MEDICAL-SURGICAL NURSING II · STUDY GUIDE

Exam 7 Study Guide

This guide covers the last two chapters. You will learn to score function, move patients without injuring anyone, fit and teach every walking device, predict what a spinal cord injury level leaves behind, and treat autonomic dysreflexia in the right order. Then you will learn the legal and ethical skeleton of end-of-life care, the drugs that make dying comfortable, the signs that death is near, and how brain death and donation are handled. Work one chapter at a time. Read the "what to know" paragraphs, study the tables, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts the rules and numbers in one place.

WHAT THIS GUIDE COVERS

- Chapter 13 · the rehab team and settings (IRF, SNF, LTACH, home health), ADLs and IADLs, Barthel, FIM and Section GG, TUG and Berg, charting assist levels, delegation, weight-bearing orders, gait belts and safe patient handling, fitting canes, walkers and crutches, gait patterns and stairs, falls, spinal and neurogenic shock, retained function by level, ASIA scale and cord syndromes, autonomic dysreflexia, neurogenic bladder and bowel, immobility complications, spasticity and baclofen, chronic illness and caregivers.
- Chapter 14 · ethical principles, capacity and its four abilities, the surrogate hierarchy and standards, living will, DPOA and POLST, DNR language, withholding versus withdrawing, time-limited trials, opioids and equianalgesic math, dyspnea, secretions, terminal delirium, double effect and palliative sedation, nutrition at the end of life, hospice rules, signs of imminent death, pronouncement and postmortem care, brain death and the apnea test, organ donation and decoupling, moral distress.

CHAPTER 13

Rehabilitation, Mobility and Chronic Illness

Read it in full: **Chapter 13 in the textbook**. Practice it in the lab: **Autonomic Dysreflexia: Sit Him Up First** and **Before the First Step: Transfers, Fitting and Gait**.

What to know

Rehabilitation is graded in **function**, not cure. The nurse is the one discipline present 24 hours a day and carries therapy into daily life. An **inpatient rehabilitation facility** needs a patient who can take about 3 hours of therapy a day, 5 days a week, from two or more disciplines; a **skilled nursing facility** gives about 1 to 2 hours a day for slower, frailer patients. Score function: ADLs (bathing, dressing, toileting, transferring, continence, feeding), IADLs (which fail first), Barthel (0 to 100), **FIM** (18 items scored 1 to 7, total 18 to 126; the 5-to-4 line separates hands-off from hands-on help), TUG (12 seconds or more is fall risk). Chart distance, device, helpers, assist level and why you stopped.

