# Nursing Concepts 3



The icon ✦ denotes content of special importance for NCLEX®.

# STRESS AND ADAPTATION

## Homeostasis

✦ *Definition:* The maintenance of a constant state in the internal environment through self-regulatory techniques that preserve the organism's ability to adapt to stresses.

A. Dynamics of homeostasis.
   1. Danger or its symbols, whether internal or external, result in the activation of the sympathetic nervous system and the adrenal medulla.
   ✦ 2. The organism prepares for *fight* or *flight* (attack–withdrawal; one's immediate response to stress—an archaic and often inappropriate response, but part of our biological heritage).

B. Adaptation factors.
   1. Age—adaptation is greatest in youth and young middle life, and least at the extremes of life.
   2. Environment—adequate supply of required materials is necessary.
   3. Adaptation involves the entire organism.
   4. The organism can more easily adapt to stress over a period of time than suddenly.
   5. Organism flexibility influences survival.
   6. The organism usually uses the adaptation mechanism that is most economical in terms of energy.
   7. Illness decreases the organism's capacity to adapt to stress.
   8. Adaptation responses may be adequate or deficient.
   9. Adaptation may cause stress and illness (e.g., ulcers, arthritis, allergy, asthma, and overwhelming infections).

## Stress

A. Definitions of stress.
   ✦ 1. A physical, chemical, or emotional factor that causes bodily or mental tension and that may be a factor in disease causation; a state resulting from factors that tend to alter an existing equilibrium.
   2. Selye's definition of stress.
      a. The state manifested by a specific syndrome that consists of all the nonspecifically induced changes within the biologic system.
      b. The body is the common denominator of all adaptive responses.
      c. Stress is manifested by the measurable changes in the body.
      d. Stress causes a multiplicity of changes in the body.
   3. Wolff's theory of stress.
      a. Poor adaptation to a life situation may lead to a breakdown in homeostasis with subsequent development of disease.
      b. Wolff believed that a person's total life situation (with its positive as well as negative aspects) affects a person's susceptibility to disease.
      c. Disease may result from attempts to restore homeostasis.

✦ B. General aspects of stress.
   1. Body responses to stress are a self-preserving mechanism that automatically and immediately becomes activated in times of danger.
      a. Caused by physical or psychological stress: disease, injury, anger, or frustration.
      b. Caused by changes in internal and/or external environment.
   2. There are a limited number of ways an organism can respond to stress (for example, a cornered amoeba cannot fly).

## Stress and Disease

A. Stress and individual methods of coping are associated with heart disease, cancer, and other diseases.
B. Actual physical changes occur with high stress levels.
   1. Increased release of adrenalin, cortisol, and other hormones lead to increased heart rate, blood pressure, and platelet stickiness, which may accelerate atherosclerosis and other causes of heart disease.
   2. Changes in immune system may interfere with individual ability to recognize and destroy cancer cells.
C. Stress can be both positive and negative. Individual must have adaptive mechanism to cope with stress to increase health and avoid risk for disease.

**DANGER SIGNALS OF STRESS**

- Depression, lack of interest in life
- Uncontrolled hyperactive behavior
- Lack of concentration, inability to focus
- Feelings of unreality, feelings of dread
- Loss of control, emotional instability
- Pervasive high anxiety level
- Physical manifestations
  - Irregular heartbeats
  - Tremors, tics
  - Gastrointestinal disturbance
  - Skin disturbance
  - Changes in respiratory patterns
- Insomnia
- Disease
- Increased dependence on alcohol, drugs

Adapted from Smith, S. F., Duell, D. J., & Martin, B. C. (2008). *Clinical nursing skills* (7th ed.). Upper Saddle River, NJ: Prentice Hall Health.

## Selye's Theory of Stress

A. General adaptive syndrome (GAS).
   1. Alarm stage (call to arms).
      a. Shock: The body translates it as sudden injury, and the GAS becomes activated.
      b. Countershock: The organism is restored to its preinjury condition.
   2. Stage of resistance: The organism is adapted to the injuring agent.
   3. Stage of exhaustion: If stress continues, the organism loses its adaptive capability and goes into exhaustion, which is comparable to shock.

B. Local adaptive syndrome (LAS).
   1. Selective changes within the organism.
   2. Local response elicits general response.
   3. Example of LAS: a cut, followed by bleeding, followed by coagulation of blood.
   4. The ability of parts of the body to respond to a specific injury is impaired if the whole body is under stress.

C. Whether the organism goes through all the phases of adaptation depends on both its capacity to adapt and the intensity and continuance of the injuring agent.
   1. Organism may return to normal.
   2. Organism may overreact; stress decreases.
   3. Organism may be unable to adapt or maintain adaptation, a condition that may lead to death.

✦ D. Objective of stres5s response.
   1. To maintain stability of the organism during stress.
   2. To repair damage.
   3. To restore body to normal composition and activity. (See **Table 3-1**.)

## Psychological Stress

*Definition*: All processes that impose a demand or requirement upon the organism, the resolution or accommodation of which necessitates work or activity of the mental apparatus.

### Characteristics

A. May involve other structures or systems, but primarily affects mental apparatus.
   1. Anxiety is a primary result of psychological stress.
   2. Causes mental mechanisms to attempt to reduce or relieve psychological discomfort.
      a. Attack/fight.
      b. Withdrawal/flight.
      c. Play dead/immobility.

**Table 3-1 SELYE'S STRESS ADAPTATION SYNDROME**

| Stage | Function | Interpersonal | Behavioral | Affective | Cognitive | Physiological |
|---|---|---|---|---|---|---|
| **1. Alarm reaction** | Mobilization of body defenses | Interpersonal communication effectiveness decreases | Task-oriented<br>Increased restlessness<br>Apathy, regression<br>Crying | Feelings of anger, suspiciousness, helplessness<br>Anxiety level increases | Alert<br>Thinking becomes narrow and concrete<br>Symptoms of thought blocking, forgetfulness, and decreased productivity | Muscle tension<br>Increase in epinephrine and cortisone<br>Stimulation of adrenal cortex and lymph glands<br>Increase in blood pressure, heart rate, and blood glucose |
| **2. Stage of resistance** | Adaptation to stresses<br>Resistance increases | Interpersonal communication is self-oriented<br>Uses interpersonal relationships to meet own needs | Automatic behaviors<br>Self-oriented behaviors<br>Fight or flight behavior apparent | Increased use of defense mechanisms<br>Emotional responses may be automatic or exaggerated | Thought processes more habitual than problem-solving oriented | Hormonal levels return to prealarm stage if adaptation occurs<br>All physiological responses return to normal or are channeled into psychosomatic symptoms |
| **3. Stage of exhaustion** | Depletion or exhaustion of organs and resources<br>Loss of ability to resist stress | Disintegration of personal interactions<br>Communication skills are ineffective and disorganized<br>Self-oriented | Restless, withdrawn, agitated; may become violent or self-destructive<br>Diminished productivity | Depressed, flat, or inappropriate affect<br>Exaggerated or inappropriate use of defense mechanisms<br>Decreased ability to cope | Thought disorganization, hallucinations, preoccupation<br>Reduced intellectual processes | Exhaustion, with increased demands on organism<br>Adrenal cortex hormone depletion<br>Death, if stress is continuous and excessive |

B. Causes of psychological stress.
   1. Loss of something of value.
   2. Injury/pain.
   3. Frustrations of needs and drives.
   4. Threats to self-concept.
   5. Many illnesses cause stress.
      a. Disfigurement.
      b. Sexually transmitted diseases (STDs).
      c. Long-term or chronic diseases.
      d. Cancer.
      e. Heart disease.
   6. Conflicting cultural values (e.g., the American values of competition and assertiveness vs. the need to be dependent).
   7. Future shock: physiological and psychological stress resulting from an overload of the organism's adaptive systems and decision-making processes brought about by too rapidly changing values and technology.
   8. Cultural shock: stress developing in response to transition of the individual from a familiar environment to an unfamiliar one.
      a. Involves unfamiliarity with communication, technology, customs, attitudes, and beliefs.
      b. Examples: individual moving to new area from foreign country or individual placed in hospital environment.
   9. Social stress: stress that develops as a result of social rather than psychological problems.
      a. Personal relationships may be a source of stress.
      b. A sense of not belonging or lack of identification with a social group or friends.
      c. Feelings of isolation or separation from others.
      d. Social pressure of being pushed to join group activities or engage in social behaviors that make one uncomfortable.

#### Assessment

A. Assess increased anxiety, anger, helplessness, hopelessness, guilt, shame, disgust, fear, frustration, or depression.
B. Evaluate behaviors resulting from stress.
   1. Apathy, regression, withdrawal.
   2. Crying, demanding.
   3. Physical illness.
   4. Hostility, manipulation.
   5. Senseless violence, acting out.

#### Implementation

A. Gather information about client's internal and external environment.
B. Modify external environment so that adaptation responses are within the capacity of the client.
C. Support the efforts of client to adapt or to respond.
D. Provide client with the materials required to maintain constancy of internal environment.
E. Understand body's mechanisms for accommodating stress.
F. Prevent additional stress.
G. Reduce external stimuli.
H. Reduce or increase physical activity depending on the cause of and response to stress.

## DEVELOPMENT THROUGH THE LIFE CYCLE*

### Early Adolescence

A. Physical development.
   1. Exhibits further development of secondary sex characteristics.
   2. Shows poor posture.
   3. Exhibits rapid growth and becomes awkward and uncoordinated.
   4. Shows changes in body size and development.
✦ B. Social development.
   1. Needs social approval of peer group.
   2. Strives for independence from family.
   3. Has one or two very close friends in peer group.
   4. Becomes more interested in opposite sex.
   5. Period of upheaval: Displays confusion about body image.
   6. Must again learn to control strong feelings (e.g., love, aggression).
✦ C. Counseling guidelines.
   1. Provide adult understanding when adolescent deals with social, intellectual, and moral issues.
   2. Allow some financial independence.
   3. Provide limits to ensure security.
   4. Provide necessary assurance to help adolescent accept changing body image.
   5. Show flexibility in adjusting to emotional and erratic mood swings.
   6. Be calm and consistent when dealing with an adolescent.
✦ D. Developmental tasks (**Table 3-2**).
   1. Finds identity; moves out of role diffusion.
      a. Integrates childhood identifications with basic drives.
      b. Expands concept of social roles.
   2. Moves toward heterosexuality.
   3. Begins separation from family.
   4. Integrates personality.

*For infancy to adolescence, see Pediatric Nursing, Chapter 13.

**Table 3-2 PIAGET'S COGNITIVE DEVELOPMENT**

| Age | Developmental Level |
|---|---|
| **Infancy–2 years** | Sensorimotor<br>Development of intellect through sensory–motor apparatus<br>Simple problem solving |
| **2–7 years** | Preoperational Thought |
| 2–4 years | Preconceptual Phase<br>Use of symbols—language<br>Imitative play to understand the world |
| 4–7 years | Intuitive Phase<br>Egocentric and stage of "moral realism"<br>Beginning use of symbols for cognition<br>Asks questions |
| **7–12 years** | Concrete Operational Thought<br>Wide use of symbols<br>Observes relationships between objects<br>Understands cause and effect<br>Visualizes conclusions |
| **12+ years** | Formal Operational Thought<br>Abstract thinking processes<br>Conceptualization<br>Ability to test hypotheses |

## Adolescence to Young Adulthood

A. Physical development.
   1. Completes sexual development.
   2. Exhibits signs of slowing down of body growth.
   3. Is capable of reproduction.
   4. Shows more energy after growth spurt tapers off.
   5. Exhibits increased muscular ability and coordination.

B. Menstruation.
   1. Menstruation is the sloughing off of the endometrium that occurs at regular monthly intervals if conception fails to take place. The discharge consists of blood, mucus, and cells, and it usually lasts for 4 to 5 days.
   2. Menarche—onset of menstruation—usually occurs between the ages of 11 and 14.
   3. Discomforts associated with menstruation.
      a. Breast tenderness and feeling of fullness.
      b. Tendency toward fatigue.
      c. Temperament and mood changes—because of hormonal influence and decreased levels of estrogen and progesterone.
      d. Discomfort in pelvic area, lower back, and legs.
      e. Retained fluids and weight gain.
   ✦ 4. Abnormalities of menstruation.
      a. Dysmenorrhea (painful menstruation).
         (1) May be caused by psychological factors: tension, anxiety, preconditioning (menstruation is a "curse" or should be painful).
         (2) Physical examination is usually done to rule out organic causes.
      b. Treatment.
         (1) Oral contraceptives—produce anovulatory cycle.
         (2) Mild analgesics such as aspirin.
         (3) Urge client to carry on normal activities to occupy her mind.
         (4) Dysmenorrhea may subside after childbearing.
      c. Amenorrhea (absence of menstrual flow).
         (1) Primary—over the age of 17 and menstruation has not begun.
            (a) Complete physical necessary to rule out abnormalities.
            (b) Treatment aimed at correction of underlying condition.
         (2) Secondary—occurs after menarche; does not include pregnancy and lactation.
            (a) Causes include psychological upsets or endocrine conditions.
            (b) Evaluation and treatment by physician is necessary.
      d. Menorrhagia (excessive menstrual bleeding)—may be due to endocrine disturbance, tumors, or inflammatory conditions of the uterus.
      e. Metrorrhagia (bleeding between periods)—symptom of disease process, benign tumors, or cancer.
   ✦ 5. Counseling guidelines.
      a. Provide education about the physiology of normal menstruation and correct misinformation.
      b. Provide education about abnormal conditions associated with menstruation—absence of menstruation, bleeding between menstrual periods, etc.
      c. Provide education related to normal hygiene during menstruation.
         (1) Importance of cleanliness.
         (2) Use of perineal pads and tampons.
         (3) Continuance of normal activities.

