

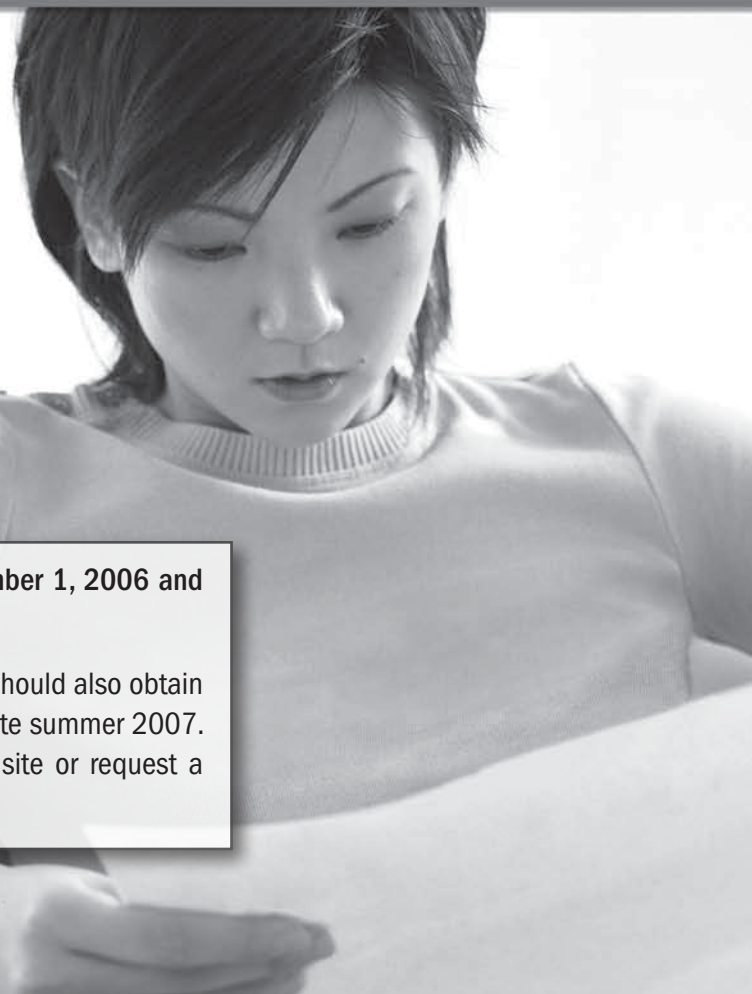
nal Psychology 6/U
can Dream 6/U
omy & Physiology 3/L
ege Writing 6/L
English Composition 3/U
ics: Theory & Practice 3/U
oundations of Gerontology 3/U
German 3/U



Excelsior College® Examination Content Guide for

Fundamentals of Nursing

Organizational Behavior 3/U
Pathophysiology 3/U
Psychology of Adulthood & Aging 3/U
Religions of the World 3/U
Research Methods in Psychology 3/L
Statistics 3/U
World Conflicts Since 1900 3/U
World Population 3/U



Use this guide if you are planning to test between September 1, 2006 and September 30, 2007.

If you are planning to test on or after October 1, 2007, you should also obtain the revised version of this guide which will be available in late summer 2007. You may access the revised version online from our Web site or request a printed copy by contacting the College.

Education
Literacy Instruction in the
ary School 6/U



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Free Content Guides for Excelsior College Examinations

Check out an exam you are considering and begin your studies with a free content guide. Each guide contains an outline of the topics covered in the exam as well as a list of references, sample questions and answer rationales, and a special section titled, “How to Study with Excelsior College Examinations Content Guides.” You can download content guides by visiting our Web site at www.excelsior.edu and then clicking on the Excelsior College Examinations link. (If you haven’t already, you will be prompted to set up a MyEC page.)

To receive a single content guide by mail, call toll free at 888-72EXAMS (888-723-9267). We strongly advise you to prepare for your examination(s) by studying from the resources recommended by the Excelsior College faculty who develop our examinations. The recommended resources are listed near the back of each content guide.

Comprehensive Guided Learning Packages

For several selected Excelsior College Examinations, you can get all the study resources you need for successful preparation in a comprehensive Guided Learning Package produced exclusively by Excelsior College, available from the Excelsior College Bookstore. Each Guided Learning Package has been carefully developed to provide thorough, integrated learning resources for you. Included are a course guide, sample exam questions, tips, textbooks, and associated materials. Visit our Web site for a current list of Guided Learning Packages.

Excelsior College Bookstore

The Excelsior College Bookstore offers recommended textbooks, educationally priced software, and other resources to help you prepare for Excelsior College Examinations and courses, GRE Subject Tests, and other exams and coursework you may undertake as you work toward your Excelsior College degree.

You can also order complete packages of guided learning materials through the bookstore. Items within the packages can also be ordered separately.

Specialty Books, which distributes materials on behalf of the Excelsior College Bookstore, is open Monday through Friday from 7:00 am to 11:00 pm and Saturday from 8:00 am to 2:00 pm Eastern Time.

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Electronic Peer Network

The Electronic Peer Network (EPN) is a Web-based environment that enables enrolled Excelsior College students (and alumni) to interact academically and socially online. As a member of the EPN, you will be able to identify students with common interests, participate in live chats and threaded discussion groups, exchange books and study materials, locate study partners, access career resources, or join an online study group.

You can now use your user name and password for all online services (including the EPN) at Excelsior College by visiting the Web site homepage and clicking on the Online Services button. Once you complete the short registration form, you will obtain a user name and password for the EPN immediately.

(continued on page 33)

Important information to help you prepare for this Excelsior College® Examination

General Description of the Examination

The Excelsior College Examination in Fundamentals of Nursing measures knowledge and understanding of the material usually taught in a course in fundamentals of nursing in an associate degree nursing program. The examination assumes a basic knowledge of anatomy and physiology, chemistry, and mathematics. Questions on the examination focus on the health problems of adult patients that are commonly encountered by associate degree nurses in health care settings.

The examination requires you to demonstrate knowledge and understanding of the theoretical framework for each content area as well as the ability to apply this knowledge through use of the nursing process.

The major content areas on the examination and the percent of the examination devoted to each content area are listed below.

| Content Area | Percent of the Examination |
|---|----------------------------|
| I. The Profession of Nursing | 8% |
| II. Communication and Interpersonal Relations | 10% |
| III. Protection and Promotion of Safety | 25% |
| IV. Comfort, Rest, and Activity | 15% |
| V. Nutrition | 10% |
| VI. Elimination | 11% |
| VII. Oxygenation | 10% |
| VIII. Fluid and Electrolyte Balance | <u>11%</u> |
| Total | 100% |

Uses for the Examination

Excelsior College, the test developer, recommends granting eight (8) semester hours of lower-level undergraduate credit to students who receive a letter grade of C or higher on this examination. This recommendation is endorsed by the American Council on Education. However, the exam is not applicable toward a nursing degree at Excelsior College. Other colleges and universities also recognize this exam as a basis for granting credit or advanced standing. Individual institutions set their own policies for the amount of credit awarded and the minimum acceptable score. Before taking the exam, you should check with the institution

from which you wish to receive credit to determine whether credit will be granted and/or to find out the minimum grade required for credit.

Examination Length and Scoring

The examination consists of approximately 160 four-option multiple-choice questions, some of which are unscored, pretest questions. The pretest questions are embedded throughout the exam, and they are indistinguishable from the scored questions. It is to your advantage to do your best on all of the questions. You will have three (3) hours to complete the examination. Scores are based on ability level as defined in the item response theory (IRT) method of

exam development and scoring, rather than simply on your total number of correct answers. Your score will be reported as a letter grade.

Examination Administration

The examination is administered by computer at Pearson Professional Centers throughout the United States and in Canada, American Samoa, Guam, Puerto Rico, Saipan (Northern Mariana Islands), and the Virgin Islands. All questions regarding international administration of the examinations should be directed to the Test Administration office at Excelsior College. This office is also responsible for considering requests for exceptions such as reasonable accommodations for those with disabilities.