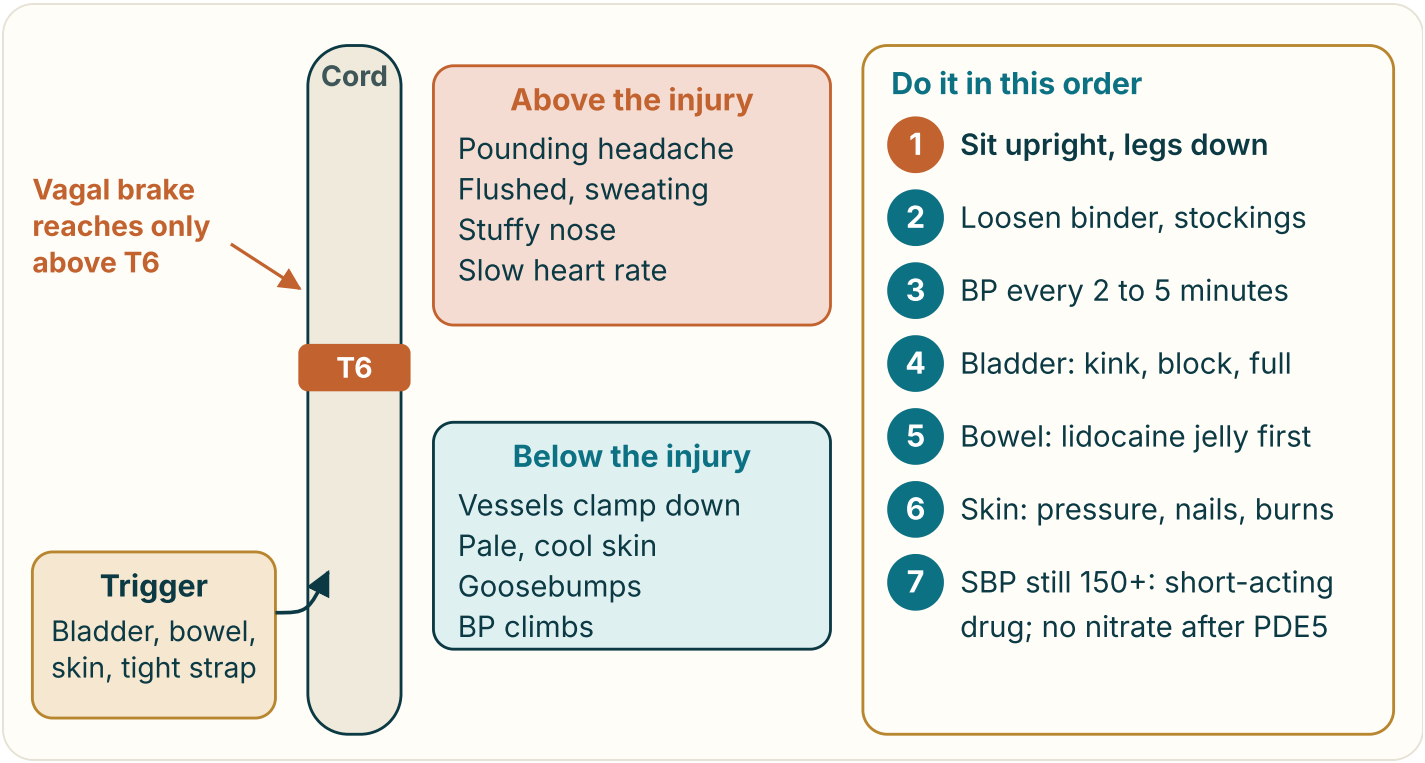
Before mobilizing, check the weight-bearing order (non-weight-bearing means the foot never touches the floor), orthostatic vital signs, hemoglobin, glucose, pain timing and the environment (bed low, brakes locked, non-skid footwear, chair on the **strong side**). The gait belt goes at the waist with two fingers of slack. **Never lift by the axillae.** The manual lifting limit is about 35 lb; use lifts and slide sheets. If a patient falls, ease them down and assess before moving them.

Fit devices at the wrist crease (20 to 30 degrees of elbow flexion). The **cane** goes in the hand opposite the weak leg; cane and weak leg move together. A walker is never used on stairs. Axillary crutch pads sit 2 to 3 finger widths (1.5 to 2 inches) below the axilla; weight goes through the hands. Gaits: four-point (most stable), two-point, **three-point** (one leg non-weight-bearing), swing-through. Stairs: **up with the good, down with the bad.**

In spinal cord injury, **spinal shock** is temporary flaccid areflexia and says nothing about prognosis. **Neurogenic shock** (T6 and above) is hypotension with bradycardia and warm dry skin; hemorrhage is hypotension with tachycardia and cool clammy skin, so rule it out first. MAP target about 85 to 90 for the first week. Levels: C3 to C5 keep the diaphragm; C4 may wean from the ventilator; C6 tenodesis grasp; **C7 is the independence level** (triceps); T6 and above risk autonomic dysreflexia. ASIA A is complete; any sacral sparing means incomplete. Central cord: arms worse than legs.

Autonomic dysreflexia (T6 or above): a noxious stimulus below the lesion drives a huge rise in blood pressure with bradycardia, pounding headache, flushing and sweating above the lesion, pale

goosebump skin below. **Sit the patient up first**, loosen everything tight, check BP every 2 to 5 minutes, then search bladder, bowel (lidocaine jelly first), skin. If systolic stays at or above about 150, a short-acting antihypertensive (no nitrates after a PDE5 inhibitor). Bladder: clean intermittent catheterization every 4 to 6 hours with volumes under about 400 to 500 mL and fluid about 2 L a day. Reflexic bowel: suppository plus digital stimulation 20 to 30 minutes after a meal. Sudden worse spasticity is a symptom: look for a trigger. Abrupt intrathecal baclofen withdrawal (fever, rebound spasticity, confusion) is an emergency.



Sit up first, then hunt the trigger. The blood pressure is judged against the patient's own low baseline. Bladder first, bowel second, skin third.

LOCK THESE IN

- IRF needs about 3 h of therapy a day, 5 days a week. SNF about 1 to 2 h.
- FIM 1 to 7 per item, 18 to 126 total; 5 = supervision, 4 = minimal assist.
- Gait belt at the waist; never lift by the axillae; manual limit about 35 lb.
- Cane opposite the weak leg; walker never on stairs; crutch pads 2 to 3 fingers below the axilla.
- Stairs: up with the good, down with the bad.
- Neurogenic shock: low BP, slow pulse, warm dry skin. Hemorrhage: low BP, fast pulse, cold clammy skin.
- C4 diaphragm; C6 tenodesis; C7 independence; T6 and above dysreflexia.
- Dysreflexia: sit up first, loosen, then bladder, bowel, skin. CIC volumes under 400 to 500 mL.

