NUR 133 NURSING DIAGNOSES PREP WORKBOOK

Diagnostic accuracy is as important to safety and quality care as dosage calculation. A recent study revealed that nursing students were having difficulty making good clinical judgments, and this learning activity was developed to aid students in mastering the diagnoses reviewed in Fundamentals of Nursing. Additional will be provided throughout the semester to master clinical judgments in the adult health nursing setting.

The purpose of this booklet is to improve the student's understanding of nursing diagnoses and PES format studied in Fundamentals of Nursing in order to improve diagnostic accuracy and information literacy. Students will use on the Carpenito-Moyet nursing diagnoses text to complete these exercises, Nursing diagnoses identified in this learning activity will be tested at the start of the NUR 133 course next semester. **It would be beneficial to read the preface of the Carpenito-Moyet text and the diagnoses indentified in your book first.**

After you complete these activities, you will need to complete the jeopardy game on the Evolve website that will be available to you after January 16, 2012. Do not attempt complete the Jeopardy game until you have mastered these diagnoses.

Please submit your completed workbook on the first day of lecture. You will need to finish the jeopardy game on Evolve before your first clinical session.

Thank you for giving this assignment your best effort and good luck.

NUR 133 NURSING DIAGNOSIS WORKSHEET
REVIEW OF NUR 101 NANDA-I NURSING DIAGNOSIS REFERENCE LIST

Source: Carpenito-Moyet, Lynda.(2009) Handbook of Nursing Diagnosis, 13th Edition. Lippincott Williams & Wilkins, 9781609138776

ACTIVITY ONE instructions to students: Fill in last two columns. Record only the major defining characteristics for each nursing diagnosis using a current Carpenito-Moyet edition. Study each of the diagnoses for testing.

	Diagnostic Label	Definition	Carpenito-Moyet's author notes	All Major Defining Characteristics (pg #)	List One Minor Defining charact
1.	Activity intolerance	A reduction in one's physiologic capacity to endure activities to the degree desired or required (Magnan, 1987).	Activity Intolerance is a diagnostic judgment that describes a person with compromised physical conditioning. This person can engage in therapies that increase strength and endurance. Activity Intolerance is different than Fatigue. Fatigue is a pervasive, subjective drained feeling. Rest does not relieve fatigue but it will relieve tiredness. For Activity Intolerance, the goal is to increase tolerance to activity; in Fatigue, the goal is to assist the person to adapt to the fatigue, not to increase endurance.		
2.	Anxiety	The state in which an individual or group experiences feelings of uneasiness (apprehension) and activation of the autonomic nervous system in response to a vague, nonspecific threat.	Anxiety is a vague feeling of apprehension and uneasiness from a threat to one's value system or security pattern (May, 1987). The person may be able to identify the situation (e.g., surgery, cancer), but in actuality the threat to self relates to the uneasiness and apprehension enmeshed in the situation. The situation is the source of, but is not itself, the threat. In contrast, fear is the feeling of apprehension over a specific threat or danger to which one's security patterns alert one (e.g., flying, heights, and snakes). When the threat is removed, the fearful feeling dissipates (May, 1987). Fear can exist without anxiety, and anxiety can be present without fear. Clinically, both may coexist in a person's response to a situation. An individual who is facing surgery may be fearful of pain and anxious about a possible cancer diagnosis.		
3.	Ineffective Coping	The state in which the individual experiences or is at risk of experiencing an inability to manage internal or environmental stressors adequately because of inadequate resources (physical, psychological, behavioral, or cognitive).	This diagnosis can be used to describe a variety of situations in which an individual does not adapt effectively to stressors. Examples can be isolating behaviors, aggression, and destructive behavior. If the response is inappropriate use of the defense mechanisms of denial or defensiveness, the diagnosis Ineffective Denial or Defensive Coping can be used instead of Ineffective Coping.		
4.	Situational Low Self Esteem	The state in which an individual who previously had positive self-esteem experiences negative feelings about self in response to an event (loss, change)	Although Situational Low Self-Esteem is an episodic event, repeated occurrences or the continuation of these negative self-appraisals over time can lead to Chronic Low Self-Esteem.		