C. Social development.
   1. Is less attached to peers.
   2. Shows increased maturity.
   3. Exhibits more interdependence with family.
   4. Begins romantic love affairs.

5. Increases mastery over biologic drives.
6. Develops more mature relationship with parents.
7. Values fidelity, friendship, and cooperation.
8. Begins vocational development.

D. Counseling guidelines.
1. Assist adolescent in making a vocational choice.
2. Provide safety education, especially regarding driving and drugs.
3. Encourage positive attitudes toward health in issues of nutrition, drugs, smoking, and drinking.
4. Attempt to understand own (parental) difficulties in accepting transition of the adolescent to independence and adulthood.

E. Developmental tasks (**Table 3-3**).
1. Intimacy and solidarity versus isolation.
a. Moves from security of self-involvement to insecurity of building intimate relationships with others.
b. Becomes less dependent and more self-sufficient.
2. Able to form lasting relationships with others.
3. Learns to be productive and creative.
4. Handles hormonal changes of developmental period.

## ADULTHOOD

### Developmental Tasks

✦ A. Achieves goal of generativity versus stagnation or self-absorption.
1. Shows concern for establishing and guiding next generation.
2. Exhibits productiveness, creativity, and an attitude of looking forward to the future.
3. Stagnation results from the refusal to assume power and responsibility of the goals of middle age.
a. Suffers pervading sense of boredom and impoverishment.
b. Undergoes but does not resolve midlife crisis.

B. Has relaxed sense of competitiveness.

C. Opens up new interests.

**Table 3-3 ERIKSON'S EIGHT STAGES OF PERSONALITY DEVELOPMENT—INFANT TO ADULT**

| Stage | Approx. Age | Psychological Crises | Significant Persons | Accomplishments |
|---|---|---|---|---|
| **Infant** | 0–1 yrs. | Basic trust vs. mistrust | Mother or maternal figure | Tolerates frustration in small doses<br>Recognizes mother as separate from others and self |
| **Toddler** | 1–3 yrs. | Autonomy vs. shame and doubt | Parents | Begins verbal skills<br>Begins acceptance of reality vs. pleasure principle |
| **Preschool** | 3–6 yrs. | Initiative vs. guilt | Basic family | Asks many questions<br>Explores own body and environment<br>Differentiates between sexes |
| **School** | 6–12 yrs. | Industry vs. inferiority | Neighborhood school | Gains attention by accomplishments<br>Explores things<br>Learns to relate to own sex |
| **Puberty and adolescence** | 12–20 yrs. | Identity vs. role diffusion | Peer groups<br>External groups | Moves toward heterosexuality<br>Begins separation from family<br>Integrates personality (e.g., altruism) |
| **Young adult** | 18–25 yrs. | Intimacy and solidarity vs. isolation | Partners in friendship; sexual partners | Is able to form lasting relationships with others, committed to work |
| **Adulthood** | 25–65 yrs. | Generativity vs. stagnation | | Creative, productive life, caring for others |
| **Late adulthood, elderly** | 65 yrs.–death | Ego integrity vs. despair | | Acceptance of worth and value of one's life |

Based on Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York, NY: Norton.

D. Shifts values from physical attractiveness and strength to intellectual abilities.
E. Shows productivity (may be most productive years of one's life).
F. Has more varied and satisfying relationships.
G. Exhibits no significant decline in learning abilities or sexual interests.
H. Shifts sexual interests from physical performance to the individual's total sexuality and need to be loved and touched.
I. Assists next generation to become happy, responsible adults.
J. Achieves mature social and civic responsibility.
K. Accepts and adjusts to physiological changes of middle life.
L. Uses leisure time satisfactorily.
M. Failure to complete developmental tasks may cause the individual to approach old age with resentment and fear.
    1. Neurotic symptoms may appear.
    2. Increased psychosomatic disorders develop.

## Values of Adulthood

A. Becomes more introspective.
B. Shows less concern as to what others think.
C. Identifies self as successful even though all life goals may not be achieved.
D. Shows less concern for outward manifestations of success.
E. Lives more day to day and values life more deeply.
F. Has faced one's finiteness and eventual death.

## Parenting in Adulthood

A. Characteristics.
    1. Tendency toward smaller families.
    2. Career-oriented women who limit family size or who do not want children.
    3. Early sexual experimentation, necessitating sexual education, and contraceptive information.
    4. Tendency toward postponement of children.
        a. To complete education.
        b. Economic factors.
    5. High divorce rates.
    6. Alternative family designs.
        a. Single parenthood.
        b. Communal family.
✦ B. Family planning.*
    1. General concepts.
        a. Dealing with individuals with particular ideas regarding contraception.
        b. No perfect method of birth control.
        c. Method must be suited to individual.
        d. Individuals involved must be thoroughly counseled on all available methods and how they work—including advantages and disadvantages. This includes not only female but also sexual partner (if available).
        e. Once a method is chosen, both parties should be thoroughly instructed in its use.
        f. Individuals involved must be motivated to succeed.
    2. Effectiveness depends on several factors:
        a. Method chosen.
        b. Degree to which couple follows prescribed regimen.
        c. Thorough understanding of the chosen method.
        d. Motivation on part of individuals concerned.

* See Contraceptive Methods in Chapter 12.

## Physiological Changes

### Menopause

A. Characteristics.
    1. The cessation of menstruation caused by physiologic factors; ovulation no longer occurs.
    2. Menopause usually occurs between the ages of 45 and 55.
B. Mechanisms in menopause.*
    1. Ovaries lose the ability to respond to pituitary stimulation and normal ovarian function ceases.
    2. Gradual change due to alteration in hormone production.
        a. Failure to ovulate.
        b. Monthly flow becomes smaller, irregular, and gradually ceases.
    3. Menopause is accompanied by changes in reproductive organs. The vagina gradually becomes smaller; the uterus, bladder, rectum, and supporting structures lose tone, leading to uterine prolapse, rectocele, and cystocele.
    4. Atherosclerosis and osteoporosis are more likely to develop at this time.

### Assessment

A. Assess presence of symptoms—varies with individuals and may be mild to severe.
B. Assess feelings of loss as children grow and leave home and aging process continues.
✦ C. Assess presence of physiological symptoms: hot flashes, night sweats, vaginal atrophy, mood swings, and fatigue.

* See Menopause, Chapter 8: Genitourinary System.

#### Implementation

A. Refer client to physician who can discuss hormone replacement therapy (HRT), now controversial, versus natural methods of controlling symptoms.
   1. Diet: more vegetarian with essential fatty acids; limiting caffeine, sugar, meat and dairy, and saturated oils.
   2. Herbs: black cohosh, dong quai, fennel, red clover, and other phytoestrogen plants.
   3. Progesterone substitute—skin cream made from the Mexican yam, natural progesterone, and natural estrogen (estriol) via a skin patch.

B. Monitor estrogen therapy—usually given on cyclic basis: one pill daily except for 5 days during the month; progesterone 10–12 days per month.

C. Evaluate need for treatment of psychological problems.

#### Major Health Problems

A. Heart disease occurs in both male and female clients (as of 2010 more than 500,000 die each year).
B. Diabetes.
C. Hypertension.
D. Accidents.
E. Confrontation with the most acute psychological problems of any age group.
   1. Depression.
   2. Involutional psychosis.
F. Cancer.

### Psychosocial Changes

#### Midlife Crisis

A. A normal stage in the ongoing life cycle in which the middle-aged person reevaluates his or her total life situation in relation to youthful achievements and actual accomplishments.
   1. Struggles to maintain physical attractiveness in relation to younger people.
   2. Feels partner or lover is essential.
   3. Feels he or she has peaked in ability.
   4. Blames environment or others for failure to succeed.
   5. Displays increased interest in sexuality.
   6. Exhibits competitiveness in career plans.

B. Unresolved crisis.
   1. May result in stagnation, boredom, and decreased self-esteem and depression.
   2. Age for crisis varies.
      a. Women usually pass through it at age 35 to 40.
      b. Men usually experience the crisis at age 40 to 45.

#### Causes of Psychological Problems

A. Fear of losing job.
B. Competition with younger generation.
C. Loss of job.
D. Loss of nurturing functions.
E. Loss of spouse, particularly females.
F. Realization that person is not going to accomplish some of the things that he or she wanted to do.
G. Changes in body image.
H. Illness.
I. Role change within and outside of family.
J. Fear of approaching old age.
K. Physiological changes.

**MASLOW'S HIERARCHY OF NEEDS THEORY**

- Abraham Maslow identified a hierarchy of human needs. The most basic must be met before the next levels can be fulfilled.
- The most basic needs are bodily drives—hunger, thirst, and physical needs for shelter, sleep, exercise.
- More general needs follow (also necessary for life) and become the focus after essential physical needs.
  1. Feeling safe in the world.
  2. Sense of belonging and love.
  3. Failure to meet these needs negates fulfillment of even higher needs (respect, self-esteem, and self-actualization).
- Nursing implications: Use Maslow's hierarchy of needs when you are answering a priority question that involves issues of physiological needs versus needs such as recognition, belonging, and loving. Basic physical needs (such as hunger and pain) must be met first.

## THE AGED*

### Developmental Tasks

✦ A. Maintains ego integrity versus despair.
   1. Integrity results when an individual is satisfied with his or her own actions and lifestyle, feels life is meaningful, remains optimistic, and continues to grow.
   2. Despair results from the feeling that he or she has failed and that it is too late to change.

B. Continues a meaningful life after retirement.
C. Adjusts to income level.
D. Makes satisfactory living arrangements with spouse.
E. Adjusts to loss of spouse. (Forty-five percent of women older than age 65 are widowed.)
F. Maintains social contact and responsibilities.
G. Faces death realistically.

*For more in-depth coverage see Chapter 15.

H. Provides knowledge and wisdom to assist those at other developmental levels to grow and learn.
I. In the year 2010, there were approximately 40 million people older than age 65 in the United States.

## Physiological Changes

A. Decrease in ability to maintain homeostasis.
    1. Decrease in physical strength and endurance.
    2. Decrease in muscular coordination and strength.
B. Changes in bone composition.
    1. Loss of density and increased brittleness.
    2. Increased spine curvatures.
C. Tendency to gain weight.
D. Loss of pigment in hair and elasticity of skin.
E. Diminution of sensory faculties.
    1. Vision decreases.
    2. Loss of hearing occurs.
    3. Smell and taste become dull.
    4. Greater sensitivity to temperature changes occurs with low tolerance to cold.
F. Lowered immune system—decreased resistance to infection and disease.
G. Degenerative changes in the cardiovascular system.
    1. Heart pump action diminishes.
    2. Blood flow decreases—may be due to fat deposits in arteries.
    3. Vascular changes result in less effective oxygenation.
H. Changes in respiratory system.
    1. Blood flow decreases to lungs: Contributes to decrease in function.
    2. Less oxygen diffusion so tolerance is less.
I. Changes in gastrointestinal system.
    1. Absorption function impaired.
        a. Body absorbs less nutrients.
        b. Decrease in gastric enzymes affects absorption.
    2. Peristalsis weakens and constipation is common.
J. Changes in urinary system.
    1. Structural and functional changes occur in kidney through degeneration.
    2. Decreased musculature ability leads to atonic bladder.

## Major Health Problems

A. All systems are more vulnerable because of the aging process; degeneration can be affected.
    1. Chronic disease and disability.
    2. Nutritional deprivation; dehydration.
    3. Sensory impairment—blindness and deafness.
    4. Organic brain changes.
        a. Not all persons become senile.
        b. Most people have memory impairment.
        c. The change is gradual.
B. Impact of disease on aged.
    1. Diseases may be multiple and chronic (more than 40% have more than one illness concurrently).
    2. Disability results more readily when an aging person becomes ill.
    3. Response to treatment is diminished.
    4. Resistance is lower due to the aging process so the person is more susceptible to disease.
    5. The aged have less resistance to stressors—mental, environmental, and physical.
    6. Changes in the neurological system make aged persons more prone to organic brain changes.
    7. Many elderly take numerous medications and are susceptible to drug reactions and side effects.

## Psychosocial Changes

A. Developmental process retrogresses.
    1. Exhibits increasing dependency.
    2. Concerns focus increasingly on self.
    3. Displays narrower interests.
    4. Needs tangible evidence of affection.
B. Major fears of the aged.
    1. Physical and economic dependency.
    2. Chronic illness.
    3. Loneliness.
    4. Boredom resulting from not being needed.
✦ C. Major problems of the aged.
    1. Alteration in living style (e.g., nursing home, moving in with children).
    2. Economic deprivation.
        a. Increased cost of living on a fixed income.
        b. Increased need for costly medical care.
    3. Chronic disease and disability.
    4. Social isolation/loneliness.
    5. Sensory deprivation (blindness and deafness).
    6. Senility, confusion, and lack of awareness.
    7. Nutritional deprivation.
    8. Series of losses (e.g., relationships, friends, family).
    9. Loss of physical strength and agility.
D. Sexuality and aging.
    1. Older people are sexual beings.
    2. There is no particular age at which a person's sexual functioning ceases.
    3. Frequency of genital sexual behavior (intercourse) may tend to decline gradually in later

years, but capacity for expression and enjoyment continue far into old age.
4. Touching and companionship are of importance for older people and should be encouraged.

