EMERGENCY NURSING COMPREHENSIVE EXAMINATION ANSWERS AND RATIONALES

1. 1. Orientation to person, place, and time should be assessed on all clients, but this information will not provide specific information about the chest trauma.
2. Current use of all medication and the last doses should be assessed for all clients.
3. When a client suffers from multiple rib fractures, the client has an increased risk for flail chest. The nurse should assess the client for paradoxical chest wall movement and, if respiratory distress is present, for pallor and cyanosis.
4. The time of this last meal is important if the client were to have surgery or intubation planned. A nutritional assessment should be performed on all clients.

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2. **1. A diagnostic peritoneal lavage is performed to assess the presence of blood, bile, and feces from internal bleeding induced by injury. If any of these are present, surgery should be considered to explore the extent of damage and repair of the injury.**
2. Palpating the client's peripheral pulses indicates blood flow to the extremities. Femoral pulses are not necessarily assessed if all distal pulses are strong.
3. Leopold's maneuver is performed on pregnant clients to assess the position of the fetus.
4. Dietary history is information which is assessed, but not in an emergency situation. Assessments need to be efficient and direct to eliminate any time-wasting activities.

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3. 1. Elderly clients lose the defense mechanism of increased thirst with dehydration. This does not accurately indicate fluid deficit.
2. An intravenous fluid should be administered, but the solution should correct fluid and electrolyte imbalances. D5W does not replace electrolytes lost, and 250 mL/hr could place the client at risk for heart failure if the body cannot adjust rapidly to the fluid replacement.
3. The nurse should encourage the client to rest and should maintain a cool environment to assist the client to recover from heat exhaustion. The elderly are more susceptible to this condition.
4. If the client can tolerate oral fluids, the client should be encouraged to drink fluids to replace electrolytes lost in excessive sweating.

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4. 1. An expected outcome is a desired occurrence, not a common event. Tachycardia is a common manifestation of a near-drowning event, but it is not desired. A combination of physiological changes, hypothermia, and hypoxia put the client at risk for life-threatening cardiac rhythms.
2. Any near-drowning causes a decrease in alveolar surfactant, which results in alveolar collapse. A decrease in surfactant is not the desired outcome.
3. The client needs to be rewarmed slowly to reduce the influx of metabolites. These metabolites, including lactic acid, remain in the extremities.
4. The oxygen level needs to be maintained greater than 93%. The client needs as much support as necessary for this. Mechanical ventilation with peak end-expiratory pressure (PEEP) and high oxygen levels may be needed to achieve this goal.

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5. **1. The onset of pinky, frothy sputum indicates the client is experiencing pulmonary edema. This needs to be treated to prevent further decline in this client.**
2. An oral temperature of 97°F is in the lower level of within normal limits.
3. A blood alcohol of 100 mg/dL is an elevation but should not be considered priority over pulmonary edema. Treatments for elevations in toxicology levels can be considered after the client is stable.

4. A heart rate of 100 beats/min is tachycardia but not at a critical level. The nurse needs to follow the ABCs of treatment: A is for airway, B is for breathing, and C is for circulation. Pulmonary edema interferes with breathing.

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6. 1. The use of drugs can alter the treatment of and recovery from the near-drowning event. This is information needed, but it is not priority at this time.
2. An injury of the spinal cord should be considered and the spine should be assessed, but after the client has been stabilized. The nurse does not complete an assessment of a potential spinal injury before assessing oxygenation status.
3. **The nurse should assess the victim for hypoxia. Signs and symptoms of hypoxia include confusion or irritability and alterations in level of consciousness, such as lethargy.**
4. The amount of alcohol ingestion will affect the treatment, but this is not a higher priority than oxygenation.

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7. 1. The client diagnosed with carbon monoxide poisoning frequently has black sputum from inhaling soot, so the RRT does not need to be notified.
2. The client admitting to attempting suicide requires the client being placed on one (1)-to-one (1) suicide precautions and psychological counseling.
3. A pulse oximeter reading of 94% indicates the client is being well oxygenated and does not require notifying the RRT.
4. **Stridor or dizziness indicates an occlusion of the airway, which is a medical emergency. The RRT is called when the client is experiencing a decline but is still breathing.**

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8. 1. **Injuries from a motor-vehicle accident can be life threatening. This client should be assessed first to rule out respiratory difficulties and hemorrhage.**
2. Epigastric pain with nausea after eating sounds like gallbladder disease. Pain has high priority but not over breathing and hemorrhage.
3. Elderly clients have special fluid and electrolyte issues after a fall. The cause of the fall may be cardiac, but the question does not indicate this.
4. Migraine headaches are painful experiences, but they do not have a higher priority than breathing and hemorrhage.