5.	Disturbed Body Image	The state in which an individual experiences, or is at risk to experience a disruption in the way he/she perceives his/her body.	None		
6.	a. Confusion - Acute	The state in which there is an abrupt onset of a cluster of global, fluctuating disturbances in consciousness, attention, perception, memory, orientation, thinking, sleep-wake cycle, and psychomotor behavior	None		
	b. Confusion - Chronic	A state in which the individual experiences an irreversible, long-standing, and/or progressive deterioration of intellect and personality.	None		
7.	Deficient Knowledge (specify)	The state in which an individual or group experiences a deficiency in cognitive knowledge or psychomotor skills concerning the condition or treatment plan.	Deficient Knowledge does not represent a human response, alteration, or pattern of dysfunction; rather, it is an etiologic or contributing factor (Jenny, 1987). Lack of knowledge can contribute to a variety of responses (e.g., anxiety, self-care deficits). All nursing diagnoses have related client/family teaching as a part of nursing interventions (e.g., Impaired Bowel Elimination, Impaired Verbal Communication). When the teaching relates directly to a specific nursing diagnosis, incorporate the teaching into the plan. When specific teaching is indicated before a procedure, the diagnosis Anxiety related to unfamiliar environment or procedure can be used. When information is given to assist a person or family with self-care at home, the diagnosis Ineffective Self Health Management may be indicated.	Use Ineffective Self Health Management	
8.	Ineffective Health Maintenance	The state in which an individual or group experiences or is at risk of experiencing a disruption in health because of an unhealthy lifestyle or lack of knowledge about managing a condition.	Ineffective Health Maintenance can describe persons who desire to change an unhealthy lifestyle (obesity, tobacco use). Ineffective Self-Health Management can be used for those who need teaching for self-management of a disease or condition.		
9.	Noncompliance	The state in which an individual or group desires to comply, but factors are present that deter adherence to agreed-upon health-related advice given by health professionals.	Noncompliance describes the individual who desires to comply, but the presence of certain factors prevents him or her from doing so. The nurse must attempt to reduce or eliminate these factors for the interventions to be successful. However, the nurse is cautioned against using the diagnosis of Noncompliance to describe an individual who has made an informed, autonomous decision not to participate. Behaviors may be acts of omission or commission and may be intentional or unintentional.		

<table>
<tr><td>10.</td><td>Constipation</td><td>The state in which an individual experiences stasis of the large intestine, resulting in infrequent (two or less weekly) elimination and/or hard, dry feces.</td><td>None</td><td></td><td></td></tr>
<tr><td>11.</td><td>Diarrhea</td><td>The state in which an individual experiences or is at risk of experiencing frequent passages of liquid stool or unformed stool.</td><td>None</td><td></td><td></td></tr>
<tr><td>12.</td><td>Bowel incontinence</td><td>The state in which an individual experiences a change in normal bowel habits characterized by involuntary passage of stool.</td><td>This diagnosis represents a situation in which nurses have multiple responsibilities. Clients experiencing bowel incontinence have various responses that disrupt functioning, such as embarrassment and skin problems related to the irritative nature of feces on skin. For some spinal cord–injured persons, Bowel Incontinence related to lack of voluntary control over rectal sphincter would be descriptive.</td><td></td><td></td></tr>
<tr><td>13.</td><td>Disturbed Sensory Perception</td><td>The state in which an individual/group experiences, or is at risk of experiencing, a change in the amount, pattern, or interpretation of incoming stimuli.</td><td>The diagnosis Disturbed Sensory Perception describes a person with altered perception and cognition influenced by physiologic factors (e.g., pain, sleep deprivation, immobility, and excessive or decreased meaningful stimuli from the environment). Disturbed Sensory Perception results when barriers or factors interfere with a person’s ability to interpret stimuli accurately.
The diagnosis Disturbed Sensory Perception has six subcategories: visual, auditory, kinesthetic, gustatory, tactile, and olfactory. When a person has a visual or hearing deficit, how does the nurse intervene with the diagnosis Disturbed Sensory Perception: Visual related to effects of glaucoma? What would the goals be? The nurse should assess for the individual’s response to the visual loss and specifically label the response, not the deficit.
The diagnosis Disturbed Sensory Perception is more clinically useful without the addition of the specific sense. Examples of responses to sensory deficits may be:
<table>
<tr><td>Visual</td><td>Risk for Injury Self-Care Deficit</td></tr>
<tr><td>Auditory</td><td>Impaired Communication
Social Isolation</td></tr>
<tr><td>Kinesthetic</td><td>Risk for Injury</td></tr>
<tr><td>Olfactory</td><td>Imbalanced Nutrition</td></tr>
<tr><td>Tactile</td><td>Risk for Injury</td></tr>
<tr><td>Gustatory</td><td>Imbalanced Nutrition</td></tr>
</table></td><td></td><td></td></tr>
</table>