Computer-Delivered Testing

If you are testing at Pearson Professional Centers, your exam will be delivered by computer. You will enter your answers on the computer using either the keyboard or the mouse.

The system used for our computer-delivered testing is designed to be as user-friendly as possible, even for those with little or no computer experience. Instructions provided on screen are similar to those you would receive in a paper examination booklet.

To learn more about the Pearson computer-delivered testing system, you can use an interactive tutorial or view screenshots that show you how each feature of the system works. The tutorial is available from the Examinations page on the Excelsior College Web site or from the Pearson registration page dedicated to Excelsior College Examinations. Go to **www.excelsior.edu**, click on the Excelsior College Examinations link, then click on the Computer-Delivered Exam Tutorial link in the Examination Resources and Services box.

For your benefit:

A Word of Caution About Test Preparation and Tutorial Services

There are tutorial and test preparation services and for-profit publishing companies that claim they can assist you with passing Excelsior College Examinations or in earning an Excelsior College degree. They may imply an affiliation with the College and may allege that their materials or services will provide you with a special advantage in passing Excelsior College Examinations or in completing Excelsior's degree requirements. Despite such representations, the materials and services offered by these organizations usually do not provide any special advantage and often do not accurately reflect the current content of Excelsior College Examinations. Many of these organizations will charge you hundreds, even thousands, of dollars for the same services you can receive directly from Excelsior College—services that are included in the fees you pay as an enrolled student.

Excelsior College is headquartered in Albany, New York, where our admissions counselors and academic advisors offer assistance and support to our students. Additionally, our School of Nursing has a network of Regional Performance Assessment Centers where Excelsior College representatives help nursing students and administer the College's clinical performance examinations. We do not have branch offices.

Make sure your dollars and time are spent wisely: come directly to the source for your Excelsior College degree. If you are approached by or are considering using a company or organization to help you earn your degree or take an examination, check with us first to find out if the services or materials offered are endorsed or recognized by Excelsior College. If they are not endorsed or recognized by us, you cannot be assured that their services and materials reflect the quality and accuracy of those available directly from Excelsior. Contact our Admissions Office toll free at 888-647-2388 or via email at admissions@excelsior.edu.

How to Study with Excelsior College Examinations Content Guides

A committee of teaching faculty and practicing professionals determines the content to be tested on each Excelsior College Examination. Excelsior College Assessment Unit staff oversee the technical aspects of test construction in accordance with current professional standards. To promote fairness in testing, we take special care to ensure that the language used in the exams and related materials is consistent, professional, and user friendly. Editorial staff perform systematic quantitative and qualitative reviews that address accuracy, clarity, and compliance with conventions of bias-free language usage.

How Long Will It Take Me to Study?

An Excelsior College Examination is a way to document that you have learned material comparable to the content of one or more college-level courses. To prepare, you should study and review as you would if you were taking a college course. Remember, as an independent student, you are acting as your own teacher.

To fully prepare for an Excelsior College Examination requires self-direction and discipline. Study involves careful reading and reflection and systematic review. College professors advise that in each week of a semester, you should plan on spending three hours studying for every semester hour of credit you will be earning. For example, for a three-credit course, you can expect to study for nine hours in each week of a 15-week semester:

$$9 \times 15 = 135 \text{ hours of study for a 3-credit exam}$$

Use this system to determine how much time you should plan to spend studying and reviewing for your Excelsior College Examination:

My exam is

$$\begin{aligned} & \text{_____ credits} \times 3 \text{ hours per week} \times 15 \text{ weeks} = \\ & \text{_____ total hours of study.} \end{aligned}$$

The Content Outline

At the core of each content guide is a detailed content outline that begins with a content/percent chart showing the relative importance of each major content area to your learning. These weightings may be useful to you as you allocate your study time. For example, if you are preparing for the 3-credit exam in Foundations of Gerontology, and wish to take the exam 15 weeks from today, you might create the following schedule, knowing that you should plan a total of 135 hours of study:

| Content Area | Percent of Exam | Hours | Week |
|--------------------------------------|-----------------|-------|-------|
| Important Concepts of Gerontology | 10% | 13.5 | 1 |
| Demography of Aging | 12% | 16.2 | 2–3 |
| Biology and Physical Health | 17% | 23 | 3–5 |
| Psychology and Mental Health | 14% | 19 | 6–7 |
| Sociology | 14% | 19 | 8–9 |
| Economics, Work, and Retirement | 14% | 19 | 10–11 |
| Political Behavior and Public Policy | 14% | 19 | 12–13 |
| Death and Dying | 5% | 6.75 | 14 |
| (General Review, Catching Up) | xx | ?? | 15 |

We have annotated your content outline in two ways to help you plan your study. First, we have indicated the minimum hours of study you should expect to devote to each content area. Second, for those exams that do not have guided learning materials, we have indicated sections of the recommended resources that are most important to your understanding of that area of the outline. These annotations are not intended to be comprehensive. To cover all of the material in the content outline, you may need to refer to other chapters in the recommended textbooks. **Chapter numbers and titles may differ in subsequent editions.**

Most of the content outlines contain many examples to illustrate the types of information you should be studying. Although these examples are numerous, you should not assume that everything on the exam will come from these examples only. Conversely,

you should not expect that every detail you have studied will be directly tested on the exam. Any exam is only a broad sample of all the questions that could be asked about a given subject matter.

Using the Recommended Resources

It is important to structure your study using the content outline along with the Recommended Resources: regular college textbooks, primary and secondary source materials, publications prepared especially by Excelsior College staff to support your exam preparation, and in some cases audiovisual materials or journal articles. Additional or Other Resources may provide clarification for some of the topics on the content outline or provide enrichment in areas of interest, but are not essential to your preparation.

Pay close attention to whether we are recommending that you use all of the resources or offering you a choice. Many of our content guides provide a brief description of the materials that may help you to choose among alternatives. You can also look up the books on the publisher's Web site, where you may be able to view sample pages, review the table of contents, and explore supplementary materials. If you encounter topics in the content outline that are not covered in the resource you are using, try using one of the alternatives, or check the list of additional resources.

Some textbook publishers sell workbooks or study guides to accompany their texts. If the committee developing your examination has evaluated such workbooks, you will find them listed in the content guide.

If your exam has a Guided Learning Package, it will be to your advantage to use the entire package. You will have a coherent course of study to follow in preparation for your exam, and you will save money over purchasing the materials individually. An integral part of each guided learning package is the course guide, prepared by Excelsior College distance learning specialists in collaboration with the test developers. Excelsior College course guides may be purchased only from the Excelsior College Bookstore. Do not confuse these with study guides sold by other publishers.

Using the Sample Questions and Rationales

For each examination, sample questions are provided to illustrate those typically found on the particular examination. The sample questions are not intended to be a practice test, but they may serve as models if you wish to create your own test questions for review purposes.

In the last pages of this guide, you will find rationales for the multiple-choice sample questions. The key (correct answer) is indicated in bold. The rationales explain why the key is the correct answer and what is wrong with the other answer choices. In addition, each question is referenced to the content outline. Especially if you chose one of the wrong answers, you should return to its section of the content outline for additional study.

Study Tips

You should be an active user of the resource material. Aim for understanding rather than memorization. The more active and involved you are when you study, the more likely you will be to retain the information and be able to understand and appropriately apply it. As a preparatory activity, you may find it fun to search on "learning style" on the Internet for a variety of information and "tests" designed to identify how you learn best.

Students and educators generally agree that the following techniques are valuable:

- **preview or survey** each chapter
- **highlight or underline text** you believe is important
- **write questions or comments** in the margins
- **practice re-stating content** in your own words
- **try to determine how what you are reading relates** to the chapter title, section headings, and other organizing elements of the textbook
- **find ways to engage** your eyes, your ears, and your muscles, as well as your brain, in your studies
- **study with a partner or a small group** (are you an enrolled student? try the Electronic Peer Network [EPN])
- **prepare your review notes** as flashcards or create audiotapes that you can use while commuting or exercising

When you feel confident that you understand a content area, review what you have learned. Review involves taking a second look at the material to evaluate how well you have learned it. If you have a study partner, you can review by explaining the content to your partner or writing test questions for each other to answer. Review questions from textbook chapters may be helpful for partner or individual study, as well.