## CULTURAL SENSITIVITY

A. Demographic shifts influence the direction of health care.
   1. In the United States, 29% of the population are people of color and more than 12% are of Hispanic origin.
   2. In 2010, there were more than 40 million foreign-born Americans and 34 million did not speak English.
   3. These statistics create barriers to health care.
      a. The major barrier is language.
      b. The other barriers are poverty, poor nutrition, and poor prevention practices.
   4. Reduced access to health care is a major problem for non–English-speaking peoples.
B. It is important for nurses to understand the impact of various cultures on healthcare practices.
C. Cultural diversity implications (**Table 3-4**).
   1. Differences in values, beliefs, customs, folklore, traditions, language, and patterns of behavior.
   2. Other aspects of differences are personal space related to culture, gender, and group behavior.

**Table 3-4 CULTURAL BELIEFS**

| Ethnic Group | Cultural Beliefs |
|---|---|
| **Asian/Pacific Islander** → | Extended family has strong influence on client.<br>Older family members are honored and respected, and their authority is unquestioned. Oldest male is decision maker and spokesman.<br>Strong emphasis on avoiding conflict and direct confrontation.<br>Respect authority and do not disagree with healthcare recommendations; however, they may not follow recommendations. |
| **Chinese** → | Chinese clients will not discuss symptoms of mental illness or depression because they believe this behavior reflects on family; therefore it may produce shame and guilt.<br>Use herbalists, spiritual healers, and physicians for care. |
| **Japanese** → | Believe physical contact with blood, skin diseases, and corpses will cause illness.<br>Believe improper care of the body, including poor diet and lack of sleep, causes illness. Believe in healers, herbalists, and physicians for healing, and energy can be restored with acupuncture and acupressure.<br>They use group decision making for health concerns. |
| **Hindu and Muslim** → | Indians and Pakistanis do not acknowledge a diagnosis of severe emotional illness or mental retardation because it reduces the chance of other family members getting married. |
| **Vietnamese** → | Vietnamese accept mental health counseling and interventions, particularly when they have established trust with the healthcare worker. |
| **Hispanic** → | Older family members are consulted on issues involving health and illness.<br>Patriarchal family—men make decisions for family.<br>Illness is viewed as God's will or divine punishment resulting from sinful behavior.<br>Prefer to use home remedies and consult folk healers known as curanderos rather than traditional Western healthcare providers. |
| **African American** → | Family and church oriented.<br>Extensive extended family bonds.<br>Key family member is consulted for important health-related decisions.<br>Illness is a punishment from God for wrongdoing, or is due to voodoo, spirits, or demons.<br>Health prevention is through good diet, herbs, rest, cleanliness, and laxatives to clean the system. Wear copper and silver bracelets to prevent illness. |
| **Native American** → | Oriented to the present.<br>Value cooperation.<br>Value family and spiritual beliefs. Strong ties to family and tribe.<br>Believe a state of health exists when the client lives in total harmony with nature.<br>Illness is viewed as an imbalance between the ill person and natural or supernatural forces. Use a medicine man or woman known as a shaman.<br>Illness is prevented through elaborate religious rituals. |

**Table 3-5 RELIGIOUS DIVERSITY CONSIDERATIONS**

| Religious Orientation | Baptism | Death Rituals | Health Crisis | Diet |
|---|---|---|---|---|
| **Adventist** | Opposed to infant baptism | No last rites | Communion or baptism may be desirable | No alcohol, coffee, tea, or any narcotic |
| **Baptist** | Opposed to infant baptism | Clergy supports and counsels | Some believe in healing and laying on of hands<br>Some sects resist medical help | Condemn alcohol<br>Some do not allow coffee and tea |
| **Islam** | No baptism | Prescribed procedures by family for washing body and shrouding after death | No faith healing<br>Ritual washing after prayers every day | Prohibit alcohol and pork |
| **Buddhist** | Rites are given after child is mature | Send for Buddhist priest<br>Last rite chanting | Family should request priest to be notified | Alcohol and drugs discouraged; some are vegetarian |
| **Christian Scientist** | No baptism | No last rites<br>No autopsy | Deny the existence of health crises<br>Many refuse all medical help, blood transfusions, or drugs | Alcohol, coffee, and tobacco viewed as drugs and not allowed |
| **Episcopalian** | Infant baptism mandatory | Last rites not essential for all members | Medical treatment acceptable | Some do not eat meat on Fridays |
| **Jehovah's Witness** | No infant baptism | No last rites | Opposed to blood transfusions | Do not eat anything to which blood has been added |
| **Judaism** | No baptism but ritual circumcision on eighth day after birth | Ritual washing of body after death | All ill people seek medical care<br>Treatment supersedes dietary restrictions | Orthodox observe kosher dietary laws, which prohibit pork, shellfish, and the eating of meat and milk products at the same time |
| **Methodist** | Baptism encouraged | No last rites | Medical treatment acceptable | No restrictions |
| **Mormon** | Baptism at eight years or older | Baptism for the dead can be done by proxy | Do not prohibit medical treatment, although they believe in divine healing | Do not allow alcohol, caffeine, tobacco, tea, and coffee |
| **Roman Catholic** | Infant baptism mandatory | Last rites required | Sacrament of the sick | Most ill people are exempt from fasting |

Note: There may exist circumstances that require a court order to supervene religious practices (e.g., a blood transfusion to save the life of a child).

D. Cultural assessment—important to include in a complete client assessment.
   1. Cultural background and orientation.
   2. Communication patterns.
   3. Nutritional practices.
      a. Cultural/religious beliefs that do not eliminate whole food groups (**Table 3-5**).
      b. Beliefs that interfere with receiving a healthy, balanced diet (such as a macrobiotic diet).
      c. Food practices that do not allow foods to lose all nutrient value during preparation (overcooking vegetables).
   4. Family relationships.
   5. Beliefs and perceptions related to health, illness, and treatment.
   6. Values related to health.
   7. Education.
   8. Issues affecting healthcare delivery.

## THE GRIEVING PROCESS

### ✦ Stages of Grief

*Definition*: A process that an individual goes through in response to the loss of a significant or loved person. The grieving process follows certain predictable phases—classic description originally defined by Dr. Eric Lindeman. The

normal grieving process is described by George Engle, M.D., in "Grief and Grieving," *American Journal of Nursing*, September 1964.

A. **Shock and disbelief**: First response is shock and refusal to believe that the loved one is dead.
B. **Developing awareness**: As awareness increases, the bereaved experiences severe anguish.
   1. Crying is common in this stage.
   2. Anger directed toward those people or circumstances thought to be responsible.
C. **Restitution**: Mourning is the next stage where the work of restitution takes place.
   1. Rituals of the funeral help the bereaved accept reality.
   2. Support from friends and spiritual guidance comfort the bereaved.
D. **Resolution of the loss**: Occurs as the mourner begins to deal with the void.
E. **Idealization**: Negative feelings are repressed and only the pleasant memories are remembered.
   1. Characterized by the mourner's taking on certain qualities of the deceased.
   2. This process takes many months as preoccupation with the deceased diminishes.

✦ F. Outcome of the grief process takes a year or more.
   1. Indications of successful outcome are when the mourner remembers both the pleasant and unpleasant memories.
   2. Eventual outcome influenced by:
      a. Importance of the deceased in the life of mourner.
      b. The degree of dependence in the relationship. The amount of ambivalence toward the deceased.
      ✦ c. The more hostile the feelings that exist, the more guilt that interferes with the grieving process.
      d. Age of both mourner and deceased.
      e. Death of a child is more difficult to resolve than that of an aged loved one.
      ✦ f. Number and nature of previous grief experiences. Loss is cumulative.
      g. Degree of preparation for the loss.

| Stages of Grief | Stages of Dying |
|---|---|
| • Shock and disbelief<br>• Developing awareness<br>• Restitution/mourning<br>• Resolution<br>• Idealization | • Denial<br>• Anger<br>• Bargaining<br>• Depression<br>• Acceptance |
| According to George Engle | According to Elisabeth Kübler-Ross |

Adapted from Smith, S. F., Duell, D. J., & Martin, B. C. (2008). *Clinical nursing skills* (7th ed.). Upper Saddle River, NJ: Prentice Hall Health.

### Counseling Guidelines

✦ A. Recognize that grief is a syndrome with somatic and psychological symptomatology.
   1. Weeping, complaints of fatigue, digestive disturbance, and insomnia.
   2. Guilt, anger, and irritability.
   3. Restless, but unable to initiate meaningful activity.
   4. Depression and agitation.
B. Be prepared to support the family as they learn of the death.
   1. Know the general response to death by recognizing the stages of the grief process.
   2. Understand that the behavior of the mourner may be unstable and disturbed.
C. Use therapeutic communication techniques.
   1. Encourage the mourner to express feelings, especially through crying.
   2. Attempt to meet the needs of the mourner for privacy, information, and support.
   3. Show respect for the religious and social customs of the family.
D. Recognize the difference between grief and loss.
   1. Grief is the emotion experienced in response to loss.
   2. When one is grieving, he or she is feeling all of the emotions that accompany loss.
      a. Grief is not one emotion, but a combination of feelings.
      b. Grief encompasses all of the initial feelings of loss and moves through the stages to resolution.

## DEATH AND DYING

A. The dying process is described in *On Death and Dying*, by Elisabeth Kübler-Ross, New York, Macmillan Publishing Company, Inc., 1969.

✦ B. Stages of dying.
   1. **Denial**: Individual is stunned at the knowledge he or she is dying and denies it.
   2. **Anger**: Anger and resentment usually follow as the individual questions, "Why me?"
   3. **Bargaining**: With the beginning of acceptance of impending death comes the bargaining stage—that is, bargaining for time to complete some situation in his or her life.
   4. **Depression**: Full acknowledgment usually brings depression; individual begins to work through feelings and to withdraw from life and relationships.
   5. **Acceptance**: Final stage is full acceptance and preparation for death.
C. Throughout the dying process, hope is an important element that should be supported but not reinforced unrealistically.

D. Psychosocial clinical manifestations—behaviors and reactions the nurse will expect to observe in clients who are going through the dying process.
   1. Depression and withdrawal.
   2. Fear and anxiety.
   3. Focus is internal.
   4. Agitation and restlessness.

### The Concept of Death in the Aging Population

A. In American culture, death is very distasteful.
B. Older adults may see death as an end to suffering and loneliness.
C. Death is not feared if the person has lived a long and fulfilled life, having completed all developmental tasks.
D. Religious beliefs and/or philosophy of life is important.

### Death and Children

✦ A. Understanding of death for the young child.
   1. Death is viewed as a temporary separation from parents, sometimes viewed synonymously with sleep.
   2. Child may express fear of pain and wish to avoid it.
   3. Child's awareness is lessened by physical symptoms if death comes suddenly.
   4. Gradual terminal illness may simulate the adult process: depression, withdrawal, fearfulness, and anxiety.

B. Older children's concerns.
   1. Death is identified as a "person" to be avoided.
   2. Child may ask directly if he or she is going to die.
   3. Concerns center on fear of pain, fear of being left alone, and fear of leaving parents and friends.

C. Adolescent concerns.
   1. Death is recognized as irreversible and inevitable.
   2. Adolescent often avoids talking about impending death, and staff may enter into this "conspiracy of silence."
   3. Adolescents have more understanding of death than adults tend to realize.

### Nursing Management

✦ **Nursing Management of the Dying Adult**

A. Minimize physical discomfort.
   1. Evaluate pain as the fifth vital sign.
      a. Alleviate client's pain according to orders—be the client's advocate for pain relief.*
      b. Explore all options (drugs and alternative therapy) for achieving pain relief.
   2. Attend to all physical needs.
   3. Make client as comfortable as possible.

B. Recognize crisis situation.
   1. Observe for changes in client's condition.
   2. Support client.

C. Be prepared to give the dying client the emotional support needed.

D. Encourage communication.
   1. Allow client to express feelings, to talk, or to cry.
   2. Pick up cues that client wants to talk, especially about fears.
   3. Be available to form a relationship with client.
   4. Communicate honestly.

E. Prepare and support the family for their impending loss.

F. Understand the grieving process of client and family.

✦ **Nursing Management of the Dying Child**

A. Always elicit the child's understanding of death before discussing it.
B. Before discussing death with child, discuss it with parents.
C. Parental reactions include the continuum of grief process and stages of dying.
   1. Reactions depend on previous experience with loss.
   2. Reactions also depend on relationship with the child and circumstances of illness or injury.
   3. Reactions depend on degree of guilt felt by parents.
D. Assist parents in expressing their fears, concerns, and grief so that they may be more supportive to the child.
E. Assist parents in understanding siblings' possible reactions to a terminally ill child.
   1. **Guilt**: belief that they caused the problem or illness.
   2. **Jealousy**: demand for equal attention from the parents.
   3. **Anger:** feelings of being left behind.

## PAIN MANAGEMENT

✦ **Characteristics**

A. Pain now considered the fifth vital sign—must be assessed regularly (The Joint Commission) to maintain client's quality of life.
B. The experience of pain.
   1. Pain source—direct causative factor.
   2. Stimulation of pain receptor—mechanical, chemical, thermal, electrical, or ischemic.

* See Pain Management in the next column and on following pages.

3. Pain pathway.
   a. Sensory pathways through dorsal root, ending on second-order neuron in posterior horn.
   b. Afferent fibers cross over to anterolateral pathway, ascend in lateral spinothalamic tract to thalamus.
   c. Fibers then travel to postcentral gyrus in parietal lobe.

## Theories of Pain

A. Specificity theory—certain pain receptors are stimulated by a type of sensory stimulus that sends impulses to the brain.
B. Pattern theory—pain originates in spinal cord and results in receptor stimulation coded in central nervous system (CNS) and signifies pain.
C. Gate control theory.
   1. Pain impulses can be modulated by a transmission-blocking action within CNS.
   2. Large-diameter cutaneous pain fibers can be stimulated (rubbing, scratching) and may inhibit smaller diameter excitatory fibers and prevent transmission of that impulse.
   3. Cerebral cortical mechanisms that influence perception and interpretation may also inhibit transmission.
D. Endorphins—the brain produces natural brain opioids that fit (lock) into special receptors. Antilocks, called antagonists, keep endorphins from working.