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9. 1. Alcoholic beverages should be avoided to prevent nausea and vomiting. The client should be taught where and how to cut wires if vomiting occurs.
2. A combination of foods should be blended into a milk shake and consumed to maintain caloric intake and promote nutrition.
3. Carbonated sodas can cause foam in the back of the throat and may induce vomiting.
4. **Hygiene is helpful in healing. The mouth should be rinsed and an irrigation device should be used frequently. Gentle brushing and rinsing the mouth after each meal and at bedtime can begin after edema and tenderness subside.**

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10. 1. **The amputated finger and all tissue should be rinsed with sterile normal saline to remove dirt and sent to the ED with the client.**
2. **Place the finger and all tissue in a watertight, sealed plastic bag to prevent loss and contamination.**
3. The finger or other tissue should not be placed on ice or in saline solution because this will cause severe damage to the tissue cells.
4. **The finger should be wrapped in gauze moistened with sterile normal saline.**
5. The finger should not be replaced on the hand and wrapped with gauze in the field. The surgeon will determine if reattachment is possible.

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Effective Care Environment, Management of Care: ***Cognitive Level*** *– Application.*

11. 1. Exercises should be performed several times each day, not weekly.
2. Smoking causes vasoconstriction, which will compromise the implanted finger's survival.
3. The client should take extra care to protect the finger from injury. The peripheral nerves protecting the finger require months to regenerate.
4. The client needs to report any signs of rejection of the finger, such as infection or impaired circulation, not just an elevated temperature.

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12. 1. Massaging or rubbing tissue with frostbite will cause further damage.
2. Soaking the feet in a warm bath of 107°F causes rapid continuous rewarming.
3. Heating pads are not used to rewarm tissue with frostbite. Heating pads can cause tissue damage from burns, especially in tissue with impaired sensation.
4. Petroleum jelly does not affect the temperature of the tissue.

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13. 1. The stinger should not be grasped because the wasp's venom sac may release more toxin. The stinger should be scraped in the opposite direction.
2. Warmth increases the blood flow, which will increase the edema.
3. The site should be cleaned with soap and water, not alcohol.
4. The nurse should apply an ice pack to the site. The cold will decrease the blood flow and sensation. The ice should be applied intermittently.

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14. **1. Clients who have severe reactions to insect stings should wear identifying bracelets to provide information. If the client is unconscious, the bracelet can alert the health-care provider so treatment can be started.**
2. Corticosteroid creams treat local reactions, not systemic ones.
3. Epinephrine 1:10,000 is administered intravenously during a code situation or for a severe anaphylactic reaction to an allergen. This client is being discharged and may need an EpiPen to carry at all times, but not IV epinephrine.
4. Bright-colored clothing attracts insects. Clients who are allergic to insect stings should learn how to avoid them to decrease the risk. Flowery-smelling perfumes and lotions should also be avoided.

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15. 1. The creatinine and BUN assess kidney function, but the nurse should assess bladder function by checking the amount and color of the urine.
2. Checking the urine output hourly is appropriate data to assess but not the most important for a client with bladder trauma.
3. The amount and color of urine assists with diagnosing the extent of injury. Color of the urine indicates the presence of blood. The amount indicates whether the urine is contained throughout the pathway from bladder to urinary meatus.
4. The nurse should not palpate a client with bladder trauma because it could cause further damage.

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16. 1. The laceration should be cleaned well to prevent infection. A sterile saline solution or water should be used. This is done after donning nonsterile gloves and applying pressure.
2. The nurse should apply direct pressure to a deep laceration to stop the bleeding after donning nonsterile gloves.
3. The nurse must follow Standard Precautions in the school nurse setting by donning nonsterile gloves prior to caring for the client.
4. The school nurse must notify the parents but not prior to taking care of the client.