Key terms and comparisons: retained function by level

Level	Key muscle	Practical function
C1 to C3	Neck muscles only	Ventilator dependent; sip-and-puff chair; total assist
C4	Diaphragm, trapezius	May wean from ventilator; head control; power chair
C5	Deltoid, biceps	Feeds with mobile arm support; dependent for transfers
C6	Wrist extensors	Tenodesis grasp; slide-board transfers with assist; hand-control driving
C7 to C8	Triceps, finger flexors	Independent transfers, manual chair, most ADLs
T1 to T6	Full arms and hands	Independent self-care; autonomic dysreflexia risk
T7 to T12	Abdominals, trunk	Good trunk control and cough
L1 to L4	Hip flexors, quadriceps	Braces and crutches; functional walking by L3 to L4
S2 to S4	Bowel, bladder, sexual reflexes	Walking preserved; flaccid bowel and bladder

Key terms and comparisons: devices and gaits

Device or gait	For whom	Sequence
Cane	Mild one-sided weakness	Cane in opposite hand; cane and weak leg, then strong leg
Walker	Bilateral weakness, partial weight bearing	Walker, weak leg, strong leg; never on stairs
Four-point	Weak but weight bearing both legs	Right crutch, left foot, left crutch, right foot
Two-point	Partial weight bearing both legs	Crutch with opposite foot together
Three-point	One leg non-weight-bearing	Both crutches and affected leg, then strong leg
Stairs	All except walker	Up: strong leg first. Down: device and weak leg first

Worked cases

WORKED CASE 1 · THE C5 PATIENT WITH A HEADACHE

Mr. Achterberg, C5 ASIA A, has a pounding headache, BP 202/112 (baseline 94/58), heart rate 44, flushed sweating face and goosebumps on his legs. His indwelling catheter has drained nothing for four hours.

STEP 1 · NAME IT

Autonomic dysreflexia: a rise of about 108 systolic over his own baseline, with bradycardia and the split body.

STEP 2 · POSITION

Sit him bolt upright with legs down. Gravity is the fastest antihypertensive.

STEP 3 · LOOSEN

Remove the abdominal binder, stockings and leg-bag straps; recheck BP every 2 to 5 minutes; call for help.

STEP 4 · BLADDER FIRST

Check the tubing for kinks; irrigate gently with 10 to 15 mL warm saline or replace the blocked catheter; drain slowly.

STEP 5 · IF BP STAYS HIGH

If systolic stays at or above about 150, a short-acting agent per order; ask about PDE5 inhibitors before any nitrate. Monitor 2 hours after resolution.

WORKED CASE 2 · FITTING AND TEACHING CRUTCHES

Ms. Varga had ORIF of the right ankle and is non-weight-bearing on the right. She will go home to a house with four front steps.

STEP 1 · FIT

Axillary pads 2 to 3 finger widths (1.5 to 2 inches) below the axilla; handgrips at the wrist crease (20 to 30 degrees of elbow flexion); tips about 6 inches to the side and 6 inches forward.

STEP 2 · CHOOSE THE GAIT

Three-point: both crutches and the right leg forward together, then the left leg swings through. The right foot never touches.

STEP 3 · TEACH STAIRS UP

Strong left leg steps up first, then crutches with the right leg.

STEP 4 · TEACH STAIRS DOWN

Crutches with the right leg go down first, then the strong left leg.

STEP 5 · WARN

Weight through the hands, never the armpits, or crutch palsy follows.

WORKED CASE 3 · THE BLADDER VOLUMES

Mr. Fenwick, T10, does intermittent catheterization every 6 hours. Volumes are 620 to 700 mL.

STEP 1 · COMPARE TO THE LIMIT

Volumes should stay under about 400 to 500 mL. These are too high.

STEP 2 · EXPLAIN THE HARM

Overdistension raises bladder pressure, drives reflux, infection and stones, and can trigger dysreflexia in higher injuries.

STEP 3 · CHANGE THE PLAN

Catheterize every 4 hours and spread about 2 L of fluid evenly, tapering in the evening. Do not just use a bigger catheter.

