## Enteric-Coated Medications

Patients with ulcerative colitis should avoid enteric-coated medications because they are designed to dissolve in the intestines rather than the stomach. The inflamed intestinal tissue may:

- Be irritated by these medications
- Absorb medications inadequately
- Lead to unpredictable drug effects



## Medication Alternatives

Patients should discuss with their healthcare provider about alternative formulations that won't exacerbate their condition.

# Medication Safety

When a nurse identifies a medication dosage that exceeds recommendations and cannot locate the prescribing healthcare provider, the appropriate action is to:

## Contact the Nursing Supervisor

This follows the chain of command and ensures patient safety while seeking appropriate guidance on the medication discrepancy.



# Promoting Patient Autonomy



## Activity Choices

Allowing clients to choose social activities promotes autonomy in long-term care settings



## Personal Preferences

Respecting clothing and grooming preferences



## Schedule Input

Involving clients in decisions about daily routines



## Dietary Choices

Providing options for meals when possible

# Tuberculosis Screening

The Purified Protein Derivative (PPD) test is performed to determine if a client has been exposed to tuberculosis bacillus (TB).

This statement is TRUE. The PPD test:

- Introduces tuberculin protein under the skin
- Measures immune response through induration
- Indicates previous exposure, not active disease
- Requires reading within 48-72 hours



# Breaking the Chain of Infection

**Infectious Agent**  
Pathogen capable of causing disease

**Susceptible Host**  
Person at risk for infection

**Portal of Entry**  
How pathogens enter a new host

**Reservoir**  
Where pathogens live and multiply

**Portal of Exit**  
How pathogens leave the reservoir

**Mode of Transmission**  
How pathogens travel



Turning, positioning, and adequate nutrition help maintain skin integrity, eliminating the portal of entry for pathogens.

# Pain Management Delegation

## Appropriate Delegation

When managing a patient's pain, the nurse can safely delegate to nursing assistive personnel:

- Providing a therapeutic back massage

This non-pharmacological intervention is within the scope of trained assistive personnel and can help with pain relief.





# Emergency Response to Opioid Overdose

## Stop Opioid Administration

Immediately discontinue any ongoing opioid infusions

## Call Rapid Response Team

Activate emergency response for additional support

## Prepare Naloxone

Consider administering naloxone to reverse opioid effects

## Monitor Vital Signs

Continuously assess respiratory status and level of consciousness

# Pharmacology: Colchicine

## Purpose in Gout Treatment

Colchicine is used in acute gout attacks to:

- Decrease joint inflammation
- Inhibit neutrophil migration
- Reduce uric acid crystal phagocytosis
- Alleviate pain and swelling



# SBAR Communication



## Situation

Brief statement of the current problem



## Background

Relevant clinical context and history



## Assessment

"Respirations are 32 breaths per minute. The pulse oximetry is 89% on 2 L via nasal cannula. Lungs have wheezing in all lung fields. Slight nasal flaring is noted."