14.	a. Excess Fluid Volume	The state in which an individual experiences or is at risk of experiencing intracellular or interstitial fluid overload.	This diagnosis represents situations in which nurses can prescribe definitive treatment to reduce or eliminate factors that contribute to edema or can teach preventive actions. Situations that represent vascular fluid overload should be considered collaborative problems, not nursing diagnoses. They can be labeled Risk for Complications of Congestive Heart Failure or Risk for Complications of Hypervolemia.		
	b. Deficient Fluid Volume	A state in which an individual is at risk for decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration, water loss alone without change of sodium.	If the individual is NPO, refer to the collaborative problem Risk for Complications of Hypovolemia. If the person can drink, refer to Deficient Fluid Volume for interventions.		
15.	Hyperthermia	The state in which an individual has or is at risk of having a sustained elevation of body temperature >37.8° C (100° F) orally or 38.8° C (101° F) rectally because of external factors.	None		
16.	a. Imbalanced Nutrition: more than body requirements	The state in which an individual experiences or is at risk of experiencing weight gain related to an intake in excess of metabolic requirements.	Obesity is a complex condition with sociocultural, psychological, and metabolic implications. This diagnosis, when used to describe obesity or overweight conditions, focuses on them as nutritional problems. The focus of treatment is behavioral modification and lifestyle changes. It is recommended that Ineffective Health Maintenance related to intake in excess of metabolic requirements be used in place of this diagnosis. In addition, Ineffective Coping related to increased food consumption secondary to response to external stressors may be used. When weight gain is the result of physiologic conditions (e.g., altered taste); pharmacologic interventions, such as corticosteroid therapy; or history of excessive weight gain during pregnancy, this diagnosis can be clinically useful.		
	b. Imbalanced Nutrition: less than body requirements	The state in which an individual, who is not NPO, experiences or is at risk for inadequate intake or metabolism of nutrients for metabolic needs with or without weight loss.	This diagnosis describes individuals who can ingest food but have an intake of less-than-adequate amounts. This diagnosis should not be used to describe individuals who are NPO or cannot ingest food. These situations should be described by the collaborative problems of Risk for Complications of Electrolyte Imbalances and Risk for Complications of Negative Nitrogen Balance. In addition, some nursing diagnoses that relate to an individual who is NPO are Risk for Impaired Oral Mucous Membrane and Impaired Comfort.		

