Stage 1 pressure ulcer	Intact skin with nonblanchable redness
Stage 2 pressure ulcer	Partial loss of dermis. Shallow open ulcer, usually shiny, or dry. Red-pink wound bed without sloughing or bruising.
Stage 3 pressure ulcer	Full thickness tissue loss, subcutaneous fat may be visible. Possible undermining and tunneling.
Stage 4 pressure ulcer	Full thickness tissue loss with exposed bone, tendon,or muscle. Slough or eschar may be present as well as undermining and tunneling.
Unstageable pressure ulcer	Full thickness tissue loss, wound base covered by slough and eschar therefor dull depth cannot be determined.
Slough	Fibrous tissue in wound bed that can be yellow, tan, gray, green, or brown.
Nursing interventions to prevent pressure unlcers	Reposition bed bound pt every two hours, instruct pt in wheelchair to shift their weight every hour. Use of cushions and barrier cream. Manage moisture, optimize nutrition and hydration.
Cognition	All the processes involved in human thought
External nutrition	Nutrition support via tube feedings
Parenteral nutrition	Nutrition supplied intravenously
DRI	Refers to a set of nutritional based values that serve for both assessing and planning diets
Three ways to confirm proper NG placement	Chest x-ray, PH test gastric contents, air bolus.
With tube feeding what must be monitored daily	I/O, daily weight, daily labs

Fatal risk of dysphagia	Aspiration pneumonia
Nectar thickened	A little slower of the spoon than water
Honey thickened	Very much slower off the spoon than water
Spoon thickened	Will not drop off spoon
Puréed	Pudding consistency such as mashed potatoes, vegetables, pasta in pudding consistency
Mechanical soft	All foods except hard, crunchy, or sticky
Dysphagia advanced	Includes moist and soft foods such as cooked cereal, canned fruit, noodles in sauce.
Cold therapy NC	Recommended for first 24-48 hours after injury. Do not apply to red or blue areas. Check condition of skin every 5 minutes when using electrical cooling device.
What color should the contents be when aspirating an NG tube	Green, brown, or tan
Caution with digital impaction removal	Cardiac patients
How many enemas should you do in a row	Until everything comes out clear, no more than 3
HILDA	Pain assessment: how does pain feel? Intensity? Location? Duration? Aggregating or alleviating factors?
The fifth vital sign	Pain
Organ that inacativates and metabolizes drugs	Liver
Organ that eliminates the metabolites of the drug from the body	Kidneys
AC	Before meals
PC	After meals

Used to treat inflammatory responses- decreases edema, muscle spasms, pain, and decreases blood flow to the area.	Cold and Heat Therapy
when is cold and heat therapy recommended for an injury	first 24 to 48 hours
whose responsibility is it to evaluate proper application, adverse signs and symptoms and is also responsible for the patient's safety	LPN
where should you not apply a cold pack to	red or blue areas
how often should you check the skin of a patient who is using an electrical cooling device or an electrical heating device	every 5 minutes
what are common symptoms when using an electrical cooling device	numbness and tingling
How long should you leave a cooling device in place	15 to 20 minutes
what are some adverse skin reactions when using a cooling device	mottling, redness, burning, blistering and numbness
what should you record when using a cooling device or heating device	what device you used, location, duration, patient response, patient teaching and patients response to teaching
when should you immediately stop application of a cooling device	areas become mottled, red or blue/purple, or if the patient Is complaining of pain/numbness
when should you immediately stop application of a heating device	skin becomes reddened and sensitive to touch, extreme warmth noted at the area, and body part becomes painful to move
How long should you leave the heating device in place	20 to 30 minutes or as prescribed

whose responsibility is it to assess skin areas prior to applications of heating and cooling device and assess for risks	LPN
what is one of the nurse's highest priority of care	prevention and treatment of skin impairment
how often should you reposition a chair bound patient	every hour
how often should you reposition a patient that is bed bound	every 2 hours at a 30 degree angle
whose responsibility is it to properly collect a culture of the pressure ulcer	nurse
how do you properly label a specimen	patients name, medical record number, date of birth, date and time of collection, what the collection is for, your name and initials. send as quickly as possible to the lab
what are anaerobic collections of	inside of body cavities
what are aerobic collections of	wound secretions
occurs when the tissue layers of skin slide on each other , causing subcutaneous blood vessels to kink or stretch resulting in an interruption of blood flow to the skin	shearing force
the rubbing of skin against another surface produces what	friction
what are the 2 mechanical factors that play a common role in the development of pressure ulcers	shearing force and friction
which patients are at risk for pressure ulcers	chronically ill, debilitated, older, disabled, or incontinent patients, patients with spinal cord injuries, circulatory impairment or poor overall nutrition
how can the nurse assess a patients skin for skin impairment	blanching the area