On the Day of Your Exam

Do yourself some favors:

- arrive at the test site rested and prepared to concentrate for an extended period
- be sure to allow sufficient time to travel, park, and locate the test center
- practice healthy eating and stress control
- dress comfortably: the computer will not mind that you're wearing your favorite relaxation outfit
- be prepared for possible variations in temperature at the test center due to changes in the weather or energy conservation measures
- bring your IDs and ATT letter and some pencils and pens, but otherwise, don't weigh yourself down with belongings that will have to be kept in a locker during the test.

Academic Honesty

Remember, professional ethical principles and the Excelsior College academic honesty policy both assume that your work is your own, that you will not cheat, plagiarize, copy, steal, or otherwise acquire or distribute the College's intellectual property. While the temptation may be strong to jot down what you remember of questions on your exam and share your memories with your friends, or to search out Web sites or study guides where other test takers or publishers have posted what they allege to be questions (with or without proposed answers) from Excelsior College Examinations, you owe it to yourself to resist. Regardless of whether you are caught, your grade and your professional credentials will always be tainted if you know that they were awarded based on false information about What You Know.

Academic Honesty Nondisclosure Statement

Beginning April 2003, all test takers must agree to abide by the terms of the Excelsior College Academic Honesty Policy before taking an exam. The agreement will be presented on screen at the testing center prior to the start of your exam. By accepting the terms of the agreement, you will be able to proceed with your exam. If you choose not to accept the terms of this agreement, your exam will be terminated, and you will be required to leave the testing center. You will not be eligible for a refund.

Content Outline

I. The Profession of Nursing (8%)

29 hours

Kozier (2004)

- Ch. 3, Nursing Theories and Conceptual Frameworks
- Ch. 4, Legal Aspects of Nursing
- Ch. 5, Values, Ethics, and Advocacy
- Ch. 6, Health Care Delivery Systems
- Ch. 8, Health Promotion
- Ch. 11, Health, Wellness, and Illness
- Ch. 15, Critical Thinking and the Nursing Process
- Ch. 20, Documenting and Reporting
- Ch. 40, Stress and Coping

A. Legal issues in nursing

1. General legal concepts: statutory, common, civil, and criminal laws
2. Nurse practice acts
 - a. Definition and purposes of nurse practice acts
 - b. Impact on the practice of nursing
 - c. ANA Standards of Care
 - d. Licensure: legal requirements, grounds for revocation, grounds or suspension
3. Legal liability in nursing
 - a. Types of crimes: felonies, misdemeanors
 - b. Areas of liability: torts, negligence, invasion of privacy, defamation of character, assault and battery, false imprisonment, abandonment
 - c. Good Samaritan Laws

- d. Informed consent
- e. A Patient's Bill of Rights

B. Roles and functions of the nurse

1. Caregiver
2. Decision maker
3. Communicator
4. Manager of care
5. Advocate
6. Teacher

C. Ethics and values in nursing

1. ANA Code of Ethics
2. Resolution of ethical problems
3. Nature and function of values

D. Basic nursing concepts

1. The health continuum
 - a. Wellness-illness continuum
 - b. Factors influencing health
 - 1) Individual factors (for example: genetics, age)
 - 2) Environmental factors (for example: occupational hazards, stress)
 - 3) Socioeconomic and cultural factors (for example: lifestyle, single-parent households, fast foods, health practices)
 - c. Effects of hospitalizations and/or illness (for example: loss of income, change in self-image, disruption of family)
2. The health care delivery system

3. Maslow's hierarchy of needs
 - a. Structure of hierarchy
 - b. Implication for nursing care
4. Homeostasis and adaptation to stress
 - a. General concepts of homeostasis and regulatory mechanisms
 - b. General concept and nature of stress based on Selye's theory
 - c. Factors influencing adaptation (for example: age, lifestyle, occupation, coping strategies)
 - d. Psychophysiological signs of increased stress (for example: changes in vital signs, memory or perceptual changes)
5. Psychophysiological adaptations to stress (for example: fight or flight response, rest and activity changes, defense mechanisms)

E. Nursing process methodology

1. Purposes
2. Steps
 - a. Assessment: establishing a database concerning patient needs, including gathering subjective and objective data and assessing individual factors related to health
 - b. Diagnosis: identification of the patient's actual or potential nursing diagnoses after analyzing and interpreting data
 - c. Planning: setting priorities, identifying patient-centered outcomes and selecting nursing interventions to achieve those outcomes using clinical pathways
 - d. Implementation: using nursing interventions to help the patient achieve goals

F. Recording and reporting

1. Concepts and principles
 - a. Purposes of recording: charting, documentation (for example: providing a record of care given, charting patient's response to care, evaluation and revision of the nursing care plan)
 - b. Purposes of reporting: intermittent, change-of-shift (for example: promoting continuity of patient care, evaluation of effectiveness of nursing interventions)
 - c. Principles of written communication (for example: accuracy, legibility, legality, abbreviations)
 - d. Principles of oral communication (for example: objectivity, clarity, timeliness)
2. Inclusion of appropriate information when recording and reporting (for example: when using narrative method, when using SOAP method; on a medication administration record, on a nursing care plan, in a team conference, at change-of-shift)

II. Communication and Interpersonal Relations (10%)

36 hours

Kozier

- Ch. 16, Assessing
- Ch. 17, Diagnosing
- Ch. 18, Planning
- Ch. 19, Implementing and Evaluating
- Ch. 24, Caring, Comforting, and Communicating
- Ch. 25, Teaching
- Ch. 28, Health Assessment

A. Theoretical framework

1. Therapeutic communication
 - a. Definition and goals
 - b. Types of communication: verbal, nonverbal
 - c. Principles of therapeutic communication
 - 1) Techniques that facilitate communication
 - 2) Techniques that block communication
2. The nurse-patient relationship
 - a. Definition and outcomes of the nurse-patient relationship
 - b. Components of the nurse-patient relationship
 - c. Phases of the nurse-patient relationship
3. Factors influencing the communication process (for example: cultural, sensory losses, language barriers, perception of the relationship, personal experiences and needs, attitudes)
4. Patient instruction: principles of teaching/learning

B. Nursing care

1. Assessment: establish a database concerning communication
 - a. Gather objective and subjective data (for example: primary language, use of sign language, unable to read, hearing ability)
 - b. Assess factors influencing communication and the nurse-patient relationship (see IIA3)
2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to communication
 - a. Analyze and interpret data (for example: patterns of communication, readiness for learning)
 - b. Identify nursing diagnoses (for example: impaired verbal communication related to oral surgery; knowledge deficit: low-calorie diet related to recently ordered therapy)
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to communication
 - a. Set priorities and establish outcomes (for example: patient will communicate needs using an alternate means of communication [chalkboard]; patient will make appropriate meal selections)
 - b. Incorporate factors influencing communication in planning patient care (see IIA3)
 - c. Select nursing interventions to facilitate communication (for example: provide the patient with a "magic slate"; select materials appropriate to the patient's educational level)

4. Implementation: use nursing interventions to achieve outcomes related to communication and the nurse-patient relationship
 - a. Use facilitative communication techniques (see IIA1c)
 - b. Establish a therapeutic nurse-patient relationship (see IIA2)
 5. Evaluation: determine the extent to which outcomes have been achieved
 - a. Evaluate, record, and report the patient's response to nursing actions (for example: due to sedation, patient is not able to use the magic slate; patient selects foods appropriate to a low-calorie diet)
 - b. Modify the plan of care if necessary
- e. Factors influencing an individual's susceptibility to infection (for example: stress, nutritional status, physical status, medications, heredity, lifestyle, socioeconomic status, occupation)
2. Nursing care
 - a. Assessment: establish a database concerning asepsis
 - 1) Gather objective and subjective data (for example: WBC count [normal values], history of exposure to pathogens, fever, thirst)
 - 2) Assess factors influencing susceptibility to infection (see IIIA1e)
 - b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to asepsis
 - 1) Analyze and interpret data (for example: identify pathogen and possible method of transmission)
 - 2) Identify nursing diagnoses (for example: high risk for infection related to poor nutritional status and exposure to pathogens)
 - c. Planning: set priorities, identify patient-centered outcomes and select appropriate interventions related to asepsis
 - 1) Set priorities and establish outcomes (for example: patient will wash hands after using the toilet)
 - 2) Incorporate factors influencing the individual's susceptibility to infection (see IIIA1e)
 - 3) Select nursing interventions to help the patient achieve the outcomes (for example: utilize appropriate aseptic measures, determine appropriate barriers)