### Assessment

✦ A. Assess for type of pain.
   1. Acute—localized, shorter duration, sharp sensation. Occurs over defined period—6 months or less.
   2. Chronic pain—long duration, diffuse, dull aching quality; associated autonomic responses, musculoskeletal tension, nausea. Occurs over 6-month period or longer.
   3. Malignant—recurrent, acute episodes; also includes chronic varying in intensity—lasts longer than 6 months.
   4. Psychogenic—due to emotional factors without anatomic or physiological explanation.
B. Assess onset of pain.
C. Assess location, where it originates and travels.
D. Evaluate intensity and character of pain.
   1. Select a tool based on client's preferences and cognitive abilities.
   2. Examples of pain scales—verbal descriptor, numeric rating, FACES, and pain thermometer.
E. Quality—searing, dull, sharp, throbbing.
F. Pattern—timing.
G. Check precipitating factors.
H. Assess associated factors.
   1. Nausea and/or vomiting.
   2. Bradycardia/tachycardia.
   3. Hypotension/hypertension.
   4. Profuse perspiration.
   5. Apprehension or anxiety.
I. Assess duration of pain.
J. Evaluate previous experience of pain.

**IDENTIFYING PAIN IN YOUNG CHILDREN**

**Unidimensional indicators:**

- Increase in heart rate
- Elevations in blood pressure
- Sweating
- Changes in skin color

**Multidimensional indicators:**

- High-pitched cry
- Baby or child is inconsolable
- Awake continuously—not able to sleep
- Fussy
- Grunting sounds

**Behavioral responses:**

- Facial movement
- Bulging of area between eyebrows
- Tightly closed eyes
- Rigid mouth and tongue

### Implementation

A. Assess pain before treating.
B. Give reassurance, reduce anxiety and fears.
C. Offer distraction.
D. Give comfort measures: Positioning, rest, elevation, heat/cold applications; protect from painful stimuli.
E. Massage nonsurgical area of pain—but never massage calf due to danger of emboli.
F. Administer pain medication as needed: Monitor therapeutic, toxic dose and side effects.
G. Monitor alternative methods to control pain.
   1. Dorsal column stimulator: stimulation of electrodes at dorsal column of spinal cord by client-controlled device to inhibit pain.
   2. Analgesics: Alter perception, threshold, and reaction to pain.
   3. Anesthesia: Block pain pathway.
   4. Local nerve block.
   5. Neurosurgical procedures: interrupt sensory pathways; usually also affect pressure and temperature pathways.
      a. Neurectomy: Interrupt cranial or peripheral nerves.
      b. Sympathectomy: Interrupt afferent pathways (ganglia).

**THE JOINT COMMISSION (TJC) PAIN STANDARDS (2014)***

TJC pain management standards address the assessment and management of pain. The standards require organizations to:

- Recognize the right of clients to appropriate assessment and management of pain.
- Screen clients for pain during their initial assessment and, when clinically required, during ongoing, periodic reassessments.
- Educate clients suffering from pain and their families about pain management.
- Healthcare providers must be knowledgeable about pain assessment and management.
- Facilities must have policies in place for analgesics and other pain control therapies.

*http://www.jointcommission.org

# HUMAN SEXUALITY

## Overview of Human Sexuality

✦ A. Biological sexuality is determined at conception.
   1. Male sperm contributes an X or a Y chromosome.
   2. Female ovum has an X chromosome.
   3. Fertilization results in either an XX (female) or an XY (male).

B. Preparation for adult sexuality originates in the sexual role development of the child.
   1. Significant differences between male and female infants are observable even at birth.
   2. Biological changes are minimal during childhood, but parenting strongly influences a child's behavior and sexual role development.
   3. Anatomical and physiological changes occur during adolescence that establish biological sexual maturation.
   4. Learning about sexuality has several stages.
      a. First stage: Person becomes aware that he or she is a sexual being and accepts the fact.
      b. Second stage: Person seeks to learn about the sexual self—experiments with bodies and emotions.
      c. Third stage: Involves sharing self with a partner.

C. Human sexuality pervades the whole of an individual's life.
   1. More than a sum of isolated physical acts.
   2. Functions as a purposeful influence in human nature and behavior.
   3. Observable in everyday life in endless variations.

D. Each society develops a set of normative behaviors, attitudes, and values in respect to sexuality, which are considered "right" and "wrong" by individuals.

E. Freud described the bisexual (androgynous) nature of the person.
   1. Each person has components of maleness–femaleness, masculinity–femininity, and heterosexuality–homosexuality.
   2. These components are physiological and psychological in nature.
   3. All components influence an individual's sexuality and sexual behavior.

F. Gender identity (identified at birth) refers to whether a person is male or female.
   1. Cases of "ambiguous genitalia" are rare (1/3000 births) and require special care for the infant and parents.
   2. *Ambiguous genitalia* is a clinical label similar to slang term *morphodite*, or biological term *hermaphrodite*.

G. Sexual object choice is the selection of a mode of outlet for sexual desire, usually with another person.
   1. Generally occurs during adolescence and beyond.
   2. Includes heterosexuality, homosexuality, bisexuality, celibacy, and narcissism/onanism.

H. Sexual object choice has strong influence on a person's lifestyle.
   1. Individual must establish patterns of intimacy and sexual behavior that are acceptable to self, to significant others, and to society to a certain extent.
   2. Psychological demands and expectations throughout life influence an individual's sexual interest, activity, and functional capacity.
   3. Sexual object choice can affect a person's choices in life such as whether to be a parent, where to live, and which career to pursue.

## Sexual Behavior

A. Sexual behavior is a composite of developed patterns of intimacy, psychological demands and expectations, and sexual object choice.
   1. Can be genital (sexual intercourse), intimate (holding, hugging), or social (dating, choice of clothing).
   2. Beyond the obvious examples, one never stops "behaving sexually."
   3. Dress, communication, and activity are all expressions of sexuality.
   4. Every person exhibits sexual behavior continually; no one is sexless.

B. *Transvestite* and *transsexual* are two terms that often cause confusion and need definition and differentiation.
   1. Transvestite refers to one who enjoys wearing clothing of the opposite sex; may or may not be homosexual.

2. Transsexual is a person who chooses sexual reassignment: a complex physical (surgical), psychological, and social process of taking on the gender identity, sex role, sexual object choice, and sexual behavior of the opposite sex.

C. Sexuality, although difficult to define, is pervasive from birth to death, and nurses need to look beyond the framework of reproduction and procreation to understand the influence of sexuality on clients' health and illness.

**Characteristics**

A. Difficult to define precisely, human sexuality is considered to be a pervasive life force and includes a person's total feelings, attitudes, and behavior.
B. It is related to gender identity, sex-role identity, and sexual motivation.
C. Touching, intimacy, and companionship are factors that have unique meaning for each person's sexuality.
D. Sex role describes whether a person assumes masculine or feminine behaviors, usually a combination of both.
   1. This role is generally considered to be fairly established by age 5.
   2. Usually referred to by the concepts boy/girl and man/woman.

**Assessment**

A. If necessary, obtain a full sexual history.
B. Include consideration of each client's sexuality in assessing health and illness status.
C. Assess primary sexual concerns.
D. Listen for nonverbal cues of sexual problems.
E. Elicit verbalization of underlying concerns.
F. Identify major problem area.
   1. Be aware that the most common problem is the need for sexual recognition of each client.
   2. Allow sexual expression within appropriate limits.
   3. Assess whether client has correct information or misconceptions about sexuality.
   4. Assess the relationship between each client's health problems and his or her sexuality needs.

**Implementation**

A. Provide sex education and counseling.
   1. Clients consider nurses to be experts in sexuality.
   2. Intervention requires knowledge and skill.
   3. Nurses need to know referral sources for interventions beyond their ability.
✦ B. Give clients "permission" or acceptance to maintain sexuality and sexual behavior.
C. Be aware of the effect of medications on clients' sexuality and sexual functioning.
   1. Oral contraceptives are considered by some to have played a major role in creating a sense of sexual freedom in contemporary society.
   2. Drugs that decrease sexual drive or potency may act directly on the physiological mechanisms or may decrease interest through a depressant effect on the central nervous system.
   3. Drugs with an adverse effect on sexual activity include antihypertensive drugs, antidepressants, antihistamines, antispasmodics, diuretics, sedatives and tranquilizers, ethyl alcohol, and some hormone preparations and steroids.
D. Medications for sexual dysfunction.
   1. Example—sildenafil (Viagra): oral therapy (25–100 mg) for erectile dysfunction.
      a. Rapidly absorbed, 30–120 minutes, with resulting ability to achieve an erection sufficient for sexual intercourse.
      b. Appropriate for healthy young and elderly males.
   2. Precautions: any male who is at cardiac risk, has peptic ulcer disease.
✦ E. Be aware of the problems to which nursing personnel should direct themselves in relation to the area of human sexuality.
   ✦ 1. Attitudes.
      a. Nurses should increase their self-awareness of their own attitudes and the effect of these attitudes on the sexual health care of their clients.
      b. Nurses should suppress negative biases and prejudices and/or make appropriate referrals when they cannot give effective or therapeutic sexual health care.
   2. Knowledge.
      a. May have to be actively sought, although nursing programs are increasing the sexuality content in their curricula.
      b. Also available through books, journal articles, classes and workshops, and preparation for sexuality therapy on the graduate level.
   3. Skills.
      a. Primary skills needed are interpersonal techniques such as therapeutic communication, interviewing, and teaching.
      b. As with any skill, practice is needed for proficiency in sexual-history taking, education, and counseling.

## Sexual Behaviors Related to Health

A. Masturbation.
   1. A common sexual outlet for many people.
   2. For clients requiring long-term care, masturbation may be the only means for gratifying their sexual needs.
   3. Nurses frequently react negatively to any type of masturbatory activity, especially by male clients.
✦ 4. Clients should be allowed privacy; if a nurse walks in on a client masturbating, he or she should leave with an apology for having intruded on the client's privacy.
   5. Frequent or inappropriate masturbation may be harmful to the client's health.
      a. Nurse should use team planning to identify what need the client is attempting to meet.
      b. Limits need to be set to protect client and other clients if behavior is inappropriate.

B. Gender identity issues—homosexuality.
   1. Homosexuality is accepted as a viable lifestyle.
   2. Nurses may have negative attitudes based on incorrect knowledge about homosexuality.
✦ 3. A client's homosexual (gay) or lesbian lifestyle should be accepted and respected. These clients should be treated without judgments.
   4. As with any client, visitors should be encouraged as appropriate for the health/illness status, and these people should not be embarrassed or ridiculed.
   5. For chronically ill clients, such as in a nursing home, it is essential that sexuality needs be considered in the total care plan and special efforts be made to have these needs met.

C. Inappropriate sexual behavior.
   1. Difficult to precisely define "inappropriate" sexual behavior.
   2. Sometimes sexual behavior is in reaction to unintentional "seductive" behavior of nurses.
✦ 3. Specific nursing interventions.
      a. Set limits to unacceptable behavior immediately.
      b. Interact without rejecting client.
      c. Help client express feelings in an appropriate manner.
      d. Teach alternative behaviors that are acceptable.
      e. Provide acceptable outlets to sexual feelings.

D. Venereal disease.
   1. Based on reported cases, the incidence of gonorrhea and syphilis is increasing slowly.
✦ 2. Both syphilis and gonorrhea can be cured with appropriate antibiotic therapy. (Recently there has occurred a strain of syphilis resistant to antibiotic therapy, so prevention is an important teaching concept.)
✦ 3. Treatment and care should be given without judgment.
   4. Case finding and treatment are still very difficult, especially for adolescents who may need parental consent to obtain health services.

✦ E. Contraception.*
   1. Nurses are considered experts on forms of birth control.
   2. Nurses should be familiar with different methods and relative effectiveness of each one.
   3. Clients should be assisted to make their own choices as to whether to use contraception and which method is best for them.

F. Therapeutic abortion.†
   1. Clients need information about resources for and procedures of therapeutic abortions.
✦ 2. Clients should be given nonjudgmental assistance and support in decision-making process.
   3. If nurse cannot in good conscience assist the client because of conflicting religious or spiritual beliefs, referral should be made to someone who can.

## Sexuality and Disability

A. Physically and developmentally disabled persons are sexual beings also.
✦ B. Developmentally disabled persons should be given sexuality education and counseling in preparation for sexual expression and behavior.
C. After spinal cord injury, the level of the lesion and degree of interruption of nerve impulses influence sexual functioning; adaptation of previous sexual practices may be needed after the injury.
D. Fertility and the ability to bear children are usually not compromised in women with spinal cord injury.
✦ E. Nurses working with disabled clients must make special effort to include sexuality in total health care and services.
   1. Discuss sexual needs openly with client so he or she will not feel embarrassed to ask questions.
   2. Discuss previous sexual activity and how current needs can be met.
   3. Nurse must maintain a nonjudgmental attitude or relationship will be jeopardized.
   4. Support client and partner during sexual adjustment period.
   5. Refer to therapy support groups for ongoing support.

*For a more detailed outline of contraception, see Chapter 12.
†For a more detailed outline of abortion, see Chapter 12.

### Child Sexual Abuse*

A. There is only a beginning awareness of this problem area.
B. Most child sexual abuse involves a male adult and female child, but male children can also be victims of female or male sexual abusers.
C. The child may need special protection or temporary placement outside the home, but often the family unit can be maintained.
✦ D. Child sexual abuse or molestation is a form of child abuse, and nurses should know local regulations and procedures for case finding and reporting.
✦ E. Nursing interventions.
1. Establish a safe environment for the child.
2. Allow and encourage child to verbalize or communicate in his or her own way (through drawings or play acting).
3. Observe for appearance of symptoms over time (withdrawal, depression, phobias).
4. Encourage ongoing therapy to work through trauma.