Content *– Medical:* ***Category of Health Alteration*** *– Emergency:* ***Integrated Nursing***

Process – *Implementation:* ***Client Needs*** – *Safe Effective Care Environment, Management of Care:* ***Cognitive Level*** – *Application.*

17. 1. Inserting an indwelling catheter may cause further injury. Until the extent of injury is determined, prevention of further damage should have high priority.
2. Vital signs should be taken frequently to assess for covert bleeding. The hematoma in the flank area may indicate the presence of trauma to the kidney. Because of the large amount of blood flow through the kidney, hemorrhage is a high risk.
3. Assessing skin turgor is important in determining the fluid balance, but it is not higher priority than monitoring vital signs.
4. The nurse could mark the bruised area to better assess if the hematoma is enlarging, but this is not the first intervention.

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18. 1. Pain management is a goal for clients. At this time in the care of this client, it is not realistic to expect no pain.
2. Maintaining homeostasis is an appropriate outcome, but the priority is to maintain respiratory status. Remember Maslow's hierarchy of needs.
3. Symmetrical chest expansion indicates the client's lungs have not collapsed and air is being exchanged. This is the client's priority outcome.
4. A urine output of 30 mL/hr indicates the tissues are being adequately perfused and is an indicator of kidney functioning. Kidney function is important but is not a priority over respiratory status in a client with a gunshot wound.

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19. 1. A potential for infection is an appropriate nursing diagnosis, but there is no indication of infection from this question.
2. Bleeding results in an impairment of tissue perfusion. Because of the large amount of blood flow through the renal system, bleeding is a major problem.
3. Skin integrity is not necessarily an issue in trauma. There is no indication from the question the skin is not intact.
4. An alteration in temperature is not a problem for this client unless infection occurs. This intervention is not indicated at this time.

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20. **1. Any client who has not had a tetanus injection within five (5) years will need to receive an injection as prophylaxis.**
2. The nurse may need to determine if the usual HCP can remove the sutures or the client should return to the ED for suture removal, but this is not the most important information.
3. This information is important to teach the client, but preventing tetanus (lockjaw) is priority.
4. This client has been treated, so it is too late to determine if the client has allergies.

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21. 1. The nurse should assess the client's blood pressure but not prior to stopping the bleeding. The most common cause of spontaneous epistaxis is hypertension.
2. Most nosebleeds will stop after applying pressure on the nose between thumb and index finger for 15 minutes.
3. The nurse should position the client with the head tilted forward. This position will prevent the client from swallowing the blood. The blood can be aspirated if the head is tilted back.
4. Most nosebleeds respond to pressure. If pressure for 15 minutes does not stop the bleeding, the health-care provider may need to use electrocautery or silver nitrate. This is performed by the HCP, not the nurse.

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22. 1. Removing clothing causes further chilling.
2. The warm air blanket blows warm air over the client and is an active warming method.

3. Hospital gowns have openings down the back and can increase chilling.
4. Raising the temperature of the room will not directly raise the client's temperature.

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23. 1. Evaluation of airway and breathing is assessment and cannot be delegated.
2. Monitoring the rate of intravenous fluid is a part of administering a medication. Medication administration cannot be delegated.
3. The UAP can attach leads to the client for the cardiac monitor.
4. The nurse cannot delegate an unstable client to the UAP. A client being transferred to the intensive care unit is unstable.

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24. 1. The client already has an intravenous access; therefore, the nurse would not need to start an intravenous line.
2. A STAT chest x-ray will be done to evaluate the extent of the chest trauma, but it is not the first intervention.
3. The client will require a chest tube because the Heimlich valve is only temporary; therefore, the nurse should prepare for this first.
4. Assessing the cardiac rhythm is important, but the client is in distress and needs circulatory support, not further assessment.

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25. 1. Assessing the site and rate is not the first intervention.
2. Sodium bicarbonate is not administered unless indicated by arterial blood gases.
3. The rhythm on the monitor should be assessed. Many clients who become unresponsive have a lethal rhythm requiring defibrillation immediately.
4. Cardioversion is not appropriate. Defibrillation may be needed.

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26. In order of priority: 4, 2, 3, 1, 5.
4. This is done first before any action is taken to decrease suspicions on the part of the significant other. The nurse needs to ask the client questions regarding the injuries and may not get truthful answers with the significant other in the room.
2. The nurse should assess the actual physical problems before assessing the potential abuse situation.
3. This is one of the first questions the nurse should ask to determine if abuse is occurring.
1. The nurse should determine if the client has a plan to escape the violence. The nurse should provide the client with hotline numbers for safe houses.
5. The nurse should refer the client to the social worker for further evaluation and referral needs.

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