## Recommendation

Suggested actions based on assessment

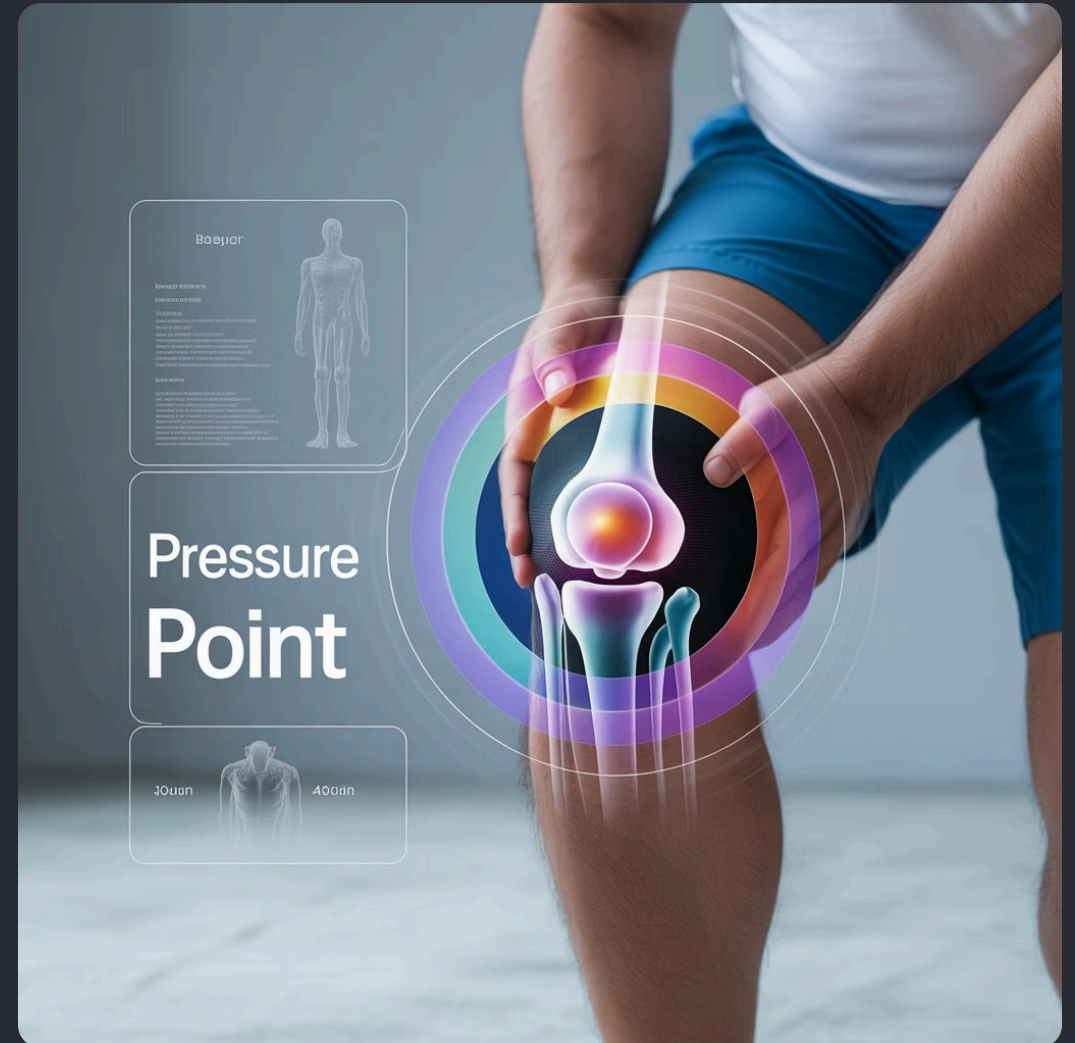
# Osteoarthritis Management

## Weight Management Rationale

For obese clients with osteoarthritis, weight loss is recommended because:

The extra weight of obesity increases the degeneration rate of hip and knee joints.

Each pound of weight creates 3-6 pounds of pressure on weight-bearing joints, accelerating cartilage breakdown.



# Pressure Injury Prevention



## Gentle Cleansing

Clean reddened areas with mild soap



## Thorough Drying

Pat skin dry completely



## Moisturizing

Apply protective moisturizer



## Regular Repositioning

Turn client every 2 hours

These interventions help prevent pressure injuries when redness is noted on bony prominences like the coccyx.

# Legal Considerations: Slander

## Legal Tort: Slander

When a nursing student makes false verbal statements about an instructor having AIDS and being an IV drug user, this constitutes slander - the spoken defamation of character.