STEP 4 · CONSIDER DRUGS

Ask whether an antimuscarinic or mirabegron is indicated for detrusor overactivity.

TRAPS PEOPLE FALL INTO

- **Laying a patient flat during autonomic dysreflexia.** It worsens the hypertension. Sit them up first.
- **Lifting a hemiplegic patient under the arms.** It injures the brachial plexus and the shoulder. Use a gait belt or a lift.
- **Holding the cane on the weak side.** The cane goes in the hand opposite the weak leg.
- **Calling an injury complete before checking sacral sparing.** Any S4 to S5 sparing means incomplete, with a better prognosis.
- **Raising baclofen for suddenly worse spasticity.** Look for the trigger first: bladder, bowel, skin, infection, fracture.

Chapter 13 self-test · ten items

1. Which patient best fits an inpatient rehabilitation facility?

A. A patient who is homebound with a caregiver
B. A patient weaning from a ventilator after sepsis
C. A frail 90-year-old who tires after 20 minutes
D. A stroke survivor who can do 3 hours of therapy a day

D. A stroke survivor who can do 3 hours of therapy a day IRF requires tolerance of about 3 hours of therapy a day from two or more disciplines.

2. A patient does 60% of a transfer while the nurse does the rest. What is the FIM score?

A. 4, minimal assistance
B. 5, supervision or set-up
C. 3, moderate assistance
D. 2, maximal assistance

C. 3, moderate assistance Moderate assistance means the patient does 50 to 74 percent of the effort.

3. Which transfer technique is unsafe?

A. Using a gait belt snug at the waist
B. Lifting the patient under the arms to stand
C. Blocking the weak knee with your knee
D. Placing the chair on the strong side

B. Lifting the patient under the arms to stand Lifting by the axillae injures the brachial plexus and shoulder.

4. A patient with left leg weakness uses a cane. Which teaching is correct?

A. Hold it in the right hand and move it with the left leg
B. Hold it in the right hand and move it with the right leg
C. Hold it in either hand and move it after both legs
D. Hold it in the left hand and move it with the left leg

A. Hold it in the right hand and move it with the left leg The cane goes opposite the weak leg and advances with it.

5. A patient on crutches must go down stairs. What leads?

A. Both legs step down together, then crutches
B. The crutches go first, then the strong leg
C. The crutches and the weak leg go down first
D. The strong leg steps down first, then crutches

C. The crutches and the weak leg go down first Down with the bad: device and weak leg first.

6. A trauma patient with a T3 injury has BP 80/46, heart rate 50 and warm dry skin. What is likely?

A. Neurogenic shock
B. Cardiogenic shock
C. Hemorrhagic shock
D. Septic shock

A. Neurogenic shock Hypotension with bradycardia and warm dry skin fits neurogenic shock. Still rule out bleeding.

7. What is the lowest usual injury level for independent transfers and a manual wheelchair?

A. C5, because of the biceps
B. C7, because of the triceps
C. T6, because of the intercostals
D. C4, because of the diaphragm

B. C7, because of the triceps Triceps allow push-ups, transfers and wheelchair propulsion.

8. A C6 patient has BP 190/104, heart rate 48 and a pounding headache. What is first?

A. Lay the patient flat and raise the legs
B. Give nifedipine before anything else
C. Insert a rectal finger to check stool
D. Sit the patient upright with the legs down

D. Sit the patient upright with the legs down Autonomic dysreflexia: sit up first, then loosen clothing and find the trigger.

9. A patient on intermittent catheterization drains 650 mL each time. What should change?

A. Accept the volumes as safe for this patient
B. Catheterize more often, about every 4 hours
C. Use a larger catheter size for each one
D. Drink more fluid in the evening hours

B. Catheterize more often, about every 4 hours Volumes should stay under about 400 to 500 mL.

10. A patient with a baclofen pump has fever, severe rebound spasticity and confusion. What is likely?

A. Intrathecal baclofen withdrawal
B. An allergic reaction to the pump
C. A simple urinary tract infection
D. Expected spasticity at night

A. Intrathecal baclofen withdrawal Abrupt withdrawal mimics sepsis and can kill. Escalate, interrogate the pump, bridge with oral baclofen.

CHAPTER 14

End-of-Life Care, Ethics and Complex Decisions

Read it in full: **Chapter 14 in the textbook**. Practice it in the lab: **Capacity, Surrogates and the Three Standards** and **The Directive Desk: Which Document Governs**.