17.	Impaired Communication	The state in which an individual experiences or is at high risk to experience difficulty exchanging thoughts, ideas, desires, wants, or needs with others.	Impaired Communication and Impaired Verbal Communication are diagnoses to describe people who desire to communicate but who are encountering problems. Impaired Communication may not be useful to describe a person for whom communication problems are a manifestation of a psychiatric illness or coping problem. If nursing interventions are focusing on reducing hallucinations, fear, or anxiety, the diagnosis of Fear, Anxiety, or Disturbed Thought Processes is more appropriate.		
18.	Impaired Physical Mobility	The state in which an individual experiences or is at risk of experiencing limitation of physical movement but is not immobile.	Impaired Physical Mobility describes an individual with limited use of arm(s) or leg(s) or limited muscle strength. Impaired Physical Mobility should not be used to describe complete immobility; instead, Disuse Syndrome is more applicable. Limitation of physical movement can also be the etiology of other nursing diagnoses, such as Self-Care Deficit or Risk for Injury. Nursing interventions for Impaired Physical Mobility focus on strengthening and restoring function and preventing deterioration.		
19.	Impaired Skin Integrity	The state in which an individual experiences or is at risk for altered epidermis and/or dermis.	See impaired tissue integrity		
20.	Impaired Urinary Elimination	Impaired Urinary Elimination Maturational Enuresis* Functional Incontinence Reflex Incontinence Stress Incontinence Continuous Incontinence Urge Incontinence Urge Incontinence, Risk for Overflow Incontinence*	All of these diagnoses pertain to urine elimination, not urine formulation. Anuria, oliguria, and renal failure should be labeled collaborative problems, such as Risk for Complications of Anuria. Impaired Urinary Elimination represents a broad diagnosis, probably too broad for clinical use. It is recommended that a more specific diagnosis such as Stress Incontinence be used instead. When the etiologic or contributing factors have not been identified for incontinence, the diagnosis can temporarily be written Urinary Incontinence related to unknown etiology		
21.	Impaired Gas Exchange	The state in which an individual experiences an actual or potential decreased passage of gases (oxygen and carbon dioxide) between the alveoli of the lungs and the vascular system.	This diagnosis does not represent a situation for which nurses prescribe definitive treatment. Nurses do not treat Impaired Gas Exchange, but nurses can treat the functional health patterns that decreased oxygenation can affect, such as activity, sleep, nutrition, and sexual function. Thus, Activity Intolerance related to insufficient oxygenation for activities of daily living better describes the nursing focus. If an individual is at risk for or has experienced respiratory dysfunction, the nurse can describe the situation as Risk for Complications of Ineffective Respiratory Function or be even more specific with Risk for Complications of Pulmonary Embolism.		

22.	Ineffective Airway Clearance	The state in which an individual experiences a threat to respiratory status related to inability to cough effectively.	None		
23.	Ineffective Breathing Pattern	The state in which an individual experiences an actual or potential loss of adequate ventilation elated to an altered breathing pattern.	This diagnosis has limited clinical utility except to describe situations that nurses definitively treat, such as hyperventilation. For individuals with chronic pulmonary disease with Ineffective Breathing Patterns, refer to Activity Intolerance. Individuals with periodic apnea and hypoventilation have a collaborative problem that can be labeled Risk for Complications of Hypoxemia to indicate that they are to be monitored for various respiratory dysfunctions. If the person is more vulnerable to a specific respiratory complication, the nurse can write the collaborative problem as Risk for Complications of Pneumonia or Risk for Complications of Pulmonary Embolism. Hyperventilation is a manifestation of anxiety or fear. The nurse can use Anxiety or Fear related to (specify event) as manifested by hyperventilation as a more descriptive diagnosis.		
24.	Insomnia	The state in which a client reports a persistent pattern of difficulty falling asleep and frequent awakening that disrupts daytime life.	See Sleep Pattern, Disturbed ; Sleep Deprivation		
25.	a. Pain- Acute	The state in which an individual experiences and reports the presence of severe discomfort or an uncomfortable sensation lasting from 1 second to <6 months.	The NANDA list contains Acute Pain and Chronic Pain. For clarity and usefulness, the author has organized diagnoses associated with pain and discomfort under two levels: Impaired Comfort • Acute Pain • Chronic Pain		
	b. Pain- Chronic	The state in which an individual experiences pain that is persistent or intermittent and lasts for >6 months.	none		
26.	Risk for Aspiration	The state in which a person is at risk for entry of secretions, solids, or fluids into the tracheobronchial passages.	See risk for injury		