III. Protection and Promotion of Safety (25%)

90 hours

Kozier

Ch. 29, Asepsis

Ch. 30, Safety

Ch. 33, Medications

Ch. 34, Skin Integrity and Wound Care

Ch. 36, Sensory Perception

A. Asepsis

1. Theoretical framework
 - a. Chain of infection
 - b. Principles of medical and surgical asepsis
 - c. Methods of transmission (for example: direct contact, vehicles, airborne)
 - d. Standard (universal) precautions

- d. Implementation: use nursing interventions to achieve the outcomes related to asepsis
 - 1) Use nursing measures to contain organisms (for example: use medical asepsis)
 - 2) Use nursing measures to exclude organisms (for example: use surgical asepsis when providing wound care)
 - 3) Instruct the patient regarding prevention of infection (for example: handwashing)
 - e. Evaluation: determine the extent to which outcomes have been achieved
 - 1) Evaluate, record, and report the patient's response to nursing actions (for example: wound is approximated and free of drainage)
 - 2) Continually reassess the physical environment (for example: dressings are disposed of in a closed container)
 - 3) Modify the plan of care if necessary
- 1) Individual factors (for example: age, nutritional status, skin integrity, hygienic practices, physical activity, health status, cigarette smoking)
 - 2) Environmental factors (for example: climate, occupational hazards, exposure to communicable diseases, cigarette smoke, radiation)
- c. Techniques commonly used to promote the body's defenses (for example: application of heat and cold, tetanus booster, flu vaccine)
- 2. Nursing care
 - a. Assessment: establish a database concerning defenses
 - 1) Gather objective and subjective data (for example: condition of the patient's skin and mucous membrane, vital signs, redness, pain, swelling, WBC count, history of immunizations)
 - 2) Assess factors influencing the body's defenses (see IIB1b)
 - b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to defenses
 - 1) Analyze and interpret data (for example: culture reports, identify impairment of the skin, WBC count [normal values], characteristics of drainage)
 - 2) Identify nursing diagnoses (for example: high risk for infection related to altered skin integrity)

B. The body's defenses (includes the body systems, the immune system, and the inflammatory response)

- 1. Theoretical framework
 - a. Physiological responses (for example: antigen-antibody response, leukocytosis, signs of inflammation, secretion of mucus, movement of cilia, removal of waste products, wound healing, fever)
 - b. Factors influencing the body's defenses

- c. Planning: set priorities, identify patient-centered outcomes and select interventions related to defenses
 - 1) Set priorities and establish outcomes (for example: patient will remain afebrile)
 - 2) Incorporate factors influencing the body's defenses (see IIIB1b)
 - 3) Select nursing interventions to help the patient achieve the outcomes (for example: monitor vital signs q4h)
- d. Implementation: use nursing interventions to achieve outcomes related to the body's defenses
 - 1) Use nursing measures to promote the body's defenses (for example: provide adequate nutrition, apply heat and cold treatments, provide wound care, collect specimens for culture)
 - 2) Instruct the patient to support and/or restore the body's defenses (for example: emphasize the need to avoid exposure to infectious agents)
- e. Evaluation: determine the extent to which outcomes have been achieved
 - 1) Evaluate, record, and report the patient's response to nursing actions (for example: patient's temperature remains within normal limits)
 - 2) Modify the plan of care if necessary

C. Medication administration

- 1. Theoretical framework
 - a. Pharmacokinetics: absorption, distribution, metabolism, excretion
 - b. Principles of administration: calculations (including equivalents), routes and sites, safety measures, controlled substances, use of nasogastric and gastrostomy tubes, transcribing medication orders
 - c. Factors influencing medication action and effectiveness (for example: age, sex, weight, psychological factors, time of administration, environment)
- 2. Nursing care
 - a. Assessment: establish a database concerning the patient's medication regimen
 - 1) Gather objective and subjective data (for example: history of allergies, vital signs, duration of pain)
 - 2) Assess factors influencing medication action and effectiveness (see IIIC1c)
 - b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to medications
 - 1) Analyze and interpret data (for example: changes in vital signs, recognize side effects)
 - 2) Identify nursing diagnoses (for example: noncompliance related to fear of side effects)
 - c. Planning: set priorities, identify patient-centered outcomes and select interventions related to the patient's medication regimen
 - 1) Set priorities and establish outcomes (for example: patient will adhere to regimen as agreed)

- 2) Incorporate factors influencing medication action and effectiveness (see IIC1c)
 - 3) Select nursing interventions to help the patient achieve outcomes (for example: instruct the patient to take the medication with food)
- d. Implementation: use nursing interventions to achieve outcomes related to the medication regimen
- 1) Use nursing measures to safely administer medications (for example: calculation and measurement, patient identification, transcription, accurate recording, selection of correct site, administration of controlled substances)
 - 2) Provide information and instruction regarding the medication regimen (for example: self-administration, storage, reporting side effects)
- e. Evaluation: determine the extent to which outcomes have been achieved
- 1) Evaluate, record, and report the patient's response to nursing actions (for example: patient adheres to the medication regimen)
 - 2) Modify the plan of care if necessary
- 3) Socioeconomic and cultural factors (for example: ability to communicate, unemployment)
 - 4) Psychological factors (for example: stress, anxiety)
- b. Identification of environmental hazards (for example: physical and mechanical, thermal, chemical, radiation, ecological)
- c. Devices commonly used to promote safety (for example: restraints, walkers, siderails)
2. Nursing care
- a. Assessment: establish a database concerning the patient's safety needs
- 1) Gather objective and subjective data (for example: confusion, visual acuity)
 - 2) Determine presence of environmental hazards (see IID1b)
 - 3) Assess factors influencing the patient's safety (for example: age, hearing impairment) (see IID1a)
- b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to safety
- 1) Analyze and interpret data (for example: recognize loss of equilibrium)
 - 2) Identify nursing diagnoses (for example: high risk for injury related to sensory deficit)
- c. Planning: set priorities, identify patient-centered outcomes and select interventions related to safety
- 1) Set priorities and establish outcomes (for example: patient will request assistance with ambulation)

D. Safety

1. Theoretical framework
 - a. Factors influencing an individual's safety
 - 1) Individual factors (for example: age, medications, level of awareness, sensory perception, emotional state)
 - 2) Environmental factors (for example: occupation, presence of lead paint)

- 2) Incorporate factors influencing safety in planning for individualized patient care (for example: consider age, lifestyle, level of consciousness, mobility)
 - 3) Select nursing interventions for alleviating or minimizing safety hazards (for example: modify the environment)
 - 4) Select the appropriate safety device based on the individual's needs (for example: walkers, restraints)
- d. Implementation: use nursing interventions to achieve outcomes related to safety
- 1) Use nursing measures to provide a safe environment (for example: elevate siderails, use restraining jacket)
 - 2) Use equipment and devices safely (for example: walkers, ice packs, heat applications)
 - 3) Instruct the patient regarding safety (for example: orient to environment, explain use of wheelchair)
- e. Evaluation: determine the extent to which outcomes have been achieved
- 1) Evaluate, record, and report the patient's response to nursing actions (for example: patient ambulates with the nurse's assistance)
 - 2) Modify the plan of care if necessary

