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# Nclex-Rn Study Guide (Quick Study Academic)

WORLD OF ACADEMIC OUTLINE  
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## NCLEX-RN Study Guide

Assessment, prognosis, & medical, care models, ethics, preventive care, nutrition, pain management, change education, medication education, CME & differential, medication journal, documentation & more

### COMPONENTS OF THE NURSING PROCESS

- Assessment:** The process by which a nurse recognizes the physical, psychosocial, and spiritual needs of a patient through the collection of subjective and objective data.
- Analysis (aka diagnosis):** For data collected during the assessment phase are analyzed to determine the plan of care.
- Planning:** The data from the assessment and analysis phases are used to develop measurable goals and outcomes for nursing interventions.
- Implementation:** The nursing interventions are put into practice.
- Evaluation:** The outcomes of the nursing interventions are measured.

### BASIC HEAD-TO-TOE ASSESSMENT

- General:** Assess general appearance and behavior, posture, gait, hygiene, speech, mental status, height and weight, hearing and vision, and vital signs and reflexes.
- Head and neck:** Assess skull size, shape, and consistency; hair, and scalp. Palpate for masses or tenderness, fontanelles, and neck. Palpate sinuses for tenderness and masses. Inspect vision and coordination. Assess pupal response (see PERRL). A pupal response to eye light does not determine a new object, pupal (accidental), accommodation (the extent of the peripheral field), and correct light reflex. Inspect and palpate mouth and gums. Test color of nails and gum reflex. Assess sense of smell and taste. Check range of motion (ROM) in neck and shoulders. Palpate lymph nodes for tenderness and swelling, mediastinal size, and depth for masses.
- Upper extremities:** Inspect skin, nail capillary refill, palpate peripheral pulses, and muscle strength, assess ROM, and check deep tendon reflexes.
  - Rothmann flexion:** Inspect sites for alignment, assess interphalangeal joint flexion, assess distal range of motion, palpate for tenderness, auscultate brachial, radial, and ulnar pulses, palpate for tenderness, and palpate for tenderness.
- Anterior thorax:** Observe respiratory pattern, palpate respiratory excursion, auscultate breath sounds, percuss chest sounds, inspect jugular veins, and perform breast exam.
- Abdomen:** Auscultate for bowel sounds, inspect the umbilicus and tenderness, palpate the liver and spleen, and palpate the kidneys.
- Lower extremities:** Inspect skin, palpate peripheral pulses, assess for Homan's sign, inspect and palpate for swelling, assess for pitting and edema, and assess ROM.

### ASSESSMENT TECHNIQUES

#### Inspection

Inspection is the careful examination of the patient as a whole, as well as each body system, using the visual, auditory, and olfactory senses to gather information. Inspection:

- Looks at color, shape, symmetry, and position of body parts.
- Should be purposeful and systematic; body parts should be compared bilaterally throughout the entire examination.
- Requires good lighting to visually inspect the body without distortion or shadows.

#### Palpation

Palpation is the technique of using touch to gather information about temperature, turgor, texture, location, size, shape, consistency, location, and tenderness of an organ or body part.

- Palpation can be **light** (the application of pressure by depressing the skin and underlying structures approx. 1 inch).
- The dominant hand is used as the working hand by exerting a deep downward motion against so that the tip of the middle finger of the dominant hand rests the joint of the middle finger on the nondominant hand.
- There are five types of percussion sounds:
  - Tympanic:** Loud, drumlike sound.
  - Resonance:** Moderate to loud, low-pitched, hollow sound.
  - Hyperresonance:** Very loud, low-pitched, booming sound.
  - Flattness:** Soft, high-pitched, flat sound.
  - Dullness:** Soft to moderate, high-pitched, flat sound.

#### Percussion

Percussion is the art of striking one object with another to create sounds to assess the location, size, and density of underlying tissues. The sound changes as you move from one area to the next. Percussion is done with the middle finger of the dominant hand tapping on the middle finger of the nondominant hand while the nondominant palm is on the body.

- The nondominant hand is placed on the area to be percussed, with fingers slightly separated.
- The dominant hand is used as the working hand by exerting a deep downward motion against so that the tip of the middle finger of the dominant hand rests the joint of the middle finger on the nondominant hand.
- There are five types of percussion sounds:
  - Tympanic:** Loud, drumlike sound.
  - Resonance:** Moderate to loud, low-pitched, hollow sound.
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Percussion Sound	Normal Causes	Pathologic Causes
Tympanic	Abdomen	Emphysema
Resonance	Chest	Healthy lung
Hyperresonance	Chest	COPD, asthma, pneumothorax
Flattness	Head (skull)	Skull fracture, skull fracture
Dullness	Liver or heart	Organ, pneumonia, tumor, pleural effusion

#### Auscultation

Auscultation is the art of listening to sounds produced by the body using a stethoscope. Auscultation is performed for the purposes of examining the circulatory system, respiratory system, and gastrointestinal system.