What to know

Six principles do most of the ethical work: autonomy, beneficence, nonmaleficence, justice, veracity and fidelity. **Capacity** is a clinical, decision-specific, time-specific judgment; **competence** is a legal status set by a court. Test four abilities: **understand**, **appreciate**, **reason**, **express a stable choice**. An unwise decision is not incapacity. Fix reversible problems first (pain,

hypoxia, glucose, retention, drugs, hearing loss). The nurse contributes and documents; the provider makes the formal determination.

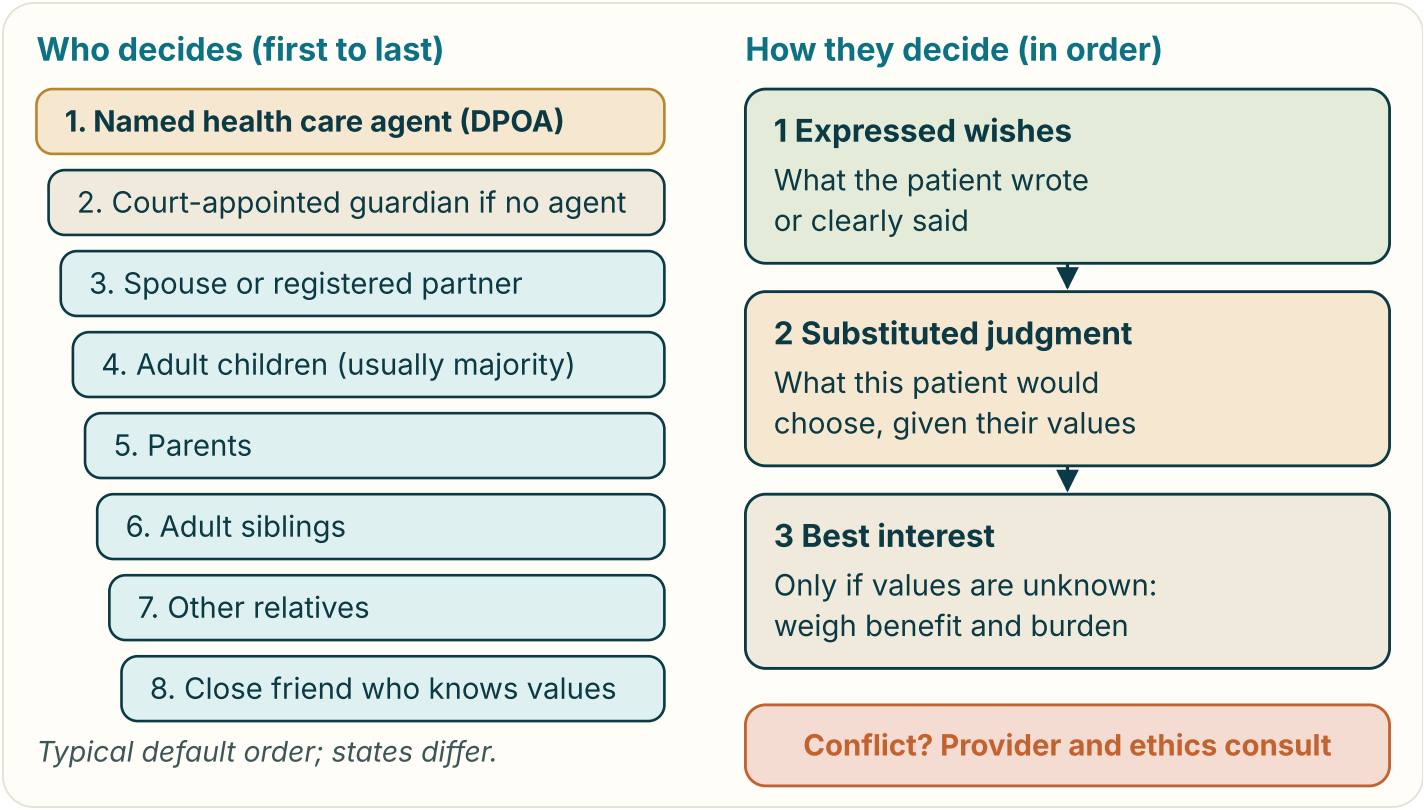
When capacity is lost, a named **health care agent** (DPOA) decides; otherwise the state hierarchy, usually spouse, adult children, parents, siblings. Standards in order: the patient's **expressed wishes**, then **substituted judgment** (what this patient would choose), then **best interest** only if values are unknown. A **living will** states wishes and applies only after capacity is lost; a **POLST** is a signed portable order that EMS can follow. DNR means no compressions or defibrillation, nothing else. **Withholding and withdrawing** are ethically and legally equal, which makes time-limited trials with set endpoints safe to start.