IV. Comfort, Rest, and Activity (15%)

54 hours

Kozier

Ch. 31, Hygiene

Ch. 42, Activity and Exercise

Ch. 43, Rest and Sleep

Ch. 44, Pain Management

A. Hygiene

1. Theoretical framework
 - a. Components of hygiene
 - b. Factors influencing hygiene (for example: cultural factors, age, physical status, body image, self-esteem)
 - c. Agents commonly used on the skin and mucous membrane (for example: soaps, lotions, emollients, mouthwashes)
2. Nursing care
 - a. Assessment: establish a database concerning hygiene
 - 1) Gather objective and subjective data (for example: cleanliness of the skin, condition of the nails, complaints of dryness)
 - 2) Assess factors influencing the patient's hygiene (see IVA1b)
 - b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to hygiene
 - 1) Analyze and interpret data
 - 2) Identify nursing diagnoses (for example: altered oral mucous membrane related to mouth breathing)

- c. Planning: set priorities, identify patient-centered outcomes and select interventions related to hygiene
 - 1) Set priorities and establish outcomes (for example: patient's oral mucous membrane will be pink and moist)
 - 2) Incorporate factors influencing hygiene in planning patient care (see IVA1b)
 - 3) Select nursing interventions to achieve outcomes (for example: provide mouth care q2h)
- d. Implementation: use nursing interventions to achieve outcomes related to hygiene
 - 1) Use nursing measures to provide comprehensive hygienic care (for example: bathing, hair care, nail care, skin care, perineal care)
 - 2) Use nursing measures to promote psychological comfort (for example: provide privacy during bathing)
 - 3) Provide information and instruction (for example: instruct the patient on the use of dental floss, discuss indications for use of skin lotions rather than alcohol-base skin products)
- e. Evaluation: determine the extent to which outcomes have been achieved
 - 1) Evaluate, record, and report the patient's response to nursing actions (for example: the patient's lips remain dry and cracked)
 - 2) Modify the plan of care if necessary

B. Rest and sleep

- 1. Theoretical framework
 - a. Principles related to rest and sleep (for example: sleep stages, circadian rhythm)
 - b. Factors influencing rest and sleep (for example: age, noise level, fatigue, use of caffeine, use of alcohol, hospitalization, sensory deprivation)
 - c. Agents commonly used to promote rest and sleep (sedatives, hypnotic)
- 2. Nursing care
 - a. Assessment: establish a database concerning rest and sleep
 - 1) Gather objective and subjective data (for example: usual sleep habits, use of over-the-counter medications, bedtime routines)
 - 2) Assess factors influencing the patient's rest and sleep (see IVB1b)
 - b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to rest and sleep
 - 1) Analyze and interpret data (see IVB2a)
 - 2) Identify nursing diagnoses (for example: sleep pattern disturbance related to unfamiliar surroundings)
 - c. Planning: set priorities, identify patient-centered outcomes and select interventions
 - 1) Set priorities and establish outcomes (for example: patient will get six hours of uninterrupted sleep per night)
 - 2) Incorporate factors influencing rest and sleep (see IVB1b)

- 3) Select nursing interventions to help the patient achieve outcomes (for example: reorient the patient to the surroundings)
 - d. Implementation: use nursing interventions to achieve outcomes related to rest and sleep
 - 1) Use nursing measures to induce rest and sleep (for example: administer a backrub, provide a bedtime snack, provide a quiet environment)
 - 2) Use nursing measures specific to drug classifications for prescribed medications (for example: raise the siderails after administering a sleep medication)
 - 3) Use nursing measures to modify the environment (for example: provide sensory stimulation, prevent sensory overload)
 - 4) Provide information and instruction (for example: discuss relaxation techniques with the patient)
 - e. Evaluation: determine the extent to which outcomes have been achieved
 - 1) Evaluate, record, and report the patient's response to nursing actions (for example: patient states that he feels well rested)
 - 2) Modify the plan of care if necessary
- b. Responses of body systems to mobility (for example: improved circulation, peristalsis)
 - c. Complications resulting from immobility (for example: muscle weakness, contractures, retained secretions, decubitus ulcers, hypostatic pneumonia, constipation)
2. Nursing care
 - a. Assessment: establish a database concerning mobility and immobility
 - 1) Gather objective and subjective data (for example: range-of-motion, skin integrity, elimination patterns, activity level, joint mobility)
 - 2) Assess the patient's responses to mobility and immobility (see IVC1b–c)
 - b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to mobility or immobility
 - 1) Analyze and interpret data
 - 2) Identify nursing diagnoses (for example: high risk for impaired physical mobility related to bed rest)
 - c. Planning: set priorities, identify patient-centered outcomes, and select appropriate interventions related to mobility or immobility
 - 1) Set priorities and establish outcomes (for example: patient will maintain usual range of motion in all joints)
 - 2) Consider the responses of the body to mobility and immobility (see IVC1b–c)

C. Mobility and immobility

1. Theoretical framework
 - a. Principles of body mechanics, transfer, ambulation, range-of-motion, exercise

- 3) Select nursing interventions to help the patient achieve outcomes (for example: supervise the patient in active range-of-motion exercises t.i.d.)
- d. Implementation: use nursing interventions to achieve outcomes related to mobility or immobility
 - 1) Use appropriate devices to maintain normal body alignment (for example: footboard, pillows, trochanter roll)
 - 2) Use nursing measures to promote mobility and maintain muscle tone (for example: range of motion, ambulation, positioning)
 - 3) Use nursing measures to prevent tissue breakdown (for example: massage, pressure-relieving devices, turning)
 - 4) Use nursing measures to prevent complications related to immobility (for example: leg exercises, antiembolism stockings, deep breathing and coughing)
 - 5) Instruct the patient regarding activity needs
- e. Evaluation: determine the extent to which outcomes have been achieved
 - 1) Evaluate, record, and report the patient's response to nursing actions (for example: patient's joints are freely movable within normal range of motion)
 - 2) Modify the plan of care if necessary

D. The pain experience

1. Theoretical framework
 - a. Concepts related to pain (for example: gate control theory, acute vs. chronic pain, pain threshold, endorphins)
 - b. Factors influencing pain (for example: etiology of pain, duration of pain, sensory overload, cultural factors)
 - c. Agents and techniques commonly used to control pain (for example: guided imagery, relaxation, administration of nonnarcotic analgesics, narcotic analgesics, patient-controlled analgesia, placebos, cutaneous stimulation)
2. Nursing care
 - a. Assessment: establish a database concerning pain
 - 1) Gather objective and subjective data (for example: changes in vital signs, facial expression, body language, verbalization by the patient)
 - 2) Assess factors influencing the patient's pain (see IVD1b)
 - b. Diagnosis: identify the patient's actual or potential nursing diagnoses related to pain
 - 1) Analyze and interpret data
 - 2) Identify nursing diagnoses (for example: pain related to recent abdominal surgery)
 - c. Planning: set priorities, identify patient-centered outcomes and select interventions related to pain
 - 1) Set priorities and establish outcomes (for example: patient will report decrease in pain)
 - 2) Incorporate factors influencing pain (see IVD1b)

- 3) Select nursing interventions to help the patient achieve outcomes (for example: position the patient to minimize stress on the incision; administer pain medication on a regular schedule)
- d. Implementation: use nursing interventions to achieve outcomes related to pain
- 1) Use nursing measures to reduce the patient's pain (for example: positioning, cutaneous stimulation, assess the operative site, promote relaxation)
 - 2) Use nursing measures specific to drug classifications for prescribed medications (for example: monitor vital signs for a patient receiving a narcotic analgesic, schedule administration of medications to maximize effectiveness)
 - 3) Instruct the patient regarding pain (for example: use of relaxation techniques, use of guided imagery)
- e. Evaluation: determine the extent to which outcomes have been achieved
- 1) Evaluate, record, and report the patient's response to nursing interventions (for example: patient states that pain has been relieved)
 - 2) Modify the plan of care if necessary