- Stethoscopes must be calibrated for proper identification and evaluation.
- The stethoscope has a diaphragm, which detects high-pitched sounds, and a bell, which detects low-pitched sounds best.
- Four characteristics of sounds should be noted: pitch, location, quality, and duration.

### SYSTEMS ASSESSMENT

#### Integumentary

- Inspect skin for color, texture, size, and lesions. Palpate with the back of the hand for temperature, moisture, and texture. Note any abnormal findings (skin color on lower extremities, such as with irregular borders, lesions, rashes, bruising, swelling, high or low temperature).
- Inspect hair for distribution and presence of head lice.
- Inspect nails for lesions.
- Inspect teeth for color, texture, normal, symmetry, and capillary refill. Note any abnormal findings (white spots, pitting, ridges, chipping, recession, slow capillary refill).

#### Cardiovascular

- Inspect heart sounds.
- Auscultate the carotid arteries using the ball of the stethoscope.
- Listen for heart sounds. Note any abnormal findings (murmurs, gallops, clicks, rubs).
- Palpate pulses (carotid, radial, brachial, femoral, popliteal, posterior tibial, dorsalis pedis).
- Assess feet for coolness, turgor, capillary refill, edema, pulses, dependent rubor.

#### Respiratory

- Inspect skin color and observe level of consciousness.
- Look for signs of respiratory distress (trachea, pulled in breathing, accessory muscle use, nasal flaring, retractions).
  - Evaluate rate, depth, and rhythm of breathing.
- Palpate for tracheal deviation, egophony, crackles, and equal thoracic expansion.
- Pericardial friction rub may indicate myocardial infarction (presence of fluid or edema may indicate pleural effusion, pneumonia, or tumor).
- Listen to breath sounds. Note any abnormal breath sounds (adventitious sounds, crackles, wheezes, rales, rhales).

#### Gastrointestinal (GI)

- Inspect mouth for lesions, irritation, or lesions.
- Check gag reflex.

#### Genitourinary (GU)

- Assess urinary output and output.
- Ask about potentially abnormal urinary symptoms (urgency, pain with urination, pelvic pain, back pain, nocturia, dysuria, incontinence). Assess in urine, albumin, or staining or changing urinary stream, pain in urination, leaking or feeling of full bladder after voiding.
- Inspect genitalia for discharge, lesions, swelling, sores, bumps, lesions, and edema.
- Ask about pain during intercourse, history of sexually transmitted diseases, and recurrent history (menstrual, irregularity, duration, flow, dyspareunia).

#### Musculoskeletal

- Inspect each extremity bilaterally for symmetry.
- Inspect each joint for size, position, motion, and deformities.
- Palpate each extremity for edema.
- Perform ROM tests of the extremities bilaterally (shoulders, elbows, wrists, fingers, hips, knees, ankles, toes).
- Test ROM of the spine by asking the patient to bend forward and touch his/her toes.

#### Types of Musculoskeletal Pain

- Acute pain:**
  - Is sharp, stinging, and constant.
  - Is unrelated to movement unless further injury occurs.
- Chronic pain:**
  - May be related to posture or occur with movement.
  - Is unrelated to movement unless further injury occurs.

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## Synopsis

Taking the NCLEX-RN is a turning point in any nursing student's education, so it is no wonder that many nursing students stress about studying for the exam. Let BarCharts help you prepare with our NCLEX-RN Study Guide, an essential tool for exam preparation. Following the same clutter-free format as our best-selling Nursing guide, the NCLEX-RN Study Guide can help you reach your goal of becoming a registered nurse.

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Tons of information crammed neatly into a few pages, laminated to refer back to once I pass boards. Definitely worth the few dollars!!!

Very basic information but pertinent to basic nursing.

Great study Tool and I can put it in my Binder

Really good review, very compact. Helped me

I love these kind of cheat sheets, it is jam packed with lots of good information. Great to use as a study guide especially if you can't carry heavy books everywhere. ..would recommend

Nice quality, nice and thick and fit into my clinical notebook nicely. Lots of info on these! Wow!!

Thank you!

Very helpful

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