27.	Risk for Falls	The state in which an individual has increased susceptibility to falling.	See risk for injury		
28.	Risk for Injury	The state in which an individual is at risk for harm because of a perceptual or physiologic deficit, a lack of awareness of hazards, or maturational age.	This diagnosis has five subcategories: Risk for Aspiration, Falls, Poisoning, Suffocation, and Trauma. Should the nurse choose to isolate interventions only for prevention of poisoning, then the diagnosis Risk for Poisoning would be useful.		
29.	Risk for Infection	The state in which an individual is at risk to be invaded by an opportunistic or pathogenic agent (virus, fungus, bacterium, protozoan, or other parasite) from endogenous or exogenous sources.	Risk for Infection describes a situation when host defenses are compromised, making the host more susceptible to environmental pathogens. Nursing interventions focus on minimizing introduction of organisms or increasing resistance to infection (e.g., improving nutritional status). If the client has an underlying problem causing infection, consider the collaborative problem, *Risk for the Complication of Sepsis.*		
30.	Self-Care Deficit (specify)	The state in which the individual experiences an impaired motor function or cognitive function, causing a decreased ability to perform each of the five self-care activities.	Self-care encompasses the activities needed to meet daily needs, usually called activities of daily living. Activities of daily living are learned and become life-long habits. Enmeshed in the broad category of self-care activities are tasks that are to be done (hygiene, bathing, dressing, toileting, feeding), how these tasks are done, and when, where, and with whom they are to be done. Self-Care Deficit Syndrome, not currently on the NANDA list, has been added to describe a person with compromised ability in all five self-care activities. The nurse will assess functioning in each of the five areas and identify the level of participation of which the person is capable. The goal will be to maintain that functioning or to increase participation and independence. The syndrome distinction will cluster all five self-care deficits together to provide clustering of interventions when indicated (e.g., to ensure that the individual is wearing the corrective lenses required). It also will permit specialized interventions for one of the five activities e.g., to lay out clothes in the order in which they will be put on by the person). The danger of Self-Care Deficit diagnoses is that the nurse could prematurely label a person as unable to participate at any level. This would eliminate a rehabilitation focus. The nurse must classify the client's functional level to promote independence.		

ACTIVITY TWO INSTRUCTIONS: Match the diagnostic label to the definition. Record the label number in the blank space next to the correct definition.

Label #	Diagnostic Label	Record Label #	Definition
1.	Situational Low Self Esteem		A reduction in one's physiologic capacity to endure activities to the degree desired or required (Magnan, 1987).
2.	Confusion - Chronic		The state in which an individual or group experiences feelings of uneasiness (apprehension) and activation of the autonomic nervous system in response to a vague, nonspecific threat.
3.	Confusion - Acute		The state in which the individual experiences or is at risk of experiencing an inability to manage internal or environmental stressors adequately because of inadequate resources (physical, psychological, behavioral, or cognitive).
4.	Activity intolerance		The state in which an individual who previously had positive self- esteem experiences negative feelings about self in response to an event (loss, change)
5.	Anxiety		The state in which an individual experiences, or is at risk to experience a disruption in the way he/she perceives his/her body.
6.	Ineffective Coping		The state in which there is an abrupt onset of a cluster of global, fluctuating disturbances in consciousness, attention, perception, memory, orientation, thinking, sleep-wake cycle, and psychomotor behavior
7.	Disturbed Body Image		A state in which the individual experiences an irreversible, long-standing, and/or progressive deterioration of intellect and personality.

ACTIVITY TWO INSTRUCTIONS (Continued): Match the diagnostic label to the definition. Record the label number in the blank space next to the correct definition.