At the end of life, opioids are titrated to the symptom with no ceiling. Know the equivalents: oral morphine 30 mg = IV morphine 10 mg = oral oxycodone 20 mg = oral hydromorphone 7.5 mg = IV hydromorphone 1.5 mg. Reduce by 25 to 50% when rotating; breakthrough is 10 to 15% of the 24-hour dose every 1 to 2 hours. Avoid morphine in renal failure. **Dyspnea**: low-dose opioid, a fan to the face, oxygen only if hypoxemic. **Secretions**: reposition, reduce fluids, glycopyrrolate; avoid deep suction. **Terminal delirium**: check bladder, bowel and drugs first, then haloperidol. Mouth care hourly.

The **doctrine of double effect** allows an act with a foreseen but unintended harm when the act is good or neutral, the intent is the good effect, the harm is not the means, and the reason is proportionate. Titrated opioids do not measurably shorten life. Palliative sedation for refractory symptoms is not euthanasia, which is illegal in the United States. **Hospice** needs two physicians certifying a prognosis of 6 months or less; periods of 90, 90, then 60 days; four levels of care (routine, continuous, general inpatient, respite up to 5 days); bereavement support for 13 months. Signs of hours to days: mottling from the knees, cool limbs, narrowed pulse pressure, anuria, Cheyne-Stokes breathing, terminal secretions.

Brain death is legal death. Prerequisites: a known irreversible cause, core temperature 36 C or higher, systolic 100 or higher, no sedatives or blockade. Then no brainstem reflexes and a positive **apnea test** (PaCO2 60 or more, or a rise of 20 above baseline, with no breathing effort). Spinal reflexes may still move a limb. Vegetative state is wakefulness without awareness and is alive. Notify the **organ procurement organization** early for every imminent death; **decouple** the death

news from the donation request, which a trained requestor makes. For a medical examiner case, leave all lines and tubes in. Moral distress is knowing the right action and being blocked; name it, and use ethics consults and debriefs.



The surrogate speaks for the patient, not for themselves. Ask the family "what would she say if she could hear all this?" State default orders vary, and disputes go to the ethics committee rather than being settled at the bedside.

LOCK THESE IN

- Capacity: understand, appreciate, reason, express a stable choice. Unwise is not incapacity.
- Surrogate order: named agent, then statutory hierarchy. Standards: wishes, substituted judgment, best interest.
- Living will = wishes; POLST = portable order EMS can follow. DNR means no CPR, not no care.
- Withholding = withdrawing. Time-limited trials need endpoints and a date.
- PO morphine 30 = IV morphine 10 = PO oxycodone 20 = PO hydromorphone 7.5 = IV hydromorphone 1.5.
- Dyspnea: opioid plus fan; oxygen only if hypoxemic. Secretions: glycopyrrolate, reposition; no deep suction.
- Hospice: 6-month prognosis by 2 physicians; respite up to 5 days; bereavement 13 months.
- Brain death: prerequisites, absent brainstem reflexes, apnea test. Refer to OPO early; decouple.

Key terms and comparisons: the three documents

Feature	Living will	DPOA for health care	POLST / MOLST
What it is	Statement of wishes	Appointment of an agent	Signed portable medical orders
Who it is for	Every adult	Every adult	Seriously ill or frail (prognosis about a year)
Takes effect	After capacity is lost and conditions are met	After capacity is lost	Immediately, in every setting
EMS can act on it	No	No	Yes
Travels with patient	Rarely	Rarely	Yes

Key terms and comparisons: end-of-life symptom drugs

Symptom	First-line	Monitor
Pain	Mu opioid (morphine, hydromorphone, fentanyl)	Symptom score, sedation, breathing, bowels, myoclonus
Dyspnea	Low-dose opioid; fan; oxygen only if hypoxemic	Air hunger report, accessory muscles, respiratory rate
Secretions	Glycopyrrolate 0.2 mg SC; scopolamine; atropine drops	Rattle, family distress; scopolamine and atropine can cause delirium
Terminal delirium	Haloperidol 0.5 to 2 mg after reversible causes	Agitation, extrapyramidal signs
Opioid constipation	Senna with or without docusate; methylnaltrexone if refractory	Last BM; never methylnaltrexone with obstruction
Anxiety	Lorazepam 0.5 to 1 mg	Paradoxical agitation in older adults

Worked cases

WORKED CASE 1 · ROTATING AN OPIOID

Mrs. Delacourt takes oral morphine 120 mg a day for cancer pain. She can no longer swallow and has worsening kidney function. The team plans IV hydromorphone. Worked calculation example only.