Slander can result in:

- Legal liability
- Damage to professional reputation
- Disciplinary action



# IV Site Complications

When a client reports pain at an IV insertion site and assessment reveals a vein that is red, warm, and hard, the nurse should:

## **Discontinue Infusion**

Stop the IV fluid immediately

## **Apply Pressure**

Place a pressure dressing on the site

## **Remove Catheter**

Take out the IV from the affected site

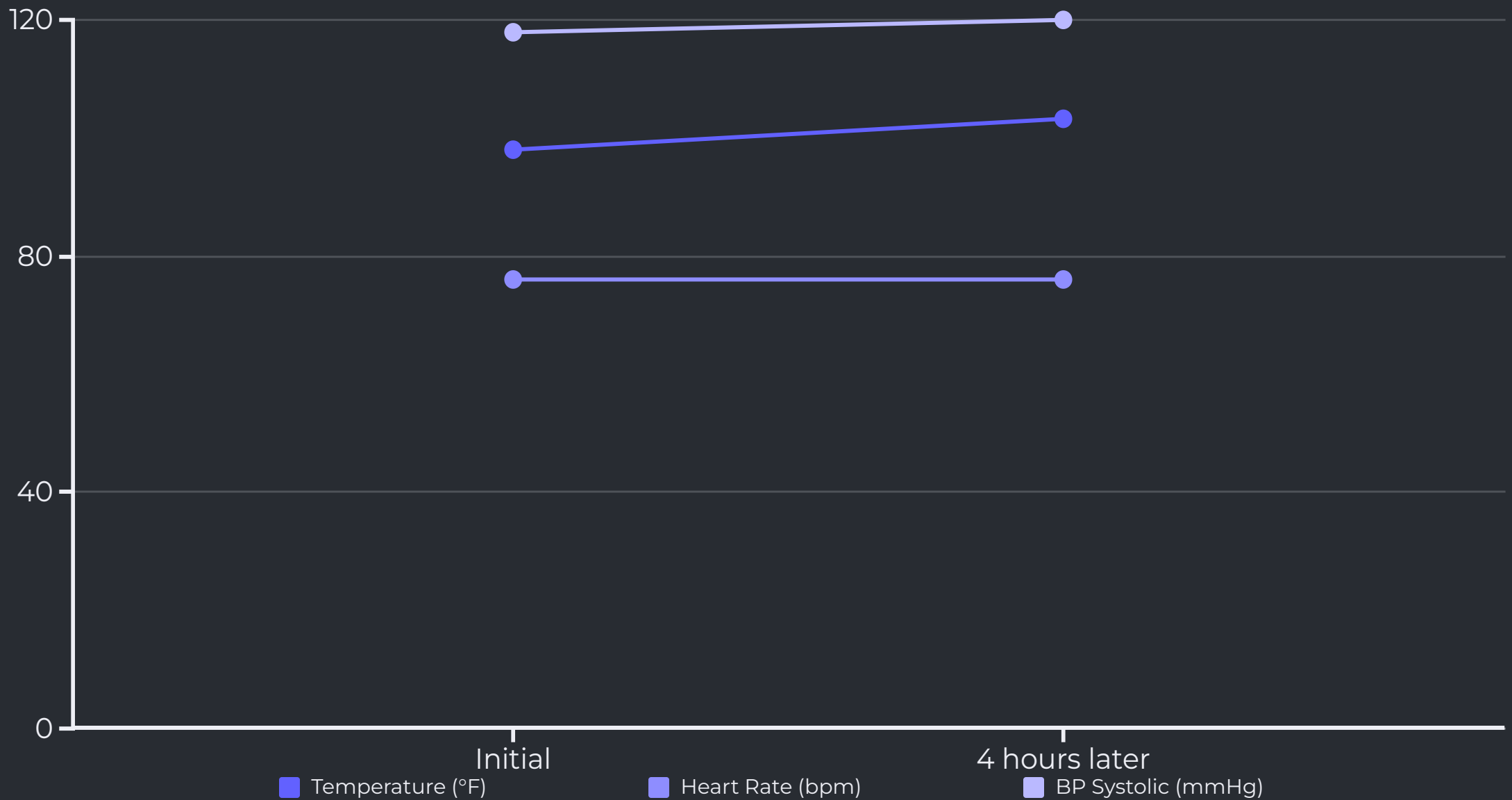
## **Document**

Record assessment, actions taken, and client response

These signs indicate phlebitis, which requires prompt intervention to prevent complications.