Label #	Diagnostic Label	Record Label #	Definition
8.	Excess Fluid Volume	_____	The state in which an individual or group experiences a deficiency in cognitive knowledge or psychomotor skills concerning the condition or treatment plan.
9.	Constipation	_____	The state in which an individual or group experiences or is at risk of experiencing a disruption in health because of an unhealthy lifestyle or lack of knowledge about managing a condition.
10.	Bowel incontinence	_____	The state in which an individual or group desires to comply, but factors are present that deter adherence to agreed-upon health-related advice given by health professionals.
11.	Deficient Fluid Volume	_____	The state in which an individual experiences stasis of the large intestine, resulting in infrequent (two or less weekly) elimination and/or hard, dry feces.
12.	Deficient Knowledge (specify)	_____	The state in which an individual experiences or is at risk of experiencing frequent passages of liquid stool or unformed stool.
13.	Diarrhea	_____	The state in which an individual experiences a change in normal bowel habits characterized by involuntary passage of stool.
14.	Noncompliance	_____	The state in which an individual/group experiences, or is at risk of experiencing, a change in the amount, pattern, or interpretation of incoming stimuli.
15.	Ineffective Health Maintenance	_____	The state in which an individual experiences or is at risk of experiencing intracellular or interstitial fluid overload.
16.	Disturbed Sensory Perception	_____	A state in which an individual is at risk for decreased intravascular, interstitial, and/or intracellular fluid. This refers to dehydration, water loss alone without change of sodium.

ACTIVITY TWO INSTRUCTIONS (Continued): Match the diagnostic label to the definition. Record the label number in the blank space next to the correct definition.

Label #	Diagnostic Label	Record Label #	Definition
17.	Imbalanced Nutrition: more than body requirements	_____	The state in which an individual has or is at risk of having a sustained elevation of body temperature >37.8° C (100° F) orally or 38.8° C (101° F) rectally because of external factors.
18.	Impaired Physical Mobility	_____	The state in which an individual experiences or is at risk of experiencing weight gain related to an intake in excess of metabolic requirements.
19.	Hyperthermia	_____	The state in which an individual, who is not NPO, experiences or is at risk for inadequate intake or metabolism of nutrients for metabolic needs with or without weight loss.
20.	Impaired Urinary Elimination Imbalanced Nutrition: less than body requirements	_____	The state in which an individual experiences or is at high risk to experience difficulty exchanging thoughts, ideas, desires, wants, or needs with others.
21.	Impaired Communication	_____	The state in which an individual experiences or is at risk of experiencing limitation of physical movement but is not immobile.
22.	Pain- Chronic	_____	The state in which an individual experiences or is at risk for altered epidermis and/or dermis.
23.	Pain- Acute	_____	Maturational Enuresis* ,Functional Incontinence, Reflex Incontinence Stress Incontinence ,Continuous Incontinence ,Urge Incontinence Urge Incontinence, Risk for ,Overflow Incontinence*
24.	Imbalanced Nutrition: less than body requirements	_____	The state in which an individual experiences and reports the presence of severe discomfort or an uncomfortable sensation lasting from 1 second to <6 months.
25.	Impaired Skin Integrity	_____	The state in which an individual experiences pain that is persistent or intermittent and lasts for >6 months.

ACTIVITY TWO INSTRUCTIONS (Continued): Match the diagnostic label to the definition. Record the label number in the blank space next to the correct definition.

Label #	Diagnostic Label	Record Label #	Definition
26.	Ineffective Breathing Pattern	_____	The state in which an individual experiences a threat to respiratory status related to inability to cough effectively.
27.	Risk for Infection	_____	The state in which an individual experiences an actual or potential loss of adequate ventilation elated to an altered breathing pattern.
28.	Self-Care Deficit (specify)	_____	The state in which a client reports a persistent pattern of difficulty falling asleep and frequent awakening that disrupts daytime life.
29.	Ineffective Airway Clearance	_____	The state in which a person is at risk for entry of secretions, solids, or fluids into the tracheobronchial passages.
30.	Risk for Injury	_____	The state in which an individual has increased susceptibility to falling.
31.	Insomnia	_____	The state in which an individual is at risk for harm because of a perceptual or physiologic deficit, a lack of awareness of hazards, or maturational age.
32.	Risk for Aspiration	_____	The state in which an individual is at risk to be invaded by an opportunistic or pathogenic agent (virus, fungus, bacterium, protozoan, or other parasite) from endogenous or exogenous sources.
33.	Risk for Falls	_____	The state in which the individual experiences an impaired motor function or cognitive function, causing a decreased ability to perform each of the five self-care activities.

ACTIVITY THREE INSTRUCTIONS: Read the scenario and select the correct diagnostic label; nursing diagnosis or collaborative problem (RC:). You do not need to enter the complete diagnostic statement. Record your answer in the space provided.