STEP 1 · FIND THE EQUIVALENT

Oral morphine 30 mg = IV hydromorphone 1.5 mg. 120 / 30 x 1.5 = 6 mg IV hydromorphone a day.

STEP 2 · REDUCE FOR CROSS-TOLERANCE

Cut 25 to 50%: 3 to 4.5 mg a day, about 0.125 to 0.19 mg per hour by infusion.

STEP 3 · PLAN BREAKTHROUGH

10 to 15% of the 24-hour dose, offered every 1 to 2 hours as needed, then titrate to the symptom.

STEP 4 · WHY ROTATE

Morphine metabolites build up in renal failure and cause sedation, myoclonus and pain sensitivity.

STEP 5 · MONITOR

Symptom score, sedation, breathing pattern, myoclonus, bowels.

WORKED CASE 2 · WHO DECIDES

Mr. Ibanez, 80, has advanced dementia and pneumonia. He has no named agent. His wife died; his two adult sons disagree about a feeding tube. A neighbor says he "never wanted machines."

STEP 1 · CONFIRM INCAPACITY

The provider makes and documents the formal determination.

STEP 2 · FIND THE SURROGATE

No agent, no spouse: adult children decide, usually by majority. The neighbor is not first in line.

STEP 3 · APPLY THE STANDARD

Ask what their father would have chosen (substituted judgment). The neighbor's report is useful evidence of his values.

STEP 4 · SHARE THE EVIDENCE

In advanced dementia, tube feeding does not prolong life or prevent aspiration. Offer careful hand feeding and mouth care.

STEP 5 · ESCALATE THE CONFLICT

Disagreement goes to the provider and an ethics consult, not to a bedside ruling.

WORKED CASE 3 · THE CONFLICTING CODE STATUS

Mr. Alvarado arrives with a signed POLST (DNR, comfort-focused). The admission orders say full code. His pressure is now 84/50 and respiratory rate 30.

STEP 1 · SEE THE RED FLAG

A valid portable order conflicts with the admission orders.

STEP 2 · ESCALATE NOW

SBAR to the provider to reconcile code status before he arrests.

STEP 3 · DO NOT DECIDE ALONE

Neither document "wins" on your own authority.

STEP 4 · MEANWHILE

Treat his symptoms; DNR or not, a rising respiratory rate still gets assessed and managed.

TRAPS PEOPLE FALL INTO

- **Treating DNR as "do not treat."** DNR covers compressions and defibrillation only. Antibiotics, surgery and rapid response still apply.
- **Believing withdrawing is worse than withholding.** They are equivalent; this is what makes time-limited trials possible.
- **Putting oxygen on a dyspneic, non-hypoxemic dying patient.** A fan and a low-dose opioid help; oxygen helps only with hypoxemia.
- **Deep suctioning terminal secretions.** It stimulates more secretions and distress. Reposition, reduce fluids, glycopyrrolate.
- **Asking the family about donation yourself.** Refer to the OPO; a trained requestor asks, decoupled from the death news.

Chapter 14 self-test · ten items

1. A patient restates his diagnosis, knows he will likely die without surgery and refuses it based on his values. How should the nurse view this?

A. His daughter may overrule him if she disagrees
B. He needs a court ruling before refusing care
C. He shows capacity; an unwise choice is not incapacity
D. He lacks capacity, since he refuses needed care

C. He shows capacity; an unwise choice is not incapacity Understanding, appreciation, reasoning and a stable choice are present.

2. A patient lacks capacity and named no agent. Her husband and adult daughter disagree. Who usually decides?

A. The daughter, as next of kin
B. The attending physician
C. The hospital ethics chair
D. The husband, as spouse

D. The husband, as spouse Without a named agent, the spouse usually ranks first in statutory hierarchies.

3. Paramedics are called to the home of a frail man who has stopped breathing. Which paper on the refrigerator can they legally follow?