V. Nutrition (10%)

36 hours

Kozier

Ch. 45, Nutrition

A. Theoretical framework

1. Processes of ingestion, digestion, and absorption of nutrients
2. Normal nutritional requirements
 - a. Food Guide Pyramid
 - b. Basic functions and common food sources of carbohydrates, proteins, fats, vitamins, minerals
 - c. Caloric values
3. Common nutritional disturbances (for example: vomiting, heartburn, obesity, anorexia, malnutrition)
4. Factors influencing nutrition
 - a. Individual factors (for example: age, sedentary lifestyle, vegetarian diet, dental status, physical condition, need for assistance with feeding)
 - b. Socioeconomic and cultural factors (for example: income, religion)
 - c. Psychological factors (for example: fad diets, anorexia)
5. Adaptations of normal diet: definitions, foods allowed, and indications for use
 - a. Clear liquid
 - b. Full liquid
 - c. Soft
6. Alternative feeding methods (for example: gavage, gastrostomy)
7. Agents commonly used to promote nutrition (for example: vitamins and minerals)

B. Nursing care

1. Assessment: establish a database concerning nutritional status
 - a. Gather objective and subjective data (for example: weight, height, anorexia)
 - b. Assess factors influencing nutrition (see VA4)
2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to nutrition
 - a. Analyze and interpret data (for example: serum albumin, body weight)
 - b. Identify nursing diagnoses (for example: altered nutrition: less than body requirements related to anorexia)
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to nutrition
 - a. Set priorities and establish outcomes (for example: patient will gain one pound per week until ideal body weight is achieved)
 - b. Incorporate factors influencing nutrition in planning for patient's dietary needs (for example: plan nutritionally adequate diet based on patient's cultural preferences) (see VA4)
 - c. Select nursing interventions to help the patient achieve outcomes related to nutrition
4. Implementation: use nursing interventions to achieve outcomes related to nutrition
 - a. Use nursing measures to increase nutritional intake (for example: assist in food selection, assist in feeding, modify the environment, place the patient in the most appropriate position)
 - b. Use nursing measures appropriate to particular feeding methods (for example: nasogastric tube feedings, gastrostomy tube feedings)
 - c. Use nursing measures specific to drug classifications for prescribed medications (for example: administer liquid iron through a straw)
 - d. Instruct the patient regarding nutrition
5. Evaluation: determine the extent to which outcomes have been achieved
 - a. Evaluate, record, and report the patient's response to nursing interventions (for example: the patient has gained two pounds this week)
 - b. Modify the plan of care if necessary

VI. Elimination (11%)

40 hours

Kozier

Ch. 46, Fecal Elimination

Ch. 47, Urinary Elimination

A. Theoretical framework

1. Urinary elimination
 - a. Anatomy and physiology of urinary tract
 - b. Common disturbances (for example: incontinence, frequency, retention)
2. Intestinal elimination
 - a. Anatomy and physiology of intestinal tract
 - b. Common disturbances (for example: constipation, diarrhea, impaction, flatulence, incontinence)

3. Factors influencing elimination
 - a. Individual factors (for example: age, activity level, dietary habits)
 - b. Environmental factors (for example: privacy)
 - c. Psychological factors (for example: stress)
4. Agents commonly used to promote elimination (for example: laxatives, stool softeners, antidiarrheal agents)

B. Nursing care

1. Assessment: establish a database concerning elimination
 - a. Gather objective and subjective data (for example: changes in normal elimination patterns; color, odor, and consistency of urine and feces)
 - b. Assess factors influencing elimination (see VIA3)
2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to elimination
 - a. Analyze and interpret data (for example: urinalysis, [normal values], frequency of elimination, intake and output, presence of occult blood)
 - b. Identify nursing diagnoses (for example: constipation related to insufficient intake of dietary fiber)
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to elimination
 - a. Set priorities and establish outcomes (for example: patient will have one soft brown stool daily)
 - b. Incorporate factors influencing elimination in planning patient care (for example: the patient is on bed rest) (see VIA3)
4. Implementation: use nursing interventions to achieve outcomes related to elimination
 - a. Use nursing measures to facilitate elimination (for example: perform catheterization, administer enema, administer laxatives and stool softeners, provide appropriate intake, collect specimens, ensure appropriate activity, decrease stress, provide proper positioning, ensure privacy)
 - b. Use nursing measures specific to drug classifications for prescribed medications (for example: administer a laxative at the time that evacuation is desired, encourage the patient to retain the suppository for 15 minutes)
 - c. Instruct the patient regarding elimination (for example: assist patient to plan an exercise program and to increase intake of fluids)
5. Evaluation: determine the extent to which outcomes have been achieved
 - a. Evaluate, record, and report the patient's response to nursing actions (for example: patient reports passing a hard, dry stool)
 - b. Modify the plan of care if necessary

VII. Oxygenation (10%)

36 hours

Kozier

Ch. 48, Oxygenation

A. Theoretical framework

1. Normal respiratory functions
 - a. Anatomy and physiology
 - b. Ventilation, diffusion, and transport
2. Common respiratory disturbances (for example: dyspnea, tachypnea, orthopnea, hypoxia)
3. Factors influencing oxygenation
 - a. Individual factors (for example: fever, activity level, excess secretions)
 - b. Environmental factors (for example: smoking, room ventilation)
 - c. Psychological factors (for example: stress, anxiety)
4. Techniques commonly used to promote oxygenation (for example: administration of oxygen via nasal cannula and face mask, incentive spirometry, chest physiotherapy)

B. Nursing care

1. Assessment: establish a database concerning oxygenation status
 - a. Gather objective and subjective data (for example: skin color, tolerance for activity, vital signs, respiratory status, shortness of breath, confusion, restlessness)
 - b. Assess factors influencing oxygenation (see VIIA3)
2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to oxygenation

- a. Analyze and interpret data (for example: vital signs, hemoglobin, hematocrit [normal values])
 - b. Identify nursing diagnoses (for example: ineffective breathing pattern related to abdominal pain)
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to oxygenation
 - a. Set priorities and establish outcomes (for example: patient will demonstrate increased depth of respiration)
 - b. Incorporate factors influencing oxygenation in planning patient care (for example: pain assessment, anxiety, positioning)
 - c. Select nursing interventions to help the patient achieve outcomes (for example: provide comfort measures, reposition the patient, administer the prescribed analgesic)
 4. Implementation: use nursing interventions to achieve outcomes related to oxygenation
 - a. Use nursing measures to promote oxygenation (for example: turning, deep breathing, and coughing; administering oxygen; nasopharyngeal suctioning; monitoring vital signs; reducing anxiety)
 - b. Use nursing measures appropriate to the method of oxygen administration (humidifiers, oxygen masks, cannula)
 - c. Instruct the patient regarding oxygenation (for example: demonstrate coughing and deep-breathing exercises)

5. Evaluation: determine the extent to which outcomes have been achieved
 - a. Evaluate, record, and report the patient's response to nursing actions (for example: patient's respirations are 12–14/minute, deep and rhythmic)
 - b. Modify the plan of care if necessary

VIII. Fluid and Electrolyte Balance (11%)

40 hours

Kozier

Ch. 50, Fluid, Electrolyte, and Acid-Base Balance

A. Concepts and principles

1. Principles related to fluid and electrolyte balance (for example: composition, regulation, and movement of fluid and electrolytes)
2. Common disturbances of fluid and electrolyte balance
 - a. Hypercalcemia, hypocalcemia
 - b. Hyperkalemia, hypokalemia
 - c. Hyponatremia, hypernatremia
 - d. Hypermagnesemia, hypomagnesemia
 - e. Hypervolemia, hypovolemia
3. Common intravenous fluids
 - a. Lactated Ringer's
 - b. 5% dextrose and water
 - c. Normal saline
 - d. Half saline
4. Factors influencing fluid and electrolyte balance
 - a. Physical status (for example: vomiting, fever, diarrhea, use of diuretics, exercise)
 - b. Environmental factors (for example: temperature, humidity)

