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# Nclex-Rn Study Guide (Quick Study Academic)

**Quick Study Academic**

**NCLEX-RN Study Guide**

Assessment, planning & evaluation, care, medical, safety, preventative care, nutrition, pain management, dosage calculations, pharmacology, infection, CNA & LPN/PN, medications, safety, documentation & more

**COMPONENTS OF THE NURSING PROCESS**

- Assessment:** The process by which a nurse gathers data about a patient through the collection of subjective and objective data.
- Analysis & Diagnosis:** The data collected during the assessment process is analyzed to determine the patient's health status.
- Planning:** To determine the nursing interventions that are necessary to meet the patient's needs.
- Implementation:** The nursing interventions are put into practice.
- Evaluation:** The outcome of the nursing interventions are assessed.

**BASIC HEAD-TO-TOE ASSESSMENT**

- General:** Assess general appearance and behavior, personality, hygiene, speech, mental status, height and weight, hearing and vision, skin, and nails.
- Head and neck:** Assess the head, neck, and face for symmetry, tone and color. Palpate for masses on the scalp, ears, face, neck, and neck. Palpate for masses on the neck, ears, face, neck, and neck. Assess for tenderness and masses. Tympanic membranes and reflexes. Assess for respiratory rate, rhythm, and rate. Check range of motion (ROM) in neck and shoulder. Assess lymph nodes for tenderness and swelling, reaches for past history of lymphoma.
- Upper extremities:** Inspect skin, test capillary refill, palpate peripheral pulses, take blood pressure, assess ROM, and assess for edema.
- Posterior thorax:** Inspect skin for alignment, assess anteroposterior to lateral thorax, assess ribcage, palpate posterior, palpate heart, lungs, assess for tenderness, and assess for tenderness.
- Abdomen:** Assess for bowel sounds, assess the rectum and rectum for tenderness, assess for tenderness and pain.
- Lower extremities:** Inspect skin, test capillary refill, swelling, assess for venous signs, inspect and palpate joints for swelling, assess for tenderness and pain, and assess ROM.

**ASSESSMENT TECHNIQUES**

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

- Locate skin, shape, symmetry, and position of body parts
- Look for proportional and symmetric body parts should be compared bilaterally throughout the entire examination
- Inspect for symmetry and position of body parts
- Inspect for lighting to visually inspect the body without distortion or shadow.

**Palpation:** Palpation is the technique of using touch to gather information about temperature, texture, tone, mobility, and tenderness of an organ or body part.
 

- Palpation should be applied to the skin and underlying structures (e.g., tendons) in a slow, rhythmic, sweeping motion.
- The patient should be provided with privacy, and the nurse should have bare hands and clean fingernails. Any area of tenderness should be palpated last.
- Using palpation, the nurse can assess consistency of tissue, alignment and structure of structures, symmetry of body parts, and transmission of fine vibrations.

**Percussion:** Percussion is the art of striking one object with another to create sounds—such as the location, size, and density of underlying tissue. The sound frequency may vary from one area to another. Percussion is done with the middle finger of the dominant hand on the middle finger of the patient's hand while the thumb rests on the middle finger of the patient's hand.
 

- The non-dominant hand is placed on the area to be percussed, with fingers slightly separated.
- The dominant hand is used as the striking hand by moving a sharp downward stroke, so that the tip of the middle finger of the dominant hand strikes the joint of the middle finger on the non-dominant hand.
- Two types of sounds are produced:
  - Transepithelial: High-pitched, hollow sound
  - Resonant: Moderate to low-pitched, hollow sound
- Hyporesonant: Very low-pitched, hollow sound
- Dullness: Non-pitched sound
- Hyperresonance: High-pitched, clear sound

**Percussion Results & Potential Causes:**

Percussion Result	Where Normally Heard	Potential Cause
Hyperresonant	All areas	Normal, healthy lungs
Resonant	Abdomen	Normal, healthy liver
Hyporesonant	Left	Large, solid mass, e.g., tumor
Dullness	Abdomen	Abdominal organ, e.g., liver, kidney, ascites
Hyperdullness	Uterus in heart	Organ, pregnancy, tumor, fibroid, fibrosis

**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.
 

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

**SYSTEMS ASSESSMENT**

**Integumentary:**

- Inspect skin for color, texture, tone, and lesions. Palpate with the back of the hand for temperature, moisture, and texture. Note any abnormal findings (e.g., skin or tissue color, tone, texture, tone, with irregular borders, lesions, masses, bleeding, elevation, high or low temperature).
- Inspect skin for tenderness and presence of hair loss.
- Inspect skin for edema, swelling, and presence of hair loss.
- Inspect skin for color, texture, tone, and lesions with skin. Note any abnormal findings (e.g., skin or tissue color, tone, texture, tone, with irregular borders, lesions, masses, bleeding, elevation, high or low temperature).
- Inspect skin for color, texture, tone, and lesions with nail. Note any abnormal findings (e.g., skin or tissue color, tone, texture, tone, with irregular borders, lesions, masses, bleeding, elevation, high or low temperature).

**Cardiovascular:**

- Assess heart rate, rhythm, and degree of consciousness.
- Assess the carotid arteries using the back of the stethoscope.
- Listen for carotid bruits (bleeding or occluding vessels).
- Assess for heart sounds. Note the presence of murmurs, gallops, clicks, rubs.
- Palpate jugular veins, radial, brachial, femoral, popliteal, posterior tibial, dorsal pedis.
- Assess for tachycardia (rhythm, regularity, rate), bradycardia (rhythm, regularity, rate), and arrhythmia (rhythm, regularity, rate).

**Respiratory:**

- Assess heart rate, rhythm, and degree of consciousness.
- Look for signs of respiratory distress (cyanosis, grunting by breathing, accessory muscle use, nasal flaring, tachypnea).
- Evaluate rate, depth, and rhythm of breathing.
- Evaluate for crackles, wheezes, and rales.
- Palpate for trachea, mediastinum, and chest wall for tenderness, crepitus, and edema.
- Palpate for trachea, mediastinum, and chest wall for tenderness, crepitus, and edema.
- Assess for respiratory distress (cyanosis, grunting by breathing, accessory muscle use, nasal flaring, tachypnea).
- Listen to breath sounds. Note any abnormal breath sounds (dysrhythmias, stridor, wheezes, rales, stridor).

**Gastrointestinal (GI):**

- Inspect mouth for lesions, irritations, or lesions.
- Check for rectal prolapse.

**Types of Masses/Indicators:**

- Skin:**
  - Is dry, scaling, and crusted.
  - Is tender to touch or movement when skin is present.
- Muscle:**
  - May be relaxed or tense or occur with movement.

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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 "fluff-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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Perfect tool for any novice nursing student. Hits the high points on many areas. Get this before you start nursing school. **ESPECIALLY** for 6\$

They also come with 3 punch holes to allow it to be in a binder which is **EXTREMELY** helpful!

Sturdy and nicely laminated as well. Great info that is going to help a lot through nursing school.

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

Very basic information but pertinent to basic nursing.

writing is very small.

Very helpful

good

Not bad, pretty handy all in all.

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