## JOINT COMMISSION NATIONAL PATIENT SAFETY GOALS, 2014

A. The purpose of the National Patient Safety Goals is to improve client safety. The goals focus on problems in healthcare safety and how to solve them (see **Table 3-6**).

**Table 3-6 NATIONAL PATIENT SAFETY GOALS 2014**

| Goal | Implementation |
|---|---|
| **Identify clients correctly.** | |
| NPSG.01.01.01 | Use at least two ways to identify clients. For example, use the client's name *and* date of birth. This is done to make sure that each client gets the correct medicine and treatment. |
| NPSG.01.03.01 | Make sure that the correct client gets the correct blood when they get a blood transfusion. |
| **Improve staff communication.** | |
| NPSG.02.03.01 | Get important test results to the right staff person on time. |
| **Use medicines safely.** | |
| NPSG.03.04.01 | Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups, and basins. Do this in the area where medicines and supplies are set up. |
| NPSG.03.05.01 | Take extra care with clients who take medicines to thin their blood. |
| NPSG.03.06.01 | Record and pass along correct information about a client's medicines. Find out what medicines the client is taking. Compare those medicines to new medicines given to the client. Make sure the client knows which medicines to take when he/she is at home. Tell the client it is important to bring his/her up-to-date list of medicines every time he/she visits a doctor. |
| **Use alarms safely.** | |
| NPSG.06.01.01 | Make improvements to ensure that alarms on medical equipment are heard and responded to on time. |
| **Prevent infection.** | |
| NPSG.07.01.01 | Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning. |
| NPSG.07.03.01 | Use proven guidelines to prevent infections that are difficult to treat. |
| NPSG.07.04.01 | Use proven guidelines to prevent infection of the blood from central lines. |
| NPSG.07.05.01 | Use proven guidelines to prevent infection after surgery. |
| NPSG.07.06.01 | Use proven guidelines to prevent infections of the urinary tract that are caused by catheters. |
| **Identify client safety risks.** | |
| NPSG.15.01.01 | Find out which clients are most likely to try to commit suicide. |
| **Prevent mistakes in surgery.** | |
| UP.01.01.01 | Make sure that the correct surgery is done on the correct client and at the correct place on the client's body. |
| UP.01.02.01 | Mark the correct place on the client's body where the surgery is to be done. |
| UP.01.03.01 | Pause before the surgery to make sure that a mistake is not being made. |

*Data from:* The Joint Commission (TJC), National Patient Safety Goals (effective January 1, 2014). http://www.jointcommission.org/assets/1/6/AHC_NPSG_Chapter_2014.pdf.

* For more detailed information on child abuse, see Psychiatric Nursing, Chapter 14.

**Table 3-7 OFFICIAL "DO NOT USE" LIST**

| Do Not Use | Potential Problem | Use Instead |
|---|---|---|
| U, u (unit) | Mistaken for "0" (zero), the number "4" (four), or "cc." | Write "unit." |
| IU (International Unit) | Mistaken for IV (intravenous) or the number 10 (ten). | Write "International Unit." |
| Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day) | Mistaken for each other. Period after the Q mistaken for "I" and the "O" mistaken for "I." | Write "daily." Write "every other day." |
| Trailing zero (X.0 mg)* Lack of leading zero (.X mg) | Decimal point is missed. | Write X mg. Write 0.X mg. |
| MS | Can mean morphine sulfate or magnesium sulfate. | Write "morphine sulfate." |
| MSO4 and MgSO4 | Confused for one another. | Write "magnesium sulfate." |

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.



B. In 2014, TJC created an official "Do Not Use" List of Abbreviations (see **Table 3-7**).
   1. Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on preprinted forms.

C. The Institute of Medicine's strategies for reducing medication errors (see Appendix 3-1 for a list of commonly confused drug names).
   1. Complete steps to improve communication between clients and providers.
   2. Improve drug naming, labeling, and packaging.
   3. Assign appropriate groups (FDA) to create easy-to-understand drug information for consumers.
   4. Write all prescriptions electronically.
   5. Inform clients of clinically significant medication errors made in their care, even if the mistake did not lead to harm.

## ALTERNATIVE AND COMPLEMENTARY THERAPIES

A. Alternative or complementary medicine became popular in the early 1990s.
   1. More than 600 million Americans use alternative therapy.
   2. Bills in Congress have authorized healthcare providers to give alternative treatments.

B. There are more than 200 alternative methods available. A short sampling of these treatment modes follows:
   1. **Acupuncture**: Use of sharp needles inserted along energy lines called meridians. Used for pain and to treat diseases caused by blocked or a lack of energy in the body.
   2. **Chiropractic**: Manipulation of bones and muscles to realign the spinal column as well as other areas in the body, thus enabling the body to heal itself.
   3. **Energy Medicine**: Use of varying frequencies of light and sound to heal the body. This mode is based on the premise that the body is made of electronic and magnetic vibrations.
   4. **Herbal Medicine**: Plant-based remedies with a long history of safety and efficacy used as an adjunct or in place of drugs to treat diseases and conditions.
   5. **Homeopathy**: A system of treatment that uses a minute dose of a substance (may be herbal or chemical) that mimics a disease resulting in a positive effect on the body. The principle with this therapy is that "like cures like."
   6. **Massage**: The oldest form of alternative medicine, massage is the application of touch to the skin to relieve stress and tension. This is a non-pharmacological approach to relieve pain.
   7. **Naturopathy**: A more global alternative therapy that includes natural therapies such as nutrition, herbs, homeopathy, massage, body work (Rolfing), and other treatments, all designed to help the body heal itself.
   8. **Relaxation and Visualization**: A form of therapy that uses exercise, visualization, and mental imagery to control the autonomic nervous system. These techniques have proven to be beneficial in controlling stress, oxygen consumption, respiratory and heart rate, and blood pressure.

C. Other therapies of note in the alternative medicine arena include ayurveda, biofeedback, aromatherapy, kinesiology, reflexology, Tai Chi, and yoga.

## CASE MANAGEMENT

*Definition:* Case management is the process of organizing and coordinating resources and services in response to individual healthcare needs along the illness and care continuum. This occurs in hospital-based and community-based settings.

**Goals:** The goals of case management are to:

1. treat clients at optimal times to:
   a. keep them healthy and
   b. out of the hospital
2. center services around the client's needs
3. foster client self-managed care, and
4. maximize efficient and cost-effective use of health resources
5. linking clients back to their:
   a. community
   b. primary care physician and
   c. local resources.

**Focus:** The focus is:

1. cost-saving through
   a. adherence to:
      i. plan of care
      ii. medication regime
      iii. understanding of importance of self monitoring

Case management nurses (CMN) are specialized registered nurses who manage the long-term care plans for clients with chronic or complicated medical conditions. They work collaboratively with all members of the healthcare team to assess the medical, physical, social, financial and emotional needs of clients and their families. These nurses work closely with clients and their loved ones to evaluate clients' needs and come up with a comprehensive healthcare plan that speaks to their preferences and goals. The case managers work to honor client choices, minimizing time constraints, maintaining a holistic focus, linking care-team members, and impacting quality and cost. They act as advocates to ensure that each client receives the most cost-effective care possible while exploring resources available to assist the client with achieving or maintaining independence. Advocacy includes medication management and scheduling medical testing and any necessary follow-up to ensure that each client is heard and afforded the care he needs.

A CMN consults with attending and primary care physicians, while collaborating with insurance-based case managers to develop a posthospital treatment plan by using clinical pathways in assessment and monitoring of clients and healthcare delivery. The CMN is responsible for the coordination of care and services, case finding, screening, determination of eligibility, comprehensive assessment; development, monitoring, and evaluation of the plan of care and use of resources and arrangement of services needed to reach outcomes in specific time frames. The critical help they provide provides peace of mind and a sense of security to clients and their families.

Using research and evidence-based practice, case managers participate in quality assurance and quality improvement processes to evaluate the impact of performance improvement measures on client care and resource utilization.

## QUALITY AND SAFETY EDUCATION FOR NURSES

Today, healthcare facilities are operating in an interconnected, globalized world with demands for quality and safety in care provided. Client demands, government policies, and third-party insurer regulations are changing rapidly and will impact professional nursing practice and client outcomes. Against this background of increasing complexity, a new set of challenges faces nurses, requiring them to demonstrate specific interdisciplinary core competencies. The concepts from which these competencies have been derived are from the Quality and Safety Education for Nurses (QSEN) Institute (2012). The goal of these competencies is to ensure that clients receive care that is safe and of the highest quality. The complexities that are ubiquitous in today's healthcare system require nurses to work within a simple yet comprehensive framework. The QSEN framework and competencies are used to assure that clients are receiving safe, quality care that is planned in collaboration with all disciplines involved to improve client outcomes. These competencies are expected to be part of the nurses' practice on a daily basis to ensure they perform safely and successfully in all areas of the complex heathcare systems in which they work.

QSEN provides the framework for the **k**nowledge, **s**kills and **a**ttitudes (KSAs) required for nurses to demonstrate competency in these vital areas, which include:

**Client-Centered Care:** The focus is that the client is in control and a full partner in all decision making related to their health care. It is important that we involve the client in all we do. The care is focused on client goals and solving problems based on respect for the client's personal, religious, and cultural preferences, values, and needs. This helps to promote relationship building with clients. *When we offer more control and choices that support individualization of care, clients' outcomes improve.*

**Teamwork and Collaboration:** This helps nurses to achieve quality client outcomes by effectively communicating with nurses and interprofessional teams having mutual

*Retrieved from http://qsen./competencies/pre-licensure-ksas/

respect and shared decision making while acknowledging other team members' contributions. The synergistic effect of valuable interdisciplinary collaboration is the interaction of multiple elements in the collaboration efforts to produce a result different from or greater than the sum of their individual effects.

**Evidence-Based Practice (EBP):** The goal of EPB is to integrate best current evidence into practice, while supporting client preferences and values to deliver optimal health care. EBP translates new knowledge into practice and provides guidance in weighing evidence and the opportunity to share the evidence. It then links studies to optimum clinical outcomes and business results. This approach reduces variability through evidence and the integration of standards. It becomes "a way to do" as opposed to "another thing to do." Examples of very successful evidence-based initiatives include hand washing and hand hygiene, pressure ulcer prevention (HAPU bundle); ventilator-associated pneumonia prevention (VAP bundle), catheter-associated urinary tract infection (CAUTI) and catheter-related bloodstream infections (CRBSI).

**Quality Improvement (QI):** The goal of QI programs is to monitor outcomes of care processes and use improvement methods to test changes and design mistake-proof processes to improve the healthcare system. It helps to develop a "just culture" and a culture of safety where individuals are comfortable in reporting errors, adverse events, and near misses without the fear of loss of job. QI provides systematic investigations of problems where it is safe to ask for help, look at waste and variation, and eliminate it. QI processes help to identify where to make changes and often result in systemwide transformations. Individual nursing-sensitive indicators reflect the structure, process, and outcomes of nursing care and are benchmarks for QI. Often QI projects use the PDSA (plan, do, study, act) model when problems are identified. This model helps to answer the questions: What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?

**Safety:** Client safety competencies are implemented to minimize risk of harm to clients and providers. Here the focus is through both system effectiveness and individual performance. This competency looks at human factors and other basic safety design principles as well as commonly used unsafe practices that impact on client care. A culture of safety is a just culture that provides learning opportunities to identify errors in a safe environment.

**Informatics and Technology:** The goal is to learn to use information and technology to communicate, enhance knowledge, mitigate error, and support safe, effective processes of care and decision making. Nursing involvement in design, selection, implementation, and evaluation of information technologies to support client care are important. In addition, navigating resources such as medical records and databases effectively are crucial.

These six competencies will be presented throughout the text in the areas of the NCLEX test plan of Safe and Effective Care Environment, Health Promotion and Maintenance, Psychosocial Integrity, and Physiological Integrity. For detailed presentations of the QSEN KSAs, go to the Pre-licensure KSAs that can be found at http://qsen.org/competencies/pre-licensure-ksas/

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES**

# ISMP's List of *Confused* Drug Names

This list of confused drug names, which includes look-alike and sound-alike name pairs, consists of those name pairs that have been published in the *ISMP Medication Safety Alert!*® and the *ISMP Medication Safety Alert!*® Community/Ambulatory Care Edition. Events involving these medications were reported to ISMP through either the ISMP National Medication Errors Reporting Program (ISMP MERP) or ISMP National Vaccine Errors Reporting Program (ISMP VERP). We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors. This may include strategies such as: using both the brand and generic names on prescriptions and labels; including the purpose of the medication on prescriptions; configuring computer selection screens to prevent look-alike names from appearing consecutively; and changing the appearance of look-alike product names to draw attention to their dissimilarities. Both the FDA-approved and the ISMP-recommended tall man (mixed case) letters have been included in the list below.