# Vital Signs Assessment



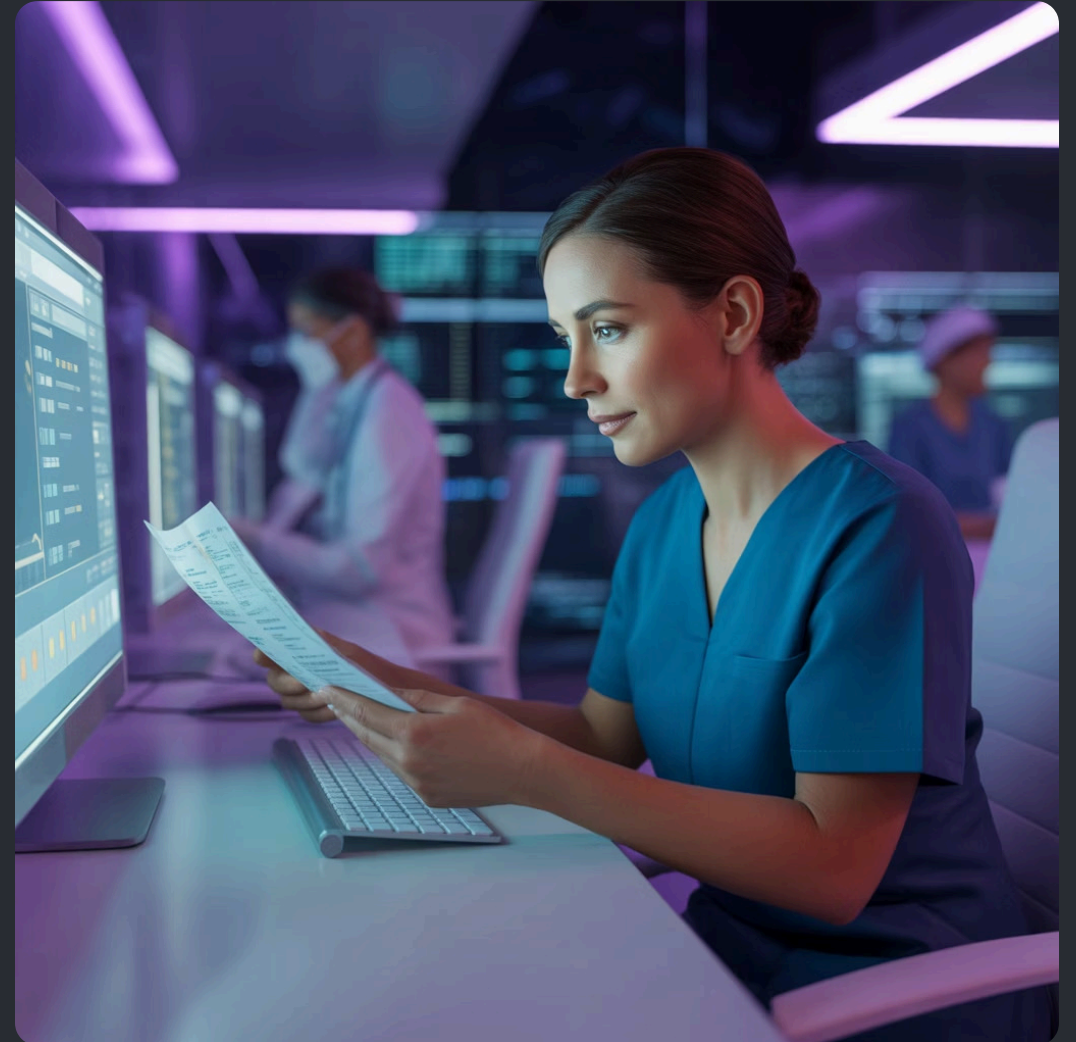
When a client's temperature rises significantly while other vital signs remain stable, the nurse's first intervention should be to ask if the client has had a warm drink in the last 30 minutes, which could falsely elevate an oral temperature reading.