B. Nursing care

1. Assessment: establish a database concerning fluid and electrolyte status.
 - a. Gather objective and subjective data (for example: skin turgor, pulse quality, condition of oral mucous membranes, output, weight, edema, muscle weakness, thirst)
 - b. Assess factors influencing fluid and electrolyte status (see VIII A4)
2. Diagnosis: identify the patient's actual or potential nursing diagnoses related to fluids and electrolytes
 - a. Analyze and interpret data (for example: serum electrolyte level, hematocrit [normal values] specific gravity of urine [normal values])
 - b. Identify nursing diagnoses (for example: fluid volume deficit related to insufficient intake)
3. Planning: set priorities, identify patient-centered outcomes and select interventions related to fluids and electrolytes
 - a. Set priorities and establish outcomes (for example: patient's total fluid intake will be 2,500 cc/day)
 - b. Incorporate factors influencing fluid and electrolyte status (for example: establish a pattern of fluid intake based on individual patient preferences) (see VIII A4)
 - c. Select nursing interventions to help the patient achieve outcomes (for example: monitor IV therapy, provide oral fluids)

4. Implementation: use nursing interventions to achieve outcomes related to fluid and electrolyte balance
 - a. Promote fluid and electrolyte balance (for example: assist with food and fluid selection, measure and record intake and output)
 - b. Use nursing measures appropriate to oral and parenteral replacement (for example: establish daily fluid regimen with patient, assist with parenteral administration of fluids [gravity flow and IV infusion pumps], identify signs and symptoms of untoward reactions)
 - c. Instruct the patient regarding fluid and electrolyte requirements (for example: discuss dietary sources of potassium)
5. Evaluation: determine the extent to which outcomes have been achieved
 - a. Evaluate, record, and report the patient's response to nursing actions (for example: patient's 24-hour fluid intake is 2,500 cc)
 - b. Modify the plan of care if necessary

Sample Questions

The questions that follow illustrate those typically found on this examination. These sample questions are included to familiarize you with the type of questions you will find on the examination. The answer rationales can be found on pages 27–30 of this guide.

1. A mentally competent patient refuses an injection. The nurse administers the injection despite the patient's refusal. In this situation, the nurse can be held liable for which offense?
 - 1) assault
 - 2) battery
 - 3) invasion of privacy
 - 4) a misdemeanor
2. Which term describes the rules or principles that govern professional conduct?
 - 1) beliefs
 - 2) ethics
 - 3) morals
 - 4) values
3. A patient is being admitted to the hospital. The nurse notes that the patient's pulse and blood pressure are higher than they were on previous routine office visits. How should the nurse interpret these findings initially?

The findings are indicative of

 - 1) the resistance stage of stress.
 - 2) an autonomic nervous system response.
 - 3) an inflammatory response.
 - 4) the local adaptation syndrome.
4. Which observation is most indicative of a localized infection?
 - 1) diaphoresis
 - 2) fatigue
 - 3) fever
 - 4) swelling
5. Which information in a patient's health history indicates that the patient is at risk for infection?
 - 1) The patient had mumps three years ago.
 - 2) The patient had rubella one year ago.
 - 3) The patient had a tetanus booster 12 years ago.
 - 4) The patient was a year late receiving the polio vaccine.
6. A patient is being discharged with an indwelling urinary catheter. Which instruction should the nurse give to the patient to help prevent a urinary tract infection?
 - 1) Allow the collection bag to fill completely before emptying it.
 - 2) Separate the catheter from the tubing when emptying the collection bag.
 - 3) Clamp the tubing before exercising or ambulating.
 - 4) Position the tubing so the urine flows into the collection bag.
7. Which assessment finding indicates that a hospitalized patient is at risk for physical injury?
 - 1) diminished lung sounds
 - 2) hyperactive bowel sounds
 - 3) weak right hand grasp
 - 4) bilateral +1 ankle edema
8. When administering a medication via the Z-track method, the nurse should include which action?
 - 1) Massage the site following the injection.
 - 2) Give the injection into subcutaneous tissue.
 - 3) Change the needle prior to the injection.
 - 4) Administer the medication rapidly.

9. When administering a medication to a patient with decreased liver function, the nurse should be most concerned with which mechanism of the drug's action?
 - 1) absorption
 - 2) distribution
 - 3) excretion
 - 4) metabolism
10. Which instruction should the nurse give to a patient who uses a bath oil?
 - 1) Be certain to remove all oil residue from the skin.
 - 2) Take precautions to prevent falls in the bathtub.
 - 3) Alternate the use of bath oil with a skin lotion.
 - 4) Use a washcloth to apply the bath oil.
11. To which stage of sleep will a patient return after being awakened for a treatment?
 - 1) the stage from which she was awakened
 - 2) the first stage of sleep
 - 3) the rapid eye movement stage
 - 4) the second stage of sleep
12. A patient is on bed rest. To avoid a complication of immobility, the nurse should give priority to which assessment?
 - 1) activity tolerance
 - 2) bowel sounds
 - 3) lung sounds
 - 4) urinary output
13. Which analgesic is most commonly associated with an increased incidence of gastric bleeding in older adults?
 - 1) acetaminophen (Tylenol)
 - 2) codeine
 - 3) indomethacin (Indocin)
 - 4) meperidine hydrochloride (Demerol)
14. Which measure should the nurse include in the plan of care for a patient who is experiencing pain?
 - 1) Implement pain relief measures before the pain becomes severe.
 - 2) Use the same pain relief measure for each pain experience.
 - 3) Administer pain medications on a predetermined schedule.
 - 4) Encourage the patient to increase the intervals between pain medication requests.
15. Which food is highest in saturated fat?
 - 1) butter
 - 2) margarine
 - 3) olive oil
 - 4) peanut oil
16. Which observation indicates that a patient is responding positively to oxygen therapy?
 - 1) dyspnea
 - 2) eupnea
 - 3) hyperpnea
 - 4) orthopnea
17. Which assessment data should alert the nurse to the likelihood that a patient may be experiencing fluid volume deficit?
 - 1) increased hematocrit
 - 2) leukocytosis
 - 3) distended neck veins
 - 4) peripheral edema
18. When a patient's serum sodium level is 129 mEq/L, the nurse should anticipate an order for which IV fluid?
 - 1) 5% dextrose in water
 - 2) 5% dextrose in 0.45% NaCl
 - 3) 5% dextrose in 0.9% NaCl
 - 4) lactated Ringer's solution

19. The physician orders an IV infusion of 1,000 cc 0.9% NaCl to run over 10 hours. The IV administration set delivers 10 drops per cc. The nurse should regulate the flow rate at how many drops per minute?

- 1) 6 to 7
- 2) 16 to 17
- 3) 25 to 26
- 4) 31 to 32

20. Which instructional technique should maximize independence for a patient who needs to limit sodium in the diet?

- 1) Calculate the actual volume of salt in the patient's usual diet.
- 2) Provide the patient with a list of foods that must be avoided.
- 3) Give the patient a set of written, preplanned, low-sodium menus.
- 4) Explain to the patient how to read and interpret food labels.

Learning Resources for this Exam

The study materials listed below are recommended by Excelsior College as the most appropriate resources to help you study for the examination. For information on ordering from the Excelsior College Bookstore, see the inside front cover of this guide. You may also find resource materials in the libraries of colleges, schools of nursing, medical schools, and hospitals. Public libraries may have some of the textbooks or may be able to obtain them through an interlibrary loan program.

You should allow sufficient time to obtain resources and to study before taking the exam.

Recommended Resources

Kozier, B., Erb, G., Berman, A., & Snyder, S. (2004). *Fundamentals of nursing: Concepts, process, and practice* (7th ed.). Upper Saddle River, NJ: Prentice Hall.

Study Guide:

Barnes, S., & Snyder, S. (2004). *Study guide for Fundamentals of nursing: Concepts, process, and practice* (7th ed.). Upper Saddle River, NJ: Prentice Hall.

Additional Resources

The examination development committee has also suggested the following textbooks which may provide further clarification of the content.

Aschenbrenner, D.S., & Venable, S.J. (2005). *Drug therapy in nursing* (2nd ed.). Philadelphia: Lippincott, Williams and Wilkins.

Kozier, B. et al. (2004). *Techniques in clinical nursing: Basic to intermediate skills* (5th ed.). Menlo Park, CA: Prentice Hall.