**Updated April 2014**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| Abelcet | amphotericin B | amiodarone | amantadine |
| Accupril | Aciphex | am**LODIP**ine | a**MIL**oride |
| aceta**ZOLAMIDE** | aceto**HEXAMIDE** | amphotericin B | Abelcet |
| acetic acid for irrigation | glacial acetic acid | amphotericin B | Ambisome |
| aceto**HEXAMIDE** | aceta**ZOLAMIDE** | Anacin | Anacin-3 |
| Aciphex | Accupril | Anacin-3 | Anacin |
| Aciphex | Aricept | antacid | Atacand |
| Activase | Cathflo Activase | Antivert | Axert |
| Activase | TNKase | Anzemet | Avandamet |
| Actonel | Actos | Apidra | Spiriva |
| Actos | Actonel | Apresoline | Priscoline |
| Adacel (Tdap) | Daptacel (DTaP) | argatroban | Aggrastat |
| Adderall | Inderal | argatroban | Orgaran |
| Adderall | Adderall XR | Aricept | Aciphex |
| Adderall XR | Adderall | Aricept | Azilect |
| ado-trastuzumab emtansine | trastuzumab | **ARIP**iprazole | proton pump inhibitors |
| Advair | Advicor | **ARIP**iprazole | **RABE**prazole |
| Advicor | Advair | Arista AH (absorbable hemostatic agent) | Arixtra |
| Advicor | Altocor | | |
| Afrin (oxymetazoline) | Afrin (saline) | Arixtra | Arista AH (absorbable hemostatic agent) |
| Afrin (saline) | Afrin (oxymetazoline) | | |
| Aggrastat | argatroban | Asacol | Os-Cal |
| Aldara | Alora | Atacand | antacid |
| Alkeran | Leukeran | atomoxetine | atorvastatin |
| Alkeran | Myleran | atorvastatin | atomoxetine |
| Allegra (fexofenadine) | Allegra Anti-Itch Cream (diphenhydr**AMINE**/allantoin) | Atrovent | Natru-Vent |
| | | Avandamet | Anzemet |
| Allegra | Viagra | Avandia | Prandin |
| Allegra Anti-Itch Cream (diphenhydr**AMINE**/allantoin) | Allegra (fexofenadine) | Avandia | Coumadin |
| | | **AVIN**za | **INV**anz |
| Alora | Aldara | **AVIN**za | Evista |
| **ALPRAZ**olam | **LOR**azepam | Axert | Antivert |
| Altocor | Advicor | aza**CITID**ine | aza**THIO**prine |
| amantadine | amiodarone | aza**THIO**prine | aza**CITID**ine |
| Amaryl | Reminyl | Azilect | Aricept |
| Ambisome | amphotericin B | B & O (belladonna and opium) | Beano |
| Amicar | Omacor | BabyBIG | HBIG (hepatitis B immune globulin) |
| Amikin | Kineret | Bayhep-B | Bayrab |
| a**MIL**oride | am**LODIP**ine | Bayhep-B | Bayrho-D |

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| Bayrab | Bayhep-B | Clindets | Clindesse |
| Bayrab | Bayrho-D | clobazam | clonaze**PAM** |
| Bayrho-D | Bayhep-B | clomi**PHENE** | clomi**PRAMINE** |
| Bayrho-D | Bayrab | clomi**PRAMINE** | clomi**PHENE** |
| Beano | B & O (belladonna and opium) | clonaze**PAM** | clobazam |
| Benadryl | benazepril | clonaze**PAM** | clo**NIDine** |
| benazepril | Benadryl | clonaze**PAM** | LORazepam |
| Benicar | Mevacor | clo**NIDine** | clonaze**PAM** |
| Betadine (with povidone-iodine) | Betadine (without povidone-iodine) | clo**NIDine** | Klono**PIN** |
| Betadine (without povidone-iodine) | Betadine (with povidone-iodine) | Clozaril | Colazal |
| Bextra | Zetia | coagulation factor IX (recombinant) | factor IX complex, vapor heated |
| Bicillin C-R | Bicillin L-A | codeine | Lodine |
| Bicillin L-A | Bicillin C-R | Colace | Cozaar |
| Bicitra | Polycitra | Colazal | Clozaril |
| Bidex | Videx | colchicine | Cortrosyn |
| Brethine | Methergine | Comvax | Recombivax HB |
| Bio-T-Gel | T-Gel | Cortrosyn | colchicine |
| Brevibloc | Brevital | Coumadin | Avandia |
| Brevital | Brevibloc | Coumadin | Cardura |
| bu**PROP**ion | bus**PIR**one | Cozaar | Colace |
| bus**PIR**one | bu**PROP**ion | Cozaar | Zocor |
| Capadex [non-US product] | Kapidex | cyclophosphamide | cyclo**SPORINE** |
| Capex | Kapidex | cyclo**SERINE** | cyclo**SPORINE** |
| Carac | Kuric | cyclo**SPORINE** | cyclophosphamide |
| captopril | carvedilol | cyclo**SPORINE** | cyclo**SERINE** |
| car**BAM**azepine | **OX**carbazepine | Cymbalta | Symbyax |
| **CARBO**platin | **CIS**platin | **DACTIN**omycin | **DAPTO**mycin |
| Cardene | Cardizem | Daptacel (DTaP) | Adacel (Tdap) |
| Cardizem | Cardene | **DAPTO**mycin | **DACTIN**omycin |
| Cardura | Coumadin | Darvocet | Percocet |
| carvedilol | captopril | Darvon | Diovan |
| Casodex | Kapidex | **DAUNO**rubicin | **DAUNO**rubicin citrate liposomal |
| Cathflo Activase | Activase | **DAUNO**rubicin | **DOXO**rubicin |
| Cedax | Cidex | **DAUNO**rubicin | **IDA**rubicin |
| ce**FAZ**olin | cef**TRIAX**one | **DAUNO**rubicin citrate liposomal | **DAUNO**rubicin |
| cef**TRIAX**one | ce**FAZ**olin | Denavir | indinavir |
| Cele**BREX** | Cele**XA** | Depakote | Depakote ER |
| Cele**BREX** | Cerebyx | Depakote ER | Depakote |
| Cele**XA** | Zy**PREXA** | Depo-Medrol | Solu-**MEDROL** |
| Cele**XA** | Cele**BREX** | Depo-Provera | Depo-subQ Provera 104 |
| Cele**XA** | Cerebyx | Depo-subQ Provera 104 | Depo-Provera |
| Cerebyx | Cele**BREX** | desipramine | disopyramide |
| Cerebyx | Cele**XA** | dexmethylphenidate | methadone |
| cetirizine | sertraline | Diabinese | Diamox |
| cetirizine | stavudine | Diabeta | Zebeta |
| chlordiaze**POXIDE** | chlorpro**MAZINE** | Diamox | Diabinese |
| chlorpro**MAZINE** | chlordiaze**POXIDE** | Diflucan | Diprivan |
| chlorpro**MAZINE** | chlorpro**PAMIDE** | Dilacor XR | Pilocar |
| chlorpro**PAMIDE** | chlorpro**MAZINE** | Dilaudid | Dilaudid-5 |
| Cidex | Cedax | Dilaudid-5 | Dilaudid |
| **CIS**platin | **CARBO**platin | dimenhy**DRINATE** | diphenhydr**AMINE** |
| Claritin (loratadine) | Claritin Eye (ketotifen fumarate) | diphenhydr**AMINE** | dimenhy**DRINATE** |
| Claritin-D | Claritin-D 24 | Dioval | Diovan |
| Claritin-D 24 | Claritin-D | Diovan | Dioval |
| Claritin Eye (ketotifen fumarate) | Claritin (loratadine) | Diovan | Zyban |
| Clindesse | Clindets | Diovan | Darvon |

(*Continues*)

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES (*Continued*)**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| Diprivan | Diflucan | Florinef | Florastor |
| Diprivan | Ditropan | Flovent | Flonase |
| disopyramide | desipramine | flumazenil | influenza virus vaccine |
| Ditropan | Diprivan | **FLU**oxetine | **PAR**oxetine |
| **DOBUT**amine | **DOP**amine | **FLU**oxetine | **DUL**oxetine |
| **DOP**amine | **DOBUT**amine | **FLU**oxetine | Loxitane |
| Doribax | Zovirax | fluvoxa**MINE** | flavox**ATE** |
| Doxil | Paxil | Folex | Foltx |
| **DOXO**rubicin | **DAUNO**rubicin | folic acid | folinic acid (leucovorin calcium) |
| **DOXO**rubicin | **DOXO**rubicin liposomal | folinic acid (leucovorin calcium) | folic acid |
| **DOXO**rubicin | **IDA**rubicin | Foltx | Folex |
| **DOXO**rubicin liposomal | **DOXO**rubicin | fomepizole | omeprazole |
| Dulcolax (bisacodyl) | Dulcolax (docusate sodium) | Foradil | Fortical |
| Dulcolax (docusate sodium) | Dulcolax (bisacodyl) | Foradil | Toradol |
| **DUL**oxetine | **FLU**oxetine | Fortical | Foradil |
| Durasal | Durezol | gentamicin | gentian violet |
| Durezol | Durasal | gentian violet | gentamicin |
| Duricef | Ultracet | glacial acetic acid | acetic acid for irrigation |
| Dynacin | Dynacirc | glipi**ZIDE** | gly**BURIDE** |
| Dynacirc | Dynacin | Glucotrol | Glycotrol |
| edetate calcium disodium | edetate disodium | gly**BURIDE** | glipi**ZIDE** |
| edetate disodium | edetate calcium disodium | Glycotrol | Glucotrol |
| Effexor | Effexor XR | Granulex | Regranex |
| Effexor XR | Enablex | guai**FEN**esin | guan**FACINE** |
| Effexor XR | Effexor | guan**FACINE** | guai**FEN**esin |
| Enablex | Effexor XR | HBIG (hepatitis B immune globulin) | BabyBIG |
| Enbrel | Levbid | Healon | Hyalgan |
| Engerix-B adult | Engerix-B pediatric/adolescent | heparin | Hespan |
| Engerix-B pediatric/adolescent | Engerix-B adult | Hespan | heparin |
| Enjuvia | Januvia | HMG-CoA reductase inhibitors ("statins") | nystatin |
| e**PHED**rine | **EPINEPH**rine | | |
| **EPINEPH**rine | e**PHED**rine | Huma**LOG** | Humu**LIN** |
| epirubicin | eribulin | Huma**LOG** | Novo**LOG** |
| eribulin | epirubicin | Huma**LOG** Mix 75/25 | Humu**LIN** 70/30 |
| Estratest | Estratest HS | Humapen Memoir (for use with Huma**LOG**) | Humira Pen |
| Estratest HS | Estratest | | |
| ethambutol | Ethmozine | Humira Pen | Humapen Memoir (for use with Huma**LOG**) |
| ethaverine [non-US name] | etravirine | | |
| Ethmozine | ethambutol | Humu**LIN** | Novo**LIN** |
| etravirine | ethaverine [non-US name] | Humu**LIN** | Huma**LOG** |
| Evista | **AVIN**za | Humu**LIN** 70/30 | Huma**LOG** Mix 75/25 |
| factor IX complex, vapor heated | coagulation factor IX (recombinant) | Humu**LIN** R U-100 | Humu**LIN** R U-500 |
| Fanapt | Xanax | Humu**LIN** R U-500 | Humu**LIN** R U-100 |
| Fastin (phentermine) | Fastin (dietary supplement) | Hyalgan | Healon |
| Fastin (dietary supplement) | Fastin (phentermine) | hydr**ALAZINE** | hydr**OXY**zine |
| Femara | Femhrt | Hydrea | Lyrica |
| Femhrt | Femara | **HYDRO**codone | oxy**CODONE** |
| fenta**NYL** | **SUF**entanil | Hydrogesic | hydr**OXY**zine |
| Fioricet | Fiorinal | **HYDRO**morphone | morphine |
| Fiorinal | Fioricet | hydroxychloroquine | hydroxyurea |
| flavox**ATE** | fluvoxa**MINE** | hydroxyurea | hydroxychloroquine |
| Flonase | Flovent | hydr**OXY**zine | Hydrogesic |
| Floranex | Florinef | hydr**OXY**zine | hydr**ALAZINE** |
| Florastor | Florinef | **IDA**rubicin | **DAUNO**rubicin |
| Florinef | Floranex | **IDA**rubicin | **DOXO**rubicin |