# Post-Operative Pain Management

When a client reports pain of 8/10 forty minutes after transfer from PACU, with stable vital signs (RR 18, BP 135/85, P 90), the nurse should:

## Examine Transfer Orders

The nurse should review the transfer orders and select the appropriate pain medication based on the prescribed options, considering the timing of the last dose (morphine 2mg IV one hour ago).



# Fluid Volume Deficit

## Assessment Findings

- Dry skin
- Delayed skin turgor
- Hypotension
- Fever
- Vomiting and diarrhea

## Nursing Diagnosis

Deficient fluid volume related to active fluid loss secondary to vomiting and diarrhea

## Interventions

- IV fluid replacement
- Intake and output monitoring
- Vital signs assessment

# Medication Reactions Documentation

## Proper Documentation

When a client reports experiencing nausea, vomiting, and dizziness after taking diazepam, the nurse should document:

"Client experiences nausea, vomiting, and dizziness after ingesting diazepam"

This factual documentation describes the reaction without labeling it as an allergy, which is a specific immune response.



# Fever Management



## Sponge Bath Considerations

When a client with high fever begins shivering during a sponge bath, the nurse's priority action is to:

Stop sponging the client immediately

Shivering is counterproductive as it raises core temperature through muscle activity and negates the cooling effect of the sponge bath.



## Alternative Approaches

Consider antipyretic medications, lightweight coverings, and room temperature adjustments instead.

# Nutrition and Wound Healing

For a client with poorly healing infected leg ulcers, nutritional history is of primary importance because:

Wound healing and infection prevention are negatively impacted by poor nutrition

Adequate protein, vitamins (especially C and A), zinc, and calories are essential for tissue repair and immune function.



# Paget's Disease Management

## **Pain Relief**

Highest priority in severe Paget's disease

## **Mobility**

Maintaining function and preventing complications

## **Preventing Fractures**

Safety measures to protect weakened bones

## **Medication Management**

Bisphosphonates to slow bone turnover

Pain relief takes priority as it significantly impacts quality of life and ability to participate in other aspects of care.



# Child Safety Education

## Statement Requiring Further Teaching

When a parent states:

"Now that my child is two years old, I can let her sit in the front seat of the car with me."

This indicates a need for further education, as children under 13 years should always ride in the back seat with appropriate restraints.



# Osteomalacia Risk Assessment



## Dietary Assessment

Evaluating 24-hour intake to identify vitamin D and calcium deficiencies



## Sun Exposure

Assessing sunlight exposure for vitamin D synthesis



## Medication Review

Identifying drugs that affect bone metabolism

Typical 24-hour dietary intake assessment is most important for determining osteomalacia risk, as vitamin D and calcium deficiencies are primary contributors.

# Diabetic Ketoacidosis: ABG Values

**7.32**

**pH**

Below normal range (7.35-7.45), indicating acidosis

**18**

**Bicarbonate (mEq/L)**

Below normal range (22-26 mEq/L), confirming metabolic acidosis

These values reflect the metabolic acidosis characteristic of diabetic ketoacidosis, caused by the accumulation of ketone bodies from fat metabolism when insulin is insufficient.

# End-of-Life Care Planning

When a client with advanced cancer states, "The doctor says my chemotherapy isn't working anymore. They can only treat my symptoms now. I don't want to die in the hospital. I want to be in my own bed," the nurse's next action should be to:

## Explain Advance Directives

Discussing advance directives helps the client formally document their wishes regarding end-of-life care, including preferred location of death.



# Transplant Immunology



## Organ Transplantation

Surgical transfer of donor kidney to recipient

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## Immune Response

"The immune system will try to destroy the kidney if we don't suppress it"



## Immunosuppression

Medications prevent rejection by dampening immune response

Lifelong immunosuppression is necessary to prevent the body from recognizing and attacking the transplanted organ as foreign.

# Crohn's Disease Management

## Statement Needing Correction

During discharge teaching for a client with newly diagnosed Crohn's disease, the statement indicating a need for further instruction is:

"I should increase the fiber in my diet."

