

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

**Susan C. deWit, Patricia A. Williams,
RN, MSN, CCRN**



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Table of Contents Answer Key 36 Fundamentals Nursing Study Guide

1. Understanding the eBook Answer Key 36 Fundamentals Nursing Study Guide
 - The Rise of Digital Reading Answer Key 36 Fundamentals Nursing Study Guide
 - Advantages of eBooks Over Traditional Books
2. Identifying Answer Key 36 Fundamentals Nursing Study Guide
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Answer Key 36 Fundamentals Nursing Study Guide
 - User-Friendly Interface
4. Exploring eBook Recommendations from Answer Key 36 Fundamentals Nursing Study Guide
 - Personalized Recommendations
 - Answer Key 36 Fundamentals Nursing Study Guide User Reviews and Ratings
 - Answer Key 36 Fundamentals Nursing Study Guide and Bestseller Lists
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 - Adjustable Fonts and Text Sizes of Answer Key 36 Fundamentals Nursing Study Guide
 - Highlighting and Note-Taking Answer Key 36 Fundamentals Nursing Study Guide
 - Interactive Elements Answer Key 36 Fundamentals Nursing Study Guide
- 8. Staying Engaged with Answer Key 36 Fundamentals Nursing Study Guide
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Answer Key 36 Fundamentals Nursing Study Guide
- 9. Balancing eBooks and Physical Books Answer Key 36 Fundamentals Nursing Study Guide
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Answer Key 36 Fundamentals Nursing Study Guide
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Answer Key 36 Fundamentals Nursing Study Guide
 - Setting Reading Goals Answer Key 36 Fundamentals Nursing Study Guide
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Answer Key 36 Fundamentals Nursing Study Guide
 - Fact-Checking eBook Content of Answer Key 36 Fundamentals Nursing Study Guide
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development

- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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