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| Inderal | Adderall | Letairis | Letaris [non-US product] |
| indinavir | Denavir | Letaris [non-US product] | Letairis |
| in**FLIX**imab | ri**TUX**imab | leucovorin calcium | Leukeran |
| influenza virus vaccine | flumazenil | leucovorin calcium | levoleucovorin |
| influenza virus vaccine | tuberculin purified protein derivative (PPD) | Leukeran | Alkeran |
| | | Leukeran | Myleran |
| Inspra | Spiriva | Leukeran | leucovorin calcium |
| Intuniv | Invega | Levaquin | Lariam |
| **INV**anz | **AVIN**za | Levbid | Enbrel |
| Invega | Intuniv | lev**ETIRA**cetam | lamo**TRI**gine |
| iodine | Lodine | Levemir | Lovenox |
| Isordil | Plendil | lev**ETIRA**cetam | lev**OCARN**itine |
| **ISO**tretinoin | tretinoin | lev**ETIRA**cetam | levofloxacin |
| Jantoven | Janumet | lev**OCARN**itine | lev**ETIRA**cetam |
| Jantoven | Januvia | levofloxacin | lev**ETIRA**cetam |
| Janumet | Jantoven | levoleucovorin | leucovorin calcium |
| Janumet | Januvia | levothyroxine | lamo**TRI**gine |
| Janumet | Sinemet | levothyroxine | Lanoxin |
| Januvia | Enjuvia | levothyroxine | liothyronine |
| Januvia | Jantoven | Lexapro | Loxitane |
| Januvia | Janumet | Lexiva | Pexeva |
| K-Phos Neutral | Neutra-Phos-K | liothyronine | levothyroxine |
| Kaopectate (bismuth subsalcylate) | Kaopectate (docusate calcium) | Lipitor | Loniten |
| Kaopectate (docusate calcium) | Kaopectate (bismuth subsalcylate) | Lipitor | Zyr**TEC** |
| Kadian | Kapidex | lithium | Ultram |
| Kaletra | Keppra | lithium carbonate | lanthanum carbonate |
| Kapidex | Capadex [non-US product] | Lodine | codeine |
| Kapidex | Capex | Lodine | iodine |
| Kapidex | Casodex | Loniten | Lipitor |
| Kapidex | Kadian | Lopressor | Lyrica |
| Keflex | Keppra | **LOR**azepam | **ALPRAZ**olam |
| Keppra | Kaletra | **LOR**azepam | clonaze**PAM** |
| Keppra | Keflex | **LOR**azepam | Lovaza |
| Ketalar | ketorolac | Lotronex | Protonix |
| ketorolac | Ketalar | Lovaza | **LOR**azepam |
| ketorolac | methadone | Lovenox | Levemir |
| Kineret | Amikin | Loxitane | Lexapro |
| Klono**PIN** | clo**NID**ine | Loxitane | **FLU**oxetine |
| Kuric | Carac | Loxitane | Soriatane |
| Kwell | Qwell | Lunesta | Neulasta |
| La**MIC**tal | Lam**ISIL** | Lupron Depot-3 Month | Lupron Depot-Ped |
| Lam**ISIL** | La**MIC**tal | Lupron Depot-Ped | Lupron Depot-3 Month |
| lami**VUD**ine | lamo**TRI**gine | Luvox | Lasix |
| lamo**TRI**gine | lami**VUD**ine | Lyrica | Hydrea |
| lamo**TRI**gine | lev**ETIRA**cetam | Lyrica | Lopressor |
| lamo**TRI**gine | levothyroxine | Maalox | Maalox Total Stomach Relief |
| Lanoxin | levothyroxine | Maalox Total Stomach Relief | Maalox |
| Lanoxin | naloxone | Matulane | Materna |
| lanthanum carbonate | lithium carbonate | Materna | Matulane |
| Lantus | Latuda | Maxzide | Microzide |
| Lantus | Lente | Menactra | Menomune |
| Lariam | Levaquin | Menomune | Menactra |
| Lasix | Luvox | Mephyton | methadone |
| Latuda | Lantus | Metadate | methadone |
| Lente | Lantus | Metadate CD | Metadate ER |

(*Continues*)

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES (*Continued*)**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| Metadate ER | Metadate CD | Neulasta | Neumega |
| Metadate ER | methadone | Neulasta | Nuedexta |
| met**FORMIN** | metro**NIDAZOLE** | Neumega | Neupogen |
| methadone | dexmethylphenidate | Neumega | Neulasta |
| methadone | ketorolac | Neupogen | Neumega |
| methadone | Mephyton | Neurontin | Motrin |
| methadone | Metadate | Neurontin | Noroxin |
| methadone | Metadate ER | Neutra-Phos-K | K-Phos Neutral |
| methadone | methylphenidate | Nex**AVAR** | Nex**IUM** |
| methadone | metolazone | Nex**IUM** | Nex**AVAR** |
| methadone | metoprolol | ni**CAR**dipine | **NIFE**dipine |
| Methergine | Brethine | **NIFE**dipine | ni**CAR**dipine |
| methimazole | metolazone | **NIFE**dipine | ni**MOD**ipine |
| methylphenidate | methadone | ni**MOD**ipine | **NIFE**dipine |
| metolazone | methadone | Norcuron | Narcan |
| metolazone | methimazole | Normodyne | Norpramin |
| metoprolol | methadone | Noroxin | Neurontin |
| metoprolol succinate | metoprolol tartrate | Norpramin | Normodyne |
| metoprolol tartrate | metoprolol succinate | Norvasc | Navane |
| metro**NIDAZOLE** | met**FORMIN** | Novo**LIN** | Humu**LIN** |
| Mevacor | Benicar | Novo**LIN** | Novo**LOG** |
| Micronase | Microzide | Novo**LIN** 70/30 | Novo**LOG** Mix 70/30 |
| Microzide | Maxzide | Novo**LOG** | Huma**LOG** |
| Microzide | Micronase | Novo**LOG** | Novo**LIN** |
| midodrine | Midrin | Novo**LOG** Flexpen | Novo**LOG** Mix 70/30 Flexpen |
| Midrin | midodrine | Novo**LOG** Mix 70/30 Flexpen | Novo**LOG** Flexpen |
| mifepristone | misoprostol | Novo**LOG** Mix 70/30 | Novo**LIN** 70/30 |
| Miralax | Mirapex | Nuedexta | Neulasta |
| Mirapex | Miralax | nystatin | HMG-CoA reductase inhibitors ("statins") |
| misoprostol | mifepristone | Occlusal-HP | Ocuflox |
| mito**MY**cin | mito**XANTRONE** | Ocuflox | Occlusal-HP |
| mito**XANTRONE** | mito**MY**cin | **OLANZ**apine | **QUE**tiapine |
| morphine | **HYDRO**morphone | Omacor | Amicar |
| morphine—nonconcentrated oral liquid | morphine—oral liquid concentrate | omeprazole | fomepizole |
| | | opium tincture | paregoric (camphorated tincture of opium) |
| morphine—oral liquid concentrate | morphine—nonconcentrated oral liquid | Oracea | Orencia |
| | | Orencia | Oracea |
| Motrin | Neurontin | Orgaran | argatroban |
| MS Contin | Oxy**CONTIN** | Ortho Tri-Cyclen | Ortho Tri-Cyclen LO |
| Mucinex | Mucomyst | Ortho Tri-Cyclen LO | Ortho Tri-Cyclen |
| Mucinex D | Mucinex DM | Os-Cal | Asacol |
| Mucinex DM | Mucinex D | oxaprozin | **OX**carbazepine |
| Mucomyst | Mucinex | **OX**carbazepine | oxaprozin |
| Myleran | Alkeran | **OX**carbazepine | car**BAM**azepine |
| Myleran | Leukeran | oxy**CODONE** | **HYDRO**codone |
| nalbuphine | naloxone | oxy**CODONE** | Oxy**CONTIN** |
| naloxone | Lanoxin | Oxy**CONTIN** | MS Contin |
| naloxone | nalbuphine | Oxy**CONTIN** | oxy**CODONE** |
| Narcan | Norcuron | **PACL**itaxel | **PAC**Litaxel protein-bound particles |
| Natru-Vent | Atrovent | **PACL**itaxel protein-bound particles | **PAC**Litaxel |
| Navane | Norvasc | Pamelor | Panlor DC |
| Neo-Synephrine (oxymetazoline) | Neo-Synephrine (phenylephrine) | Pamelor | Tambocor |
| | | Panlor DC | Pamelor |
| Neo-Synephrine (phenylephrine) | Neo-Synephrine (oxymetazoline) | paregoric (camphorated tincture of opium) | opium tincture |
| Neulasta | Lunesta | **PAR**oxetine | **FLU**oxetine |

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| **PAR**oxetine | piroxicam | Provera | **PRO**zac |
| Patanol | Platinol | **PRO**zac | Prograf |
| Pavulon | Peptavlon | **PRO**zac | Pri**LOSEC** |
| Paxil | Doxil | **PRO**zac | Provera |
| Paxil | Taxol | Purinethol | propylthiouracil |
| Paxil | Plavix | Pyridium | pyridoxine |
| pazopanib | ponatinib | pyridoxine | Pyridium |
| **PEME**trexed | **PRALA**trexate | **QUE**tiapine | **OLANZ**apine |
| penicillin | penicillamine | qui**NID**ine | qui**NINE** |
| penicillamine | penicillin | qui**NINE** | qui**NID**ine |
| Peptavlon | Pavulon | Qwell | Kwell |
| Percocet | Darvocet | **RABE**prazole | **ARIP**iprazole |
| Percocet | Procet | Ranexa | Prenexa |
| Pexeva | Lexiva | Rapaflo | Rapamune |
| **PENT**obarbital | **PHEN**obarbital | Rapamune | Rapaflo |
| **PHEN**obarbital | **PENT**obarbital | Razadyne | Rozerem |
| Pilocar | Dilacor XR | Recombivax HB | Comvax |
| piroxicam | **PAR**oxetine | Regranex | Granulex |
| Platinol | Patanol | Reminyl | Robinul |
| Plavix | Paxil | Reminyl | Amaryl |
| Plavix | Pradax [non-US Product] | Renagel | Renvela |
| Plavix | Pradaxa | Renvela | Renagel |
| Plendil | Isordil | Reprexain | Zy**PREXA** |
| pneumococcal 7-valent vaccine | pneumococcal polyvalent vaccine | Restoril | Risper**DAL** |
| pneumococcal polyvalent vaccine | pneumococcal 7-valent vaccine | Retrovir | ritonavir |
| Polycitra | Bicitra | Rifadin | Rifater |
| ponatinib | pazopanib | Rifamate | rifampin |
| potassium acetate | sodium acetate | rifampin | Rifamate |
| **PRALA**trexate | **PEME**trexed | rifampin | rifaximin |
| Pradax [non-US Product] | Plavix | Rifater | Rifadin |
| Pradaxa | Plavix | rifaximin | rifampin |
| Prandin | Avandia | Risper**DAL** | Restoril |
| Precare | Precose | risperi**DONE** | r**OPINIR**ole |
| Precose | Precare | Ritalin | ritodrine |
| predniso**LONE** | predni**SONE** | Ritalin LA | Ritalin SR |
| predni**SONE** | predniso**LONE** | Ritalin SR | Ritalin LA |
| Prenexa | Ranexa | ritodrine | Ritalin |
| Pri**LOSEC** | Pristiq | ritonavir | Retrovir |
| Pri**LOSEC** | **PRO**zac | ri**TUX**imab | in**FLIX**imab |
| Priscoline | Apresoline | Robinul | Reminyl |
| Pristiq | Pri**LOSEC** | r**OPINIR**ole | risperi**DONE** |
| probenecid | Procanbid | Roxanol | Roxicodone Intensol |
| Procan SR | Procanbid | Roxanol | Roxicet |
| Procanbid | probenecid | Roxicet | Roxanol |
| Procanbid | Procan SR | Roxicodone Intensol | Roxanol |
| Procardia XL | Protain XL | Rozerem | Razadyne |
| Procet | Percocet | Salagen | selegiline |
| Prograf | **PRO**zac | Sand**IMMUNE** | Sando**STATIN** |
| propylthiouracil | Purinethol | Sando**STATIN** | Sand**IMMUNE** |
| Proscar | Provera | saquinavir | **SINE**quan |
| Protain XL | Procardia XL | saquinavir (free base) | saquinavir mesylate |
| protamine | Protonix | saquinavir mesylate | saquinavir (free base) |
| proton pump inhibitors | **ARIP**iprazole | Sarafem | Serophene |
| Protonix | Lotronex | selegiline | Salagen |
| Protonix | protamine | Serophene | Sarafem |
| Provera | Proscar | **SERO**quel | **SERO**quel XR |

(*Continues*)

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES (*Continued*)**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| **SERO**quel | Serzone | tia**GAB**ine | ti**ZAN**idine |
| **SERO**quel | **SINE**quan | Tiazac | Ziac |
| **SERO**quel XR | **SERO**quel | Ticlid | Tequin |
| sertraline | cetirizine | ti**ZAN**idine | tia**GAB**ine |
| sertraline | Soriatane | TNKase | Activase |
| Serzone | **SERO**quel | TNKase | t-PA |
| silodosin | sirolimus | Tobradex | Tobrex |
| Sinemet | Janumet | Tobrex | Tobradex |
| **SINE**quan | saquinavir | **TOLAZ**amide | **TOLBUT**amide |
| **SINE**quan | **SERO**quel | **TOLBUT**amide | **TOLAZ**amide |
| **SINE**quan | Singulair | Topamax | Toprol-XL |
| **SINE**quan | Zonegran | Toprol-XL | Topamax |
| Singulair | **SINE**quan | Toradol | Foradil |
| sirolimus | silodosin | t-PA | TNKase |
| sita**GLIP**tin | **SUMA**triptan | Tracleer | Tricor |
| sodium acetate | potassium acetate | tra**MAD**ol | tra**ZOD**one |
| Solu-**CORTEF** | Solu-**MEDROL** | trastuzumab | ado-trastuzumab emtansine |
| Solu-**MEDROL** | Depo-Medrol | tra**ZOD**one | tra**MAD**ol |
| Solu-**MEDROL** | Solu-**CORTEF** | **TREN**tal | **TEG**retol |
| Sonata | Soriatane | tretinoin | **ISO**tretinoin |
| Soriatane | Loxitane | Tricor | Tracleer |
| Soriatane | sertraline | tromethamine | Trophamine |
| Soriatane | Sonata | Trophamine | tromethamine |
| sotalol | Sudafed | tuberculin purified protein derivative (PPD) | influenza virus vaccine |
| Spiriva | Apidra | | |
| Spiriva | Inspra | tuberculin purified protein derivative (PPD) | tetanus diptheria toxoid (Td) |
| stavudine | cetirizine | | |
| Sudafed | sotalol | Tylenol | Tylenol PM |
| Sudafed | Sudafed PE | Tylenol PM | Tylenol |
| Sudafed PE | Sudafed | Ultracet | Duricef |
| **SUF**entanil | fenta**NYL** | Ultram | lithium |
| sulf**ADIAZINE** | sulfa**SALA**zine | val**ACY**clovir | val**GAN**ciclovir |
| sulf**ADIAZINE** | sulfi**SOXAZOLE** | Valcyte | Valtrex |
| sulfa**SALA**zine | sulf**ADIAZINE** | val**GAN**ciclovir | val**ACY**clovir |
| sulfi**SOXAZOLE** | sulf**ADIAZINE** | Valtrex | Valcyte |
| **SUMA**triptan | sita**GLIP**tin | Varivax | VZIG (varicella-zoster immune globulin) |
| **SUMA**triptan | **ZOLM**itriptan | Vesanoid | Vesicare |
| Symbyax | Cymbalta | Vesicare | Vesanoid |
| T-Gel | Bio-T-Gel | Vexol | Vosol |
| Tambocor | Pamelor | Viagra | Allegra |
| Taxol | Taxotere | Videx | Bidex |
| Taxol | Paxil | vin**BLA**Stine | vin**CRIS**tine |
| Taxotere | Taxol | vin**CRI**Stine | vin**BLAS**tine |
| **TEG**retol | **TEG**retol XR | Viokase | Viokase 8 |
| **TEG**retol | Tequin | Viokase 8 | Viokase |
| **TEG**retol | **TREN**tal | Vioxx | Zyvox |
| **TEG**retol XR | **TEG**retol | Viracept | Viramune |
| Tenex | Xanax | Viramune | Viracept |
| Tequin | **TEG**retol | Viramune (nevirapine) | Viramune (herbal product) |
| Tequin | Ticlid | Viramune (herbal product) | Viramune (nevirapine) |
| Testoderm TTS | Testoderm | Vosol | Vexol |
| Testoderm TTS | Testoderm with Adhesive | VZIG (varicella-zoster immune globulin) | Varivax |
| Testoderm with Adhesive | Testoderm | | |
| Testoderm with Adhesive | Testoderm TTS | Wellbutrin SR | Wellbutrin XL |
| Testoderm | Testoderm TTS | Wellbutrin XL | Wellbutrin SR |
| Testoderm | Testoderm with Adhesive | Xanax | Fanapt |
| tetanus diptheria toxoid (Td) | tuberculin purified protein derivative (PPD) | Xanax | Tenex |
| | | Xanax | Zantac |
| Thalomid | Thiamine | Xeloda | Xenical |
| Thiamine | Thalomid | Xenical | Xeloda |