During exacerbation episodes, high-fiber foods can worsen symptoms by increasing intestinal motility and irritating inflamed areas.



# Pain Assessment: Alleviating Factors

## Key Assessment Question

To assess alleviating factors related to a client's pain, the nurse should ask:

"What methods do you use to control your pain?"

## Importance

Identifying effective pain management strategies helps develop personalized interventions and builds on existing coping mechanisms.

## Examples

May include positioning, heat/cold application, relaxation techniques, or specific medications.



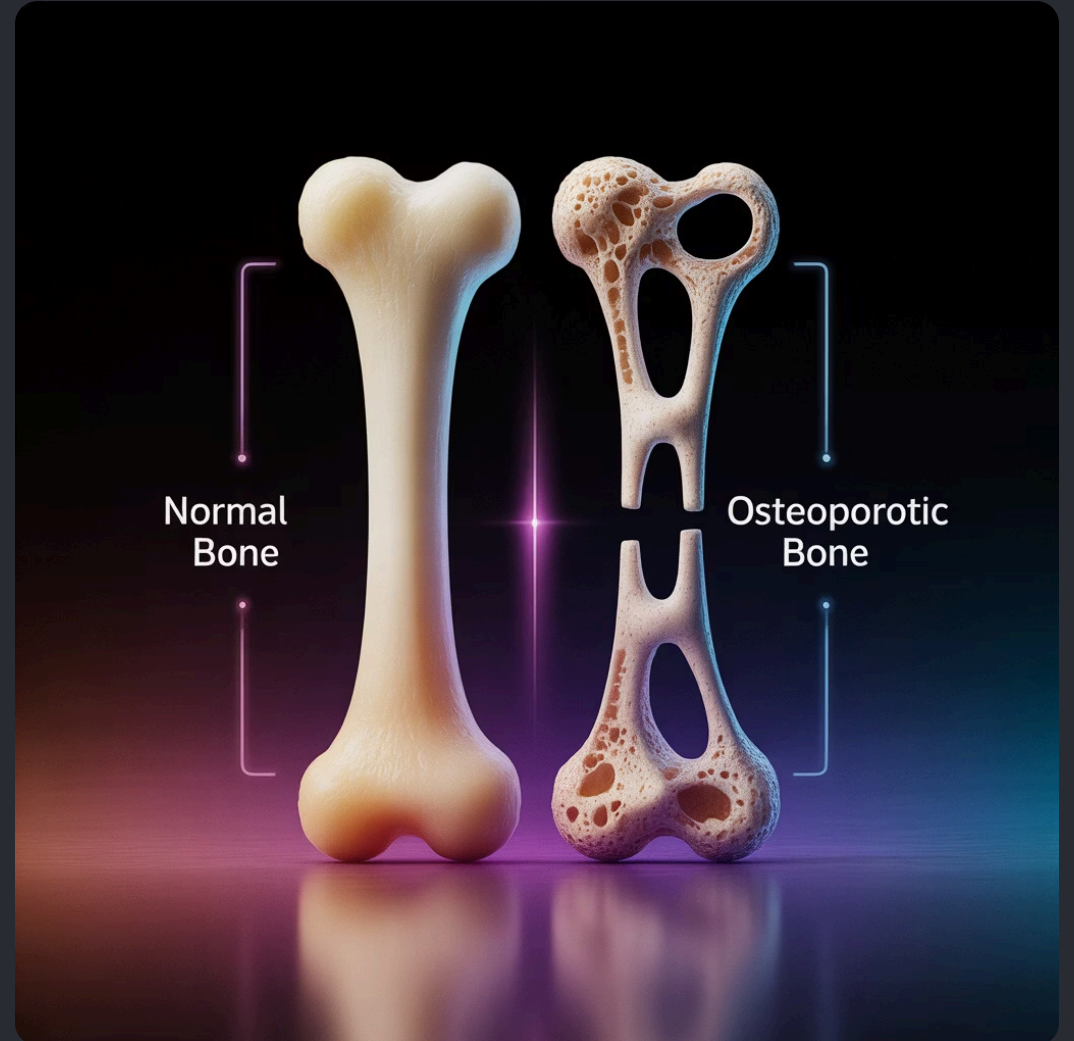
# Osteoporosis Education

## Incorrect Statement

When educating a client with newly diagnosed osteoporosis, the statement that would NOT apply is:

"The disease is inherited and caused by an inability to tolerate milk products."