A. A living will
B. A signed POLST form
C. A family member's letter
D. A health care proxy form

B. A signed POLST form A POLST is a portable medical order; the others are directives.

4. A patient has a DNR order and develops a rising respiratory rate. What should the nurse do?

A. Assess and call a rapid response as needed
B. Call the family before assessing
C. Take no action, since the patient is DNR
D. Stop all of the current medications

A. Assess and call a rapid response as needed DNR means no compressions or defibrillation; other care continues.

5. A dying patient is short of breath with an SpO2 of 95% on room air. Which plan is best?

A. Deep suctioning every hour as needed
B. A benzodiazepine as the only treatment
C. High-flow oxygen by non-rebreather mask
D. Low-dose opioid, upright position and a fan

D. Low-dose opioid, upright position and a fan Opioids and a fan relieve dyspnea; oxygen helps only if hypoxemic.

6. A patient takes oral morphine 90 mg a day. What is the equivalent IV morphine dose before any reduction?

A. 45 mg a day
B. 30 mg a day
C. 9 mg a day
D. 90 mg a day

B. 30 mg a day Oral 30 = IV 10, a 3:1 ratio.

7. A family is upset by loud rattling breaths. What is the best intervention?

A. Apply oxygen by face mask at 10 L/min
B. Increase the IV fluids to thin secretions
C. Reposition to the side and give glycopyrrolate
D. Deep suction the airway every 30 minutes

C. Reposition to the side and give glycopyrrolate Repositioning and an antimuscarinic help; deep suction and extra fluids make it worse.

8. Which finding most suggests death within hours to days?

A. Mottling spreading up from the knees
B. A brief burst of energy last week
C. Sleeping more over several weeks
D. Eating less over the past month

A. Mottling spreading up from the knees Mottling with cool limbs signals the last hours to days.

9. During an apnea test, which result supports brain death?

A. SpO2 falls to 84% and the test is stopped
B. PaCO2 reaches 62 mmHg with one small breath
C. PaCO2 rises to 48 mmHg with no breathing effort
D. PaCO2 reaches 62 mmHg with no breathing effort

D. PaCO2 reaches 62 mmHg with no breathing effort Apnea is confirmed at a PaCO2 of 60 or 20 above baseline with no effort.

10. After a brain death determination, the family asks about donation. What should the nurse do?

A. Answer briefly and bring in the OPO coordinator
B. Say donation is not possible after brain death
C. Tell them it is what the patient would want
D. Make the request now while the family is here

A. Answer briefly and bring in the OPO coordinator A trained requestor handles the request; the nurse does not make it alone.

ONE PAGE

Cram sheet

One page of rules and numbers for both chapters. Cover the right column and say each rule out loud.

Rehabilitation and spinal cord injury

Item	Rule or value
Settings	IRF about 3 h/day x 5 days, 2+ disciplines; SNF about 1 to 2 h/day
FIM	1 to 7 per item; 18 to 126; 7 independent, 4 minimal (75%+), 3 moderate (50 to 74%), 1 total
TUG and Berg	TUG 12 s or more fall risk; Berg under about 45 fall risk
Transfers	Gait belt at waist, 2 fingers slack; never axillae; manual lift limit about 35 lb
Devices	Wrist crease, 20 to 30 degrees elbow flexion; crutch pads 1.5 to 2 in below axilla
Gaits	Four-point stable; three-point for NWB leg; up with the good, down with the bad
Shock	Neurogenic: low BP, low HR, warm dry skin; MAP 85 to 90 first week; no phenylephrine
Levels	C3 to C5 diaphragm; C6 tenodesis; C7 independence; T6+ dysreflexia
Dysreflexia	Sit up, loosen, BP every 2 to 5 min, bladder, bowel, skin; drug if SBP stays 150+
Bladder	CIC every 4 to 6 h, volumes under 400 to 500 mL, fluid about 2 L/day
Bowel	UMN: suppository plus digital stimulation 20 to 30 min after a meal; LMN: manual removal

End of life

Item	Rule or value
Capacity	Understand, appreciate, reason, express choice; decision and time specific
Surrogates	Agent, then spouse, adult children, parents, siblings; wishes, substituted judgment, best interest
Documents	Living will (wishes); DPOA (person); POLST (orders EMS follows)
Opioids	PO morphine 30 = IV 10 = PO oxy 20 = PO HM 7.5 = IV HM 1.5; cut 25 to 50% on rotation
Breakthrough	10 to 15% of 24-h dose every 1 to 2 h
Secretions	Glycopyrrolate 0.2 mg SC; reposition; no deep suction
Hospice	Prognosis 6 months or less; 90, 90, then 60-day periods; respite up to 5 days; bereavement 13 months
Brain death	Temp 36 C+, SBP 100+, no sedatives; apnea PaCO2 60 or +20 with no effort
Donation	Notify OPO early; decouple; trained requestor asks
ME case	Leave lines, tubes and devices in; do not wash

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