**Appendix 3-1. INSTITUTE FOR SAFE MEDICATION PRACTICES**

| Drug Name | Confused Drug Name | Drug Name | Confused Drug Name |
|---|---|---|---|
| Yasmin | Yaz | Zonegran | **SINE**quan |
| Yaz | Yasmin | Zostrix | Zovirax |
| Zantac | Xanax | Zovirax | Doribax |
| Zantac | Zyr**TEC** | Zovirax | Zyvox |
| Zavesca (escitalopram) [non-US product] | Zavesca (miglustat) | Zovirax | Zostrix |
| | | Zyban | Diovan |
| Zavesca (miglustat) | Zavesca (escitalopram) [non-US product] | Zyloprim | zolpidem |
| | | Zy**PREXA** | Cele**XA** |
| Zebeta | Diabeta | Zy**PREXA** | Reprexain |
| Zebeta | Zetia | Zy**PREXA** | Zestril |
| Zegerid | Zestril | Zy**PREXA** | Zyr**TEC** |
| Zelapar (Zydis formulation) | Zy**PREXA** Zydis | Zy**PREXA** Zydis | Zelapar (Zydis formulation) |
| Zerit | Zyr**TEC** | Zyr**TEC** | Lipitor |
| Zestril | Zegerid | Zyr**TEC** | Zantac |
| Zestril | Zetia | Zyr**TEC** | Zerit |
| Zestril | Zy**PREXA** | Zyr**TEC** | Zocor |
| Zetia | Bextra | Zyr**TEC** | Zy**PREXA** |
| Zetia | Zebeta | Zyr**TEC** | Zyr**TEC**-D |
| Zetia | Zestril | Zyr**TEC** (cetirizine) | Zyr**TEC** Itchy Eye Drops (ketotifen fumarate) |
| Ziac | Tiazac | Zyr**TEC**-D | Zyr**TEC** |
| Zocor | Cozaar | Zyr**TEC** Itchy Eye Drops (ketotifen fumarate) | ZyrTEC (cetirizine) |
| Zocor | Zyr**TEC** | | |
| **ZOLM**itriptan | **SUMA**triptan | Zyvox | Vioxx |
| zolpidem | Zyloprim | Zyvox | Zovirax |

*Brand names always start with an uppercase letter. Some brand names incorporate tall man letters in initial characters and may not be readily recognized as brand names.



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# NURSING CONCEPTS REVIEW QUESTIONS

**1.** According to Selye's stress theory, when the individual is in the alarm phase of the general adaptive syndrome, the body first responds by

1. Going into shock and countershock.
2. Resisting the stressor.
3. Adapting to the stressor.
4. Moving to a state of exhaustion.

**2.** Which of the following danger signals of stress would it be important to identify so that an appropriate intervention can be made?

1. Lack of concentration.
2. Depression.
3. Anxiety.
4. Skin rash.

**3.** When the nurse is counseling a couple on family planning, the effectiveness most strongly depends on the

1. Method and understanding of the contraceptive choice.
2. Belief in the method of contraception chosen.
3. Degree to which the couple wishes not to have children.
4. Degree to which the method suits the individual using it.

**4.** A 12-year-old can accomplish formal operational thought, according to Piaget. The nurse understands that this statement means that a young person is able to

1. Ask direct questions.
2. Use symbols.
3. Conceptualize.
4. Understand cause and effect.

**5.** Erik Erikson's theory of personality explains that a child who was never allowed to function autonomously may, in later life, experience the psychological crisis of

1. Mistrust.
2. Inferiority.
3. Guilt.
4. Shame and doubt.

**6.** One of the primary developmental tasks of adolescence is

1. Feeling independent.
2. Finding one's identity.
3. Experiencing intimacy.
4. Achieving generativity.

**7.** A client has just received a diagnosis of breast cancer from her physician. When the nurse asks if she would like to talk about the diagnosis, the client replies, "Oh, no, I'm sure they are wrong—I've always had cysts in my breasts." The nurse recognizes that this may be a grief response, which probably means that the client is

1. Not ready to accept the diagnosis.
2. In the disbelief stage of the grief process.
3. Not comfortable in discussing the diagnosis with the nurse.
4. Mourning the loss she will have to experience.

**8.** The ultimate outcome, when the grieving process is successfully completed, will be when the bereaved

1. Is able to think of the deceased without emotion.
2. Remembers only the pleasures of the relationship.
3. Is no longer emotionally dependent on the deceased.
4. No longer feels the need to talk about the deceased.

**9.** A nurse who is sensitive to his or her client's need to talk about dying would recognize which of the following cues as the "need to talk"?

1. The client's refusal to talk to anyone.
2. Constant crying and looking depressed.
3. The client's asking the nurse to stay a while.
4. Constantly asking to be released to go home.

**10.** The registered nurse (RN) observes the nursing assistant (NA) regulating the IV of an oncology client receiving morphine sulfate for pain. A licensed vocational nurse (LVN) on the RN's team is responsible for the client and has assigned the client to the NA. The RN's intervention is to

1. Inform the LVN so that he or she intervenes to instruct the NA that this action is not within the realm of responsibility of an NA.
2. Immediately inform the charge nurse and fill out an incident report.
3. Call a staff meeting and confront the LVN and the NA.
4. Ask the LVN and the NA to meet with the RN to discuss the responsibility parameters each of them has.

**11.** A nurse enters the private room of a male client and realizes he is masturbating. The appropriate response is to

1. Set limits on his behavior in the hospital.
2. Apologize for intruding on the client's privacy.
3. Tell the client his behavior is inappropriate.
4. Ignore the behavior and continue with the intervention planned when entering the room.

**12.** In the area of human sexuality, nurses may encounter problems in relating to their clients. A major barrier or problem the nurse should be aware of is

1. Lack of knowledge about human sexuality.
2. The nurse's personal attitudes toward human sexuality.
3. Lack of appropriate referrals in this area.
4. Lack of proficiency in sexual-history taking.

**13.** Pain is now considered the fifth vital sign according to The Joint Commission. For a client who is in pain, this change would be important because

1. The nurse is now responsible for monitoring a client's pain level.
2. It helps to maintain the client's quality of life.
3. As a vital sign it will now be monitored every 15 minutes.
4. The client's pain level was often ignored in the past by the nursing staff.

**14.** The most effective method of evaluating a client's pain level is to

1. Ask the client where he or she feels the pain.
2. Select a tool to measure pain based on the client's preferences and cognitive level.
3. Observe the nonverbal cues to pain level.
4. Determine if the pain medication ordered is actually relieving the client's pain.

# NURSING CONCEPTS ANSWERS WITH RATIONALE

1. (1) The first stage is alarm—shock and countershock. The body translates the shock as sudden injury and then is restored to preinjury state (countershock). Resistance (2) is the second stage, and exhaustion (4) is the third stage, according to stress theory.

   **NP:AN; CN:H; CL:K**

2. (2) All of the conditions may be considered danger signals of stress, but depression is the most dangerous owing to the possibility of suicide (which may occur with any degree of depression).

   **NP:A; CN:PS; CL:AN**

3. (1) The effectiveness of family planning depends most on the method chosen and the degree of understanding of the method. Motivation and the degree to which the couple follow the prescribed regimen also affect the outcome. Belief in the method (2) and the wish to have or not have children (3) do not affect the success of family planning. The degree to which the method suits the person (4) may have some influence, but is not definitive enough as an answer.

   **NP:AN; CN:H; CL:C**

4. (3) At age 12 years and older, a young person is able to conceptualize and do abstract thinking. Before this age, the young person is only able to think concretely. Using symbols (2) and understanding cause/effect (4) occurs at 7 to 12 years. Answer (1) occurs from 4 to 7 years. This is important theoretical information for the nurse to have when the child is in the hospital, because it will give cues as to how much the child or young adult will understand the diagnosis or instructions.

   **NP:AN; CN:H; CL:C**

5. (4) Erikson's theory explains that at every age the individual has to go through a psychological crisis period of development. In this case, if the toddler is allowed to gain autonomy, he or she will not experience shame and doubt in later life. If the infant develops trust in the maternal figure, he will not mistrust; if the school-age child is industrious, he will not feel inferior later; and, if the preschooler is allowed to show initiative, in later life he or she will not experience guilt.

   **NP:AN; CN:PS; CL:C**

6. (2) Early adolescence has the primary task of finding one's identity and moving out of role diffusion. Later adolescence to young adulthood's task is to experience intimacy (3), not isolation. Adults should achieve generativity (4) versus stagnation.

   **NP:AN; CN:H; CL:K**

7. (2) The first stage of grief is often disbelief, along with shock. The client may also not be ready to accept the diagnosis or wish to discuss it with the nurse. Mourning is a later stage of the grief process.

   **NP:AN; CN:H; CL:A**

8. (3) When the grieving process is completed, the bereaved will no longer feel emotionally dependent on the person who died. The individual will always feel emotion (1) when thinking of the loved one, but he or she will be able to realistically recall both the good and the bad times. There will always be the need to talk about the loved one (4), even when the grief has been resolved.

   **NP:E; CN:PS; CL:C**

9. (3) Asking the nurse to stay a while may be a cue that the client is ready to talk about the difficult subject. The other behaviors do not indicate a willingness to talk.

   **NP:A; CN:H; CL:AN**

10. (4) While regulating or even touching an IV is definitely not within the scope of behaviors that an NA can legally perform, both teaching and clarification of duties

Coding for Questions/Answers Abbreviations: Nursing Process: NP, Assessment: A, Analysis: AN, Planning: P, Implementation: I, Evaluation: E; Client Needs: CN, Safe, Effective Care Environment: S, Health Promotion and Maintenance: H, Psychosocial Integrity: PS, Physiological Integrity: PH; Clinical Area: CA, Medical Nursing: M, Surgical Nursing: S, Maternal/Newborn Nursing: MA, Pediatric Nursing: P, Psychiatric Nursing: PS; Cognitive Level: CL, Knowledge: K, Comprehension: C, Application: A, Analysis: AN.

are needed in this situation. Before accusing the NA, a nonpunitive environment should be created so that teaching of both the LVN and the NA can occur, and so that this action will not happen again. Unless too much medication was given, an incident report does not need to be filled out (2). Confronting the team member in a staff meeting (3) would not be following good management principles.

**NP:I; CN:S; CL:AN**

11. (2) The appropriate response is to apologize, leave the room, and return later. Clients should be allowed privacy, and this is a common sexual outlet for many people. When the behavior is inappropriate, limits should be set (1). The client's behavior is not necessarily inappropriate for him (3). Continuing with the nurse's intended intervention (4) is also inappropriate because it intrudes on the client's privacy.

    **NP:I; CN:H; CL:A**

12. (2) Negative attitudes, biases, prejudices, or judgments on the part of the nurse can present a major problem for nurses working in the area of sexual health. If these attitudes are negative, the relationship will be compromised. Lack of knowledge (1), referrals (3), or proficiency (4) may all present problems, but do not affect relating to the client.

    **NP:P; CN:H; CL:A**

13. (2) As a fifth vital sign, pain will be monitored as often as the other vital signs, which will help to maintain the client's quality of life. (1) The nurse has always been responsible for monitoring the pain level. Pain does not have to be monitored every 15 minutes (3). A client's pain level has not been ignored, but this additional reminder will assist the nurse to monitor pain more frequently.

    **NP:P; CN:H; CL:C**

14. (2) The most effective way to measure pain is with a scale (either zero to five or zero to ten) that the client can understand. This allows the evaluation to be consistent over time. Just asking the client will not yield enough data (1), nor will observing nonverbal cues. This measure will be helpful with a young child or a cognitively impaired adult. Just evaluating the pain medication is not an accurate measure for pain control.

    **NP:E; CN:PH; CL:A**