Wilkinson, J. (2005). *Nursing diagnosis handbook: With NIC interventions and NOC outcomes* (8th ed.). Redwood City, CA: Prentice Hall.

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See page ii for ordering information.

Rationales for Sample Questions

1.(IA3b)

- 1) Assault is a threat or an attempt to make bodily contact with another person without that person's consent. This nurse actually touched the patient.
- *2) Battery is assault carried out and includes the willful, angry, and violent touching of another person's body or clothes. Administering an injection after a patient has refused it is a classic example of battery.**
- 3) The nurse's action is not an invasion of privacy. An example of invasion of privacy is breach of confidentiality.
- 4) A misdemeanor is a classification of a crime; it is not in itself a type of offense.

2.(IC)

- 1) Beliefs are individually held attitudes and are not the rules of a profession.
- *2) Ethics are the rules or principles that govern professional conduct; ethics are the expected, publicly stated standards of a particular group.**
- 3) Morals are personal standards of right and wrong, not the standards of a group.
- 4) Values are the beliefs of an individual, not the rules of a profession.

3.(IIB)

- 1) The stage of resistance occurs later in an illness, as the body adapts.
- *2) Stress activates the sympathetic nervous system, causing the findings.**
- 3) The inflammatory response is a localized response to tissue injury or infection.
- 4) The local adaptation syndrome occurs when one part of the body responds to an injury.

4.(IIB2a)

- 1) Diaphoresis is a systemic response to fever and infection.
- 2) Fatigue is a systemic response to infection.
- 3) Fever is a systemic response to infection.
- *4) Swelling occurs when blood vessels dilate to increase blood flow to localized infectious agents.**

5.(IIB 1b)

- 1) This would have no effect on a patient's risk for infection.
- 2) See 1).
- *3) A tetanus booster should be repeated every 10 years in adults, so this patient is susceptible to tetanus, that is, at risk for infection.**
- 4) The patient did receive the polio vaccine, even though it was late, so the patient is immune to polio and not at risk for infection.

6.(IIB2c)

- 1) A full bag of standing urine is a medium for bacterial growth.
- 2) The drainage system should remain intact. Breaking the connection allows a portal for bacteria to enter the system.
- 3) Clamping the tubing promotes stasis of urine in the bladder.
- *4) Positioning the tubing correctly promotes drainage and limits urinary stasis, thereby limiting bacterial growth.**

*correct answer

7.(IIB2a)

- 1) Diminished breath sounds place a patient at risk for impaired gas exchange, not physical injury.
- 2) Hyperactive bowel sounds do not place a patient at risk for physical injury.
- *3) A weak right hand grasp indicates the patient has altered mobility, placing the patient at risk for physical injury.**
- 4) Bilateral ankle edema is an indicator of fluid volume excess which does not place a patient at risk for physical injury.

8.(IIC1b)

- 1) Massaging the site following the injection is not recommended because it may force the medication back into the needle track and cause irritation.
- 2) The Z-track method is used for intramuscular injections, not subcutaneous injections.
- *3) Changing the needle prior to the injection ensures that no medication clings to the needle as it is inserted through the subcutaneous tissue into the muscle where it is injected.**
- 4) The medication should not be administered rapidly. It is injected slowly and the needle is allowed to remain in place for 10 seconds after injecting the medication.

9.(IIC2a)

- 1) Absorption is the process by which a drug is transferred from its site of entry to the bloodstream.
- 2) Distribution is the movement of a drug throughout the body. The rate of distribution depends on perfusion and capillary permeability of the drug. Distribution usually does not involve the liver.
- 3) Excretion is the removal of a drug from the body. The kidneys excrete most drugs.
- *4) Metabolism is the breakdown of a drug into inactive form. Liver disease may interfere with this process.**

10.(IID2d)

- 1) A small amount of oil on the skin will help to moisturize.
- *2) Oil is a slippery substance and can cause falls in the bathtub.**
- 3) Alternating the use of bath oil with a skin lotion is personal preference and not a priority instruction for the patient.
- 4) The oil can be applied any way the patient likes. This is not a priority instruction.

11.(IVB1a)

- 1) The patient will not return to the stage from which she was awakened.
- *2) After being awakened, a patient begins the sleep cycle at stage one and progresses through all of the stages.**
- 3) See 2).
- 4) See 2).

12.(IVC1c)

- 1) The inability to endure or complete daily activities is not life threatening.
- 2) Poor gastrointestinal elimination is not life threatening.
- *3) Loss of respiratory functioning may become a serious threat to health.**
- 4) Urinary problems have a lower priority than do pulmonary problems.

13.(IVD1c)

- 1) Tylenol is not associated with gastric bleeding.
- 2) Codeine is a narcotic analgesic and is not associated with gastric bleeding.
- *3) Indocin is a nonsteroidal anti-inflammatory agent (NSAID). NSAIDs have been associated with gastric irritation and bleeding. Indocin is especially difficult to tolerate and should be used cautiously, if at all, in older adults.**
- 4) Demerol is a narcotic analgesic and is not associated with gastric bleeding.

*correct answer

14.(IVD2c)

- *1) Providing an analgesic before the onset of pain is preferable. If the nurse waits for the patient to report pain, a larger dose may be required.
- 2) Pain may vary in intensity from moment to moment and different pain relief measures may be required to control pain.
- 3) The choice of pain relievers is based on the patient's report of pain. Report of mild pain may require a different analgesic than more severe pain.
- 4) Pain therapy should not increase discomfort or harm the patient. In a trusting relationship, the nurse should manage the patient's pain regardless of the time intervals.

15.(VA2b)

- *1) **Butter, being of animal origin, contains saturated fat.**
- 2) Margarine contains monounsaturated fat.
- 3) Olive oil contains monounsaturated fat.
- 4) Peanut oil contains monounsaturated fat.

16.(VIIB1b)

- 1) Dyspnea, feeling short of breath, is not a positive response to oxygen therapy.
- *2) **Eupnea, normal effortless breathing, is a positive response to oxygen therapy.**
- 3) Hyperpnea, an increased depth of respiration, is not a positive response to oxygen therapy.
- 4) Orthopnea, the inability to breathe except in an upright position, is not a positive response to oxygen therapy.

17.(VIIIA1)

- *1) **Loss of fluid makes the blood more concentrated and results in an increased hematocrit.**
- 2) Leukocytosis is an elevated WBC and is evidence of infection, not fluid volume deficit.
- 3) Distended neck veins are an indicator of fluid volume excess.
- 4) Peripheral edema is an indicator of fluid volume excess.

18.(VIIB1b)

- 1) A 5% dextrose in water solution is sodium-free and would not be used for a patient with hyponatremia.
- 2) A 5% dextrose in 0.45% NaCl solution only contains half as much sodium as does normal blood and would not be used for a patient with hyponatremia.
- *3) **A 5% dextrose in 0.9% NaCl solution is normal saline and would provide additional intake of sodium for a patient with hyponatremia.**
- 4) Lactated Ringer's solution is an isotonic solution used primarily for maintaining or replacing volume.

19.(VIIB3b)

- 1) See 2).
- *2) **The standard formula for calculating IV flow rate is:**

$$\frac{\text{volume (mL)} \times \text{drop factor (gtt/mL)}}{\text{time in minutes}}$$

$$\frac{1,000 \times 10}{600} = 16.66$$
- 3) See 2).
- 4) See 2).

*correct answer

20.(VIII B3c)

- 1) Calculating the volume of salt in the patient's diet does not teach the patient how to limit sodium in the diet.
- 2) Giving the patient a list of foods to avoid may provide information regarding food high in sodium, but it does not teach the patient how to read and interpret food labels.
- 3) Giving the patient a set of preplanned menus does not allow for flexibility in the diet and patients often have difficulty complying with strict plans.
- *4) **Sodium is found in many foods and the patient must know how to read and interpret food labels in order to calculate a daily intake. The patient can then include personal preferences in the dietary plan, which should improve compliance with limiting sodium.**

*correct answer

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Notes

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