This statement incorrectly combines osteoporosis (bone density loss) with lactose intolerance (inability to digest milk sugar).



# Temperature Conversion

**101.1**

**Fahrenheit**

Original temperature reading

**38.4**

**Celsius**

Converted temperature

To convert Fahrenheit to Celsius:  $(^{\circ}\text{F} - 32) \times \frac{5}{9} = ^{\circ}\text{C}$

$(101.1 - 32) \times \frac{5}{9} = 69.1 \times \frac{5}{9} = 38.4^{\circ}\text{C}$

This elevated temperature indicates fever requiring monitoring and intervention.

# Acid-Base Imbalances



## ABG Results

pH 7.33; PaCO<sub>2</sub> 42; HCO<sub>3</sub><sup>-</sup> 20



## Interpretation

Uncompensated metabolic acidosis



## Likely Cause

Severe diarrhea causing bicarbonate loss

The normal PaCO<sub>2</sub> indicates lack of respiratory compensation, while low pH and bicarbonate confirm metabolic acidosis.

# Thermoregulation Risk Factors

## Incorrect Risk Factor

During orientation to an emergency department, the nurse educator would be concerned if a new nurse identified "physical agility" as a risk factor for impaired thermoregulation.

Physical agility is actually protective, while risk factors include:

- Age extremes (very young, very old)
- Malnutrition
- Certain medications
- Endocrine disorders



# Carbon Monoxide Poisoning

## Key Teaching Point

When counseling about carbon monoxide dangers, the nurse should explain:

"Carbon monoxide binds with hemoglobin in the body"

## Mechanism

CO binds to hemoglobin 200-250 times more strongly than oxygen, forming carboxyhemoglobin and preventing oxygen transport

## Prevention

Functioning CO detectors, proper ventilation, and regular inspection of fuel-burning appliances

# Renal Calculi Management

## Key Intervention

For a client with renal calculi reporting severe flank and abdominal pain, an appropriate nursing intervention is to:

- Strain all urine

This allows for collection and analysis of passed stones, which helps determine composition and guide treatment.



# Pediatric Pain Assessment

## **Wong-Baker FACES Scale**

A visual analog scale with faces showing different expressions from happy to crying

## **Incorrect Use**

The nurse should intervene if a student observes the child's facial expression and matches it to a face on the scale

## **Correct Use**

The child should self-report by pointing to the face that best represents their pain level



# Post-Operative Wound Management

## Priority Intervention

When a nurse notes moderate dark reddish-brown drainage on a midline abdominal incision one day after sigmoid colon resection, the first intervention should be to:

- Reinforce the dressing with a sterile gauze pad

This maintains the sterile barrier while monitoring the amount of drainage.



# Non-Pharmacological Pain Management

## Music Therapy

Using music to promote relaxation and distraction



## Pet Therapy

Animal interaction for comfort and distraction



## Relaxation

Progressive muscle relaxation and breathing techniques



## Meditation

Mindfulness practices to reduce pain perception



## Prayer

Spiritual practices that provide comfort



## Guided Imagery

Visualization techniques to redirect focus



# Key Takeaways



## Patient Advocacy

Always act as the patient's advocate in all healthcare settings

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## Clinical Assessment

Develop strong assessment skills to identify changes in patient condition

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## Safety First

Prioritize patient safety in all nursing interventions

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## Ethical Practice

Maintain ethical standards and respect patient autonomy

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## Continuous Learning

Commit to lifelong learning and evidence-based practice