		Answer (see choices in instructions)
1.	The client scheduled for surgery expresses concern about the upcoming event.	
2.	The client is incontinent of stool following an acute stroke.	
3.	The client admitted to a long term care facility is bedfast and unable to turn or feed himself.	
4.	The client gains 20 lbs over after 2 months while taking large doses of prednisone for the treatment of an autoimmune disease.	
5.	The client experiences an impaired gag reflex following sedation for a surgical procedure.	
6.	The client develops shortness of breath when walking to the bathroom and performing ADLs.	
7.	The client experiencing pneumonia can't cough up the mucus and becomes short of breathe.	
8.	The client with chronic lung disease develops tachypnea and shortness of breath. The pulse oximetry has decreased on room air.	
9.	The client is NPO after major abdominal surgery and is unable to eat for a week.	
10.	The client whose IV site has become reddened and painful develops a high temperature and change in mental status.	
11.	The older client is forgetful and drinks only one liter of fluids daily.	
12.	The client experiences edema as a result of a worsening heart condition,	
13.	The client recently fired from their job, shows up for work on what would have been his next scheduled day as if nothing had happened.	

ACTIVITY FOUR INSTRUCTIONS: Read the scenario and select the correct PES format; 3 part-actual (has major defining characteristics); 2-part risk (needs major defining characteristics), one part-syndrome (has data that does not require an AEB statement). Record you answer in the space provided.

		Answer (see choices in instructions)
14.	The client scheduled for surgery expresses concern about the upcoming event.	
15.	The client is incontinent of stool following an acute stroke.	
16.	The client admitted to a long term care facility is bedfast and unable to turn or feed himself.	
17.	The client gains 20 lbs over after 2 months while taking large doses of prednisone for the treatment of an autoimmune disease.	
18.	The client experiences an impaired gag reflex following sedation for a surgical procedure.	
19.	The client develops shortness of breath when walking to the bathroom and performing ADLs.	
20.	The client experiencing pneumonia can't cough up the mucus and becomes short of breathe.	
21.	The client with chronic lung disease develops tachypnea and shortness of breath. The pulse oximetry has decreased on room air.	
22.	The client is NPO after major abdominal surgery and is unable to eat for a week.	
23.	The client whose IV site has become reddened and painful develops a high temperature and change in mental status.	
24.	The older client is forgetful and drinks only one liter of fluids daily.	
25.	The client experiences edema as a result of a worsening heart condition,	
26.	The client recently fired from their job, shows up for work on what would have been his next scheduled day as if nothing had happened.	

ACTIVITY FIVE INSTRUCTIONS: Read the scenario and select the correct class of etiology or related to statement based on the information provided. Use the Carpenito –Moyet text to determine the class as one of the following; pathophysiologic, treatment-related, situational, maturational. Record you answer in the space provided.

Answer (see choices in instructions)

27. The client scheduled for surgery expresses concern about the upcoming event. _____

28. The client is incontinent of stool following an acute stroke. _____

29. The client admitted to a long term care facility is bedfast and unable to turn or feed himself. _____

30. The client gains 20 lbs over after 2 months while taking large doses of prednisone for the treatment of an autoimmune disease. _____

31. The client experiences an impaired gag reflex following sedation for a surgical procedure. _____

32. The client develops shortness of breath when walking to the bathroom and performing ADLs. _____

33. The client experiencing pneumonia can't cough up the mucus and becomes short of breathe. _____

34. The client with chronic lung disease develops tachypnea and shortness of breath. The pulse oximetry has decreased on room air. _____

35. The client is NPO after major abdominal surgery and is unable to eat for a week. _____

36. The client whose IV site has become reddened and painful develops a high temperature and change in mental status. _____

37. The older client is forgetful and drinks only one liter of fluids daily. _____

38. The client experiences edema as a result of a worsening heart condition, _____

39. The client recently fired from their job, shows up for work on what would have been his next scheduled day as if nothing had happened. _____

Congratulations! You are now ready to progress to the Jeopardy game on Evolve!!!!